This article describes, compares, and analyzes the roles and functions of guardianship and several decision-making interventions previously identified as potential alternatives to guardianship. An analytical framework, comprised of capacity, risk, complexity, and support, is developed to assess performance expectations and identify limitations of four types of decision-making interventions. Using case examples to illustrate how the framework applies to practice, the capacity of different types of interventions to address needs and to substitute or divert older adults from guardianship is examined. The article concludes with propositions introduced to guide future research.

Key Words: Financial management, Alternatives to guardianship, Alternatives to conservatorship, Protective services

Rethinking Alternatives to Guardianship

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Over the last decade, a variety of financial and health-related decision-making interventions have been identified as potential alternatives to legal guardianship. Guardianship, called conservatorship in some states, refers to court appointment of surrogate decision makers for persons judged not competent to make their own decisions. The search for alternatives (Hommel & Wood, 1990; Kapp & Detzel, 1992; Stiegel, 1992; Wilber, 1991) is driven, largely, by the restrictive and paternalistic nature of guardianship as an intervention. Underlying this search is the assumption that less restrictive approaches will balance the need for protection with the need for self-determination by processes that Schmidt (1990) distinguishes as diversion (delaying or preventing the need for court appointment of a surrogate decision maker) and substitution (acting in place of guardianship). Because financial and medical decision-making interventions are important components of guardianship, they are viewed as means to help older persons avoid guardianship.

Societal aging and increasingly complex institutional transactions suggest a growing role for services that provide older persons assistance with money management, benefits advocacy, estate planning, and medical decision making. For example, current estimates are that between 1.5 and 3 million persons age 65 and older need help managing their finances (National Center for Health Statistics, 1987; Stone & Murtaugh, 1990). Of these, a conservatively estimated 500,000 who are without relatives or friends to assist them must look to social services or to the private sector for help (American Association of Retired Persons, 1992). Despite a high level of need among low and moderate-income older adults, financial management and health-related decision-making interventions represent what Estes, Swan and Associates (1993) refer to as a “no-care zone” or underdeveloped social service in many communities (Wilber & Buturain, 1992).

Although financial management and health-related decision-making services have the potential to affect the lives of dependent persons significantly, these areas have received little attention from researchers. Studies that have been conducted have focused primarily on the process and problems of legal guardianship. Identified problems with guardianship include lack of due process in court proceedings, poor performance and abuse by guardians, the high economic costs of guardianship, the immutable nature of the decision, and lack of oversight by the courts (Alexander, 1990; Associated Press, 1987; Bulcroft, 1992; Iris, 1988, 1990; Kapp, 1981, 1992; Keith & Wacker, 1993; Steinberg, 1985; Stiegel, 1992). Although efforts have been underway during the last decade to reform guardianship policies and practices, implementation has been uneven. In addition, despite reforms, guardianship remains the intervention of last resort because, without requiring consent, it transfers an adult’s authority to make personal and estate-related decisions to a surrogate.

The search for interventions that prevent or substitute for guardianship placement is a recent area of interest, initiated by conceptually grouping a broad array of services together as “alternatives to guardianship” much the same way that community based long-term care services have been considered “alternatives to institutionalization.” Although such an
approach is an important first step to differentiating service areas, it tends to overshadow the distinct roles, capabilities, and functions of financial management and health-related decisional options.

The purpose of this article is to describe, analyze, and conceptualize financial and medical decision-making interventions for older adults. We do this by developing a theoretical framework to differentiate the roles and functions of four types of service options within the context of current institutional arrangements, policies, and practices. Although our primary emphasis is on financial decision making, we also discuss health-related decision-making approaches. We begin by presenting a typology of decision-making interventions through which we examine current institutional arrangements, distinguish the benefits and liabilities associated with different types of interventions, and differentiate the roles of various services. This typology is followed by the development of an analytical framework comprised of capacity, risk, complexity, and support. The framework is applied to a case study to illustrate which alternatives are most appropriate under different conditions. The article concludes with the presentation of several propositions regarding the substitution and diversion parameters of different decision-making alternatives.

Typology of Decision-Making Options

In Chart 1, decision-making approaches are categorized according to the locus of decisional responsibilities as: (1) services that support the older person as decision maker; (2) services in which the older person shares decisional responsibility with another party; (3) services where the older person delegates current and/or future decisional authority to another party; and (4) services in which a surrogate decision maker is appointed for the older person. Chart 1 also identifies service options available within each category.

Supportive decision-making approaches, shown in Cell 1, presume that the older adult has decisional authority to direct transactions but requires help executing decisions (Collopy, 1988; Smyer, 1993). Supportive options, therefore, require decisional capacity for execution, can be terminated by the older person at any time, and become invalid if the person loses capacity. Supportive financial management arrangements include formal bill-paying services (BPS) provided by social service agencies and certified financial planners (CFP); powers-of-attorney (POA) assigned to a family member, friend, bank officer, or attorney; and personal trusts, if language is not included that allows the trust to continue after incapacity. In addition to basic bill paying assistance, BPS includes client education and counseling, benefits advocacy, insurance billing, budgeting, and credit management. Private fiduciaries (e.g., CFP) provide similar services augmented by investment counseling and estate planning. Although BPS offered by social service providers have not been shown to substitute for guardianship (Wilber, 1991), potential benefits include protection against financial exploitation and consumer fraud and reduced risks of utility shut-off, damaged credit, and eviction or foreclosure. BPS provides some measure of safety, as most programs have reasonable oversight mechanisms, such as external audit procedures (Kapp, 1992; Wilber & Buturain, 1993).

POA arrangements grant specific or general powers to an agent to act on behalf of the older adult. Benefits are client control, privacy, and ease of execution and cancellation. Limitations are that POAs lack oversight mechanisms such as bonding, notice, and legal advice, unless a corporate agent is involved; POAs do not survive incapacity.

Case Example: Mrs. S., 76, suffered from hemiplegia and mild cognitive impairment resulting from a stroke. Although she was able to make decisions for herself, she was unable to write and had difficulty organizing and paying her mounting bills, including a number of medical claims from an extended hospital stay. The case management agency that coordinated her home health, housekeeping, and personal care services referred her to a non-profit daily money management (DMM) service that assisted her with her banking, budgeting, bill paying, and medical claim

| Chart 1. Typology of Financial Management and Health-Related Decision-Making Services |
|----------------------------------|--------|--------|
| **Supportive**                   | **Cell 1** | **Cell 2** |
| Elder retains decisional authority |        |        |
| Elder delegates executional authority |    |        |
| Examples:                         |        |        |
| Powers of Attorney (POA)          |        |        |
| Bill Paying Services (BPS)        |        |        |
| Trusts (can be supportive)        |        |        |
| **Shared**                        | **Cell 2** |        |
| Elder shares and negotiates both decisional and executional authority |        |        |
| Examples:                         |        |        |
| Joint Accounts                     |        |        |
| Joint Tenancy                      |        |        |
| Trusts (can be shared)            |        |        |
| **Delegated**                     | **Cell 3** |        |
| Elder exercises decisional authority prior to incapacity with advance directives |        |        |
| Examples:                         |        |        |
| Living Wills                       |        |        |
| Durable Powers of Attorney (DPA)  |        |        |
| Durable Powers of Attorney for Health Care (DPAHC) | |        |
| Trusts (usually delegated)        |        |        |
| **Surrogate**                     | **Cell 4** |        |
| Decisional and executional authority transferred by formal mechanisms |        |        |
| Examples:                         |        |        |
| Family Consent Laws               |        |        |
| Representative Payee (rep payee)  |        |        |
| Limited Guardianship              |        |        |
| Plenary Guardianship              |        |        |
forms. Because DMM is not designed to serve persons who lack decisional capacity, her money manager also helped her execute health and financial advance directives so that her preferences would continue to guide decisions in the event that she became mentally incapacitated.

Shared decision making, shown in Cell 2, involves joint or negotiated responsibility between the older person and another party. Shared decision making includes joint accounts and joint tenancy arrangements in which an elderly person with income or assets other than federal transfer payments (e.g., Social Security, Supplemental Security Income, Veterans Administration Pension, etc.) establishes joint accounts or holds property with another person, presumably a trusted family member or friend. Although these arrangements require capacity when they are executed, joint accounts and joint tenancy (with rights of survivorship, as most are) survive both incapacity and death. While joint accounts can provide authority for a designated party to access funds to assist the older person in bill paying and investing, no oversight is provided; nor is there any obligation for the joint tenant to perform services.

Because older adults with capacity are frequently co-trustees of their own estate, sharing decision-making powers with another fiduciary, trusts are included as a shared financial management service. Trusts involve the drawing of documents that set forth the instructions of the grantor for the management of assets and income. Revocable Trusts, which are the most widely used, can be changed or rescinded by the grantor at any time prior to incapacity or death. Because most are written to anticipate future incapacity, trusts also are included in Cell 3.

Case Example: Shortly after Mr. McD., 80, placed his bank accounts and his home in joint tenancy with one of his two sons, he suffered a massive infection from a ruptured gall bladder. Rushed into surgery, he spent 3 months in the hospital in a semiconscious state. Although he eventually recovered fully and resumed control of his property and assets, during his hospitalization his son was able to manage all of his financial affairs. Had he not recovered, however, upon his death the property would transfer to the joint tenant, suggesting that survivorship issues need to be considered in this type of arrangement.

Delegated decision making (Cell 3) relies on planning tools such as a durable power-of-attorney (DPA), a durable power-of-attorney for health care (DPAHC), and trusts to ensure that financial and health care preferences of the person will survive incapacity. Under DPA and DPAHC arrangements, the older adult selects a responsible party to make decisions in identified areas. Both the DPA and DPAHC are relatively easy documents to enact, yet they confer considerable authority to the agent. In part, because they convey authority to address complex decisional areas, DPA and DPAHC advance directives are believed to offer a viable means to divert adults from guardianship (Alexander, 1990). Authority is not absolute, however, as the agent may be challenged if family conflict or competing interests lead to problems. Because the presence of the DPAHC does not always relieve the medical service provider from the threat of legal action by a family embroiled in conflict, some nursing homes and hospitals may be unwilling to follow DPAHC directives, for fear of costly litigation (Kapp & Detzel, 1992; Moody, 1992). As with joint tenancy arrangements, advance directives lack oversight protection while conveying decisional authority to another.

Trusts are included in Cell 3 as well, because most are written with language that specifies continuation of the terms, under a designated fiduciary, after the grantor no longer has the cognitive capacity to make reasoned decisions. A trust allows the older adult to designate a trustee to manage assets and to stipulate the circumstances under which the trustee assumes control. The trust also describes the manner in which the assets are to be managed after the death or incapacity of the grantor. A major benefit of trusts is their versatility, in that they can be written to address almost any need or concern of the grantor or beneficiaries including complex investment and estate management issues. Disadvantages include the costs and complexity of arranging a trust including drawing up the document, which generally must be done by an attorney, and ongoing trustee's fees, typically 1–2% of the value of the assets per year for a corporate fiduciary. The benefits of using a corporate trustee (typically, bank trust departments or law firms) include regular methods of accountability and the use of a neutral party in situations where competing interests create conflict. A family member or friend can also be named as the trustee, thereby keeping ongoing fees to a minimum. In addition to durable powers-of-attorney and trusts, adults may also nominate a guardian prior to incapacity. Courts generally try to honor these preferences unless there is a compelling reason (e.g., exploitation, neglect) not to do so.

Case Example: Mr. B., 68, was rushed to the hospital after suffering a massive heart attack. Some months earlier he had executed a DPA and a DPAHC identifying the oldest of his three daughters as his agent. Because Mr. B. had previously notified his family and his physician about the advance directive and had addressed family members’ concerns about his wishes for a “do not resuscitate” order, his daughter was accepted by significant others and medical personnel as his legitimate decision maker. Although Mr. B. never recovered consciousness, his daughter managed his finances and participated in making decisions about his medical care during his hospitalization and the 6 months he spent in a skilled nursing facility prior to his death. Had Mr. B. been less explicit about his decisions, family or physician disagreement may have undermined the execution of his wishes.

Surrogate decision-making authority (Cell 4) is transferred formally from an adult to another by state statute (family consent laws), government stipulation (representative payee), or court order (guardianship). Currently 25 states have provisions for family consent laws, which determine the order in which family members may act as health care decision
makers (e.g., spouse, adult children, other relatives) (Sabatino, 1991). Although family consent laws have provisions that ensure that a responsible party is available in most instances, they do not address the suitability of family members or the preferences of the older person. A representative payee (rep payee) is a person or entity specifically designated by the Social Security Administration or other government agency to receive federal transfer payments, such as Social Security or Veterans Administration Pension payments. Rep payee services are authorized based on an assessment by a physician or other health care professional that the beneficiary is unable to manage finances because of a long-term or permanent dementing illness or mental disorder (Hortum, 1989).

Plenary guardianship is a legal process that grants the guardian authority to act in virtually all areas of the ward’s life (Schmidt, Miller, Bell, & New, 1981). Most often, a guardian is appointed after the observance of certain court procedures (i.e., petition, investigation, and hearing), if a person of authority, usually a physician, determines that an individual lacks capacity to make decisions and if a responsible party is available to serve as guardian (Kapp, 1990). To address both financial and personal risk, most states separate guardianship into decisional power of the person (e.g., living arrangements, physical well-being, and medical treatment) and the estate (e.g., managing property, assets, and income). A guardian can be appointed for one or both areas. The majority of states’ statutes also acknowledge that capacity is situation-specific through provisions for limited guardianship, which tailor surrogate decision-making authority to the individual needs of the ward by granting powers to the guardian only in areas specifically stipulated by the court (Kapp, 1992). Advantages of guardianship are that it serves as a vehicle to protect dependent adults and to conserve assets by transferring decisional control to a surrogate. The authority to grant custodial and economic control of an adult to a proxy represents a highly problematical solution, however, because it rescinds basic civil rights and autonomous decision making. Some of these disadvantages are mitigated by limited guardianships that protect dependent persons without excessive restrictions. Disadvantages of limited guardianship include resistance by some courts to tailor guardianship because of the potential time involved and the concern that the intervention will be insufficient.

Case Example: Mr. S., 71, a resident of a single room occupancy (SRO) hotel, received a modest Social Security benefit and Supplemental Security Income. When Mr. S. failed to pay his rent for the third month in a row, his building manager contacted a case manager at the local senior center for assistance. In talking with Mr. S., the case manager learned that he had been signing his checks over to “a friend.” He did not know the friend’s name or where he lived. A medical workup suggested that Mr. S. was physically healthy but suffered from moderate cognitive impairment as a result of a dementing illness. In addition to home-delivered meals and a shopping assistance program, the case manager arranged for a local volunteer pro-

gram to serve as a rep payee for Mr. S. After paying all the bills each month, the rep payee provided Mr. S. with the remaining money to spend as he wished. This arrangement worked well until Mr. S. was hospitalized with congestive heart failure resulting from a damaged heart valve. Although his condition required treatment decisions, Mr. S. appeared to lack capacity to make an informed medical decision or to execute a DPAHC. Using the state’s family consent law, his closest relative, a niece, agreed to make health-related decisions on his behalf. Had Mr. S. resided in a state without health care consent legislation, guardianship might have been necessary.

A Framework for Analyzing Alternatives to Guardianship

With the exception of the criterion of least restrictive appropriate alternative (Stiegel, 1992), the literature offers little guidance for determining the specific financial service or combination of services most suitable to the needs of a particular older person. Guidelines have been suggested, however, for determining the appropriateness of guardianship, including assessment of the older person’s capacity and potential risk (Heller, 1989; Nathanson, 1990). To assess the suitability of decisional interventions to address various executional and decisional needs and the potential for substitution between interventions, we incorporate capacity and risk standards into a framework that also includes the complexity of decisional issues and the availability and efficacy of informal assistance. The relationship of different decisional interventions to capacity, risk, and complexity is shown in Table 1. The following case example is used to illustrate how different characteristics of the person and his/her situation affect decisional interventions.

Case Example: Scenario No. 1. Mrs. F., 83, recently widowed, owned her own home and a small rental home. She had a savings account of approximately $35,000 and a modest stock portfolio. In addition to a small return on her investments, her income included rent from her second home and Social Security benefits. Although she was mentally and physically able to manage her finances, she had never done the bookkeeping and had no interest in learning how to review bank statements, balance her checkbook, and make investment decisions. After several weeks, she noticed that a large number of bills and checks had accumulated including several past due statements. Confronting piles of bills on the kitchen counter, she was unsure about how much she owed or what was entailed in maintaining her investments.

In assessing the appropriateness of financial and medical decision-making interventions for Mrs. F., her competence or decisional capacity is a critical factor.

Competence/Capacity

Competence, or the cognitive capacity to make decisions is both a legal term and a construct (AARP, 1992; Kapp, 1992). Legally, individuals are presumed competent unless a court of law has rendered a
formal judgment of incompetence. Conceptually, competence refers to clinical judgment about the extent to which an individual has a reasonable understanding of the nature and consequences of available choices and can reach a reasoned decision, regardless of the actual choice made (Kapp, 1990). As with competence, individuals are presumed to have capacity unless there is clear evidence to the contrary. Although there is considerable variation among state statutes as well as within the literature on the definition of competence and capacity, and they are often used interchangeably, we follow Kapp (1990) in using competence to refer to legal judgments and capacity to mean clinical assessments. Decisions about capacity made in a court of law generally are a prelude to a finding of incompetence and the appointment of a proxy decision maker. Such decisions rely, to a certain extent, on clinical judgments as to whether clients possess capacity; but judges, not clinicians, rule on whether the client is legally competent (Kapp, 1990).

In the legal sense, competence is viewed as a threshold concept — one either has it or does not. In a clinical sense, however, capacity may be intermittent, decision-specific (e.g., capacity to make informed medical decisions versus ability to conduct financial transactions), complete or limited (Buchanan & Brock, 1986). Because a clinical determination of the extent and consequences of mental impairment is inexact, Buchanan and Brock suggest that standards of capacity represent value choices rather than scientific ones. (A comprehensive discussion of the determinants of competence and capacity is beyond the scope of this article. For competing perspectives see Buchanan & Brock, 1986, and Culver & Gert, 1990.)

Despite its vagueness, assessing whether or not an individual has capacity to make decisions is an important consideration for determining which services are appropriate and which are not. As the first panel of Table 1 indicates, decision-making service options can be separated into those that assume capacity when they are transacted, those that initially assume capacity yet survive incapacity, and those granted based on incapacity. Substitution between services that differ on the presumption of capacity is problematical for two reasons. First, from a practical perspective, transactions by persons who lack capacity may be invalid. Second, there is an inherent contradiction in substituting a service that assumes decisional authority for one that is designed for persons who lack the capacity to make reasoned choices.

While the first column under capacity, "Required for execution," groups service arrangements according to whether or not the older person must have decisional capacity to establish the intervention, the second column identifies approaches that survive incapacity. For example, decisional capacity is required to execute trusts and durable powers-of-attorney, as well as arrangements for shared decision-making such as joint tenancy and joint accounts. Unlike supportive arrangements, however, these tools continue to be legally binding after the person loses capacity. (Trusts must contain specific language stipulating survival past incapacity of the grantor.) Therefore, when considering the capacity component of the framework, delegated approaches overlap with surrogate approaches, including legal guardianship, as a means to address the needs of persons who lack capacity.

Case Commentary: Because Mrs. F. has capacity, she may decide to use BPS from a daily money management (DMM) social service program if one is available in her community and she meets the income guidelines. While some DMM BPS accept clients with mod-
Assessing and Addressing Risk to the Older Person

Case Example: Scenario No. 2. Mrs. F. turned to her tenant for help. Prior to Mr. F.'s death, the tenant had provided assistance with home repairs, grocery shopping services, and gardening in exchange for rent reduction. Several months after Mr. F.'s death, the tenant began to take responsibility for paying Mrs. F.'s bills and doing her banking. Eventually, she assigned him POA and included him on her bank account as a joint tenant. According to a concerned neighbor, the tenant pressed her to negotiate a purchase agreement on her rental property that was considerably below its market value and even suggested that she deed the property to him based on "the considerable rent that he had paid."

Risk, presented in the middle panel of Table 1, is the second component used to delineate service appropriateness. Whereas decisional ability resides within the person, risk involves the degree of danger present in the contextual situation (Culver & Gert, 1990; Heller, 1989). Questions about risk address the extent to which the older person's behavior, in the context of environmental factors, threatens or supports his/her well-being. In the following discussion, we consider two related areas of competing values used to address risk: (a) decisional freedom versus protection; and (b) privacy versus oversight.

Assessing risk involves balancing the right to self-determination with the need for protection and requires providers to confront the dilemma of whether to protect a vulnerable incapacitated person from serious harm overides the older person's right to self-determination (Culver & Gert, 1990). Although a determination of incapacity should be the sine qua non of legal guardianship and other interventions that remove choice, decisional incapacity is a necessary but not sufficient determinant for appointment of a surrogate. The second is the extent to which risk threatens the well-being of an older person who lacks capacity.

Risk can be divided into threats to the person's health, personal safety, or financial well-being. For example, an aged person who lacks capacity to assess dangerous situations but who stays within a supportive housing environment is not likely to require intervention as long as the situation remains stable. Conversely, an older adult who lives independently, lacks capacity, refuses assistance, and endangers herself by wandering at night, walking in traffic, or neglecting important health and hygiene care is a candidate for intervention. In the area of financial risk, a person with marginal capacity to manage finances may not require formal financial management assistance if adequate family support and assistance is available. (Informal support, the fourth area of the framework, is discussed more extensively below.) Conversely, intervention is suggested when an older person lacks capacity and is at imminent risk of being defrauded.

In situations where risk is questionable, a "lesser of two evils" philosophy can be applied. This approach suggests that the severity of an intervention should be considered in light of the potential consequences if a less restrictive intervention or no intervention at all is pursued. A guiding principle when weighing which intervention to pursue for a person who lacks capacity is that the anticipated direct benefits of the intervention should outweigh the potential costs to the older adult. When the situation is ambiguous, concern for freedom overshadows safety. (For a comprehensive discussion of weighing the costs and benefits of competing interests see Rein, 1992.)

The degree of risk that various financial management and health-related decision-making interventions are geared to address is depicted as high, medium, and low in Table 1, middle panel, column 1 (personal risk) and Table 1, middle panel, column 2 (financial risk). When intervention is necessary, it is important to consider which interventions are most likely to reduce risk appropriately. For example, if protective placement is found to be necessary because the person is in imminent danger, does the intervention provide the designated decision maker with the authority to make a protective placement? If not, what other interventions would be more appropriate?

A corollary to the costs and benefits of intervention is the trade-off between privacy and oversight. (Oversight mechanisms of various interventions are depicted in Table 1, middle panel, column 3.) To some extent, older persons who delegate decisional authority to agents through trusts or DPAs do so to protect their financial and personal privacy. In exchange for privacy and the autonomy of selecting the surrogate, older people lose oversight and public accountability. Although the extent of fiduciary abuse by agents and trustees is unknown because of the difficulty of obtaining information on private arrangements, it appears to be a problem of some magnitude (Quinn, personal communication, August 5, 1993; Schmidt, in press; Stiegel, in press). Risk is high because of the private nature of the relationships and the lack of redress. Unless a corporate fiduciary is involved, legal action through the courts and bonding of the agent are the only methods of recourse for malfeasance by private agents. When corporate surrogates are used, institutional methods of oversight and accountability generally are adequate. In contrast to private arrangements,
surrogate decision-making mechanisms such as guardianship and rep payee services have public mechanisms to ensure accountability of the surrogate. It should be noted, however, that the effectiveness of oversight has been questioned in these programs as well (Associated Press, 1987; U.S. Congress, 1981).

Case Commentary: In Case Scenario No. 2, Mrs. F. has chosen to rely on a POA and joint tenancy, approaches that entail virtually no oversight. Although this appears to put her at risk for financial exploitation, she has the decisional capacity to make her own choices. Given Mrs. F.’s relationship with a third party, referral to a supportive financial management service such as BPS at this juncture is unlikely to result in a successful intervention unless Mrs. F. is seeking to change her financial management arrangements. Although BPS providers support and execute clients’ decisions and offer advice on financial matters, they have neither legal nor ethical authority to control clients or assume responsibility for their decisions. Nor do they have the authority to resolve complex financial problems such as competing interests between family members or competing claims by third parties. BPS providers have little authority to intervene in instances of potential financial exploitation or in situations where a person with capacity jeopardizes her own safety. Assuming that she maintained capacity and remained unwilling to change the arrangement with her tenant, there is little in the way of financial management remedies, short of advising her of potential problems and offering to be available if needed, that could be pursued.

Complexity
Case Example: Scenario No. 3. Two years after the death of her husband, Mrs. F. had a massive stroke which impaired both her cognitive and physical functioning. After a prolonged period of recovery, findings from a comprehensive assessment were that she had moderate to severe irreversible dementia. Clearly much of what happens after this depends on the steps she had taken to plan for incapacity. If she had not planned in any way and there were no appropriate family members available to assist her, her options would be limited. In addition, if her tenant had managed her affairs in his own interest instead of hers, her assets may have been diminished.

The question of which service is most appropriate prior to incapacity and after a person loses capacity is related to the extent to which the management of the estate involves complex financial and real estate transactions. Whereas capacity resides with the person and risk addresses the interaction with the environment, complexity refers to the ability of decisional intervention to manage a variety of resources and assets. For example, financial management needs may range from modest federal transfer payments used to maintain basic necessities to complex investments, real estate transactions, and estate management needs. Using a ranking of high, medium and low, the third panel of Table 1 identifies financial management services designed to handle complicated, moderately complex, or limited financial management or medical issues. For example, rep payee is ranked low because it allows a surrogate to collect federal transfer payments (Social Security, Veterans Pensions, etc.) and disburse funds, but confers no authority over other areas (i.e., checking accounts, other income, real estate, or investments). Similarly, joint tenancy allows flexibility to both tenants on the property concerned, which typically consist of bank accounts (less frequently real estate, depending on the type of joint tenancy), but is silent on any property not placed in joint tenancy. In contrast, advance directives such as DPA or trust accounts usually grant an agent authority to manage complex investments, while providing for current and future estate and money management.

With advances in medical technology and increasing institutional complexity, medical decision making adds an additional component to complexity. Concerns have been raised that guardianship is used inappropriately because the interests of third parties (i.e., hospitals, nursing homes, heirs, etc.) take priority over the interests of incapacitated patients. In response, legislation such as the Patient Self Determination Act has been passed in an effort to encourage the use of advance directives for health care decisions. The effectiveness of this legislation, however, has not yet been determined.

Case Commentary: Because Mrs. F. lacks capacity at this juncture, BPS, shared powers, or advance directives are inappropriate. Options that assume incapacity such as rep payee do not confer authority needed to manage her affairs in most areas. Family consent laws would cover her medical decision making but she would still need a surrogate to manage her finances. In this situation, few options appear to be available except for limited or plenary guardianship placement.

Availability of an Adequate Support System
Case Example: Scenario No. 4. If Mrs. F. had failed to plan by executing a trust or advance directive and if she retained property and financial assets, in addition to her Social Security income, it is unlikely that any combination of financial or health-related decision-making services initiated at this time could substitute for guardianship. The exception would be if she had had an adequate informal support system. For example, if the tenant had managed her affairs in her interests and if his authority included health care decision-making the current arrangement may be adequate.

The ability of family or close friends to provide informal decisional support for those with questionable capacity is often overlooked as a possible alternative to formal approaches. Research on guardianship and family caregiving has tended to ignore the informal financial assistance provided by friends and family. While formal interventions involve weighing the trade-offs of freedom versus safety to determine whether protective intervention is warranted, decisional power is not always a zero sum game. In the context of family decision making, Kapp (1991) suggests that conceptualizing safety and freedom as opposites is a mistake because it limits financial decision-making choices to an either/or situation. In
practice, decision making among older persons and their families or significant others may be enhanced when authority is shared (Jecker, 1990), or when those with marginal or fluctuating capacity are assisted informally by others. Close family members, in particular, may be able to guide their relative to a reasoned decision because they are likely to understand the historical context of decisions, the older person’s previous preferences, and how best to convey information. Assuming that the older person benefits from the arrangement, adequate informal support may eliminate the need for formalized surrogate interventions. The dilemma is ensuring that the interests of the individual are served by informal as well as the formal arrangements, as noted in the earlier discussion of privacy.

Informal family decision making may provide an effective method for some elderly persons, but it assumes certain ideal conditions, including geographic proximity to significant others willing and able to fulfill such roles, and the absence of competing interests, family conflicts, or uncomfortable relationships between those involved (Buchanan & Brock, 1986). Additional problems with “influenced” decision making include the possibility that third parties will serve their own interests rather than the interests of the older person, and the erosion of the elderly person’s autonomy and self-determination that is likely to occur over time. For some older adults, however, sharing or relinquishing significant areas of authority is the solution of choice. Research on decision making between caregiving dyads of mothers and daughters suggests that both favor child-directed decisions, partly due to the mothers’ surprisingly strong belief in the propriety of “paternalism” directed from child to parent (Cicirelli, 1992). Such findings, however, may be specific to the cohort of women who participated in the study. Research on decisional autonomy in health care among different cultures and cohorts (Wetle, 1991) suggests that attitudes are related to such characteristics as ethnicity and age/cohorts differences.

As the preceding discussion has attempted to show, the choice of which financial service or service mix is most appropriate is driven by characteristics of the older person (capacity), the situation (risk), and the mix of assets and income (complexity). In addition to examining each alternative separately, it is important to recognize that some interventions can be used in concert (e.g., DPAHC and rep payee) to balance the person’s desire for autonomy and self-determination, the family’s and community’s concerns about safety, and corporate/provider concerns about the need for an authorized decision maker.

Discussion

By delineating potential roles and areas of responsibilities for each type of service, the analytical framework illustrates how interactions between characteristics of the older person and the environment govern which service mix is appropriate and which is not. In addition, because only those services that share functions will provide viable substitutions, we suggest the following propositions:

- Financial services that demand capacity (BPS, POA) will not substitute for services designed for older persons who lack capacity (rep payee, limited or plenary guardianship).
- Financial services that survive incapacity (DPA, joint accounts, trusts) will not divert older persons from guardianship if the individual’s personal well-being is imminently threatened unless they contain provisions to address risk.
- Limited financial services targeted to older adults who lack capacity (rep payee) will not substitute for guardianship if the individual’s personal well-being is imminently threatened.
- Limited financial services targeted to older people who lack capacity (rep payee) will not substitute for guardianship if the individual’s financial asset mix exceeds the authority of the “substitute” to act.
- Financial services that survive incapacity (DPA, joint accounts) or those targeted to older adults who lack capacity (rep payee, DPA) will not substitute or divert older persons from guardianship if the individual’s financial well-being is threatened by the payee/agent.

The viability of alternatives also must be addressed in light of institutional requirements, such as the reluctance of many institutions to accept a POA to convey real estate without the security of a court appointment. Other instances include banks who are unwilling to accept POAs that are not on their own forms. This represents at most a minor delay for the mentally competent elderly person who is asking an agent or BPS provider to assist with supportive decision making, but it is unmanageable for an agent acting under a DPA for a client who has now become incapable of signing the bank’s papers.

Although the framework illustrates why BPS and other approaches that assume capacity are not viable substitutes for guardianship, it does not offer a rationale for why there has been widespread optimism about the viability of these less restrictive approaches to serve as alternatives. Experience suggests, however, that service providers look to guardianship as a default bill-paying service because they lack other available options. Confronted with the choice of a restrictive intervention or no intervention, providers and even friends and family often prefer to err on the side of safety by referring marginal older adults to guardianship. For example, in Los Angeles County, 80–90% of referrals are “non-handled” by the Office of the Public Guardian (OPG) because they are inappropriate. Steinberg (1985) found that a high percentage of inappropriate referrals were based on the need for money management. These observations lead to two final propositions:

- While supportive interventions do not substitute for appropriate guardianship, they can reduce the number of inappropriate referrals to the guardianship system and inappropriate use of guardianship as a bill-paying service.
Supportive interventions, initiated while the individual has capacity, may delay somewhat the need for guardianship for older adults with marginal capacity, particularly when family or providers are willing to err on the side of autonomy rather than safety.

The study of substitution of decisional interventions is still in its infancy. So far, the debate has focused primarily on alternatives to guardianship, in part, as a response to values of self-determination and autonomy. In addition, guardianship has been the standard policy response to incapacity and risk, in older adults and the developmentally disabled. It is instructive to remember that policy decisions tend to define options and create incentives for certain choices over others (Buchanan & Brock, 1986). Policies have developed that support the concept of guardianship and, consequently, research has developed to evaluate such policies. While this emphasis is natural, it overlooks the fact that the same policies de-emphasize the rest of the repertoire of financial and health-related decisional interventions.

The focus on less restrictive alternatives, while important, also diverts attention from other pressing problems that fall under the general area of financial services for older persons. In addition to testing the propositions proposed earlier, important areas of future research include assessing unmet needs for financial assistance and evaluating various strategies and programs for how those needs can be addressed, examining how financial service support affects quality of life, and clarifying the dimensions of financial exploitation and evaluating potential interventions.

Excessive reliance on initiatives to reduce guardianship diverts decision makers from considering appropriate types and levels of other financial management and health-related decision-making services. While we agree that guardianship should only be imposed in the highly circumscribed instances of incapacity, high risk, complexity, and lack of informal solutions, those who assume that guardianship is always the least desirable alternative, simply because it is the most restrictive, overlook the possibility that for some, it is the only viable option. Only in a broader context can guardianship and other service options be evaluated in terms of their ability to address the problems of functionally and cognitively dependent older adults.

References


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