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Assessing Mental Capacity and Susceptibility to Undue Influence

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Clinicians are commonly asked to participate in the determination of an individual's mental capacity and susceptibility to undue influence. Vague statutory definitions and lack of operational criteria for both determinations have contributed to inconsistency in the quality and usefulness of expert input to these determinations. Questionnaire responses of 119 probate judges from the U.S. indicate that this input is quite influential despite the problems mentioned above. This paper presents and discusses the judges' views on selected procedural and conceptual aspects of expert evaluation and testimony.

The legal system employs concepts called "mental capacity" (MC) and "susceptibility to undue influence" (SUI). Despite the fact that these terms "do not have immediately discernable scientific counterparts . . . (and it) is therefore necessary for clinicians operationally to define or translate legal concepts into observable, definable, and measurable scientific terms" (Marlowe, 1994, p. 12), participants in the legal system usually turn to clinicians to assist in determining MC and SUI when there is a suspicion of mental impairment. Partly because key statutory terms lack discernable scientific counterparts, clinical expert evaluation and testimony has been widely criticized as generally unreliable and of little value to the judicial process (Ennis & Litwack, 1974; Faust & Ziskin, 1988). Although a substantial body of literature has emerged addressing various aspects of this unreliability as it applies to assessment of competency (e.g., Appelbaum & Grisso, 1988; Draper & Dawson, 1990; Galen, 1993; Madigan, Checkland, & Silberfeld, 1994; Pepper–Smith, Harvey, Silberfeld, Stein, & Rutman, 1992;) and SUI (Perr, 1981; Wertheimer, 1993; Wrosch, 1992), legal standards remain quite variable from jurisdiction to jurisdiction, and it may be difficult for the expert to derive clear guidelines from this literature. With the aim of providing a perspective on some of

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the issues related to assessment of MC and SUI, we conducted a multistate survey of probate judges which solicited their views on expert assessment of MC and SUI, the format of clinical expert testimony on MC and SUI, and the relative degree of mental intactness required to have "mental capacity" for various civil actions.

BACKGROUND

Lack of Mental Capacity

The survey concerned two types of legal incompetence that are adjudicated in civil courts: (1) specific incompetence (Gutheil & Appelbaum, 1982), wherein an individual is (or was) incompetent to engage in one or more specific types of transaction (e.g., entering into a contract, marrying, making a gift, executing a will or trust, giving informed consent to medical treatment) during a particular time period; and (2) general incompetence, wherein an individual is incompetent to engage in all or most legal transactions. A finding that a person is (or was) incompetent to carry out a transaction means that the transaction is not legally valid or binding. Specific incompetence may be determined prospectively or in retrospect; a retrospective finding invalidates a transaction that has already been carried out. Findings of general incompetence are usually made prospectively in the context of a determination that a person cannot care for self and/or property, or is susceptible to exploitation.

Susceptibility to Undue Influence

If a court finds that a person is generally unable to resist undue influence, this finding, like a finding of general incompetence, can lead to appointment of a conservator or guardian of the person's estate, even if the person is otherwise competent. A retrospective finding that a person *was* the victim of UI, like a finding of specific incompetence, may be the basis for rescission of all or part of a will, trust, gift, or contract. The two major legal theories of undue influence are the susceptibility theory, which focuses on the vulnerability of the victim, and the presumption theory, which focuses on the gift or bequest itself and the alleged influencer and his or her relationship to the victim (Wrosch, 1992).

Evaluation Procedures and Expert Testimony

Clinical expert testimony on mental functioning has been the subject of much discussion in the forensic literature, mainly focusing on two related issues: the reliability of assessment, diagnosis, and prediction, and the boundary between medical opinion and the ultimate legal issues before the trier of fact. Appelbaum and Gutheil succinctly expressed one recurring theme of the discussion as follows: ". . . many experts . . . maintain that while all the relevant data that a judge might need in order to decide if a . . . (subject) . . . is competent . . . should be presented clearly, the evaluator should not offer an opinion as to whether, based upon this information, she considers the . . . (subject) . . . competent or incompetent" (1991,

p. 267). In *Washington v. U.S.* (1967), Judge David Bazelon clearly agreed: "The function of the psychiatrist is not to try to tell the jurors what verdict they should render but rather portray, as fully and completely as possible, the mental and emotional makeup of the defendant, how his emotional and intellectual processes work and how they affected his capacity . . . in the specific situation . . . " (p. 455, n 31). In this regard, various criteria sets and standardized tests for the forensic assessment of mental capacity have been proposed (Appelbaum & Grisso, 1988; Galen, 1993; Roth, Meisel, & Lidz, 1977), but to our knowledge no previous investigators have solicited judges' opinions regarding the value of such tests.

What is the Rank Ordering of Capacities?

The conduct of an evaluation of mental capacity may depend upon the expert's understanding of the relative degree of mental intactness required for the specific capacity being evaluated: ". . . certain competencies require 'more' than others in terms of abilities, understanding, or general functioning . . . this 'more' . . . correlates with some general standard of cognitive functioning" (Silberfeld, Stevens, Lieff, Checkland, & Madigan, 1993, p. 483). Unfortunately, neither the law itself nor the forensic literature is always clear as to the relative degree of cognitive functioning required by various capacities. For example, is a greater degree of cognitive function required to execute a contract or a trust, as compared to that required to execute a will? Is a different standard applicable to consent to hospitalization as compared to consent to treatment with an antidepressant?

METHOD

Questionnaire Design

A six-page questionnaire (questionnaire items available on request from the first author) asked respondents for their age and gender, the number of years they had been probate judges, the number of contested cases they had heard involving an issue of competence or UI, how often professional expert testimony was heard, what type of professional testified, and how influential they found this testimony to be. The additional survey items (described below) comprised 18 statements (6 regarding incompetence, 7 on SUI, and 5 on expert testimony) and asked respondents to agree or disagree with the statements using a 9-point Likert scale, with 1 = "totally agree", 5 = "no opinion", and 9 = "totally disagree". Responses of 1, 2, or 3 are counted as "agreement" and 7, 8, or 9 as "disagreement". Another item asked respondents to "rank order" various capacities in order of mental intactness required for each, and a final item was an open-ended inquiry about expert testimony.

Although we expected respondents' opinions to reflect a mixture of their knowledge of applicable case law and statute and their own personal judgment, to encourage responses based more upon personal judgment, the questionnaire asked for "spontaneous, unresearched" responses.

Questionnaire items

Mental Capacity and the Factors that Influence It

We queried judges on several aspects of mental capacity, beginning with the concept of "capacity" itself. To illustrate this problem, in the evaluation of a testator, the clinician can avoid the ambiguity of the notion of capacity and conclude that the testator is competent to ". . . recollect the nature and situation of his or her property" if, when asked, the testator recites an accurate listing of his or her assets. A clear record that a testator recited an accurate listing of his or her assets may be equally valuable to the consultant conducting a retrospective evaluation of a deceased testator. But if the testator does not (or did not) recite an accurate list, what if any further evaluation is appropriate, and under what circumstances, if any, will the trier of fact be convinced that the testator has (or had) the capacity to do so? Several authors (Gutheil & Appelbaum, 1982; Spar & Garb, 1992) have maintained that "capacity" is best represented by the testator's *optimal* performance, uninfluenced by extraneous factors, such as a concomitant physical illness, unusual psychosocial stress, normal diurnal or other variation, or the anxiety induced by an unskilled examiner. But is "capacity" better represented by the testator's *typical* performance, or even by his or her *worst* performance? Further, to which specific mental function does the term "recollect" refer, and how would one test it? Would recognition memory suffice, or is spontaneous recall required? How do judges see the relationship between lack of mental capacity and mental illness; that is, is a formal diagnosis of mental illness required to support an impression of incompetence?

Beyond assessment of the subject's mental status, which aspects of the subject's history are proper matters of expert evaluation and testimony? In the testamentary context, for example, historical material may be crucial in identifying delusional beliefs that may be withheld or denied at the time of the expert examination. But should the examiner also attempt to elucidate past dispositive inclinations to compare them to the subject's stated intentions in the document at issue? Comparison with the way the law regards undue influence may serve to clarify this issue; the widely cited *Estate of Ricks* decision (1911) for example, defined influence as undue if it "causes the testator to make a disposition contrary to and different from the one he would have made had he been left to the free exercise of his own inclination or judgment." It follows that the same conduct on the part of another person is not undue influence if it does not result in a different dispositive inclination than that held before the influencer's efforts. If similar logic applied to lack of testamentary capacity, then a will made by an incompetent person could be valid if it could be shown that it is the same will that he would have made if he were competent, and the expert's exploration of the testator's past dispositive inclinations could provide critical evidence.

What is the impact upon the validity of an assent (e.g, to a will, contract, or medical procedure) if the assentor suffers from a severe mood disorder but is not psychotic? Although the law recognizes that psychosis can produce legally significant changes in decision-making capacity, it is less clear that nonpsychotic mood disorder can. To survey opinion on this issue we presented a hypothetical scenario in which a man suffering from mania enters into a contract on the basis of

wildly optimistic (but not frankly delusional) expectations of success in business, then attempts to rescind the contract on the claim that his manic state adversely affected his judgment. A related question concerned the effects of advanced age *per se* on competency; that is, to what extent changes in mentation associated with normal aging, in the absence of mental illness, are recognized by judges as capable of impairing competence?

Susceptibility to Undue Influence

In the susceptibility theory of undue influence, "weakness of mind" is an often-cited cause of increased susceptibility. *Estate of Yale* (1931) defined five elements of UI, one being that "the testator was mentally and physically weak enough to permit a subversion of his freedom of will. *Estate of Anderson* (1921) found "Since this [UI] can happen but rarely in cases of persons of normal strength of mind and in full possession of their faculties, unimpaired by infirmity, evidence justifying the conclusion that it did occur in a particular case must be very strong." California Civil Code [S]1575, relating to contracts, states that UI consists of ". . . (2) in taking an unfair advantage of another's weakness of mind." But what is the relationship between "weakness of mind" and mental illness? We asked judges if a diagnosis of mental illness is required to prove increased susceptibility to UI, or if mere "weakness of character" would suffice. We also asked whether advanced age *per se* could increase SUI, and if, in cases where mental illness is the basis for a claim of increased susceptibility, the mental illness must be persistent. That is, can a person be rendered susceptible to UI by mental illness that is only intermittent. We also inquired about the potential effects on SUI of nonpsychotic mood disorder, using the hypothetical scenario described above, and about the probative significance of assessment of an alleged influencer. If an alleged influencer is necessarily aware of and intends to influence his or her victim, expert evaluation of the influencer (aimed at uncovering motivation) may allow the examiner to contribute in yet another way to the adjudication of UI.

A major element of UI is coercion or duress applied by the influencer to the victim, such that the victim's ". . . will is replaced by that of . . . (the influencer)." To explore the boundaries of the concept of "coercion" we proposed another hypothetical situation in which a son attempts to persuade his father to give a large gift of cash by threatening to "lose his business and house and be 'homeless' " if the gift is denied, and asked judges if this would constitute coercion for purposes of adjudicating a claim of undue influence.

Expert Evaluation and Testimony

The survey included the following three items on this topic: (1) "psychiatrists who testify as experts on mental capacity to perform an act should focus on assessment of the specific mental functions (e.g., recent and remote memory, attention, concentration, receptive and expressive language function, insight, judgment, etc.) required to perform that act"; (2) The above item with "undue influence" replacing "mental capacity"; and, (3) "Psychiatrists who testify as experts on mental capacity or susceptibility to undue influence should support their opinions by including in their testimony results of standardized tests that measure the specific

mental functions (e.g., recent and remote memory, attention, concentration, receptive and expressive language function, insight, judgment, etc.) required to perform the contested act or to resist undue influence."

A fourth item concerned a central element of the "presumption model" of UI, that being a "confidential relationship" between the influencer and the subject (Wrosch, 1992). Proof of such a relationship gives rise to a presumption of UI in some states, and in many others is one of the indicia of UI. Accordingly, an expert's exploration of the victim's thoughts and feelings about his or her alleged influencer could be important to the trier of fact. To explore this issue, the questionnaire included the statement: "Psychiatric testimony can be highly probative on the subject's relationships to others." In a similar vein, many experts are skilled at helping patients and clients gain insight into and understand their own motives and intentions. In the context of an allegation of undue influence, this skill could allow experts to elicit information on the "real intentions" of an individual whose will has allegedly been "replaced" by that of an alleged influencer. On this point a questionnaire item stated "Psychiatric testimony can be highly probative on a subject's real intentions." Finally, the last item on this topic was open-ended: "Psychiatric expert testimony on matters of mental capacity and susceptibility to UI would be most useful to the court if psychiatrists would . . ."

The Relative Ranking of Selected Capacities

We asked respondents to place 14 different mental capacities on a hypothetical "timeline" (a type of "visual analog scale") representing the deteriorating time course of a person's dementing illness, at the point where they thought each capacity would be lost. We defined the left end of the timeline as the present, when the person is still cognitively intact, and the right end of the timeline as the end of the disease process, when the person is in an "essentially vegetative state." In effect, this item asked respondents to rank the relative degree of mental capacity required for each act. To quantify responses we analyzed each respondent's timeline and assigned each capacity a number representing its relative position on the timeline. We assigned the most leftward mark the number one and the most rightward mark the highest number recognized by that respondent, up to 14. Because "ties" were allowed, some capacities were placed on the same spot on the timeline, so not all respondents recognized 14 different degrees of capacity. We assigned ties the same rank number; that is, if three capacities were placed in the second place from the left, we assigned each the number 2, and we assigned the next capacity to the right the number 5.

Respondents

With the assistance of the National College of Probate Judges (NCPJ), the questionnaire was sent to 300 probate judges (whose names and addresses remain unknown to us) around the country. This number represents approximately half of the membership of the NCPJ, and was compiled by selecting every other name on their membership list. From 29 states, with disproportionate representation from Connecticut, Ohio, Michigan and Georgia, 119 judges returned completed

Table 1. Respondents' experience with cases involving mental capacity N=119

Years as probate judge	9.1 *SD* 6.7
Age	51.9 *SD* 8.7
Number of capacity cases heard in past 5 years	76.7 *SD* 182.6
% of experts that were nonpsychiatric physicians	35.3 *SD* 30.5
% of experts that were psychiatrists	32.0 *SD* 29.8
% of experts that were nonphysician mental health professionals	30.7 *SD* 30.3
% of expert testimony that was extremely influential . . .;	51.0 *SD* 40.1
% of expert testimony that was somewhat influential . . .;	39.0 *SD* 36.5
% of expert testimony that was not a factor	4.9 *SD* 12.4

questionnaires. There were 91 men and 25 women (three did not indicate gender) of mean age 51.9 years.

RESULTS AND DISCUSSION

At the outset, it should be noted that the 119 judges who responded to the survey represent less than 20% of the NCPJ membership, and may not be a random sample. Moreover, cases involving an issue of mental capacity or undue influence can be adjudicated by general and limited jurisdiction trial courts, and judges from these courts were not surveyed at all. Because of this limitation, it would be inappropriate to draw inferences from these data regarding the opinions of judges not represented, so we present the survey data without statistical analysis. Generalizations based upon these findings should be made with extreme caution, and only in light of law applicable to the jurisdiction in question.

Respondents' Experiences and Attitudes Towards Expert Testimony

Respondents reported that the majority of experts testifying on both competence and undue influence were physicians, of which about half were psychiatrists (Tables 1 and 2). About 30% were nonphysicians. Despite the controversy surrounding mental health expert testimony, respondents found expert testimony to be "extremely influential" 51% of the time regarding incompetence and 37% of the time regarding SUI. It must be noted, however, that there was significant variability as revealed by the relatively high standard deviations in the responses, and attention to the mean responses alone may be misleading.

Table 2. Respondents' experience with cases involving undue influence

Undue influence cases heard in past 5 years	22.1 *SD* 64.2
% of experts that were nonpsychiatric physicians	39.7 *SD* 61.3
% of experts that were psychiatrists	19.4 *SD* 26.3
% of experts that were nonphysician mental health professionals	30.7 *SD* 30.3
% of expert testimony that was extremely influential . . .;	37.4 *SD* 38.8
% of expert testimony that was somewhat influential . . .;	47.6 *SD* 39.2
% of expert testimony that was not a factor	8.6 *SD* 19.7

Table 3. Respondents' opinions of mental capacity

Item	1	2	3	4	5	6	7	8	9	Mean
Evaluations should be timed to capture the person's best performance	7	8	5	7	21	8	16	18	10	5.7
Recognition memory alone qualifies as "recollection"	6	18	30	8	11	7	10	8	2	4.1
Lack of capacity requires mental illness	24	21	16	6	3	4	6	8	11	3.9
An incompetent person's gift may be valid if it would have been given anyway	3	3	9	8	5	3	14	28	26	6.7
Mania without psychosis can impair mental capacity	15	22	22	9	7	7	9	6	3	3.8
Age alone does not impair capacity	57	22	10	2	3	2	2	2	1	2.0

Column numbers one through nine represent Likert scale ratings: "1" = strongly agree, "5" = no opinion, "9" = strongly disagree. "Mean" column represents mean Likert score for that item. Data represent percentages of respondents for each rating point. Rows do not add to 100 due to rounding.

Mental Capacity

Forty-four percent of respondents disagreed with the statement that competency evaluation should be timed and conducted so as to elicit the subject's best performance (Table 3). A plausible explanation may lie in the nature of the probate system itself, a major responsibility of which is to appoint conservators and guardians to protect the interests of those who are particularly vulnerable to exploitation by others. In that context, it may be more appropriate to consider the individual's typical or worst performance as most determinative of his or her vulnerability. Since the majority of respondents accepted recognition memory (the ability to identify the correct items from a list containing false but plausibly similar items) as adequate to satisfy the requirement that a testator have the capacity to "recollect the nature and situation of his or her property," it seems advisable to add testing of this function to the evaluation protocol whenever the subject is unable to spontaneously recall relevant information.

Although most respondents agreed that a finding of incompetence requires evidence of mental illness (Table 3), a substantial minority apparently shared the view expressed by Morse (1982): "Indeed, there is no necessary relationship between mental disorder and legal incompetence . . . many normal persons are incompetent, and many, if not most, mentally disordered persons are not" (pp. 64–65). This view reflects a narrower conception of mental illness than that held by American psychiatry, whose official diagnostic classification, DSM-IV (APA, 1994), includes categories so broadly defined (e.g., "cognitive disorder not otherwise specified") that some diagnosis would seem to apply to anybody who lacks any legally-defined mental capacity. The closer relationship between lack of capacity and mental illness acknowledged by the majority of respondents was recently echoed by the Supreme Court in *Zinermon v. Burch* (1990): "The very nature of mental illness makes it foreseeable that a person needing mental health care will be unable to understand any proffered 'explanation and disclosure of the subject matter' of the forms that person is asked to sign, and will be unable 'to make a knowing and willful decision' . . ." (p. 987).

A large majority of respondents rejected the idea that an incompetent person's will could be valid as long as its content was not a product of the person's incompetence. Although these responses were likely influenced by prevailing law, they also may reflect respondent's reluctance to assume the responsibility for determining the disposition of a testator's entire estate based upon the vagaries of retrospective reconstruction of the testator's dispositive wishes.

The majority of respondents (Table 3) eschewed the opinion expressed in *Smalley v. Baker* (1968), which, addressing the validity of a contract, said: "This language . . . establishes the 'understanding' or cognitive test as the prevailing standard of legal competency . . . The manic phase of the manic-depressive psychosis does not impair such understanding, but only relates to the motivation", rather agreeing with commentators such as Gutheil and Bursztajn (1986) that nonpsychotic mania could adversely affect competence. Finally, only five respondents held the view that advanced age in the absence of mental illness could cause incompetence, and these respondents may have been influenced by statutory age bias. The New York Mental Hygiene Law, sec. 78.01, for example, allows a person to be found incompetent if "by reason of advanced age, illness, infirmity, . . . or other cause . . . he has suffered substantial inability to care for his property, or has become unable to provide for himself . . ." (Marlowe, 1994, p. 14).

Susceptibility to Undue Influence

As a group, respondents seemed to hold a relatively broad conception of UI and its antecedents (Table 4). Forty-seven percent disagreed that mental illness is required to prove that UI occurred, while a majority agreed that "weakness of character" in the absence of mental illness, could render a person susceptible to UI. The majority agreed that age alone could not increase susceptibility to UI, but agreed that fluctuating mental impairment could. Only 40% of respondents agreed that mania could increase susceptibility to UI, compared to 57% who agreed mania could affect mental capacity, even though manic patients typically demonstrate greater impairment of judgment and impulse control than cognition.

Table 4. Respondents' opinions of susceptibility to undue influence

Item	1	2	3	4	5	6	7	8	9	Mean
SUI requires mental illness	12	10	9	11	4	6	11	21	14	5.4
"Weakness of character" can increase SUI	11	20	27	9	13	3	8	5	4	3.8
Age alone does not increase SUI	30	27	23	3	3	3	8	2	1	2.8
Intermittant impairment can increase SUI	12	35	35	5	0	0	3	3	3	2.9
Mania without psychosis can increase SUI	6	19	15	13	15	3	15	8	5	4.5
UI must be deliberate	0	3	11	10	10	7	19	20	19	6.4
A threat to induce guilt is coercion	9	18	17	13	14	3	9	14	3	4.3

Column numbers one through nine represent Likert scale ratings: "1" = strongly agree, "5" = no opinion, "9" = strongly disagree. "Mean" column represents mean Likert score for that item. Data represent percentages of respondents for each rating point. Rows do not add to 100 due to rounding.

Table 5. Respondents' opinions of evaluation procedures and expert testimony

Item	1	2	3	4	5	6	7	8	9	Mean
Psychiatric testimony on capacity should focus on specific mental functions	23	34	26	8	6	2	2	0	0	2.5
Psychiatric testimony on SUI should focus on specific mental functions	18	28	27	9	8	1	8	0	1	3.0
Psychiatrists testifying on capacity or SUI should use standardized tests	15	23	28	9	17	2	3	2	2	3.3
Psychiatric testimony can be highly probative on the subject's relationships to others, or	6	9	24	17	13	6	10	13	2	4.6
Psychiatric testimony can be highly probative on the subject's real intentions	8	13	21	8	12	8	13	13	4	4.7

Column numbers one through nine represent Likert scale ratings: "1" = strongly agree, "5" = no opinion, "9" = strongly disagree. "Mean" column represents mean Likert score for that item. Data represent percentages of respondents for each rating point. Rows do not add to 100 due to rounding.

A majority of respondents agreed that a person's undue influence of another need not be deliberate, but responses were scattered regarding whether a son's threat to make his father feel guilty qualifies as "coercion" for purposes of determining whether UI has been exerted. According to Wertheimer (1993), the key question in determining whether coercion has been applied is whether the son's proposal to his father threatens to make the father worse off if he does not comply than he was before the proposal was made. In our view, this question in turn depends upon the father's actual and perceived moral obligation or lack thereof to make the requested gift, the son's perception of his father's moral obligation to make the gift, and the son's moral justification or lack thereof to ask for it. The son's moral justification in turn depends upon the son's intent; that is, does he mean, just in case the gift is refused, to allow or bring about his financial demise in a way that he would not if the gift were never requested? Despite these complexities, we note that 11 respondents strongly agreed, while four strongly disagreed, that the son's proposal is coercive.

Expert Evaluation and Testimony

A large majority of respondents agreed that experts should specify the specific mental functional impairments identified in their evaluation of mental capacity and susceptibility to UI, and almost as large a majority supported the use of standardized tests in both situations, although seven judges disagreed with the use of such tests. Respondents expressed mixed opinion regarding the probative weight of psychiatric testimony regarding "the quality of a person's relationships to the beneficiaries of a will or gift, or to the other party to a contract." Despite the apparently weaker connection between mental illness and SUI perceived by the respondents, when experts testify, their testimony is as influential regarding UI as it is regarding incompetence.

The item "Psychiatric expert testimony on matters of mental capacity and susceptibility to UI would be most useful to the court if physicians would . . ."

Table 6. Respondents' relative ranking of various capacities

Capacity	Mean rank (n=75)	Times ranked first	Times ranked last
Contract to purchase home	3.5	39	1
Execute irrevocable trust	3.7	24	2
Contract to purchase securities	4.9	17	3
Execute revocable trust	5.0	16	3
Open a Totten trust account	5.9	13	3
Execute a will	6.1	14	12
Open joint tenancy account	6.8	11	8
Manage one's finances	6.9	10	7
Inter vivos gift of real property	6.9	14	8
Consent to electroconvulsive therapy	7.0	10	10
Assign durable power of attorney for property	7.2	10	6
Consent to treatment with antidepressant	7.4	10	16
Consent to mental hospitalization	8.1	10	18
Inter vivos gift of personal property	8.1	11	15

A lower mean rank designates a higher level of mental capacity required on that function.

elicited only one repeated response, but it was a fundamental and enlightening one. Fourteen of the 73 who responded at all said something equivalent to "use lay terms and avoid technical language." These responses reiterate a common criticism of mental health expert witnesses who express conclusory opinions in unnecessarily technical terms. This reputation notwithstanding, respondents' narrative remarks expressed more favorable impressions of clinician's participation in competency and undue influence cases than we expected. Only one was unequivocally hostile: "Stay out of court!"

Respondents Rankings of Capacities

There was striking lack of agreement among the 75 judges who completed the "timeline" item (Table 6). Some capacities (to execute a will, to consent to electroconvulsive therapy) were rated by almost as many judges as "first to go" (i.e., requiring the highest degree of intactness) as rated them "last to go". If we ignore the scatter and look at mean rankings, the order is quite different than that reported by Silberfeld and colleagues (1993), who presented a similar visual analog scale to attendees to the 2nd International Conference of Public Trustees and Official Guardians. Although significant differences in methodology (their 10 competencies do not correspond well to our 14), limit the validity of direct comparison of their results with the present results, raters in their study did agree with our respondents that contractual capacity requires a relatively high level of mental intactness. On the other hand, raters in Silberfeld *et al.*'s study saw capacity to consent to medical treatment and to assign power of attorney as also requiring a relatively high level of mental intactness, while both capacities were seen as requiring relatively less mental intactness by respondents in the present study.

The judges' mean ranking of capacities were consistent with two general principles. First, since the aim of the legal notion of incompetence, as part of the larger notion of *parens patriae*, is to protect the incompetent individual, those actions

with the most serious and irreversible potential consequences for the subject should require the "highest" level of competence, a "sliding scale" principle that has been advocated by several authorities (Drane, 1984; Schaffner, 1991). In keeping with this principle, respondents ranked contractual capacity and capacity to execute an irrevocable trust as requiring the greatest degree of mental intactness. Second, most respondents agreed that mental illness is the cause of loss of competence in the first place. If treatment of that mental illness might restore competence, then it would be important to retain the capacity to consent to (or refuse) treatment for as long as possible. Holding to this principle, respondents ranked the two treatment consent capacities (consent to [1] mental hospitalization and [2] treatment with an antidepressant) as among those requiring the lowest degree of mental intactness. Respondents' mean rankings did not support the view expressed by Spar and Garb (1992) that the same standard of mental capacity would apply to the execution of a trust as to a will.

Justice Harry Blackmun (1994) wrote: "We are all in the same boat afloat on the same sea, and the medical and legal minds must work together to alleviate human aches, pains, and stresses . . . Venturesomeness, experimentation, flexibility and an open mind should be our watchwords . . . (as we seek) . . . to make sense of law and medicine combined" (p. 804). In the spirit of Justice Blackmun's remarks, and in light of the findings reported above, two of the authors (JS and MH) have collaborated with the California Medical Association, the California State Bar Association, and representatives of other agencies to propose legislation addressing the general problem of competency determination. This bill (1995 SB 730, authored by State Senator Henry Mello) will, if enacted, allow judges to require testifying experts to identify specific impairments in mental functions (a list of which is included in the bill), and to describe the connection between such impairment and the alleged lack of capacity in question. It also includes "general criteria" for competency to assent that are roughly consistent with several models proposed in the literature (Appelbaum & Grisso, 1988; Tancredi, 1982). We agree with Justice Blackmun that such collaborative legislative effort is an important mechanism whereby the law can keep up with relevant advances in science and clinical practice.

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