

DOES “NO” MEAN “NO?”: AN ANALYSIS OF INDIANA’S GUIDELINES ON INFORMED CONSENT TO HEALTH CARE FOR INCAPACITATED ADULTS UNDER GUARDIANSHIP

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I. INTRODUCTION

A. Does “No” Mean “No?”

A.P. was a woman in her late twenties prescribed Invega Sustenna injections used to treat schizophrenia during her incarceration at the Marion County Jail.¹ In her relatively youthful state, A.P. didn’t fit the stereotypical “elderly” adult under guardianship. Rather, A.P. came under guardianship when the jail requested for a health care decision maker to be appointed on her behalf due to her complex mental status and healthcare needs.² The Center for At-Risk Elders (“CARE”) was appointed as legal guardian for A.P. in March of 2022 after the court determined that A.P. was mentally incapacitated and required a health care decision-maker despite her younger age.³ A.P.’s troubles at the detention center began shortly after CARE’s appointment.⁴

On June 16, 2022 the Marion Superior Court granted CARE’s request to voluntary transfer A.P. to Eskenazi Health’s Neuro Diagnostic Institute and Advanced Treatment Center for a mental health assessment.⁵ CARE sought transfer because the professionals were concerned that A.P.’s mental health was deteriorating during her incarceration and were uncertain if A.P. was receiving necessary medical care.⁶ Timely administrations of medication were paramount

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1. Complaint at 1, Ctr. for At-Risk Elders, Inc. v. Wellpath, LLC, No. 1:24-CV-983 (S.D. Ind. June 10, 2024), <https://static1.squarespace.com/static/5404c9f2e4b0a7034afd1a95/t/6668a7569d422d71fa1a79f3/1718134614742/1+-+Complaint.pdf> [https://perma.cc/3DES-DVRN] [hereinafter At-Risk Elders Complaint]. The complaint explains A.P. required medical treatments and received forced injections of Invega Sustenna, *id.* at 1, and A.P.’s prescription for Invega Sustenna and dosage is inferred from the complaint and conversations with her guardian.; Kristine Phillips & Tim Evans, *Marion County sheriff, contractor forced drug injections on mentally ill woman, suit says*, AOL (June 11, 2024), <https://www.aol.com/marion-county-sheriff-contractor-forced-184748240.html> [https://perma.cc/2F4S-M4H9] (identifying A.P.’s age and schizophrenia diagnosis); *Patient Website: Injections for Schizophrenia*, JOHNSON & JOHNSON, <https://www.injectionsforschizophrenia.com/> [https://perma.cc/5G73-CCKD] (last visited Mar. 8, 2026) (explaining the use of Invega Sustenna to treat schizophrenia).

2. *See* Petition for Appointment of Health Care Representative, *In re: The Guardianship of Adilah Patton*, No. 49D08-2111-GU-039784 (Marion Super. Ct. Nov. 30, 2021) (showing the Marion County Sheriff’s petition for the appointment of health care representative) [hereinafter Petition for Appointment of Health Care Representative].

3. At-Risk Elders Complaint, *supra* note 1, at 4.

4. *See id.*

5. *Id.* at 5.

6. *Id.* at 4.

in the management of A.P.'s symptoms from schizophrenia, and missing a dosage could have compounding effects on her mental health.⁷ However, the correctional facility was *not* authorized—by CARE, any court, or treating physician—to force these injections.⁸

The night before A.P. was going to be transferred to Eskenazi Health, Marion County Sheriff employees and/or agents and the facility's hired care provider, Wellpath, attempted to administer her Invega injection.⁹ When A.P. resisted, she was forcefully held down by a cell extraction response team while a nurse administered the injection against her will.¹⁰ CARE was never contacted, meaning no one had provided the necessary informed consent for A.P.'s injection.¹¹ The trauma didn't stop there. Making matters worse, it was not until the next day when A.P. arrived at Eskenazi that the medical team discovered that A.P.'s thumb had been painfully dislocated, likely while the agents held her down.¹² This wasn't the first time the injection had been forced by the detention center without consent from CARE.¹³ CARE later learned that two additional injections had been forced upon A.P. during her time at the detention center.¹⁴

A.P.'s case is just one example of the problems that arise from the complex intersection of Indiana's guardianship, criminal, and healthcare laws. A.P. desperately needed her injections, and the detention center was charged with providing her medical care—including said injections. However, Indiana's statutory framework fails to provide essential guidance for detention centers on providing proper care to adults under guardianship. Consequently, detention centers' policies and procedures neglect to advise staff on the appropriate measures to take when identifying and treating adults under permanent guardianship, particularly when it comes to obtaining informed consent to medical treatment. Additionally, although in this case the guardian, CARE, did

7. See *Invega Sustenna, Getting Started*, JOHNSON & JOHNSON, <https://www.invegasustenna.schizoaffective.com/getting-started/> [https://perma.cc/3P82-9U42] (last visited Mar. 2024). Invega Sustenna treats symptoms of schizophrenia rather than curing the condition. *Id.* Injections like Invega Sustenna are administered by health care professionals periodically and the medication is gradually released between the doses. *Id.* Missing an injection risks symptoms returning and disrupts the release of the medication in the body. *Id.*; *Understanding Schizophrenia, Living With Schizophrenia*, JOHNSON & JOHNSON, <https://www.injectionsfor.schizophrenia.com/> [https://perma.cc/MZX6-RYC8] (last visited Dec. 24, 2024). It is crucial for individuals undergoing treatment for schizophrenia to continue medication even when they are not experiencing symptoms. *Id.* Missed or untimely dosages can lead to relapses in symptoms and declines in physical and mental health. *Id.*

8. At-Risk Elders Complaint, *supra* note 1, at 6.

9. *Id.* at 5.

10. See *id.* The complaint explains that A.P. was held down by a cell extraction response team during administration of the injection of Invega Sustenna, *id.*, and an inference is drawn as to A.P.'s resistance leading to the forceful injection, *id.*

11. *Id.*

12. *Id.* at 5–6.

13. *Id.* at 4 (identifying an incident on May 16, 2022, in which the same nurse administered another injection against A.P.'s will and without CARE's consent).

14. *Id.* at 1.

not consent to the forced injections, another question arises from the ambiguity in Indiana’s treatment of adults under guardianship—just what can a court-appointed guardian consent to against the will of an incapacitated adult? For an adult under guardianship in Indiana, does “No” ever truly mean “No?”

B. The Size of the Issue

Adult guardianship in the United States remains somewhat of a mystery because there is currently no national database providing an estimate of the number of adults in the nation that are under guardianship due to an incapacitated status (also known as “protected persons”).¹⁵ Furthermore, state-specific requirements for guardianship databases vary, leaving aggregation of cases nearly impossible.¹⁶ As of 2017, the U.S. Senate Special Committee on Aging estimated that 1.3 million older adults and people with disabilities across the nation were under guardianship.¹⁷

The lack of guardianship data has been a growing concern across the nation, and many states are pushing for the adoption of a Guardianship Court Improvement Program (“GCIP”) providing funding and assistance for data collection.¹⁸ Guardianship standards as a whole have been analyzed as well.¹⁹ In 2021 alone, sixteen (16) states enacted thirty-seven (37) guardianship bills, and in the last decade, there have been nearly four hundred (400) similar bills.²⁰

In addition to the lack of macro-level data on the overall number of guardianship cases in the nation, there is a lack of micro-level data depicting the “who” and “why” of the guardianship cases.²¹ Specifically, there is a lack of data on the identity of the individuals under guardianship including their: age, race, sex, gender identity and expression, sexual orientation, ethnicity, immigration status, language(s) spoken, health issues, cognitive impairments, finances, housing, living conditions, and factors that led to their incapacitation status.²² Anecdotal evidence suggests that marginalized older adults, due to their

15. Kahli Zietlow et al., *Guardianship: Medicolegal review for clinicians*, 70 J. AM. GERIATRICS SOC’Y 3070, 3075 (2022) (“There is no centralized database capturing the number of guardians, individuals under guardianship, or data about the profession, experience, education, or other descriptions of existing guardians.”); see e.g., *Guardianship Oversight Task Force Final Report*, GUARDIANSHIP OVERSIGHT TASK FORCE 6 (2025), <https://www.in.gov/courts/iocs/files/guardianship-tf-report-2025.pdf> [<https://perma.cc/3LLZ-ZTRV>] (explaining “protected person” terminology).

16. Zietlow et al., *supra* note 15.

17. Casey, Braun Urge Examination of Guardianship Laws, U.S. SENATE SPECIAL COMM. ON AGING (May 31, 2023), <https://www.aging.senate.gov/press-releases/casey-braun-urge-examination-of-guardianship-laws> [<https://perma.cc/698J-D3J9>].

18. Elizabeth Moran, *2021 Guardianship Legislation: Highlights & Trends Effectuating Improved Processes & Outcomes in U.S. Guardianship Systems*, 43 BIFOCAL 102, 103 (2022).

19. *Id.* at 104.

20. *Id.*

21. Jim Berchtold, *Guardianship Data Reform*, JUSTICE IN AGING (Mar. 24, 2024), <https://justiceinaging.org/guardianship-data-reform/> [<https://perma.cc/5VFE-GF5X>].

22. *Id.*

increased risk of chronic disease, face an increased risk of being placed under guardianship.²³ This trend is in part due to health disadvantages caused by disparities related to race, ethnicity, gender, and socioeconomic status.²⁴ For example, Black adults make up a disproportionately high number of the individuals under CARE's guardianship as compared to Marion County census percentages of Black individuals.²⁵ This indicates that Black adults are at increased risk for placement under guardianship—at least in Marion County, Indiana.

Fortunately, Indiana is one of the few states that maintains a publicly accessible guardianship registry.²⁶ This online service is managed under the Adult Guardianship Office and provides: the name of the protected person; their appointed guardian; their birth year; the status of the guardianship case; the issuance of the guardianship letters; the county of issuance; and the guardianship cause number.²⁷ As an added benefit, the registry interfaces with Indiana's online case management system, Odyssey, thus courts and clerk staff only need to update the information once for both online databases to reflect changes.²⁸ However, even with the state-wide registry, guardianship statistics are not readily reported in Indiana as only eighty-seven (87) of Indiana's ninety-two (92) counties use the system as of 2025.²⁹ This information is not succinctly provided or analyzed outside of guardianship organizations. In their report published in 2026, Indiana's Guardianship Oversight Task Force recommended the state improve the registry by creating a guardianship data dashboard that would show the total number of guardianships in Indiana broken down by sex, age, and location among other guardianship data measures to provide up-to-date guardianship data to the public.³⁰ Nevertheless, Indiana state officials estimate that over 11,000 adults in the state are currently under permanent guardianship

23. *Id.*

24. *Id.*

25. See *QuickFacts Marion County, Indiana*, U.S. CENSUS BUREAU, <https://www.census.gov/quickfacts/fact/table/marioncountyindiana/PST045225> [https://perma.cc/7JLK-RSG2] (showing 30.3% of the population of Marion County as “Black alone”); *Cf.* CTR. FOR AT-RISK ELDER, NEW STUDENT PRESENTATION 4, available at <https://perma.cc/EL3H-94QN> (explaining that 37% of CARE's clients are Black) (last visited June 10, 2026).

26. See *Search Guardianship Registry*, ADULT GUARDIANSHIP OFF., <https://public.courts.in.gov/grp/> [https://perma.cc/CB4R-F2JL] (last visited Mar. 8, 2026).

27. *Adult Guardianship*, IN.GOV, <https://www.in.gov/courts/iocs/adult-guardianship/> [https://perma.cc/5XHF-5PQU] (last visited Mar. 8, 2026).

28. LaJuan Epperson, *INCite Project Overview Factsheet Guardianship Registry* (May 15, 2016), <https://www.in.gov/courts/iocs/files/ad-guard-registry-factsheet.pdf> [https://perma.cc/3BBQ-MX33]; See *Odyssey Case Management System*, IN.GOV, <https://www.in.gov/courts/admin/tech/odyssey/> [https://perma.cc/SXJ8-Z7XB] (last visited Jan. 31, 2025). Odyssey Case Management System (Odyssey) is an online, integrated case and financial management system utilized in Indiana to maintain court records, see *id.* Odyssey centralizes data across the state and provides information to entities including law enforcement agencies (including probation officers), state policy makers, and state and federal agencies, see *id.*

29. See OVERSIGHT TASK FORCE, *supra* note 15, at 28.

30. See *id.* at 31–32.

as of 2021.³¹ However, this estimate does not address the number of these protected persons who are also incarcerated. As exemplified by A.P.’s case, the presence of incapacitated individuals in correctional facilities creates difficult ethical and technical questions for informed consent to healthcare in Indiana for adults under guardianship.

Evidence supports the inference that the current dilemmas concerning adults who are both under guardianship and incarcerated will increase soon. Since 1970, the United States prison population has increased by 700%.³² An increasing rate of this population is either elderly and/or mentally ill.³³ This shift has been partly attributed to the increasing number of life sentences which has created an aging population in prisons.³⁴ Consequently, it is estimated that by 2030, more than one-third of the prison population will be adults over 55.³⁵

Furthermore, the incarcerated population disproportionately suffers from mental illness, disease, addiction, and other health conditions.³⁶ These health issues and mental health complications may be further compounded by the effects of confinement which can exacerbate pre-existing conditions.³⁷ While not every mentally ill or elderly person will be placed under guardianship, there is an overlap between mentally ill and/or elderly status and court-appointed guardianship.³⁸ Thus, as the number of incarcerated mentally ill and/or elderly people increases, the number incarcerated adults under court-appointed guardianship will likely increase as well.

Although guardianship, healthcare in correctional facilities, and informed consent have been considered as topics separately in publications, so far, the Indiana specific legislation at the intersection of these topics has yet to be formally analyzed. However, the state’s attention to the issue of constitutional and individual liberties in correctional facilities has been growing.

31. Carter Barrett, *Conservatorship system is slow to change, despite availability of less restrictive options*, WFYI INDIANAPOLIS (Nov. 22, 2021), <https://www.wfyi.org/news/articles/conservatorship-system-slow-change-despite-availability-less-restrictive-options> [https://perma.cc/5URS-S84Z].

32. Megan Cox, *U.S. Prison System: Pseudoscience in an Empirical World*, 16 LOGOS 9, 10 (2023), https://www.missouristate.edu/LOGOS/_Files/LOGOSVolume16WebVersionUPDATED.pdf#page=15 [https://perma.cc/WE5Q-FMWJ].

33. See Sarah Batbold et al., *Decision-Making for Hospitalized Incarcerated Patients Lacking Decisional Capacity*, 184 JAMA INTERNAL MED. 28 (Dec 2023) (discussing the rapidly aging prison population and increased prevalence of health conditions including mental health disorders).

34. See Meg Anderson, *The U.S. prison population is rapidly graying. Prisons aren’t built for what’s coming*, NPR (Mar. 11, 2024, 5:12 AM ET), <https://www.npr.org/2024/03/11/1234655082/prison-elderly-aging-geriatric-population-care> [https://perma.cc/54P5-RG6Y].

35. Batbold et al., *supra* note 33.

36. Joe Russo, *Caring for Those in Custody*, NAT’L INST. OF JUST. (Aug. 1, 2019), <https://nij.ojp.gov/topics/articles/caring-those-custody> [https://perma.cc/9DGY-4SVH].

37. *Id.*

38. See Berchtold, *supra* note 21.

C. Setting the Stage

This Note argues that Indiana's current statutory framework of both procedures for obtaining consent to healthcare for incarcerated adults under guardianship as well as regulation of guardians' authority to consent to healthcare on behalf of protected persons are insufficient to protect the autonomy of the individuals and to guide correctional facilities. Part II broadly explains the concept of informed consent to healthcare, provides an overview of Indiana's statutory scheme for adult guardianship, and introduces correctional facilities as healthcare providers. Part III provides an analysis of the statutory authority of guardians in Indiana to consent to healthcare on behalf of protected persons and the relevant procedures in place in the state's correctional facilities. This section then analyzes options for procedures correctional facilities may implement in obtaining informed consent to healthcare for adults under guardianship. This analysis ends with a comparison of states' limitations placed on guardians' authority to consent to healthcare on behalf of protected persons without court approval. Finally, Part IV concludes with a practical revision to Indiana law that will protect autonomy of adults under guardianship and support correctional facilities in providing healthcare to these individuals.

II. BACKGROUND INFORMATION

A. Informed Consent to Healthcare in Indiana

Informed consent as it is understood in the United States today began as a common law doctrine most notably established in the case of *Schloendorff v. Society of New York Hospital*.³⁹ In *Schloendorff*, a woman suffering from a stomach disorder consented to a non-surgical examination under anesthesia of a lump—which turned out to be a tumor—found by the physicians at the Society of New York Hospital.⁴⁰ The woman notified the physician attending to her case that she did not consent to any operation during the examination, however the lump was removed while she was unconscious during the examination.⁴¹ The court recognized that the physician's actions in this case went beyond mere negligence and that a *trespass* or *assault* had been committed against the woman in rendering treatment without consent.⁴²

The specific terminology of “informed consent” was first recognized in 1957 in *Salgo v. Leland Stanford Jr. University Board of Trustees*.⁴³ In this case,

39. Kim Dayton, *Standards for Health Care Decision-Making: Legal and Practical Considerations*, 2012 UTAH L. REV. 1329, 1331 (2012).

40. *Schloendorff v. Soc'y. of New York Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) (abrogated on other grounds by *Bing v. Thunig*, 143 N.E.2d 3 (N.Y. 1957)).

41. *Id.*

42. *Id.* (emphasis added).

43. Dayton, *supra* note 39, at 1332; see *Salgo v. Leland Stanford Jr. Univ. Bd. of Trs.*, 317 P.2d 170, 181 (Cal. App. 1st Dist. 1957).

Salgo was paralyzed during an aortography when his physician injected him with sodium urokon.⁴⁴ Salgo alleged that his physicians failed to inform him of the nature of his procedure thus failing to provide him the facts necessary for an informed consent to the procedure.⁴⁵ The court held that physicians have a duty to disclose any facts necessary for the patient to reach an “informed consent.”⁴⁶ Such facts include alternative courses of action and the risks attendant to procedures.⁴⁷ However, the necessary disclosures are subject to physician discretion as to when disclosure of facts will have a detrimental effect on the patient’s mental wellbeing.⁴⁸ A physician may not disclose facts if they determine the effect would have an adverse effect on the patient.⁴⁹ Following *Salgo*, the doctrine of informed consent has become cemented in American tort law and remains a frequent topic of scholarly attention.⁵⁰

Indiana case law has applied a similar doctrine of informed consent. In Indiana, informed consent to medical care is defined as “consent voluntarily given by an individual after a sufficient explanation and disclosure of the subject matter involved to enable that individual to have a general understanding of the treatment or procedure and the medically acceptable alternatives, including the substantial risks and hazards inherent in the proposed treatment or procedure, and to make a knowing health care decision without coercion or undue influence.”⁵¹ Under Indiana’s standards of informed consent, the physician has the duty of disclosing information material to the proposed course of treatment to their patients.⁵²

In determining physician obligations for informed consent, Indiana follows the reasonably prudent physician standard requiring that the physician act as a reasonably prudent physician would “in taking a history, performing a physical examination, ordering appropriate tests, reaching a diagnosis, prescribing a course of treatment, and in discussing with the patient the medical facts of the proposed procedure, including the risks inherent in either accepting or rejecting the proposed course of treatment.”⁵³ Indiana statute codified these sentiments requiring explicitly that the information disclosed to the patient for purposes of obtaining informed consent include: (1) the general nature of the patient’s condition; (2) the proposed treatment, procedure, examination, or test; (3) the expected outcome of the treatment, procedure, examination, or test; (4) the

44. *See Salgo*, 317 P.2d at 173–75.

45. *See id.* at 181.

46. *Id.*

47. *Id.*

48. *Id.*

49. *Id.*

50. *Cruzan by Cruzan v. Dir., Missouri Dept. of Health*, 497 U.S. 261, 269 (1990) (“The informed consent doctrine has become firmly entrenched in American tort law.”); *see generally* Derek Kroft, *Informed Consent: A Comparative Analysis*, 6 J. INTL. L. & PRAC. 457 (1997); *see also* Dayton, *supra* note 39.

51. IND. CODE § 16-36-7-16 (2025).

52. *Perez v. Hu*, 87 N.E.3d 1130, 1134–35 (Ind. Ct. App. 2017).

53. *Id.* at 1135.

material risks of the treatment, procedure, examination, or test; and (5) the reasonable alternatives to the treatment, procedure, examination, or test.⁵⁴ Furthermore, informed consent is presumed (but rebuttable) when there is a written consent which is: (1) signed by the patient or the patient's authorized representative; (2) witnessed by an individual at least eighteen years of age; and (3) explained, orally or in the written consent, to the patient or the patient's authorized representative before a treatment, procedure, examination, or test is undertaken.⁵⁵

Any treatment performed without informed consent can be pursued as either a battery claim, if there has been a complete lack of consent, or as a specific form of negligence for a breach of the standard required of professional conduct.⁵⁶ For instance, CARE is pursuing a claim of battery against Wellpath, the Marion County Sheriff, and the nurse who administered the forced injections on A.P.⁵⁷ Notably, still missing from the Indiana landscape of informed consent are the specific obligations placed on physicians in obtaining informed consent from incarcerated protected persons.

B. Adult Guardianship in Indiana

A court-appointed guardian is a person who is a fiduciary and is appointed by a court to be a guardian or conservator responsible for the person or the property of an incapacitated person.⁵⁸ In Indiana, a "guardian" and a "conservator" are interchangeable, although this is not the case in every state.⁵⁹ To be deemed "incapacitated," it must be determined that a person is unable to comprehend and weigh relevant information and to make and communicate a reasoned health care decision.⁶⁰

The court must be petitioned for a guardian to be appointed to an incapacitated person.⁶¹ Such petition may be filed by any person and must state, among other factors, the nature of the incapacity, the particular limitations requested, the reasons the order is sought for, a description of the petitioner's efforts to use less restrictive alternatives, and the reason a less restrictive alternative is insufficient to meet the needs of the alleged incapacitated person.⁶² If the court determines it is in the best interests of the person to appoint a guardian, the court will issue the guardian letters of guardianship permitting

54. IND. CODE § 34-18-12-3 (2025).

55. IND. CODE § 34-18-12-2 (2025).

56. Perez, 87 N.E.3d at 1135.

57. At-Risk Elders Complaint, *supra* note 1, at 10. Notably, CARE also alleged a violation of A.P.'s 14th Amendment Due Process right to informed consent. *Id.* at 7–8.

58. IND. CODE § 29-3-1-6 (2025).

59. *Id.*

60. IND. CODE § 16-36-7-15 (2025).

61. IND. CODE § 29-3-5-2 (2025).

62. IND. CODE § 29-3-5-1 (2025).

them to act on behalf of the legally incapacitated person.⁶³ Notably, the court may remove a guardian upon a similar petition by the protected person or someone authorized to petition on their behalf, typically coupled with medical records to support the termination of the incapacitated status.⁶⁴

In selecting the individual or entity to be appointed as guardian for an incapacitated person, the court follows an ordered list of individuals provided by statute.⁶⁵ The order of these individuals and entities is as follows: (1) any person who is designated in a durable power of attorney; (2) a person who has been designated as a standby guardian; (3) the spouse of the incapacitated person; (4) an adult child of the incapacitated person; (5) the parent of an incapacitated person or a person nominated in the will of a deceased parent of the incapacitated person provided the will complies with wills formalities; (6) any person related to the incapacitated person by blood or by marriage whom the incapacitated person has resided with for more than six months before the filing of the petition; and (7) any person nominated by the incapacitated person who is caring for or paying for the care of the incapacitated person.⁶⁶ The court may pass over a person of a higher priority and appoint a person of lower priority if it determines this is in the best interest of the incapacitated person.⁶⁷

As the statute suggests, family members and friends are given priority for guardian status. However, the court may appoint private or public guardians if it is in the best interest of the incapacitated person.⁶⁸ Private guardians are paid professionals who receive fees out of the assets of the incapacitated person or through state funding.⁶⁹ These entities include individuals, non-profit, and for-profit agencies.⁷⁰ Public guardians are considered “guardians of last resort” and are often provided through a state or local public guardianship program.⁷¹ Indiana is one of the few states that do not currently have a state-supported public guardianship service.⁷² Rather, Indiana’s Adult Guardianship Office provides funding for Volunteer Advocates for Seniors and Incapacitated Adults (VASIA) programs across the state.⁷³ While private or public guardians are often appointed when an incapacitated person lacks other individuals to serve as their guardian, these entities may be appointed when the incapacitated

63. IND. CODE § 29-3-7-3 (2025).

64. IND. CODE § 29-3-12-1(c) (2025).

65. IND. CODE § 29-3-5-5 (2025).

66. *Id.*

67. *Id.*

68. *Guardianship Overview*, U.S. DEP’T OF JUST. (last updated Sep. 30, 2024), <https://www.justice.gov/elderjustice/guardianship-overview> [<https://perma.cc/P2UQ-97LU>].

69. *Id.*

70. *Id.*

71. *Id.*

72. *Guardianship*, VASIA, <https://indianavasias.org/guardianship> [<https://perma.cc/MV4V-H7MW>] (last visited Feb. 1, 2025).

73. *See Adult Guardianship*, IND. JUD. BRANCH, <https://www.in.gov/courts/iocs/adult-guardianship/> [<https://perma.cc/6YK2-NTDM>] (last visited Feb. 1, 2025).

person's relatives or friends are unable or unwilling to serve.⁷⁴ CARE, as a non-profit organization, serves as a private guardian for its constituents.⁷⁵ Many of these individuals are without family to step in as guardians, but others have involved family members who simply cannot take on the challenges and obligations associated with being a court-appointed guardian.

In Indiana, the legal authority for guardians to make decisions for incapacitated adults derives solely from state law.⁷⁶ The powers appointed to a guardian of an incapacitated adult include the power to consent to medical or other professional care.⁷⁷ However, the court may limit the scope of the guardianship to encourage the development of the incapacitated person's self-improvement, self-reliance, and independence.⁷⁸ This means that a guardian may not have control over a protected person's healthcare despite being their court-appointed guardian in financial situations. Specifically, Indiana differentiates between the guardian of the person, guardian of the estate, and guardian of both the person and estate.⁷⁹ A guardian of the person oversees living conditions and treatment, while a guardian of the estate oversees investment and financial affairs.⁸⁰ Furthermore, the guardian is charged with the responsibility of encouraging self-reliance and independence of the protected person as well as considering options relating to the appropriate standard of support, care, education, and training for the protected person.⁸¹ While this therapeutic model is a step in the right direction, it still leaves many intimate healthcare decisions for the protected person largely up to the discretion of the guardian.

C. Correctional Facilities as Healthcare Providers

The right to medical treatment for incarcerated individuals stems from the Supreme Court's decision in *Estelle v. Gamble* in 1976.⁸² In this decision, the Court held that prisoners have a right to adequate medical treatment during incarceration under the Eighth Amendment's protections against cruel and

74. U.S. DEP'T OF JUST., *supra* note 68.

75. See Who We Are, CTR. FOR AT-RISK ELDERS, <https://www.indianacare.org/who-we-are> [https://perma.cc/WRX4-GTX5] (last visited Mar. 9, 2026).

76. Dayton, *supra* note 39.

77. IND. CODE § 29-3-8-2 (2025).

78. IND. CODE § 29-3-5-3 (2025).

79. *Guardianship & Alternatives to Guardianship, What Is Limited Guardianship*, ARC OF IND., <https://www.arcind.org/future-planning/guardianship/> [https://perma.cc/23NZ-MUX8] (last visited June 6, 2026); see also GUARDIANSHIP OVERSIGHT TASK FORCE, *supra* note 15, at 41.

80. ARC OF IND., *supra* note 79.

81. IND. CODE § 29-3-8-3 (2025).

82. See *Estelle v. Gamble*, 429 U.S. 97 (1976); see also *Prisoners' Rights: Medical and Mental Health*, ACLU, <https://www.aclu.org/issues/prisoners-rights/medical-and-mental-health-care> [https://perma.cc/Z3F7-VLXF] (last visited June 6, 2026).

unusual punishment.⁸³ To succeed in a claim against a prison, the prisoner must show sufficiently harmful acts or omissions amounting to a deliberate indifference to serious medical needs that offends the “evolving standards of decency” as a violation of the Eighth Amendment.⁸⁴ When there is a deliberate indifference to the medical needs of an incarcerated individual, regardless of how evidenced, the incarcerated individual has a cause of action under 42 USCS §1983.⁸⁵ To make a successful claim of deliberate indifference, the prisoner must show that the maltreatment was sufficiently harmful and a “culpable state of mind on the part of prison officials.”⁸⁶

Conversely, the Supreme Court has held that the Fourteenth Amendment Due Process Clause creates a constitutional right to refuse medical care as well.⁸⁷ However, for incarcerated individuals, this right has been limited in certain instances where the Court has found under a “standard of reasonableness” that the state has a legitimate interest in prison safety and security and the state’s forced medication policy is a rational means of advancing these interests.⁸⁸ This line of reasoning has been applied in a number of cases, including issues such as forced psychotropic treatments.⁸⁹ The practical implications of this standard mean that prisoners’ rights to refuse medical treatment may be overridden by the interests of security and orderly operation of correctional institutions.⁹⁰

Importantly, the ability of prisoners to assert their rights is limited—or at least procedurally delayed—by the implications of the Prison Litigation Reform Act of 1996 (“PLRA”).⁹¹ The PLRA imposes the requirement on prisoners to “exhaust” all administrative remedies prior to filing a lawsuit.⁹² As such, the prisoner must first pursue all available administrative appeals before taking their grievance to court.⁹³ If the administrative remedies have not been exhausted prior to the filing of a lawsuit, the correctional facility may raise the failure to exhaust, and courts may dismiss the case without prejudice such that the lawsuit may only be filed again once the prisoner has exhausted the administrative

83. *Estelle*, 429 U.S. 97 at 116 (explaining that deliberate indifference to serious medical needs of prisoners constitutes the unnecessary and wanton infliction of pain).

84. *Id.* at 106.

85. *Id.* at 105.

86. Benjamin N. Parks, *Eighth and Fourteenth Amendment Concerns with the BoP Guidelines for Advance Directives*, 6 VOICES IN BIOETHICS 1, 1 (2020), <https://journals-test.library.columbia.edu/index.php/bioethics/article/view/5906> [<https://perma.cc/JH4U-WLAT>].

87. *Amdt14.S1.6.5.1 Right to Refuse Medical Treatment and Substantive Due Process*, CONST. ANNOTATED, https://constitution.congress.gov/browse/essay/amdt14-S1-6-5-1/ALDE_00000903/#ALDF_00019224 [<https://perma.cc/P45W-GV9B>] (last visited Mar. 9, 2026).

88. *Id.*

89. *Id.*

90. Parks, *supra* note 86.

91. 42 U.S.C.S. § 1997e; 28 U.S.C.S. § 1915; 18 U.S.C.S. § 3626.

92. 42 U.S.C.S. § 1997e; *The Prison Litigation Reform Act (PLRA)*, ACLU, https://www.aclu.org/sites/default/files/images/asset_upload_file79_25805.pdf [<https://perma.cc/TU2S-QUNQ>] (last updated Nov. 2002).

93. ACLU, *supra* note 92.

remedies, assuming the statute of limitations has not run.⁹⁴ The statute of limitations continues to run while the prisoner exhausts the administrative remedies.⁹⁵ While the PLRA was intended to discourage frivolous suits, it further complicates the remedies available for individuals under guardianship in incarceration and forces guardians to be even more proactive in their involvement with incarcerated incapacitated persons.⁹⁶

In Indiana, the right to healthcare in prison is codified at the state level.⁹⁷ Under Indiana law, a confined person is entitled to medical care, emergency treatment, and mental health care.⁹⁸ However, this care does not entitle inmates to substance abuse treatment or programming in the state.⁹⁹ Notably, the state's regulation of correctional facilities has not explicitly addressed considerations for incarcerated protected persons.

III. ANALYSIS

A. Indiana's Current Framework

1. Guardian's Responsibility in Providing Consent to Healthcare for a Protected Person

Indiana has codified its position on informed consent to healthcare for incapacitated individuals in its Health Care Consent Act.¹⁰⁰ Under the Health Care Consent Act, when a person's mental state raises concern as to whether they are able to manifest informed consent, a health care provider or any interested person may petition the probate court to make a health care decision, order health care for an individual incapable of consenting, or appoint a representative to act on behalf of the individual.¹⁰¹ Court action on behalf of an incapacitated person is established if the court finds: (1) a health care decision is required; (2) the individual is incapable of consenting; and (3) there is no authorized person readily available, willing to act, or already acting in the individual's best interest.¹⁰² Once the need is established, the court may order that health care be provided, appoint a representative to make health care decisions with or without limitations, or provide other appropriate remedies as

94. *Id.*

95. *Id.*

96. See Daniel Greenfield, Easha Anand, & Emily Clark, *How The Prison Litigation Reform Act Has Failed For 25 Years*, THE APPEAL (Apr. 26, 2021) <https://theappeal.org/the-lab/explainers/how-the-prison-litigation-reform-act-has-failed-for-25-years/> [https://perma.cc/DBY7-86HS].

97. See IND. CODE § 11-10-3-2 (2025).

98. *Id.*

99. Cohn v. Strawhorn, 721 N.E.2d 342, 349 (Ind. Ct. App. 1999).

100. IND. CODE § 16-36-1 et seq. (2025).

101. IND. CODE § 16-36-1-8 (2025).

102. *Id.*

it sees fit.¹⁰³ If a guardian has been appointed, informed consent of the guardian—rather than the protected person—is required to provide mental health treatment for patients who are deemed mentally incapacitated.¹⁰⁴ For instance, in A.P.’s case, the correctional facility served as the interested party who initiated the appointment of A.P.’s court-ordered guardian.¹⁰⁵

Indiana’s statutory framework broadly grants the guardian authority to consent to the “medical or other professional care and treatment for the [protected person’s] health and welfare.”¹⁰⁶ Notably, this statute simultaneously addresses guardians of minors and adults.¹⁰⁷ This authority is qualified first by a duty of the guardian to act in “good faith and in the best interest” of the protected person.¹⁰⁸ Furthermore, valid advance directives take precedence over a guardian’s decision.¹⁰⁹

Though guardians in Indiana are given significant latitude in healthcare decisions on behalf of a protected person, they must petition the court to change the protected person’s residence.¹¹⁰ As such, guardians need court approval to admit protected persons to a mental health facility or residential care facility, for example. Indiana otherwise allows the guardian to consent to quite controversial healthcare decisions so long as the guardian demonstrates good faith and consideration of the protected person’s best interests.¹¹¹ For instance, in one case, the Court of Appeals affirmed that the guardian may consent to tubal ligation on a protected person so long as the guardian exercises good faith and acts in the best interest of the individual.¹¹² Furthermore, Indiana does not explicitly restrict guardians’ ability to consent to involuntary medical treatment on behalf of the protected person. Guardians’ decisions remain subject to judicial scrutiny, however, as interested individuals may petition the court to terminate or limit the guardianship if the guardian has acted against the protected person’s best interests.¹¹³

What these standards mean for individuals under guardianship in Indiana is that there are very few limits on what their appointed guardian can consent to on their behalf. In cases in which the guardian meets the protected person only after they have been deemed incapacitated, determining the person’s prior

103. *Id.*

104. IND. CODE § 16-36-1.5-5 (2025).

105. *See* Petition for Appointment of Health Care Representative, *supra* note 2.

106. IND. CODE § 29-3-8-2 (2025).

107. *Id.* at (b) (explaining that the powers enumerated for the guardian of a minor are granted to guardians of incapacitated persons).

108. IND. CODE § 16-36-1-5(d) (2025).

109. IND. CODE § 16-36-7-42 (2025).

110. IND. CODE § 29-3-9-2 (2025).

111. *See, e.g.,* V.S.D. v. Williams-Huston (In re Guardianship of V.S.D.), 660 N.E.2d 1064, 1067 (Ind. Ct. App. 1996).

112. *See id.*

113. *See* IND. CODE § 29-3-12-4 (2025) (allowing interested parties to petition for removal as under outlined IND. CODE § 29-1-10-6 (2025) which permits removal where the guardian has failed to perform any duty imposed by law).

desires and personal values can be a difficult task. While Indiana law requires the guardian to become acquainted with the protected person if they did not know the individual personally, this process can be complicated.¹¹⁴ Additionally, many court-appointed guardians in the state of Indiana represent a multitude of incapacitated persons with whom they share no personal relationship. As such, individuals under guardianship in Indiana may be appointed a guardian who lacks knowledge of their wishes concerning their healthcare, despite the guardian's best attempts and intentions. Although guardians are still required to become acquainted with the person and to act in the best interest of the person regardless of their knowledge of the individual, this remains a gray area and a difficult task for guardians. With minimal, broad limitations on the scope of the ability of guardians to consent to care for protected persons, the true autonomy of these individuals is questionable.

These vague policies have created an uncertain task for guardians who intend to protect the individuals they serve. While the broad ability of the guardian to consent may provide for simpler, quicker access to care, it may also lead to extraordinary measures taken by the guardian who does not want to restrict their protected person's liberty to such an extent without a court order—or at least a second opinion. Some guardians may petition the court for approval before consenting to major health care decisions even when not legally obligated to do so rather than make extreme choices unilaterally.

2. Correctional Facilities' Responsibility to Adults Under Guardianship

Issues of informed consent for healthcare and autonomy of individuals under guardianship are only compounded for protected persons who are incarcerated in the state of Indiana. Currently, the Indiana Department of Corrections follows a Policy and Administrative Procedure Manual for Health Services ("Manual") which governs practices on healthcare of incarcerated individuals.¹¹⁵ The Manual outlines care for the physical and mental health of inmates providing incarcerated individuals access to treatment for "serious medical conditions."¹¹⁶ However, the Manual does not explicitly include a requirement of informed consent and does not contemplate obtaining consent from of incapacitated persons under guardianship.¹¹⁷ In fact, the Manual does not reference incapacitated persons under guardianship at all.¹¹⁸ Despite Indiana's codified status on health care during incarceration, the requirement of informed consent, and guidelines for obtaining consent from a guardian, there are no clear procedures for correctional facilities to follow when they provide

114. See IND. CODE § 29-3-8-1 (2025).

115. IND. DEP'T OF CORR., POL'Y & ADMIN. PROC. MANUAL OF POL'YS & PROCS., 01-02-101 (Apr. 1, 2022), <https://www.in.gov/idoc/files/01-02-101-Health-Services-4-1-2022.pdf> [<https://perma.cc/ALL2-J7QG>].

116. *Id.*

117. *Id.*

118. *Id.*

healthcare to protected persons. This leads not only to injustices against protected persons at the correctional facilities, but also to confusion among correctional facility staff who lack the regulatory guidance needed to act lawfully.

Furthermore, the Manual refers incarcerated individuals to another publication, “The Offender Grievance Process,” for information on the grievance process for claims of inadequate healthcare.¹¹⁹ Considering the implications of the PLRA on administrative remedies, this second procedure manual provides insight as to the process inmates must follow prior to pursuing any court remedies. Under the grievance policy, an offender must submit the grievance form within ten (10) business days of the incident giving rise to the complaint.¹²⁰ This form requires that the offender sign, date, and submit the grievance on their own behalf and specifies that another offender or staff member may write the grievance on behalf of the offender if they are unable to do so due to a “physical impairment, language impairment, or other obstacle.”¹²¹ While the policy does, therefore, contemplate the need for a surrogate for the inmate in some applications, it does not explicitly reference the abilities of the guardian of the individual.¹²² Rather, this grievance process places the burden of diligence upon the inmate without considering the complexities faced by incapacitated individuals at the facility.¹²³ For guardians, like CARE, who have a large caseload of protected persons they are serving, this ten-day window may be easily missed when the guardian sees each person maybe once per month. Problematically, much of the reporting duty in such instances is left to the protected person who lacks sufficient capacity to advocate on their own behalf when it comes to informed consent and/or financial instances. This further illustrates the state’s lack of consideration of protected persons within the criminal justice system.

B. Optional Approaches for Correctional Facilities in Obtaining Informed Consent to Healthcare from Guardians of Protected Persons

An analysis of state legislatures concerning healthcare for incarcerated individuals under guardianship shows that while many states have acknowledged the issue of the lack of procedures, no state seems to have found an adequate policy solution.¹²⁴ Although states such as Utah have started reforming policies concerning the responsibility of correctional facilities in

119. *Id.*

120. IND. DEP’T OF CORR., POL’Y & ADMIN. PROC. MANUAL OF POL’YS & PROCS., 00-02-301 (Apr. 1, 2022), <https://www.in.gov/doc/files/policy-and-procedure/policies/00-02-301-Offender-Grievance-Process-9-1-2020.pdf> [<https://perma.cc/29UF-HRTL>].

121. *Id.*

122. *Id.*

123. *Id.*

124. See generally M. Scott Smith et al., *Healthcare Decision-Making for Mentally Incapacitated Incarcerated Individuals*, 22 ELDER L.J. 175 (2014).

finding an appropriate decision-making surrogate for incarcerated individuals who may be unable to make their own informed decisions, the issue of how to interact with the existing guardian remains largely unaddressed.¹²⁵

One proposed method of reform that some states have considered implementing includes the use of written advance directives as a tool to determine the correctional facility's course of action and the desired guardian to be appointed for prisoners who may become incapacitated.¹²⁶ Ideally, creating these directives reduces the need for others to make healthcare decisions on behalf of prisoners who have become critically ill.¹²⁷ In such cases, the prisoner can determine their healthcare preferences and identify a potential surrogate decision-maker before becoming incapacitated.¹²⁸ However, complications with implementing such a procedure include a lack of inmate trust and cooperation necessary to create such objectives, insufficient prison resources, complications with prisoners who already lack decision-making capacity, and the complexities of having such an advance directive in instances where a public guardian becomes necessary.¹²⁹

Analyzing what notice correctional facilities should provide to the guardians of incarcerated individuals, one article examines the parallel notification procedures used for juveniles.¹³⁰ The authors note that guardians of juveniles are notified at certain stages of the juvenile proceedings in Texas.¹³¹ Specifically, any person "taking a child into custody [must] promptly give notice of the person's action and a statement of the reason for taking the child into custody, to the child's parent, guardian, or custodian; and the office or official designated by the juvenile board."¹³² Conversely, no such notification requirement exists for adults under guardianship who find themselves in custody.¹³³

Performing a similar comparison to Indiana's requirements for notification to guardians and consent to healthcare for juveniles in the criminal justice system may be beneficial in determining the appropriate measures for the state's treatment of adults under guardianship. While an adult under guardianship differs from a juvenile in the sense of individual autonomy and life experiences, correctional facilities may still glean guidance for notification and coordination of healthcare purposes from the juvenile correctional systems. Furthermore, this practice aligns with the state's current approach to guardianship as many of the

125. *See generally id.*

126. *Id.* at 191.

127. *Id.*

128. *Id.*

129. *Id.* at 191–93.

130. *See* Hon. Claudia Laird & Darlene Payne Smith, *Elder Abuse: Criminal Aspects Estates & Guardianships, and Mental Commitments*, 10 TEX. TECH EST. PLAN & CMTY. PROP. L.J. 225 (2018).

131. *Id.* at 282–83.

132. *Id.* at 282.

133. *Id.*

Indiana statutes governing guardianship address guardians of minors and adults simultaneously already.¹³⁴

When a child in Indiana is taken into custody, the law enforcement officer must immediately notify the child’s parent, guardian, or custodian.¹³⁵ Once a juvenile has been committed to the Indiana Department of Corrections, an assigned case manager establishes an Individual Growth Plan (IGP).¹³⁶ Indiana could use its policies regarding juveniles who come into custody as a basis for reforming policies concerning protected persons who come into custody. Requiring similar notifications to the guardian when adults under guardianship are taken into custody would first require the legislation to require that the correctional facility take measures to identify if a person who is brought into custody is under guardianship. Additionally, a similar individualized plan could be created once an adult under guardianship has been identified. This plan could include a procedure for obtaining informed consent from the guardian for any healthcare during the protected person’s incarceration. The individualized plan may also outline protocols for emergency situations as well as plans for providing care when the protected person is uncooperative. Unlike the advance directives being considered in other states, Indiana’s individualized plan could be made by the guardian, the protected person’s physician(s), and the correctional facility. This avoids the complications associated with an already incapacitated inmate making their own decisions while promoting a proactive process of administering care to the inmate. Thus, an individualized plan specific to inmates who have already been appointed a guardian may resemble a blend between the juvenile plan and an advance directive.

C. State Comparison of Limitations on Guardians in Providing Consent to Healthcare on behalf of a Protected Person

The issue of setting standards for when a guardian can provide informed consent on behalf of protected persons is a nationwide dilemma. States vary widely in their limitations on guardians’ ability to consent to certain healthcare procedures on behalf of a protected individual. These restrictions range in severity with some states granting guardians broad power to consent to almost any healthcare on behalf of a protected individual without court interference to extensive limitations requiring court approval for any decisions a protected

134. See, e.g., IND. CODE § 29-3-8-2 (2025) (addressing guardianship of minors and adults).

135. IND. CODE § 31-37-5-4 (2025).

136. Division of Youth Services, *Juvenile Programs, Treatment Programming & Mental Health Services*, IND. DEP’T OF CORR., https://www.in.gov/idoc/dys/juvenile-programs/#IDOC_Health_Services [<https://perma.cc/27ME-UXVL>] (last visited Nov. 24, 2024); see also IND. DEPT. OF CORR., YOUTH CASE MANAGEMENT (Feb. 15, 2026), <https://www.in.gov/idoc/files/policy-and-procedure/policies/03-02-115-Youth-Case-Mgmt-2-15-26.pdf> [<https://perma.cc/ALP9-3XU3>].

individual objects to.¹³⁷

In 2017, the Uniform Law Commission amended the Uniform Guardianship and Protective Proceedings Act of 1997 to the Uniform Guardianship, Conservatorship, and Other Protective Arrangements Act (“UGCOPAA”).¹³⁸ Broadly, the UGCOPAA’s three goals are to: (1) prioritize “person-centered” guardianship rejecting the use of “ward” in reference to a protected person; (2) create legal rules ensuring implementation of the least restrictive means necessary in guardianship appointments allowing for limited guardianships; and (3) ease the burdens of all involved personnel through simplified petition requirements emphasizing access to information necessary to adopt limited guardianship.¹³⁹ Under the UGCOPAA, a guardian has the authority to consent to health or other care, treatment, or service on behalf of the protected person.¹⁴⁰ However, protected persons cannot be committed to mental health facilities without prior court approval as mandated by the state’s procedure for involuntary civil commitment.¹⁴¹ Furthermore, the UGCOPAA broadly requires the guardian to consider the needs, best interests, preferences, values, and prior directions of the protected person to the extent known or reasonably ascertainable in all of the guardian’s decisions regarding the protected person.¹⁴² Despite the noble efforts of the Uniform Law Commission in drafting the UGCOPAA, as of 2026 only nine states have enacted it or its predecessor.¹⁴³

Although Indiana has not enacted the UGCOPAA as of 2026, Indiana’s guardianship framework shares the main tenants of the Act. Like the UGCOPAA, Indiana places minimal limitations on the guardian’s ability to consent to healthcare on behalf of a protected person.¹⁴⁴ As such, Indiana is among minimally restrictive states granting guardians lenient authority to consent to healthcare on behalf of a protected person, generally only requiring court approval for the guardian to place the protected person in a mental health

137. See Karna Sandler, *A Guardian’s Health Care Decision-Making Authority: Statutory Restrictions*, 35 BIFOCAL 106 (2014), <https://www.americanbar.org/content/dam/aba/publications/bifocal/BIFOCALMarch-April2014.pdf> [<https://perma.cc/S34F-G2FN>].

138. See *The Uniform Guardianship, Conservatorship, and other Protective Arrangements Act: A Summary*, UNIF. LS. COMM’N, <https://www.guardianship.org/wp-content/uploads/2018/04/UGCOPAA-Summary-Oct-2017.pdf> [<https://perma.cc/D72B-9DPV>] (last visited Mar. 12, 2026).

139. *Uniform Guardianship, Conservatorship, and Other Protective Arrangements Act*, NAT’L CONF. OF COMM’RS OF UNIF. STATE L. 1–2 (Apr. 3, 2020), <https://www.uniformlaws.org/viewdocument/final-act-77?CommunityKey=2eba8654-8871-4905-ad38-aabbd573911c&tab=librarydocuments> [<https://perma.cc/Q8TY-N8VE>].

140. *Id.* at 107.

141. *Id.* at 112.

142. *Id.* at 116.

143. *Guardianship, Conservatorship, and Other Protective Arrangements Act*, UNIF. L. COMM’N, <https://www.uniformlaws.org/committees/community-home?CommunityKey=2eba8654-8871-4905-ad38-aabbd573911c> [<https://perma.cc/K74D-9LTK>].

144. See *supra* notes 103–13 and accompanying text.

facility.¹⁴⁵ However, some states grant guardians even more leeway by allowing the guardian to place an incapacitated person in a mental health facility for a limited time period prior to getting court approval.¹⁴⁶ For instance, North Dakota permits a guardian to consent to commitment of an incapacitated person for forty-five (45) days without following the state’s civil commitment process.¹⁴⁷

As of 2014, a small trend has emerged in which states are restricting guardians’ authority to make healthcare decisions on behalf of a protected person.¹⁴⁸ Such statutes require the guardian to petition the court for approval to give consent to procedures that implicate the protected person’s “moral, ethical, or religious beliefs” where delegation of authority to the guardian alone poses a greater risk of undermining the individual’s autonomy.¹⁴⁹ States that follow this approach limit guardians’ authority to consent in one or more categories of healthcare including admissions to residential care facilities, invasive procedures, experimental treatment, withholding or withdrawing life sustaining treatment, and mental health treatment.¹⁵⁰ For instance, Maryland and Iowa require broader court approval before guardians may place protected persons in any residential settings more restrictive than their home.¹⁵¹ This includes placement within a nursing home facility. Similarly, California prohibits involuntary placement in a mental health treatment facility and administration of experimental drugs without court approval.¹⁵² Some states, such as Montana, also limit the guardian’s ability to withhold or withdraw from life-sustaining treatment and to sign a do not resuscitate form on behalf of a protected person.¹⁵³ Notably, Indiana’s statutory scheme is silent in each of these categories.

Several states have even greater restrictions limiting guardians’ authority in multiple categories of healthcare. Alaska, for example, requires court approval before the guardian may consent to abortion, sterilization, psychosurgery, removal of bodily organs, experimental medical procedures, and withholding of lifesaving medical procedures unless these procedures only prolong an individual’s death.¹⁵⁴ Similarly, New Hampshire, restricts the ability of the guardian to consent to psychosurgery, electro-convulsive therapy, sterilization, and experimental treatment of any kind without a court order.¹⁵⁵ Michigan takes another approach restricting guardians’ authority in categories of healthcare that

145. See Sandler, *supra* note 138, at 107 (explaining that all states required guardians to conform with the state civil commitment process for placing a protected person in a mental health-care institution).

146. *Id.*

147. N.D. CENT. CODE § 30.1-28-12 (2026).

148. Sandler, *supra* note 138, at 106.

149. *Id.* at 107–09.

150. *Id.*

151. *Id.*; MD. EST. & TRUSTS § 13-708 (2025); IOWA CODE § 633.635 (2025).

152. CAL. PROB. CODE § 2356 (Deering 2025).

153. MONT. CODE ANN. § 72-5-321 (2025); *see also* IOWA CODE § 633.6435 (requiring court approval for withholding or withdrawing life-sustaining procedures, abortions, and sterilization).

154. ALASKA STAT. § 13.26.316 (2025).

155. N.H. REV. STAT. ANN. § 464-A:25 (LexisNexis 2026).

encompass a wide variety of treatment. Specifically, Michigan requires court approval for any inpatient hospitalization and involuntary mental health treatment.¹⁵⁶

States with even greater restrictions on the guardian's ability to consent to healthcare on behalf of a protected individual require court approval for "involuntary" medical decisions which arise anytime the protected person objects to the guardian's intended treatment plan.¹⁵⁷ It is important to make a technical distinction between the protected person granting legal consent and being unwilling to undergo treatment. Specifically, these statutes refer to instances where the protected person is unwilling to undergo treatment and limit the guardian's ability to provide the legal consent to proceed with treatment. As such, A.P.'s refusal of her mental health injection would qualify as an involuntary medical treatment under these statutory schemes. Several states limit the guardian's ability to consent to certain involuntary procedures rather than prohibiting any involuntary medical decision without court approval. One such example is Michigan's restriction on involuntary mental health treatment.¹⁵⁸ Additionally, Wisconsin requires court consent for psychotropic medication when the protected person protests and defines "protest" as "mak[ing] more than one discernible negative response, other than mere silence, to the offer of, recommendation for, or other proffering of voluntary receipt of the medical examination, medication, or medical treatment."¹⁵⁹

Vermont is among the most restrictive states requiring court approval for *any* involuntary treatment or medication on a protected person's behalf.¹⁶⁰ Vermont also requires court approval for admitting a protected person into a nursing home or similar facility, consenting to a do-not-resuscitate order, sterilization, having a person committed to the state hospital, and withholding or withdrawing life-sustaining support.¹⁶¹ Vermont's revised statutory scheme for obtaining consent to involuntary treatment of protected persons was passed as part of a reform effort in Vermont occurring largely in 2006 and 2008.¹⁶² During this time period, Vermont introduced changes to the guardianship framework to better balance the need for protection with the dignity of self-determination.¹⁶³ In doing so, Vermont recognized the deprivation of individual

156. MICH. COMP. LAWS § 700.5314 (2025).

157. See Sandler, *supra* note 138, at 109

158. MICH. COMP. LAWS § 700.5314 (2025).

159. WIS. STAT. § 54.25 (2025).

160. VT. STAT. ANN. tit. 14, § 3074 (2026).

161. VT. STAT. ANN. tit. 14, § 3073 (2026); VT. STAT. ANN. tit. 14, § 3075(g)(1)(D) (2026); VT. STAT. ANN. tit. 14, § 3074 (2026); VT. STAT. ANN. tit. 14, § 3075(g)(1)(C) (2026); *Adult Guardianships, Limitations on a Guardian's Powers*, VT. JUDICIARY, <https://www.vermontjudiciary.org/probate/adult-guardianships> [<https://perma.cc/3FCK-ASTG>] (last visited Mar. 9, 2025).

162. Barbara W. Prine, *Guardianship Reform in Vermont: What You Need to Know*, 37 VT. B.J. 18, 18 (Spring 2011).

163. See generally *id.*

and civil rights that a person under guardianship faces.¹⁶⁴ The state further emphasized that guardianship cannot deprive a protected person of their constitutional rights—including the right to refuse medical treatment—and ordered that courts may only grant powers to the guardian in the least restrictive manner appropriate to the circumstances of the respondent.¹⁶⁵

IV. PROPOSED SOLUTION

A. Correctional Facilities Procedures on Guardianship

Based on the lack of policies available for Indiana correctional facilities to follow when it comes to incarcerated protected persons, Indiana would benefit from legislation providing guidance for state correctional facilities on procedures for identifying these individuals and obtaining consent to their healthcare while incarcerated.¹⁶⁶ Correctional facilities in Indiana must first use the state-wide online guardianship registry, which allows for correctional facility staff to determine whether a person is under guardianship as part of their intake process.¹⁶⁷ Once a protected person is identified, the facility should be required to contact the guardian to create an individualized plan for obtaining consent to any healthcare provided in the facility.¹⁶⁸ This individualized plan should include contingency plans for administering healthcare when the protected person is uncooperative and should detail the correctional facility’s obligations to notify the guardian immediately of any issues. Like advance directives for healthcare utilized in some states, these plans would avoid hastily made healthcare decisions made by the guardian on behalf of the protected person.¹⁶⁹ Furthermore, such plans should also include an explanation of the healthcare decisions that the guardian would need to obtain court approval before consenting to on their protected person’s behalf.

B. State Regulation of Involuntary Medical Treatment of Protected Persons

Once Indiana clarifies the procedures correctional facilities must follow to ensure that incarcerated individuals under guardianship are properly identified and adequate consent for medical care is obtained, the state should address its position on guardians’ ability to consent to involuntary medical treatment of protected persons. While guardians should maintain emergency decision authorization to avoid negative health outcomes driven by untimely care, the autonomy of the protected person would best be protected by requiring court

164. *See generally id.*

165. *Id.* at 19.

166. *See supra* notes 115–18 and accompanying text.

167. *See supra* notes 26–28 and accompanying text.

168. *See supra* note 136 and accompanying text.

169. *See supra* note 126 and accompanying text.

approval for involuntary medical treatment.

Status quo in Indiana requires only that the guardian take the protected person's prior wishes and personal desires into account when making medical decisions on their behalf.¹⁷⁰ However, a guardian only appointed after the protected person became incapacitated—which is often the case where there is no prior personal relationship—may not know the person's earlier wishes, despite their efforts to become “acquainted” with the individual.¹⁷¹ As such, the state legislation currently allows the guardian to consent to the involuntary medical treatment of incapacitated individuals with limited review of the guardian's decisions.

Requiring, as Vermont does, the guardian to obtain court approval for the authority to consent to involuntary medical treatment would create a safeguard for the autonomy of the protected person. Court approval before action requires the guardian to present a case providing reasoning and evidence which the court weighs before administering any treatment to a protected person against their will. Furthermore, a public defender would be assigned to defend the protected person against commitment, thus ensuring that all ramifications of the proposed authorization are adequately considered. When the court then makes its determination, it can weigh the circumstances as a whole and ensure that the rights of the individual are not being denied without sufficient, documented cause. While this creates an additional step for guardians to take before consenting to healthcare of protected persons, this step is crucial to protect individual liberties among a vulnerable population. These safeguards benefit guardians as well by alleviating some of the onus of making intimate healthcare decisions for protected persons. Many liberties and rights of protected persons are limited by their need for a court-appointed guardian, but their ability to say “no” to unnecessary healthcare does not have to be one of them.

C. The Plan in Action

What would A.P.'s outcome have looked like if Indiana had enacted the recommended legislation? First, A.P.'s status as a protected person would have been identified each time she encountered the correctional facility. As part of the intake process, the correctional facility would have searched the guardianship registry and found the contact information for A.P.'s guardian, CARE. Next, the correctional facility would have been required to attempt to contact CARE and create an individualized plan for A.P.'s medical care and other processes requiring consent. The plan would have proactively outlined a procedure to follow if A.P. refused necessary medical treatment rather than waiting until treatment timeliness became a concern. This collaborative plan developed by CARE, the correctional facility, and its physicians would have guaranteed a therapeutic administration of these necessary injections.

170. *See supra* notes 106–08 and accompanying text.

171. *See supra* note 114 and accompanying text.

When A.P. then refused to consent to her Invega Sustenna injections, CARE would have been contacted and required to petition the court to be able to consent to such involuntary injections if another solution could not be successfully implemented. The court would have made the ultimate decision as to whether injections could be “forced” after considering medical evidence and testimony from CARE and A.P.’s public defender. With the court’s approval, CARE, A.P.’s healthcare providers, and the correctional facility could have developed procedures for therapeutically administering the injections after CARE provided informed consent. With these safeguards in place, A.P. could have received medical care without the use of excessive force and ultimately could have avoided trauma and a dislocated thumb.

Guidance protects correctional facilities as well. Such regulations shield correctional facilities from the responsibility of making complicated healthcare decisions on behalf of incarcerated individuals under guardianship. Correctional facilities and staff, too, benefit from having a clear procedure for handling situations such as A.P.’s.

Furthermore, both guardians and protected persons benefit from legislation requiring court approval for guardians to consent to involuntary medical treatment of protected persons. Such regulation protects guardians from liability and responsibility in making major medical decisions on behalf of protected persons against their will. Most importantly, these safeguards guide guardians in protecting the interests of protected persons to the greatest extent possible.

Ultimately, comprehensive regulation and guidance benefit all stakeholders. This framework ensures that the protected person’s individual liberty and autonomy are protected to the best of the guardian’s, court’s, and correctional facility’s abilities despite the complexities such individuals face. Furthermore, these measures provide correctional facilities and guardians a team to rely on in making such pivotal decisions. This opportunity for collaboration among these entities further benefits the community at large.

Unfortunately, “no” might still not always mean “no” for incarcerated adults under guardianship. However, an updated framework can, at the very least, provide a documented procedure and collaborative rationale for overriding the wishes of the protected person centering the goal of upholding their best interests.