The Gerontologist
Vol. 47, No. 5, 604–612

Clinical Evidence in Guardianship of Older Adults Is Inadequate: Findings From a Tri-State Study

Jennifer Moye, PhD,[1] Stacey Wood, PhD,[2] Barry Edelstein, PhD,[3]
Jorge C. Armesto, PhD,[1] Emily H. Bower, MS,[3]
Julie A. Harrison, MA,[2] and Erica Wood, JD[4]

Purpose: This preliminary study compared clinical evaluations for guardianship in three states with varying levels of statutory reform. ***Design and Methods:*** Case files for 298 cases of adult guardianship were reviewed in Massachusetts, Pennsylvania, and Colorado, three states with varying degrees of statutory reform. The quality and content of the written clinical evidence for guardianship and the hearing outcome were recorded. ***Results:*** The quality of the written clinical evidence for guardianship was best in Colorado, the state with the most progressive statutory reform, earning a grade of B in our ratings, and worst in Massachusetts, a state with minimal reform, earning a grade of D – with nearly two thirds of the written evidence illegible. Information on specific functional deficits was frequently missing and conclusory statements were common. Information about the individual's key values and preferences was almost never provided, and individuals were rarely present at the hearing. Limited orders were used for 34% of the cases in Colorado, associated with more complete clinical testimony, but such orders were used in only 1 case in either Massachusetts or Pennsylvania. ***Implications:*** In this study, states with progressive statutes that promote functional assessment are associated with increased quality of clinical testimony and use of limited orders. A continuing dialogue between clinical and legal professionals is needed to advance reform in guardianship, and thereby provide for the needs and protect the rights of adults who face guardianship proceedings.

Clinical evaluations of capacity are often the primary evidence supplied to the courts in guardianship hearings for older adults. Although guardianship is intended to be protective, it results in substantial losses of individual autonomy and rights. In the eyes of the law, the guardian essentially stands for the protected person and is empowered to make all life decisions—including those of a most personal nature. Ideally, clinicians provide documentation of both cognitive and functional abilities in order to allow the courts evidence that may be used to craft effective guardianship orders. Unfortunately, the existing research on clinical evaluations for adult guardianship suggests that these evaluations may not provide such data. Our goal, with this preliminary project, is to examine the quality of clinical evaluations present in guardianship cases in three states that vary in terms of statutory reform.

Concerns about guardianship have been raised since the 1970s, including limited due process, lack of protection of rights, poor interface between medical providers and the court, and overly paternalistic interventions (Horstman, 1975; Mitchell, 1978). There is limited empirical study of adult guardianship. In early studies (Alexander & Lewin, 1972; Blenkner, Bloom, Nielson, & Weber, 1974), concerns were raised that guardianship, although usually well meaning, often benefited the guardian more than the ward and could hasten institutionalization for the

This work was funded by the Charles H. Farnsworth Trust. We thank Kelly Petersen, David Dicenso, and Ross Davis for their assistance in data collection and coding. Kelly Petersen was also instrumental in examining oral testimony in Pennsylvania. We thank Judge Rebecca Bromley for her facilitation of file access in Colorado. We are also grateful to the court staff members in Massachusetts, Pennsylvania, and Colorado, who were very accommodating to data-collection efforts at their sites. We are thankful to Daniel Marson and Charles Sabatino, and to the ABA-APA Assessment of Capacity in Older Adults Working Group for their supportive and incisive discussions about the topic of capacity over the years. Dr. Stacey Wood is now at Scripps College.

Address correspondence to Jennifer Moye, VA Medical Center, 940 Belmont Street, Brockton, MA 02301. E-mail: jennifer.moye@va.gov
[1]VA Boston Healthcare System and Harvard Medical School, Boston, MA.
[2]Department of Psychology, University of Colorado at Colorado Springs.
[3]Department of Psychology, West Virginia University, Morgantown.
[4]American Bar Association, Commission on Law and Aging, Washington, DC.

protected person. A later study (Lisi, Burns, & Lussenden, 1994) involving the observation of hearings and an examination of court files found that hearings were extremely brief, did not rely upon medical testimony, and often resulted in plenary orders (that is, orders transferring all rights and powers to guardians). In comparison with other older adults, those at risk for guardianship are older, more likely to suffer dementia, to have physical or emotional limitations, and to have limited social supports (Reynolds, 2002; Reynolds & Wilber, 1997).

State statutes for guardianship have undergone significant reform over the past 20 years to enhance due-process protections and match statutory definitions of decision-making capacity to more contemporary understandings of brain and behavior. Some states have made minor revisions; other states major revisions; and still others have replaced their guardianship statutes entirely, frequently based on the Uniform Guardianship and Protective Proceedings Act (UGPPA; National Conference of Commissioners on Uniform State Laws, 1997). The UGPPA is consistent with reforms recommended by national organizations concerned with guardianship, including the use of clinical evaluation to sensitively assess functional strengths and weaknesses by "a physician, psychologist, or other individual appointed by the court who is qualified to evaluate the respondent's alleged impairment" (§5-306). National organizations and UGPPA recommend that orders be linked to retained abilities ("limited guardianship"); that less restrictive alternatives to guardianship be fully explored before its use; and that the allegedly incapacitated person attend the hearing unless excused by court for good cause. The thrust of limited guardianship is to foster autonomy and maintain opportunity to make independent choices, which is critical in promoting mental health (Quinn, 2004).

There is little empirical study of whether statutory reform impacts the use of limited guardianship, or when and whether limited guardianship is preferable. In a seminal report, statutory language on limited guardianship in Iowa and Missouri did not increase the actual use of limited guardianship (granted 1% of the time postreform in Iowa, and 2% of the time in Missouri; $n = 766$; see Keith & Wacker, 1992). The authors noted that few petitions were denied or diverted to less restrictive alternatives, and they expressed concern that statutory reform at the state level may not alter guardianship practice by local courts. However, some concern has been raised that limited guardianship may place a burden on the courts that has to be balanced with possible benefit to the ward, especially if powers are overly restricted (Kotyk-Zalisko, 1996).

In most states, a critical piece of evidence used to establish the need for a guardian is the report of evaluation by a health care professional. A limited body of research suggests that capacity evaluation in adult guardianship may be suboptimal. An early study (1987–1988; $n = 63$) found capacity evaluation to be "sketchy" and "conclusory" in examination of case files in Ohio and Washington (Bulcroft, Kielkopf, & Tripp, 1991). Most of the orders were plenary (93%) and wards were rarely present at hearings (3%). A later study (1996–1999; $n = 119$) concluded that capacity evaluations in adult guardianship were "substandard" in West Virginia and Pennsylvania. Although most of the evaluations had some description of cognitive functioning, they did not usually describe emotional functioning and activities of daily living (ADLs) or instrumental activities of daily living (IADLs; see Dudley & Goins, 2003). In these cases, 92% of the orders were plenary and the ward was present 18% of the time. Recent work by a joint panel of the American Bar Association and the American Psychological Association recommends that clinicians document key clinical indicators such as the individual's neurological or psychiatric diagnoses, cognitive abilities, functional abilities, values, and preferences (American Bar Association Commission on Law and Aging and American Psychological Association, 2006).

In summary, incapacity and the associated use of guardianship proceedings is a rising concern for older adults with neurocognitive or neuropsychiatric illness. The guardianship reform movement has encouraged reforms to protect vulnerable adults, including the use of functional evaluation then tied to limited guardianship orders. At this point, however, the extent of reform varies widely by state, and we know little from an empirical standpoint about the impact of reform on guardianship proceedings.

In this preliminary study we aimed to compare three states that have undertaken varying degrees of statutory reform on the quality of clinical assessments for guardianship and the use of limited guardianship orders for allegedly incapacitated persons in three states. We predicted that Massachusetts, a state with minimal reform, would require less evidence and have fewer limited guardianship orders. Conversely, we predicted that Colorado, a state with a guardianship code based on the UGPPA, would require more evidence and have more limited orders. Finally, we predicted that Pennsylvania, a state with moderate reform, would rank in between Massachusetts and Colorado on these outcome measures.

Methods

Study States

We selected three states with different levels of statutory reform: Massachusetts, Pennsylvania, and Colorado. In Massachusetts, guardianship statutes have seen little modification in the past 30 years, with only minor amendments such as to allow guardianship for "physical incapacity" and to permit nurses as examiners. By comparison, Pennsylvania

amended its code in 1992 to include many progressive provisions such as notice in large type and simple language, presence of the individual at the hearing unless good cause is shown otherwise, and annual reporting. Importantly, Pennsylvania law states that "the court shall prefer limited guardianship" (§5512.1). In 2000, Colorado replaced its statute with one based substantially on the UGPPA, enhancing procedural due process, strengthening evaluation, and providing for limited orders and boosting accountability.

Statutes in Massachusetts provide no specific requirements for the evaluation of capacity. Statutes in Pennsylvania and Colorado are similar, requiring information on the nature and extent of incapacities; the person's mental and physical condition, adaptive behavior, and social skills; treatments and services tried; and prognosis. Massachusetts was a particular focus of this study as the funding agency for the study was located in Massachusetts, and it emphasizes local projects.

Criteria for Case Selection

We pulled cases from four courts in Massachusetts and two courts each in Pennsylvania and Colorado involving guardianship of adults aged 55 and older with a hearing date between January 1, 2002 and December 31, 2005. We chose the time frame to begin after initiation of new guardianship statutes in Colorado up through the period of data collection (September–December, 2005). We selected courts that were proximal to the research teams and that permitted file access (for example, one court in Massachusetts had files in an inaccessible storage room as a result of court space restrictions, so it could not be used). We excluded cases in which the identified diagnosis included mental retardation or developmental delay, as some states have special provisions for guardianship of individuals with such conditions.

For cases that met inclusion criteria, we scanned and de-identified petitions, clinical evaluations, and orders. Researchers made notes of other testimony in the file (e.g., court investigator reports, or affidavits from family or friends). In cases in which oral testimony from health care professionals was used instead of or in addition to written testimony, we scanned the oral transcriptions when available. In cases with more than one petition, evaluation, or order, we scanned all documents. After data cleaning, we found that there were 298 cases in the study file; 154 were from Massachusetts, 74 were from Pennsylvania, and 70 were from Colorado.

Coding

We developed a coding form on the basis of pilot research (Moye, 2004) for scoring the presence or absence of information on the petition, the clinical evaluation, and the order. In addition to counting the number of words in the clinical evaluation and noting the format (hand written or typed), we coded 15 variable categories: demographics, examination procedures, diagnosis, prognosis, level of impairment, duration of illness, current medication, symptoms, ADLs, IADLs, general statements of decisional or functional abilities, and any mention of family, strengths, or preferences. We rated symptoms in four categories: altered consciousness (words that described problems with arousal or alertness such as stupor, coma), cognitive impairment (memory, concentration, comprehension, reasoning, insight, judgment, orientation, and confusion), psychotic symptoms (hallucinations, delusions, and disordered thought process), and mood disturbance (depression, anxiety, emotional lability, mania, and irritability). Specific ADLs coded were eating, toileting, dressing, bathing, grooming, walking, and transferring. Specific IADLs coded were problems with money, home care (e.g., ability to do laundry, chores), health care (e.g., ability to manage medications), transportation (e.g., ability to drive car or use public transportation), meals, and mail or telephone communication (see, e.g., Center for the Study of Aging and Human Development, 1978; Lawton & Brody, 1969; Loeb, 1996). Information coded from the order included whether the appointment was on an emergency basis (potentially indicating reduced due-process protections) or a "permanent" (at least 1 year) basis, whether the order was limited or plenary, whether the order was for person or estate, and whether the order provided any special powers or instructions for the guardian.

Following training to establish interrater reliability ($r > .90$) of the coding process, a team of researchers in the three states coded the files for content. The training process involved in-person and telephone meetings to review the general goals of the study and coding methods. After initial training, on-site coders (two per site) coded cases and faxed completed coding forms for review by the Principal Investigator (PI). Feedback was provided on coding errors. This process was repeated until consistency between the on-site coders and the PI was obtained. Subsequently, 10 new files were pulled for independent coding to establish interrater reliability. As coding progressed, if coders were unsure how to categorize symptom descriptions, the PI issued a decision that was added to the coding books at each site. Records of oral testimony in Pennsylvania (accepted in place of written testimony in some cases) were coded by use of the same categories.

Analyses

Content of Files.—We used descriptive analyses, primarily frequency distributions, to describe the nature of the respondents or allegedly incapacitated

Table 1. Characteristics of Allegedly Incapacitated Persons in the Study Sample

Demographic Variable	MA	PA	CO	Test Statistic	*p*
Age (years)					
Range	55–98	58–94	55–98		
M (*SD*)	77.22 ± 10.42	80.00 ± 8.44	76.17 ± 10.01	$F = 3.03$	.05
Gender (%)					
Female	61.7	63.5	47.1	$\chi^2 = 5.13$	.08
Male	38.3	36.5	52.9		
Setting (%)					
Community	5.2	44.6	31.4	$\chi^2 = 129.38$	<.001
Acute hospital	13.6	1.4	34.3		
Long-term care	41.6	28.4	24.3		
Other	7.8	25.7	8.6		
Not indicated	31.8	0.0	1.4		

persons, petitioners, and guardians, as well as the information on the clinical evaluation and the order.

Comprehensiveness of Clinical Evaluations.—To rate the comprehensiveness of the clinical evaluations, we determined a "quality score" on the basis of the presence or absence of information on six key quality indicators. The six indicators, drawn in part from the recommendations by the American Bar Association–American Psychological Association panel, were as follows: (a) diagnosis, (b) prognosis, (c) cognitive or psychiatric symptoms, (d) functional abilities, (e) values or preferences, and (f) social system. Thus, we rated an indicator as "yes" if there was any diagnosis or prognosis provided, any (even one) mention of a cognitive or psychiatric symptom, any mention of a specific ADL or IADL impairment (e.g., "problems dressing"), any notation of a personal value or preference (e.g., who is favored as a substitute decision maker or what is favored as a medical treatment), and any mention of family. For example, we coded the cognitive indicator as present if memory impairment was described. However, this does not indicate that memory was assessed with a performance-based approach; merely that there was a mention of memory impairment. Overall quality scores thus ranged from 0 to 6.

To provide an overall short-hand summary rating of the comprehensiveness of each clinical evaluation, we calculated a letter grade for each report on the basis of the quality score; we assigned an A to reports that had five or six of the elements, a B for four elements, a C for three elements, a D for two elements, and an F for reports that provided only one element.

Finally, reports were rated for the presence of "conclusory" comments – a particular concern for the courts. A conclusory comment is a statement of opinion without supporting facts. We therefore examined the clinical evaluations for the presence of a general statement of decision-making ability *in the absence* of mention of specific cognitive symptoms, or a general statement of functional ability (e.g., "unable to manage affairs") *in the absence* of description of any specific ADL or IADL abilities.

Relationship Between Clinical Evaluation and Juridical Action.—We examined the potential impact of the quality of the clinical evaluation on the form of the order by comparing the mean quality score in cases with and without limited guardianship orders by using a *t* test.

Results

Who Were the Allegedly Incapacitated Persons in This Sample?

The allegedly incapacitated persons (AIPs) were similar in age and diagnosis. As shown in Table 1, the mean age of the AIPs ranged from 76 to 80 years across states. Most participants were women, with variability across states. A majority of AIPs in Massachusetts lived in a nursing home setting, whereas the majority of such persons in Pennsylvania and Colorado were community dwelling. Information on race, ethnicity, marital status, and income was not available in most files.

Summarizing across states, we found that the majority (82.8%) of AIPs were described as having a diagnosis found in the fourth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, the most common of which was dementia (59%), followed by mood disorder (13.8%) and other neurological disorders, such as Parkinson's disease (11.4%). The most common mental impairments were problems with cognition, including poor orientation, confusion, memory, reasoning, or judgment. Psychotic symptomatology and mood disturbance was described in about one fifth of the cases. More profound disturbance of consciousness (e.g., coma) was noted rarely. When information on functional

abilities was available, the most common deficits were in ADLs (18%), followed by problems in managing one's health (12.9%) and money (12.9%) or home (6.4%). Issues around driving capacity were typically not addressed.

Who Were the Petitioners?

In most cases, the petitioner was a family member or a friend (Massachusetts = 81.2%, Pennsylvania = 58.1%, and Colorado = 55.7%). Of interest, 33.8% of the petitioners in Pennsylvania and 38.6% of the petitioners in Colorado were agencies, which was higher than the percentage in Massachusetts (7.8%; $\chi^2 = 36.09$, $p < .001$).

In What Format Is Written the Clinical Testimony Submitted to Courts?

We located written evaluations in all but one case in Massachusetts and Colorado, and in 75% of the cases in Pennsylvania (of 18 without written testimony, 14 cases had a record of oral testimony; 12 cases had both written and oral testimony), These evaluations were almost always signed by physicians in Massachusetts (98%) and Pennsylvania (88%), whereas in Colorado the clinical reports were submitted by physicians (57%), psychologists (27%), other professionals (9%), or a multidisciplinary team (6%), consistent with UGPPA provisions.

The mean report length differed significantly between the states ($F = 77.93$, $p < .001$). In Massachusetts, the mean length of clinical reports was 83 words ($SD = 61.38$; range = 3–404). In Pennsylvania, the mean length was 244 words ($SD = 285.61$; range = 18–1,802). In Colorado, the mean length was 781 words ($SD = 730.22$; range = 19–2,600). Most (75%) of the Massachusetts reports were hand written, and of these 65% had at least some portion that was illegible. In contrast, Pennsylvania and Colorado reports were almost always typed.

How Is the Clinical Status of the AIP Evaluated?

Information on the procedures used to evaluate respondents was scant, but it was most complete in the Colorado cases. In Colorado, 18.6% of respondents were evaluated with cognitive screening, which was more than in Massachusetts (5.2%) or Pennsylvania (5.3%; $\chi^2 = 11.91$, $p = .003$); in Colorado, 34.3% were evaluated with neuropsychological testing, which was more than in Massachusetts (0.7%) and Pennsylvania (1.8%; $\chi^2 = 68.99$, $p < .001$). Brain imaging was described for more cases in Colorado (22.9%) than in Massachusetts (1.3%) or Pennsylvania (1.8%; $\chi^2 = 38.13$, $p < .001$). However, interviews with family (Massachusetts = 0%, Pennsylvania = 5.3%, Colorado = 4.3%) or facility staff (Massachusetts = 0.7%, Pennsylvania = 1.8%, Colorado = 11.4%) were noted infrequently in all states.

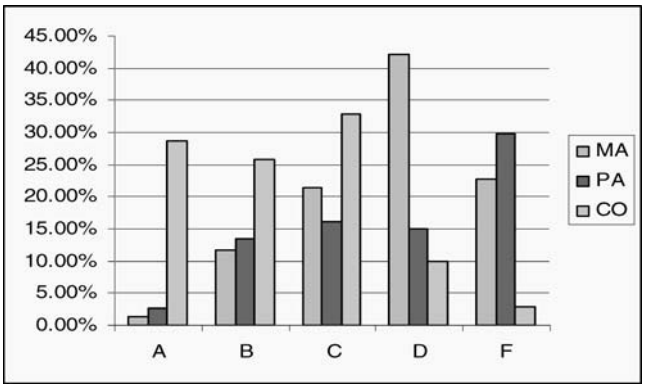

Figure 1. Grades for clinical evaluations in three states.

How Comprehensive Is Written Clinical Testimony?

As described in the Methods section, to give an overall picture of the quality of clinical evaluation, we assigned a letter grade to each clinical report on the basis of the presence of six key clinical variables. The distribution of grades across states is shown in Figure 1. In Colorado, 28.6% of the reports earned an A, whereas only 1.3% of reports in Massachusetts and 2.7% of the reports in Pennsylvania earned this grade. The median grade level for Massachusetts was D; for Pennsylvania it was C, and for Colorado it was B.

What Information Is Absent in Written Clinical Testimony?

The presence of six key clinical variables in written clinical reports is presented in Table 2. The information most often missing concerned functional status, social support, and prognosis. A prognosis—key to judges in planning for guardianship monitoring—was provided in only half the cases in Colorado, with lower rates in Pennsylvania and Massachusetts. In addition, values and preferences of the individual were almost never described. In general, reports in Colorado were more comprehensive, with information provided on each key element more often.

As shown in Table 3, a diagnosis and symptoms of the mental disorder were provided in the majority of the cases, along with the severity, although the duration of the illness and associated medications were less often described. ADLs were described in 35.7% of the Colorado cases, but in fewer cases in Pennsylvania (19.3%) and Massachusetts (9.3%; $\chi^2 = 22.76$, $p < .001$). Similarly, IADLs were described in 52.2% of the Colorado cases but only

Table 2. Presence of Key Clinical Indicators in Written Clinical Evidence for Guardianship

Clinical Indicator	MA (%)	PA (%)	CO (%)	χ^2
Diagnosis of a mental disorder	85.6	63.2	86.6	9.08
Severity of illness	41.8	35.1	87.1	47.48**
Duration of illness	9.8	21.1	45.7	37.24**
Current medications	7.8	22.8	45.7	42.75**
Prognosis	22.9	22.8	54.3	24.37**
Symptoms of mental disorder	73.4	62.2	90.0	14.88**
Description of functional abilities	25.3	47.3	64.3	32.68**
Values and preferences	2.0	0	17.1	25.89**
Social support	14.4	33.3	60.0	48.40**

Notes: MA, $n = 154$; PA, $n = 56$; CO, $n = 70$.
*$p < .01$; **$p < .001$.

21.1% of the Pennsylvania cases and 18.3% of the Massachusetts cases ($\chi^2 = 28.91$, $p < .001$).

How Common Are Conclusory Statements in Written Clinical Testimony?

Across states, 28.8% of the files included conclusory comments about decision making; that is, they provided a general conclusion about decision-making abilities but did not describe specific symptoms of mental impairment. Across states, 64.1% of the files offered conclusory comments about functioning; that is, they included a statement about the ability to care for self with no description of specific functional symptoms.

Is Oral Testimony More Complete Than Clinical Testimony?

A comparison of written versus oral testimony in Pennsylvania revealed that, for each key clinical variable, more information about the clinical status of the AIP was present in records of oral testimony than in written testimony. A review of oral testimony found that a diagnosis was given in 100% of the cases (compared with 63.2% in written testimony), and a prognosis in 59.3% of the cases (compared with 33.3% in written testimony). Symptoms of mental disorders were described in 92.6% of the cases (compared with 62.2% in written testimony) and functional deficits in 81.5% of the cases (compared with 47.3% in written testimony). However, the individual's values and preferences were not described in either written or oral testimony.

How Often Are AIPs Present at the Hearings?

The AIP was much more likely to attend his or her own hearing in Colorado. Of 154 cases, the AIP was present at the hearing in only 1 case in Massachusetts (<1%). It was not possible to determine the respondent's presence on the basis of information in the order for 55.7% of the cases in Pennsylvania and 33.8% of the cases in Colorado. For those cases in Pennsylvania and Colorado in which the AIP presence was determinable, the respondent was present in 1 case in Pennsylvania and 27 cases in Colorado (i.e., 60% of determinable cases).

Table 3. Clinical Diagnoses and Symptomatology

Clinical Variable	MA (%)	PA (%)	CO (%)
DSM-IV diagnoses			
Dementia	63.4	43.9	62.9
Delirium	2.6	0.0	1.4
Other neurological	8.4	23.0	5.7
Mood disorder	5.2	29.7	15.7
Psychotic disorder	9.8	12.3	2.9
Substance use disorder	3.9	0.0	8.6
Symptom reports			
Altered consciousness	0	5.3	7.1
Cognitive impairment	61.4	47.4	85.5
Psychotic symptoms	19.0	17.5	17.1
Mood disturbance	4.6	17.5	22.9
ADL impairment	9.3	19.3	35.7
IADL impairment			
Money management	7.2	8.8	29.0
Home maintenance	1.3	3.5	20.0
Health management	7.2	12.3	25.7
Driving	0.7	3.5	7.1

Notes: Because of concerns about incomplete data (i.e., missing information in the original clinical reports), these percentages are not compared through chi-square analyses. DSM-IV = the fourth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*; ADL = activity of daily living; IADL = instrumental ADL.

How Frequently Were Limited Orders Written?

Most orders were for guardianship of person and estate (70.8% in Massachusetts; 95.6% in Pennsylvania; 89.7% in Colorado). Only one case in either Massachusetts or Pennsylvania had a limited order compared with 34% of the cases in Colorado. In examination of the content of limited orders, we found that the wards' rights were reserved in various ways, including reserving the right to choose social activities, or limiting the guardian's authority to move the AIP, sell property, or consent to medical treatment.

How Frequently Are Less Restrictive Alternatives to Guardianship Explored?

Orders stated that less restrictive alternatives had been considered in 51.5% of the cases in Pennsylvania and 75.0% of the cases in Colorado (and none in Massachusetts); however, the language was

pro forma in nature for most of these cases. For example, many case files in Colorado contained the identical phrase "the court finds ... that the respondent's identified needs cannot be met by less restrictive means including the use of appropriate and reasonably available technological assistance." Six cases in Colorado described specific examples of less restrictive alternatives attempted prior to guardianship.

Do More Comprehensive Reports Support the Use of Limited Guardianship or Less Restrictive Alternatives?

We compared cases with limited orders against those without on the basis of six key clinical variables. Those cases with more comprehensive clinical testimony were more likely to have limited orders (cases with limitations had $M = 3.7$ out of 6 elements; cases without had $M = 2.4$; $t = 4.69$, $p < .001$). Similarly, cases with more comprehensive clinical testimony were more likely to explore less restrictive alternatives to guardianship (cases with comments on less restrictive alternatives had $M = 3.2$ out of 6 elements; cases without had $M = 2.3$; $t = 4.83$, $p < .001$).

Discussion

Prior to our discussion of the results, we note several limitations to the study. First, we sampled only three states and a small number of courts within these states. Because we only sampled a small number of courts, we cannot say that our sample is representative of the state or if it reflects local court practice. Second, our study did not employ a before–after design; therefore we cannot identify whether differences between states existed prior to statutory change. Third, our assessment of the written clinical testimony was restricted to the information provided by the health care professional to the court. Clinicians may have relied on specific data but did not describe those facts to the court, instead focusing on their conclusions. Therefore, these study results have to be replicated and extended in future work.

This preliminary study examined written clinical testimony for guardianship of older adults from eight courts in three states with varying degrees of statutory reform. In general, guardianship orders were often written for older adults on the basis of inadequate clinical evidence. These orders are typically plenary; that is, they result in the loss of all rights for the older adult. Much clinical evidence is incomplete, failing to provide information on basic indicators of clinical status. In Massachusetts, a state with minimal guardianship reform, the evaluations earned a median grade of D, meaning only two elements of clinical information are typically present. The mean length of written clinical reports for guardianship of older adults ranged between 83 words (Massachusetts) to 781 words (Colorado); in other words, this is from less than 1 page to about 3 pages. By way of contrast, the mean length of clinical evaluations for child custody is 24 pages (Bow & Quinnell, 2002).

Documentation of the assessment of functional strengths and weaknesses is particularly rare. This is an important finding, given the rising focus on functional abilities in guardianship proceedings. If the judge is to write a limited order, it is essential to know the specific functional strengths retained so the related rights can be retained in the order. Instead, conclusory statements about functioning are common in clinical evidence, which in Massachusetts is brief and usually illegible. Further, clinical testimony rarely provides a picture of the allegedly incapacitated individual as a whole person, that is, his or her values and preferences related to the decisional issues before the court or the person's social support system. Information on values is crucial to the judge in weighing the fairness of any intervention and is also essential to the guardian in developing a plan of care. Except in Colorado, the allegedly incapacitated individual is rarely present at the hearing to convey this information to the court in person, if possible.

This study shows that health care professionals tend to be fairly consistent in providing a diagnosis and some description of cognitive functioning. However, upon close examination of the clinical reports, we find that the description of cognitive functioning tends not to include a description of cognitive test results; instead, general clinical descriptors such as "confusion" are used. Such descriptors may provide the court with neither the information needed to fully understand the individual's decisional strengths and weaknesses, nor the level of impairment. Similarly, most clinical reports in Massachusetts and Pennsylvania fail to describe a prognosis, which is essential to the judge in determining if and when the guardianship should be reheard or administratively reviewed to determine a possible change in capacity. Information about the prognosis—specifically information that any incapacity may change or lessen—is required by statute in Pennsylvania.

Consistent with our hypotheses, the quality of clinical evaluation varied with level of statutory reform. Colorado, the state with the most progressive reform, has more frequent presence of the AIPs at the hearing, and more use of limited orders, in comparison with the other two test states. Further, Colorado has longer, legible, and more comprehensive reports by a range of health care professionals that were more likely to include cognitive and functional information, and appear to facilitate the use of limited guardianship. In contrast to the data of other studies (Bulcroft et al., 1991; Dudley & Groins, 2003), these data suggest that statutory reform may be associated with court practice. These findings also

suggest that in these two courts in Colorado, it was at least possible to limit orders one third of the time. We did not study these cases longitudinally to learn how the limited orders operated over time. Further study on the feasibility and appropriateness of limited guardianship is much needed.

Clinical information was more complete and comprehensive in Pennsylvania when based on oral testimony versus written testimony. This finding may indicate that clinicians may have information on key factors within their knowledge base (e.g., functional abilities, prognosis), and they are able to provide it when directly asked; if so, incomplete written clinical testimony may be less the case of "I am not aware of that information" and more the case of "I did not know that information would be helpful to the court." However, more study is needed to fully understand this finding.

Taken together, the data reported in this study provide compelling preliminary evidence that guardianship statutory reform may be associated with improved quality of clinical evaluations—and further, that improved clinical evaluations, possibly in conjunction with statutory language preferring limited guardianship, are associated with more use of limitations to guardianship orders.

Recommendations

We believe these results highlight the need for ongoing dialogue between clinical and legal professionals to improve the quality of clinical information available to the courts in cases of guardianship of older adults. The context guardianship of older adults is complex, potentially focusing on an individual with a lifetime of competent decision making who may now have a late-onset neurocognitive disorder affecting some abilities and not others. The task for the clinician and for the courts is therefore onerous. For the clinician, there are competing demands on clinical time. Often petitioners who are family members may ask the clinician to provide the written report as part of usual care. When in-depth evaluation is needed, state courts tend to have limited funds, if any, for such evaluation. Importantly, clinicians may have key information but may be unaware of exactly what the court needs within guardianship proceedings. Similarly, courts may be well versed in legal aspects of guardianship but unaware of what information clinicians can provide.

For this reason, the education of health care professionals about the guardianship process and the education of court professionals about disorders of aging may be useful. The provision of assessment guidelines and templates by the courts may help health care practitioners to provide information that the courts will find useful in their proceedings. In some cases, more extensive clinical documentation will be necessary, more cognitive or functional testing, and more exploration of the personal values and preferences of the individual. In other cases, a brief description of a severely and permanently impaired individual, with relevant accompanying values information, may be appropriate. Therefore, it will be important to develop strategies for screening cases to determine which need more extensive evaluation. For example, individuals who appear to have minimal impairment, or impairment in some areas and not others, could be referred for more extensive clinical evaluation. It will also be important to develop a means to pay for such evaluations through the courts, personal assets, or other sources.

Conclusions

A comparison of three states with varying degrees of statutory reform suggests that clinical and juridical practice is improved in states with more progressive statutory guidance. However, even in Colorado, our study state with the most progressive statutes and highest overall grades for reports, clinical evidence was often incomplete. In Massachusetts, our study state with minimal guardianship reform, older adults often stand to lose all rights on the basis of a few illegible sentences of conclusory commentary. Documentation of functional assessment, important for limited guardianship, is infrequent. Description of individual values and preferences, key to the judge in his or her decision making and in any guardianship plan, is rare. Finally, information on prognosis, critical to the judge in determining when and how the guardianship should be monitored, is often absent. Some individuals in guardianship proceedings have conditions that will result in continued functional deterioration, whereas others may not. It is important that the judge is able to clearly discern these two categories of individuals. Continued study and ongoing clinical–legal dialogue is urgently needed to improve the process of guardianship appointments for older adults.

References

American Bar Association Commission on Law and Aging and American Psychological Association. (2006). *Determining capacity of older adults in guardianship proceedings: A handbook for judges.* Washington, DC: American Bar Association and American Psychological Association.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Alexander, G., & Lewin, T. (1972). *The aged and the need for surrogate management.* Syracuse, NY: Syracuse University.

Blenkner, B., Bloom, M., Nielson, M., & Weber, R. (1974). *Final report: Protective services for older people: Findings from the Benjamin Rose Institute study.* Cleveland: Benjamin Rose Institute.

Bow, J. N., & Quinnell, F. A. (2002). A critical review of child custody evaluation reports. *Family Court Review, 40,* 164–176.

Bulcroft, K. A., Kielkopf, M. R., & Tripp, K. (1991). Elderly wards and their legal guardians: Analysis of country probate records in Ohio and Washington. *The Gerontologist, 31,* 156–164.

Center for the Study of Aging and Human Development. (1978). *Multidimensional functional assessment: The OARS methodology.* Durham, NC: Duke University.
Dudley, K. C., & Goins, R. T. (2003). Guardianship capacity evaluations of older adults: Comparing current practice to legal standards in two states. *Journal of Aging and Social Policy, 15,* 97–115.
Horstman, P. (1975). Protective services for the elderly: The limits of parens patriae. *Missouri Law Review, 40,* 215–236.
Keith, P. M., & Wacker, R. R. (1992). Guardianship reform: Does revised legislation make a difference in outcomes for proposed wards. *Journal of Aging and Social Policy, 4,* 139–155.
Kotyk-Zalisko, P. (1996, November). *Perspectives from the New Jersey guardianship program.* Paper presented at the annual meeting of the Gerontological Society of America, Washington, DC.
Lawton, M. P., & Brody, E. M. (1969). Assessment of older people: Self-maintaining and instrumental activities of daily living. *The Gerontologist, 9,* 179–186.
Lisi, L., Burns, A., & Lussenden, K. (1994). *National study of guardianship systems: Findings and recommendations.* Ann Arbor, MI: The Center for Social Gerontology.
Loeb, P. (1996). Independent living scales. San Antonio, TX: Psychological Corporation.
Mitchell, A. (1978). Involuntary guardianship for incompetents: A strategy for legal services advocates. *Clearinghouse Review, 12,* 451–468.
Moye, J. (2004). Capacity assessment: A burgeoning area of research and practice. *Psychologists in Long Term Care, 18,* 2–5.
National Conference of Commissioners on Uniform State Laws. (1997). Uniform Guardianship and Protective Proceedings Act. Retrieved June 6, 2005, from http://www.law.upenn.edu/bll/ulc/fnact99/1990s/ugppa97.htm
Quinn, M. J. (2004). *Guardianships of adults: Achieving justice, autonomy, and safety.* New York: Springer.
Reynolds, S. L. (2002). Guardianship primavera: A first look at factors associated with having a legal guardian using a nationally representative sample of community-dwelling adults. *Aging & Mental Health, 6,* 109–120.
Reynolds, S. L., & Wilber, K. H. (1997). Protecting persons with severe cognitive and mental disorders: An analysis of public conservatorship in Los Angeles County, California. *Aging & Mental Health, 1,* 87–97.

Received November 30, 2006
Accepted March 5, 2007
Decision Editor: Linda S. Noelker, PhD