

# Incompetence, Treatment Refusal, and Hospitalization

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Psychiatrists have proposed broadened commitment statutes based on need for care and treatment, and under which judges have no role in deciding cases of treatment refusal. The mental health bar has consistently opposed these proposals on constitutional and common law grounds. The authors propose new commitment criteria based on incompetency to decide about hospitalization, and inability to live safely in freedom. The proposed standards would meet the Constitutional requirements, and would permit hospitalization and/or treatment for many persons who are in need but who now go without. The authors recognize that new commitment law without adequate clinical resources will not greatly improve patient care.

Under current commitment and right to refuse treatment laws, many persons with chronic, severe mental disorders cannot be hospitalized or treated. Therefore, many psychiatrists favor broadening commitment laws, with clinical rather than judicial resolution of cases of treatment refusal. The psychotic homeless are a particular concern, and Lamb<sup>1</sup> has argued that society should provide services for them, voluntarily if possible but involuntarily if not.

Many within the mental health bar have vigorously opposed proposals to broaden commitment laws. They argue that public mental hospital treatment is often inadequate, and that involuntary civil commitment violates the constitutional right to liberty and self-determi-

nation. Many courts have agreed, holding that the state can deprive someone of liberty only when it has a compelling interest in doing so. Current commitment laws have a foundation in two compelling state interests: protecting the public from certain dangerous persons and protecting those who cannot protect themselves.

In 1975<sup>2</sup> and again in 1990<sup>3</sup> the Supreme Court clearly stated the principles governing involuntary civil commitment. In *O'Connor v. Donaldson* the Court said, "there is still no constitutional basis for confining such (mentally ill) persons involuntarily if they are dangerous to no one and can live safely in freedom." (p. 563-4)<sup>2</sup> In *Zinerman v. Burch*, the Court said, "The involuntary placement process serves to guard against the confinement of a person, who though mentally ill, is harmless and can live safely outside an institution.

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Confinement of such a person . . . is unconstitutional.” (p. 987)<sup>3</sup>

In this paper we propose a change in commitment standards that is consistent with these holdings, but that permits involuntary hospitalization of some persons who cannot be hospitalized under existing law. Our proposal is firmly grounded in the developing law of right to refuse treatment. The proposal permits involuntary hospitalization of psychotic persons who are incompetent to refuse hospitalization and who, without hospitalization, could not live safely in freedom. The proposal would authorize a limited guardian or other independent decision maker to make decisions about hospitalization for the incompetent person.

The commitment proposal is not meant to replace existing standards based on danger to self or others or grave disability. We propose that persons are committable if they meet either existing standards or the proposed standard.

Several states, e.g. Utah, Texas, require a finding of incompetence to make treatment decisions in addition to dangerousness as a basis for civil commitment.<sup>4, 5</sup> However, no state, to our knowledge, permits civil commitment based on incompetence in the absence of danger to self or others or grave disability.

***The Proposed Commitment Standard*** We propose that a person who meets three criteria may be temporarily civilly committed. The person: a) is incompetent to refuse hospitalization, b) has a severe mental disorder, c) cannot live safely in freedom.

Whether this proposed standard represents a significant addition to current commitment laws depends in part on whether “inability to live safely in freedom” is distinguishable from “gravely disabled.” “Gravely disabled” standards in most jurisdictions set a higher threshold for commitment than is required for committing persons who are dangerous to self or others. For example, the Massachusetts statute requires a “very substantial risk” of serious harm by reason of mental illness for commitment as gravely disabled. For danger to self or others the standard is “substantial risk.” Other jurisdictions draw a similar distinction.

As articulated by the U.S. Supreme Court, the ability to live safely in freedom appears to be a somewhat broader criterion than absence of grave disability. A finding of grave disability requires an immediate, ongoing threat to life or safety. By contrast, a finding that the person cannot live safely in freedom requires only the risk of foreseeable harm. “The test as respects foreseeability is not the balance of probability, but the existence, in the situation in hand, of some real likelihood of some damage and the likelihood is of such appreciable weight and moment as to induce, or which reasonably should induce, action to avoid it on the part of a person of reasonably prudent mind.” (p. 148)<sup>6</sup>

Our reliance on competency as a basis for deciding on involuntary hospitalization is consistent with the evolving law of right to refuse treatment. Under right to refuse treatment law, a competent decision maker may refuse medication.

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However, if a person is incompetent to decide about treatment, a substitute decision maker will make the decision. Similarly, under our proposal, a competent nondangerous decision maker may refuse involuntary hospitalization, even if unable to live safely in freedom.

***Procedures Required Under the Proposed Commitment Standard*** Current commitment law requires psychiatrists to evaluate presence or absence of mental disorder, potential danger to self or others, and grave disability. Under our proposal, psychiatrists would also evaluate the patient's competency to decide about hospitalization, and whether the person could live safely in freedom. If the psychiatrist concluded that the patient would benefit from hospitalization, was incompetent to decide about hospitalization and could not live safely in the community, then the psychiatrist could temporarily commit the patient. This would be the case even if the patient was not dangerous to self or others or gravely disabled. However, any patient who is involuntarily hospitalized would have the right to a full due process hearing in court as is now true in all jurisdictions.

The psychiatrist as substitute decision maker should rely on the substituted judgment standard if there is good evidence of what the patient would have chosen if competent. If such evidence is lacking, the psychiatrist would use the best interests standard, or some combination of substituted judgment and best interests. In every case, as is now true, the standard of least restrictive alterna-

tive should govern the choice of disposition.

***Assessment of Competency*** Our proposal requires that psychiatrists have a set of rules for determining competency to decide about hospitalization. These rules must meet two conditions: they must make clinical sense, and they must satisfy later judicial review. In law, a competent decision is one in which the individual has a rational as well as a factual understanding of the alternatives. That is, he or she understands not only the facts, in this case hospitalization versus the community, but how those facts apply to his or her particular situation.

Generally, the courts have held that a competent medical decision is one in which the individual understands the risks and benefits of the alternatives. Judges have requested psychiatric assistance in applying these criteria in cases involving refusal of antipsychotic medication. In response, psychiatrists have suggested an analytic framework that courts have found helpful.<sup>7,8</sup> That analysis can apply equally to decisions about hospitalization.

Psychiatrists suggest that, as a general rule, mentally ill persons who deny their illness lack a rational understanding of how treatment could benefit them.<sup>7</sup> Thus, persons who deny their illness are incompetent to make this decision. Denial of illness is the most common basis for incompetence to decide about antipsychotic medication, but there are others.<sup>9</sup> Medication refusal for a delusional reason is incompetent as is refusing medication and refusing to give a reason

for refusing. Refusing to make a choice also indicates incompetency.<sup>10</sup>

A similar analysis applies to assessing competence to refuse hospitalization. Denial, delusional reasons, no reasons, and no choice are all a basis for concluding the patient is incompetent.

Criteria for a finding of incompetency to decide about a living situation may vary depending on the choices. A mentally ill person who denies being ill is incompetent to decide about a psychiatric hospital versus the street. However, denial of illness might not interfere with his competency to decide between the street and a shelter. A man who denied his illness might competently prefer the street to life in a shelter, giving, for example, the reason that other men in shelters would rip him off.

Psychosis alone is an insufficient basis for a finding of incompetence to make a particular decision. A person may have a delusional system that does not affect that particular decision. The clinician must assess how the patient's mental status or disorder renders him or her unable to appreciate the risks and benefits of the decision at issue.

### Comment

This paper proposes a substantial modification in commitment law. We propose to extend the existing legal theory of right to refuse treatment cases to a new decision: the right to refuse hospitalization. As is now true, our proposal reserves to a judge the ultimate authority to declare a person legally incompetent. However, the proposed procedure would permit a psychiatrist to make an initial,

preliminary assessment of competence to decide about hospitalization. If the psychiatrist found the patient to be incompetent to decide for or against hospitalization, and hospitalization was necessary for the person to live safely, then the psychiatrist would have the authority to order temporary involuntary commitment.

The model commitment statute of Stromberg and Stone,<sup>11</sup> adopted by APA over 10 years ago included incompetence to decide about hospitalization as one necessary criterion for involuntary hospitalization. A second criterion was that, the person, "As a result of severe mental disorder . . . is likely to suffer substantial mental or physical deterioration." (p. 330)<sup>11</sup>

Our proposal is similar in that it makes incompetence to decide about hospitalization a criterion for involuntary hospitalization. Our proposal provides the criterion, "cannot live safely in freedom" in place of "likely to suffer substantial mental or physical deterioration."

Is this a distinction without a difference? Just possibly, it is not. No jurisdiction has adopted the model commitment statute. Opposition from the mental health bar has focussed on the "deterioration" criterion which opponents see as a thinly disguised "in need of care and treatment." The opponents state that this expands *parens patriae* without any substantive legal foundation.

"Unable to live safely in freedom" has a clear foundation in cases decided over 15 years, and authored by courts sepa-

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rated even more widely by their composition and ideology. Perhaps it is naive to believe that anchoring our proposed standard in constitutional law would make a difference, but we think it may. At the least, attorneys who base their objections in legal theory must find some new basis for objecting to this proposal.

Our proposal deals effectively with one common problematic case: the emergency evaluation of the mute or monosyllabic, apparently psychotic street person. Uncommunicative, apparently psychotic street people are not committable as gravely disabled absent evidence of immediate danger. However, if they fail to make a choice when asked about possible hospitalization, then they are assessed as incompetent and therefore potentially committable. This incompetence, coupled with the risk of foreseeable harm on the street and evidence of mental illness would satisfy our criteria, and the patient could be committed.

A second common, but perhaps more complex, clinical problem is the adult, typically a man with chronic severe mental disorder who is cared for by his parents. When he stops taking his medication and becomes abusive, under present commitment law many families face a Hobson's choice: either evict the patient or put up with the abuse. Most families regard eviction as cruel, and they choose to put up with the abuse, but they deeply resent the system that forces them to do so.

Many such patients insist that they have no mental or emotional problem.

Those who deny their illness cannot rationally evaluate the usefulness of a hospital or of antipsychotic medication, and on that basis they are incompetent to make both decisions. However, while at home these patients seldom deteriorate to the point of grave disability, and they continue to live safely in freedom at home as long as the family puts up with the abuse. Even under our proposal the patient is not immediately committable.

In this situation, families with money can hire an attorney to petition for a limited guardian to make treatment decisions for the patient. Most jurisdictions impose no sanctions on outpatients who fail to abide by court ordered involuntary medication. Nevertheless, some patients who refuse medication will take it under court ordered guardianship.

As an alternative to seeking guardianship, any family could tell the patient either to take medication or leave home. Suppose the family offers this choice and the patient declines both options. If a psychiatric evaluation indicates that the family has the necessary resolve to evict this patient and that the patient would be foreseeably endangered in the community, then, under our proposal, he would be committable. This scenario offers the family of these patients a potentially acceptable way of dealing constructively with these patients.

Colorado deals with this problem by creating an exception in its definition of grave disability for certain patients with chronic, severe mental disorder who live at home.<sup>12</sup> If such a person is not disabled but would likely become disabled

outside the home, then the person is committable if he meets specific criteria of illness, chronicity, and is likely to benefit. Our proposal accomplishes the same end, but consistent with existing law, rather than as an exception to a rule.

Outpatient commitment is an alternative approach to treating some of these patients. Outpatient commitment only works well when there are sanctions—inpatient treatment for patients who fail to follow an outpatient treatment regimen. Few jurisdictions impose such sanctions. However, outpatient commitment requires the same findings as inpatient commitment, namely danger to self or others or grave disability. Our proposal would raise inpatient treatment as a possible sanction for outpatients who would not be able to live safely in freedom without medicine. This is conceptually close to outpatient commitment. Here again, the value of this approach depends on the extent of the difference between grave disability and inability to live safely in freedom.

Many persons who need care and treatment and who are not now committable would be committable under our standard. These are, first, homeless psychotic persons who are not an immediate danger to themselves or others. Second, there are patients who are cared for by family or others and who deteriorate after refusing medication. Many of these latter patients would choose outpatient medication in preference to hospitalization. Thus, it is not clear that our proposal would necessarily lead to increased commitments of these patients.

It could, equally, lead to increased compliance with outpatient treatment regimens.

Our proposal seeks to reconcile two goals, one medical and one legal, that up until now have been in conflict. Psychiatrists seek to treat patients. Attorneys seek to protect their legal rights. If adopted, our proposals would permit psychiatrists to treat and/or hospitalize involuntarily some patients in need of care and treatment who now go untreated. These are the patients who otherwise would "rot with their rights on."<sup>13</sup> They are the casualties of the failure of law and psychiatry to reach agreement.

No proposal to change the law will by itself improve patient care. If, as we believe, this proposal leads to the commitment of some patients who would not be committed otherwise, then, as a matter of justice and of good clinical care, states must allocate resources to meet the needs of these and all other committed patients.

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