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THE BENEFITS OF VOLUNTARY INPATIENT PSYCHIATRIC HOSPITALIZATION: MYTH OR REALITY?

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Throughout the United States, mentally ill persons are confined against their will in psychiatric hospitals as a result of being accused of dangerous behavior. Some are committed involuntarily by a judge after an administrative hearing during which they are afforded legal representation, a right to be present, and important due process protections, including the right to cross-examine witnesses and present one's own witnesses. However, a significant number of individuals, initially confined in psychiatric institutions for allegedly posing a danger to life or safety, never see an impartial judge, lawyer, or even a family member. These mentally ill individuals are not involuntarily committed. They are committed, without any benefit of due process protections, as voluntary patients.

The legal and medical implications of imposing voluntary status to a patient being admitted to a psychiatric hospital are of paramount importance. This Article focuses primarily on the specific criteria to be used in determining whether a patient's admission into a psychiatric hospital is voluntary. The questions it seeks to answer include: should psychiatrists be required to administer a mental status exam? Should witnesses be present at the time the person is voluntarily admitted and what, if any, documentation should be required? Should the mental disorder diagnosis of the patient be a major factor in determining competence to give voluntary consent? Should periodic review be required to determine whether the person continues to meet the criteria for voluntary admission? This Article will make specific recommendations as to when a psychiatric hospital will be permitted to accept and treat a mentally ill person as a voluntary patient and will ask what the legal significance is of the phrase "knowingly and competently" as used in defining consent to hospitalization.

Related to its primary focus, this Article examines the process through which a mentally ill person is voluntarily confined to a psychiatric hospital. It reviews diagnostic methods in order to help identify the existence of patient coercion. It

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discusses the need for a waiting period before the time the hospital assigns patient status and the time a patient signs an admission form. It also discusses the relevance of the proximity between the time a patient signs the form and his initial confinement involuntary civil commitment hearing. In particular, the Article explores whether there are certain time periods during the initial observation status of a patient in which there is more likely to be stress, anxiety, misunderstanding, coercion, or clear understanding as to the significance of the voluntary status.

A further aspect of the article is an exploration of the legal issues surrounding voluntary confinement. The questions addressed in this regard include: should a legal guardian or power of attorney be permitted to voluntarily admit a person into a psychiatric facility? What are the legal implications of an advanced medical directive or living will? Should an attorney be consulted by the patient prior to any voluntary admission, and should a judge review the voluntary admission to ensure that the patient is legally competent to be voluntarily admitted? What is the relevance of a prior court determination of the patient to being found legally incompetent?

Voluntary psychiatric hospitalization should be the result of a competent and informed decision arrived at within a non-coercive environment. Hospitalization based on anything less is not only involuntary, but it is an infringement of personal liberty. Because of the uncertainties surrounding voluntary patient status—uncertainties exacerbated by the absence of due process protections—the criteria and procedures of voluntary admission demand careful and thorough scrutiny. By ensuring that voluntary admission is in fact voluntary, such scrutiny is the first step in protecting a mentally ill patient's personal liberty.

I. THE PREFERENCE FOR VOLUNTARY ADMISSION

Beginning in the 1970s, there has been an increasing shift from involuntary commitment to voluntary hospitalization of the mentally ill.¹ The number of mental health organizations in the United States that provide 24-hour services (hospital inpatient and residential treatment) doubled between 1970 and 1994. The number of 24-hour hospital and residential patients, however, decreased from 1969 to 1992.²

¹ See Bruce J. Winick, *Voluntary Hospitalization after Zinermon v. Burch*, 21 PSYCHIATRIC ANNALS 10 (Oct. 1991) (estimating that greater than 70% of public mental hospital admissions and an even higher percentage of private mental hospital admissions are voluntary).

² See CENTER FOR MENTAL HEALTH SERVICES, MENTAL HEALTH, UNITED STATES 144, 150 (Manderscherd & Henderson eds., 1998). The overall number of patient beds decreased by half (524,878 to 290,604). See *id.* at 144, 146. State and county mental hospitals represented 78.7% of hospital beds in 1970 and 28% in 1994. See *id.* at 146. However, private psychiatric hospitals increased from 2.7% to 14.6% in the same period. See *id.* at 150, 151. In 1969, there were 471,451 patients; in 1992, there were 214,714 patients; and in 1994, there were 236,110 patients. See *id.*

Voluntary psychiatric treatment is strongly encouraged by both the psychiatric profession and the courts.³ For example, as articulated by the court in *Appeal of Niccoli*:⁴

the advantage of voluntary admissions flow from the absence of compulsion in the initiation of psychiatric treatment. Psychiatric evidence indicates that a patient who recognizes his condition and voluntarily undertakes therapy is more likely to be rehabilitated than one upon whom treatment is forced. Moreover, the consensual relationship between the voluntary patient and the hospital may obviate the legal problems of involuntary commitment—the state's power to infringe fundamental liberties, the procedures by which such power may be exercised, the permissible conditions of hospitalization and the ability of the patient to obtain release.

In order for an individual to be admitted as a voluntary patient into a psychiatric hospital, the individual must (1) have a mental disorder that is susceptible to care or treatment, (2) understand the nature of his request for admission, (3) be able to give continuous assent to retention, and (4) be able to ask for release.

A physician's endorsement is necessary for a psychiatric hospital to accept a patient.⁵ The physician must examine the patient and decide whether the patient meets the above-listed criteria. Once accepted, the facility is permitted to care or treat the patient. The physician decides a voluntary patient's competency without the protection of an impartial review. A clear preference for the voluntary admission to a psychiatric hospital, as pronounced by scholars, courts, and state legislatures is expressed in a variety of ways. The reasons given for voluntary admission include:

1. it involves less stigma to the patient;
2. it is less coercive;
3. it allows the patient to acknowledge a desire for help and treatment;
4. it respects individual autonomy;⁶
5. it allows the patient the legal right to request release;⁷
6. it increases patient involvement and personal responsibility;⁸

³ See *In re J.S.*, 586 A.2d 909, 910 (Pa. 1991).

⁴ 372 A.2d 749 (Pa. Supreme Ct. 1977).

⁵ See Maryland Department of Health and Mental Hygiene 4 (Rev. 3/90) Application for Voluntary Admission Form, app. 1.

⁶ See Norman G. Poythress et al., *Capacity to Consent to Voluntary Hospitalization: Searching for a Satisfactory Zimerman Screen*, 24 BULL. AM. ACAD. PSY. L. 439, 440 (1996).

⁷ See *id.* at 440; see also *In re Lawrence*, 239 Ill. App. 3d 424 (1993) (noting that if a voluntary patient did not submit an effective request for discharge, then an involuntary admission procedure could not be initiated).

7. it prevents further deterioration while awaiting the civil commitment hearing;⁹
8. it is less time consuming than a hearing;¹⁰
9. involuntary admission forces doctor and patient into an adversarial relationship that undermines the therapeutic alliance and adversely affects the patient's participation in treatment;¹¹
10. the patient is more likely to succeed;¹²
11. there is a perception that the stay is shorter;
12. the patient who voluntarily undertakes treatment is more likely to be rehabilitated than an involuntary patient;¹³
13. it is normalizing since it is very similar to other medical admission.¹⁴

The reasons against voluntary admission include:

1. the potential for patient abuse exists;¹⁵
2. the patient is subject to coercion;¹⁶
3. the patient has fewer opportunities for discharge;¹⁷
4. the patient is admitted under the threat of involuntary commitment;¹⁸

⁸ See Poythress, *supra* note 6, at 440. See also Sarah C. Kellogg, *The Due Process Right to a Safe and Humane Environment for Patients in State Custody: The Voluntary/Involuntary Distinction*, 23 AM. J.L. & MED. 339 (1997) (discussing the preference for voluntary admissions as well as the due process right to a safe and humane environment in a psychiatric facility).

⁹ See Poythress, *supra* note 6, at 440.

¹⁰ See *id.*

¹¹ See *id.*

¹² See S. BRAKEL ET AL., *THE MENTALLY DISABLED AND THE LAW* 178 (American Bar Foundation ed., 3d ed. 1985).

¹³ See *In re Bennett*, 623 N.E.2d 887, 889 (1993); *In re Hays*, 102 Ill.2d 314, 419 (1984).

¹⁴ See WILLIAM R. BREakey, *INTEGRATED MENTAL HEALTH SERVICES: MODERN COMMUNITY PSYCHIATRY* 264-275 (1996).

¹⁵ See Michael L. Perlin, *Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization*, 28 HOUS. L. REV. 63, 117-18 (1991).

¹⁶ See *id.* at 118.

¹⁷ See *id.*

¹⁸ See Gilboy & Schmidt, *Voluntary Hospitalization of the Mentally Ill*, 66 NW. U. L. REV. 429, 452 (1971).

5. the patient does not consult an attorney;
6. there is no adversarial process;
7. there is no judicial determination;
8. there is no maximum length of stay;
9. the patient is not free to leave;
10. it is unavailable when the patient is incapable of being in charge.

A review of various state statutes on civil commitment of the mentally ill demonstrates a preference for voluntary admission. In Minnesota, "voluntary admission is preferred over involuntary commitment and treatment."¹⁹ The New York legislature prompts state and local mental health professionals to encourage mentally ill individuals voluntarily to apply for treatment at a psychiatric hospital.²⁰ Louisiana physicians who consider patient admissions into psychiatric facilities are encouraged to pursue voluntary admission status whenever medically feasible.²¹ A Florida statute also demonstrates the preference for voluntary admission even for those patients who are initially placed involuntarily in the hospital by asking all staff members at treatment facilities to encourage involuntary patients to transfer to voluntary status.²²

Legislatures provide strong encouragement for the voluntary admission and treatment in psychiatric facilities because they prefer a non-adversarial process. This is because the adversarial involuntary civil commitment process introduces dynamics that are undesirable at best and can be quite harmful in the therapeutic relationship. However, the legislature still needs to address whether there are sufficient safety nets in place to protect individuals suffering from mental illnesses such as schizophrenia, bipolar disorder, and depression from coercion and duress when they voluntarily accept treatment in an in-patient psychiatric facility. In addition, the legislature should ask whether the patient is fully informed as to the risks and benefits of the decision.

It should be noted, however, that the adversarial process has its advantages, such as providing legal representation for the patient and impartial reviews as to the need for inpatient hospitalization. Psychiatrists and attorneys must acknowledge the vital role that each play in the care and treatment of the mentally ill person.

¹⁹ MINN. STAT. § 253B.04(1) (1997).

²⁰ See N.Y. MENT. HYG. § 9.21 (1997).

²¹ See L.A.R.S. §28.52.1 (1989).

²² See FLA. STAT. ANN. § 394.4625 (1997) (encouraging voluntary status unless patient has criminal charge, patient is unable to understand nature of voluntary placement, or such placement is harmful to the patient).

II. CRITERIA FOR VOLUNTARY ADMISSION

Most state statutes addressing the voluntary admission of an individual to a psychiatric facility provide the criteria listed below.

Minimum Age

The minimum age provided in statutes ranges from twelve to eighteen²³ with a general agreement on sixteen.²⁴ All states should set the minimum age of eighteen to prevent the coercion of minors.

*Mental Disorder*²⁵

An individual can apply for voluntary admission when he has a mental illness, disease or disorder, or exhibits symptoms of mental illness. It is encouraged that the admitting psychiatrist do a preliminary diagnosis of the individual accepted for voluntary admission. The psychiatrist should use the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV*²⁶ to ensure the patient is admitted with more than just a suspicion of mental illness.

*Mental Disorder Susceptible to Care or Treatment*²⁷

To accept an individual, the hospital must show the individual "will benefit from care and treatment,"²⁸ is "clinically suitable for admission,"²⁹ and needs "observation, diagnosis, evaluation, care or treatment."³⁰ The Massachusetts statute appropriately addresses this element with a two-prong test that requires the mentally ill person to be "in need of care and treatment [and] the admitting facility is suitable for [providing the appropriate] care and treatment."³¹ An additional safeguard requires the prohibition of voluntary admission when the chief clinical officer finds that hospitalization is inappropriate.³²

²³ See GA. CODE ANN. § 37-3-20 (1995).

²⁴ See MD. CODE ANN., HEALTH-GEN. I § 10-609(a) (1994); 415 ILL. COMP. STAT. § 53-400 (West 1997).

²⁵ See MD. CODE ANN., HEALTH-GEN. I §§ 10-609, 10-101(f)(2)(3) (1999) (stating a "mental disorder includes a mental illness that so substantially impairs the mental or emotional functioning of an individual as to make care or treatment necessary or advisable for the welfare of the individual or for the safety of the person or property of another, [and it] does not include mental retardation").

²⁶ See AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS: DSM-IV, (4th ed. 1994).

²⁷ See MD. CODE ANN., HEALTH-GEN. I § 10-609 (c)(2)(1994).

²⁸ ARIZ. REV. STAT. § 36-518(A) (1995).

²⁹ 405 ILL. COMP. STAT. 405, § 400 (West 1993).

³⁰ IDAHO CODE §66-318(a)(5) (1989).

³¹ 123 MASS. GEN. LAWS ANN. § 10(a) (1986 & Supp. 1999).

³² See OHIO REV. CODE ANN. § 5122.02(B) (1998).

*Individual Understands the Nature of the Request for Admission*³³

The individual must have the ability to understand that he is voluntarily applying for admission into a hospital for the mentally ill.³⁴ The requirements that the individual understand the request for admission and the nature of the voluntary status should be included in every state. Also, the individual should have a reasonable understanding of both the risks and benefits of his decision as well as the alternatives available, such as patient treatment.

*Competent to Provide Express and Informed Consent for Admission*³⁵

The informed consent for admission "shall be made voluntarily by the person, at a time when he is in such condition of mind as to render him competent to make it."³⁶ Also, the individual must have the "capacity to make knowing and voluntary consent" to the admission.³⁷ Louisiana provides a helpful definition of "knowing and voluntary consent."³⁸

Knowing and voluntary consent shall be determined by the ability of the individual to understand that the treatment facility to which the patient is requesting admission is one for mentally ill persons, . . . that he is making an application for admission, [and] that the nature of his status and the provisions governing discharge or conversion to any involuntary status.³⁹

One interpretation of informed consent consists of a "voluntary decision following presentation of all facts necessary to form the basis of an intelligent consent by the patient or guardian with no minimizing of known dangers of any

³³ See MD. CODE ANN., HEALTH-GEN I § 10-609 (1994). See also *Davis v. Reenie*, 997 F.Supp. 137, 139 (D. Mass. 1998) (discussing a Massachusetts law that requires the opportunity to consult with an attorney prior to a patient signing a voluntary admission).

³⁴ See N.Y. MENT. HYG. § 9.17 (1996). Cf. *In re Rusick*, 450 N.E.2d 418 (Ill. App. Ct. 1983) (holding that when there is a history of voluntary admissions followed shortly by a request to be released, and when the patient is not yet well enough to be discharged, testimony from treating physician as to advisability of voluntary admission is relevant to the court on appropriateness of voluntary admission).

³⁵ See FLA. STAT. ch. § 394.4625(1)(a) (1998).

³⁶ CAL. WELF. & INST. CODE § 6000 (West 1998).

³⁷ LA. REV. STAT. ANN. § 28:52(G) (1989 & Supp. 1999); see also MINN. STAT. § 253B.04 (1998 & Supp. 1999) (stating that if the "mental health provider determines person lacks capacity to give informed consent for the treatment or admission . . . the designated agency . . . may give informed consent"). *Id.*

³⁸ LA. REV. STAT. ANN. § 28:52(G) (1989 & Supp. 1999); see also MINN. STAT. § 253B.04 (1998 & Supp. 1999).

³⁹ LA. REV. STAT. ANN. § 28:52(G) (1989 & Supp. 1999); see also MINN. STAT. § 253B.04 (1998 & Supp. 1999).

procedures."⁴⁰ An alternate, less stringent interpretation is that "the individual is able to give continuous *assent* to retention by the facility."⁴¹

The distinction between informed consent and assent is significant. Informed consent requires a competent patient's active and voluntary acceptance of a prescribed course of treatment following his physician's full disclosure of associated risks and benefits by his physician.⁴² Assent, however, requires acquiescence, a tacit acceptance, or non-response such as silence. Consent proceeds from the will. It is neither constrained by interference nor impelled by another's influence. Assent means passivity.⁴³ Because informed consent better ensures that a patient's hospitalization is in fact voluntary, it is a more appropriate standard than mere assent.

*Individual Is Able To Ask For Release*⁴⁴

The ability to ask for release presumes an awareness of one's surroundings and an understanding of the procedures for seeking release. Many state statutes require a written request to be discharged from voluntary inpatient status. For example, New York requires that a written request be given to the hospital director.⁴⁵ North Carolina also requires a written request, but also imposes a procedural framework for responding to patients' written requests.⁴⁶ Within this framework, upon receipt of the patient's request, the facility may either approve the request and release the patient or deny the request and institute proceedings for involuntary commitment. Many states provide a 72-hour window in which to consider the patient's request and decide whether to grant release or begin involuntary commitment procedures.⁴⁷

⁴⁰ ARIZ. REV. STAT. ANN. § 36-501 (17) (1993 & Supp. 1999).

⁴¹ MD. GEN. CODE ANN., HEALTH GEN. I § 10-609(c)(4) (1994) (emphasis added).

⁴² See Bruce J. Winick, *Competency to Consent to Treatment: The Distinction Between Assent and Objection*, 28 HOUS. L. REV. 15 (1991); see also Perryman v. State, 12 S.E.2d 388 (390 Ga. Ct. App. 1940) (noting that consent implies positive action and submission, while assent means passivity or submission and does not include consent); see also Jackson v. Wilson, 262 S.E.2d 547 (1979).

⁴³ See Jackson, 262 S.E.2d at 549. Assent has also been further distinguished as an act of understanding, while consent is considered an act of the will or feelings. See *id.* See Klundby v. Hogden, 232 N.W. 858 (Wisc. 1930).

⁴⁴ See MD. CODE ANN. HEALTH-GEN. I § 10-609 (1994).

⁴⁵ See N.Y. MENT. HYG. L. § 9.13 (1996). See *In re Lesley B.*, 567 N.Y.S. 2d 999, 1000 (N.Y. Sup. Ct. 1991) (referring to New York law that states that if a voluntary patient admitted to a hospital wishes to leave, he or she must give notice in writing upon which the hospital must either release the patient or apply within 72 hours for a court order authorizing the involuntary retention of the patient).

⁴⁶ See N.C. GEN. STAT. § 122C-211. See also *In re M.D.*, 596 A.2d 766 (N.J. Super. Ch. Div. 1991) (stating that voluntary patient once admitted does not have the unfettered freedom to leave).

⁴⁷ See FLA. STAT. ANN. § 394.4625 (1998) (providing a 24-hour period, which may be extended to three days, excluding weekends and holidays); see also IDAHO CODE § 66-

A patient should be able to seek release from voluntary commitment by either written or oral request.⁴⁸ A facility should be given a relatively short period to respond, which may be extended when necessary for adequate discharge planning.⁴⁹ During this time, the facility must either release the patient or institute involuntary commitment proceedings. Involuntary commitment hearings should be held within ten days after proceedings begin.⁵⁰

An application for involuntary admission indicates by its very nature that the patient is incapable of control.⁵¹ The degree of control a person has over the course of treatment is significant in terms of one's investment in the outcome of the treatment plan. However, a patient on involuntary status should not be stripped of all rights and responsibilities.

Several compelling issues arise in the context of voluntary admission. For example, should a legal guardian or an individual with durable power of attorney be authorized to voluntarily admit a mentally ill patient into a psychiatric facility? In a few states a conservator or a person with durable power of attorney can admit a mentally ill person into a psychiatric facility.⁵² Such allowance, however, is ripe for abuse absent judicial review. Accordingly, states should not allow persons with power of attorney, conservatorship, or guardianship to voluntarily admit a mentally ill person under their care without a formal court review. The U.S. Supreme Court has authorized a parent or legal guardian to admit a minor child for treatment to a state mental hospital.⁵³

Another question statutes should address is whether patients has the right to consult an attorney before signing a voluntary admission. Consultation with an attorney is essential in contemplating voluntary admission into a psychiatric facility. The circumstances surrounding a person's arrival at a psychiatric facility, often a result of police involvement, necessitate the right to consult with an attorney in order to understand the implications of a voluntary admission.

320 (providing three days, excluding weekends and legal holidays). Cf. CONN. GEN. STAT. § 17a-506 (providing five days).

⁴⁸ See FLA. STAT. ANN. § 394.4625 (1998) (requiring the patient's written or oral request for release to be entered in patient's clinical record).

⁴⁹ See *id.*

⁵⁰ Cf. *In re J.S.*, 586 A.2d at 909 (holding that where a hospital prolongs commitment by beginning involuntary commitment procedures after voluntary patient gives written notice of intent to be released, the patient is not entitled to a hearing regarding involuntary commitment that does not exceed the time frame of the voluntary confinement).

⁵¹ See *In re Hays*, 451 N.E.2d 9 (Ill. 1984) (holding that a voluntary patient could not be made an involuntary patient where release from the psychiatric facility was not requested).

⁵² See CAL. WELF. & INST. CODE § 6000 (West 1998).

⁵³ See *Parham v. J.R.*, 442 U.S. 584 (1979) (finding that the gravity of a parent's decision to institutionalize a child for mental health care warrants an inquiry by a neutral fact finder to determine whether the statutory requirements for institutionalization are satisfied). See also D. Stone, *The Civil Commitment of Juveniles: An Empirical Study*, 65 U. DET. L. REV 679 (1988).

Several states provide an attorney at this step in the process to insure the voluntariness of the consent⁵⁴ and the legal effect of the voluntary admission.⁵⁵ In Wisconsin, a mentally ill person confronted with the decision to voluntarily admit himself into a psychiatric facility is provided with a guardian ad litem to ascertain whether the patient wishes a less restrictive form of treatment.⁵⁶ An attorney should be appointed to consult with all mentally ill persons admitted into psychiatric facilities against their will as well as those who are considering admitting themselves voluntarily.⁵⁷ As part of the consultation, the attorney should interview the patient and the patient's psychiatrist, review all relevant medical records, assess the legal competency of the patient, and seek administrative review of those cases in which the patient is unable to provide informed consent to the voluntary admission in order for the court to determine issues of competency and voluntariness.⁵⁸

Another issue the statutes should deal with is whether a hearing to verify the voluntariness of the patient's consent should be provided. The question of whether a mentally ill person provides informed consent to a voluntary admission to a psychiatric facility is complex. One could argue that a psychiatrist and an admitting facility would not accept a patient for voluntary admission unless they were convinced that the patient understood the implications of the decision. On the other hand, it could be speculated that coercion and duress are common in psychiatric hospitals, and therefore an impartial judicial review should be a predicate of all voluntary admissions.⁵⁹ Perhaps as a middle ground, a patient should be permitted to voluntarily admit himself to a psychiatric facility after an

⁵⁴ For example, under N.Y. MENT. HYG. L. § 9.25 (1996), mental hygiene legal service reviews patient's willingness to remain voluntarily. *See also* *Namor v. Lopez*, 541 N.Y.S.2d 315 (1989) (denying *habeas corpus* petition relating to voluntary patient's requested release where instituting involuntary commitment has been denied by the court).

⁵⁵ *See, e.g.,* MASS. GEN. LAW. Ch. 123 § 10 (1997). *See also* *Bucaro v. Keegan*, Keegan, Hecker & Tully, 483 N.Y.S.2d 564 (N.Y. Sup. Ct. 1984) (discussing termination of attorney-client representation).

⁵⁶ According to WIS. STAT. §51.10(4) (1997), the role of a guardian ad litem, namely to insure the best interest of the patient, is different than that of an attorney toward his client.

⁵⁷ Under MD. REGS. CODE tit. x, § 21.01.02 (8) (1999), observation status is defined as the status of an individual between the time the individual is initially confined in an inpatient facility on the basis of application and certificates for IVA and the time the individual is either admitted, voluntarily or involuntarily, to the inpatient facility or is released by a physician or by an ALJ from the inpatient facility without being admitted. This status is often viewed as a patient in limbo, because the patient is confined to a psychiatric hospital against his will while awaiting an involuntary civil commitment hearing.

⁵⁸ *See* D.C. CODE ANN. § 6-1922 (requiring the court to appoint an officer to determine whether the individual is competent and voluntarily agrees to admission). *See In re Bernard Johnson*, 691 A.2d 628 (D.C. App. 1997) (encouraging voluntary admissions and discussing the different statutory definitions between a voluntary and involuntary patient).

⁵⁹ *See* VT. STAT. ANN. tit. 18, § 7503(b) (1977) (stating that voluntary admission should be without coercion and duress).

attorney consultation. If after a thorough interview and investigation, the attorney concludes that his client cannot provide informed consent, the hospital should prohibit voluntary admission until further review by an administrative judge. If the attorney concludes, however, that his client is capable of knowingly and voluntarily admitting himself into the hospital, the patient should be permitted to exercise this option without judicial review.

Finally, state statutes should provide a maximum period of confinement as a basis for voluntary admission to avoid an indeterminate confinement. Many states provide a maximum period of confinement, from Illinois's 30-day review by the facility director followed by subsequent 60-day reviews,⁶⁰ to Colorado's six-month review,⁶¹ and Pennsylvania's annual review.⁶² A 30-day review with reauthorization of voluntary documents should be a standard practice to ensure the need for continued inpatient confinement and that the patient is receiving a benefit from such hospitalization.

Capacity of a Mentally Ill Patient to Consent to Voluntary Hospitalization

When psychiatrists in psychiatric hospitals accept a patient for treatment, they must conduct an evaluation of the patient's competency. Although psychiatrists prefer to allow mentally ill individuals to receive treatment voluntarily, in *Zinerman v. Burch* the United States Supreme Court examined mentally ill patients' capacity to give informed consent to voluntary admission.⁶³ In *Zinerman*, voluntary patients alleged that they were heavily medicated, disoriented and suffering from psychotic disorders when they were admitted to a Florida state mental health treatment facility.⁶⁴ The patients claimed that they were deprived of liberty without due process of law.⁶⁵ Darrell E. Burch, the named patient in the case, alleged that the Florida state mental hospital violated state law by admitting him as a voluntary patient when they "knew or should have known that [he] was incapable of voluntary, knowing, understanding and informed consent" to his admission. Burch further alleged that the hospital's failure to initiate Florida's involuntary placement procedure denied him constitutionally guaranteed procedural safeguards.⁶⁶ The Court held that the hospital should have only allowed patients who were competent to consent to voluntary admission.⁶⁷

⁶⁰ See 405 ILL. COMP. STAT. ANN. 5/3-404 (West 1993); see also R.I. GEN. LAWS § 40.1-5-6 (1997) (establishing a 30-day maximum, followed by successive 90-day periods).

⁶¹ See COLO. REV. STAT. § 27-10-103 (1994).

⁶² See PA. STAT. ANN. tit. 50, § 4402 (d) (West 1966); see also WIS. STAT. ANN. § 51.13(4) (1995).

⁶³ See *Zinerman v. Burch*, 494 U.S. 113 (1990).

⁶⁴ See *id.* at 118-19, 121-22.

⁶⁵ See *id.* at 121.

⁶⁶ See *id.*

⁶⁷ See *Zinerman*, 494 U.S. at 136-37. For those patients that are incompetent and those unwilling to consent to admission, Florida's involuntary placement procedures should be initiated. See *id.*

The Supreme Court's position in *Burch* is advisable because often a mentally ill patient, upon arrival at a psychiatric hospital, is disoriented or distressed. Because the patients are disturbed, confused, frightened, and distraught, there are indications that they are unable to comprehend the major step they take through self-admission.⁶⁸ Individuals are taken from their home community and escorted through the door of the psychiatric facility accompanied by police, family members, or other interested individuals seeking inpatient psychiatric care and treatment for the patients. At that time, patients may be asked to avoid involuntary commitment and accept treatment on a voluntary basis. Hospital staff and other interested individuals may promise a quicker release date, a less adversarial posture, and general sentiments that this is best for all concerned.

At the time a patient considers signing the "voluntary" admission document, one should look carefully at the patient's documented behavior as recorded by the hospital staff. As was noted in Darrell Burch's nursing assessment shortly after his arrival at the Florida psychiatric hospital, he was confused and unable to state the reason for his hospitalization and believed he was "in heaven."⁶⁹ Progress reports written by psychiatrist Marlus Zinermon reflected Burch's condition upon admission, describing him as disoriented, semi-mute, confused, and bizarre in appearance and thought, uncooperative at the initial interview, extremely psychotic, and apparently paranoid and hallucinating.⁷⁰ Burch remained a voluntary patient at Florida State Hospital for five months, although it held no hearing regarding his hospitalization and treatment.⁷¹ Burch alleged that the hospital and staff knew or should have known that he was incapable of voluntary, knowing, understanding, and informed consent to admission and treatment.⁷² The Court recognized that Mr. Burch was confined, imprisoned, and subjected to involuntary commitment and treatment for 149 days without the benefit of counsel or a hearing to challenge his involuntary admission and treatment.⁷³ Burch's five-month stay, without hearing or attorney consultation, demonstrates an obvious due process violation.

In order to explain when a mentally ill person can voluntarily consent to psychiatric inpatient treatment, the Court in *Zinermon* stated that "[m]ental hospitals may admit for treatment any adult 'making application by express and

⁶⁸ See Albert B. Palmer & Julian Wohl, *Voluntary Admission Forms: Does the Patient Know What He's Signing?*, 23 HOSP. & COMMUNITY PSY. 38 (Aug. 1972) Forty patients were voluntarily admitted to the Toledo Mental Health Center by signing the admission forms. See *id.* Twelve of the 40 patients could not remember signing the forms, and of the 28 who could recall signing them, 23 either could not recall what its provisions were or gave responses related to other forms; only one person could give the essence of the contents from memory. See *id.*

⁶⁹ *Zinermon*, 494 U.S. at 118.

⁷⁰ See *id.* at 119-20. Dr. Zinermon also described Burch as disoriented, delusional, and psychotic. See *id.* at 120.

⁷¹ See *id.*

⁷² See *id.* at 121.

⁷³ See *id.* at 121, 138-39.

informed consent' if he is 'found to show evidence of mental illness and to be suitable for treatment.'"⁷⁴ The term "express and informed consent" is defined as "consent voluntarily given in writing after sufficient explanation and disclosure . . . to enable the person . . . to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion."⁷⁵

The hospital's decision regarding the competence of a person like Burch to consent to his admission and treatment may have grave consequences. At the initial admission, thorough screening is necessary to determine a person's capacity to provide informed consent to voluntary psychiatric hospitalization. The Court noted that "[a] person who is willing to sign forms but is incapable of making an informed decision is . . . unlikely to benefit from the voluntary patient's statutory right to request discharge."⁷⁶ The Court recognized that such a person is in danger of indefinite confinement without the "procedural safeguards of the involuntary placement process, a process specifically designed to protect persons incapable of looking after their own interests."⁷⁷

Mentally ill persons who are incapable of giving informed consent to admission may not necessarily meet the statutory standard for involuntary placement. Most states require either that the patient is likely to injure himself or others, or that the patient's neglect or refusal to care for himself threatens his well-being.⁷⁸ Therefore, some patients who are incapable of providing informed consent to psychiatric hospitalization will not meet the criteria for involuntary confinement and may be discharged.

By guarding against undue pressure and influence to accept patients lacking in capacity to consent, some mentally ill persons who want to receive inpatient care may be denied treatment as long as they can live safely outside an institution.⁷⁹ Some mentally ill patients who are not a danger to themselves or others, or can safely live outside the hospital setting, will not receive the benefits of a psychiatric

⁷⁴ *Id.* at 123 (quoting FLA. STAT. ANN. § 394.465(1)(a) (West 1998).

⁷⁵ *Zinerman*, 494 U.S. at 123 (quoting FLA. STAT. ANN. § 394.465(22) (West 1998). Burch claims that the hospital knew or should have known that he was incapable of making an informed decision as to his admission. *See id.* at 121. *See also* Dept. of Social Services v. Waltz, 180 Cal. App. 3d 722, 730 (1986) (discussing voluntary informed consent for electro-convulsive therapy).

⁷⁶ *Zinerman*, 494 U.S. at 123. *See, e.g.,* Addington v. Texas, 441 U.S. 418 (1979) (recognizing that civil commitment is a significant deprivation of liberty that requires due process protection); Jackson v. Indiana, 406 U.S. 715 (1972) (noting that due process requires that the nature and duration of commitment to a mental hospital bear some reasonable relation to the purpose of the commitment).

⁷⁷ *Id.* The procedural safeguards provide for notice, judicial hearing, counsel, examination by independent expert, appointment of guardian advocate, etc. *See id.*

⁷⁸ *See id.* (construing FLA. STAT. ANN. § 394.467(1)(b) (West 1998).

⁷⁹ *See id.* at 133. *See also* O'Connor v. Donaldson, 442 U.S. 560, 563 (1979) (noting that there is no constitutional basis for confining mentally ill persons involuntarily if they are not dangerous and can live safely in freedom).

hospital. However, they will still be able to receive outpatient care in a less restrictive setting.

In *Zinerman*, the Court inquired into whether predeprivation safeguards would protect against the deprivation of liberty that Burch claimed.⁸⁰ The Court acknowledged that in situations where the State feasibly can provide a predeprivation hearing, it must do so.⁸¹ The psychiatric hospital's staff members are in a position to note any misuse and to follow proper procedure in the voluntary admission process.⁸² To ensure that mentally ill persons who cannot be admitted voluntarily due to an inability to provide informed consent receive appropriate care, hospitals should follow the procedures for involuntary placement. Burch and others like him are deprived of a substantial liberty interest without either valid consent or an involuntary placement hearing by the very state officials charged with the power to deprive mental patients of their liberty and the duty to implement procedural safeguards.⁸³

Subsequent to the U.S. Supreme Court mandating the need for psychiatrists to evaluate the competency of mentally ill persons to consent to voluntary psychiatric hospitalization, scholars have attempted to articulate the test to screen for capacity to commit. Psychiatrists are called upon to evaluate whether a patient has a mental disorder that compromises her ability to make or communicate choices and decisions.⁸⁴ According to Dr. Robert Roca, Director of Geriatric Services at the Sheppard and Enoch Pratt Hospital, a psychiatric history and mental status examination is undertaken to obtain information relevant to decisions about diagnosis and functional capacity.⁸⁵ The examiner pays particular attention to such areas as: motor activity; form of talk (disruption in organization of thought); mood (changes in mood, self-esteem and vitality); belief (delusions); perceptions (hallucinations); and cognition (ability to reason, remember and orient oneself in time and space).⁸⁶

⁸⁰ See *Zinerman*, 494 U.S. at 135 (distinguishing several cases involving deprivation of property, including *Parratt v. Taylor*, 451 U.S. 527 (1981), and *Hudson v. Palmer*, 468 U.S. 517 (1984). These cases involved a state's inability to provide predeprivation process because of the random and unpredictable nature of the deprivation).

⁸¹ See *id.*

⁸² See *id.*

⁸³ See *id.* at 138. Such deprivation is seen as foreseeable due to the nature of mental illness and will occur at a predictable point in the admission process.

⁸⁴ See Robert P. Roca, *Determining Decisional Capacity: A Medical Perspective*, 62 *FORDHAM L. REV.* 1177 (1994).

⁸⁵ See *id.* at 1178. The psychiatric history is a biography, focusing in the case of dementia on the onset of forgetfulness, rate of decline in cognitive functioning, family history of mental illness, and the patient's educational and occupational attainment. The mental status exam uncovers the presence of signs and symptoms of psychiatric disorders.

⁸⁶ See *id.* at 1180. Dr. Roca writes in detail about incapacity in such psychiatric disorders as dementia, delirium, major depression, bipolar affective disorder, mood disorders, and schizophrenia.

Dr. Roca has concluded that mentally ill patients can often show decisional impairment, but they have "lucid intervals or at times . . . reasonable explanations for the choices made."⁸⁷ Dr. Roca's finding raises several questions. In determining competency, should the examiner test at different times of the day and on different days? Can a patient be capable of providing informed consent at one moment and lack such ability at a later time? Do exam locations and the presence of other hospital staff influence patients' ability to express their opinions and seek clarification in a non-threatening setting? Contacting a patient to sign a voluntary admission document and to re-sign such a document three days later provides one solution to these problems. If the patient is unable or unwilling to re-sign such a document, the hospital should be required to either release the patient or begin the process for involuntary certification.

Dr. Roca recognizes the significance of the decision and its consequences as important factors.⁸⁸ If the patient's decision potentially causes minimal harm, then a moderate degree of uncertainty regarding capacity is tolerable.⁸⁹ However, when the decision is of such paramount importance as obtaining treatment in an inpatient psychiatric hospital, the potential for loss of liberty and freedom is great. According to Dr. Roca, "If the patient is likely to be seriously harmed or to lose out on substantial benefit by virtue of her decision, then the examiner will tolerate much less uncertainty regarding decisional capacity."⁹⁰ The consequences of the patient's choice to be voluntarily admitted, such as the loss of liberty, should be heavily weighed in the examiner's determination. The symptoms of mental illness affect their decisional capacity and hinder their ability to make autonomous choices.⁹¹ If there is great harm at stake (i.e., if the decision is dangerous), very little uncertainty regarding a patient's decision-making ability is tolerable.⁹² The physician will tend toward finding the patient incompetent to choose, initiating the process of assigning a surrogate decision-maker.⁹³ The appointment of a patient advocate or legal guardian could be the option in the context of a psychiatric hospital setting. However, one could advance the theory that the proper procedure for patients who are unable to voluntarily consent to hospitalization is involuntary civil commitment.

⁸⁷ *Id.* at 1189. Dr. Roca asks how the examiner makes a judgment in the face of substantial uncertainty.

⁸⁸ *See id.* at 1189.

⁸⁹ *See id.* at 1189. See also *Mental Competency of Patient to Consent to Surgical Operation or Medical Treatment*, 25 A.L.R.3d 1439 (1999) for discussion of cases dealing with consent to surgery and medical treatment and presumption of competency and sanity.

⁹⁰ Roca, *supra* note 84, at 1189. The physician will want to be as certain as possible that the patient knows what she is doing before rendering the opinion that the patient has the capacity to make the dangerous choice. *See id.*

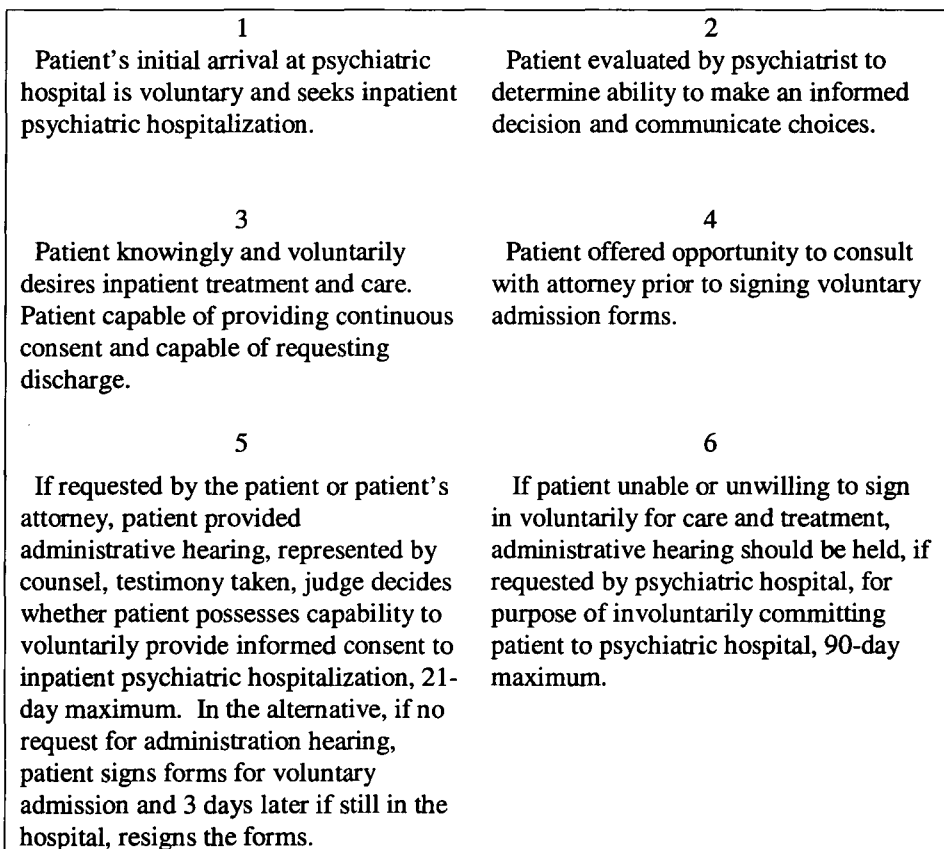
⁹¹ *See id.* at 1191.

⁹² *See id.*

⁹³ *See id.*

Psychiatric hospitals should initiate new procedures to guide their handling of inpatient psychiatric cases. A flow chart is provided for explanation, depending on whether the patient's initial arrival at the hospital is voluntary or involuntary:

Voluntary Hospitalization



Involuntary Hospitalization

1

Patient's initial arrival at psychiatric hospital is involuntary and subsequently seeks inpatient psychiatric hospitalization on voluntary basis.

2

Patient evaluated by psychiatrist to determine ability to make an informed decision and communicate choices.

3

Patient knowingly and voluntarily desires inpatient treatment and care, capable of providing continuous consent and capable of requesting discharge.

4

Patient offered opportunity to consult with attorney prior to signing voluntary admission forms.

5

Mandatory requirements that patient is provided opportunities for administrative hearing; legal representation; and oral testimony. Judge decides whether patient possesses capability to voluntarily provide informed consent to inpatient psychiatric hospitalization, 21-day maximum. If judge finds patient capable of voluntary admission, the voluntary admission forms are signed. If the patient still remains in the hospital 3 days later, re-signs the forms, with a maximum length of confinement of 21 days. Further hospitalization would require resigning forms subsequent to psychiatric evaluation, consultation with attorney and administrative hearing.

6

If patient is unable or unwilling to sign in voluntarily for care and treatment, administrative hearing will be held, if requested by psychiatric hospital, for purpose of involuntarily committing patient to psychiatric hospital, 90-day maximum.

These two distinct procedures are structured to offer one process for a person who is brought initially to a psychiatric hospital *involuntarily*, i.e., by police, care provider, or family, and a slightly different process when his or her initial arrival is *voluntary*. After a hospital psychiatrist determines the proper care and treatment for the patient, she evaluates the patient's ability to provide informed consent. If a patient is incapable of providing informed consent, and if the hospital desires to treat the patient in the hospital setting, the hospital should be forced to institute involuntary civil commitment procedures. Due process protections will be afforded the person, and an administrative law judge will determine the patient's need for inpatient care and treatment. In cases where patients are incapable of providing voluntary consent, the existence of a legal guardian, durable power of attorney, or patient advocate are irrelevant because the only recourse will be the involuntary commitment process and its right to representation by an attorney.

For mentally ill patients who can provide informed consent to inpatient psychiatric care, the procedural safeguards that can be provided by a psychiatrist's further review are essential. As one commentator explained,

[The s]kill of the examiner, the willingness of the patient to cooperate, the current medical status of the patient, the availability of history from other informants and other variables . . . may require revision [as to determination of competency to consent] after an additional interview with the patient or a critical informant . . . subject to review and repair in the future if conditions change or new data become available.⁹⁴

Therefore, consideration of the factors suggests that voluntary admission status in psychiatric hospitals should expire in 21 days. If both the psychiatrist and patient agree that continuous care and treatment beyond the 21-day period is necessary and helpful, then the voluntary admission forms should be re-signed after the psychiatrist has conducted additional evaluation of the patient's competence.

III. COMPETENCE TO CONSENT TO VOLUNTARY PSYCHIATRIC HOSPITALIZATION: A TEST OF A STANDARD PROPOSED BY THE AMERICAN PSYCHIATRIC ASSOCIATION (APA)⁹⁵

In response to the U.S. Supreme Court's decision in *Zinerman v. Burch*,⁹⁶ the APA created a task force to study competency required for consent to voluntary hospitalization. The task force suggested that "strong policy interests support the establishment of a low threshold for competence in this situation."⁹⁷ The research

⁹⁴ *Id.* at 1196.

⁹⁵ See Benjamin C. Appelbaum et al., *Competence to Consent Voluntary Consultation: A Test of Standard Proposed by APA*, 12 PSYCHIAT. SERV. 1193 (1998) [hereinafter Appelbaum, *Competence to Consent*].

⁹⁶ See 494 U.S. at 113.

⁹⁷ Appelbaum, *Competence to Consent*, *supra* note 95, at 1193. The study involved 100 voluntarily hospitalized patients who were read two brief paragraphs.

tested a voluntarily admitted patient's ability to recall and recognize the presented information. A large majority of patients were found to be able to comprehend the information that the APA task force believed was relevant to their decision.⁹⁸ However, a subgroup of patients who were initially admitted involuntarily was reported to have significantly poorer performance. The task force recommended that these patients might need special educational efforts that provide them information about the consequences of voluntary admission.⁹⁹ The circumstances of mentally ill patients who voluntarily seek inpatient psychiatric care are significantly different from individuals who receive involuntary psychiatric hospitalization, because they are alleged to pose a danger to themselves or others. When such individuals, after several days of observation at the psychiatric hospital, convert their status to "voluntary," a competent execution should be carefully conducted to determine the patients' understanding of their decision. A close examination should also show the absence of coercion by hospital staff prior to the decision to be voluntarily admitted. The APA task force recognized that involuntary admissions in psychiatric hospital should initially call for heightened and meaningful scrutiny.

As reported by Appelbaum and his colleagues, voluntary hospitalization is the cornerstone of inpatient psychiatric treatment, constituting for the majority of episodes of hospital-based care in the United States.¹⁰⁰ The benefits of voluntary admission include simplicity, fewer restrictions on patients' liberty, and a greater level of patient involvement and responsibility in treatment decisions about their own care.¹⁰¹ From the hospital's perspective, the removal of the burden of proof on the hospital at an adversarial psychiatric commitment hearing provides an additional benefit. In addition, without the necessity for a hearing, there is no requirement that psychiatrists demonstrate that there is no less restrictive form of intervention consistent with their care. The treating psychiatrist is never forced to prove to an administrative law judge that the criteria for involuntary hospitalization have been met. The process is quicker, less confrontational, and less of a burden on the hospital. Legal advocates have long recognized that voluntary admissions forms may induce incompetent patients to surrender the greater procedural rights that are often afforded to involuntary committed patients.¹⁰²

A clinical study of the competency of mentally ill patients voluntarily admitted at St. Vincent's Hospital and Medical Center of New York was conducted,¹⁰³

⁹⁸ See *id.*

⁹⁹ See *id.*

¹⁰⁰ See *id.*

¹⁰¹ See *id.*

¹⁰² See *id.* Research suggests that many voluntary patients may lack substantial awareness of the consequences of hospitalization. For a description of tools used by mental health professionals, see THOMAS GRISSO, *EVALUATING COMPETENCIES: FORENSIC ASSESSMENTS AND INSTRUMENTS* (1986).

¹⁰³ See S.B. Billick et al., *A Clinical Study of Competency in Psychiatric Inpatients*, 24 BULL. AM. ACAD. PSYCHIATRY LAW 505 (1996) based on 37 adult psychiatric inpatients.

comparing the use of the competency questionnaire,¹⁰⁴ Brief Psychiatric Rating Scale,¹⁰⁵ the Mini-Mental State Exam,¹⁰⁶ and the Weschler Adult Intelligence Scale-Revised vocabulary subtest.¹⁰⁷ As a consequence of the U.S. Supreme Court decision in *Zinerman v. Burch*,¹⁰⁸ Billick and colleagues undertook an examination of various competency screening tools used to assist hospitals and mental health legal advocates. The Competency Questionnaire developed by Appelbaum and colleagues was found to be a valid instrument to measure competency to consent to psychiatric hospitalization and treatment, and was similar in its clinical determinations to the blind forensic interview evaluation and standard psychiatric assessments.¹⁰⁹

The APA task force suggested that establishing a low threshold for competence to consent to voluntary hospitalization might be the best method of accomplishing such admissions. It further proposed that the required capacities be limited to the abilities to communicate a choice and to understand relevant information.¹¹⁰ In response to the task force, Norman Poythress, Michele Cascardi, and Lee Ritterband examined 120 patients in Florida psychiatric hospitals, using the Measuring Understanding Disclosure-Voluntary Hospitalization (MUD-VH) to study a patient's capacity to make treatment decisions.¹¹¹ These researchers acknowledged that the *Zinerman* court did not specify the appropriate test to explore a patient's competency status, so they set out to establish an appropriate standardized assessment procedure. They reviewed other studies and found results that cast considerable doubt upon the capacity of most psychiatric patients.¹¹²

¹⁰⁴ See Paul Appelbaum et al., *Empirical Assessment of Competency to Consent to Psychiatric Hospitalization*, 138 AM. J. PSYCHIATRY 1170 (1981) (used 15 questions and found a majority of patients have a severe impairment of competency and poor appreciation of their condition and their legal rights).

¹⁰⁵ See John E. Overall, Jr. & Donald R. Gorham, *The Brief Psychiatric Rating Scale*, 10 PSYCHOL. REP. 799 (1962).

¹⁰⁶ See Marshall Folstein et al., *Mini-Mental State: A Practical Method for Grading the Cognitive State of Patients for the Clinician*, 12 J. PSYCHIATRIC RES. 189 (1975).

¹⁰⁷ See D. WECHLER, WAIS-R MANUAL (Psychological Corp.) (1981).

¹⁰⁸ See 494 U.S. at 113.

¹⁰⁹ See S.B. Billick et al., *supra* note 103, at 505.

¹¹⁰ See AMERICAN PSYCHIATRIC ASSOCIATION, CONSENT TO VOLUNTARY HOSPITALIZATION TASK FORCE REPORT n. 34 (1993) [hereinafter APA TASK FORCE].

¹¹¹ See Norman G. Poythress et al, *supra* note 6, *Capacity to Consent to Voluntary Hospitalization: Searching for a Satisfactory Zinerman Screen*, 24 BULL. AM. ACAD. PSYCHIATRY & LAW 439, 442-443 (1996).

¹¹² See *id.* at 440-441. See also G.B. Olin & H.S. Olin, *Informed Consent in Voluntary Mental Hospital Admissions*, 132 AM. J. PSYCHIATRY 938-41 (1975). The authors interviewed patients from 81 state hospitals and 19 private psychiatric hospitals to determine understanding of the voluntary admission contract signed by patients. They found a massive lack of comprehension by patients of their voluntary status. See also Stuart Levine et al., *Competency of Geropsychiatric Patients to Consent to Voluntary Hospitalization*, 72 AM. J. GERIATR. PSYCHIATRY 300 (1993) (patients' understanding of legal and clinical information

The study conducted by Poythress and colleagues at Florida's mental health centers involved 120 persons under court order for involuntary evaluations between October 1994 and July 1995.¹¹³ They were initially brought to crisis stabilization units in west central Florida. The primary aims of the study included:¹¹⁴

- (1) evaluating patients' capacity to give informed consent for voluntary hospitalization under a weak model, as operationalized by comprehension of the MUD-VH disclosures (weak model is described as a relatively less demanding model of informed consent);¹¹⁵
- (2) examining MUD-VH performance separately for patients in voluntary versus involuntary commitment status based on psychiatric assessments completed within seventy-two hours of admission for involuntary evaluation; and
- (3) examining patient factors associated with measured capacity to understand disclosed information relevant to the voluntary admission decision.¹¹⁶

Of the 120 research participants, half (sixty) were judged by the psychiatrist (upon completion of the 72-hour evaluation) to require involuntary commitment via the court and half (sixty) were permitted to sign into the crisis stabilization unit as voluntary treatment patients.¹¹⁷ The primary research instrument was the MUD-VH,¹¹⁸ which consists of two brief paragraphs. The first paragraph articulates several explanations why patients may enter psychiatric hospitals, such as diagnosis, treatment, or preventing harm. The second paragraph explains that discharge from voluntary psychiatric hospitalization is not automatic.¹¹⁹ The paragraph is read aloud, the patients in the study are asked, "What are all the reasons that a person might come into a psychiatric hospital?" and their responses are scored 2/1/0 for *recalling*, respectively, two, one, or none of three reasons in the disclosure.¹²⁰ The patients are then asked, "When a person who has come into the hospital for psychiatric treatment asks to leave, how might the doctors respond?" and their responses are scored 2/1/0 for recalling two, one, or neither of the ways that the doctors might respond.¹²¹

was poor, especially among elderly patients).

¹¹³ See Poythress et al., *supra* note 6, at 443.

¹¹⁴ See *id.* at 443.

¹¹⁵ See Susan Hoge, *On Being "Too Crazy" to Sign into a Mental Hospital: The Issue of Consent to Psychiatric Hospitalization*, 22 BULL. AM. ACAD. PSYCHIATRY & LAW 431-50 (1994).

¹¹⁶ See *id.* Factors included diagnosis and present mental status.

¹¹⁷ See *id.* Both groups were similar in clinical and demographic characteristics.

¹¹⁸ See Poythress et al., *supra* note 6, at 445.

¹¹⁹ See *id.*

¹²⁰ See *id.*

¹²¹ *Id.* The range of possible scores on the MUD-VH is 0 to 4.

More than half (65 of 120, 55%) of the patients in the study displayed some impairment.¹²² The study's comparison of competency of voluntary and involuntary patients revealed some startling findings. Voluntary patients were found to be more impaired in capacity, as measured by the MUD-VH, than involuntary patients.¹²³ The study revealed that 55 % of all patients, and 62.3 % of those permitted to sign into the crisis stabilization units on a voluntary basis, demonstrated impaired capacity to consent as measured by the MUD-VH.¹²⁴ This data raises serious concerns about voluntary patients' ability to understand their admission status.

The study also points out the situations where the psychiatrist refuses to accept a patient as a voluntary admission unless the patient agrees to take psychotropic medications.¹²⁵ The study reports that a number of involuntary patients may have been denied the right to voluntary admission because of doctors' concerns about medication.¹²⁶

The most troubling data from the study, according to the authors, are the relatively poor performances of the voluntary admission patients on the MUD-VH.¹²⁷ If passing the MUD-VH were necessary to demonstrate capacity to consent to voluntary hospital admission, the researchers suggest that involuntary commitment hearings would be required for a considerable number of persons now admitted voluntarily.¹²⁸ As the authors point out, a significant increase in the number of required involuntary placement hearings would not be a desired result, as people with mental illness prefer treatment that is not coerced and that values individual autonomy in treatment decisions.¹²⁹

The researchers of the study propose two courses of action. One proposal is to lower the threshold for demonstrating sufficient capacity.¹³⁰ The second suggested approach would be to explore alternative ways of measuring what patients understand about disclosures such as the MUD-VH.¹³¹ For example, there could be a *recognition* task, demanding only that patients identify correct information from alternatives in multiple-choice format.¹³² The MUD-VH utilized a *recall* format, which places greater demands on patients to retain, remember, and mentally

¹²² See *id.* at 446.

¹²³ See *id.* at 449 (Study found 63.3% of voluntary patients scored <4, compared with 46.7% of involuntary patients).

¹²⁴ See Poythress et al., *supra* note 6, at 447.

¹²⁵ See *id.* at 448.

¹²⁶ See *id.* at 449.

¹²⁷ See *id.*

¹²⁸ See *id.*

¹²⁹ See *id.* at 449-450. Mental health professionals consider involuntary commitment resource-consuming, counter-therapeutic and of value only as a last resort. See *id.* at 450.

¹³⁰ See Poythress et al., *supra* note 6, at 450 (reducing MUD-VH score to less demanding list of understanding). See also APA TASK FORCE, *supra* note 112.

¹³¹ See Poythress et al., *supra* note 6, at 450.

¹³² See *id.* at 451.

organize their responses for verbal presentation.¹³³ The recognition format alleviates the need for significant recall and mental organization.¹³⁴ These studies suggest that mental illness patients may know more than they are able to show when challenged with a test of capacity that relies on recall.¹³⁵ The screening test that focuses on recognition may allow patients to earn a passing "competency" score. However, the question really is whether patients in acute phases of mental illness at the hospital door can mentally organize their thoughts clearly and verbally express their ideas in a competent way. We should not seek a test that is easy to pass: we should develop an accurate screening tool that will help a judge determine the competency of a patient contemplating a voluntary admission.

It is urged that an attorney be appointed to advise and consult with patients with mental illness who arrive at the hospital against their will and subsequently consider signing a voluntary admission document. If patients still seek voluntary admission, an administrative law judge should conduct a hearing to determine by clear and convincing evidence the following:

- (1) The patient has a mental disorder.
- (2) The mental disorder is susceptible to care or treatment.
- (3) The individual understands the nature of the request for admission.
- (4) The individual is able to give continuous consent to retention by the facility.
- (5) The individual is able to ask for release.

The hearing should determine the validity of the voluntary admission. It should check to see that the request for voluntary admission was not coerced and that the patient understands the risks and benefits of the hospitalization. The patient will be represented by counsel and the rights of the parties will be similar to those individuals who have an involuntary civil commitment hearing.¹³⁶

The patients who sign papers for voluntary commitment after involuntary admission, according to Appelbaum and colleagues, seem to be particularly at risk for impaired capacity.¹³⁷ The patients initially admitted on an involuntary basis are at high risk of impaired capacity to consent to voluntary hospitalization, in contrast to those signing voluntary papers at the time of admission. The former group

¹³³ See *id.* The recall format is considered quite challenging to persons in an acute phase of psychiatric disturbance, where expansive thinking, flight of ideas, and personalized associations to disclosed materials may substantially interfere with mental organization and verbal expression of complex materials. See *id.*

¹³⁴ See *id.* (precluded erroneous responses due to multiple choice testing).

¹³⁵ See *id.*

¹³⁶ Such rights include live testimony, right to counsel, record of testimony, and a hearing in a timely manner.

¹³⁷ See Appelbaum, *Competence to Consent*, *supra* note 95, at 1196.

warrants genuine concern, according to these researchers. This is precisely the reason for insisting on a judicial review to screen for capacity to consent to voluntary hospitalization, a protection the U.S. Supreme Court urged at the time of the *Zinermon* decision.

Some might argue that a judicial review of voluntary admissions for patients who initially arrive at the hospital against their will and seek to exercise their right to voluntary admission might have antitherapeutic consequences. Those consequences include an increase in unnecessary use of incompetence labeling and relegating those with mental illness to a form of second-class citizenship.¹³⁸ The MacArthur study challenges the *Zinermon* dicta that imply that those with mental illness should not receive a presumption of competence.¹³⁹ The MacArthur study, according to Bruce Winick, should cause the *Zinermon* court to retreat from the furthest reaches of its broad dicta and should buttress the presumption in favor of competency that has been the direction of modern mental health law reform.¹⁴⁰ Persons with mental illness should be able to exercise free will and choose voluntary admission, if capable of doing so.

However, the significant number of individuals who arrive at psychiatric hospitals against their will and sign a voluntary admission document the day preceding the scheduled involuntary admission hearing, or on the day of the scheduled hearing, should raise a suspicion as to the true voluntary nature of their consent. Psychiatrists have attempted to maximize voluntary admission to psychiatric hospitals and minimize involuntary admission, which in part has been accomplished by persuasion.¹⁴¹ Psychiatrists have allowed patients to assent to be voluntary patients when they may not have been competent to give fully informed consent to hospitalization as voluntary patients.¹⁴²

Balancing the individual autonomy and exercise of free will against the risk of loss of liberty and freedom as a result of coercion, duress, and lack of understanding as to the legal implications of voluntary admission to a psychiatric hospital should lead one to accept the minor intrusion into the rights of both patient and hospital psychiatrist by requiring a judicial determination of capacity to consent to voluntary psychiatric hospitalization.

IV. THE DATA; VOLUNTARY ADMISSION, POSTPONEMENT, DISCHARGE, OR HEARING: THE FOUR OPTIONS AT A PENDING INVOLUNTARY CIVIL COMMITMENT HEARING

A review of patients who are involuntarily committed to psychiatric hospitals because they are alleged to be a danger to themselves or others reveals interesting

¹³⁸ See Bruce Winick, *The MacArthur Treatment Competency Study: Legal and Therapeutic Implications*, 2 PSYCHOL. PUB. POL'Y & LAW 137, 154 (1996).

¹³⁹ See *id.*

¹⁴⁰ See *id.*

¹⁴¹ See Jeffrey Janofsky, *Competency Assessment of Medical and Psychiatric Patients Under Maryland's Health Care Decisions Act*, 44 MD. MED. J. 105, 107 (1995).

¹⁴² See *id.*

findings. In Maryland, an individual proposed for involuntary admission is afforded a hearing to determine whether the individual should be involuntarily admitted to a psychiatric facility or should be released within ten days of the date of the individual's initial confinement.¹⁴³ During the period between the individual's initial confinement in the facility and hearing date, the patient is under observation,¹⁴⁴ during which a number of events may occur. Of the thirty patients on a weekly involuntary commitment hearing docket at a particular psychiatric hospital, 41% of the patients converted their status to voluntary patients prior to the scheduled hearing.¹⁴⁵ The empirical data that is provided in this article is submitted to demonstrate the extent and variety of patient status at a specific psychiatric hospital. During the period between April 8, 1998, and May 26, 1999, this author recorded and tabulated the disposition status of those psychiatric patients scheduled for an involuntary civil commitment hearing, a total of 1,433 patients.¹⁴⁶

The graphs at the end of this Article demonstrate the outcome of these "observation" status patients.¹⁴⁷ Nearly half of the patients had their status converted to voluntary patients and only 10% have formal involuntary civil commitment hearings.¹⁴⁸ Consequently only a few psychiatric hospital patients had access to an attorney and were afforded an administrative hearing in front of an administrative law judge to determine whether they should continue to be hospitalized. When patients sign consent forms converting them to voluntary status, they are not afforded the right to consult an attorney or have an administrative law judge review their capacity to consent to the voluntary admission. In many states, including Maryland, after the patient signs a voluntary admission document, there is neither an expiration date nor an automatic renewal requirement.¹⁴⁹

Patients admitted on voluntary status tend to appreciate and accept the benefits of care and treatment, and as a result, avoid the societal stigma attached to involuntary commitment. Their autonomy is respected, and the therapeutic relationship between psychiatrist and patient is protected.

Conversely, the significant number of patients involuntarily confined on observation status who subsequently are admitted as voluntary patients do not enjoy the right to judicial review or legal representation. In contrast with an involuntary civil commitment hearing, where patients have access to judicial

¹⁴³ See MD. CODE ANN § 10-632(b) (1999).

¹⁴⁴ See Maryland Hygiene Regulations, COMAR § 10.21.01.02(18).

¹⁴⁵ See Donald Stone, *Involuntary Civil Commitment Status Survey* (April 8, 1998-May 26, 1999).

¹⁴⁶ See *id.*

¹⁴⁷ See *id.*

¹⁴⁸ See *id.*

¹⁴⁹ See COMAR § 10.21.01.08(C). Semiannual hearing not later than six months from the date the individual is involuntarily admitted to an inpatient facility, however, no corresponding hearing is required for voluntarily admitted patients.

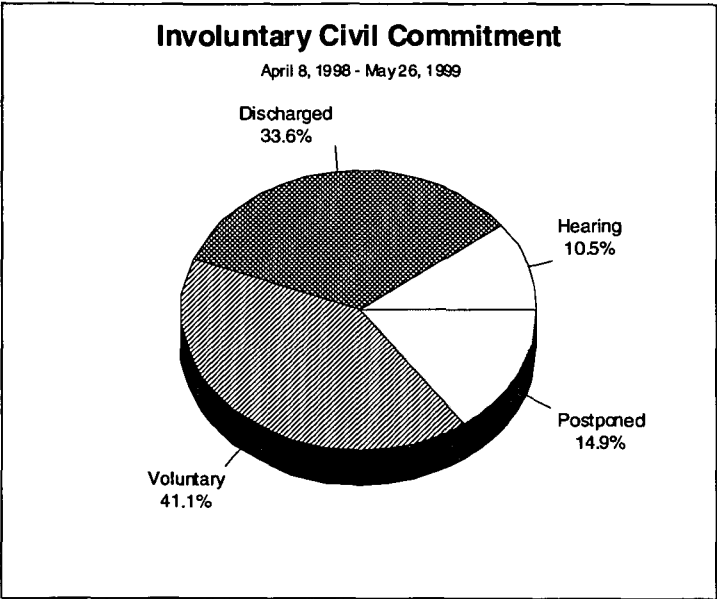
review and legal representations, a voluntary admission is signed in private, away from the view of a judge, lawyer or others scrutinizing the potentially coercive nature of the process. After a patient agrees to a voluntary admission, the treating psychiatrist determines the duration of confinement. The patient receives neither judicial review of the initial voluntary admission decision nor the patient's continued need for hospitalization. A voluntary patient, in most states, does not have a right to discharge on demand. Usually 72 hours advance notice must be provided to the hospital, at which time either discharge is arranged or the process of conversion to involuntary status begins.¹⁵⁰

These state statutes fail to provide necessary legal protections. An attorney should be appointed to counsel "observation status" patients who seek voluntary commitment in an inpatient facility after they have been involuntarily committed. In addition, the administrative hearing should make formal findings that the patient knowingly and voluntarily consented to the voluntary admission and understood its legal implications. This additional layer of protection will ensure that patients with mental illness are capable of requesting a voluntary admission and have their legal rights protected and, above all, due process respected.

¹⁵⁰ See, e.g., MD. CODE ANN. (HEALTH GENERAL) §10-803(b) (1999).

APPENDIX

Graph #1



Graph #2

