



7-1-1977

# On Being Imposed Upon by Artful or Designing Persons - The California Experience with the Involuntary Placement of the Aged

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## Automated Citation

George J. Alexander, *On Being Imposed Upon by Artful or Designing Persons - The California Experience with the Involuntary Placement of the Aged*, 14 *SAN DIEGO L. REV.* 1083 (1977),

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# On Being Imposed Upon By Artful or Designing Persons — The California Experience with the Involuntary Placement of the Aged

GEORGE J. ALEXANDER\*

## INTRODUCTION

Under California law, a person is considered incompetent when “by reason of old age . . . [he] is unable, unassisted, properly to manage and take care of himself or his property, and by reason thereof is likely to be deceived or imposed upon by artful or designing persons.”<sup>1</sup>

As this provision of California law suggests, defenselessness in old age is often treated as incompetency. When the victim is younger, being imposed on by artful and designing persons is likely to be seen as a reason for taking action against those who have so

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1. CAL. PROB. CODE § 1460 (West 1956). For a similar definition of incompetency, see CAL. PROB. CODE § 1751 (West Supp. 1977).

victimized. With old age, a new response creeps in: holding the victim incompetent, managing his or her property, and often providing enforced institutionalization.

I have referred to the aged as the least militant minority.<sup>2</sup> Passage of life slows physical functioning. That in turn provides others an excuse for wresting control of a person's life and diminishes the victim's capacity to resist. Consequently, it is not surprising that old people in our society are often wards of their own wealth and "patients" in hospitals and nursing homes in which they see themselves as prisoners. These two problems—wardship and involuntary hospitalization—are inseparable. Both provisions respond to the aged person's infirmity by depriving him or her of the right to manage property and/or liberty. Surrogate management of the ward's property may unfairly advantage the beneficiaries of the ward's wealth.<sup>3</sup> This article is principally concerned with the deprivation of liberty inherent in forced placement. However, this article will concentrate on California surrogate management standards because they provide a better frame of reference for the assumptions which underlie various types of involuntary interventions, and because they are closer to the open-ended commitment statutes of many other states.

It is customary to distinguish involuntary hospitalization from other forms of forced placement, such as placement associated with homes. While the level of deprivation of rights may vary with the type of placement, both types of placement have much in common and will therefore be treated together in this article.

Both involuntary placement and surrogate property management are products of a paternalistic philosophy akin to the attitude of elders toward children. In this instance, however, the paternalism experienced by elders is a product of their children and society. If there is no vengeance in the role reversal, there is at least comparably harsh discipline. The treatment accorded cannot be justified ethically. Moreover, it raises serious constitutional questions, and may itself be seriously contra-indicated from a medical perspective.

#### STANDARDS FOR INVOLUNTARY INTERVENTION

The aged are not unique in being subject to surrogate management of property and involuntary hospitalization. Likewise,

2. Alexander, *Foreword: Life, Liberty, and Property Rights for the Elderly*, 17 ARIZ. L. REV. 267 (1975).

3. See, e.g., Alexander, *Surrogate Management of the Property of the Aged*, 21 SYRACUSE L. REV. 87, 91 (1969).

my opposition to surrogate management and involuntary hospitalization is not limited to their imposition on the aged. Nonetheless, older people are among the most pitiful of involuntary patients.

Although there is wide statutory variance, most states provide procedures for intervention in the lives of the elderly for purposes of managing their property.<sup>4</sup> The statute usually provides a procedure for surrogate management which does not *depend* on old age, but which makes old age a factor militating toward involuntary intervention. Standards such as "old age," "senility," "extreme old age," "physical and mental weakness on account of old age," or "mental infirmities of old age" are quite common.<sup>5</sup>

Although surrogate management does not automatically lead to involuntary placement, there appears to be incredible overlap between the two. Many states still retain relatively open-ended involuntary commitment statutes which allow involuntary treatment of those who are in need of treatment. In those states, old age militates toward a finding of that need. Thus, in both commitment and surrogate management, aging makes one more amenable to involuntary process.

To the extent that the criteria for involuntary commitment and those for declaration of incompetency differ, the standards for incompetency tend to be more encompassing. The California incompetency provisions are chosen for discussion here primarily for that reason. Moreover, incompetency is often the first step toward involuntary hospitalization.

The language of the California Probate Code is typical.<sup>6</sup> While this commitment statute only provides for involuntary placement of persons who are either dangerous or so gravely disabled as to be unable to provide for their basic needs, the conservatorship provision reached a broader group—those people who cannot manage their affairs unassisted. In addition, the statute vaguely suggests a relationship between that functional inability and old age. It also implies that there is a relationship between that inability and being deceived or imposed upon by artful and designing persons. No doubt both qualifications help slightly to limit

4. *Id.* at 98-128.

5. *Id.* at 130.

6. See text accompanying note 1 *supra*.

the statute since most people could be accused of being unable properly to manage their affairs unassisted.

The former qualification requires no further examination. It is obviously a product of an assumption that older people are more likely to need surrogate managers than others. Yet, the second qualification tends to obscure the fact that the provision may not protect those who cannot manage their affairs. Rather, it protects their heirs and keepers from the overreaching of third parties. If the standard were intended to be solicitous only of the potential ward, it would end at a finding of the ward's need. Instead, the standard apparently focuses on the dynamics of the ward's relationship with others. In the case of a needy person, money spent on new friends deprives both the heirs of a wealthy person and the state of resources. As thus structured, incompetency proceedings are, in reality, adversary proceedings in which the petitioner may vindicate his or her personal interest, rather than the interest of the ward.<sup>7</sup> In both incompetency proceedings and involuntary commitment proceedings, the law is cast as though only the ward's benefit were in issue. In actuality, the petitioner frequently has a great deal at stake. The proceedings are not designed to and do not in fact examine the petitioner's interest. Consequently, the proceedings lend themselves to abuse by favoring petitioners to the disadvantage of the ward.

In California, there has been a recent mood of reform with respect to intervention, involuntary commitment, and conservatorship/guardianship. Even before the adoption of the Lanterman-Petris-Short Act in 1969, section 5571 of the California Welfare and Institutions Code provided that "[n]o case of harmless chronic mental unsoundness or mental deficiency shall be committed to the Department of Mental Hygiene for placement in any state hospital for the care and treatment of the mentally ill."<sup>8</sup> Nonetheless, the Assembly Subcommittee on Mental Health found that these old people—presumably the ones described in section 5571—represented a disproportionate percentage of state hospital residents.<sup>9</sup>

Concerned about that fact and about other abuses in involuntary commitment, the legislature passed the Lanterman-Petris-

7. See G. ALEXANDER & T. LEWIN, *THE AGED AND THE NEED FOR SURROGATE MANAGEMENT* (1972); Alexander, note 2 *supra*.

8. CAL. WELF. & INST. CODE § 5571 (West 1966) (repealed 1969).

9. ASSEMBLY INTERIM COMM. ON WAYS AND MEANS, SUBCOMM. ON

Short Act in 1969.<sup>10</sup> Prior law allowed persons to be involuntarily hospitalized because they were in need of supervision, treatment, care or restraint. The new bill replaced this language with only two general provisions for confinement of mentally ill persons for longer than emergency seventy-two hour incarceration: "danger to others" and "danger to self".<sup>11</sup> Both provisions were restrictively defined.<sup>12</sup> The new law also added a provision for the hospitalization of those who are gravely disabled, defining grave disability as "[a] condition in which a person, as a result of a mental disorder, is unable to provide for his basic personal needs for food, clothing or shelter."<sup>13</sup> The rigor of grave disability conservatorships stood in bold relief to conservatorships established under the California Probate Code.<sup>14</sup>

During 1977, probate conservatorships were altered by the Lanterman bill incorporating much of the philosophy of the Lanterman-Petris-Short Act into the Probate Code. A study by the National Senior Citizens Center had determined that eighty percent of persons for whom conservatorship had been ordered were over sixty-five. In addition, they found that ninety-three percent of these people had been conserved without their appearance in court. Finally, the study noted that ninety-seven percent had been conserved without legal representation in the proceedings.<sup>15</sup> The new bill was designed to assure that the elderly would no longer be the objects of such casual deprivations of their liberty. As the Lanterman-Petris-Short Act had done before it, the new Lanterman bill establishes strong procedural safeguards against improperly obtained conservatorships. Chief among these safeguards is a

MENTAL HEALTH, THE DILEMMA OF MENTAL COMMITMENTS IN CALIFORNIA, A BACKGROUND DOCUMENT 78 (1976).

10. CAL. WELF. & INST. CODE §§ 5000-5401 (West 1972).

11. *Id.* § 5250.

12. *Id.* §§ 5260, 5300.

13. *Id.* § 5008(h) (amended 1976). See *id.* § 5008(h) (West Supp. 1977) for further additions to this statutory provision.

14. *Id.* §§ 5350-5368 (West 1972).

15. The National Senior Citizens Center is a federally funded legal services center concerned with the legal problems of the elderly poor. The study cited above was an empirical study covering the complete Los Angeles County central district guardianship and conservatorship filings under CAL. PROB. CODE §§ 1460-1470 (West 1956) and CAL. PROB. CODE §§ 1701-2207 (West Supp. 1977) from July 1, 1973 to June 30, 1974. Included in this research was an individual examination of 1,010 case files.

provision which prohibits, in most circumstances, the granting of orders of conservatorship or guardianship in the absence of the ward.<sup>16</sup> Another provision requires a court investigator to visit the proposed ward in those infrequent circumstances where the ward is certified as unable to attend the hearing.<sup>17</sup> Finally, review provisions for conservatorships and guardianships are more stringent than those under prior law, and notice and hearing provisions are strengthened.<sup>18</sup>

As mentioned above, the conservatorship/guardianship provisions are related to involuntary commitment of the elderly.<sup>19</sup> The tests themselves, and the arguments surrounding their adoption, are instructive of involuntary placement issues. Under the new bill, the vague standards which allowed the appointment of guardians and conservators to such things as infirmities of old age have been abolished. The new law makes clear that the standard is functional and non-medical. The precise wording was the result of a compromise between the State Bar Legal Services representatives and representatives of the State Bar Committee on Probate and Trust. On the one hand, the Legal Services members insisted on limiting the standard for intervention to those aspects of dysfunction which directly relate to providing food, clothing and shelter. On the other hand, the Probate and Trust people strongly insisted on retaining much of the prior language, especially the provisions regarding deception by artful or designing persons.

The "artful and designing persons" test was not unique to California.<sup>20</sup> Moreover, the test was often difficult to employ.<sup>21</sup> This standard is based on a belief that it is important to intervene in the lives of older people, even though those people may be able to manage their own lives. One authority has commented that

[t]hese [old] people . . . cannot be judged to be incompetent. They know what they are doing, they want to do just what they are doing, and to live the way they are living. Still, from our present

16. 1976 Cal. Adv. Legis. Serv., ch. 1357, § 6, at 94-96 (amending CAL. PROB. CODE § 1461 (West 1956)).

17. *Id.* § 7, at 96-97 (amending CAL. PROB. CODE § 1461.1 (West 1956)).

18. *Id.* §§ 11-13, at 99-100 (amending CAL. PROB. CODE §§ 1470-1472 (West 1956)).

19. See text accompanying notes 4-9 *supra*.

20. Alexander, *supra* note 3, at 129.

21. The courts have disagreed over the interpretations to be given the property management standard. It has been held to mean anything from rationally, to that of ordinary reasonable care, to a comparative community standard, to an ability to manage it in a rational manner, to an ability to manage it intelligently, to a disposition of mind which *might* lead to the wasting away of an estate.

*Id.* (footnotes omitted).

sociological way of thinking they need care, some of them their estates, most of them their persons.<sup>22</sup>

Although Probate and Trust representatives insisted that the "artful and designing persons" language be retained in the new law, the final bill entirely excluded it from consideration in the granting of guardianships. As an alternative ground to the appointment of a conservator, the bill included novel language which allows such appointment when a person is considered "substantially unable to manage his own financial resources or resist fraud or undue influence."<sup>23</sup> The law limits the application of the new standard by providing that isolated instances of fraud or undue influence should not suffice as proof of incapacity.

In this respect, the old and new laws differ substantially. The old law allowed predictions of future conduct under its *susceptible to influence* standard.<sup>24</sup> The new law requires proof of present functional inability.<sup>25</sup> Prior law did not require even a single instance of improvidence—only a likelihood of future improvident behavior.<sup>26</sup> The new statute not only requires present improvidence but also mandates that improvidence be demonstrated by more than isolated instances of conduct. Even more significantly, in my view, the new law requires that the proposed ward be the focus of functional inability, rather than those who deal with him.

The prior law's concern for old age and artful or designing persons forced courts to focus on third parties rather than on the ward. Since courts neither understand the process of aging nor the notion of mental debility, the language itself probably provided strong suggestions as to grounds for declaration of incompetency. If a judge were in doubt as to whether a person was able properly to manage, the language of the statute provided that people might be unable to manage because of diseases, weak mind, or by reason of old age.

Consider the "artful and designing persons" language. It encouraged the judge to focus on persons other than the proposed ward or

22. McAvinchey, *The Not-Quite-Incompetent Incompetent*, 95 TR. & EST. 872, 873 (1956).

23. CAL. PROB. CODE § 1751 (West 1956) (amended 1977).

24. *Id.* §§ 1460, 1751.

25. *Id.* § 1751 (West Supp. 1977).

26. *Id.* (West 1956). See also *In re Cassidy's Guardianship*, 95 Cal. App. 641, 273 P. 69 (1928).



the petitioner. Who? Daddy's young girlfriend? Mother's hairdresser? A new religious figure or charity? At the same time, that language directed the judge's attention from the possible best interests of the petitioner.

Efforts of near relatives are not the only interests which can be protected by intervention in the life of an older person. In one study, it was found that the state of New York was the largest petitioner for incompetency.<sup>27</sup> Similarly, a Los Angeles study suggests that a large percentage of incompetency proceedings brought against the aged poor are brought by the state of California.<sup>28</sup> Although the state is probably less interested than are the aged persons' children in preventing the aged from forming new alliances, the state has an interest in insuring the preservation of whatever resources exist less it have to expend its own funds. Moreover, the state may have administrative concerns which can be managed more effectively if someone has the legal right to make decisions for the elderly person.<sup>29</sup> To the extent that incompetency proceedings are used by the state to provide an easy mechanism for paying government services or insuring that assets remain stable, the state, like other petitioners, promotes its own interest rather than those of the ward.

In other states which have not adopted the relatively strict involuntary commitment standards adopted by California, the debate over surrogate management procedure may more closely parallel disputes directly concerning involuntary commitment.

#### A CONSTITUTIONALLY REQUIRED MINIMUM STANDARD?

For a long time, it had apparently been assumed that there were no serious constitutional questions concerning involuntary placement, presumably because it was conceived to be in the ward's interest. In *O'Connor v. Donaldson*,<sup>30</sup> the United States Supreme Court suggested otherwise. Petitioner in *Donaldson* successfully sued for damages resulting from fifteen years of court ordered incarceration in a mental hospital. He argued that he had not been dangerous to himself or to others, and that he was capable of surviving outside of a mental institution. In addition, he alleged that he had not been treated during his confinement.

27. G. ALEXANDER & T. LEWIN, *supra* note 7, at 12.

28. *See* note 15 *supra*.

29. *See, e.g.,* Wilkie v. O'Connor, 261 App. Div. 373, 25 N.Y.S.2d 617 (1941).

30. 422 U.S. 563 (1975).

The Court ultimately held that “[a] State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.”<sup>31</sup> California’s involuntary commitment law provides that a person may be placed under a Lanterman-Petris-Short conservatorship if he or she is gravely disabled.<sup>32</sup> The statutory “grave disability”<sup>33</sup> criterion appears to be more stringent than the Supreme Court’s test. However, as applied, the opposite is true. According to *Donaldson*, it is significant that a person’s survival outside a mental institution *may* depend on relatives or friends without impairing his or her constitutional right to release.<sup>34</sup> The “gravely disabled” provisions of the California statute still await authoritative interpretation by the courts. However, the provisions have been applied by trial courts to persons who would clearly have been adequately cared for by others but were incapable of providing that care without assistance. If the Supreme Court’s language is to be taken at face value, such an interpretation by the California trial courts apparently violates fourteenth amendment due process. It may seem strange that, in defining “gravely disabled,” the clear language of the Lanterman-Petris-Short Act could be interpreted so expansively. Looking to legislative history, the Lanterman-Petris-Short Act replaced the law under which one could be involuntarily confined in a mental institution if in need of “supervision, treatment, care or restraint.”<sup>35</sup> Grave disability was expressly designed to eliminate the vagaries of that broad language. Both constitutional interpretation and statutory draftsmanship seemed intent on insuring that those who could function in safety to themselves and others outside of mental institutions would not be involuntarily incarcerated. Yet, as is characteristic of involuntary commitment, a combination of prejudice, superstition, confusion and awe of medical diagnosis continues in practice what appears to have been prohibited by law. The Supreme Court used strong language:

A finding of “mental illness” alone cannot justify a State’s locking a person up against his will and keeping him indefinitely in sim-

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31. *Id.* at 576.

32. CAL. WELF. & INST. CODE § 5350 (West 1972).

33. See text accompanying note 13 *supra* for the statutory definition of *grave disability*.

34. *O’Connor v. Donaldson*, 422 U.S. 563, 576 (1975).

35. THE DILEMMA OF MENTAL COMMITMENT, *supra* note 9, at 38, quoting former CAL. WELF. & INST. CODE § 5550 (West 1966) (repealed 1968).

ple custodial confinement. Assuming that that term can be given a reasonably precise content and that the "mentally ill" can be identified with reasonable accuracy, there is still no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom.

May the State confine the mentally ill merely to insure them a living standard superior to that they enjoy in the private community? That the State has a proper interest in providing care and assistance to the unfortunate goes without saying. But the mere presence of mental illness does not disqualify a person from preferring his home to the comforts of an institution. Moreover, while the State may arguably confine a person to save him from harm, incarceration is rarely if ever a necessary condition for raising the living standards of those capable of surviving safely in freedom, on their own or with the help of family or friends. . . .

May the State fence in the harmless mentally ill solely to save its citizens from exposure to those whose ways are different? One might as well ask if the State, to avoid public unease, could incarcerate all who are physically unattractive or socially eccentric. Mere public intolerance or animosity cannot constitutionally justify the deprivation of a person's physical liberty.<sup>36</sup>

Unfortunately, the Court was confronted with a jury finding that petitioner was not mentally ill or, if mentally ill, had not received treatment. Therefore the Court was not required to decide the constitutionality of a statutory provision providing for involuntary incarceration of people in need of treatment.<sup>37</sup> This is important, because the district court had found that "[a] person who is involuntarily civilly committed to a mental hospital does have a constitutional right to receive such treatment as will give him a realistic opportunity to be cured . . . ."<sup>38</sup>

In a concurring opinion, Chief Justice Burger noted that the Supreme Court had not adopted the trial court's statement.<sup>39</sup> According to the Chief Justice, it is not clear that treatment is a concomitant obligation to incarceration. The problem, as he sees it, is principally a question of the extent of the *parens patriae* power.<sup>40</sup> Chief Justice Burger realized that mental illness is a fuzzy concept when applied to law. He recognized that there is considerable debate regarding the definition of mental disease and what constitutes treatment. In addition, he noted that there are many areas of so-called mental illness for which effective therapy does not exist. Finally, the Chief Justice acknowledged the uncertainty of diagnosis and the paradox that "it is universally recog-

36. *O'Connor v. Donaldson*, 422 U.S. 563, 575 (1975).

37. *Id.* at 573.

38. *Id.* at 570 n.6 (emphasis added).

39. *Id.* at 580 (Burger, C.J., concurring).

40. *Id.* at 583-84.

nized as fundamental to effective therapy that the patient acknowledge his illness and cooperate with those attempting to give treatment; yet the failure of a large proportion of mentally ill persons to do so is a common phenomenon.”<sup>41</sup>

According to Chief Justice Burger, the question does not turn on further refinement of medical evidence. Instead, he inquires whether there are persons who are “unable to function in society and will suffer real harm to themselves unless provided with care in a sheltered environment.”<sup>42</sup> If there are such persons, then he believes the legislature has the power to provide for their involuntary protection.

Whether one accepts the Chief Justice’s approach or that of the district court makes a great deal of difference, although that difference would not affect the result in *Donaldson*. The petitioner’s claim was on the *absence* of treatment, although petitioner did not concede that treatment was a sufficient justification for involuntary hospitalization. The Chief Justice insisted on a far higher standard for involuntary hospitalization, but would allow hospital confinement without treatment. In fact, the petitioner, a Christian Scientist, *refused* treatment. The Court apparently did not adjudicate the question of how the defect in petitioner’s case could be remedied. If Chief Justice Burger’s reasoning were followed, the remedy would appear to lie in legislative articulation of standards under which one can be adjudged so helpless as to require protective shelter. If the district court’s path were chosen, the state would simply have to provide effective treatment. That, in turn, would seem principally to require an increase in the budget of state institutions in order to provide greater contact between patients and professionals.

If one accepts the latter viewpoint, the so-called patient’s rights to be treated becomes more a duty to treat him. At the same time, it becomes a sufficient justification to disregard his or her wishes not to be treated. In rejecting this notion, the Chief Justice mentioned that:

Rather than inquiring whether strict standards of proof or periodic redetermination of a patient’s condition are required in civil con-

41. *Id.* at 584.

42. *Id.*

finement, the theory accepts the absence of such safeguards but insists that the State provide benefits which, in the view of the court, are adequate "compensation" for confinement. In light of the wide divergence of medical opinion regarding the diagnosis of and the proper therapy for mental abnormalities, that prospect is especially troubling . . . .<sup>43</sup>

Although *Donaldson* applies directly to involuntary commitment in mental hospitals, it may have broader application as well. As has previously been noted, while involuntary incarceration exists, so-called "voluntary" hospitalization may in fact be involuntarily imposed on threat of formal involuntary commitment.<sup>44</sup> Assuming this proposition to be accurate, some of the considerations mentioned in *Donaldson* might spill over to "voluntary hospitalization."

In addition, conservatorships raise similar issues even when, as in California, a sharp line is drawn between conservatorships which lead to involuntary hospitalization—legal only under Lanterman-Petris-Short commitment standards—and probate conservatorships. Moreover, until July 1977, California will allow imposition of a guardianship on an old person who is unable to properly care, "unassisted," for himself or his property.<sup>45</sup> It seems strange that old age coupled with the inability properly to manage should suffice as a reason for the appointment of a conservator.

The loss of control of one's property on the appointment of a conservator is, of course, the most obvious consequence of that appointment.<sup>46</sup> A somewhat less recognized consequence is the ability of a conservator to determine the place in which the conservatee will reside.<sup>47</sup> Although California law prohibits forcing one's ward to live in a mental institution, that prohibition is rare in other states. Moreover, even in California, the ability to confine the conservatee to a place in which he or she may not want to live seems to impose some of the restraints of liberty discussed in *Donaldson*. It is improbable that a court would enforce the conservator's requirement that the ward live in a certain place by punishing the ward's refusal to do so. It seems likely, however, that the court would allow the conservator to use economic coercion in designating the ward's residence. Because the constitution-

43. *Id.* at 587.

44. The author has interviewed a number of psychiatrists who have stated that they routinely use the threat of involuntary process to hold "voluntary" patients whom they fear to release.

45. CAL. PROB. CODE § 1751 (West Supp. 1977).

46. I have written a book on this issue and will not belabor the point here. See G. ALEXANDER & T. LEWIN, note 7 *supra*.

47. CAL. PROB. CODE § 1851 (West Supp. 1977).

ality of involuntary hospitalization has only recently become of interest to most courts, it is not surprising to find scant authority on the issue of whether the Constitution protects one's right to choose his location of residence. Hence, it is not clear whether requiring a person to live in an unlocked ward within a private hospital is as onerous a requirement as that he or she live behind lock and key. The distinction may be academic to a patient unable to afford rent outside of the hospital because a conservator controls his or her money.

Present California guardianship law appears suspect to the extent that residence provisions can be brought within the *Donaldson* holding. The California statute requires a person to be able to care for himself or his property "unassisted,"<sup>48</sup> whereas the *Donaldson* standard requires that one take into account the help of family and friends.<sup>49</sup> The new law<sup>50</sup> will alter the unassisted management provision by eliminating the word unassisted.<sup>51</sup> Of course, that still leaves open the possibility of adopting the vagaries of interpretation to the "gravely disabled" clause which continually plagued the Lanterman-Petris-Short Act.

#### DOES INVOLUNTARY PLACEMENT HELP?

This article has so far been chiefly concerned with the ethical and constitutional objections to involuntary treatment of the aged. In addition, it seems appropriate to briefly review some clinical evidence of the impact of involuntary placement. As I have mentioned earlier, the aged are overrepresented in the population of involuntary mental patients. Professor Regan has observed that "the percentage of mental hospital first admissions of elderly persons is increasing more rapidly than the total population of the aged" and that the aged make up thirty percent of mental hospital patients.<sup>52</sup> It is unclear to what extent these sta-

48. *Id.* § 1460 (West 1956).

49. See text accompanying note 31 *supra*.

50. The new law becomes effective on July 1, 1977. See CAL. PROB. CODE § 1460 (West Supp. 1977).

51. *Id.*

52. Regan, *Protective Services for the Elderly: Commitment, Guardianship, and Alternatives*, 13 WM. & MARY L. REV. 569, 574 (1972) (footnote omitted).

tistics simply reflect increased debility in the aged. Also unknown is the number of patients who have non-psychiatric medical problems. Unfortunately, as is true of much of psychiatric diagnosis, non-psychiatric diagnoses tend to reflect the expectations of those who bring patients to the diagnostician. "Dad is just not himself." "Mom is so much more forgetful." "Dad's leg is giving him so much more trouble." These and similar statements provide a strong impression for a physician who may not have previously seen the patient and who has had experience with patients who were out of touch with their own functioning.

One of the most common diagnoses is acute or chronic brain syndrome. Brain syndrome is considered acute if reversible and chronic if otherwise. The disorder is typically thought to be an organic dysfunction. Acute brain syndrome may, however, mask such physical or mental conditions as simple depression, vitamin deficiency, traumatic injury, or a variety of other ills. If the underlying condition is not treated, deterioration may in fact confirm the original diagnosis of brain syndrome.<sup>53</sup> A brain syndrome diagnosis, in general, and certainly a chronic brain syndrome diagnosis, in particular, may be a self-fulfilling prophecy. In addition, the diagnosis may mask needed treatment in a less dramatic way. For example, a colleague recently discussed a situation in which his mother had suffered a stroke. She made a miraculous recovery; all but bladder function returned to normal. The treating physician was pleased, so pleased in fact that it did not occur to him to investigate the cause of the remaining problem. At my colleague's insistence, the physician eventually diagnosed the condition. He found a massive infection which quickly responded to treatment. The patient was cured of all symptoms.

Much of the initial data on which mental health diagnosticians act in these cases concerns behavior.<sup>54</sup> The symptomatology of brain syndrome is that a previously healthy individual suddenly becomes disturbed, confused, restless, or disoriented.<sup>55</sup> Because a significant portion of chronic brain syndrome diagnosis is comparative, data must be matched against the patient's prior mental history. Most of the behavioral symptoms on which a decision must be made will already have taken place by the time the

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53. See, e.g., Busse, *Mental Disorder in Later Life—Organic Brain Syndrome*, in *MENTAL ILLNESS IN LATER LIFE* 89 (E. Busse & E. Pfeiffer eds. 1973); Goldfarb, *Memory & Aging*, in *THE PHYSIOLOGY AND PATHOLOGY OF HUMAN AGING* 149 (R. Goldman & M. Rockstein eds. 1975).

54. Busse, *Mental Disorder in Later Life*, *supra* note 53, at 89.

55. Regan, note 52 *supra*.

physician sees the patient. Therefore, heavy reliance must be placed on an informer's observation of the person's conduct. The opportunity for bias on the informer's part is obvious. Just as an incompetency proceeding can be used to indicate the petitioner's interest in the finances of an older person, so too can information about the older person's behavior be used to cast him or her as sufficiently debilitated to require involuntary treatment.

I do not suggest that the informant must necessarily be conscious of his or her role, or that he or she must necessarily be lying. The entire inquiry is sufficiently unclear that it is possible to paint a picture of gross disability simply by the selective recollections, however innocent, of recent events. The diagnosis in turn reflects the same vague standards. Wang reports that 77.7% of first time geriatric admissions in the year he studied were admitted for brain syndrome.<sup>56</sup> Another study of diagnoses of patients over sixty-five on first admissions to mental hospitals in Toronto, New York and London found the respective percentages to be 41.8% in Canada, 79.8% in New York and 42.8% in England. The study concluded that the difference in percentages was probably not the result of differences in patients but rather differences in the diagnostic bias of United States physicians.<sup>57</sup> In Canada and England, the percentages of functional (non-organic) disorders were comparably higher. Because there is wide textbook difference between non-organic dysfunction and organic brain syndrome, these discrepancies indicate some reason for skepticism about chronic brain syndrome diagnoses.

Apparently the early experience in California under Lanterman-Petris-Short confirms this belief. One group has noted,

Some mentally disordered patients were placed involuntarily in locked facilities under the diagnosis of chronic brain syndrome and were not provided the opportunity for judicial review of the involuntary hold. The locked facilities licensed by the state DMH [California Department of Mental Health] were generally used to

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56. Wang, *Organic Brain Syndromes*, in *BEHAVIOR AND ADAPTATION IN LATE LIFE* 263, 265 (E. Busse & E. Pfeiffer eds. 1969).

57. Duckworth & Ross, *Diagnostic Differences in Psychogeriatric Patients in Toronto, New York and London, England*, 112 *CAN. MED. A. J.* 847 (1975). For a similar study with equally disturbing results, see Copeland, Kelleher, & Kellett, *Diagnostic Differences in Psychogeriatric Patients in London and New York: United Kingdom—United States Diagnostic Project*, 19 *CAN. PSYCHIATRIC A. J.* 267 (1974).



provide care for the geriatric, senile patient who would otherwise wander out into the community, and needed a protective setting to prevent harm from coming to him because of his condition of incompetency. The diagnosis of chronic brain syndrome was considered to be an irreversible condition from which the patient would not "clear" or improve. In actual practice, some patients so placed in these facilities with a diagnosis of chronic brain syndrome became "clear", and did improve. A number of professional persons were concerned that the mentally disordered were being placed in locked facilities and forgotten rather than being placed in a protective, but not locked facility such as a board-and-care home.<sup>58</sup>

Throughout this article it has been assumed that the principal reason for intervention in an old person's life was not because of danger to himself or others but rather because of his or her debility. Consequently, it seems appropriate to examine the extent to which intervention is helpful to that person in living out his or her life. One study, while concluding that the most traumatic form of protective service was involuntary placement, attempted to discern the efficacy of all protective services, not just involuntary placement.<sup>59</sup> The study went on to note, however, that service increases the likelihood of institutionalization: "[e]xperienced social workers appear to have a strong tendency to move old people into 'protective settings' when assigned responsibility for their welfare."<sup>60</sup> The initial study found that, as to all protective services: "[o]ne must conclude on the basis of data gathered from following up . . . service and control cases the project service was not effective in slowing down deterioration and physical functioning—two major reasons frequently given for intervening in a protective case."<sup>61</sup> The study's alarming conclusion was that protective services did not lengthen life. On the contrary, these services appeared to shorten people's lives. The hypothesis was restudied and reconfirmed. At the conclusion of the second study the author noted:

Taking the findings as a whole it is difficult to avoid the conclusion that (a) participants in the experimental service program were institutionalized earlier than they would have otherwise been and (b) that this earlier institutionalization did not—contrary to intent—prove protective in terms of survival of the older person although it did relieve collaterals and community agents.<sup>62</sup>

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58. ENKI RESEARCH INSTITUTE, A STUDY OF CALIFORNIA'S NEW MENTAL HEALTH LAW 159 (1972).

59. BENJAMIN ROSE INSTITUTE, PROTECTIVE SERVICES FOR OLDER PEOPLE: FINDINGS FROM THE BENJAMIN ROSE INSTITUTE STUDY (1974).

60. *Id.* at 138.

61. BENJAMIN ROSE INSTITUTE, PROGRESS REPORT ON PROTECTIVE SERVICES FOR OLDER PEOPLE 68-69 (1967).

62. BENJAMIN ROSE INSTITUTE, *supra* note 59, at 157.

## CONCLUSION

Whether one views the problem from the standpoint of ethics or constitutional law, it seems clear that the state must demonstrate some reason for depriving an elderly person of autonomy. Absent such a showing, disposing of the elderly by institutionalization violates the liberty ethic and its constitutional counterpart. Far from articulating the rationale, present law is premised largely on unexamined assumptions. Chief among these assumptions is the notion that involuntary process is somehow of benefit to the older person. When examined, the benefit appears more frequently to run to collateral persons. Even if benefit were generally established, it is contended that such a benefit would not suffice to offset the ethical and constitutional deprivation unless the "benefited" person would be a bad survival risk left to his or her own devices.

In any event, under present circumstances, diagnoses under which many older persons are institutionalized are vague and capable of misapplication. It is equally apparent that diagnoses *are* misapplied. Moreover, it is of significance that precisely the same group of collateral persons standing to benefit from their petition for surrogate management of the older person's property are also in a position to petition for institutionalization and to provide determinative input for the diagnosis of the need for that institutionalization. There is also a predilection to incarcerate in the social service group which doubtlessly contributes to the level of involuntary placement. Finally, and most tragically, it seems notable that protective services often leading to involuntary incarceration do not prolong life but shorten it. These services appear not to satisfy the needs of the elderly but to aid the concerns of their collaterals and of institutions.