Report of the Task Force on Consent to Voluntary Hospitalization

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I. Introduction

In February 1990, the U.S. Supreme Court issued a decision, *Zinermon v. Burch*, which may lead to changes in law and practice that will make it more difficult to allow patients with doubtful capacity to consent to voluntary hospitalization. If patients who agree to admission are prevented from becoming voluntary patients because of doubts about their capacity, this change could reverse many of the gains of the last several decades, during which voluntary admission has become the most common means of entry into psychiatric facilities.[1] A 1986 survey of 1,508,302 admissions to psychiatric inpatient settings of all types showed that 71 percent were voluntary.[2]

Our task force was formed to review the relevant issues and draw conclusions about how best to handle patients who agree to voluntary admission but for whom there is a question about their capacity to consent to it. We made two assumptions.

1. It is far more desirable to preserve voluntary admission whenever possible than to attempt to reroute large numbers of voluntary patients into the involuntary admission system.

We noted many reasons for this. Voluntary admission: (a) upholds patients' autonomy by allowing them to make this important health care decision; (b) maximizes patients' rights, including the right to treatment in the least restrictive setting and the right to request discharge; (c) reduces the stigma associated with psychiatric hospitalization; (d) broadens access to inpatient care, since not every patient who could benefit significantly from voluntary hospitalization will meet the more restrictive requirements for involuntary hospitalization; (e) allows treatment to begin before significant deterioration has occurred; (f) sets the stage for establishing a collaborative relationship by increasing patients' responsibility for and participation in their own treatment; (g) may lead to a more favorable outcome when compared with hos-

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pitalization undertaken on an involuntary basis; (h) avoids the vastly increased costs to both the mental health and judicial systems that would occur if large numbers of voluntarily admitted patients were handled as involuntary admissions.

2. The primary safeguards for patients who are voluntarily hospitalized are clinical, and not legal.

The *Zinermon* decision highlights the need to assure that widely recognized clinical safeguards are carried out with every hospital admission: namely, that a physician assures that the admission is necessary and appropriate, that the diagnoses and treatment plans are periodically reviewed, and that the need for continued hospitalization is adequately documented.

Our recommendations therefore emphasize both the importance of preserving voluntary admission and the essential nature of clinical safeguards.

II. Summary of *Zinermon v. Burch*

Darrell Burch, whose condition was later diagnosed as paranoid schizophrenia, was found wandering along a Florida highway, bruised, bloody, and disoriented.[3] He was taken to a community mental health center for evaluation. Upon arrival, Burch was hallucinating and confused, and stated that he believed he was "in heaven." At the request of the staff member, Burch then signed forms giving his consent to voluntary admission to the facility and authorizing treatment.

After three days at this facility, Burch was transferred to a state hospital. On arrival at the hospital, he was given additional admission forms by a clerical worker and, after signing them, was considered a voluntary patient. Apparently, no clinical or other staff member inquired into Burch's competency to execute the forms. They were accepted at face value even though under Florida law a patient who desires voluntary admission must make "application by express and informed consent," and there was much in Burch's hospital record that suggested he lacked the capacity to make such application.

Burch remained hospitalized for five months without a hearing or any other review of his voluntary status. After discharge, he filed a federal civil rights action against various officials at the state hospital, alleging that he was deprived of his liberty without due process when they admitted him to the hospital as a voluntary patient, since he was incompetent to give his informed consent.

The Court's ruling had a narrow and highly technical focus. It concerned whether the application of a specific section of the federal civil rights laws was a remedy available to Burch. The decision explicitly stated that the question of whether a voluntary patient must be competent to consent to admission was not before the Court, and would not be decided.[1]

Nonetheless, the Court expressed a broad range of concerns apart from the decision itself. The Court questioned whether hospital personnel should assume that a mentally ill patient who agrees to voluntary admission is making

"a knowing and willful decision" about hospitalization. The majority also affirmed that the manner of Burch's confinement "clearly infringe(d) on his liberty interest."

Although technically not deciding the question, the Court suggested the existence of a new substantive due process requirement of competency to consent to voluntary hospitalization, and a related procedural due process requirement that such competency be determined prior to admission. Moreover, although only a community mental health center and state hospital were involved, the Court's decision might be applicable to other psychiatric facilities as well. If *Zinermon*'s language is read this broadly, existing practices concerning voluntary admission will need substantial reexamination.

Zinermon, however, need not be read this broadly.[4] First, the suggestion that there should be an inquiry into the competency of patients who consent to voluntary hospitalization appears in dicta, which neither the Court itself nor other courts are bound to follow. In any case even if further inquiry were deemed necessary, the Court's opinion does not indicate the nature of the required procedure. It should not be assumed that a judicial hearing would be necessary.[4-6]

III. The Problem Posed by the *Zinermon* Decision

The *Zinermon* decision calls our attention to some problems, largely unexamined until now, that may arise when patients assent to voluntary admission but have doubtful capacity to do so. Under these circumstances, patients may not be able to understand the nature and purposes of inpatient admission, or to assess the costs and benefits of hospitalization over time. To address these concerns, standards must be established for identifying patients who may lack capacity to consent to admission and procedures defined for protecting their interests, while at the same time encouraging the use of voluntary hospitalization. As is so often the case, when a previously unstudied mental health practice is exposed to sustained scrutiny, the need for improvement becomes evident.

It must be said at the outset, though, that remedies are best sought in better clinical safeguards.[7] In reviewing Burch's experience, the court noted a lack of attention by clinicians as to whether Burch was a suitable voluntary patient, stating ". . . he was simply given admission forms to sign by clerical workers." In addition, he continued as a voluntary patient for five months "without a hearing or any other procedure" to review the appropriateness of this status. These are problems that clinicians can correct without resort to legal proceedings.

IV. State Statutes and Practices Concerning Voluntary Hospitalization

Massachusetts enacted the nation's first provision for voluntary hospitalization in 1881.[8] By 1969, only Alabama lacked a provision for voluntary hospi-

talization.[8] To understand the impact of *Zinermon* and the potential costs and benefits to patients, we need to examine how law and practice differ from state to state.

A. Requirements for Admission At the time of voluntary admission, three factors can be considered in the decision to admit the patient: appropriateness, voluntariness, and capacity. To ascertain which of these are required by law, we reviewed voluntary admissions statutes in all 50 states between September 1990 and December 1990 using statute books and computer-based legal retrieval systems.

Almost all states require a determination of appropriateness. Less than one-third of states explicitly require a determination of voluntariness; less than one-third require a determination of capacity. In Florida, where *Zinermon* originated, a review of all three elements was mandated, but clearly most states have elected to adopt less restrictive criteria for voluntary admission. Of those states that require one or more of these factors, only a minority mandate specific procedures for establishing their presence.

B. Provisions for Release It is important to know not only how easy it is for patients to gain admission, but also how difficult it is for them to successfully request discharge. A voluntary admission that requires immediate release on the request of the patient (sometimes called an informal admission) differs from a "conditional" voluntary admission, which allows for the temporary retention of a voluntary patient over the patient's objection. The potential disadvantages to a patient of questionable capacity who consents to voluntary admission will vary with these retention provisions.[9-11]

Almost every state addresses release provisions. Although several states require immediate discharge, in most states, the conditional voluntary admission model is used, allowing for a retention period of one to five days to permit initiation of involuntary commitment proceedings where this would be appropriate.[8, 10] Here, too, however, state statutes vary widely, and one state allows for a period of retention for up to 60 days. Because of the period of time required for adjudication, additional delays in release sometimes occur when a patient successfully contests a petition for commitment. Half of the states require that patients be advised concerning their right to release. In addition, 10 states permit informal admission. All informal statutes require release within 24 hours at the latest.

C. Hospitalization Practices In addition to variations in the state statutes themselves, there are significant differences in actual practice. This is particularly noticeable in public mental hospitals. In some jurisdictions, state hospitals admit the majority of patients on a voluntary status, in others on an informal status, and in still others on an involuntary status. The degree of concern about *Zinermon* increases in states where the proportion of patients admitted voluntarily is greater.

D. State Responses to Zinermon Our task force sampled state responses to the *Zinermon* decision and found most

states had not introduced new legislation or regulations. However, some state mental health agencies were instituting or recommending changes in procedure or practice such as documenting capacity at the time of admission, using informal admission more often, or appointing guardians in more cases. One state passed a court rule several months following the *Zinermon* decision requiring judicial hearings for voluntary patients within 20 days of either admission or conversion from an involuntary to a voluntary status. However, plans for this change were under way prior to the *Zinermon* ruling. In Florida, where this case originated, proposed revisions to the Florida Administrative Code were developed. But the changes were not implemented because interested parties argued forcefully that these revisions would deprive many patients of voluntary admission. There is continuing work to develop appropriate and acceptable changes in rules or statutes.

Concerns expressed by mental health lawyers in response to *Zinermon* included the following:

1. State statutes that favor voluntary over involuntary admission discourage or even prevent channeling assenting patients of doubtful capacity into the involuntary admission system.

2. Patients currently in the hospital on a voluntary status who have questionable capacity may not meet criteria for commitment.

3. Introducing the idea that mental patients have to prove their competence could create vast problems in other areas, such as the right of patients to receive and control their own entitlement benefits.

4. Systematic review of capacity may have major impact on adult patients who are mentally retarded or elderly.

5. Determining a patient's capacity requires a very subjective judgment.

Our proposed model for responding to *Zinermon* attempts to be sensitive to these concerns and flexible enough to be used by states operating under varying regulations and accepted practices.

APA Guidelines on Voluntary Hospitalization

The American Psychiatric Association strongly believes that it is preferable, wherever possible, for patients to be able to initiate their own psychiatric treatment. Voluntary admission represents progress in the humane and respectful treatment of people with mental illness. Until well into the 20th century, inpatient psychiatric hospitalization in the United States was available mainly to those who had been formally committed[12] through legal procedures borrowed, with little modification, from criminal law.[13, 14] As mental disorders came to be viewed more as illnesses than moral defects, a transition from a legal model of commitment to a medical model of voluntary hospitalization occurred.[15] We believe preserving this medical model is in the interest of all parties—patients, their families, mental health professionals, and the judicial system.

The challenge raised by *Zinermon* is how to protect patients who may be too incapacitated to make a fully informed

decision while continuing to encourage the use of voluntary admission. The APA established safeguards for voluntary admission a decade ago in its policy statement "Guidelines for Legislation in the Psychiatric Hospitalization of Adults." [16]

These guidelines direct the admitting physician to address all three factors that pertain to the voluntary admission of a patient—appropriateness, voluntariness, and capacity. In Section 5.A.3 the guidelines specifically address the problem of a voluntary patient who may lack capacity in the following way:

> If the responsible psychiatrist (optional provision: "the responsible physician") has substantial reason to believe that a person seeking to admit himself or to consent to further hospitalization lacks capacity to make an informed decision concerning treatment, he shall obtain, in addition to the consent of the patient, the informed consent of the patient's next of kin or guardian. The responsible psychiatrist (optional provision: "the responsible physician") shall renew his effort to obtain the informed consent of the patient if the patient regains the capacity to make an informed decision concerning treatment.

The task force believes these Guidelines form a sound foundation for protecting voluntary patients. However, the Guidelines fail to address certain issues raised by the *Zinermon* decision. Insofar as third party consent to voluntary admission is appropriate and permitted in a given state, it need not be restricted to the next of kin or a guardian. A third party decision maker could be an individual designated by health care proxy or any other surrogate that the law permits.[17] Even so, many severely mentally ill patients presenting for admission will not have any third party decision maker available to participate in this urgent decision. In addition, the existing guidelines do not distinguish among standards for capacity to consent to hospitalization, capacity to refuse hospitalization, and capacity to consent to or refuse treatment. Finally, the Guidelines do not specifically deal with post-hospitalization procedures for the protection of the interests of assenting patients with doubtful capacity.

An adequate response to *Zinermon* therefore requires modification of the direction taken by the Guidelines. We describe below the two elements of that response: standards for identifying those patients who may lack capacity to consent to voluntary hospitalization, and procedures for protecting the interests of such patients while continuing to encourage the use of voluntary hospitalization.

VI. Capacity to Consent to Voluntary Hospitalization

There is no single definition of capacity,[18-23] although any definition contains within it an attempt to balance individual autonomy on the one hand and the protection of the patient's needs and the public's safety on the other. A definition must be adjusted to the particular costs and benefits of a given situation.[19, 21, 22]

A. Standards of Capacity In this section, we use the term capacity to refer to a patient's decision-making ability as determined by a physician and avoid the term competence, which is often associated with a judicial determination of decision-making ability.

A review of the literature suggests significant limitations in the decision-making capacity of medical patients in general, and of elderly medical patients in particular.[23–35] Despite this fact, medical patients are not generally subjected to strict tests of capacity. As the 1982 President's Commission report entitled *Making Health Care Decisions* points out, "neither the self-determination nor the well being of a patient would usually be advanced by insisting on an inquiry into the patient's decision-making capacity (or lack thereof) when patient, physician, and family all agree on a course of treatment." [36] In general, it is assumed that little harm will occur to the patient under these circumstances. The agreement of the admitting physician, and, where present, the family, constitutes a check on the reasonableness of the patient's decision.

Although there are differences between medical and psychiatric hospitalization,[3, 36] we believe it is in the best interest of all parties to use a similar approach, including a relatively lenient standard of capacity.[21, 25] The benefits to patients who accept voluntary hospitalization will, in the vast majority of cases, outweigh the costs. This is so because the patient is willing to enter the hospital, the admitting physician has concurred with the patient's decision, and the treatment team will provide clinical safeguards following admission. Under these circumstances, the interests of the patient are carefully guarded and his or her expressed wishes are not interfered with. The occasional unwarranted admission of a voluntary patient (unlikely in most public facilities where the primary pressure is to reduce the use of hospital care) will be quickly detected with the use of proper clinical safeguards.

There is a genuine concern that some psychiatric patients may be accepted for voluntary admission when they are clearly incapable of giving consent.[37] But the issue of using legal safeguards to protect patients is most often raised when patients are at risk of receiving inadequate care.[5, 38] A stringent standard of capacity that would block the admission of many voluntary patients, or reroute them into the involuntary system in order to protect them from poor care, does not address the underlying problem. Inadequate care must be remedied with clinical solutions, not legal procedures.

Our task force therefore has described, for the purposes of voluntary admission, both standards of capacity for patients and clinical obligations of staff.

B. Defining a Standard of Capacity for Consent to Voluntary Hospitalization It is probably a good idea to screen the capacity of each potential voluntary patient since some patients will lack even the most basic understanding of the decision to accept voluntary hospitalization.[18, 29, 39–41] The goal of the screening is to identify this group, not to make every patient pass a laborious capacity test.[4] This inquiry should be clinical rather than judicial and should use an undemanding threshold for determining capacity. A requirement for a routine brief clinical assessment of capacity is simple and inexpensive, and

minimizes the need for formal legal proceedings.

But what definition of capacity should be used at the time of this screening? To answer this question, we considered four widely accepted tests of capacity: (1) communicating choices, (2) understanding relevant information, (3) appreciating the situation and its consequences, and (4) manipulating information rationally. Our task force recommends using the first two tests of capacity: communicating choices and understanding relevant information.[20]

A patient can be considered for voluntary admission if the choice communicated by the patient is one of assent to the admission. This requires that the patient, by verbal, written, or behavioral actions, express agreement with the admission decision. Coercion to obtain agreement is not appropriate.[42] Any level of objection by the patient is incompatible with voluntary admission, and a patient who objects can only be considered for commitment.

A patient who can express no opinion whatsoever is not an appropriate candidate for voluntary admission. How such a patient should then be handled will depend on the procedures available under state law. In some states, for example, a guardianship procedure can be initiated. In others, a less formal method of surrogate consent (by the next of kin, for example) may be available. In still others, the only available procedure may be involuntary commitment. Although the admission procedure utilized in these cases will have to be derived from the governing statutes in a particular state, we encourage the use of some formal method of surrogate decision making based solely on the patient's need for hospitalization, rather than reliance on the civil commitment process, which, in our view, is most appropriate for objecting patients.

If the patient has communicated a preference for admission, meeting the capacity standard "communicating choices," the psychiatrist must then determine whether the patient meets the "understanding relevant information" standard. This need not involve a formal interview when it is obvious to the psychiatrist that the patient is capable. Concerns about capacity should be documented in the medical record. A capable patient under the standards defined by the task force is one who: i. understands that he/she is being admitted to a psychiatric hospital or ward for treatment, and ii. understands release from the hospital may not be automatic, and he/she can get help from the staff to initiate procedures for release (this element is not necessary for informal admissions, for voluntary admissions that require immediate release, or for those patients who will be continuously residing on unlocked units and are free to leave at any time).

These capacity standards should be assessed only after the psychiatrist has discussed the nature of the voluntary hospitalization decision with the patient, and disclosed sufficient information to maximize the patient's opportunity to understand the decision, repeating material and inquiring as necessary to clarify misunderstandings.[24, 43]

The task force believes that this threshold for capacity is lenient but meaningful, set at a level that most patients currently admitted on a voluntary status would pass.[39, 41, 45] The costs and benefits weight heavily in favor of allowing patients to choose voluntary hospitalization. Other decisions may call for other standards and tests of capacity need to be appropriate to the specific context.[21, 52] Our definition of capacity assures that decisions about hospitalization made by obviously incapacitated patients are not accepted without further protection being afforded, and that due process is respected. At the same time, consenting patients who demonstrate some capacity and are clinically in need of hospitalization can have their requests honored.

More rigorous standards of capacity have been applied to patients who refuse hospitalization or treatment.[5, 7] We believe the practice of applying a higher capacity standard for refusing treatment than for accepting it takes into account the greater harm that may follow from the failure to accept necessary medical care, and is consistent with the approach of most commentators on this issue.[21, 36, 52] The harm of allowing severe mental illness to go untreated can be substantial.

C. Procedure for Capacity Assessment The assessment of capacity can usually be performed unobtrusively in the course of a routine psychiatric examination prior to admission. If a patient is obviously capable, no action need be taken. If there are doubts about a patient's capacity to consent to voluntary admission, they should be documented in the medical record.

VII. Procedures for Admission of Assenting Patients Whose Capacity Is in Doubt or Impaired

Using the above approach, some assenting patients will have doubtful or impaired capacity. In some states, provisions already exist to deal with this problem. State law may permit an assenting patient who does not appear capable to be admitted on a voluntary status with involvement by a third party. In these cases, the decision maker might be the next of kin, a guardian, a designated substitute decision maker, etc. Wisconsin law, for example, allows a patient who is unwilling or unable to sign an application for admission, but who does not indicate a desire to leave the treatment facility, to be admitted on a voluntary status for up to seven days. A guardian *ad litem* is appointed within 24 hours after a patient is admitted under this procedure. A separate provision authorizes a facility's treatment director to admit an individual temporarily when there is reason to question the competency of that person. The director must apply to the court for appointment of a guardian within 48 hours of admission. The guardian may then admit the person as a voluntary patient, so long as the patient does not object.

Another alternative is to permit a patient whose competence is in question to sign in, and then provide access to a judicial hearing once the patient is in the hospital. This happens, for example, in Ohio. Laws permitting the voluntary

admission of assenting patients with doubtful capacity vary considerably from state to state.

Our task force recognizes the value of these laws and acknowledges that there will be further developments in this area. We favor approaches that avoid lengthy and costly judicial involvement, and that respect the assent of patients to voluntary hospitalization whenever that appears to be in their interests.[18, 51, 53] We recommend, therefore, that assenting patients whose capacity is in doubt or impaired be admitted on a voluntary status when an admitting psychiatrist concurs that hospitalization is in the patient's interest.

The patient's capacity should be reviewed by the treating psychiatrist within 72 hours of admission. If, within that time, the assenting patient's capacity to consent to admission has not yet become fully evident, an independent psychiatrist should be asked to perform a supplemental evaluation of the appropriateness of the patient's hospitalization. The independent psychiatrist should be selected in a manner that minimizes conflicts of interest, or any appearance of conflicts of interest. If the independent psychiatrist confirms the appropriateness of hospitalization, the patient should be maintained on a voluntary status.

This general approach, requiring ongoing clinical assessment, fosters patients' interests in having their choices respected, while protecting their rights to adequate treatment. In many cases, doubts about assenting patients' capacity to meet the "understanding relevant information" standard outlined earlier will be relieved in a few days. The number of patients whose capacity remains impaired more than a week will be very small. Nonetheless, it is extremely important that procedures for periodic independent review be in place in these cases.

This process of review, beginning with a reassessment of the patient's capacity by the treating psychiatrist, should be repeated periodically, perhaps every week during the first 30 days of hospitalization, and whenever the treatment plan is updated.

In the rare cases where the independent reviewer fails to confirm the need for hospitalization, the facility director will have to assume ultimate decision-making authority in light of his or her legal responsibilities under state law. For example, the director may want to develop an additional level of independent review to resolve the clinical disagreement between the treatment team and the independent reviewer. At a minimum, however, the director will want to assure that the patient's clinical status is carefully reviewed and to take appropriate precautions to minimize the risk of a premature discharge on the one hand, or of retaining a patient inappropriately on the other.

VII. Safeguards for Voluntarily Hospitalized Patients

Regarding clinical safeguards, our task force recommends reviews of voluntariness, appropriateness, and capacity prior to admission and again within 72 hours

after hospitalization. By the third day, the intake evaluation should be completed, and the initial treatment plan developed. Clinical reassessment and treatment plan review should occur periodically following admission. These timeframes should be updated as necessary, so that they are consistent with prevailing standards of practice and the expectations of organizations monitoring the quality of care in psychiatric settings. Periodic reviews are essential to ensure the monitoring of changes in the patient's clinical condition, and adjustments in treatment to respond to these changes.

Hospitalization should continue only if it is medically necessary, the patient is receiving active treatment, and hospitalization is the least restrictive alternative available or potentially useful. Sections 9 and 10 of the APA Guidelines for Legislation on the Psychiatric Hospitalization of Adults contain additional requirements for the provision of treatment to hospitalized patients.

Quality assurance mechanisms must be in place to review the quality of care. Existing quality assurance committees may be suitable to monitor the quality of care given to voluntary patients. Such a committee could pay particular attention to voluntary patients whose capacity is impaired. Reviews might include:

—Compatibility between the medications prescribed and the patient's diagnoses.

—Appropriateness of other psychiatric interventions.

—Appropriateness of the patient's length of stay.

—Quality of medical oversight and treatment.

The subcommittee findings could then be referred to the appropriate committee of the institution's medical staff for consideration and action.

The clinical safeguards described are the best way of assuring that voluntary admission is in the best interest of the patient and that voluntary patients do not remain in the hospital without careful ongoing reviews.[54, 55]

As indicated earlier, there may be a small number of patients who have assented to admission but whose capacity to understand the relevant information remains impaired for an extended period of time. In these cases we recommend coupling the ongoing clinical review of appropriateness of hospitalization with a formal surrogate decision-making process, after a designated period of time not to exceed 30 days.

IX. Summary and Conclusions—Recommendations for the Admission of Patients for Voluntary Hospitalization

The task force recommends that state laws be modified, where necessary, to permit the following approach to voluntary hospitalization.

1. The admitting psychiatrist* has primary responsibility for assessing the patient's voluntariness, appropriateness, and capacity prior to hospitalization.

2. The following steps are recommended on admission:

* When a psychiatrist is not available, another physician may perform the role.

(a) The psychiatrist determines appropriateness for hospitalization.

(b) The psychiatrist discusses the nature of the voluntary hospitalization decision with the patient, disclosing sufficient information to maximize the patient's opportunity to understand the decision.

(c) The psychiatrist determines whether the patient objects or assents to admission.

(d) The psychiatrist determines whether the assenting patient has capacity to accept voluntary admission using the understanding relevant information standard defined as follows:

i. The patient understands that he/she is being admitted to a psychiatric hospital for treatment.

ii. The patient understands that release from the hospital may not be automatic, and he/she can get help from the staff to initiate procedures for release (this element is not necessary for informal admissions or for voluntary admissions that require immediate release).

3. If the above examination finds the patient assenting and capable, the patient can be admitted voluntarily without any additional process.

4. If the examination finds that the patient does not assent verbally, in writing, or behaviorally, such a patient should not be hospitalized as a routine voluntary admission. Hospitalization may still be possible in accordance with state law by use of a guardianship procedure, surrogate consent, filing a petition for commitment, or any other appropriate and authorized measure.

5. If the capacity of an assenting patient is in doubt, he or she may be admitted on a voluntary status. The concerns about capacity should be documented in the medical record.

6. A voluntary patient should have his or her capacity to accept voluntary hospitalization reviewed by the treating psychiatrist within 72 hours of admission.

7. If this post-admission review finds that an assenting patient's capacity remains unclear, and that further hospitalization is indicated, our task force recommends review by an independent psychiatrist. The independent psychiatrist should be selected in a manner that minimizes conflicts of interest or any appearance of conflicts of interest.

8. If the independent psychiatrist confirms that hospitalization is appropriate and that the patient is continuing to assent to hospitalization, the patient may be continued on a voluntary status. Subsequent reviews should be performed on a regular basis while the patient remains hospitalized. These reviews will protect patients' interests and rights without involving the judicial system. In the rare cases in which the capacity of an assenting patient to understand information relevant to the admission remains impaired for an extended period of time, some formal procedure for surrogate decision making should be utilized after a designated period of time not to exceed 30 days.

9. If the independent reviewer decides at any time that further hospitalization of an assenting patient is not appropriate, the facility's medical director should assume ultimate decision-making responsibility for the case. The disposition

by the medical director will depend upon the review procedures he or she utilizes to resolve the clinical disagreement regarding the patient's need for hospitalization and the necessity to protect the patient from both premature discharge and inappropriate retention.

10. If, at any time, a previously assenting patient withdraws his or her assent, a determination should be made regarding the patient's continued need for hospitalization. If hospitalization is still indicated, a petition may be filed for the patient's involuntary commitment or placement under guardianship, or whatever other measures authorized by state law may be undertaken, to permit the continuation of hospitalization.

11. All voluntary patients should have periodic reviews of the quality of their care, including, but not be limited to, a review of (a) consistency between prescribed medication and diagnoses, (b) quality of medical treatment (c) appropriateness of the treatment plan, and (d) need for continued hospitalization. Such reviews should be performed by individuals who are not immediately involved in the patient's care—for example, a quality assurance committee that reports to the medical staff. Results of these reviews should be documented in the patient's chart.

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