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Swimming against the Tide: A Case Study on the Removal of Conservatorship and Guardianship

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Abstract

Objective—This article evaluates the role healthcare providers play in balancing safety versus autonomy among elders when performing capacity evaluations.

Methods—Presentation of a case study consisting of an 85-year-old, Caucasian, widowed, male, post-stroke veteran, residing in long-term care. He was assigned a permanent court-appointed joint guardian and conservator, but wanted to remove both of these as he felt he had the ability to manage his own affairs. This case study specifically addresses the issue of financial capacity.

Results—After completion of the evaluation, a case was made for the least restrictive means balancing patient autonomy and protection, opting for a limited conservatorship. The court, using the evaluation as evidence, completely removed the guardianship and conservatorship.

Conclusions—This article outlines how providers can navigate multiple roles, team dynamics, and advocate for enhancing the capacity of an older adult.

Keywords

Capacity; conservatorship; dementia; financial; guardianship; medical

Introduction

The need for accurate and high-quality assessments of decision-making capacity is on the rise. As the population of the United States continues to age (Ortman, Velkoff, & Hogan, 2014) we will see rising incidents of age-related cognitive decline, neurocognitive disorders, medical conditions, and mental health conditions that may affect a person's ability to make well-reasoned decisions. Further, as people age they may have a need to make more frequent health care and financial decisions. For these and other reasons older adults are often considered to be an "at risk" population that deserves special attention to protect them from harm, exploitation, or abuse. One such way of providing protection is to ensure that older adults are able to make decisions for themselves, and if they cannot, a surrogate decision-maker is available to assist them. In this article we present a complex capacity evaluation with considerable disagreement amongst parties involved. We recognize and value the role

of many members of the interprofessional team; in this article we focus on the role of psychologists in this case, as the co-authors are psychologists. Over recent decades, psychologists have been at the fore of capacity theory, research, and policy (Moye, Marson, & Edelstein, 2013).

Questioning the ability of an older adult to make decisions often arises in clinical settings, such as treatment team discussions. In today's increasingly integrated healthcare setting, embedded or consulting psychologists may be asked to evaluate the capacity of an older adult to make decisions regarding their healthcare, independent living, or financial management. Alternatively, psychologists may be brought in to determine whether someone has regained capacity for decision making, perhaps after an acute medical illness clears. In other instances, it may be an older adult who adamantly defends their right for autonomous decision making and challenges a previous capacity determination, or perhaps, even a wish to demonstrate their competency when a guardianship or conservatorship is already established. In the case study outlined below, we address the latter, highlighting attention to psychosocial and medical factors complicating a capacity determination, as well as handling team dynamics when there is a dissenting opinion about decisional abilities.

Case Study

Demographic, Medical, and Mental Health Background Information

Mr. Andrews (pseudonym with details altered to protect privacy), is an 85-year-old, Caucasian, widowed gentleman, who received his care at a Veterans Affairs medical center. The patient experienced a left-sided cerebrovascular accident thought to be embolic in nature with resulting contralateral hemi-paresis and no significant language impairment. Mr. Andrews was admitted to an inpatient physical rehabilitation facility for strengthening. After plateauing with rehabilitation efforts and no significant improvement in physical functioning, his treatment providers recommended placement in a longterm care facility as he was in need of a level of care that exceeded that which could be provided through in-home services. Unfortunately, Mr. Andrews' spouse died in the months preceding the stroke and he had no other in-home assistance due to lack of family members available. In addition to the stroke, the veteran's medical history was significant for the following issues: hypertension, arteriosclerotic heart disease, sleep apnea (treated with a continuous positive airway pressure [CPAP] device), age-related macular degeneration (early stage), and chronic back pain (adequately controlled). There were no abnormal laboratory data. Magnetic resonance imaging of the brain, conducted prior to his stroke, revealed mild to moderate chronic small vessel disease. Regarding mental health history, his records indicated a diagnosis of posttraumatic stress disorder related to his military service (currently asymptomatic) and a period of bereavement after the loss of his spouse.

The Case for a Joint Guardian and Conservator

Mr. Andrews lived independently at home with his spouse at the time of her unexpected death. In the months following, the veteran had difficulty managing himself and his house independently, reportedly becoming less organized and increasingly depressed at home. The stroke occurred several months later. While undergoing rehabilitation efforts Mr. Andrews

was evaluated by his community physician who, upon clinical interview and observation, diagnosed the veteran with Alzheimer's disease. Unfortunately, no other supportive documentation was available for the diagnosis of Alzheimer's disease or the differential involved (i.e., vascular cognitive impairment). A brief letter was drafted by the physician identifying his cognitive disorder and need for a guardian. Mr. Andrews strongly opposed. The veteran's power of attorney (a personal lawyer) at the time, fearing the veteran was in need of protection, petitioned the county court for a joint guardian and conservator.

In this petition, Mr. Andrews' self-neglect (e.g., uncleaned house, piles of papers around the house), diagnosis of Alzheimer's disease, and perceived "impressionability" were highlighted as reasons for need of a permanent plenary guardian and conservator. Specific examples of what constituted impressionability were not provided in court documentation. A cousin who was familiar with the patient was appointed guardian and conservator by the court. It was during this time that Mr. Andrews did not progress much with rehabilitation efforts and he transitioned into long-term care. Given the move to long-term care, the guardian proceeded to sell the veteran's house. According to the patient, however, the sale of his property and several items within the house were against his wishes.

Relevant Legal Statutes

At this point it is vital to address to relevant statutes pertaining to the case, as these can vary across jurisdictions. In this case, state statute allows for any person to petition the court for the appointment of a conservator for a proposed ward, with specific reasons why one is believed to be needed. A court may then appoint a conservator upon finding that it is in "the best interest of the proposed ward" (Wyo. Stat. § 3-3-101). Such a ruling would classify the adult as an "incompetent person" defined as "an individual who, for reasons other than being a minor, is unable unassisted to properly manage and take care of himself or his property as a result of the medical conditions of advanced age, physical disability, disease, the use of alcohol or controlled substances, mental illness, mental deficiency or intellectual disability" (Wyo. Stat. § 3-1-101). Of note, many states have moved away from relying on global determinations of incapacity in favor of more limited and specific determinations making for guardians or conservators with limited authorities (Moye & Naik, 2011).

Decisional abilities are not specifically addressed as part of the guardianship and conservatorship statutes, but may be found in statutes related to health care decisions. In this instance, "capacity" is defined as "the ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health care decision" (Wyo. Stat. § 35-25-402).

The Setting and Referral for Testing

Mr. Andrews resided in a long-term care facility and remained an active participant in his healthcare, as well as in the facility and community activities. His treatment team consisted of various disciplines (nurse practitioner, nurse manager, registered nurse, social worker, psychologist, chaplain, physical therapist, occupational therapist, recreational therapist, dentist, and dietician), who met weekly, to discuss patient care issues. The patient was formally discussed on a quarterly basis due to his long-term care status. In this particular

setting, Mr. Andrews had daily access and contact with the social worker and nurse practitioner to whom he made several requests for an evaluation of his ability to make medical decisions and manage his finances.

Notably, the patient was most concerned with regaining control over his finances, as his treatment team, and guardian, usually deferred to Mr. Andrews to make his own low risk medical decisions that arose in the context of care in the long-term care facility, for example, starting and stopping specific medications, assenting to blood draws, obtaining a flu shot, and treatment of cold symptoms. Otherwise, no emergent or urgent medical concerns arose during his time in long-term care. Of note, the treatment team is generally not concerned with the financial matters of their residents, but as Mr. Andrews was a veteran and received a monthly check from the federal government (for compensation of disability in the service of his country), should the team advocate for the removal of a conservatorship, an understanding of his financial capacity was necessary. The guardianship was considered a related but separate evaluation.

The evaluation was performed to capture diagnostic impressions and to evaluate the patient's capacity to manage his own finances. When initially consulting with the team about the assessment request, team members shared their impression that although he did not seem to evidence a major neurocognitive disorder, his poor recall of conversations and repetitive questioning equated a lack of overall capacity. Coincidentally, Mr. Andrews wanted to donate a large sum of money to a perceived suspicious charity. Nursing staff and treatment providers were concerned when a male visitor repeatedly took the resident out for meals, ending with Mr. Andrews paying for the food, and then a few weeks later, Mr. Andrews wanted to donate approximately \$50,000 to a children's charity run by this same person. A lawyer briefly working for Mr. Andrews at the time (to overturn the guardianship and conservatorship, but later fired by the patient) investigated previous court cases involving this male visitor and discovered a history of financial exploitation. This supported the treatment team's view that the veteran lacked decisional capacity.

The Current Evaluation

Mr. Andrews was provided informed consent, including that this evaluation would not necessarily overturn a court-appointed guardian and conservator and could result in a recommendation for continuance of a conservatorship. Furthermore, Mr. Andrews was informed that the evaluation would only focus on financial abilities, as an evaluation of medical decision-making capacity would require another evaluation later. He seemed to understand and provided his assent. The guardian provided consent for the evaluation.

The evaluator consulted the treatment team for the collection of collateral information. Observations regarding the patient's overall physical functioning, cognitive abilities, and perceptions of impressionability were sought. Moreover, the guardian was consulted to obtain specific information about the patient's history, concerns noted in the original petition for a conservator, knowledge of financial management skills, and to confirm information obtained from the patient regarding his financial portfolio.

A clinical interview was conducted with Mr. Andrews using recommended interview questions put forth in the American Psychological Association (APA)/American Bar Association (ABA) Assessment of Capacity in Older Adults handbook (APA/ABA, 2008). A brief neurocognitive battery was administered to identify specific cognitive strengths and weaknesses (for specific measures used, see Table 1). For the financial portion of this evaluation, legal counsel was consulted, along with professional literature and research to guide identifying specific standards (e.g., Herbert & Marson, 2007). The following standards were examined: 1) financial conceptual knowledge was assessed via an interview and standardized questions; 2) knowledge of assets and financial responsibilities was assessed via an interview and verified with the conservator; 3) performance-based financial abilities, such as counting money, making change, reading a bill, writing a check, was assessed with standardized functional measures; and 4) financial decision-making skills, including the ability to receive and evaluate information, and communicate a choice, were examined by using established hypothetical case vignettes and a personal example germane at the time (patient's request for his conservator make a large donation to a charity).

It is most notable that the patient's performance on the cognitive measures fell within the average range when compared to his same-aged peers, with exception for those tasks that required use of his dominant hand (such as visuospatial and construction skills) which was impacted by his stroke. The patient's macular degeneration was diagnosed as early stage and based on observational analysis of his performance, did not appear to be a significant factor. The hemiparesis was considered the main concern regarding his visuospatial performance. Although his cognitive performance on this evaluation was in the average range, it should be noted that this likely represents some decline from his premorbid baseline. Specifically, previous cognitive testing showed memory to be in the high average range as recently as 2 years ago.

Mr. Andrews demonstrated knowledge of basic financial information and institutions (banks, insurance, etc.), as well as adequate responses to knowledge of his own financial resources (pension from government, bank balances, etc.). To place this information in context, the patient's financial values were explored, such as his long-standing history of donating money to charities and preference for otherwise saving his money "for a rainy day." On performance-related measures, the veteran struggled due to his paresis, with tasks such as writing a check, balancing a checkbook, and using a calculator. His approach to several of these tasks consisted of a trial-and-error method and relying on what looked correct as an answer, producing incorrect responses on harder tasks of calculation (e.g. calculating the percentage of a bill insurance would pay for). Mr. Andrews did not seem concerned with this approach and did not appear to understand the limitation or risks of such as approach. Regarding financial-specific decision-making abilities, Mr. Andrews could identify the basic meaning of risk, benefit, and what it meant to have a choice. Using hypothetical financial case vignettes from the Hopemont Capacity Assessment Inventory (Edelstein, 1999), he was able to identify general tenants of the situation, the choices at hand, and what decision he would make by weighing pros and cons.

Furthermore, Mr. Andrews was questioned specifically about his desire to donate a large sum of money to the charity. The veteran consistently shared his reasons for donating,

stating a long-standing desire to assist others given his financial stability. Importantly, the sum of money was considered large by many members of the treatment team, but the amount was well within his financial means without placing him at risk for being unable to meet his own needs. On the contrary, the patient was financially well off and valued assisting others given his means. He frequently purchased gifts for others and had previously made arrangement for donating large sums of money in his trust. When confronted with concerns about the charity's spokesperson's past, Mr. Andrews accurately and consistently identified the teams concerns, factual information about the spokesperson's past, his personal values influencing his decision, and the risks of making a donation given the information available. The patient believed strongly that the person should not be judged by previous actions and appeared sincere when with him.

Finally, information obtained from collateral informants was considered. First, the treatment team largely noted a general impression that the patient was susceptible to the influence of the representative from the children's charity, as well as a sense that he did not recall aspects of their conversations with him. It is important to note that prior to this evaluation, the team did not have a dedicated geropsychologist and the mechanics of a capacity evaluation (i.e., issues to consider, importance of cognitive functioning, means to enhance capacity, professional standards, difference between various capacities, relevant statutes) were unknown to the team members. The guardian felt the patient was "very impressionable" and needed continued protection. When questioned further, this concern appeared to arise due to the request to make a large donation to the children's charity. The guardian, familiar with the patient's background, could not recall any instance of improper financial management, exploitation, or actions that would have led to an inability to care for oneself. When specifically asked about impressionability being mentioned in the court petition, he was unable to provide an example as to why that was included, outside of the patient's history of purchasing meals for others.

Based on the current evaluation, an opinion was put forth that the patient demonstrated adequate capacity to manage his own day to day financial affairs, proposing that a limited conservatorship was sufficient to balance the patient's autonomy and need for assistance. Several recommendations were made to enhance the patient's capacity to manage his affairs, rather than reliance on the more restrictive plenary guardianship and conservatorship. Most notably, Mr. Andrews needed the greatest assistance with the physical demands of financial management (e.g., writing checks, using a calculator, paperwork, etc.). This alone would not necessarily require a conservatorship, as the patient retained the ability to direct another individual to carry out these performance-related tasks. However, given the complexity of Mr. Andrews' financial portfolio, he needed assistance with oversight of stocks, investments, and more difficult financial operations in light of his trial-and-error approach. State statute implies a competent person is someone who can manage their finances without assistance. As Mr. Andrews needed both physical assistance due to his stroke and oversight due to his lack of awareness of the limitations of his problem-solving approach, he met the technical definition of the statute as being incompetent. In making the recommendation for a limited conservatorship, the aim was to increase the patient's level of involvement in his financial affairs based on the data demonstrating his abilities. Finally, specific recommendations were put forth to encourage his treatment providers to utilize effective communication strategies

when working with older adults (e.g., Gerontological Society of America, 2012), for example, speaking at a slower pace, facing the person directly, and being mindful of professional jargon.

Results and impressions gleaned from the evaluation were shared during treatment team discussion, in-person meeting with the social worker and nurse practitioner, and via a formal written report. As the treatment team was generally not concerned with financial matters, the information was directed towards the patient, and the patient's lawyer and guardian, both of whom had access to the report with Mr. Andrews' permission. The issue of the patient allowing a lawyer to access his medical record, independent of guardian permission was clarified with legal counsel who highlighted the patient's ultimate right to disagree and challenge a court-appointment guardianship/conservatorship. The patient, obtaining a copy of this evaluation from his medical record, shared the report with his lawyer who ultimately submitted it to the court.

Challenges and Reflections

When conducting assessments of capacity, there can be many complicating factors, and several competing interests at play which will need to be considered by the evaluator. In the case of older adults, it is common to see chronic health conditions that may impact thinking in permanent or temporary ways (see Appendix G of the APA/ABA Handbook for a list of medical conditions and their effects on capacity). For example, mental health conditions such as depression may lead to impairments or diminished capacity (Moye et al., 2013). The impact of medical and mental health conditions, and the prognosis of both must be weighed in determinations of capacity. In a related vein, the presence of neurocognitive impairments or disorders are essential to consider as they may affect decision-making abilities in various ways. Of note, the presence of dementia is no longer considered sufficient to declare a lack of capacity. Rather it is necessary to examine specific cognitive domains as they relate to the specific capacity in question; because of this it is not considered essential to undertake a full neuropsychological assessment to determine capacity. However, diagnostic information about a neurocognitive disorder may assist in prognostication and in crafting recommendations to help bolster capacity in an impaired person. When examining the case of Mr. Andrews, one may posit that the original basis of the guardianship and conservatorship was due to perceived lack of cognitive ability in light of a dementia diagnosis. However, there may have been several other factors, even reversible or treatable, influencing how Mr. Andrews presented to the community physician (who wrote the letter in support of a guardianship to the court), such as a depression, bereavement, and adjustment difficulties.

An additional complication can arise when thinking about who will make a persons' decisions if they no longer can. To seek guardianship is a long and expensive process that, despite many positive reforms, still all too frequently results in a person losing nearly all of their rights. When there is an appointed surrogate this process can be simpler but may still result in highly limited autonomy for the impaired person. However, it is not uncommon to see healthcare teams push for guardianship or other surrogate decision-maker in the service of protecting the patient (e.g., weighing safety over autonomy). It is in this context that

capacity evaluations must also consider the values and preferences of patients to ensure they are not unduly kept safe at the risk of losing quality of life.

In this case, a seemingly straightforward evaluation was met with many challenges along the way. Most notable of them, the treatment team members and guardian disagreed with the psychologist's finding that the patient demonstrated adequate financial capacity. Stakeholders in the patient's welfare generally agreed that he did not evidence significant cognitive impairment, but still lacked capacity to make decisions (viewed by the team members as a global decision) due to his trouble recalling aspects of conversations and perceived impressionability (his strong desire to contribute a large sum of money to what appeared to be a suspicious charity).

How does one respond to the main concern of one instance of impression-ability as grounds for needing a guardian in light of the evaluation demonstrating decisional capacity and the patient's ability to communicate risks? It can be challenging for an integrated psychologist to balance collateral information from others who provide such strong opinions about a patient's capacity. Working with older adults, especially in a long-term care setting, could play a role in activating age biases, such as the need to provide protection to a seemingly frail individual. We each have our own comfort level that dictates the balance between autonomy and safety; these comfort levels may conflict with other professionals serving on an interprofessional team. Working with staff can help team members recognize dynamics and biases that may influence decisions about how to care for (protect) older adults. Providers can also use data to help the team understand how a finding of capacity was made. In this case, the veteran's clear understanding of risks (e.g. that the person running the charity had a history of fraud) and his financial ability to donate a sum of money without putting himself at risk of impoverishment, along with his lack of serious cognitive impairment could all serve as evidence to be shared with the team to help assuage their concerns.

Owing to the pressure that the treatment team exerted by their own judgments of the patient's abilities, care was taken to discuss findings with them. In this case, consultation with other psychologists assisted with discussing team dynamics and best approaches. Fears of disrupting a working, collaborative environment were addressed by taking a professional, jargon-free approach to explaining how the results of the capacity evaluation can highlight alternative means for enhancing the patient's functioning. In doing so, these discussions aligned with the treatment providers' genuine desire to promote respect and dignity for their older patients. In addition, legal clarification on the state statutes relevant to the case provided further education to team members when patient autonomy could be curtailed by safety concerns. In the end, the case of Mr. Andrews provided ample discussion with treatment providers as to the role psychologists can play in capacity evaluations.

Outcome

All adults, regardless of age, are exposed to charlatans, whether it comes as a "can't miss" opportunity in the mail or an unsolicited knock on the door. Did Mr. Andrews demonstrate deficiencies in his reasoning abilities or safety awareness significant enough that he needed

protection from undue influence? Based on a structured, formal evaluation, Mr. Andrews was at no more risk than any other adult in the community. His tendency to help others, to do so within his financial means, and overly gracious attitude resulted in his desire to donate a large sum of money to charity—consistent with his expressed values and history. There are serious ramifications to guardianship and/or conservatorship proceedings. The clinical opinion that a person lacks decisional ability must be carefully reviewed within the parameters of legal statutes, organizational policies, cognitive functioning, and patient values. This approach ensures multiple factors are considered and patient autonomy is upheld as much as possible.

Growing discontent with his lack of control, Mr. Andrews independently contacted a lawyer to represent him in court to remove the joint guardian and conservator. The capacity evaluation was used in court proceedings to highlight recent findings. Interestingly, the patient's lawyer and the lawyer representing the guardian, directly quoted the capacity evaluation as evidence that the patient did or did not require a continued guardianship, each as suited for their argument. In the end, citing a contentious proceeding, the judge appointed an independent party to represent the patient who reviewed the capacity evaluation and interviewed the evaluator. After a nearly two-year struggle, the guardianship and conservatorship were removed without additional limitations imposed. Mr. Andrews tearfully remarked, "I have my freedom back."

Recommendations

The case of Mr. Andrews highlights how a psychologist in an integrated healthcare setting acts not only as a member of a team, but also as assessor, advocate, and educator. By virtue of our special training in team dynamics and assessment, we are uniquely placed to navigate these roles and effect change. Professionals encountering similar struggles may consider the following:

- (1) When working with treatment teams, it is very useful to elicit input up front from relevant stakeholders (e.g., the physician if the question pertains to medical decision-making, occupational therapy if there are questions about independent living). This allows for more data points on which to base your findings, but also demonstrates to the team how much you value their perspectives. These interprofessional interactions are a prime opportunity to provide informal education about capacity evaluations.
- (2) It is essential to understand, and respect, the culture of your team. If, for example, you work on a team (or in a medical center) that traditionally errs on the side of safety over autonomy it is important to know that and decide how you will proceed. You may 1) temper your own comfort with risk to more closely match your team and thereby increase team congruence, 2) you may at least try to show understanding of where they are coming from and appreciation for their perspective, while still respectfully advocating for autonomy, or 3) you may seek allies in the system who can "back you up" on difficulty cases.
- (3) If you are a provider who will conduct capacity evaluations, get to know your local or regional counsel or hospital's attorney. They are excellent sources of

information regarding local laws and practices that might be relevant for your assessments.

(4) Be aware of any hospital policies and procedures related to the type of capacity evaluation you are conducting.

(5) You may feel pressured to conclude your report a certain way or rushed to complete an evaluation. Be sure to take a step back and evaluate the situation for yourself and determine if an evaluation is even warranted. For instance, if the patient is experiencing delirium and no immediate decision needs to be made, allow the patient time to stabilize before evaluating. Guidance on approaching the capacity question can be found in APA/ABA Handbook (APA/ABA, 2008).

(6) When you have concluded your assessment and have the results, you should try to communicate those to your team in person, rather than just via the medical record (especially if your findings might be controversial or surprising). This provides an opportunity to respectfully share your findings with the team, allows you to provide additional education, and creates a space in which the team can ask questions and discuss results together. This improves team communication and helps everyone “get on the same page” before meeting with the patient.

(7) Conducting capacity assessments can be intimidating, especially if you have limited formal training or experience. It may be beneficial to assemble a (formal or informal) consultation group with whom you can discuss difficult cases and get other perspectives. This might be by finding out who else at your medical center conducts capacity assessments, or it may be finding a small number of professionals at other sites you can consult with from time to time. This consultation group can also serve as a support when you are in the midst of particularly tough or emotional cases.

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Table 1

Testing measures utilized in assessment.

Wechsler Test of Adult Reading (Wechsler, 2001)
Wechsler Memory Scale, 3rd Edition (Wechsler, 1997)
Information and Orientation
Wechsler Memory Scale, 4th Edition (Wechsler, 2009)
Clock Drawing portion of the Brief Cognitive Status Exam
Wechsler Adult Intelligence Scale, 4th Edition (Wechsler, 2008)
Matrix Reasoning
Visual Puzzles
Picture Completion
Digit Span Backwards
Repeatable Battery for the Assessment of Neuropsychological Status, Form A (Randolph, 2012)
Hopemont Capacity Assessment Inventory (Edelstein, 1999)
Financial Decision-Making Subsection
Independent Living Scales (Loeb, 1996)
Managing Money
Geriatric Depression Scale—Short Form (Sheikh & Yesavage, 1986)

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