Protecting the Elderly: The New Paternalism

By John J. Regan*

A new public policy supporting and promoting government intervention in the lives of the elderly has gathered momentum over the past decade. These services, often known as "Adult Protective Services," were developed in response to several trends in the living patterns of older people. First, because the elderly make up an increasingly larger percentage of the population, social programs designed to benefit them have attracted increasing attention from legislators and social planners. While the number of persons sixty-five and over is growing, the number of persons living to age seventy-five and beyond is increasing dramatically. This group, the oldest of the old, often has one or more health, social, economic, or environmental problems that may require supportive services. Moreover, the presence of a family to care for an elder living at home is proving to be no guarantee that the aged person will receive attentive care. The phenomenon of "elder abuse" has joined child abuse and the battered spouse as an example of the disintegrating family in modern society.

The recent trend towards "deinstitutionalization" of mental health care has provided another source of elderly candidates for these social programs. Many states, motivated by changes in phi-


1. At the beginning of 1980, 11.2% of the population—about 25,000,000 persons—was age 65 or older. Between 1970 and 1979, the number of persons age 65 or older increased 23.5%, while those under 65 rose by only 6.3%. Senate Special Comm. on Aging, Developments in Aging, 1979 (pt. I), S. Rep. No. 613, 96th Cong., 2d Sess. xv-xvi (1980).

2. R. Butler & M. Lewis, Aging and Mental Health 5 (1977); Fed. Council on Aging, Public Policy and the Frail Elderly 16 (1978). In 1975, 38% of the elderly population was age 75 or older. The group of persons who were age 85 or older constituted 8% of the elderly population. Id.

3. See generally Elder Abuse, Joint Hearing before the Senate Special Comm. on Aging and the House Select Comm. on Aging, 96th Cong., 2d Sess. (1980).
losophy of treatment and by fiscal problems, have discharged large numbers of elderly mental patients from state mental hospitals into nursing homes or into the community. At the same time, admissions of similar persons to these hospitals have been severely curtailed. A parallel need for community-based support services for the developmentally disabled has also emerged.

These elderly persons usually desire to live in the community, not in a nursing home or mental hospital, but cannot cope with the demands of day-to-day life because of physical incapacity or mental disability. Abuse or exploitation by others or self-neglect are the frequent result of such frailties, leading in turn to more extensive disability, admission to a nursing home or hospital, or even premature death. Lack of adequate community support for such persons when their frailties first develop inevitably leads to higher human, economic, and social costs.

In response to these problems, many states have recently enacted Adult Protective Services legislation, a phrase borrowed from the child protection area. These laws have created a coordinated system of social and health services, which include visiting nurses, homemakers, repair persons, visitors, and home-delivered meals. These services are coordinated by a caseworker who, after assessing each client’s needs, is responsible for arranging for the delivery of appropriate services through other agencies. Federal funding for such programs is available through Subchapter XX of the Social Security Act and Subchapter III of the Older Americans Act.


9. 42 U.S.C. §§ 1397-1397f (1976 & Supp. III 1979). One of the purposes of this section of the Social Security Act is to furnish services for “preventing or remedying neglect, abuse,
Protective services programs are rarely limited to clients who voluntarily accept their services. The legislative scheme often provides for the use of guardianship or conservatorship by the protective services agency to ensure that the client accepts the assistance that the caseworker believes is necessary. Some states also have created special court procedures to secure court orders for protective services, for placing the client in an institution, for emergency orders when there is imminent danger to the client's health or safety, or for orders authorizing entry into an uncooperative client's home. Moreover, some states have authorized state agencies to serve as "public guardians." These public guardians are appointed by the courts to provide guardianship services to persons for whom no private guardian can be found.

This Article examines the effect on the elderly of increasing Adult Protective Services legislation. The Article first summarizes the traditional methods of legal intervention in the lives of the elderly—civil commitment and guardianship. Because of the inadequacies of these methods, the due process model of intervention evolved, forming the theoretical basis underlying many of the current Adult Protective Services programs. Next, the Article analyzes the legislation enacted in eleven states, revealing serious procedural shortcomings, vague and inappropriate standards for identifying who shall receive protective services, and little accountability on the part of the public agencies that administer the services. Despite these problems, the Article concludes that reforming existing statutes by circumscribing the use of involuntary intervention is a more desirable alternative than following the abolitionist command to eliminate adult protective services.

Traditional Commitment and Guardianship Procedures

Adult protective services programs are circumscribed by the legal authority of an intervenor to impose a decision on an unwilling individual. The Anglo-American legal system traditionally has authorized such intervention through either civil commitment or guardianship proceedings. Grounded in the state's police power, civil commitment proceedings affect persons adjudged to be dan-

or exploitation of children and adults unable to protect their own interests." Id. § 1397.
10. Id. §§ 3021-3030.
gerous to others or to themselves as a result of mental illness. These individuals are sent, either by the signed order of two or three physicians or by court order, to a state mental hospital for care and treatment.11 The guardianship procedure, resting on the state’s parens patriae power, enables a court to appoint a surrogate decisionmaker for persons found to be incompetent.12 The guardian is authorized to manage the ward’s person and property; the extent of the management depends on the court’s finding on the extent of the ward’s need for help. By extension of the parens patriae power, some states have authorized the commitment of mentally ill persons who are in need of care and treatment but who do not pose any danger to anyone.13 By the end of the 1960’s, both types of statutes generally contained standards and procedures developed a half century earlier, although a few states had already begun comprehensive revisions of their civil commitment laws.14

The major inadequacies of the traditional guardianship statutes took various forms.15 The standards for determining incompetency were vague and phrased in inappropriate terms. Often the court procedures failed to provide for adequate notice to the proposed ward, the presence of the person at the hearing, adequate representation by counsel, or trial by jury.16 A guardian with an identifiable conflict of interest frequently was given control over the ward by a judge who did little more than concur in the conclusory testimony of the petitioner’s expert psychiatric witness that the person was incompetent.17 Complete power over the ward’s estate and person was transferred to the guardian, regard-

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12. AMERICAN BAR FOUNDATION, supra note 11, at 260.


less of the ward's ability to handle some of these decisions independently. In many cases, the costs of the guardianship over several years completely depleted the assets of smaller estates.  

Furthermore, legal authority for dealing with elderly persons in crisis situations often was uncertain. State mental health laws typically permit emergency civil commitment to a mental health facility on the certificate of two physicians. This procedure is not applicable to medical emergencies; however, if a person is unconscious and in need of medical treatment, physicians may provide care on a common law theory of implied consent—a presumption that the ordinary person wants the medical care necessary to avoid death or to treat serious injury or disease. Neither of these legal mechanisms is appropriate for cases of older persons who, as a result of deteriorating mental faculties and physical health, seriously neglect themselves or suffer abuse or exploitation by others.

The Development of the Due Process Model

As awareness of the needs of the elderly developed during the early 1970's and the first adult services programs appeared, proposals to reform the anachronistic legal procedures for civil commitment and guardianship to conform to the requirements of due process were suggested. It was proposed that the guardianship proceeding be made adversarial and include requirements for adequate notice, opportunity for presence at the hearing, a high standard of evidentiary proof, and the right to counsel—whether private or appointed. The use of professional screening teams to assist the court in assessing the needs of the client was proposed.

23. Regan & Springer, supra note 8, at 48-50; Chambers, Alternatives to Civil Com-
and it was recommended that the standards for determining
whether a guardian was needed emphasize functional disabilities
rather than mental disorder. 24

Following the principle of the least restrictive alternative, the
due process model suggests that guardians be given only the lim-
ited powers necessary to provide for the client's demonstrated
needs. 25 It was advocated that the client's preferences in selecting
a guardian should receive high priority, 26 and if no relative or
friend were available and willing to serve, private social agencies
and even public agencies could be appointed as guardians subject
to special controls. 27 Proposals to ensure greater accountability
of the guardian stressed requirements to submit regular reports to
the court and to demonstrate periodically the continued need for
the guardianship. 28 Special emergency intervention proceedings
were proposed to fill the gaps in the current law. 29

Against this background of "due process" reform proposals,
the states began to enact protective services legislation. Since 1973,
eleven state legislatures have established new procedures for invol-
untary intervention in the specific context of an adult protective
services program. 30 In addition, many other states have authorized
their social services agencies to provide protective services, but
have made no special provisions for involuntary intervention and
thus rely on existing guardianship law to supply the needed
authority. 31

mitment of the Mentally Ill: Practical Guides and Constitutional Imperatives, 70 Mich.
25. See Regan & Springer, supra note 8, at 40; Horstman, supra note 15, at 287.
26. See Proposed Guardianship and Conservatorship Statute § 5-311, reprinted in
Legal Research and Services for the Elderly, A Handbook of Model State Statutes
130 (1971).
27. See Regan & Springer, supra note 8, at 41.
28. Id. at 50.
29. Id. at 42.
State Protective Services Legislation

The dominant statutory theme in the majority of the eleven states that have enacted special intervention legislation is to create special court proceedings for authorizing involuntary intervention, instead of using regular guardianship proceedings to achieve the same goal. The new proceeding may lead to an order for protective services, for protective placement, or for emergency services, all of which are to be implemented by a public social services agency.

The trend towards special proceedings that bypass guardianship poses a serious threat to the personal and property rights of the clients who are the subjects of these proceedings. First, the new proceedings frequently fail to incorporate adequate procedural protection for the client. Second, the standards by which the courts determine whether the client needs involuntary assistance often are vague and inappropriate. Finally, once an order is granted, the powers and duties of the public agency are poorly defined.

Protective Services Proceedings

**General Procedures**

Most of the eleven states that have established special proceedings for the issuance of protective services orders make little or no reference to procedures designed to protect the client. Typically, no mention is made of requirements for notice to the client of the filing of the petition, the client's presence at the hearing, the person's right to counsel, or an evidentiary standard of proof. In such circumstances, there is great danger that the hearing may become a public agency's ex parte presentation of testimony to a sympathetic court that will routinely issue protective services orders exactly as requested by the agency.

In some states, limited, although not entirely adequate, protection is afforded the elderly client in the special proceedings. For example, notice requirements varying from "some notice" to five or

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ten days notice are imposed; no state, however, addresses the problem of the confused client who may not appreciate the terms or importance of the legal document conveying such notice. These same states also provide for the client to be present at the hearing. Only one state, however, discourages an inference of waiver of this right from a client's nonappearance by requiring a physician to certify in writing that the client is unable to attend the hearing. Similarly, while North Carolina and Utah mandate a showing of incompetency by clear and convincing evidence, the other states' failure to prescribe any evidentiary standards increases the risk that many courts will apply an overly flexible measure in determining the need for protective services. The only major safeguard for the client in this group of states is the requirement that counsel be appointed for indigents. In Tennessee, this right is extended to any person incapable of waiving counsel. Even under Tennessee's broad standard for the right to counsel, however, the legislature's failure to define the duties of counsel in this proceeding may lead many attorneys to function as guardians ad litem, doing what they believe is in the best interest of the client, rather than contesting the petition as an adversary.

Few limits are imposed on the agencies that provide services after a court order is obtained. Protective services are so broadly defined in many statutes that they may encompass virtually any kind of social or health service, including property management and medical care. If, therefore, the court does not limit the services, the agency is virtually free to do as it wishes with the client. Moreover, the statutes do not impose on the public agency an explicit fiduciary obligation similar to that ordinarily stipulated for a guardian or conservator. The agency is not held by statute to act in

38. See, e.g., Ala. Code § 38-9-2(9) (Supp. 1980) (“[t]hose services whose objective is to protect an incapacitated person from himself and from others”); N.C. Gen. Stat. § 108-104(a) (1978) (“services provided by the State or other government or private organization or individuals are necessary to protect the disabled adult from abuse, neglect, or exploitation”); such services “shall consist of evaluation of the need for service and mobilization of essential services on behalf of the disabled adult”); Tenn. Code Ann. § 14-25-102(9) (Supp. 1980) (“services aimed at preventing andremedying abuse, neglect, and exploitation”).
the best interests of the client or to determine how the client could act if competent. Rather, the agency's only duty appears to be to provide the services authorized in the court order, more or less in an "arm's length" relationship with the client.

The agency's relationship with the client also is strictly impersonal. The statutes typically permit the court authorization to be directed to the "department" or the "director" to provide services. There is no requirement that specific individuals within an agency develop a personal relationship with the client, and nothing to prevent the client from being shifted from one caseworker to another at the whim of the agency. The highly personal and individualized nature of the decisions required for protective services clients, however, demands something closer to the one-to-one relationship characteristic of a regular guardianship.

An agency's power to change the residence of the client, and therefore to institutionalize the person, causes special concern. A protective services order can result in the transfer of the person to a hospital, a nursing home, a boarding home, or even to a mental hospital. The classic Blenkner study indicated that institutionalization was often the remedy chosen by the protective agency; those institutionalized, however, suffered a higher frequency of deaths than did a similar group of protected persons who remained in their communities. The principle of the "least restrictive alternative" thus suggests that institutionalization should be used only as a last resort.

Despite the potentially serious, adverse consequences of institutionalization, the problem is not addressed in many of the statutory schemes. The Oklahoma statute is alone in expressing a preference for leaving clients in their present living accommodations.

41. Id. at 132, 142-45.
43. "Whenever it is consistent with the welfare and safety of the elderly person, the court shall authorize that involuntary protective services be administered to the elderly person in his or her present living accommodations." Okla. Stat. Ann. tit. 43A, § 807(b) (West 1979).
Four of the remaining states having protective services legislation make statutory reference to placement in institutions, with three of these four requiring special court findings to justify a transfer of residence. In Wisconsin, however, the heavy statutory emphasis on placement rather than delivery of services suggests that the entire protective services system is, in reality, a protective placement system. One study found that, in 1978, Wisconsin recorded a total of 1,050 protective placement petitions, compared with only 61 protective services petitions in North Carolina, whose population exceeds that of Wisconsin by 850,000. The same study noted also that known instances of judicially ordered services, as distinct from placement, were rare in Wisconsin.

Once an order for protective services is issued, the court retains no further responsibility towards the client, although the order generally is of indefinite duration. The agency need not file periodic reports about the client’s status or condition, nor is it required to seek renewal of the order. The client thus can become the agency’s ward for as long as the agency cares to stay involved, which often will be as long as program funds continue.

Emergency Intervention

Protective services or protective placement orders generally are directed towards clients who are judged to need substantial assistance in performing the tasks of daily living, but are not in danger of immediate injury or death. To meet the urgent needs of those individuals who appear to be in danger of immediate injury or death, eight of the eleven states that have enacted protective services legislation separate from traditional civil commitment and guardianship proceedings have established special court proceedings for emergency intervention. There is wide variation, how-

47. Id.
ever, in the weight given to the protection of the client’s rights in these hearings. Alabama\(^4\) and South Carolina\(^5\) authorize the courts to issue *ex parte* protective orders without requiring a subsequent adversary hearing. Connecticut similarly allows *ex parte* appointment of a temporary conservator, but limits the term of service to thirty days.\(^6\)

Depriving clients of their physical liberty, their right to make personal care decisions, and their right to control their property for extended periods without an adversary hearing may violate the due process clause of the fourteenth amendment. In *Morrissey v. Brewer*,\(^7\) the United States Supreme Court held that the loss of liberty entailed in parole revocation is a serious deprivation requiring that the parolee be accorded notice and a hearing.\(^8\) In *North Georgia Finishing, Inc. v. Di-Chem, Inc.*,\(^9\) the Court held that impounding a bank account without notice or opportunity for an early hearing violates the fourteenth amendment.\(^10\) These decisions indicate that any substantial deprivation of liberty or property must be preceded by notice and a hearing if due process is to be satisfied.

Five states with emergency protective services legislation require some form of notice or hearing; however, the flexibility of the statutory requirements for these safeguard procedures may render them vulnerable to due process attacks as well. Florida\(^11\) and Tennessee\(^12\) require a hearing, although only after an *ex parte* order has been issued. Maryland,\(^13\) North Carolina,\(^14\) and Oklahoma\(^15\) provide even greater protection by requiring an expedited adversarial hearing on notice before an emergency order can be issued. In cases in which the delay caused by the minimal notice demanded for these hearings would seriously endanger the client,
however, North Carolina permits waiver of notice, and Maryland allows a police officer to transport a person immediately to a health care facility for emergency medical care, although it requires a petition for a court hearing to be filed within twenty-four hours.

The Standards for Intervention

In addition to creating new court proceedings to authorize intervention, the states in question have also established standards for identifying candidates for protective services or protective placement. First, certain behavioral disabilities are described,

63. The following considerations are exemplary of the special criteria for identifying candidates for protective services or for protective placement: behavior indicating mental incapacity to provide adequate self-care because of physical or mental impairment which has resulted in an inability to protect against abuse, neglect, or exploitation by others, and absence of a "guardian or relative or other appropriate person able, willing and available to assume the kind and degree of protection and supervision required under the circumstances," Ala. Code § 38-9-2(1) (Supp. 1980); inability "to perform or obtain services which are necessary to maintain physical and mental health," including "the provision of medical care for physical and mental needs, . . . assistance in personal hygiene, food, clothing, adequately heated and ventilated shelter, protection from health and safety hazards, [and] protection from maltreatment," Conn. Gen. Stat. Ann. § 46a-14(2)-(3) (West Supp. 1980); "[o]rganic brain damage, advanced age, or other physical, mental or emotional dysfunctioning in connection therewith, to the extent that the person is substantially impaired in his ability adequately to provide for his own care or protection," Fla. Stat. Ann. § 410.102(1) (West, Supp. 1980); insufficient "understanding or capacity to make or communicate responsible decisions concerning [oneself], including provisions for health care, food, clothing, or shelter, because of any mental disability, senility, other mental weakness, disease, habitual drunkenness, or addiction to drugs," Md. Est. & Trust Code Ann. § 13-705(b) (Supp. 1980); insufficient "understanding or capacity to make or communicate responsible decisions concerning [oneself], including but not limited to provisions for health or mental health care, food, clothing, or shelter, because of physical or mental incapacity," N.C. Gen. Stat. § 108-104(1) (Supp. 1979); physical or mental disability that has substantially impaired the ability to provide adequately for one's own care or custody, Okla. Stat. Ann. tit. 43A, § 803(4) (West Supp. 1980); inability to provide for one's own protection from abuse or neglect by another or oneself, S.C. Code § 43-29-30(1) (1976); inability to manage one's own resources, carry out the activities of daily living, or protect oneself from neglect, hazardous or abusive situations without assistance from others, Tenn. Code Ann. § 14-25-102(2) (Supp. 1980); incapacity resulting from mental retardation, cerebral palsy, epilepsy, other neurological conditions, infirmities of aging or other like incapacities resulting from accidents, mental or physical disability, that prevents one from providing his or her own care and protection, Utah Code Ann. § 55-19-1(1) (Supp. 1979); and "organic brain damage caused by advanced age or other physical degeneration in connection therewith to the extent that the person so afflicted is substantially impaired in his ability to adequately provide
such as inability to care for oneself adequately or to protect oneself from abuse and exploitation by others. Next, a number of causes for this incapacity are listed, most of which involve impairment of mental function. "Infirmities of aging," "senility," or simply "advanced age" are terms commonly used to denote such impairment in the elderly. In a few instances, physical impairment alone is considered a sufficient basis for intervention when this condition leads to self-neglect or victimization by others, regardless of the client's mental competence.\textsuperscript{64}

These standards present several problems. First, the statutes often define the concepts of self-neglect or abuse in general terms, thereby allowing courts, agencies, and social workers too much flexibility to disapprove of a client's eccentric behavior and to impose on that person their personal views about a proper lifestyle. By contrast, Connecticut refers more precisely to the person's inability to obtain medical care for physical and mental health needs, nutritious meals, clothing, safe and adequately heated and ventilated shelter, and personal hygiene, as well as protection from physical abuse or harm that endangers such person's health.\textsuperscript{65} Maryland\textsuperscript{66} and New Hampshire\textsuperscript{67} also limit findings of incompetence to circumstances in which a person is not able to provide for his or her own food, clothing, shelter, health care, safety, or essential needs of life.

New Hampshire attaches a further limitation to its list of functional disabilities that justify intervention by requiring that the person's incapacity must be evidenced by acts within six months prior to the filing of the petition for guardianship, with at least one incident occurring within twenty days before the filing.\textsuperscript{68} This requirement focuses the court's attention on the actual functional disabilities of the person and requires the petitioner to marshal recent concrete evidence of such incapacity.

These definitions fall into two subcategories: (1) functional

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\textsuperscript{66} Md. Est. & Trusts Code Ann. § 13-705(b) (Supp. 1980).
\textsuperscript{68} Id. § 464-A:2(XI).
definitions of current inability to cope; and (2) definitions of the underlying conditions that cause these disabilities. When functional definitions are used, one may ask whether involuntary intervention should be permitted solely because severe functional incapacity in providing for the necessities of life has been proven, or whether one must always additionally show that some particular condition, such as mental disorder or "the infirmities of aging," is the underlying cause of the failure to act. The latter inquiry is the traditional basis for all state guardianship laws and for all but New Hampshire's protective services acts, presumably on the theory that the *parens patriae* power should be exercised only when a person is unable to act rationally. Critics, however, have contended that this position imposes a "medical model" of mental illness on guardianship proceedings, thereby fostering domination of these proceedings by psychiatrists. It is better for a court to examine actual behavioral limitations of the client, the argument runs, than to attempt to probe the control mechanisms of the human mind.

The Uniform Probate Code attempts to address this problem, but does not fully abandon the need to demonstrate a condition causing the functional incapacity. The Code defines an incapacitated person as one "who is impaired by reason of mental illness, mental deficiency, physical illness or disability, advanced age, chronic 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." Inability to engage in decisionmaking about matters affecting one's person thus is seen as the core of the functional disorder produced by a variety of conditions.

This formulation, however, introduces another complication. Physical illness and disability, not just mental condition, are recognized as causes of functional inability and therefore are logically included in the definition. The problem with this approach is that courts thereby are empowered to appoint guardians with important powers over the person and the estate of adults who are mentally competent, yet physically incapacitated. Thus, a court could

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69. See generally *American Bar Foundation*, supra note 11, at 250.
sanction an involuntary guardianship for an elderly stroke victim who has lost the power to speak and write, but who is otherwise mentally fit. Moreover, the Uniform Probate Code definition refers to "responsible" decisionmaking, thereby allowing a court to evaluate the merits of particular decisions by physically disabled but mentally competent persons, and, if the court disagrees with them, to find the person incapacitated and appoint a guardian.

The New Hampshire statute adopts a still more functional approach, stating explicitly that incapacity is a legal, not a medical disability, to be measured only by functional limitations.\(^2\) No cause, mental or physical, for this disability must be proven. The court need focus only on the specific evidence of the individual's recent failure to provide various necessities of life for himself or herself.

Both the Uniform Probate Code and the New Hampshire approaches may interfere with an individual's constitutional right to privacy. Although the scope of this right as interpreted by the Supreme Court has been confined to cases involving reproductive freedom,\(^3\) at least two state courts have extended the right to situations involving refusal of life support care by terminally ill patients or their representatives.\(^4\) On similar constitutional grounds, the right of voluntary, competent mental patients to refuse treatment also has been recognized recently.\(^5\) These cases suggest that the right to privacy includes the right of self-determination in important matters affecting one's person that do not infringe on the rights of others. If so, then it follows that competent but physically incapacitated persons are entitled to make their own personal care decisions, including the decision to neglect themselves, without interference from the state through involuntary protective services or appointment of a guardian. The state's interest in preserving the quality of the physically incapacitated person's life seems no greater than its interest in forcibly promoting proper self-care in any adult's life.

Interference with the rights of mentally competent persons


also conflicts with the tradition that the state’s exercise of its power as *parens patriae*, on which both protective services acts and guardianship laws rest, has always required a finding of some form of mental incompetence when adults are the objects of protection. From its origin, the state’s concern was for “idiots” and “lunatics,” authorizing guardianship for adults who lacked the power of self-control. More recently, guardianship statutes have been broadened to include alcoholics and addicts on the same basis—that such persons lack the power of self-control because of chemical dependency. Thus, the Uniform Probate Code’s extension of guardianship into the life of the mentally competent but physically incapacitated person is unprecedented.

Some finding of mental incompetence, therefore, ought to be a necessary component of protective services acts and guardianship laws. The functional limitations of a client are important factors, but mere failure to care for oneself, however recent the evidence, should not obviate the need for a finding of mental incompetence. New Hampshire and the Uniform Probate Code thus extend too far in requiring only findings of functional limitations without any need to show that such limitations are caused by mental disability.

*The Role of the Public Agency*

Most of the states provide for a “public guardianship,” that is, court appointment of a public official or agency to implement a protective services order or to serve as guardian of an incompetent person, usually when no other private person or agency is available or willing to assume this responsibility. Practical problems abound in such guardianships. There may be a conflict of interest between an agency’s fiduciary responsibility to the client and its limited fiscal authority as a public body to provide the services needed by that client. The delegation of day-to-day guardianship duties to various caseworkers within an agency may depersonalize a guardi-
anship and negate any real personal fiduciary role.\textsuperscript{81} A heavy caseload also may lead to the neglect of a client.\textsuperscript{82} Yet, none of the states has addressed these problems in its legislation.

The need for special oversight of a public agency is critical when the agency assumes complete power over a citizen’s personal life.\textsuperscript{83} Again, however, most states have ignored the issue. One exception is Maryland, where in each county a nine member Disabled Persons Review Board semiannually reviews all public guardianships and recommends to the court the continuation, modification, or termination of the guardianship.\textsuperscript{84} A second method has been adopted in Connecticut, which requires the public guardian to prepare written plans for services to the disabled client and to submit the plan to the regional ombudsman who has the right to comment on the proposal.\textsuperscript{85} The effectiveness of both methods of review, however, still remains to be evaluated.

\textbf{The Due Process Model: A Failure?}

The optimism of the proponents of due process reform in protective services legislation has not proven justified in the light of current trends in state legislation. Serious procedural flaws exist in the laws of Alabama, Florida, Oklahoma, and South Carolina, and lesser weaknesses exist in several other states.\textsuperscript{86} The standards for intervention are still vague and conclusory.\textsuperscript{87} Finally, the intervenor, even a public agency, is rarely accountable to anyone, including the court, once the court has signed the order.\textsuperscript{88} The result has been that protective services, especially when provided by a public agency, are becoming in many states a mechanism to allow the public agency to assume total dominion over elderly clients.\textsuperscript{89} A movement that promised to foster independence for the frail elderly client may become the vehicle for creating abject dependence on the public agency and its caseworkers. Admittedly, these conclusions are based only on a statutory analysis and do not take

\begin{itemize}
\item \textsuperscript{81} Id. at 200.
\item \textsuperscript{82} Id.
\item \textsuperscript{83} Id. at 197.
\item \textsuperscript{84} Md. Ann. Code art. 88A, § 110 (1979).
\item \textsuperscript{86} See text accompanying notes 33-37, 48-51 supra.
\item \textsuperscript{87} See text accompanying notes 63-78 supra.
\item \textsuperscript{88} See text accompanying notes 38-40 supra.
\item \textsuperscript{89} See text accompanying notes 79-85 supra.
\end{itemize}
into account agency regulations and practice, which may impose controls not apparent in the statutes. Nonetheless, the opportunity for oppression of the elderly must be recognized.90

The Abolitionist Model

Some commentators have opposed adult protective services programs from the outset, seeing in them the heavy hand of a paternalistic state taking over people’s lives in the name of benevolence. One author, for example, roundly condemns these programs:

[I]nvoluntary guardianship emerges as an official initiation rite of the poor and the inept. . . . The price extracted from those who are dependent on public assistance is manipulation by the managed state; coerced membership is facilitated by the increasing “medicalization” of human and societal problems. Involuntary guardianship, when used to impose forms of state assistance, is but one outgrowth of a medical model of human activity. Within this frame of reference, failure to achieve accepted norms of behavior is seen as symptomatic of a person’s diseased state. Consequently, what might be regarded as a public social problem can easily be viewed and dealt with as a private medical problem, necessitating a medical or pseudomedical solution.91

Even when guardianship is assumed by private persons, another commentator, Professor Alexander believes the practice is fundamentally wrong: “In a society which venerates liberty, conservatorship is an anachronism. Neither the interest of potential beneficiaries nor the interest of the state in having a better management position vis-a-vis the ward is justified.”92

The “abolitionist” position thus opposes not only protective services programs, but guardianship itself. The premises of this position and its practical implications in the lives of the frail elderly need to be explored. The abolitionist model rests on a belief that no such condition as mental incompetency exists. It is postulated

90. In the forty jurisdictions that do not have protective services laws, intervention is controlled by guardianship law and agency regulations. Because comparatively few of these states have adopted the Uniform Probate Code, the likelihood of abuse of the elderly through inappropriate guardianships remains very high. Many state legislatures nonetheless have been reluctant to reform guardianship law along due process lines.


that mental illness is really only behavior that deviates from society’s norms for acceptable conduct, and that psychiatry has created various diagnostic labels for such conduct and has branded it as pathological, much as medicine has done for physical disease.

This basis of the “abolitionist” view goes further than merely chastising those who determine mental illness; it denies the existence of mental illness entirely. Only behavior actually and objectively physically harmful to society should be punished by law. A mere prediction of such conduct on grounds of mental illness ought never to be the basis for involuntary treatment or institutionalization, or for usurpation of the person’s powers of self-determination over property and person.

Assuming paternalistic intervention is unjustified, the question arises as to what system, if any, should replace it. If guardianship laws ought to be repealed, it is unclear what arrangements, if any, should be made to deal with extreme cases of self-neglect. Should the confused elderly person be left to wander the streets or die of malnutrition or freeze to death? The “abolitionist,” unfortunately, has not moved beyond a condemnation of protective services programs. Instead of proposing new alternatives, proponents of this approach offer only another version of the “due process” model subsequent to having condemned it. The failure of the commentators advocating the “abolitionist” model to address the implications of that position leads one to suspect that the noninterventionist world of the future, in which all help must be freely chosen by the client, is really only an ideological fantasy emanating from a neo-conservative revival of laissez-faire individualism.

Some proponents of the abolitionist model oppose protective services because they involve government-initiated intervention, however benevolently motivated. Logically, then, these commentators should believe that protective services programs, but not all private guardianships, should be abandoned. Yet, again, when

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93. See generally T. Szasz, LAW, LIBERTY AND PSYCHIATRY (1963); Szasz, Civil Liberties and the Mentally Ill, 9 CLEV.-MAR. L. REV. 399 (1960).
94. See generally Horstman, supra note 15, at 225-30. This position should not be confused with that of many legal advocates who believe psychiatrists have improperly usurped the role of judges and juries in civil commitment and guardianship proceedings. See, e.g., G. Alexander & T. Lewin, The Aged and the Need for Surrogate Management 18 (1972).
faced with the need to develop alternatives to these programs, the commentators thus far only suggest greater affirmative efforts at reforming the existing system through litigation and media publicity.\textsuperscript{96} It would be more consistent to advocate legislative action prohibiting public agencies or officials from serving as guardians or as parties to petitions for guardianship.

The Voluntary Service Approach

The crucial difficulty in the protective services movement may be its heavy emphasis on involuntary intervention and its corresponding failure to explore and promote methods of providing voluntary assistance to the elderly. The early proponents of protective services thought the power to obtain surrogate decisionmaking authority was essential for the program.\textsuperscript{97} This belief may have been founded on a suspicion that the client would resist the offer of services unless the threat of court-ordered intervention loomed in the background. Mechanisms and procedures for providing strictly voluntary services, even to mentally disabled clients, have received relatively little attention.

Among the proposals that have surfaced are the use of friend-advocates for the elderly and of agents appointed by the person needing assistance.\textsuperscript{98} The latter idea has been expanded by Professor Alexander into a suggestion that legislatures use probate law to create a "living will"—a document that would allow individuals to direct the management of their property in case of future incompetency.\textsuperscript{99} The proposal resembles in some respects the Extended Power of Attorney Model Law proposed by the Uniform Law Commissioners.\textsuperscript{100}

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97. D. Lehmann \& G. Mathiassen, Guardianship and Protective Services for Older People 115 (1963); G. Hall, Overcoming Barriers to Protective Services 5 (1968).


100. See Uniform Probate Code § 5-501. Section 5-501 provides that a person may expressly confer authority on an attorney or agent to act for the principal notwithstanding the later disability or incapacity of the principal.
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Conclusion

Professor Halper has summarized the problems in devising a sensible public policy towards the needs of the elderly, stating:

[Even when fortunate enough to avoid such dangers, the elder may find his freedom a useless possession, for of what value is liberty to one buffeted by the violent inner winds of the mind? Does not liberty presume a minimum level of rationality and maturity (which is why, for example, children are not free to bind themselves through contracts) that the seriously mentally ill simply do not possess? ... Can the deteriorations of aging be dismissed with the fatuity that growing old is a psychosomatic or sociosomatic illness? Is the romanticization of the incompetent aged a tribute to their humanity or merely a means of exploiting their weakness for ideological purposes? If it is true that with the best of intentions it may be difficult to determine who requires the help and protection of the state, does this amount to conceding that no one needs it unless he first asks for it? Or is this merely a rationalization for a callous evasion of responsibility? ...]

The questions attack en masse, and, like feeding wolves, in slashing bites devour the flesh of our certitudes.1

If the "due process" approach has been largely ignored by the states, and if "abolitionist" views need more explanation and development, in what direction should public policy proceed? As a first step, states should impose a moratorium on the use by public agencies of guardianships or of orders for protective services, protective placement, or emergency services. Second, the energies and resources currently used in securing and implementing these forms of involuntary intervention should be channeled instead into voluntary assistance programs. Social services agencies need to find ways through creative casework to win client confidence and thus the client's consent to the recommended services. If the agency comes to realize that involuntary intervention is no longer possible, the incidence of uncooperative clients may tend to decrease and the need for involuntary intervention may drop dramatically.

State legislatures must also recognize the need to review these laws. Reform of state guardianship laws to eliminate substantive and procedural defects should be pressed vigorously. More importantly, states should focus their efforts on creating legal mechanisms whereby the citizen can make binding arrangements for con-

trol of his or her person and property in advance of the onset of any mental incapacity. Only after legislative reform has taken place and public agencies have perfected techniques for voluntary intervention can the moratorium on involuntary intervention be safely brought to an end.

102. See text accompanying notes 98-100 supra.