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PROTECTIVE SERVICES FOR THE ELDERLY COMMITMENT, GUARDIANSHIP, AND ALTERNATIVES

JOHN J. REGAN*

*Do not go gentle into that good night,
Old age should burn and rave at close of day;
Rage, rage, against the dying of the light.*¹

INTRODUCTION

Simone de Beauvoir, in her treatise on old age called *La Vieillesse*, concludes that "the manner in which a society behaves with its old people unequivocally reveals the truth—often carefully masked—of its principles and its ends."² This article will examine the legal aspects of the behavior of the American society with its elderly who can no longer function as self-reliant individuals.

The number of aged in America is growing dramatically. From three million or four percent of the population in 1900, the elderly, defined as those 65 years of age and older, now number twenty million, or ten percent of the population.³ The limits of human aging have not expanded, but people are living more often into the oldest ages as a result of prevention of death in early ages or in maturity.⁴ Thus, at present one-half of the aged population is 73 years of age or older, and one million persons (six percent of the elderly) are 85 or older, a number expected to double by 1985.

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1. D. THOMAS, *THE COLLECTED POEMS OF DYLAN THOMAS* 128 (1957).

2. S. DE BEAUVOIR, *LA VIEILLESSE*, as quoted in Lottman, *I've Been Reading*, COLUM. F 31, 33 (Fall 1970).

3. SPECIAL COMM. ON AGING OF THE UNITED STATES SENATE, *DEVELOPMENTS IN AGING 1969*, S. REP. NO. 91-875, 91st Cong., 2d Sess. 325 (1970) [hereinafter cited as *DEVELOPMENTS IN AGING 1969*].

4. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, *WORKING WITH OLDER PEOPLE*, VOL. II—BIOLOGICAL, PSYCHOLOGICAL AND SOCIOLOGICAL ASPECTS OF AGING (1970) [hereinafter cited as *WORKING WITH OLDER PEOPLE*, VOL. II]; GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, REPORT NO. 59, *PSYCHIATRY AND THE AGED: AN INTRODUCTORY APPROACH* 538 (1965) [hereinafter cited as *GROUP FOR THE ADVANCEMENT OF PSYCHIATRY*, REPORT NO. 59].

The significance of these statistics lies in the correlation among age, health, and functional capacity. As the number of elderly, particularly of the older elderly, increases, the incidence of chronic disease, long-term illness, and disability, which are the characteristic health problems of the elderly also increases, along with their dependence on others.

The vulnerability and dependency of the elderly have stimulated a substantial amount of federal financial assistance for the aged. In fiscal 1970, for example, the Social Security Administration spent a total of \$27.41 billion for insurance payments,⁵ funds which were derived largely from federal trust funds. The Department of Health, Education and Welfare spent an additional \$3.7 billion on programs for the aged,⁶ while the Administration on Aging received \$28,360,000 for programs under the Older Americans Act.⁷

The common law and the American legal system have developed a different type of assistance for the problems of the dependent elderly. This article will describe and evaluate from a legal perspective the methods and procedures for providing this assistance, which shall be denominated "protective services."

HISTORY OF LEGAL INTERVENTION

English law began to formalize assistance for the elderly with the enactment of the statute *de Praerogativa regis* sometime between 1255 and 1290.⁸ This statute dealt with the mentally ill, classified as idiots (those who were born with "no understanding") and lunatics (who had been born with understanding but had "lost the use of reason"). It granted the king custody of the person and lands of such persons, and made him responsible for maintaining the ward and his household out of the proceeds from the lands. The profits from managing the land of the "natural fool" accrued to the king during the ward's lifetime, while those from lunatic's land had to be returned to him when he came "to right mind." The land of the fool was to be returned to his "right heirs" after his death.

The procedure for determining an individual's mental status called

5. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, ACTIVITIES SERVING OLDER AMERICANS (1970).

6. *Id.*

7. DEVELOPMENTS IN AGING 1969, *supra* note 3, at 137.

8. AMERICAN BAR FOUNDATION, THE MENTALLY DISABLED AND THE LAW 7 (Lindman & McIntyre eds. 1961) [hereinafter cited as ABF].

for the Chancellor, upon petition, to issue a writ *de idiota inquirendo*, which would be tried by a jury of twelve men.⁹ If the person was found to be a lunatic, the Chancellor would commit him to the care of some friend, who would receive an allowance to provide for him. The incompetent's heir was generally made the manager of the estate but not of the person (to prevent "sinister practices"), and was responsible for the estate to the court of chancery, the recovered lunatic, or his administrator, according to a gradually developed set of customs, rules, and standards.

The nearest relatives of the incompetent played a key role.¹⁰ They cared for him during the period between the attack of lunacy and the determination by the jury. Formal proceedings, however, were initiated only if the incompetent had sufficient assets to bear the expense of the inquiry, since the purpose was to assure the proper administration of the incompetent's affairs. No proceedings were necessary for a poor person, nor was there any method for compensating the nearest relatives for their support.

Thus, the only type of protection provided for the elderly by early English law was a guardianship for those who were mentally disabled but wealthy. The rest of the aged were left to their own or their family's resources.

In early Colonial America the same pattern existed.¹¹ Those persons lacking both assets and family joined with the itinerant poor to form transient bands drifting from town to town. The Puritan ethic of the period equated work with industry and produced laws aimed at compelling the labor of these itinerants rather than providing for their needs. The mentally disabled and the elderly who could not work wandered aimlessly about the countryside eking out an existence by begging.

The mentally ill who became violent, however, began to attract special attention. If one were deemed "too dangerous to be permitted to be at large," the law, in what was to become the civil commitment process, authorized his confinement for the duration of his dangerous condition.¹² In the company of the criminal and the pauper he would be sent to a public jail, workhouse, poorhouse or to a private pen, cage,

9. *Id.* at 9.

10. *Id.* at 218.

11. *Id.* at 9.

12. A. DEUTSCH, *THE MENTALLY ILL IN AMERICA* 419 (2d ed. 1949) [hereinafter cited as DEUTSCH].

or strongroom.¹³ These institutions multiplied during the second quarter of the eighteenth century as population centered in the towns.¹⁴

A movement toward separate treatment of the mentally disabled began to develop in the second half of the eighteenth century. In response to a petition drawn by Benjamin Franklin, the Pennsylvania Assembly in 1751 authorized the establishment of a mental hospital, but it was not until 1773 that Virginia erected at Williamsburg the first hospital devoted exclusively to the care of the mentally disabled.¹⁵ Another half-century was to pass before a second hospital, the Eastern Lunatic Asylum, was established in 1824 at Lexington, Kentucky.

As might be expected, the problem of proper commitment procedures did not arise until such institutions were fully developed and began to open their doors to the less obvious cases of mental disability.¹⁶ These procedures were frighteningly simple, in striking contrast to those employed to preserve an incompetent's property. As Deutsch notes:

All that was necessary was for a relative, a friend—or, perhaps, an enemy—to apply to one of the managers or physicians for an order of admission. A few words hastily scribbled on a chance piece of paper (such as "Jas Sproul is a proper person for the Pennsylvania Hospital"), and signed by one of the physicians, and the deed was done.¹⁷

Yet to declare the same person incompetent for the purpose of the administration of his affairs required a request for a writ, adequate notice, jury trial, and appointment of a guardian.¹⁸

As the number of state hospitals increased during the 1830's and 1840's, the need for legislation defining commitment procedures became clear.¹⁹ Public attention to the problem was excited by the case of Josiah Oakes.²⁰ An elderly and ordinarily prudent man, Oakes had become engaged to young woman of unsavory character a few days after the death of his wife. He was committed by his family to the

13. *Id.* at 420.

14. *Id.* at 51. See Dershowitz, *The Law of Dangerousness: Some Fictions about Predictions*, 23 J. LEGAL ED. 24, 40 (1970).

15. *Id.* at 59, 71.

16. ABF, *supra* note 8, at 10.

17. DEUTSCH, *supra* note 12, at 62.

18. ABF, *supra* note 8, at 11-12.

19. DEUTSCH, *supra* note 12, at 422.

20. *Matter of Josiah Oakes*, 8 Law Rep. 123 (1845-46).

Massachusetts asylum on the allegation that he suffered from hallucinations and displayed unsoundness of mind in conducting his business affairs. In ordering Oakes' release after hearing his habeas corpus petition, the Massachusetts court laid down guidelines for detention of the mentally ill:

The right to restrain an insane person of his liberty is found in that great law of humanity, which makes it necessary to confine those whose going at large would be dangerous to themselves or others. And the necessity which creates the law, creates the limitation of the law. The question must then arise in each particular case whether a patient's own safety, or that of others, requires that he should be restrained for a certain time, and whether restraint is necessary for his restoration, or will be conducive thereto. The restraint can continue as long as the necessity continues. This is the limitation, and the proper limitation.²¹

The court, it should be noted, adopted a broad view of the "dangerousness" criterion, which included those considered dangerous to themselves as well as to others.

The forces of medicine and social work combined to produce a widespread and popularly supported movement to aid the mentally disabled during the second half of the nineteenth century.²² Dr. Benjamin Rush, the father of American psychiatry, and Dr. Isaac Ray, the author of an authoritative work relating law and psychiatry, led the advance of medical science. Mrs. E.W.P. Packard and Miss Dorothea Dix crusaded for changes in the treatment of the mentally ill. The result was a stream of new and revised legislation in the states, which constitutes the basic legislative patterns currently in force.

Thus 700 years of legal evolution have produced the two basic protective procedures for assisting the elderly who were mentally disabled: civil commitment and guardianship. These protective services will now be examined in detail.

CIVIL COMMITMENT

Though representing only 10 percent of the population, the aged make up about 30 percent of the patients in mental hospitals.²³ About

21. *Id.* at 125.

22. ABF, *supra* note 8, at 12-13.

23. DEVELOPMENTS IN AGING 1969, *supra* note 3, at 250.

18 to 30 percent of the first admissions to these hospitals are aged persons.²⁴ In nursing homes an estimated 55 to 80 percent of the residents are mentally impaired.²⁵ Even among those aged still living in the community, various studies indicate that from 10 to 25 percent have some degree of mental disability.²⁶

Of greater importance is the fact that the percentage of mental hospital first admissions of elderly persons is increasing more rapidly than the total population of the aged.²⁷ This change has been attributed not only to the greater longevity of the population with its concomitant increase in symptoms of chronic brain syndrome, but to the accelerating pressures of urbanization and technologic change.

These pressures are altering cultural value orientations, with productivity increasingly becoming a measure of worth, with respect for tradition and for the past diminishing, and with family life becoming more individualistic and increasingly typified by the two-generation mobile nuclear family. The aged in our society are becoming increasingly more alienated, more isolated, less valued and on each count more vulnerable to mental illness.²⁸

This article contends that the present system which authorizes the commitment of mentally ill aged persons to mental hospitals needs major reform, and in particular:

1. The process for determining which aged persons are mentally ill is defective, both in the criteria used and the procedures employed, for making this determination;
2. the process of treating those aged persons found to be mentally ill at state mental hospitals is inadequate;
3. the process for determining the type of institution which can best care for these persons fails to provide sufficient alternatives to state mental hospitals.

24. GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, REPORT NO. 59, *supra* note 4, at 542.

25. *Id.*, DEVELOPMENTS IN AGING 1969, *supra* note 3, at 250.

26. DEVELOPMENTS IN AGING 1969, *supra* note 3, at 250.

27. SPECIAL COMM. ON AGING OF THE UNITED STATES SENATE, DEVELOPMENTS IN AGING 1967, S. REP. NO. 1098, 90th Cong., 2d Sess. 66 (1968).

28. *Id.*

The Commitment Process

The state has traditionally justified its intervention in the lives of the aged by pointing to its police power and its role as *parens patriae*.²⁹ By virtue of the former, the state has the inherent power to protect itself and its citizens against breaches of the peace, and thus the focus is on the interests of society. Under the latter the state has the right and duty to protect the persons and property of those unable to care for themselves because of minority or mental illness, and therefore the interests of the individual are supposedly paramount.³⁰

The Criteria

The hinge upon which both state powers turn is the alleged mental illness of the elderly person. In theory, a hospitalization proceeding requires a two-level determination about the existence of mental illness: (1) the patient is mentally ill from a medical viewpoint, and (2) his illness is such as to satisfy the legal criterion or test.³¹

The Public Health Draft Act for the Commitment of the Mentally Ill is a typical example of state statutes.³² It provides that a person may be committed if he

(1) is mentally ill, and (2) because of his illness is likely to injure himself or others if allowed to remain at liberty, or (3) is in need of custody, care or treatment in a mental hospital and, because of his illness, lacks sufficient insight or capacity to make responsible decisions with respect to his hospitalization.³³

Mental illness, however, is an extremely elusive medical concept. The Draft Act, for example, defines a mentally ill individual as one "having a psychiatric or other disease which substantially impairs his mental health."³⁴ The circularity of such a definition is not calculated to instill confidence in decisions based on it. An American Bar Foundation

29. Ross, *Commitment of the Mentally Ill: Problems of Law and Policy*, 57 MICH. L. REV. 945, 955 (1959); Taylor, *A Critical Look into the Involuntary Civil Commitment Procedure*, 10 WASHBURN L.J. 237, 239 (1971).

30. Ross, *supra* note 29, at 956-57.

31. Weihofen, *The Definition of Mental Illness*, 21 OHIO ST. L.J. 1 (1960).

32. National Institute of Mental Health, Draft Act for the Commitment of the Mentally Ill (Public Health Service Pub. No. 51, 1952), in ABF, *supra* note 8, at 397.

33. *Id.* § (9)(g).

34. *Id.* at 400.

report noted a similar vagueness and begging of the question in many state statutes:

The statutes take one of two approaches: (1) to define mental illness solely in terms of the attributes of an ill person; or (2) to define mental illness not only in terms of such illness but also in terms of the therapeutic consequences for which his condition is an appropriate predicate. ³⁵

The difficulty is caused by the nature and breadth of mental illness. Many mental disorders, including those of the aged, are wholly functional in nature and involve no organic pathology³⁶ The concept is extremely broad, ranging "from the massive functional inhibition characteristic of one form of catatonic schizophrenia to those seemingly slight aberrancies associated with an emotionally unstable personality, but which are so close to conduct in which we all engage as to define the entire continuum involved."³⁷

The same range of coverage is found in attempts to describe mental illness caused by old age. The biological characteristics of senescence³⁸ are accompanied by a progressive loss of mental resources.³⁹ Energy decreases, responsiveness declines, initiative and creative imagination wane, egocentricity increases, and a certain warping of personality occurs. Physical and mental limitations arouse feelings of helplessness,

35. R. ROCK, HOSPITALIZATION AND DISCHARGE OF THE MENTALLY ILL 69-70 (1968).

36. Weihöfen, *supra* note 31, at 4.

37. AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (2d ed. 1968), as quoted in Livermore, Malmquist & Meehl, *On the Justifications for Civil Commitment*, 117 U. PA. L. REV. 75, 80 (1968) [hereinafter cited as Livermore]. One study of commitment proceedings found that agreement among examining physicians as to the proper diagnosis in a given case was very poor. Complete consensus was reached in one case out of five, while total disagreement marked almost three cases out of ten. *The Language of Involuntary Mental Hospitalization: A Study in Sound and Fury*, 4 U. MICH. J. OF L. REFORM 195 (1971).

38. Aging is defined as the sum total of changes that occur in an individual with the passage of time from birth throughout the course of life, which are not attributable to accident or disease. Senescence, a more specific term, refers to inborn and inevitable degenerative changes that occur after maturity has been reached, which ultimately culminate in death. WORKING WITH OLDER PEOPLE, VOL. II, *supra* note 4, at 2. See also Busse, *Theories of Aging*, in BEHAVIOR AND ADAPTATION IN LATE LIFE 12 (Busse & Pfeiffer eds. 1969).

39. P. NOYES & L. KOLB, MODERN CLINICAL PSYCHIATRY 244 (6th ed. 1962). See also NATIONAL INSTITUTE OF MENTAL HEALTH, MENTAL DISORDERS OF THE AGING, PUBLIC HEALTH SERVICE PUB. NO. 933 (1968); Dovenmuehle, *Geriatric Psychiatry*, 27 LAW & CONTEMP. PROB. 133 (1962).

loss of friends and relatives and perhaps rejection by children generate loneliness, and these in turn lead to anxiety, hostility, and a tendency toward isolation. These mental changes may range from the usual mild senescence of old age to the extreme impoverishment of senile dementia. The transition is ordinarily gradual, and the dividing line may be a matter of opinion.

Persons whose mental disorders become significant in old age may be considered in two groups: "(1) those who have disorders of affect or content in the absence of brain damage; and (2) those who have disorders in the presence of brain damage as reflected by brain syndrome."⁴⁰ A third group, persons who have grown old in hospitals or who have long-term chronic mental disorders that began before chronological old age, will not be discussed.

The first group consists of those with endogenous psychoses and the disorders of content (thinking) that are revealed, or appear to develop, in later life.⁴¹ Their mental disorders may have begun in youth, but they have escaped long-term hospitalization owing to better general health, economic resources, family protection, and special skills, or because the symptoms failed to stimulate community action.⁴²

The largest group of aged with mental disorders who are institutionalized is the "organic" group. This group is composed of (1) persons with relatively uncomplicated brain syndrome and (2) persons with disorders in which the brain damage is accompanied by disorders of affect or content.⁴³ Organic brain syndrome is defined as the "basic mental condition characteristically resulting from diffuse impairment of brain tissue function from whatever cause."⁴⁴ A temporary syndrome is called acute, and the underlying brain damage is assumed to be reversible.⁴⁵ The syndrome is termed chronic when it is permanent, and the underlying brain damage is considered irreversible. Both conditions may coexist in an aged person, and both may produce disorders characterized by impairment of orientation, memory, and in-

40. GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, REPORT No. 59, *supra* note 4, at 545.

41. *Id.* at 546.

42. *Id.* at 547..

43. *Id.* at 549.

44. Wang, *Organic Brain Syndromes*, in *BEHAVIOR AND ADAPTATION IN LATE LIFE* 263 (Busse & Pfeiffer eds. 1969).

45. *Id.* at 267

tellectual functions.⁴⁶ Judgment and ability of emotion are also usually affected.

Good diagnostic procedure avoids the use of the patient's age as a determining criterion of predominant pathology.⁴⁷ Senile brain deterioration should not be considered a normal concomitant of the passage of time,⁴⁸ nor should the organic factor be overemphasized to the neglect of environmental factors and the patient's underlying personality.⁴⁹ Geriatric psychiatry is now starting to place more emphasis on seeking mixed causes of mental illness in older persons, taking into consideration possible interactions among physical, mental, and social illnesses.

The standard procedure for diagnosing the behavioral manifestations of the cerebral status is the clinical neuro-psychiatric examination.⁵⁰ In cases of relatively severe brain damage, the primary characteristics of organic brain syndrome are easily recognized, but in patients with only

46. GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, REPORT NO. 59, *supra* note 4, at 550.

47. *Id.* at 551. The following criteria have been developed to assist in the diagnosis and classification of brain syndrome:

1. Disorientation for time, place or person.
2. Evidence of impaired immediate recall.
3. Deficits [sic] of recent and remote memory
4. Weakening of intellectual functions as indicated by difficulty and errors in doing simple calculations or in recalling simple items of general information.
5. Defects of grasp and orientation. These defects may be discernible as difficulty in retaining, and reacting to, questions or commands. They may also be identified through faulty reaction to the situation of the interpersonal transaction, revealing that it is not understood. This can be briefly called situational disorientation.
6. A reliable history, from the patient or other sources, of episodes, intermittent or persistent, of occurrences of the above.

The first four factors should all be present for a diagnosis of chronic brain syndrome, although some may be less obvious or severe than others. The presence of only one or several of the signs is good reason to suspect developing brain syndrome. The diagnosis may be supported by other clues, such as emotional lability, focal neurological signs, slovenliness or poor habits, poor judgment not related clearly to emotional disturbance, and apathy.

Acute brain syndrome is usually related to a febrile, debilitating, or exhausting illness. In the elderly it may be a side-effect of somatic illness, or it may be a symptom of infectious disease and malnutrition that lingers long after the original condition is controlled. In most elderly persons, its existence may be taken as presumptive evidence of the simultaneous presence of chronic brain syndrome. *Id.* at 553-54; *WORKING WITH OLDER PEOPLE*, VOL. II, *supra* note 4, at 6.

48. *WORKING WITH OLDER PEOPLE*, VOL. II, *supra* note 4, at 6.

49. Wang, *supra* note 44, at 267.

50. *Id.* at 270.

mild to moderate brain impairment, the reliability and effectiveness of this clinical approach become more uncertain. These patients usually present no clear-cut neurological signs, and their cognitive function, though impaired, may still remain within the normal range of variations one might expect in healthy old people. The pressure on the clinical examiner to make interpretations and judgments may lead him to bias the results of the examination by his training, experience, and personal interests.⁵¹

The factor of subjective input in the clinical diagnosis has important consequences in the context of civil commitment proceedings. The clinical diagnosis purports to establish, from a medical point of view, that the subject is mentally ill. The court is then expected to make a further determination that this illness meets the statutory requirements for a legal state of mental illness. The statutory norm reflects societal judgments concerning the types of conduct, actual or potential, which are socially intolerable. In reality, however, the clinical examiner necessarily imports into the diagnosis his own judgments about socially intolerable conduct,⁵² and to this extent he pre-empts the court's function. If the court then uncritically ratifies the medical judgment and adopts it as the legal determination of mental illness without exercising independent judgment, the decision-making process ceases to function on two levels. The psychiatrist's judgment becomes the controlling determination on the legal issue of mental illness.⁵³

Even where the court does exercise its independent judgment, the statutory criteria it must apply are often inadequate. The court must decide that, as a result of mental illness, the patient is dangerous to others or himself or needs care and treatment.

The "dangerousness" criteria call for a determination of what acts

51. *Id.*

52. Leifer, *The Competence of the Psychiatrist to Assist in the Determination of Incompetency: A Skeptical Inquiry in to the Courtroom Functions of Psychiatrists*, 14 SYRACUSE L. REV. 564, 570 (1963); Livermore, *supra* note 37, at 80.

53. Kaplan, *Civil Commitment "As You Like It,"* 49 B.U.L. REV. 14 (1969); Leifer, *supra* note 52, at 573; Ross, *supra* note 29, at 961-63; Swartz, "Mental Disease": *The Groundwork for Legal Analysis and Legislative Action*, 111 U. PA. L. REV. 389 (1963); Szasz, *Civil Liberties and the Mentally Ill*, 9 CLEV.-MAR. L. REV. 399 (1960). More specific applications to the aged are found in Brenner, *Denial of Due Process and Civil Rights under Sections 73 and 73a of the Mental Hygiene Law to Aged Seniles without Major Mental Impairment*, 34 N.Y. ST. B.J. 19 (1962); DeCain, *Commitment Procedures and the Non-mentally Ill*, 33 N.Y. ST. B.J. 151 (1961); Note, *Commitment of the Mentally Ill: Due Process for the Aged*, 7 CATH. LAW. 243 (1961).

are dangerous and how likely it is that these acts will occur.⁵⁴ The judgment that an act is dangerous is not as self-evident as might appear. It certainly includes an act which creates a serious risk of physical or psychical harm to another. But arguably the criterion might also include any act which adversely affects the social interests of another, particularly if the criminal law has labelled such an act a crime. Thus, one court recently held that the probability that the accused would issue checks drawn on insufficient funds was enough to fall within the statutory test of "dangerous to others."⁵⁵ The test might be broadened still further to encompass an act which merely offends or disquiets others.

The prediction about the probability of an act's occurrence also lacks precision. There are no actuarial data available to indicate the relative likelihood that certain classes of mentally ill persons will commit dangerous acts. Even if such information were available, it is arguable that "it is improbable that it would indicate [that] the likelihood of crime within a group of individuals with any particular psychosis would be any greater than that to be expected in a normal community cross-section."⁵⁶ Even the criminal, who has, by definition, committed a prior allegedly criminal act, cannot be confined on the basis of predictions about his future conduct.

If a sociologist predicted that a person was eighty percent likely to commit a felonious act, no law would permit his confinement. On the other hand, if a psychologist testified that a person was mentally ill and eight percent likely to commit a dangerous act, the patient would be committed.⁵⁷

In effect, commitment under the dangerousness criteria is a system of preventive detention.⁵⁸

Various remedies have been proposed. One approach is to define precisely by statute the type of harm feared, the degree of risk that it will occur, and the type of evidence necessary to support these con-

54. Livermore, *supra* note 37, at 81-82, 84.

55. *Id.* at 84.

56. *Id.* at 83. It has been suggested that systematized research into the factors which lead to anti-social conduct would equip a court to predict more accurately future dangerousness. Tao, *Some Problems Relating to Compulsory Hospitalization of the Mentally Ill*, 44 J. URBAN L. 459, 477 (1967).

57. Note, *Civil Commitment of the Mentally Ill: Theories and Procedures*, 79 HARV. L. REV. 1288, 1290 (1966).

58. Dershowitz, *supra* note 14, at 47

clusions.⁵⁹ Evidentiary standards for proving dangerousness also could be raised, replacing the traditional preponderance of the evidence test with a requirement that the finder of fact be persuaded by clear and convincing evidence.⁶⁰

Dershowitz believes that the problem will continue as long as the law continues to ask the dispositive questions in medical rather than in legally functional terms.⁶¹ He offers the following examples of the questions courts should ask in place of the traditional criteria:

What sorts of anticipated harm warrant involuntary commitment? How likely must it be that the harm will occur? Must there be a significant component of harm to others, or may it be to self alone? If harm to self is sufficient, must the person also be incapable, because he lacks insight, of weighing the risks to himself against the costs of confinement?

How long a period of involuntary confinement is justified to prevent what sorts of harms? Must the likelihood of the harm increase as the severity decreases? Or as the component of harm to others increases?⁶²

The proposed recodification of the New York Mental Hygiene Law supplies a good model for revised legislation. The criterion of dangerousness is replaced by a test that the patient has a mental illness for which immediate in-patient care and treatment in a hospital is appropriate and which is "likely to result in serious harm to himself or others."⁶³ Such "likelihood of serious harm" means either

(1) substantial risk of physical harm to himself as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that he is dangerous to himself or (2) a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm.⁶⁴

59. Kaplan, *supra* note 53, at 34.

60. Note, *supra* note 57, at 1291.

61. Dershowitz, *The Psychiatrist's Power in Civil Commitment: A Knife That Cuts Both Ways*, 2 PSYCH. TODAY 13, 44 (Feb. 1969).

62. *Id.*

63. Proposed recodification of the N.Y. MENTAL HYGIENE LAW Art. 31.37 (S.5641, A.6943).

64. *Id.*

The criterion of need for care or treatment is the typical statutory basis of hospitalizing the elderly. The motive is idealistic: society acts for the individual's own benefit, and it decides for him as it assumes he would decide for himself if he were of sound mind.⁶⁵ The essential finding of a court, as the Public Health Draft Act describes it, is "that a person is mentally ill, needs treatment in a mental hospital and, because of his illness, lacks sufficient insight or capacity to make responsible decisions with respect to his need for hospitalization."⁶⁶ The Commentary to the Act adds:

It should be emphasized that it is not a question of the individual agreeing or disagreeing with medical judgment as to the nature of his illness or the need for hospital care, but rather of whether he is *capable* of making a responsible, not necessarily a wise decision.

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It is not clear what factors should be weighed in evaluating "capacity" to make a responsible decision, nor exactly what constitutes a responsible decision. In Kafkaesque fashion, an unwise decision in itself may constitute some evidence of a lack of capacity to make a responsible decision.

The proposed New York recodification represents little advance in solving these problems. It defines "need of involuntary care and treatment" as meaning that a "person has a mental illness for which care and treatment as a patient in a hospital is essential to such person's welfare and whose judgment is so impaired that he is unable to understand the need for such care and treatment."⁶⁸

The Procedure

Several types of commitment procedures evolved out of the reform movement of the late nineteenth century. These may be classified as (1) voluntary, where the prospective patient himself initiates or actively participates in his admission; (2) non-protested, when, without initiative or resistance, the patient acquiesces in hospitalization; and (3)

65. Comment, *Compulsory Commitment: The Rights of the Incarcerated Mentally Ill*, 1969 DUKE L.J. 677, 685 (1969); Note, *supra* note 57, at 1295; Note, *Civil Restraint, Mental Illness, and the Right to Treatment*, 77 YALE L.J. 87 (1967).

66. ABE, *supra* note 8, at 20.

67. *Id.*

68. Proposed recodification of the N.Y. MENTAL HYGIENE LAW Art. 31.01 (S.5641, A.6943).

involuntary, when the patient is committed for an indefinite period through judicial proceedings or on the basis of medical certification against his will.⁶⁹ This article will concentrate on involuntary judicial proceedings, with some reference to commitment by medical certification.

From the beginning, court hospitalization proceedings reflected a basic ambiguity about their precise nature. On the one hand the criminal trial was taken as the model, and thus requirements of notice, hearing, counsel, and a jury were written into many statutes.⁷⁰ Yet at the same time, the reformers recognized that the prospective patient was not actually guilty of wrongful conduct and that commitment was intended for treatment purposes and was in the patient's own best interests, and therefore a civil label was attached to the proceedings.

The 1961 survey of state legislation well illustrates this ambiguity. Thirty-seven jurisdictions had adopted judicial hospitalization procedures.⁷¹ Half of these jurisdictions permitted any person to file an application to have another person committed, but in the remaining states the right to apply was limited to spouses, relatives, friends, guardians, public officials, physicians, or superintendents of hospitals.⁷² This pattern of authorization works well enough if all of these persons are empowered in a specific state or if the patient is living with his family in a state with more limited authorizations. But where the elderly live alone, as they frequently do, no one in the community has the responsibility or authority to intervene.⁷³ Social workers are reluctant to initiate hospitalization proceedings out of fear of the legal consequences of wrongful commitment, and social agencies often are ignorant of or misunderstand the alternatives to commitment.⁷⁴ In many communities, the lack of a practical means to obtain a medical diagnosis of mental illness further complicates the problem. The easy solution to all of these problems is to substitute criminal arrest by the police for hospitalization proceedings by the courts.

69. ABF, *supra* note 8, at 23; ROCK, *supra* note 35, at 33.

70. ABF, *supra* note 8, at 23. For a description of the worst features of the "criminal" approach to commitment proceedings, compare Note, *Analysis of Legal and Medical Considerations in Commitment of the Mentally Ill*, 56 YALE L.J. 1178, 1181 (1947), with GROUP FOR ADVANCEMENT OF PSYCHIATRY, REPORT, COMMITMENT PROCEDURES 2 (No. 4, April 1948) [hereinafter cited as COMMITMENT PROCEDURES], as quoted in ABF, *supra* note 8, at 30.

71. ABF, *supra* note 8, at 23.

72. *Id.*

73. ROCK, *supra* note 35, at 253-55.

74. *Id.* at 86.

Once the proceedings begin, many procedural safeguards for the prospective patient are lacking. Only half of the states require that notice of the forthcoming proceedings be sent to the patient himself.⁷⁵ Some states permit waiver of the requirement and others allow substituted notice to certain classes of persons likely to be associated with the patient. But even the required notice may turn out to be a hollow formality, since it may come only 24 hours before the proceedings are scheduled to begin.⁷⁶ Most states require an actual hearing, but few demand that waiver of his right be express.⁷⁷ Only 10 jurisdictions demand the presence of the patient at the hearing, while some leave the matter to the court's discretion and others provide for it only if requested by the patient.

The atmosphere of ambiguity persists through the proceedings themselves. Most jurisdictions permit counsel or a guardian ad litem to represent the patient, but only some of them require his presence, and a few more require counsel only on the patient's request.⁷⁸ Several studies have concluded, however, that such representation is often a sterile formality which provides little or no protection for the patient.⁷⁹ One cause of the trouble is the inadequate compensation allotted to private attorneys. The impact, if any, of the legal services program in this area has not yet been assessed. Another reason lies in the confusion surrounding the attorney's role in commitment proceedings, which lack the adversarial nature with which he is familiar.⁸⁰ The attorney may also be ignorant of the technical complexity of mental hygiene laws, psychiatry, psychiatric terms, and intra-disciplinary dis-

75. ABF, *supra* note 8, at 26. Psychiatrists have objected to notice and hearing on the grounds that they might produce a traumatic effect on the patient. This opinion assumes the existence of the very mental illness which the hearing purports to establish, and it ignores the trauma of the patient who suddenly finds himself confined to a mental hospital. Kittrie, *Compulsory Mental Treatment and the Requirements of Due Process*, 21 OHIO ST. L.J. 28, 48 (1960).

76. Ross, *supra* note 29, at 968-69.

77. ABF, *supra* note 8, at 27.

78. *Id.* at 29. A more recent survey of state legislation found that 22 jurisdictions made the appointment of counsel mandatory if requested by the patient, while 42 jurisdictions had some provision for appearance of counsel or a guardian ad litem. Cohen, *The Function of the Attorney and the Commitment of the Mentally Ill*, 44 TEXAS L. REV. 424, 460-66 (1966).

79. Cohen, *supra* note 78, at 427, 448; Johnson, *Due Process in Involuntary Civil Commitment and Incompetency Adjudication Proceedings: Where Does Colorado Stand?*, 46 DENVER L.J. 516, 566 (1969).

80. Johnson, *supra* note 79, at 528.

putes.⁸¹ The end result is that the attorney in a commitment proceeding often assumes little more than a ceremonial role, and the medical diagnosis takes the dominant place.⁸²

No state requires a jury trial, and only 10 authorize it if requested by the patient or his representative, while three others leave it to the court's discretion.⁸³ But those that authorize it fail to require that the patient be notified of this right, and it is therefore seldom exercised. Courts are divided on the applicability of the fifth amendment privilege against self-incrimination to the use in these proceedings of the patient's statements to a psychiatrist.⁸⁴ Only one state appears to give the patient the right to bring relatives, friends, or advisors to the psychiatric evaluation.⁸⁵

Apart from abandoning involuntary commitment altogether,⁸⁶ the basic solution to the shortcomings of the judicial commitment process is to drop the civil label and treat the proceedings as essentially criminal, in recognition of the reality that they deprive the patient of his personal liberty against his will. All of the fundamental rights that defendants possess in the criminal trial would then be made applicable to these proceedings.

In several recent cases the Supreme Court has abandoned the traditional distinction between criminal and civil proceedings.⁸⁷ The decision of *In re Gault* held that juvenile court proceedings must contain the fundamental elements of due process despite a proclaimed beneficial purpose. The determining factor lay in the obvious punitive effect of these proceedings.

The hospitalized mental patient suffers just as real a deprivation of liberty as the juvenile, and the logic of this situation has prompted lower courts to extend the *Gault* rationale to commitment proceedings. In *Heryford v. Parker*⁸⁸ the court held that due process requirements, particularly the right to counsel, should be observed in proceedings to authorize the involuntary confinement of the mentally deficient for

81. Ennis, *Mental Illness*, 1969-70 *Annual Survey of American Law*, 45 N.Y.U.L. REV. 29 (1970).

82. Cohen, *supra* note 78, at 446.

83. ABF, *supra* note 8, at 28.

84. Ennis, *supra* note 81, at 33.

85. *Id.* at 40.

86. Ennis, *Civil Liberties and Mental Illness*, 7 CRIM. L. BULL. 101, 102 (1971).

87. *In re Gault*, 387 U.S. 1 (1967); *Specht v. Patterson*, 386 U.S. 605 (1967); *Baxstrom v. Herold*, 383 U.S. 107 (1966).

88. 396 F.2d 393 (10th Cir. 1968).

treatment and training. In *Holm v. State*⁸⁹ the failure to allow rights of cross-examination and confrontation of witnesses in commitment proceedings under a statute modeled on the Draft Act⁹⁰ was held unconstitutional. The rights to notice, hearing, and counsel were considered essential in proceedings for indefinite commitment of sexually dangerous persons according to the court in *Commonwealth v. Gomes*.⁹¹ Finally, in the most sweeping decision to date, a three judge federal court held unconstitutional a Pennsylvania statute which permitted indefinite commitment without notice or hearing.⁹² In ordering discharge of the patients or meaningful commitment proceedings within 60 days, the court noted that such proceedings should include a full hearing, counsel, independent psychiatric assistance in preparation for the proceedings at public expense, evidence of mental illness that was clear, unequivocal, and convincing, and a transcript and record of the proceedings. Commitment resulting from these proceedings could last no longer than six months without a new process.

Proposed Reforms

Specific reforms in commitment proceedings should include:

1. Authorization of health and social services officials to initiate commitment proceedings.
2. Elimination of the use of police arrest as a way of taking into custody persons who appear to be mentally ill. Instead, peace officers might simply be empowered to bring such persons to approved hospitals for examination.
3. Personal notice to the patient, reasonably well in advance of the hearing, advising him of his constitutional and statutory rights. Possible traumatic effects of such notice might be reduced if relatives, friends, or a physician give it in a congenial atmosphere.⁹³
4. Mandatory presence of the patient at the hearing, or in the alternative, to leave the question of his presence to the judge, with stipulations that the judge or a court-appointed psychiatrist interview the person privately before the hearing to see if he wants to attend. Also, the

89. 404 P.2d 740 (Wyo. 1965).

90. Note 32 *supra*.

91. 355 Mass. 479, 245 N.E. 2d 429 (1969).

92. *Dixon v. Att'y Gen. of Pennsylvania*, 325 F. Supp. 966 (M.D. Pa. 1971).

93. See note 75 *supra*.

hearing should take place in a hospital or private place to minimize its potential harmful effect on the patient.⁹⁴

5. Mandatory representation by counsel. Waiver of counsel should not be permitted, or as an alternative, the court might be empowered to appoint an attorney as its amicus for the purpose of bringing to the judge's attention all information about the patient's rights and condition that might not otherwise appear.⁹⁵ The method of providing free counsel used in criminal matters should be expanded to include commitment proceedings.⁹⁶

6. Jury trial at the request of the patient.⁹⁷ This requirement should be correlated with the rephrasing of the criteria for commitment in non-medical behavioral terms.⁹⁸ Both steps would meet the psychiatrists' objections that shameful associations induced by appearance before a jury will harm the patient, prompt his relatives to postpone his commitment and treatment, and add to the emotional stress of his eventual return to the community,⁹⁹ and that juries lack the ability to determine the highly technical question of mental illness.¹⁰⁰

7. Presence of an attorney, relative, or friend at the psychiatric interview, or at least a tape recording or transcript of the interview available to the patient.¹⁰¹

8. For indigent persons, independent psychiatric assistance should be available at public expense, subject to the privilege of confidentiality

9. The evidentiary standard should be raised to require that dangerousness or need of care and treatment be established beyond a reason-

94. *But see* Note, *supra* note 57, at 1292.

95. *Id.*

96. It has also been suggested that the duties of counsel be defined by statute. ABF, *supra* note 8, at 29; Cohen, *supra* note 78, at 458-59; Johnson, *supra* note 79, at 566. But this approach might prove inadequate without an available group of lawyers with expertise in this area. Ennis, *supra* note 81, at 29.

97. Trial judges consider the jury trial unimportant in most cases, although some think a jury is of value when the patient is senile. ASSOCIATION OF THE BAR OF THE CITY OF NEW YORK, *MENTAL ILLNESS AND DUE PROCESS* 191 (1962).

98. *See* text accompanying notes 56-65 *supra*.

99. Weihofen, *Hospitalizing the Mentally Ill*, 50 MICH. L. REV. 837, 848-49 (1952).

100. COMMITMENT PROCEDURES, *supra* note 70, at 2. Some states have attempted to supply medical expertise by requiring that a doctor or a psychiatrist be a member of all commitment juries, but the reality of such a practice is that the physician, especially one actively engaged in commitment proceedings, tends to support the recommendations of the county psychiatrist and because of his expertise has a great influence on the rest of the jury. Kutner, *The Illusion of Due Process in Commitment Proceedings*, 57 NW. U.L. REV. 383, 391 (1962).

101. Ennis, *supra* note 81, at 37

able doubt or by clear and convincing evidence, rather than by the preponderance of the evidence.¹⁰²

In an attempt to compromise between the legal and medical considerations involved in commitment proceedings, several states now authorize short-term hospitalization by medical certificate alone.¹⁰³ Detailed examination of these procedures¹⁰⁴ is beyond the scope of this essay, but they contain in varying degrees a common problem: to what extent confinement for any period is tolerable without consent or a judicial hearing. It is submitted that confinement of this type should be allowed only in emergency circumstances where the patient is dangerous according to a narrow definition of the term and the detention is for a period no longer than is needed to arrange for a full hearing. Where the criterion is need for care and treatment, a full hearing should be held prior to confinement.

The Process of Treatment

What happens to the elderly person upon admission to a mental hospital? One strong possibility is that he will die within the first year. Older persons who enter state hospitals have an excessive death rate, that is, a much larger proportion of them die than would be expected in comparison with age-sex specific death rates.¹⁰⁵ This phenomenon may be due to the fact that they are already dying when they are committed and that the prodromal signs of death are mistaken for psychosis. Physical disability may have been a factor in their admis-

102. Ennis, *supra* note 86, at 110.

103. E.g., D.C. CODE ANN. § 21-501 *et seq.* (1967); ILL. REV. STAT. ch. 91½, § 5-1 *et seq.* (1965); N.Y. MENTAL HYGIENE LAW § 71 *et seq.* (1966). See also Tao, *Civil Commitment of the Mentally Ill in the District of Columbia*, 13 HOW L.J. 303 (1967); Note, *The New York Mental Health Information Service: A New Approach to Hospitalization of the Mentally Ill*, 67 COLUM. L. REV. 672 (1967); Comment, *The New Mental Health Codes: Safeguards in Compulsory Commitment and Release*, 61 NW U.L. REV. 977 (1967).

104. For a discussion of medical admission procedures, see ABF, *supra* note 8, at 32, 34-35.

105. Markson, *The Geriatric House of Death: Hiding the Dying Elder in a Mental Hospital*, 1 AGING & HUMAN DEVELOPMENT 37 (1970). The same study shows that one-fourth of the elderly admissions died within one month after entrance. *Id.* at 48. Mortality rates as high as sixty percent have been reported for the first year after admission. One study of 100 consecutive admissions to a state hospital reported that one-third of the aged patients, of whom a majority had brain syndrome, died in the first year. Berezen & Stotsky, *The Geriatric Patient*, in THE PRACTICE OF COMMUNITY MENTAL HEALTH 220 (Grunebaum ed. 1970).

sion, particularly when it occurred from another institution such as a general hospital. The general hospital sometimes transfers to the state mental hospital elderly patients who fail to respond to treatment or take too long to die.¹⁰⁶ Older rather than younger persons are selected for transfer because of the extreme pressure for beds and because they are considered helpless by family and physicians.

The very fact of institutionalization may also shorten the life-span of an elderly person. One study has concluded that first year mortality rates in a home for the aged were related to the impact of institutionalization on the aged.¹⁰⁷ Several other studies indicate that the chances of survival of older persons having severe brain dysfunction following relocation to an institution are considerably less than those of a person who shows no or only minimal signs of such impairment, regardless of how emotionally or socially disturbed or maladjusted such a person may be.¹⁰⁸

The mental hospital also has a tremendous psychological impact on those who enter its doors.¹⁰⁹ The loss of familiar objects, well-learned patterns of daily living, and environmental clues produces a feeling of defeat and uselessness. Those who had the fewest opportunities in youth are usually affected worst by the experience. In reaction, the newly institutionalized person may adopt bizarre defensive behavior which only isolates him further.

Fatalism is in the air. The hospital program begins to structure the patient's remaining life as an extended act of dying rather than one of active physical or psychiatric treatment.¹¹⁰ Once the routine post-admission examination is performed, most geriatric patients are then given "failing status because of age and general debility." This designation is almost automatic and is not associated with the presence of physical illness, ability to walk, or chronological age.

Besides the problems of overcrowding¹¹¹ and understaffing,¹¹² which are experienced in common with other patients of all age groups, the

106. Markson, *supra* note 105, at 43.

107. Leiberman, *Relationship of Mortality Rates to Entrance to a Home for the Aged*, 16 *GERIATRICS* 515 (1961).

108. Blenkner, *Environmental Change and the Aging Individual*, 7 *GERONTOLOGIST* 101 (1967).

109. Barray, *Social Services for the Aged: A Reconsideration*, in *NEW THOUGHTS ON OLD AGE* 207-08 (Kastenbaum ed. 1964).

110. Markson, *supra* note 105, at 42.

111. Rock, *supra* note 35, at 69-70.

112. *Id.*

elderly patient is condemned to his own special kind of neglect. The American Bar Foundation noted:

In each institution we studied, a number of wards were devoted to the care of elderly patients suffering from a variety of physical illnesses compounded by the debilitating effects of age itself. The attention they received was limited to nursing care. Few were discharged from the hospital since they were there because of their family's inability to care for them and the lack of suitable alternatives to meet their needs. For them the state hospital is the end of the road.¹¹³

The practice of many mental hospitals to provide only custodial care is open to challenge on both medical and legal grounds. From a medical point of view, Goldfarb refuses to accept the conclusion that treatment of the elderly is futile.¹¹⁴ Emotional factors in the elderly person may have provoked him to exhibit disorganized behavior, and this in turn may lead to an overestimate of the amount of cerebral damage and physical impairment. Many patients who are passed by as confused and senile have been found in psychiatric examination to be depressed, anxious, or angry, and classifiable as psychoneurotic despite some degree of chronic brain syndrome.¹¹⁵ Many of their disorders are transient and will respond quickly to combined physical, pharmacologic, and psychological treatment. In all cases, even with seemingly grossly brain-damaged patients, psychotherapeutic attempts are justified. He concludes:

An important aim of mental hospitals should be the treatment and good management of aged persons, not merely their "custody" as compared to active treatment of younger persons.¹¹⁶

The Group for the Advancement of Psychiatry takes the same position:

Irreversibility must never be casually (and stereotypically) assumed. Many mental disorders affecting the aged are subject to amelioration. Acute brain syndromes intervene in the course of

113. *Id.* at 70-71.

114. Goldfarb, *The Psychotherapy of Older Patients*, in *AGING AROUND THE WORLD: MEDICAL AND CLINICAL ASPECTS OF AGING* 106-07 (Blumenthal ed. 1962).

115. *Id.* at 107

116. *Id.*

chronic brain syndromes and are reversible. Depressive, paranoid, and behavioral reactions may be components in the clinical course of patients with organic brain damage and can be controlled. Depression may be masked as an organic state and, if recognized, can be treated.¹¹⁷

Further support for these opinions lies in Lowenthal's findings that 40 percent of acute brain syndromes are potentially reversible by medical management with supportive social services.¹¹⁸

The legal basis for a right to treatment begins with the decision in *Rouse v. Cameron*.¹¹⁹ The Court of Appeals for the District of Columbia Circuit, speaking through Chief Judge Bazelon, held that persons involuntarily committed to a mental hospital had a statutory right to treatment based on the 1964 Hospitalization of the Mentally Ill Act of the District. The Act provided that "a person hospitalized in a mental hospital for a mental illness shall, during the hospitalization, be entitled to medical and psychiatric care and treatment."¹²⁰ The Court declined, however, to decide the constitutional issues raised by a failure to provide such treatment, although it suggested that due process, equal protection, and cruel and unusual punishment arguments would be appropriate.¹²¹

A constitutional basis for a right to treatment has appeared for the first time in *Wyatt v. Stickney*.¹²² Chief Judge Johnson of the U.S. District Court found that Alabama's failure to afford adequate medical treatment to the geriatric and mentally retarded patients it had civilly committed for treatment violated "the very fundamentals of due process."¹²³ The court held that existing treatment practices at Bryce Hospital at Tuscaloosa, the state's leading mental institution, were "scientifically and medically inadequate" and "failed to conform to

117. GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, REPORT NO. 79, TOWARD A PUBLIC POLICY ON MENTAL HEALTH CARE OF THE ELDERLY 664 (1970) [hereinafter cited as GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, REPORT NO. 79].

118. WORKING WITH OLDER PEOPLE, VOL. II, *supra* note 4.

119. 373 F.2d 451 (D.C. Cir. 1966).

120. D.C. CODE ANN. § 21-562 (1967).

121. The New York courts also followed the statutory route in *People ex rel. Whitree v. LaBurt*, 17 N.Y.2d 738, 270 N.Y.S.2d 206 (1966). The court advised the patient to use the administrative procedures provided by the legislature to investigate care and treatment. These procedures included the authorization given to the Commissioner of Mental Health to conduct such investigations and the Mental Health Information Service, which is empowered to conduct periodic review of all patients.

122. 325 F. Supp. 781 (D. Ala. 1971).

123. *Id.* at 785.

any known minimum established for providing treatment for the mentally ill."¹²⁴ The failure to provide such treatment transformed the mental institution into a penitentiary.¹²⁵

The remedy chosen by the court was to give the state six months to submit evidence that it had established fully appropriate mental health treatment programs. Judge Johnson requested that the Justice Department, the Department of Health, Education and Welfare, and the Public Health Service enter the case to assist in drawing up new procedures for treatment and custody, to aid the state in qualifying for Social Security benefits for the geriatric patients, and to help plan the relocation of the geriatric patients to other facilities. If the State failed to take these steps, the court said it would appoint a "panel of experts in the area of mental health to determine what objective and subjective standards will be required to furnish adequate treatment to the treatable mentally ill."¹²⁶

The court's discussion of due process considerations is brief. If the state commits a person for treatment purposes, then it must validate the deprivation of liberty by providing actual treatment. The court cited the *Rouse* decision as support for its conclusion, but failed to advert to the statutory basis in *Rouse*. The court's choice of a remedy is ambitious, but its effectiveness remains to be seen. The moment of truth for Alabama might come only if the court ordered the patients released.

Critics of the right to treatment decisions question the competence of the courts to define treatment,¹²⁷ to appraise its adequacy, or to provide an appropriate remedy.¹²⁸ They believe that the problems of definition and evaluation are best left to the medical profession, which even in its own rank is unable to agree on these matters. They also argue that the legislature should supply the remedy, since the issue

124. *Id.* at 784.

125. *Id.*, citing *Ragsdall v. Overholser*, 281 F.2d 943, 950 (1960).

126. *Id.* at 786.

127. Council of the American Psychiatric Association, *Position Statement on the Question of Adequacy of Treatment*, 123 AM. J. PSYCHIATRY 1458 (1967).

128. Bazelon, *Foreword* (to Symposium on the Right to Treatment), 57 GEO. L.J. 676 (1969). See also Bassiouni, *The Right of the Mentally Ill to Care and Treatment: Medical Due Process*, 15 DEPAUL L. REV. 29 (1966); Livermore, *supra* note 37, at 93 n.53; Note, *Involuntary Civil Commitment and the Right to Treatment in Pennsylvania*, 15 VILL. L. REV. 95 (1970); Note, *Nascent Right to Treatment*, 53 VA. L. REV. 1134 (1967); Comment, *Civil Restraint, Mental Illness and the Right to Treatment*, 77 YALE L.J. 87 (1967).

concerns a basic policy judgment involving overall priorities in the allocation of social resources.

In response, one might point out that courts are likely to be as competent in reviewing right of treatment cases as they are in reviewing the actions of administrative agencies having expertise in other areas. The judge need only decide "whether the patient is receiving carefully chosen therapy which respectable professional opinion regards as within the range of appropriate alternatives, not whether the patient is receiving the best of all possible treatment in the best of all possible mental hospitals."¹²⁹ Such an inquiry would proceed at two levels. The court would first examine objective factors, such as the degree to which the hospital possesses the staff and resources to provide treatment to all its patients.¹³⁰ It would then look at the treatment of the individual patient, and in so doing, it might use as a guide the Social Security Administration's definition of "active treatment," which is employed for the purpose of reimbursing hospitals for services rendered to Medicare patients.¹³¹

The final objection goes to the very rationale for the hospitalization process. When, through its laws, the state legislature bases its deprivations of liberty, at least partially, upon a promise of treatment, it has already committed the community's resources to providing adequate facilities. If the legislature then dishonors the promise, involuntary and indeterminate hospitalization amounts to no more than preventive detention, and the mental hospital becomes a jail.

All of this assumes that the patient is treatable. What about the elderly who can no longer be treated but only held in custody, after all known courses of treatment have been exhausted?¹³² The aged person might be given the option of remaining as a voluntary patient. The logic of the situation however, appears to demand that he be re-

129. *Id.* See also Baze'on, *Implementing the Right to Treatment*, 36 U. CHI. L. REV. 742 (1969).

130. This proposal appears to contradict M. Birnbaum's reading of the *Rouse* decision as calling for only subjective standards in evaluating the adequacy of treatment. See Birnbaum, *A Rationale for the Right*, 57 GEO. L.J. 752, 753 (1969). Birnbaum is the author of the concept of a "right to treatment." Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499 (1960).

131. 20 C.F.R. § 405.1036-38 (1971). Even this approach is too objective for one writer who fears that the patient might still not be treated under these standards according to his individual needs. Halpern, *A Practicing Lawyer Views the Right to Treatment*, 57 GEO. L.J. 782, 790 (1969).

132. See text accompanying notes 116-126 *supra*. See also Katz, *The Right to Treatment—An Enchanting Legal Fiction?*, 36 U. CHI. L. REV. 755, 766 (1969).

leased if he so desires and allowed to choose his own lifestyle.¹³³ If this course of action is too drastic, then the only alternative open to the state is revision of its commitment laws to permit hospitalization for custodial purposes alone, but with a provision that the case for such detention be supported by the beyond a reasonable doubt standard of proof required for criminal incarceration.¹³⁴

Alternate Methods of Care

The latent irony in the storage of the elderly in state mental hospitals is that large numbers of them do not really belong there. As early as 1955 the Council of State Governments noted evidence that a substantial number of new admissions to mental hospitals who were 65 years of age and over might not require hospital service, but could be better cared for in other kinds of facilities.¹³⁵ The American Bar Foundation Report cited a study of the conditions in Texas, which asserted that "seventy percent of all patients do not need to be in a mental hospital. They could be treated at home, in clinics, or other institutions."¹³⁶ Another study showed that nearly one-third of the elderly patients in one hospital and nearly one-half in another were thought to be able to return to the community.¹³⁷ In the majority of cases, a group home, attendance at a day care center, or some supervision in the home seemed sufficient. In addition, a significant percentage of the elderly in both hospitals were thought suitable for nursing home care because they had minimal psychiatric symptoms but their physical condition required nursing care. Only the remaining one-quarter of the patients in these hospitals was felt to be suitably placed in the psychiatric hospital.

Other studies have shown that many of the elderly admitted to mental hospitals probably do not differ appreciably from elderly people still in the community or in nursing homes.¹³⁸ Their hospitalization is more

133. See Twerski, *Treating the Untreatable—A Critique of the Proposed Pennsylvania Right to Treatment Law*, 9 DUQUESNE L. REV. 220 (1970).

134. See Bazelon, *supra* note 129, at 748.

135. COUNCIL OF STATE GOVERNMENTS, *THE STATES AND THEIR OLDER CITIZENS, A REPORT TO THE GOVERNORS CONFERENCE* 38 (1955). See also Kolb, *Mental Hospitalization of the Aged: Is It Being Overdone?*, 112 AM. J. PSYCHIATRY 627 (1956).

136. ABF, *supra* note 8, at 19.

137. Markson, Kwoh, J. Cumming & E. Cumming, *Alternatives to Hospitalization for Psychiatrically Ill Geriatric Patients*, 127 AM. J. PSYCHIATRY 1055, 1060 (1971).

138. E. Markson & J. Hand, *Referral for Death: Low Status of the Aged and Referral for Psychiatric Hospitalization* 1 (1970) (unpublished) [hereinafter cited as Markson & Hand].

often a reflection of certain socially unacceptable characteristics,¹³⁹ rather than a greater degree of mental impairment than their contemporaries elsewhere.¹⁴⁰ Lack of education, low status occupation before retirement, low socio-economic status, and birth in a foreign country have been found to be the primary characteristics of the elderly in psychiatric hospitals. If social value is measured by productive capacity, then the aged poor have a double low-status role in society which thus helps to hasten their admission to a mental hospital.

It has also been suggested that many of the hospitalized elderly may simply have had strokes or toxic confusions mimicking psychotic symptoms.¹⁴¹ The most common complaint (40 percent) made by those seeking admission of the elderly was that they were senile, that is, forgetful, confused, wandering, likely to leave the gas stove on, and so forth. Another six percent were described as nervous but not senile or demented, and nine percent were just aggressive. Thus, nearly 50 percent of the elderly patients had been admitted on the grounds of senility or nervousness, both of which are questionable bases for inpatient psychiatric care.

Practical solutions to the misplacement problem have taken two forms. In New York the State Department of Mental Hygiene directed in 1968 that only elderly patients in need of hospitalization to obtain psychiatric care and treatment be admitted to state mental hospitals.¹⁴² Persons whose problems were primarily physical, social, or economic and who would more appropriately be treated by another facility would not be accepted.¹⁴³ The Department pointed out that the former practice of easier admission was a burden on the hospitals to which they were not equipped to respond, and it removed from the community the necessity for developing adequate services to solve such problems.

139. Bennett & Nahemow, *Social Adjustment in Residences for the Aged*, 21 J. SOCIAL ISSUES 44, 60 (1965).

140. Markson & Hand, *supra* note 138, at 5.

141. *Id.* at 4-5.

142. N.Y. State Department of Mental Hygiene, Division of Mental Health, Memorandum N. 68-27 (June 19, 1968).

143. N.Y. State Department of Mental Hygiene, Division of Mental Health, Guidelines for Admission and Referral of Elderly Patients (April, 1969), advised that elderly patients who had a serious physical disability with minor mental disorder, serious physical disease with mental symptoms arising as a direct result of the physical—"acute brain syndrome,"—or socio-economic need with no significant mental and physical pathology be denied admission to state mental hospitals. Those with irreversible mental disorder with or without physical disability would be admitted on a case by case basis in view of individual circumstances.

The short term result of this policy was to reduce the geriatric admissions to the mental hospitals from 330 per 100,000 to 142 per 100,000 in 1969¹⁴⁴ The long term result cannot be measured as yet. Proposals were formulated by interested social agencies calling for community-based geriatric centers, expansion of nursing homes and their services, broadening of the services of the state mental hospitals to care for some of the elderly being denied admission, and the enactment of conservatorship legislation. But these were proposals, not programs, and the reality is that the mental hospitals denied admission to many elderly as a move designed to cause a crisis in services, knowing that no adequate facilities then existed to care for many of those turned away¹⁴⁵

The American Psychiatric Association condemned this practice:

An arbitrary administrative decision to exclude elderly patients from admission to state hospitals [should be based on hard data]. Certainly some elderly patients *will* become chronic residents, but who can determine the outcome of treatment before it is instituted? Who should treat persons who do *not* have remedial conditions? When the aim of treatment is to obtain an optimum level of functioning, then one considers a wide spectrum of services, with some resources in the "community," and others in institutions such as our state mental hospitals. At present, it is quite clear that many elderly persons need institutional care for physical and mental impairment. Philosophically, one may conclude that nursing homes belong to the "community" and state hospitals do not, but the difference is semantic, not a functional distinction. State departments of mental health cannot discharge their overall responsibility without provision of care for some elderly persons who have chronic illness, both physical and mental.¹⁴⁶

The Presidential Task Force, in its report issued in preparation for the White House Conference on Aging in November, 1971, also expressed concern about

144. COMMUNITY SERVICE SOCIETY OF NEW YORK, PROFILE OF THE AGED IN NEW YORK CITY 3 (1970).

145. COMMUNITY SERVICE SOCIETY OF NEW YORK, THE ELDERLY AND THE STATE MENTAL HOSPITAL IN NEW YORK STATE 5-10 (1969). For a defense of the hospital policy, see Miller, *The Changing Role of the State Hospital*, in NEW YORK STATE OFFICE FOR THE AGING, PROCEEDINGS, EIGHTH ANNUAL GOVERNOR'S CONFERENCE ON AGING 29 (1969).

146. AMERICAN PSYCHIATRIC ASSOCIATION, REPORT OF THE TASK FORCE ON AGING ON CRITICAL ISSUES FACING THE 1971 WHITE HOUSE CONFERENCE ON AGING 5 (undated).

indiscriminate regulation against the admission of older patients to public psychiatric facilities and recent trends toward release of elderly patients from State institutions primarily because they are old in the face of the absence of community services to support these released patients¹⁴⁷

By contrast, Pennsylvania has shown in an experimental program that many long-term patients 65 years of age and older have "restorative potential" when moved out of the state mental hospital into a geriatric center, designed and operated exclusively for them.¹⁴⁸ Seventy percent of the first 700 patients in the program responded favorably to therapy and had improved sufficiently to return to community housing or to simplified care settings.

Other states have attempted to solve the problem by transferring elderly patients from state mental hospitals to extended care facilities in order to attract larger federal payments under Medicare.¹⁴⁹ Several studies have noted, however, that, even with careful preparation of the patient before his transfer, mortality increased in the relocated population. Moreover, often the placement is in a nursing home that provides no psychiatric care. To counteract this trend, the Group for the Advancement of Psychiatry recommended:

We must speak of alternatives not only between an adequate and comprehensive mental hospital and other community facilities, but also among various kinds of treatment aged patients need to receive *within* the hospital. All too often, there exists a sole "program" for the geriatrics ward or for all the patients aged 65 and over in state hospitals.¹⁵⁰

The judicial response to the problem begins with the decision in *Lake v. Cameron*.¹⁵¹ The Court of Appeals for the District of Co-

147. PRESIDENT'S TASK FORCE ON THE AGING, TOWARD A BRIGHTER FUTURE FOR THE ELDERLY 34 (1970).

148. COMMUNITY SERVICE SOCIETY OF NEW YORK, AGED LONG-TERM HOSPITAL PATIENTS SHOW "RESTORATIVE POTENTIAL" 1 (undated), *reprinted from* 5 FRONTIERS IN HOSPITAL PSYCHIATRY (No. 17, Oct. 15, 1968).

149. GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, REPORT No. 79, *supra* note 117, at 662. For a survey of the use of alternate facilities in some European countries, see Kleemeier, *The Mental Health of the Aging*, in AGING IN WESTERN SOCIETIES 203, 205-06 (Burgess ed. 1960).

150. *Id.* at 665.

151. 364 F.2d 657 (D.C. Cir. 1966). See NATIONAL COUNCIL ON AGING, THE LAW AND THE IMPAIRED OLDER PERSON: PROTECTION OR PUNISHMENT (Hall ed. 1966).

lumbia Circuit remanded a habeas corpus proceeding to the District Court for inquiry into alternative courses of treatment in place of confinement at St. Elizabeth's Hospital. The petitioner had been confined there after having been found wandering about, and had been diagnosed as suffering from chronic brain syndrome associated with aging and loss of memory. She also had wandered from the hospital on one occasion. She was not considered dangerous to others nor would she intentionally harm herself, but apparently her condition left her open to accidental injury or abuse from others. The Hospitalization of the Mentally Ill Act provided that if a court or jury found that a

person is mentally ill and, because of that illness, is likely to injure himself or other persons if allowed to remain at liberty, the court may order his hospitalization for an indeterminate period, or order any other alternative course of treatment which the court believes will be in the best interests of the person or the public.¹⁵²

The court was careful to confine the basis for the remand to the statutory provision authorizing alternative courses of treatment where appropriate. It expressed no opinion on the constitutional issues, such as "whether so complete a deprivation of appellant's liberty basically because of her poverty could be reconciled with due process of law and the equal protection of the laws," that would arise if the district court on remand should find no available alternative to confinement at St. Elizabeth's.

The decision, while significant in its aspirations, is not likely to have any far-reaching effects. Its narrow statutory basis means that it is of precedent value only in jurisdictions having similar statutes. The New Mexico Supreme Court refused to follow it in the absence of similar legislation.¹⁵³ Even the District Court in the District of Columbia, upon remand, found its hands tied.¹⁵⁴ After finding that the patient needed constant supervision, the court could only conclude that whatever the need for alternative facilities, none were available and therefore the patient could not be released.

Recent amendments to the Social Security Act may provide the beginnings of a legislative solution to the problem of lack of alternate care facilities. They may also lay the foundation for a statutory right

152. D.C. CODE ANN. § 21-545 (b) (1967).

153. *State v. Sanchez*, 80 N.M. 438, 457 P.2d 370 (1969).

154. *Lake v. Cameron*, 267 F. Supp. 155 (D.D.C. 1967).

to treatment generally enforceable throughout the country. These amendments authorize federal support for state plans for medical assistance to persons 65 years of age and older who are patients in institutions for mental diseases.¹⁵⁵ The legislation requires written agreements with the state agency administering the plan and with participating institutions, which set forth their operational duties, including staffing and procedure.¹⁵⁶ These agreements must also include arrangements for the development of alternate methods and plans of care outside of institutions for patients who would otherwise require institutional care and for patients no longer needing care in a mental institution.¹⁵⁷ These arrangements are designed to form part of a comprehensive mental health program, including community mental health centers, nursing homes, and other alternatives to care in public institutions for mental diseases, which the state is required to develop.¹⁵⁸

The Department of Health, Education and Welfare regulations also demand a periodic inventory of currently available alternate care arrangements, an evaluation of the suitability and quality of care in such facilities, dissemination of information about these facilities to related local departments, and annual progress in developing new and existing resources as needed by aged recipients.¹⁵⁹ These alternate arrangements include care in the patient's or a relative's home with necessary home services, particularly homemaker services, foster family care, nursing homes, and social care facilities.¹⁶⁰

The state plan must also provide for an individual plan for each patient in an institution for mental diseases.¹⁶¹ This plan should include assurances of initial and periodic review of his medical, psychiatric, and social needs, that he will be given appropriate medical treatment within the institution, and of a periodic determination of his need for continued treatment in the institution.¹⁶² Qualifying institutions must provide medical care for every patient, 24-hour nursing service, and

155. 42 U.S.C. § 1396(a) (20) (1970); 42 U.S.C. § 302(a) (12) (1970).

156. 42 U.S.C. § 1396(a) (20) (A) (1970); 42 U.S.C. § 302(a) (12) (A) (1970).

157. 42 U.S.C. § 1396(a) (20) (A), (C) (1970).

158. 42 U.S.C. § 1396(a) (21) (1970).

159. FEDERAL HANDBOOK OF PUBLIC ASSISTANCE POLICIES AND PROCEDURES § 5230(E) (1), (2) (Supp. D) quoted in Nathan, *The "Long Amendment,"* 4 CLEARINGHOUSE REV. 245, 258-59 (1970).

160. *Id.* at § 5230(e) (2).

161. 42 U.S.C. § 1396(a) (20) (B) (1970).

162. *Id.* See 36 Fed. Reg. 3102 (1971); 45 C.F.R. § 250.23 (1971) (expanded requirements intended to enforce the quality care standards).

psychiatric services, and must comply with certain licensing and accrediting procedures.¹⁶³

The major difficulty in this legislation is the loophole provided by the "maintenance of state effort" clause requiring a state to maintain a budget in each succeeding year which exceeds what was spent in any quarter in the fiscal year ending June 30, 1965.¹⁶⁴ As HEW itself notes, the fact that most states have increased their budgets for mental health on a yearly basis makes it very easy for a state to meet the requirements of this clause.¹⁶⁵ The increase, however, may be due simply to rising costs and not to any stepped-up program of care for aged patients. Having qualified for federal funds, the states need provide no further guarantee that the additional monies will be used for new methods of treatment and care.¹⁶⁶ The federal government, in effect, may be picking up the bill for the increased overhead.

The answer is to amend the legislation to require a showing by the states of increased expenditures for the programs contained in the agreement, rather than just a showing that more money was spent for mental health in general. Such an amendment, however, is no guarantee that alternate care plans and facilities would start to appear. Many states may prefer not to enter the agreement at all because of the financial burden caused by the state portion of the expenditures.

Absent statutory reform or state participation, the only solution to the problem of the aged person who needs treatment less drastic than full-time confinement in a mental hospital may lie along constitutional lines. It has been suggested¹⁶⁷ that the doctrine of *Shelton v. Tucker* is applicable here:

Even though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that stifle fundamental personal liberties when the end can be more narrowly achieved. The breadth of legislative abridgment must be viewed in the light of less drastic means for achieving the same basic purpose.¹⁶⁸

163. 42 U.S.C. § 1861(F) (1970).

164. 42 U.S.C. § 1903b (1970).

165. HEW Staff Memorandum (Jan. 28, 1969), *quoted in* Nathan, *supra* note 159, at 262-63.

166. GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, REPORT NO. 79, *supra* note 117, at 684.

167. Ennis, *supra* note 86, at 112.

168. *Shelton v. Tucker*, 364 U.S. 479, 488 (1960).

By this reasoning, those recommending commitment to a mental hospital would be required to bear the burden of proving that there are no less drastic alternatives. This argument produces the same practical result as the decision in *Lake v. Cameron*: it is useful for compelling transfer where alternative methods of care exist in a jurisdiction, but it will not create new facilities.

NON-INSTITUTIONAL PROTECTIVE SERVICES

The discussion thus far has centered on involuntary civil commitment, the legal prerequisite to providing institutional protective services to many of the elderly. As has been shown, the process and consequences of commitment are often unfair and unnecessary. This article will now consider other legal devices designed to protect the person and property of the non-institutionalized person and enable him to continue living in the community in spite of some disability.

The number of aged suffering a modicum of mental impairment and/or behavioral disturbance has been put at some 15 to 20 percent of the urban aged in the United States today.¹⁶⁹ About half of these, or eight percent, are thought to need some form of protective assistance.¹⁷⁰ This is a number twice that of the aged in mental hospitals, nursing homes, or homes for the aged.

In descriptive terms, the prospective client for protective services is an elderly person who is too frail mentally and physically to act on his own behalf, who lives alone or is without a responsible person able, willing, and available to assist him, who needs help in managing himself and his affairs, and whose incapacity might result in hazard to himself or others.¹⁷¹ The following is a composite portrait of these clients:

[He] can't recall what he did with his funds or their source or amount, forgets to eat, is either afraid to spend his money, or else squanders his funds; or is constantly moving from place to place;

169. M. BLENKNER, E. WASSER & M. BLOOM, PROTECTIVE SERVICES FOR OLDER PEOPLE, PROGRESS REPORT FOR 1966-67 3 (1967) [hereinafter cited as BLENKNER].

170. *Id.* at 4; J. LYNES, THE EVOLUTION OF PROTECTIVE SERVICES FOR OLDER PEOPLE 10 (1970).

171. G. HALL, PROTECTIVE SERVICES: EVOLVING CONCEPTS AND PRINCIPLES 4 (1966). See also V. LEHMANN & G. MATHIASSEN, GUARDIANSHIP AND PROTECTIVE SERVICES FOR OLDER PEOPLE 1-2 (1963); LYNES, *supra* note 170, at 10, 19. For a classification of the degrees of incapacity among OASDI beneficiaries, see Larson, *Protective Services for Older Adults*, 22 PUB. WELFARE 247, 248 (1964).

or wanders the streets in the dark of night and forgets where he lives or has no permanent living quarters; or spends his money on liquor and begs or starves until his next check is received; or is living in squalor in a building that has been condemned but not yet torn down; is using an old portable oil burner for heating and cooking because the gas and electricity have been turned off, or crippled by arthritis and partly bed-ridden, continues to dwell in his own vermin-infested house by reason of accumulated rubbish and rotting food remnants; refuses hospitalization for treatment of infection resulting from untreated injury; or is constantly picking quarrels with the neighbors, shouting obscenities at passers-by, using an open window as a garbage disposal unit, dressing bizarrely; or continues to operate a small neighborhood store with entangled business affairs; or is in imminent danger of sustaining grave personal injury by reason of infirmity but refuses to leave home and will not accept any help within his home.¹⁷²

The essential feature of a protective service for these clients is the surrogate function, the legal authorization to act in behalf of the older person, with or without his consent.¹⁷³ The balance of this article will consider a variety of existing and proposed kinds of protective services, ranging from the total control of a full guardianship to a single transaction authorization.

Guardianship

The legal institution devised by English law to care for those persons unable to care for themselves or their affairs but not in need of confinement was guardianship. It focused on the protection of the disabled person's property from which his support was to be drawn during the period of the guardianship. By contrast, commitment was intended to protect the public and the person himself from his potential acts of violence or from peril as well as to provide appropriate therapeutic measures for him.¹⁷⁴

172. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, *WORKING WITH OLDER PEOPLE—VOL. III: THE AGING PERSON: NEEDS AND SERVICES* 52 (1970). See also NATIONAL COUNCIL ON AGING, *SEMINAR ON PROTECTIVE SERVICES FOR OLDER PEOPLE* 197 (1964) [hereinafter cited as NATIONAL COUNCIL ON AGING].

173. Address by John Martin in LYNES, *supra* note 170, at 11. See also V. LEHMANN & G. MATHIASSEN, *supra* note 171, at 115.

174. ABE, *supra* note 8, at 219.

The Criteria

As a prerequisite for the appointment of a guardian, the disabled person must first be declared incompetent. According to a typical statutory formulation, an incompetent is one who, by reason of mental illness, drunkenness, drug addiction, or old age is incapable of caring for himself and/or managing his business affairs or providing for his family, or is liable to dissipate his property or become the victim of designing persons.¹⁷⁵ The court makes two findings: (1) that a person is mentally ill (or elderly, an alcoholic, or a drug addict), and (2) as a result of this condition, he is unable to care for himself or manage his property.

Both the statutory criteria and the conclusion of incompetency to which they lead are insensitive to the needs of the elderly. The grounds overemphasize mental illness or mental deficiency, defects which are the universal criteria in all the states, while less than half of the jurisdictions recognize such other reasons as alcoholism, drug addiction, old age, spendthrift tendencies, and physical disability.¹⁷⁶ As a result, the incompetent bears the stigma of being mentally ill in the popular mind. An elderly person who has a few of the manifestations of chronic brain syndrome, such as forgetfulness, may find these translated into the wider conclusion that he is mentally ill and therefore incapable of making any decisions for himself.¹⁷⁷

The evidence used by the courts to substantiate a finding of incompetency may not conform to the statutory criteria. Some courts tend to rely heavily on available medical testimony about mental illness,¹⁷⁸ with the result that the medical judgment, which is normally relevant only toward the first finding, tends to dominate the second finding, which should be a non-medical or behavioral judgment reserved for the trier of fact.¹⁷⁹ The more common practice in the courts, however, is that psychiatrists rarely testify in incompetency proceed-

175. *Id.* For a general discussion of the criteria used by the courts for determining incompetency, see Annot., 9 A.L.R.3d 774 (1966). For a list of the jurisdictions which specify old age as a factor, see Alexander, *Surrogate Management of the Property of the Aged*, 21 SYRACUSE L. REV. 87, 93 (1969).

176. ABE, *supra* note 8, at 219.

177. Lehmann, *Guardianship*, in *SOCIAL WELFARE OF THE AGING* 312 (Kaplan & Aldridge eds. 1962).

178. Alexander, *supra* note 175, at 130.

179. Comment, *Appointment of Guardians for the Mentally Incompetent*, 1964 DUKE L.J. 341, 345.

ings.¹⁸⁰ Courts then concentrate on evidence of erratic behavior of the alleged incompetent, particularly in terms of mismanagement of his property. If there is any evidence of mental weakness, the property mismanagement is presumed to be caused by the mental condition and, in fact, tends to reinforce the conclusion that the person is mentally ill.¹⁸¹

Another shortcut to a finding of incompetency in many jurisdictions is provided by evidence that the person is hospitalized.¹⁸² In some states such evidence leads to a conclusive presumption of incompetency, while others regard it as rebuttable.¹⁸³ This merger of hospitalization and competency determinations is open to criticism in view of recent trends in psychiatric treatment which indicate that a person may frequently be discharged after a short period of intensive therapy.¹⁸⁴ Even where there is no merger it is dangerous to attach much evidentiary value to hospitalization, because commitment proceedings often lack basic procedural safeguards or do not decide the same issues as competency proceedings, or the hospitalization may have taken place either pursuant to medical certification or with the consent of the alleged incompetent.¹⁸⁵

The Uniform Probate Code¹⁸⁶ eliminates many of the problems caused by vague or overreaching statutory criteria. The term "guardian" is restricted to guardianship of the person.¹⁸⁷ A guardian may be appointed by a court to care for an "incapacitated person," defined as

any person who is impaired by reason of mental illness, mental deficiency, physical illness or disability, advanced age, chronic

180. Note, *The Disguised Oppression of Involuntary Guardianship: Have the Elderly Freedom to Spend?*, 73 YALE L.J. 676, 680-81 (1964).

181. *Id.* at 681.

182. ABF, *supra* note 8, at 220; R. ALLEN, E. FERSTER, & H. WEIHOFEN, MENTAL IMPAIRMENT AND LEGAL INCOMPETENCY 89 (1968) [hereinafter cited as ALLEN].

183. ABF, *supra* note 8, at 224.

184. *Id.* at 223; Cobean, *The New Kansas Philosophy About "Care or Treatment" of the "Mentally Ill Person" and Obtaining a Guardian or Conservator or Both*, 6 WASHBURN L.J. 448 (1967).

185. ABF, *supra* note 8, at 225.

186. NATIONAL CONFERENCE OF COMMISSIONERS ON UNIFORM STATE LAWS, UNIFORM PROBATE CODE (1969) [hereinafter cited as UPC]. See also LEGAL RESEARCH AND SERVICES FOR THE ELDERLY & NATIONAL COUNCIL OF SENIOR CITIZENS, LEGISLATIVE APPROACHES TO THE PROBLEMS OF THE ELDERLY: A HANDBOOK OF MODEL STATE STATUTES 119 (1971) [hereinafter cited as HANDBOOK]. For a criticism of the 1946 Model Probate Code, Part IV, dealing with guardianship, see Fratcher, *Toward Uniform Guardianship Legislation*, 64 MICH. L. REV. 983 (1966).

187. UPC § 5-101(5).

use of drugs, chronic intoxication, or other cause (except minority) to the extent that he lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his person.¹⁸⁸

The comment to this section states that "[a] finding that a person is incapacitated does not amount to a finding that he is mentally ill or can be committed."¹⁸⁹

Similar criteria are recommended for establishing conservatorships and obtaining protective orders for the management of the disabled person's property¹⁹⁰ The court may take such action if it determines that:

(i) the person is unable to manage his property and affairs effectively for reasons such as mental illness, mental deficiency, physical illness or disability, advanced age, chronic use of drugs, chronic intoxication, confinement, detention by a foreign power, or disappearance; and (ii) the person has property which will be wasted or dissipated unless proper management is provided, or that funds are needed for the support, care and welfare of the person or those entitled to be supported by him and that protection is necessary or desirable to obtain or provide funds.¹⁹¹

By including non-mental causes among the reasons for ineffective management of property, the UPC criteria not only make the assistance of a guardianship available to a wider group of disabled persons but also de-emphasize the mental incompetency aspect of guardianship. It is also useful to specify the meaning of mismanagement in terms of waste or non-support, but one might hope that waste and dissipation had been more narrowly defined.

The Proceedings

Informality is the hallmark of incompetency proceedings. Any interested person may initiate them, but only eight states require that a certificate of incompetent mental condition accompany the petition.¹⁹²

188. UPC § 5-101(1).

189. UPC § 5-304 (Commissioners' Comment). See also Alexander, *supra* note 175, at 149.

190. UPC § 5-401 to -431. See Fingar, *Conservatorship under Uniform Probate Code*, 4 REAL PROPERTY, PROBATE & TRUST J. 433 (1969).

191. UPC § 5-401(2).

192. ABF, *supra* note 8, at 223.

While notice of the forthcoming proceeding must be sent to the person or close relatives in most states, some jurisdictions permit the judge to reduce the statutory period for notice or dispense with it altogether, and some waive it where the person is hospitalized.¹⁹³ At the hearing, the presence of the person may not be required if the court so orders,¹⁹⁴ and in practice the person is seldom actually present, either by choice, suggestion, or ignorance.¹⁹⁵

Half of the states provide for representation by counsel, but it is generally not mandatory.¹⁹⁶ In practice, the alleged incompetent frequently lacks the assistance of counsel. Where private counsel is appointed, the smallness of the fee tends to produce representation of the most perfunctory nature.¹⁹⁷

A jury trial is not constitutionally mandated, but 21 states require or at least permit the person to request one.¹⁹⁸ Failure to do so, however, may amount to a waiver, a result which seems unduly harsh when the person may never have received notice of his rights to the jury trial nor have been advised by counsel. Jury trials rarely occur in those states that do not mandate them.¹⁹⁹

Reform of these proceedings should move along fundamental lines. Notice of the proceedings should be sent to the person and his close relatives²⁰⁰ sufficiently well in advance to permit adequate preparation.²⁰¹ Representation by counsel should be mandatory, either at the choice of the person or by appointment of the court.²⁰² To assure that the court will be thoroughly informed of the reasons and circumstances surrounding the proposed guardianship, investigative resources must be available to the court to provide impartial information about the health of the alleged incompetent, his attitude toward the proposed guardian

193. *Id.*

194. *Id.*

195. ALLEN, *supra* note 182, at 83-84.

196. ABF, *supra* note 8, at 223.

197. *Hearings on the Legal Problems Affecting Older Americans Before the Special Comm. on Aging of the United States Senate*, 91st Cong., 2d Sess. 12 (1971) [hereinafter cited as *Special Comm. on Aging*]; ALLEN, *supra* note 182, at 82, 87-88; BLENKNER, *supra* note 169, at 38; JOHNSON, *supra* note 79, at 572.

198. ABF, *supra* note 8, at 224.

199. ALLEN, *supra* note 182, at 84.

200. See UPC § 5-309(a)(1)(3).

201. UPC § 1-401(a)(1) requires at least 14 days advance notice.

202. See UPC § 5-303(b).

or the person seeking appointment as guardian, and the proposed residence for the incompetent. Counsel for the incompetent could be charged by statute with the duty of supplying such information, although the expense to the incapacitated person might be prohibitive, especially where his estate will also be paying for the cost of the petition for the guardianship. A state might avoid this problem by adopting the approach of the Uniform Probate Code, which requires a pre-hearing examination by a court-appointed physician and an investigation by a "visitor," an agent of the court trained in law, nursing, or social work with no personal interest in the proceedings.²⁰³

The Guardian

The finding of incompetency by a court leaves the disabled person virtually incapable of performing an act with legal consequences.²⁰⁴ He will be limited in his ability to execute documents, initiate litigation, participate in business and professional activities, and exercise political rights and privileges. His eligibility for governmental assistance, such as veterans' benefits, may also be regulated.

The court may also appoint a guardian for the incompetent's person, estate, or both.²⁰⁵ In theory, the guardian of the person is authorized to act as the legal representative of the ward.²⁰⁶ He may sue and be sued on behalf of the ward, decide where the ward resides, and void contracts of the ward entered into before the guardianship began. The guardian of the estate, sometimes called a conservator, is charged with the duty of prudently managing the ward's property to prevent waste and provide for the ward's needs.²⁰⁷ He assumes possession, use, and control of the ward's property, although title remains in the ward's name. He usually must render a periodic accounting to the court,²⁰⁸ and must obtain court permission for certain activities, particularly those affecting the disposition of real property.²⁰⁹

203. UPC § 5-303(b), -308.

204. ABF, *supra* note 8, at 263. The stigma of incompetency and the loss of civil rights may lead to further debilitation of an already marginally functioning person. G. HALL, *OVERCOMING BARRIERS TO PROTECTIVE SERVICES FOR THE AGED* 36 (1968).

205. ABF, *supra* note 8, at 263.

206. Alexander, *supra* note 175, at 138.

207. *Id.* at 139.

208. Review of the accounting is lax in some jurisdictions. ALLEN, *supra* note 182, at 92-93.

209. ABF, *supra* note 8, at 225.

Proposed Reforms

Many features of guardianship are in need of revision:

1. Confusion about the purposes and functions of the guardian of the estate and the person must be eliminated. Many statutes are vague about guardianship of the person and often describe its scope of authority in terms that are more appropriate for the guardian of the estate, and in practice the two are frequently indistinguishable. One study could find no instance in which only a guardian of the person was appointed.²¹⁰

2. The all-or-nothing character of the control over the ward given to the guardian is too sweeping. The guardian assumes total control over virtually every area of decision-making in the personal and business life of the ward. This approach may have validity where the ward is patently incapable of managing himself or his affairs, but it is poorly suited to the gradual changes in capacity which occur between the full vigor of middle life and the stage we call second childhood. Many elderly people whose disability is only partial may need assistance only with certain functions of life, such as paying bills, or with certain transactions, such as selling a house, buying an annuity, or entering a nursing home. Their need is for a flexible form of guardianship tailored to their individual capacity which allows them to retain control over those decisions which they are capable of making.²¹¹

3 The cost of guardianship is very high and may rapidly deplete the estate or put the service beyond the reach of a person whose resources are limited or consist only of a monthly benefit check.²¹² In states with high charges a disabled person with a \$5000 estate might be left at the end of a five-year guardianship with only a little more than half of the original fund, the rest having been expended on administrative charges.²¹³ These charges, particularly where small estates are involved, are the result of complex procedures which paradoxically have the ostensible goal of protecting the property of the disabled person. Often it is impossible to avoid such protection even if it is not really needed. Where the aged person has only limited resources, the

210. ALLEN, *supra* note 182, at 95.

211. Lehmann, *supra* note 177, at 312.

212. NATIONAL COUNCIL ON AGING, *supra* note 172, at 197

213. ABA Comm. on Problems Relating to Persons under Disability, *Conservatorship: Present Practice and Uniform Probate Code Compared*, 5 REAL PROPERTY, PROBATE & TRUST J. 507, 517 (1970).

high cost of guardianship may tempt his relatives to spend his remaining assets to make him eligible for OAA assistance and a state-appointed guardian who might then institutionalize the ward.²¹⁴ Alternatively, the elderly person may live in a nursing home where a zealous administrator may assume fiscal management without regard for legal procedure.²¹⁵

4. Although the hearing is apparently non-adversarial, a conflict of interests may lie hidden behind the mask of concern for the welfare of the alleged incompetent and his property.²¹⁶ Close relatives, expectant heirs, and state hospitals, acting as interested parties, may petition for appointment as guardian to prevent dissipation of the assets. This laudable goal may in fact benefit the family and heirs more than the ward. Support for the hypothesis that the surrogate management of the aged incompetent is conducted in the specific interest of some person other than the ward has been found in a field study of the management of such estates.²¹⁷ The study concluded that "except for young veterans, if the specific interests of the incompetent were protected, it was out of inadvertence and not design."

5 The prospective ward usually has no voice in the selection of his guardian, nor does he have the opportunity to indicate in advance any policies which he desires the guardian to follow in managing his affairs.²¹⁸

Other Forms of Protective Service

Several other types of substitute decision-making procedures will be examined as possible models for revising the office of guardian or as alternatives to a guardianship.

Public Guardianship

The public guardianship is an increasingly popular form of protective service. Several states have already enacted various forms of public guardianship,²¹⁹ and the *Handbook of Model State Laws* re-

214. HALL, *supra* note 204, at 36.

215. *Id.*

216. Note, *supra* note 180, at 684.

217. *Special Comm. on Aging*, *supra* note 197, at 106-08; Alexander, *supra* note 175, at 165-68.

218. ALLEN, *supra* note 182, at 90.

219. See text accompanying notes 221-29, 238 *infra*.

cently published by Legal Research and Services for the Elderly contains a proposal for the creation of this office.²²⁰

California has the most extensive system of public guardians.²²¹ An official, who functions at the county level, is authorized to apply for a court appointment as guardian or conservator of the person, the estate, or both of anyone committed to county mental health facilities, persons receiving public aid, or anyone in the county requiring such assistance and for whom no one is qualified and willing to provide such help.²²² This official may also be appointed by the court to serve after regular guardianship proceedings have been initiated. His powers and duties are generally the same as those of private guardians or conservators. He is entitled to costs and a fee if a private guardian or conservator is appointed to succeed him,²²³ or at the death of his ward he may file a claim against the ward's estate for reimbursement of his expenses.²²⁴

More limited forms of guardianship exist in Kentucky and North Carolina. Kentucky originally authorized the Department of Mental Health to serve as guardian only for committed incompetents who had no committee,²²⁵ but in 1970 it extended the service to handle the personal funds of persons who were hospitalized but not adjudged mentally incompetent,²²⁶ and it authorized regional community mental health centers to perform these functions as well.²²⁷ The effect is to permit the release from state hospitals and placement in a nursing home or boardinghouse of many patients who might otherwise continue to be confined because they had no one to help them. The public guardian receives public assistance payments for his wards, makes payments to the home operators or to the patients themselves, and accounts to the court as required by law—all free of charge to the patient.²²⁸ All fees for the services are to be paid out of the estate. The North Carolina public guardian is an official appointed by the clerk of the superior court who intervenes either six months after discovery of property of

220. HANDBOOK, *supra* note 186, at 153.

221. CAL. WELF. & INST'NS CODE § 8000 (1971).

222. CAL. WELF. & INST'NS CODE § 8006 (1971).

223. CAL. WELF. & INST'NS CODE § 8006.5 (1971)

224. CAL. WELF. & INST'NS CODE § 8012 (1971).

225. KY. REV. STAT. § 210.290(2) (1970).

226. KY. REV. STAT. § 210.290(7) (1970).

227. Ch. 210(1), § 4 [1970] Ky Acts c. 278.

228. Weihofen, *Mental Health Services for the Poor*, 54 CALIF. L. REV. 920, 936 (1966).

a "miser, idiot, lunatic, insane person or inebriate" who lacks a guardian or when requested to do so by a private guardian.²²⁹

The *Handbook* statute is designed to provide free or low cost guardian or conservator services for those who have no friends or relatives within the jurisdiction able and willing to perform this service and for those whose resources are inadequate to provide the requisite compensation to a private guardian or conservator.²³⁰ The public guardian would be appointed by the court which has jurisdiction over guardianship hearings as an official of that court.²³¹ He would serve at a fixed rate of compensation and would be authorized to employ necessary staff.²³² He could petition to have himself appointed guardian or conservator,²³³ be nominated for this position by the individual in anticipation of incapacity,²³⁴ or be appointed by the court even though the individual has nominated someone else.²³⁵

The powers of this public official would be nearly identical with those of a private guardian or conservator,²³⁶ and, by contrast, substantially broader than those currently given to public guardians by most states which have similar systems. The administrative appointment costs would be paid out of public funds, but the court could order reimbursement from the individual's income or estate to the degree the funds could support such payment.²³⁷

The office of public conservator proposed by the Council of Elders of Roxbury, Massachusetts differs somewhat from the *Handbook* model.²³⁸ This official is concerned only with the property, and not the person, of the incapacitated person. He is appointed by the governor, not the court, for a five-year period as one of five or six such officials who would function in each county. He may petition the court for appointment only when no spouse, heirs, or friends living in the state are capable of properly caring for the property of the individual. A spouse claiming the right to be conservator and satisfying the court of suitability may successfully challenge the petition. The

229. N.C. GEN. STAT. § 33-47(1) (1966).

230. *HANDBOOK*, *supra* note 186, at 153.

231. *Id.* [Public Guardian § 2(a)].

232. *Id.* [Public Guardian § 1(d)].

233. *Id.* [Guardianship and Conservatorship §§ 5-503(a), -404(b)].

234. *Id.* [Guardianship and Conservatorship §§ 5-311(b) (1), (2); -410(a) (2), (3)].

235. *Id.* [Guardianship and Conservatorship §§ 5-311(d), -410(c)].

236. *Id.* [Public Guardian § 2(a)].

237. *Id.* [Public Guardian § 4].

238. *Special Comm. on Aging, supra* note 197, at 93.

legislation makes no provision for prior nomination of the public conservator by the person, nor does it indicate whether the court may make the appointment on its own initiative in a proceeding brought by another party

Substitute Payees

Several government agencies are authorized by law to appoint substitute payees for recipients of funds dispersed by those agencies.²³⁹ The general practice is that once the agency learns of the beneficiary's suspected incompetence,²⁴⁰ payments are suspended until a determination of the competency issue is made by an agency official or board.²⁴¹ If the beneficiary is found to be incompetent,²⁴² the agency tries to select as substitute payee a person who is genuinely concerned for the well-being of the beneficiary and willing to serve, make accountings, and inform the agency of other significant events in the life of the beneficiary.²⁴³ Such person need not be a relative of the incompetent.

239. 42 U.S.C. § 405(j) (1970) (Social Security Administration); 38 U.S.C. § 3202-03 (1970) (Veterans Administration); 37 U.S.C. § 601-04 (1970) (Department of Defense); 45 U.S.C. § 228s (1970) (Railroad Retirement Board); 5 U.S.C. § 8345(e) (1970) (Civil Service). For a general discussion of the policies of these agencies, see PRESIDENT'S COUNCIL ON AGING, *FEDERAL PAYMENTS TO OLDER PERSONS IN NEED OF PROTECTION* (1965) [hereinafter cited as *PRESIDENT'S COUNCIL ON AGING*]. For an example of state legislation in this area, see ILL. ANN. STAT. ch. 23, § 3-5a (Smith-Hurd 1968).

240. The need for appointment of the substitute payee may come to the agency's attention through the hospitalization of the beneficiary, information provided by a friend or relative, or, in the case of a veteran, the filing of a claim for disability benefits. Most of the agencies do not feel obliged to take the initiative in questioning the competence of a beneficiary. This policy has come under fire for its lack of aggressiveness, particularly in the light of the success the Veterans Administration has had in early identification of such persons. PRESIDENT'S COUNCIL ON AGING, *supra* note 239, at 8-9, 18, 54; ALLEN, *supra* note 182, at 116-17, 132. It is estimated that 80,000 persons are in need of representative payment but do not have it. PRESIDENT'S COUNCIL ON AGING, *supra* note 239, at 54.

241. PRESIDENT'S COUNCIL ON AGING, *supra* note 239, at 9. The Social Security Administration, in a recent change of policy, now requires payments to continue until a determination is made. 20 C.F.R. § 404.1601 (1970).

242. Various tests of capacity are used by these agencies. The Social Security Administration asks whether "the interest of the beneficiary .. would be served .. regardless of legal competency or incompetency." 20 C.F.R. § 404.1601 (1971). The Veterans Administration defines an incompetent as "one who because of injury or disease lacks the mental capacity to contract or to manage his own affairs." 38 C.F.R. § 3.353(a) (1971). The Railroad Retirement Board considers an individual incompetent "if his condition is such that he is unable to handle his affairs." 20 C.F.R. § 266.5(a) (1971).

243. *President's Council on Aging*, *supra* note 239, at 55-56. The Veterans Administra-

Supervision and review of the substitute payee's use of the funds differs widely.²⁴⁴ The periodic accounting required is not governed by the same standards of accountability applied to court-appointed guardians, and problems arise involving over-conservation of the funds despite the beneficiary's unmet needs.²⁴⁵

Power of Attorney

Another legal device for assisting the elderly is the extended or durable power of attorney. The type proposed in the Uniform Probate Code is a model of simplicity.²⁴⁶ The power can be created by the disability of the principal, or if previously undertaken, it continues in spite of the principal's disability. The Model Special Power of Attorney for Small Property Interests Act prepared by the Uniform Law Commissioners²⁴⁷ differs from the UPC in that it requires approval of the power of attorney by a judge of a court of record²⁴⁸ and proposes standards of liability for the attorney in fact.²⁴⁹ The attorney is required to account only as specified in the power, as directed by the judge of the approving court, or upon termination of his power or authority, since more frequent accounting was thought only to add unnecessary expense.²⁵⁰

Uniform Probate Code

Article V of the Uniform Probate Code contains the most sweeping reforms of guardianship yet proposed. The basic scheme of the UPC separates rules for the protection of the person from those for the

tion prefers a hospital payee where the veteran is hospitalized, but there is no conflict of interest here since veterans in VA hospitals receive free hospitalization. The Social Security Administration believes it has broad authority to bypass the legal guardian and to appoint a different substitute payee, but the legal basis for this opinion is questionable. In practice, the agency favors guardians, spouses, and relatives over institutional fiduciaries. ALLEN, *supra* note 182, at 121-22, 135.

244. ALLEN, *supra* note 182, at 124, 138.

245. *Id.* at 123, 128; *President's Council on Aging*, *supra* note 239, at 57. The Veterans Administration was empowered to inform the court whenever the administrator believed that a guardian was not properly executing his trust. 38 U.S.C. § 3202(b) (1969). For a criticism of this practice, see Fratcher, *Powers and Duties of Guardians of Property*, 45 IOWA L. REV. 264, 330 (1960).

246. UPC § 5-501.

247. HANDBOOK, *supra* note 186, at 157 (Model Special Power of Attorney for Small Property Interests Act).

248. *Id.* § 1(a).

249. *Id.* § 7.

250. *Id.* § 9.

protection of his property, and calls the appointees "guardians" and "conservators," respectively. The guardian, as part of his general custody of the disabled person, has the power to establish the ward's place of abode, either within or without the state,²⁵¹ the power to give consent for the ward's medical or other professional care, counsel, treatment, or service,²⁵² and the power to receive funds for the support and care of the ward.²⁵³ The guardian also has the duty to provide for the care, comfort, and maintenance of the ward, to take reasonable care of the ward's personal effects,²⁵⁴ and to report the condition of the ward.²⁵⁵ He is entitled to reasonable sums for his services and for room and board furnished the ward, subject to the approval of the court or the conservator.²⁵⁶

The conservator's concern, on the other hand, is exclusively property management. The court confers on him the broad powers of a trustee²⁵⁷ and requires that he adhere to the same standard of prudence and care "that would be observed by a prudent man dealing with the property of another,"²⁵⁸ which is a standard considerably higher than is now imposed on conservators by the laws of most jurisdictions.²⁵⁹

Another innovative feature of the Uniform Probate Code is the alternatives it provides to full conservatorship. The court, which is given all the powers the individual would have if he were of full capacity,²⁶⁰ may, in its own discretion, give only certain of these powers to the conservator.²⁶¹ The court may also authorize a single transaction "necessary or desirable to achieve any security, service, or care

251. UPC § 5-312(a)(1).

252. UPC § 5-312(a)(3).

253. UPC § 5-312(e)(4)(ii).

254. UPC § 5-312(a)(2).

255. UPC § 5-312(a)(5).

256. UPC §§ 5-312(a)(4)(ii), (b). The *Handbook* recommends that a provision be included explicitly denying to the guardian the power to commit the ward to a mental institution without the involuntary commitment proceeding prescribed by law. *HANDBOOK*, *supra* note 186 [Guardianship and Conservatorship § 5-312(a)(1)].

257. UPC § 5-420.

258. UPC § 7-302.

259. ABA Comm. on Problems Relating to Persons under Disability, *supra* note 213, at 513 n.32. Twenty-six jurisdictions had established the office of conservator as of January 1, 1970, although in some of these states the conservator is also the guardian of the person. McKinney, *Session Law News of New York*, A-52 n.1 (March 10, 1971); Alexander, *supra* note 175, at 139.

260. UPC § 5-408.

261. UPC § 5-426.

arrangement meeting the foreseeable needs of the protected person.”²⁶² Such protective arrangements might include a real property transaction, purchase of a single premium annuity, or entry into a contract for life care. This single transaction procedure is intended to avoid the problem present law often creates in requiring a guardianship simply to make possible a valid transfer of land or securities.²⁶³

Recommendations

In addition to the proposals already made for reforming the criteria and procedure used in guardianship proceedings,²⁶⁴ revisions in all aspects of protective services are also needed.

1. Guardianship of the person and the estate should be separated. The statutory powers and duties of each office, particularly of the former, as well as their inter-relationship, should be specified.

2. Limited guardianship of the estate should be permitted. Statutes should authorize the appointment of guardians of the estate to perform certain tasks or categories of tasks for the ward according to his needs as determined by the court with the assistance, where possible, of the ward.

3. One or more low cost systems of guardianship should be established for persons of limited means. The public guardianship is the most promising possibility.²⁶⁵ It should be available to persons whose income and assets fall below a certain dollar level, but this level should be substantially higher than the poverty level used for eligibility for public assistance programs. A provision for reimbursement of the public guardian from the remaining estate after the death of the ward would assure that the ward's assets would be used for his benefit during his lifetime.

The substitute payee system should be continued because of its low cost,²⁶⁶ but with some reform in its procedures. Benefits should not be suspended while the competency issue is pending,²⁶⁷ and representation

262. UPC § 5-409(a).

263. UPC § 5-409 (Commissioners' Comment).

264. See text accompanying notes 209-218 *supra*.

265. The cost of conservatorship proceedings will generally not be reduced by the Uniform Probate Code. ABA Comm. on Problems Relating to Persons under Disability, *supra* note 213, at 513.

266. ALLEN, *supra* note 182, at 128. See also Arnold, *Preparing for a New Kind of Ramy Day: Planning for Aging*, 42 N.Y. St. B.J. 603, 607 (1970).

267. Suspension of such benefits, which are statutory entitlements, without a hearing

of the beneficiary by counsel should be made mandatory. Even with such reforms the system is of limited usefulness because it can deal only with benefit funds and not with other assets of the beneficiary.²⁶⁸ The system should therefore be integrated into other comparable state or court-approved guardianship arrangements, especially where the state has a public guardian.

4. One method of eliminating a conflict of interests between guardian and ward is to identify by statute the legitimate interests of others in the person's property and permit a direct action by the party in interest against the estate, thereby eliminating him from consideration for appointment as guardian.²⁶⁹ This approach has merit where the interest is clearly identifiable, as, for example, the costs of care at a mental hospital. But other interests, such as those of a potential heir, are less tangible and subject to modification until the ward's death, and therefore not readily the subject of direct action before his death.

Another way of minimizing conflict is to eliminate the preference of the law for near relatives as guardians by the alternative method of obtaining professional managers where available.²⁷⁰ Relatives still wishing to serve as guardians might be required to renounce a future interest in the ward's estate. While this proposal may be of value for large estates which can afford the costs of professional management, it provides little help for the ward of limited means whose care rests, for better or worse, in the hands of those closest to him. Only where a public guardianship is available would the proposal have widespread practicality. The requirement that a willing relative renounce his interest in the estate appears unduly harsh and might be better left to the discretion of the court.

To permit the ward to select his guardian in advance of incapacity would go a long way toward softening a conflict of interests.²⁷¹ At least whatever conflict is present would be of the ward's own choosing.

5. The decisions to appoint a guardian and delegate certain powers to him should continue to be made by the court which ordinarily deals with guardianship. There seems to be little advantage in estab-

is hard to justify on due process grounds in the light of *Goldberg v. Kelly*, 397 U.S. 254 (1970), at least where the beneficiary needs the payments for the necessities of life.

268. LYNES, *supra* note 170, at 43.

269. Alexander, *supra* note 175, at 167-68.

270. *Id.*

271. See HANDBOOK, *supra* note 186 [Guardianship and Conservatorship §§ 5-311(a)(1), (2)].

lishing a separate agency for these particular purposes. It should be noted, however, that this is a separate question from that of establishing a social agency to provide a wide range of social services to elderly persons.

Protective Services in a Social Work Context

A system of protective services for the aged broader in scope than the legal procedures described above has been developed over the past decade by social workers. These services include "financial assistance, medical evaluation, psychiatric consultation, legal consultation, fiduciary and guardianship service, home aide and other home help services, nursing consultation and evaluation, and placement in a protective setting."²⁷² Such a system of services has three functions: the preventive, the supportive, and the surrogate.²⁷³ The last, the heart of these services, involves the ability to act on behalf of the older person, with or without his consent, and therefore includes legal authority or the potential for such authorization.²⁷⁴

The social agency is the key element in these protective services, since it provides the casework, continuity, and financial resources needed for such an undertaking.²⁷⁵ Two professional problems, one organizational and the other ethical, still trouble these agencies with regard to such services. At the organizational level debate continues about the merits of establishing protective services for the aged within an existing social agency or of handling them through a new, specialized, independent agency. The former approach allows the protective services program to capitalize on the agency's lines of communication with other community resources, but the agency will necessarily be required to adapt its policies and regulations to the new program and the agency's reputation, for better or worse, will affect the program.²⁷⁶

272. BLENKNER, *supra* note 169, at 16. See also AMERICAN PUBLIC WELFARE ASSOCIATION, THE GUIDE FOR IN-SERVICE TRAINING FOR DEVELOPING SERVICES FOR OLDER PERSONS 27-29 (1970); J. BURR, PROTECTIVE SERVICES FOR OLDER PERSONS (1964); NATIONAL CONFERENCE OF LAWYERS AND SOCIAL WORKERS, ADULT PROTECTIVE SERVICES: RESPONSIBILITIES AND RECIPROCAL RELATIONSHIPS OF THE LAWYER AND SOCIAL WORKER (1967); Cumming, *Growing Problems in Protective Services for the Aged*, 21 GERIATRICS 163 (1966).

273. HALL, *supra* note 204, at 5.

274. Note 173 *supra*. See also Bennett, *Protective Services for the Aged*, 39 Soc. SCI. REV. 283 (1965); Ross, *Protective Services for the Aged*, 8 GERONTOLOGIST 50 (Part II 1968).

275. HALL, *supra* note 204, at 6-7. See also NATIONAL COUNCIL ON AGING, *supra* note 172, at 198-99.

276. LYNES, *supra* note 170, at 40-41.

Formation of a new agency would probably permit the new policies and structure needed for protective services to develop more quickly, but the level of efficiency and service might be lower during the early stages of the program. It has also been suggested that such an agency be set up within the local department of public welfare or in a community mental health center and that it be given quasi-judicial powers to appoint, supervise, and terminate fiduciaryships for those it serves.²⁷⁷

The ethical problem confronting the social agency is similar to the one courts face: when should the agency remove from the client his basic right of self-determination?²⁷⁸ Does the elderly person have the right to be left exploited or neglected, to starve himself to death, or to die prematurely of an acute illness if he chooses?²⁷⁹ Does the fact that the caseworker, neighbors, relatives, or community agencies find the person's way of living intolerable or unbearably risky mean that the aged person must change his lifestyle? Whose needs are really served by legal intervention?²⁸⁰

To date, five experimental protective services projects have been attempted. One of these was administered by the Benjamin Ross Institute of Cleveland, Ohio.²⁸¹ The project accepted 164 elderly persons, referred to it by various social agencies, who fitted within the definition of one requiring protective services. All of the participants were interviewed four times during one year, but the 76 persons in the demonstration service group were provided with a full range of protective services as described above,²⁸² while the other 88 in the control group were given standard service by the referring agency. Among the criteria established in advance for evaluating the success of the project was one which required two events to occur in combination: "a) more of the service participants than controls had to survive and b) among the survivors, the service participants had to be more contented."²⁸³

The results indicated that the project service was not effective in

277. H. WEIHOFEN, *LEGAL SERVICES AND COMMUNITY MENTAL HEALTH CENTERS* 43 (1969). See also TURNER, *The Public Agency as the Social Guardian of Aged Persons*, in 1964 PROCEEDINGS, PENNSYLVANIA CONFERENCE ON PROTECTIVE SERVICES FOR OLDER PEOPLE 24 (1964).

278. LYNES, *supra* note 170, at 19.

279. HALL, *supra* note 204, at 32.

280. E. WASSER, *Casework as the Core of Protective Services* 226 (paper presented at a workshop on Protective Services for Older Adults, Portland, Oregon, Nov. 1967).

281. BLENKNER, *supra* note 169.

282. See text accompanying notes 251-59 *supra*.

283. BLENKNER, *supra* note 169, at 72.

preventing death or in slowing down deterioration in physical functioning,²⁸⁴ the two major reasons frequently given for intervening in a protective case. The service participant, in fact, showed a less favorable survival rate than the control group.²⁸⁵ Apparently the cause of the higher mortality rate in the service group was the tendency to institutionalize this group that developed as a result of the caseworkers' greater concern for the welfare of the participants.²⁸⁶ Institutionalization shortened the lives of the persons committed. It was noted, however, that contentment in that segment of the group which was not institutionalized proved higher than for the control group. Thus, it appears that a protective service program might be successful if it can resist the temptation toward commitment of the participants.

The evaluation of the other four demonstration projects also provided some interesting conclusions.²⁸⁷ The researchers found that clients who might otherwise continue to exert at least some self-determination were frequently robbed of that right by overuse of conservatorships and guardianships. They also noted that the agency tended to view the client's problems as irreversible and therefore always needing these services. The studies suggested that the clients should be assisted with the goal of helping themselves reach a point where they would no longer need to be clients.²⁸⁸ Another note of caution in the use of legal intervention by the social agency lies in the proposal that more research is needed in seeking out, reconnecting to society, and identifying the needs of the isolated elderly through long-term follow-up home visits before full protective service programs are started.²⁸⁹

A more optimistic note is struck by the Group for the Advancement of Psychiatry, which considers the pilot programs to have been "most successful."²⁹⁰ The group proposes federal funding of a Protective Service Corps of trained para-professional workers to service the elderly regardless of income, organized in outreach units with legal, medical, and psychiatric consultants attached to them. In a similar vein,

284. *Id.* at 73.

285. *Id.* at 69.

286. M. Blenkner, Service and Survival 11 (paper presented at Eighth International Congress of Gerontology, Washington, D. C., Aug. 26, 1969) (revised Sept. 12, 1969).

287. LYNES, *supra* note 170, at 20.

288. *Id.* at 21.

289. R. Bennett, Discussion of G. Mathiasen's paper on Protective Services for the Aged (presented at N.Y. State Welfare Association meeting, Syracuse, N. Y., Nov. 20, 1969).

290. GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, REPORT No. 79, *supra* note 117, at 673-74.

the Special Assistant to the President for Aging envisions a protective services unit of skilled professionals, including, where possible, a physician, a psychiatrist, and a lawyer, who would conduct diagnostic and evaluative review of the client's situation, make referrals for service to other agencies, initiate actions for appointment of guardians, and maintain follow-up review of its clients.²⁹¹ He also proposes that retired persons be trained to serve as paraprofessional conservators.

It seems clear that the goals of helping the elderly avoid commitment to a mental hospital or maintain independent living arrangements will not be achieved merely by revising the law of civil commitment and guardianship or supplying new types of decision-making procedures for the elderly. A variety of supportive services, institutional and non-institutional, which can be described only in general terms here, must accompany the legal reform.

At the present time institutional arrangements for long-term care of the elderly are limited in function, capacity, and availability. Homes for the aged, for example, typically care only for those who present no special medical or psychiatric difficulties and can afford their fees. Medicare provisions for extended care facilities and Medicaid support for nursing homes were not intended to deal with the problem of long-term care.²⁹² A coordinated program of additional beds and expanded and strengthened medical, psychiatric, and social services in nursing homes and health-related facilities is needed.

For those aged who are not institutionalized, a limited program of social services is presently available. Title III of the Older Americans Act authorizes a number of such services, including telephone reassurance calls, friendly visitation services, homemaker or home maintenance service, and meals services.²⁹³ The delivery of these services to the elderly, however, still leaves large gaps because of the lack of systematic planning and correlation between the public and private sectors.²⁹⁴ There is also a critical shortage of trained personnel, including social service workers, homemakers, home health aides, and counselors. Federal funding for these programs is precarious, and if it were withdrawn, many states would terminate them.

291. LYNES, *supra* note 170, at 12.

292. SPECIAL COMM. ON AGING OF THE UNITED STATES SENATE, DEVELOPMENTS IN AGING 1970, S. REP. NO. 92-46, 92d Cong., 1st Sess. 42 (1971) [hereinafter cited as DEVELOPMENTS IN AGING 1970].

293. 42 U.S.C. §§ 3021-25 (1970).

294. DEVELOPMENTS IN AGING 1970, *supra* note 292, at 125-26.

The possible range of ancillary services in the community is well described in the *Report of Task Force to Plan Alternatives to State Hospital Admissions of Aging* of New York City²⁹⁵ The document calls for:

1. A program of preventive and maintenance health services, including annual medical-social-psychiatric evaluations of elderly persons, and neighborhood-based medical care centers geared to the needs of the geriatric patient.

2. Services in the home setting, including increased housekeeping, homemaker-home health aide, friendly visitor, and communications services, as well as the establishment of reaching-out programs to find and service the aged who are homebound or living in hotels or specific geographic areas where there are known large concentrations of older people.

3. Supportive community services, including day and night care centers in hospitals or homes for the aging, counselling and referral services established as part of recreational agencies, ambulatory care centers, and public housing, and escort and transportation services to bring patients to the medical care center, where necessary

4. Additional low-income housing for the elderly²⁹⁶

One may hope that the White House Conference on Aging has provided the impetus needed to design a sound and coordinated approach for the organization and delivery of these services for the aged, and to muster the political support necessary to establish and pay for this program.²⁹⁷ The legal reforms suggested in this article, however, are valuable in themselves and can be implemented on their own merits.

CONCLUSION

The policies underlying the above analysis are simply stated: that the aged person should continue to enjoy the greatest amount of freedom consistent with his physical and mental abilities, that the legal system should permit him to be deprived of his independence only to the extent necessary to prevent a substantial danger of serious harm to himself or others, and that government should provide care, treatment, and

295. NEW YORK CITY OFFICE FOR THE AGING & CITIZENS' COMMITTEE FOR THE AGING, *REPORT OF TASK FORCE TO PLAN ALTERNATIVES TO STATE HOSPITAL ADMISSIONS OF AGING* (1971).

296. *Id.* at 9-16.

297. *DEVELOPMENTS IN AGING* 1970, *supra* note 292, at 88.

supportive services designed to prolong or restore functional independence.

The deeper philosophical problem presented by the emergence of a large elderly population has yet to be faced by modern society. The number of aged persons will certainly rise, but it is not at all certain that the value a youth-oriented culture places on its elderly citizens will similarly appreciate. The aged no longer have strong ties to the nuclear family. They no longer produce in a society that prizes and rewards productivity. Their role is vague and superfluous. These low-value factors make it easy to relegate the interests of the elderly to the bottom of society's list of priorities, to bury them in institutions, or to hand them over to managers. Whatever skepticism one may have about the willingness of society to change its values concerning the elderly, the law should at least allow society to make an honest choice in its care for the aged by eliminating the oppression latent in many of the present systems of commitment and guardianship.