THE LAW SCHOOL RECORD

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No Way In

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The recent decision of the United States Supreme Court in Zinermon v. Burch [110 S. Ct. 975 (1990)] may make it more difficult and more costly to obtain inpatient mental health services. This decision appears to prohibit incompetent adults from admitting themselves to inpatient mental health facilities. Since the vast majority of those who receive inpatient psychiatric care do so on a voluntary basis and large numbers of these patients may be incompetent, Zinermon v. Burch is likely to have substantial effects on the delivery of mental health services. This article will discuss those effects.

Much is wrong with our current system of delivering mental health services. Most commentators have focused on the inadequate resources available for the task, our failure to understand fully the causes of mental illness, and the failure to find either cures or fully effective treatments. These are important problems because, according to the best estimates, several million Americans suffer from serious mental illness.

The system of legal standards and procedures governing involuntary admission to hospitals for psychiatric treatment is another frequent target of critics of the mental health system. These critics complain that, in the name of due process, courts and legislatures have too narrowly limited the circumstances under which care can be imposed involuntarily and have also interposed procedural burdens which are too costly. Thus in this view, care for many seriously ill persons is either delayed or prevented in order to effectuate the patient's expressed wish to avoid hospitalization, even though we may strongly believe that wish to be irrational.

Whatever the merits of these criticisms of the involuntary admission mechanisms, however, only a fraction of patients who are hospitalized for psychiatric reasons at present are hospitalized through involuntary commitment procedures. The majority are hospitalized by applying for or consenting to admission either orally or in writing without any formal court procedures. The Zinermon decision, however, is likely to make it much more difficult to obtain inpatient mental health services through the current voluntary procedures. Zinermon may revolutionize the delivery of mental health services, particularly in the public sector, and may affect the functioning of other service systems as well.

In Zinermon, plaintiff Darrell Burch brought suit in federal district court alleging that various employees of the Florida State Hospital (FHS) deprived him of his liberty without due process of law by admitting him as a voluntary mental patient when he was incompetent to give informed consent to that admission. The majority opinion by Justice Blackmun upheld the Eleventh Circuit's en banc reversal of the District Court's dismissal for failure to state a cause of action.

The pleadings which formed the basis for the Supreme Court's decision reveal the following: Burch was found wandering along a Florida highway hurt and disoriented. After three days in a private community-based facility, Burch was transferred by that facility to FSH, a state-run mental health
hospital. Prior to transfer and again upon admission to FSH, Burch signed forms indicating a desire to be a voluntary patient at FSH. Various records prepared at the time of Burch's admission describe him as "distressed and confused" and state that Burch believed he was "in heaven." Burch was also described as disoriented, delusional, and psychotic and ignorant of the reason for his admission. He remained at FSH for approximately five months. The suit which led to the Supreme Court's decision was brought shortly after his release.

The Court held that due process requires some type of procedure to insure that persons seeking admission to inpatient mental health facilities are competent to do so. This holding is based upon the Court's reaffirmation of earlier decisions that involuntary confinement in a mental hospital constitutes a serious deprivation of liberty. Since voluntary admission generally results in treatment in the same institution and under much the same circumstances, the Court treated an application for voluntary admission as equivalent to a waiver of the right not to be involuntarily hospitalized.

Before discussing the likely consequences of the decision in Zinermon, it may be useful to consider how the mental health system works at present. In Illinois, for example, more than 19,000 individuals were admitted to state inpatient mental health facilities in 1990. More than 11,000 (or just under 58 percent) of these patients were, at least initially, voluntary patients. Typically, such a patient arrives at the facility either alone or with relatives. If the admitting staff believes hospitalization is warranted, the patient is asked to sign an application for voluntary admission. If the patient hesitates, it is quite common for involuntary commitment to be used as a threat.

Alternatively, the patient may be transported to such facilities by police or in an ambulance after a commitment petition has been completed at some other location. Typically, a physician, psychologist, or social worker has determined that the patient needs inpatient care but the patient is unwilling to accept it. Approximately one third of patients are initially admitted to state facilities accompanied by a petition to commit.

However, when patients arrive at the facility, they are usually offered the opportunity to become voluntary patients. If they accept that offer, the petition is dismissed. Ultimately, less than 5 percent of admissions to state facilities in Illinois are the result of a commitment hearing.

It is also relevant to consider the mental condition of patients who are applying for voluntary admission. For a variety of reasons, only the most seriously mentally ill are accepted for either voluntary or involuntary admission to inpatient mental health facilities run by the state. Most such patients are psychic at the time of admission. That is, they may not understand who they are, where they are, or why they are there. They are particularly unlikely to be able to understand abstract legal concepts such as waiver, the right to a hearing, and so forth. Thus, while Darrell Burch's condition might have been worse than most, it is difficult to fault Justice Blackmun's generalization that, like Burch, a large number of ostensibly voluntary patients may not be capable of meaningful consent to admission.

Finally, it is important to consider the legal rules governing voluntary admission. The most significant fact about voluntary admission in Illinois and most other jurisdictions is that people who are admitted voluntarily are not free to leave at will. The facility may continue to detain them for up to five days (plus intervening weekends and holidays) following a written request to leave. Additionally, there may be substantial restrictions on the patients' ability to correspond, use the telephone, receive visitors, and, perhaps most significant, refuse treatment, including medication. Voluntary patients may also be physically restrained and placed in seclusion. Thus, voluntary admission deprives patients of substantial control over their liberty.

The Supreme Court's decision in Zinermon has created several serious problems for the administration of the mental health system. First, by holding that due process requires some type of procedure for determining whether voluntary patients are competent to consent to admission, the Court has increased the costs of using voluntary procedures to admit patients to mental health facilities. Second, by making it more difficult to use the voluntary admission procedures, the Court's decision may increase the number of involuntary admissions. This in turn will increase the costs associated with hospitalizing the mentally ill. Third, the Court may have created a class of patients—those who are incompetent to consent to voluntary admission but are capable of living safely outside an institution—who cannot be admitted to mental hospitals either voluntarily or involuntarily. Fourth, the Court may have greatly expanded the need for and use of those statutes providing for guardianships for incompetent adults. The increased use of such statutes will have
its own costs and other difficulties.

The most direct consequence of Zinermon is that it will no longer be possible to accept applications for voluntary admission without first ascertaining that the applicant is competent. Because of the procedural posture of Zinermon, the Supreme Court did not decide what process is due. However, Justice Blackmun specifically noted that the Florida statutes "do not direct any member of the facility staff to determine whether a person is competent to give consent, nor to initiate the involuntary placement procedure for every incompetent patient." Thus it seems likely that the process required by Zinermon for determining whether a patient is competent to consent to admission will simply be to assign someone to make this determination. This added procedure should not impose substantial burdens on the state.

Zinermon is apt to have other more serious effects because it is likely that a significant percentage of patients who are currently admitted as voluntary are not in fact competent to consent to voluntary admission. Zinermon forces the states to find some other admission mechanism for such patients.

One way in which states may respond to Zinermon is to change the nature of voluntary admission. It could, for example, be made more like admission to a non-psychiatric medical facility. Such facilities have open doors and ordinarily permit patients to leave at any time. Indeed, Illinois and many other states have statutory arrangements for psychiatric patients which make admission to mental health facilities more like admissions to general hospitals. Referred to as "informal admissions," these arrangements permit patients to leave at any time during "normal day-shift hours of operation which shall include but need not be limited to 9 a.m. to 5 p.m."

Because an informal admission constitutes a less serious deprivation of liberty, due process may not require the hospital to insure that persons applying for this type of admission be competent. However, this is not free from doubt. First, while such patients cannot be held for the seven-day period permitted under the voluntary admission statute, they can be held during a long weekend. Additionally, all of the restrictions described above for voluntary patients (mail, telephone, visits, seclusion, restraint, forced medication) can also be imposed on informal patients. Moreover, informal patients may be kept in locked wards.

Of course, Illinois and other states are free to create admission systems which do not have any of the restrictions currently imposed on both voluntary and informal patients. Such systems would probably not deprive patients of liberty and, therefore, would not involve the due process clause.

However, making mental hospitals more like other medical facilities would create its own problems. The ability of mental health facilities in Illinois to continue to confine a voluntary patient who requests discharge serves several needs. The mentally ill are frequently ambivalent about their need for treatment. Providing a "cooling off" period enables patients to reconsider a decision to leave. This period is also designed to enable the hospital to determine whether the patient meets the criteria for involuntary commitment. It may be difficult to make this determination, particularly when a patient has been recently admitted. Third, if outpatient care is indicated, the hospital may use the additional time to make arrangements for this care. Finally, the ability to predict and control the timing of discharges helps institutions allocate scarce bed space and other resources.

It is also likely that hospitals would have to forgo at least some of their other powers over patients in order to insure that inpatient treatment did not violate liberties protected by the due process clause. As discussed above, those powers include the right to restrict mail, telephone, and visitors, the right to impose treatment involuntarily, and the right to restrain and seclude. Some of these restrictions may be less necessary to the treatment of truly voluntary patients. However, the serious symptoms of mental illness, which may include attempts to injure oneself or others, are often unpredictable, so hospitals may need to preserve these powers.

In short, restructuring the incidence of voluntary admissions would not be an entirely satisfactory response to the command of Zinermon. It is doubtful that many states will choose this course.

Another option open to states is to use the procedures for involuntary commitment. However, in most states these procedures are fairly complex. In Illinois, for example, the patient is entitled to the appointment of counsel, a six-person jury, and an examination by an independent expert. Additionally, no patient may be committed unless the Court finds that "clear and convincing evidence" supports the commitment; and the Court must order "the least restrictive alternative for treatment which is appropriate." Moreover, judicial hearings carry other costs. These include salaries for judges, prosecutors, clerks, and bailiffs and the cost of providing courtrooms. A substantial increase in the number of commitment hearings could be quite costly.

Since we do not know how many voluntary patients are incompetent, it is difficult to estimate how many...
new commitment hearings would be required. The fact that at present voluntary admissions outnumber involuntary commitments by a ratio of almost twenty to one suggests that a substantial increase would be likely. For example, if only 25 percent of current voluntary admittees are incompetent, this could result in a 500 percent increase in involuntary commitments.

Another serious problem has been raised by Zinermon. Not every person who is incompetent to consent to voluntary admission will meet the standards for involuntary admission. Illinois law, for example, limits involuntary commitment to those who, because of mental illness, are dangerous to self or others or unable to care for their basic needs. Many applicants for voluntary admission may not meet these criteria despite their incompetence.

Of course, Illinois might amend its statutory standard for involuntary commitment. However, it is not clear that any significant amendment could be made which would satisfy due process. In Zinermon, Justice Blackmun reiterates the holding of O'Connor v. Donaldson [422 U.S. 563, 357 (1975)] that "there is no constitutional basis for confining mentally ill persons involuntarily if they are dangerous to no one and can live safely in freedom." It therefore appears that the Illinois standard for involuntary commitment is mandated by due process.

If the foregoing interpretation of Zinermon and O'Connor is correct, then the states may not be able to amend their mental health codes so as to eliminate the class of patients—those who are incompetent but not committable—that cannot be admitted to state facilities. However, there is another procedural mechanism which is often used to provide treatment to the mentally ill. That is the guardianship system.

Most jurisdictions use guardianship proceedings to provide a system of substitute decision making for any person who "is mentally ill or developmentally disabled and who because of [that disability] is not fully able to manage his person or estate...." Under the guardianship laws, a court may appoint a guardian and give that guardian the authority to consent to mental health (and other) treatment.

However, it is not clear whether guardianship law can be used to help solve the problems created by Zinermon.

The guardianship system in most jurisdictions is less procedurally burdensome than the commitment system. For example, Illinois guardianship law does not mandate the appointment of counsel, trial by jury, or proof by clear and convincing evidence. One of the reasons for this comparative lack of procedural safeguards, however, is that in many jurisdictions guardians have not had the authority to admit their wards to inpatient mental health facilities. Using the prevailing balancing test outlined by the Supreme Court in Mathews v. Eldridge [424 U.S. 319, 338 (1976)], courts have found less process to be due in light of the presumably lesser liberty interests at stake. However, these more relaxed procedures are unlikely to survive Fourteenth Amendment scrutiny if guardians are permitted to confine their wards in inpatient mental health facilities. Of course, if the same procedures are required in guardianship proceedings as are currently required in commitment proceedings, then the guardianship system will prove to be no less burdensome than the commitment system.

The guardianship system often employs a bifurcated hearing procedure. That is, there is an initial proceeding at which it is determined whether an individual is disabled or incompetent. If so, a guardian is appointed. There may then be later hearings at which the guardian is given authority to make discrete decisions for the ward. It is possible that a system in which elaborate procedural protections are available at the initial hearing, but which provides fewer protections at the later hearings, would satisfy due process and be less burdensome than our current commitment system. The savings may accumulate if repeated hospitalizations are required, as is frequently the case for those suffering from schizophrenia and other serious forms of mental illness.

That such a system may satisfy due process is suggested by the Supreme Court's decision in J.R. v. Parham [442 U.S. 584 (1979)]. In Parham, the Court was faced with a due process challenge to the admission of minors to inpatient mental health facilities by their parents. The Court held that such admissions could be accomplished over the objection of the minor without a hearing because the parents and the admitting hospital could both be presumed to be acting in the patient's best interest. Since guardians are charged by law with acting in their wards' best interests, perhaps all that is needed are adequate procedures to insure that the guardian has been properly appointed.

This view, however, is not without difficulties. The primary one is that the serious effects of mental illness which lead to impaired decision making are often transitory. Thus it is somewhat troubling to create a system in which large numbers of mentally ill people are declared incompetent and remain under that legal disability for an extended period even though they have recovered. However, if we create a system in which patients

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are quite quickly restored to competency, then we will need to incur the costs of new proceedings every time such patients deteriorate and need readmission. If this path is followed, costs will increase rather than decrease.

Use of the guardianship system raises problems beyond the adequacy of the procedures. The principal difficulty is the substantive standard for admission. Will guardians be permitted to admit their wards based solely upon the wards' "best interests"? The use of the best interest standard would appear to violate Zinermon's statement that only those who are dangerous to self or others may be confined involuntarily in mental health facilities. Moreover, the Parham decision is of little help because there the Court was not called on to consider the standards for admitting minors, only the procedures. However, since the Zinermon opinion made no reference to the guardianship system, it is difficult to predict with confidence that the Court meant to rule out admissions by guardians based on the less rigorous "best interest" standard.

Indeed, Zinermon could lead to the unraveling of the O'Connor standard for commitment if the decision ultimately results in a clear holding that the admission of incompetent wards does not violate due process even though predicated on the "best interest" standard. The availability of this lower standard for admission could result in a substantial reduction in the use of the present commitment procedures in favor of this third way in to mental health facilities.

It is difficult to predict whether such an effort to avoid the burdens imposed by current commitment standards and procedures would be harmful or beneficial. For one, the guardianship system presupposes the existence of guardians. Most patients in the public mental health system are indigent and frequently have no family member available to serve as guardian. Most jurisdictions have some system of publicly funded guardians. However, these systems are generally underfunded at present and in any event are not equipped to handle the huge additional volume that might be created by a large scale switch to the guardianship system for admissions to mental health facilities. Adding this new volume of wards could either exacerbate current inadequacies or prove to be the catalyst for dramatic increases in funding.

If states are successful in switching to a system in which large numbers of persons confined in state hospitals have private guardians or public guardians with reasonable caseloads, services to the mentally ill in such facilities could improve. The presence of outside advocates for the mentally ill could bring to light inadequate services and patient abuse within hospitals.

Increased use of the guardianship system could also highlight and lead to the correction of some of its current weaknesses. For example, up to now little attention has been paid to the powers of guardians. In many jurisdictions guardians can admit wards to nursing homes and other residential facilities with conditions that may be as restrictive as those which exist in inpatient mental health facilities. If these powers are to continue, greater procedural protections may be needed. If admission to inpatient facilities is made more difficult and more costly, this will increase the incentives to provide treatment to the mentally ill in the community. This could have tremendously beneficial results. In most states, outpatient services are vastly underfunded. Many admissions to state facilities are the result of failures in the outpatient care system. Zinermon could encourage states to provide more adequate funding for outpatient services to reduce the need for expensive commitment or guardianship proceedings.

Unfortunately, there is also the possibility that Zinermon will have much more negative results. Some states might respond to Zinermon simply by diverting funds from services to procedures. Fortunately, the manner in which state and local governments are organized makes this less likely to occur. That is, in many states, local government funds the trial level court system, including prosecutors and public defenders, while state government funds inpatient mental health facilities. Even where this is not true, the funds of the various agencies involved are usually not viewed as directly interdependent. (Of course, in the absence of increased revenue, the need to increase spending for one agency will necessarily affect the share of the pie available to the remaining agencies.)

Zinermon is likely to result in profound changes in the delivery of mental health services, none of which was mentioned in the Court's opinion. However, it would be unfair to criticize the Court for this situation. In many ways, Zinermon was inevitable. Given the circumstances surrounding inpatient mental health treatment and the likelihood that persons seeking such treatment may not understand those circumstances, it is remarkable that we have for so long accepted the "voluntary" admission system in place in most states. States need to begin immediately to plan their response to Zinermon so as to maximize the efficient use of their resources and provide an appropriate level of procedural protections to patients.