Testamentary Capacity and Guardianship Assessments

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KEYWORDS

- Testamentary capacity
- Guardianship
- Ward
- Capacity assessment
- Geriatric psychiatric assessment
- Wills
- Insane delusion
- Undue influence

KEY POINTS

- Under common law, testamentary capacity requires the person to have the following abilities: (1) know the nature and extent of their property; (2) know the natural objects of their bounty; (3) understand how the will disposes of their property; and (4) demonstrate the ability to make a rational plan as to the disposition of their property.
- Allegations of undue influence are common and often successfully challenge the validity of a will.
- Common illnesses affecting testamentary capacity in older individuals include delirium and dementia.
- A person determined to be a ward of the state may lose many fundamental rights including: consent or refusal of medical care, management of their finances, entry into contracts, ability to marry, and self-determination of living arrangements.
- Evaluators should screen for elder abuse in their evaluations. Physical abuse, emotional abuse, financial abuse, and neglect may be present in the lives of evaluatees.

INTRODUCTION

As Americans live for longer periods of time and in greater numbers, there is an ever increasing need for mental health professionals to assist civil courts in answering questions related to issues of adult guardianship and distribution of property after an individual’s death. The US Department of Human Services reports that Americans older than 65 years numbered 40.4 million in 2010, an increase of 5.4 million since 2000. Since 1900, the number of Americans aged 65 or older has more than tripled. By this definition, 1 in every 8, or 13% of the population, is an older American.

Funding sources: None.
Conflict of interest: None.
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http://dx.doi.org/10.1016/j.psc.2012.08.011
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Projections indicate that Americans 65 years or older will reach 72.1 million by 2030 and 88.5 million by 2050.\(^1\)

Better financial security, medical advances, greater awareness of medical conditions, and the pursuit of healthier lifestyles have extended and improved the quality of life for people as they age.\(^2\) Unfortunately, while living longer, many of the elderly also live with disabilities. In 2010, nearly 37% of older persons suffered from some type of disability, such as sensory deficits, problems in ambulation, or impairment in self care or independent living. Furthermore, almost 50% of surveyed individuals older than 80 years reported a severe disability and approximately 30% of those older than 80 reported that they needed some form of assistance. In a 2009 study to evaluate older Americans’ ability to perform activities of daily living (ADLs), more than 27% of community-resident Medicare beneficiaries older than 65 had difficulty performing 1 or more ADL while 95% of institutionalized Medicare beneficiaries had difficulties with 1 or more ADLs.\(^1\)

This article reviews important factors to consider when assessing the impact of aging and disability on 2 key areas that many older people will face: testamentary capacity and guardianship assessments.

**TESTAMENTARY CAPACITY**

*Overview*

Testamentary capacity is a civil competence and involves an individual’s ability to make a will. Legally, a person is presumed to have adequate capacity to create a will and in doing so they recognize (1) the natural objects of their bounty, (2) the nature and extent of their estate, and (3) the fact that they are making a plan to dispose of the estate after their death.\(^3\) The modern right to determine who will take ownership of their property after death originates from the eleventh-century Norman principle of primogeniture, which is the passing of the estate to the first-born son. The Statute of Wills, enacted in England in 1540, allowed landowners to pass their land to others who had survived them.\(^3\) The Statute of Frauds, enacted in 1688, required that various documents, including wills, be committed in writing for the contract to be enforceable.\(^3\) The United States adopted a significant portion of English law related to wills. Many consider the act of making a will a fundamental right, although this specific activity is not described as a protected right in the Constitution.\(^4\)

Making a will is not necessarily complicated. In general, creating a will requires a statement of intent to create the will, a witness, a date, and a signature of the will’s author. The will’s author is also referred to as the “testator.”\(^4\) The termination of a will can be significantly more difficult than its creation, and care must be given to clearly resolve any conflicts that exist between different versions of an individual’s will. Revocation, and therefore termination, of a will can occur through physical destruction of the original (and any other copies) or by the valid creation of a later dated will that revokes all prior wills. A will cannot be revoked simply by an oral declaration.\(^4\)

Wills are rarely contested. In fact, studies have shown that approximately 99% of wills are executed as written.\(^5\) Only an individual directly affected by the will may contest that will. If contested, a will may be rejected for a variety of reasons. As previously mentioned, many states require a statement of intent, a valid witness or witnesses, a date, and a signature of the testator. In addition, the author of the will must have reached the age of majority accepted by the state and have the mental capacity to compose the will. Individuals are assumed mentally competent to create a will unless it is proven that they are not competent to do so. As a result, those
who contest a will bear the burden of proof that the testator lacked mental competency when the document was created.\textsuperscript{5}

A historical and illustrative English case regarding testamentary capacity was heard by Chief Justice Cockburn. In the 1870 case of \textit{Banks v Goodfellow}, Mr John Banks’ will was contested after his death and the subsequent death of his niece to whom he had passed his estate. Under normal circumstances, Mr Banks’ estate would have passed to his niece’s descendants. However, medical opinions were submitted opining that Mr Banks was “insane” and incapable of managing his affairs both before and after the time of the creation of his will.\textsuperscript{6} Ultimately, Chief Justice Cockburn found that Mr Banks’ will was valid and he set forth the following test for testamentary capacity.

\begin{quote}
It is essential to the exercise of such a power that a testator shall understand the nature of the act and its effects; shall understand the extent of the property of which he is disposing; shall be able to comprehend and appreciate the claims to which he ought to give effect; and with a view to the latter object, that no disorder of the mind shall poison his affections, pervert his sense of right, or prevent the exercise of his natural faculties—that no insane delusion shall influence his will in disposing of his property and bring about a disposal of it which, if the mind had been sound, would not been made.\textsuperscript{7}
\end{quote}

In summary, Chief Cockburn stated that a testator must understand the nature of a will itself; the general extent of their assets; be able to appreciate the claims of those who might expect to benefit from the will; understand the impact of the distribution described in the will; and not have a disorder of the mind, including delusions, that influenced the creation of the will. If the validity of a will is challenged, it must be proven by the complainant that the testator lacked at least one of the following elements at the time of the creation of the will outlined in Box 1.\textsuperscript{4}

One may better understand the unwillingness of courts to invalidate wills, even in individuals with chronic mental illness, by considering the “lucid interval” doctrine. When a witness to the signing of the will can provide testimony that the testator had a lucid interval on the signing of the document, despite chronic mental disability, the will is often considered valid.\textsuperscript{4} In such circumstances, the burden to prove a “lucid interval” was present at the time the will was created falls to those who wish to have the will survive as written.

\textbf{Insane Delusion}

Mental health professionals may be called on to assess for the presence of delusions affecting the testator’s capacity to create a will. A delusion is often defined as a fixed,

\begin{boxed_text}
\textbf{Box 1}

Components required for testamentary capacity

1. Knowledge of the nature and extent of his property
2. Knowledge of the natural objects of his bounty
3. Knowledge of how the will would dispose of his property
4. The ability to make a rational plan as to the disposition of his property

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false belief system, which is inconsistent with an individual’s culture and has no basis in fact. In testamentary capacity cases, the evaluator may find it necessary to consider if an insane delusion affected the testator’s decision-making capacity. According to one legal definition, an insane delusion is an irrational, persistent belief in an imaginary state of facts resulting in a lack of capacity to undertake acts of legal consequence, such as making a will. In the US Supreme Court Case Mutual Life Insurance Company v Terry the court examined an insurer’s responsibility to pay on a policy whereby an individual committed suicide, legally voiding the policy. The court reasoned that the proviso was valid unless the insured was insane. The court provided a more detailed definition of insane delusion when they wrote:

*If the death is caused by the voluntary act of the assured, he knowing and intending that his death shall be the result of his act, but when his reasoning faculties are so far impaired that he is not able to understand the moral character, the general nature, consequences, and effect of the act he is about to commit, or when he is impelled thereto by an insane impulse, which he has not the power to resist, such death is not within the contemplation of the parties to the contract, and the insurer is liable.*

The following hypothetical case illustrates how an insane delusion may be considered as invalidating a will.

### Insane delusion

Mr Jones is known to have a history of bipolar disorder. Despite the urgings of his family and psychiatrist he has again discontinued his psychiatric medications. Years earlier, a will was created with the assistance of attorney, which left his estate to his wife and children. His wife observes the onset of alarming behavior such as sleeplessness, rapid speech, increased anger, and paranoia regarding the government. Mr Jones leaves the family home late one night and is found a week later dead in a hotel room. A note beside his hotel bed is titled “Last Will and Testament” and contains language in his hand writing to invalidate the previous will. This new will is signed and dated by an unknown female witness named Sparkles. Mr Jones writes in the document that he will “not provide a single penny” to the “government terrorists who have been disguising themselves as my wife and child all of these years” and instead instructs that all of his property to be given to Sparkles, a female adult entertainer who he claims to have married the day before his death.

The preceding example demonstrates how an insane delusion may affect the testator’s reasoning related to making the will. While knowing the nature and extent of his property, the natural objects of his bounty, and that the will would dispose of his property, Mr Jones likely lacked the ability to make a rational plan because of his active mental illness. Sparkles could, however, testify in court that Mr Jones was having a “lucid moment” when he created the document after their marriage ceremony the night before. She will face significant difficulty in prevailing, as the delusional accusations contained in Mr Jones’ document are similar to earlier claims made by Mr Jones when known to be manic. However, having a delusional belief system alone may be insufficient to invalidate a will. The party challenging the will must demonstrate that the delusion directly affected the creation of the will.

### Undue Influence

One of the most often attempted, and most successful, challenges to the validity of a will involves allegations of “undue influence.” In the 1931 Arkansas case of Hyatt...
v Wroten, the court provided the following definition of undue influence: “...the opportunity of the beneficiary of the influenced’s bequest to mold the mind of the testator to suit his or her purposes...” Frolik outlines 4 fundamental elements of undue influence, highlighted in Box 2.

The following hypothetical vignette raises questions regarding the presence of undue influence.

### Undue influence

Ms Hall is a widowed woman who recently celebrated her 89th birthday. Ms Hall has one surviving daughter and a substantial estate worth at least 1 billion dollars. Ms Hall's daughter has become increasingly concerned about the nature of her mother’s relationship with a well-known 26-year-old male model named Mr Flash. While the relationship with her mother has always been stormy, she had some comfort in fact that, as Ms Hall's only child, she was the sole heir of the estate. Alarmed to see her mother’s face on a popular entertainment magazine she soon discovers, through her mother’s attorney, that Mr Flash is now heir to half of the estate. Ms Hall dies 13 months later with the modified will to be executed. Ms Hall’s daughter alleges that Mr Flash had undue influence over her mother and that the will should be invalidated.

Determining whether undue influence was present can be difficult because of the private nature of such relationships. The burden of proof falls on the individual who is challenging the validity of the will. The challenger may request assistance from mental health professionals to assist in the determination of whether various conditions in the testator and/or various characteristics of the alleged influencer may have contributed to a will created with undue influence. Mental health professionals should consider a wide variety of characteristics in the testator, which might increase susceptibility including their mental and physical health, their personality traits/disorders, and their overall intellectual function.

Redmond has suggested some clues to help evaluate the presence of undue influence:

1. The psychiatrist is assured by the person requesting the examination that a competency statement is routine because of the testator’s age.
2. The appointment is made by someone other than the testator or his/her attorney.
3. The testator is brought to the appointment by someone who answers most of the questions for the testator and is reluctant to allow the testator to be interviewed alone.

### Box 2

**Fundamental elements of undue influence**

1. A confidential relationship existed between the testator and the influencer
2. The influencer used that relationship to secure a change in how the testator distributed his estate
3. The change in the estate plan was unconscionable or did not reflect the true desires of the testator
4. The testator was susceptible to being influenced

4. Specifics about the will are not given, or the testator seems unclear about specific items in the will.
5. There is reluctance to give information about potential heirs and their relationship with the testator.

CONDUCTING THE FORENSIC EVALUATION

Before conducting a forensic evaluation, the evaluator should clearly understand the questions to be answered by the court, attorney, or client. If there is concern over the content or scope of the questions or areas to be explored, clarification should be made before an evaluation. In addition, the evaluator should make clear to the requesting agency when limitations such as missing medical documents or an uncooperative or deceased testator may limit the accuracy of the provided opinions.

Records relevant to the testator’s medical and psychiatric history should be reviewed when available. Additional records that may be of assistance include relevant financial records, accurate estimates of the person’s financial worth, academic records, prior neuropsychological or IQ testing, work performance records, nursing home records, lists of current medications and medications taken at/about the time of the creation of the will, and statements and interviews with collateral informants such as family members. In addition, the evaluator should review the specific will in question as well as any other versions of the will. Being familiar with these records before the evaluation may better inform lines of questioning and potential areas to more carefully explore during the evaluation. Evaluators should not conclude a lack of testamentary capacity solely because another capacity (such as the ability to consent to medical treatment) is lacking. In fact, a person could lack the capacity to make medical decisions yet still retain testamentary capacity.

Evaluations may be requested for testators who are living or deceased and may therefore be contemporaneous or retrospective. Contemporaneous evaluations of the testator should ideally occur in environments providing an adequate level of privacy and a lack of distraction for both the interviewer and interviewee. Jurisdictions vary in their requirements to have attorneys present during court-ordered evaluations. The evaluator should instruct the attorney that they should adopt a passive role during the interview, and deviations from such a role may result in an inaccurate or incomplete opinion regarding the questions posed. One-way mirrors may facilitate this arrangement. Another approach may be to have the interview recorded, though all parties should be aware of such an arrangement well in advance of the interview. Should the testator, or their attorney, wish to have the interview independently recorded, this should be agreed upon well before the evaluation.

Consider the following questions in your evaluation to determine the testator’s understanding of their will and to rule out the presence of undue influence:

1. What is your current financial worth?
2. Describe your financial assets? (Property, valuable possessions, and so forth.)
3. What types of banking accounts do you hold and how much does each account contain? (Checking, savings, and so forth.)
4. What are your monthly expenses?
5. What is your monthly income?
6. Who are your relatives?
7. What is your relationship like with each of your relatives?
8. Have any of your relatives treated you unfairly? If yes, describe.
9. What is your understanding of a will?
10. Have you ever made a will before?
11. Have you made any changes in your will(s) over time? If yes, why?
12. Explain why you left the amounts you did to your various relatives.
13. Have you excluded relatives, or bequeathed to them lower amounts than might have been expected? If yes, why?
14. Do you intend to leave anything to individuals outside of your family? If yes, explain the history of your relationship with them and why you have made them a beneficiary.
15. Does anyone disagree with the content of your will? Do you anticipate anyone contesting your will? If yes, explain.

In addition, evaluators may consider presenting various hypothetical scenarios and having the evaluee complete tasks relevant to testamentary capacity. Examples include:

1. Have the evaluee describe how they would handle a philanthropic request for an amount greater than their current financial worth.
2. Have the evaluee describe how they might distribute 1 million dollars knowing that they could keep none of it themselves. Have them explain why they provided various amounts to various individuals.
3. Provide the evaluee a hypothetical example of undue influence to determine their response. An example might include creating a narrative involving an attorney who helps the testator create a will but suggests that a majority of the money be awarded to them because of “their friendship.”

Common Cognitive Concerns

Common illnesses affecting testamentary capacity in older individuals may include delirium and dementia. The evaluator should carefully consider the presence of non-pathologic changes in memory related to normal gaining. Such changes are referred to as “benign senescence,” “age-associated memory decline,” or can be included in the term Age-Related Cognitive Decline in the Diagnostic and Statistical Manual of Mental Disorders (fourth edition, text revision) (DSM-IV-TR). Recently the Aging, Demographics, and Memory Study (ADAMS) found that 22.2% of Americans older than 71 years had cognitive impairment without dementia. The Baltimore Longitudinal Study of Aging, the longest-running scientific study of human aging, indicates several significant findings in age-related alterations in cognition. Late-life cognitive changes may include a decreased ability to solve problems and to learn rapidly. In addition, visuospatial abilities, fluency of language, and general intelligence may also decline in late life. Typically there is a shortened attention span, increased sleep fragmentation and a decrease in brain weight. Moreover, frontal-lobe functioning may be increasingly impaired during aging.

Dementia

Cognitive impairment without dementia is quite common, and 10% to 15% of those with cognitive impairment without dementia progress to dementia annually. Dementia is characterized by cognitive defects caused by medical conditions, substances, or a combination of several conditions. The DSM-IV-TR lists several presumed causes that include: Alzheimer type, Dementia Due to Other General Medical Conditions, Substance-Induced Persisting Dementia, Multiple Etiologies, or Not Otherwise Specified if the etiology is indeterminate. Several medical conditions, including heart disease, renal disease, congestive heart failure, thyroid dysfunction, and vitamin deficiencies, may present as manageable sources of dementia-type symptoms.
Medications or medical problems may induce what appears to be dementia or delirium. Scenarios whereby medications may cause such an effect include when a geriatric patient’s dosage of medication is too high, the geriatric patient does not appropriately follow dosing directions, or the patient has an increased sensitivity to or impaired metabolism for a certain medication and/or drug-drug interactions. In an effort to educate medical providers about potentially inappropriate medications (PIMs) for older adults, Beers and colleagues initially published a list of PIMs in 1991 with revisions in 1991, 1997, 2003, and most recently in 2012. The most recent Beers Criteria update includes 53 medications, or medication classes, which qualify as PIMs for older adults. The most common offending drug classes resulting in alteration of cognition are anticholinergics, antihypertensives, psychotropics, sedative-hypnotics, and narcotic analgesics.

Alzheimer disease is the most frequent cause of dementia. It is estimated that 60% to 70% of dementia cases are of the Alzheimer type. Studies have shown that Alzheimer disease has a cumulative incidence as high as 4.7% by age 70, 18.2% by age 80, and 49.6% by age 90 years. The Alzheimer’s Association estimates that 4.5 million Americans have Alzheimer disease.

Testators in the early stages of Alzheimer may demonstrate a subtle loss of short-term memory. Anecdotes of becoming easily lost in their neighborhoods may be presented by collateral or the testator themselves. In addition, they may demonstrate problems with word finding and the naming of standard objects. Individuals in the early stages of Alzheimer disease may demonstrate apraxia (an inability to perform complex movements), or may have difficulty dressing or eating. During the late stages of Alzheimer disease, judgment often becomes impaired and personality changes may become apparent. Such personality changes may demonstrate increased apathy, hostility, or withdrawal toward peers or members of custody. Alzheimer patients they may experience depression, anxiety, delusions, or hallucinations. If a will was created during the course of a dementing process, the evaluator should carefully explore the extent and content of cognitive impairment, psychiatric symptoms, and the impact of any delusions on the creation of a will.

**Delirium**

Abnormal changes in memory, judgment, and cognition may occur in both dementia and delirium; however, one of the best methods to differentiate the two is the presence or absence of a clouding of consciousness that fluctuates over the course of a short time (such as in a single day). This fluctuation is characteristic of delirium. In addition, an acute or subacute onset of symptoms more often indicates delirium as opposed to dementia. Whereas delirium in a nonhospitalized older population is rare, in an inpatient hospital setting this population may have a prevalence of delirium as high as 80%. The presence, severity, or timing of delirium may be of significant consequence during the contest of a will.

Depression that resembles dementia has been termed pseudodementia or depression-related cognitive dysfunction. Features indicating pseudodementia include the following: better premorbid functioning; a rapid onset of symptoms; a patient’s detailed complaints of cognitive dysfunction; poor motivation to perform even simple tasks; negativistic answers to questions; and a personal or familial history of depression.

**Forensic Evaluation of Cognitive Status**

A general psychiatric evaluation should be performed on the testator. In addition, the evaluator should consider the use of screening tools to detect the presence of cognitive disorders in the testator. Tools to detect cognitive dysfunction include the
Mini-Mental State Examination (MMSI), Cognitive Abilities Screening Instrument (CASI), and the Mini-Cog.

**Mini-Cog**
The Mini-Cog is a composite of a 3-item recall and a clock drawing to help determine the presence of a demented person. It has shown some advantage in comparison with other tools, in that it can be rapidly administered and can be used in individuals with a variety of educational levels and languages. To administer the Mini-Cog, the interviewer determines that they have the interviewee’s attention and then asks the evaluatee to repeat back 3 unrelated words. These words may be repeated up to 3 times if the interviewee has difficulty in repeating them back. The evaluatee is told to remember these 3 words and informed that he or she will be asked to repeat them again later. Next, the evaluatee is given a test of cognitive function, which also serves to temporarily distract them so that their memory can be later tested. The cognitive task involves having the person draw the face of a clock with specific times (such as 11:10 or 8:20). On completion of the clock task the interviewee is asked to repeat the previous 3 words. The Mini-Cog determines that the person to be “Demented” if no items are recalled or if the clock-drawing test is abnormal with 1 or 2 items recalled. An individual is “Nondemented” if he or she recalls all 3 items or if 1 to 2 items have been recalled with a normal clock test.\(^2^2\)

**Montreal Cognitive Assessment**
The Montreal Cognitive Assessment (MoCA) is another cognitive screening test designed to assist health professionals detect mild cognitive impairment. The administration of the test takes approximately 10 minutes and evaluates different cognitive domains: attention and concentration; executive functions; memory, language; visuoconstructional skills; conceptual thinking; calculations; and orientation. The MoCA is offered free of charge and can be obtained at [www.mocatest.org](http://www.mocatest.org) in a variety of languages.

**Retrospective Evaluations**
If the testator is deceased, the mental health evaluator must look toward collateral information and documentation to form an opinion regarding the testator’s testamentary capacity. As previously stated, requests should be made for relevant records including copies of all wills, financial records, academic records, prior neuropsychological or IQ testing, work performance records, medical records, nursing home records, medical records, and lists of current medications and medications taken at/about the time of the creation of the will. In addition, relevant legal documents should be requested such as the petitioner’s complaint, answer to the complaint, interrogatories, and relevant depositions. The evaluator should also request personal writings/correspondence with others for review when available. In addition, interviews with relevant collateral sources such as family members, close friends, and nursing home employees may be beneficial. In looking for the possible presence of undue influence, the evaluator may find it helpful to create a timeline of the testator and to determine when changes in various versions of the will occurred. Liptzin and colleagues\(^2^1\) suggest several questions to be asked in cases where persons change their will toward the end of their life. These questions are summarized in **Box 3**.

**GUARDIANSHIP**
Some individuals lack the ability to make important decisions about their medical care and/or other aspects of their personal lives owing to cognitive or mental impairment. In
such situations the court may classify the individual as a “ward” of the court and appoint a “guardian” (or conservator) to make important life decisions for the ward. While establishing a guardian serves to protect the ward, careful consideration regarding its implementation should be made because of the potential reduction of the individual’s rights. In particular, a person determined to be a ward of the state may lose many fundamental rights, including the following:

- Consent or refusal of medical care
- Management of their finances
- Entry into contracts
- Ability to marry
- Self-determination of living arrangements

Mental health professionals may be asked to assist in a court’s decision of whether guardianship should be initiated on an individual. Before performing an evaluation, the evaluator should be aware of the specific format and scope of the requested evaluation. A recent national review of guardianship laws found that 30 states require clinical evaluation before guardianship hearings, 15 states allow the individual court to decide, and 5 states have no specific rules. Less than half of the states include specific information to be considered/obtained by the evaluator in the opinion regarding possible guardianship.

A recent review of 298 cases of adult guardianship in 3 states revealed concerning patterns of report writing by evaluators. Many reports were illegible, lacked a discussion of specific functional deficits, and made only general conclusions about decision-making abilities. This study indicated that more effective evaluations were correlated with those states that had more progressive reforms regarding guardianship. Several progressive states have updated their guardianship statutes to be in line with the Uniform Guardianship and Protective Proceedings Act (UGPPA). The UGPPA emphasizes due process, fair proceedings, and a limitation in the power of guardians and conservators. The Act states that powers of guardianships and conservatorships should be limited to specific deficiencies in the ward and should be the least restrictive possible. Moye and colleagues suggest a conceptual model of capacity evaluation in adult guardianship that addresses the following 6 areas:

1. What medical conditions are present that produce functional disability? What are the prognoses of the various medical conditions?
2. What is their cognitive functioning? (To include exploration of sensory acuity, motor skills, attention, working memory, short-term memory, long-term memory, understanding, communication, arithmetic, verbal reasoning, visual-spatial reasoning, and executive functioning.)
3. What is their ability to function daily? This should include a consideration of their capacity for self care and to care for their finances. Additional consideration should be given regarding their ability to make decisions regarding medical and legal decisions. Their functionality in home and community life should also be explored.

4. What are their individual values, preferences and patterns? The evaluator should consider the individual’s desire to have a guardian, whether they prefer decisions be made alone or with others, where they would prefer to live, what are their goals, what general concerns are primary in their life, and what important religious or cultural beliefs should be taken into consideration that may affect decisions.

5. What is their risk of harm and what level of supervision is needed?

6. What, if any, methods can be used to enhance capacity?27

In addition, the evaluator should consider individuals' ADLs as well as their instrumental activities of daily living (IADLs). ADLs include routine behaviors frequently performed to facilitate self care such as bathing, eating, dressing, and moving throughout the living environment. IADLs are behaviors requiring the manipulation of various implements such as the management of money, taking medications, making phone calls or using a computer, maintenance of living environment, and shopping. Increasing limitation of both ADLs and IADLs is correlated with advancing age.1

When evaluating ADLs the investigator should investigate areas such as the ability to toilet, feed oneself, dress oneself, groom oneself, physically move throughout their living environment and the city, and to what extent they can bathe themselves. When exploring IADLs the evaluation should consider testators' ability to use a telephone, shop, prepare food, maintain their house, do laundry, use transportation, take their medications and handle their finances, and to what extent they require assistance from others.

Mental health professionals may be asked to perform subsequent evaluations on individuals who are already on guardianship status, as many states allow for subsequent hearings to determine whether competence to perform various functions has been restored. In such circumstances, the evaluator should review how the person's ADLs and IADLs have evolved since the establishment or previous renewal of the guardianship.

Finally, the evaluator should also screen for any potential abuse of the elderly evaluate. The National Center on Elder Abuse reports that 1 in 10 elders may experience some type of abuse, but only 1 in 5 cases of abuse are actually reported.28 Evaluators should be aware of the laws in their state regarding the reporting of elder abuse and consider the inclusion of basic questions to assess for the presence of abuse. Such questions should include exploration of the following areas:

1. Physical abuse (eg, “Have you been struck, slapped or kicked?”)
2. Emotional abuse (eg, “Have you been threatened with punishment, deprivation or institutionalization?”)
3. Neglect (eg, “Have you been left alone for long periods?”)
4. Financial abuse (eg, “Does your caregiver depend on you for shelter or financial support?”)

SUMMARY

Mental health professionals play a fundamental role in assisting courts in areas of contested wills and the need for guardianship. The need for such evaluations will inevitably increase as our population grows in numbers and age. Mental health professionals involved in such matters must clearly understand the scope of the
requested evaluation, prepare adequately for the evaluation, perform a thorough inter-
view, consider relevant documentation and collateral sources, and prepare a clear,
concise report addressing the requested areas.

REFERENCES