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THE “VOLUNTARY” INPATIENT TREATMENT OF ADULTS UNDER GUARDIANSHIP

RICHARD C. BOLDT*

I. INTRODUCTION

SOME people who have severe mental illnesses or other severe mental disabilities derive benefit from the care and treatment provided in psychiatric hospitals and other inpatient settings.¹ Frequently, the very disabilities that call for inpatient treatment also disrupt an individual patient’s capacity to participate fully in the decision-making process by which hospital admission is elected.² All jurisdictions within the United States maintain statutory schemes that allocate decision-making authority with respect to psychiatric hospital admissions, often by creating separate procedures and standards for “voluntary” admissions and involuntary commitments.³ A number of states have adopted a preference for voluntary hospitalization over involuntary civil commitment, in part based on the theory that voluntary psychiatric patients are more likely to form a therapeutic alliance with clinicians and are therefore better able to benefit from treat-

* Professor of Law, University of Maryland Francis King Carey School of Law. For help in planning and developing this Article, I thank Eileen Canfield, Cameron Connah, Susan McCarty, and Aaron Parker. This project was supported by a research grant from the University of Maryland Francis King Carey School of Law.

1. See THOMAS G. GUTHEIL & PAUL S. APPELBAUM, CLINICAL HANDBOOK OF PSYCHIATRY AND THE LAW 73 (1982) (stating that inpatient care “provide[s] structure, a supportive milieu, protection, intensive care, closely supervised pharmacotherapy, electroconvulsive therapy, or other forms of treatment”). As used throughout this Article, the phrase “mental disability” includes mental illnesses; significant developmental disabilities (particularly intellectual disabilities); and the impairments associated with geriatric dementia, Alzheimer’s disease, and the like.

2. See generally Lisa Grossman & Frank Summers, *A Study of the Capacity of Schizophrenic Patients to Give Informed Consent*, 31 HOSP. & CMTY. PSYCHIATRY 205 (1980); Robert P. Roca, *Determining Decisional Capacity: A Medical Perspective*, 62 FORDHAM L. REV. 1177 (1994).

3. See generally SAMUEL J. BRAKEL ET AL., THE MENTALLY DISABLED AND THE LAW 21–189 (3d ed. 1985); GUTHEIL & APPELBAUM, *supra* note 1, at 39–51; CHRISTOPHER SLOBOGIN, ARTI RAI & RALPH REISNER, LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS 700–867 (5th ed. 2008).

ment.⁴ Not all states, however, provide clear statutory or judicial guidelines on the degree of capacity required for a patient to consent to admission.⁵

Determining whether (and how) patients with impaired decision-making capacity may consent to inpatient treatment is a complex question that often turns on an interpretation of state laws read against the backdrop of constitutional doctrine governing the due process rights of individual patients.⁶ In addition, in some cases, impaired patients have court-appointed guardians who are authorized to make financial decisions, treatment decisions, or both, for their wards.⁷ In instances in which guardians have received either general authorization to make decisions for their wards or have been granted specific authority to make health-care decisions, difficult legal questions may arise as to the power of the guardian to consent to the ward's admission for inpatient psychiatric treatment.⁸ In a number of states, the law is clear that a guardian may not consent to the ward's admission to a psychiatric hospital, thus requiring the use of the state's involuntary civil commitment process in order to obtain inpatient treatment.⁹ In other states, it is clear that a guardian may provide the necessary consent for voluntary admission.¹⁰ In a third group of states, the guardian may consent so long as the ward also consents or, in some jurisdictions, does not object.¹¹ In a fourth group of states, the

4. See Karna Halverson, *Voluntary Admission and Treatment of Incompetent Persons with a Mental Illness*, 32 WM. MITCHELL L. REV. 161, 164–66 (2005); Donald H. Stone, *The Benefits of Voluntary Inpatient Psychiatric Hospitalization: Myth or Reality?*, 9 B.U. PUB. INT. L.J. 25, 26–28 (1999). Voluntary hospitalization is also favored by many clinicians, policy makers, and academics because it is said to be less administratively burdensome, less stigmatizing, and better aligned with the value of patient autonomy than involuntary commitment. See Bruce J. Winick, *Competency to Consent to Voluntary Hospitalization: A Therapeutic Jurisprudence Analysis of Zinermon v. Burch*, 14 INT'L J.L. & PSYCHIATRY 169, 192–99 (1991).

5. See GUTHEIL & APPELBAUM, *supra* note 1, at 50.

6. The leading United States Supreme Court decisions on the due process rights of voluntary patients are *Zinermon v. Burch*, 494 U.S. 113 (1990) (suggesting, in dicta, constitutional requirement for preadmission determination of competency of voluntary patient), and *Parham v. J.R.*, 442 U.S. 584 (1979) (recognizing authority of parents or guardians seeking to arrange minor's voluntary hospitalization).

7. See GUTHEIL & APPELBAUM, *supra* note 1, at 221–23. See generally Lawrence A. Frolik, *Plenary Guardianship: An Analysis, a Critique and a Proposal for Reform*, 23 ARIZ. L. REV. 599 (1981).

8. See BRAKEL ET AL., *supra* note 3, at 377; GUTHEIL & APPELBAUM, *supra* note 1, at 36.

9. See, e.g., ALASKA STAT. § 13.26.150(e) (2012) (prohibiting guardians from placing wards in psychiatric facilities: "A guardian may not [] place the ward in a facility or institution for the mentally ill other than through a formal commitment proceeding under [Alaska Stat. §] 47.30 in which the ward has a separate guardian ad litem").

10. See, e.g., GA. CODE ANN. § 37-3-20 (2012) (authorizing guardians to make applications for wards' voluntary commitment).

11. See, e.g., MICH. COMP. LAWS ANN. § 330.1415 (West 2014) ("[A]n individual 18 years of age or over may be hospitalized as a formal voluntary patient if the

guardian’s authority to arrange for voluntary inpatient care depends on the guardian obtaining specific court authorization, although the substantive standards and procedural requirements for securing such an order may differ from those that govern involuntary commitment.¹² Finally, a range of additional variations exists in other states, often created by the interplay between the laws regulating mental hospital admission and other provisions governing the powers and responsibilities of guardians.¹³

Several rationales have been provided for the statutory or case law rules operating in a number of states to prohibit guardians from consenting to a ward’s psychiatric hospitalization, or withholding that authority when the ward objects. One widely cited state court has reasoned:

If we were not to require at least substantial compliance with the [involuntary commitment] law to fully protect the rights of incompetents it would be possible for an unscrupulous person to have himself appointed as guardian and then lock his ward in a mental institution and proceed to waste the ward’s estate.¹⁴

It is worth comparing this skepticism about the good faith of an appointed guardian of an adult with the presumed good faith of parents who seek the “voluntary” hospitalization of a child against the child’s wishes, which was central to the United States Supreme Court’s decision in *Parham v. J.R.*¹⁵ In *Parham*, Chief Justice Burger, writing for the Court’s majority, made plain that an independent medical assessment by hospital

individual executes an application for hospitalization as a formal voluntary patient or the individual assents and the full guardian of the individual, the limited guardian with authority to admit, or a patient advocate authorized by the individual to make mental health treatment decisions under the estates and protected individuals code, 1998 [Mich. Pub. Acts] 386, [Mich. Comp. Laws Ann. §§] 700.1101 to 700.8102, executes an application for hospitalization and if the hospital director considers the individual to be clinically suitable for that form of hospitalization.”).

12. See, e.g., ARIZ. REV. STAT. ANN. § 14-5312.01 (2012) (providing that guardians must obtain court order and comply with other notice requirements and procedural provisions before placing wards in inpatient mental health settings).

13. See, e.g., N.M. STAT. ANN. § 45-5-312(B) (3) (LexisNexis 2013) (“[A] guardian may consent or withhold consent that may be necessary to enable the incapacitated person to receive or refuse medical or other professional care, counsel, treatment or service.”). However, guardians may only present their wards for evaluation for inpatient mental health treatment:

A guardian appointed under the Uniform Probate Code, an agent or surrogate under the Uniform Health-Care Decisions Act or an agent under the Mental Health Care Treatment Decisions Act shall not consent to the admission of an individual to a mental health care facility. If a guardian has full power or limited power that includes medical or mental health treatment or, if the individual’s written advance health-care directive or advance directive for mental health treatment expressly permits treatment in a mental health care facility, the guardian, agent or surrogate may present the person to a facility only for evaluation for admission
Id. § 43-1-14.

14. *Von Luce v. Rankin*, 588 S.W.2d 445, 448 (Ark. 1979) (in banc).

15. 442 U.S. 584 (1979).

officials is a sufficient check against possible abuse by parents whose motives for seeking inpatient care may be at odds with their child's best interests.¹⁶ Some writers have suggested that a similar process of medical review should suffice to ameliorate the concerns about abuse by the guardians of adult wards that animate the restrictive rules operating in a number of states.¹⁷ Other writers have suggested that state law limitations on the authority of guardians to approve voluntary hospitalization for incompetent adults stem from a concern that permitting such authority would provide a built-in end-run around these jurisdictions' involuntary commitment criteria and procedures, including their rigorous standard of proof.¹⁸

Since the 1970s, the laws governing involuntary civil commitment in virtually every state have required a finding that an individual subject to commitment must not only be mentally disabled but also dangerous to himself or herself or others.¹⁹ Voluntary hospitalization, by contrast, generally is based on the patient's need for and amenability to treatment.²⁰ Significantly, the development of more demanding civil commitment standards in the 1970s represented a move away from the mid-century approach of permitting involuntary hospitalizations on a medical-needs basis, in which the decision maker often was a board of physicians rather than a judge or jury.²¹ If a guardian is not permitted to consent to voluntary admission, however, the more restrictive involuntary commitment standard—with its dangerousness criterion in particular—may make it difficult or impossible to arrange for inpatient care for some patients with severe mental disabilities who do not present a risk of harm to themselves or others, but who would benefit from such treatment.²²

There are other important consequences as well that may flow from the requirement that a patient under guardianship be civilly committed rather than voluntarily hospitalized, including possible differences in the rules governing the provision of psychotropic medications, discharge,

16. *See id.* at 607. While Chief Justice Burger's rationale—that the law generally presumes the good faith of parents because of their natural love and affection for their children—would appear to be a sufficient basis to distinguish the court-appointed guardians of adult wards, the *Parham* decision also included minor wards hospitalized by a state department of social services. *See id.* at 587–88.

17. *See Halverson, supra* note 4, at 167.

18. *See SLOBOGIN, RAI & REISNER, supra* note 3, at 864; Stone, *supra* note 4, at 42; *see also In re Gardner*, 459 N.E.2d 17, 19 (Ill. App. Ct. 1984) (holding that placement by guardian under voluntary admission statute without ward's consent is precluded because "grant of such power would contravene the involuntary commitment provisions" of state law).

19. *See GUTHEIL & APPELBAUM, supra* note 1, at 40; SLOBOGIN, RAI & REISNER, *supra* note 3, at 705.

20. *See Stone, supra* note 4, at 30–32.

21. *See GUTHEIL & APPELBAUM, supra* note 1, at 40; SLOBOGIN, RAI & REISNER, *supra* note 3, at 703.

22. *See Stone, supra* note 4, at 37.

length of stay, and the like.²³ The question, then, is whether a set of legal standards and practices either exists or can be developed that would provide for the treatment needs of those patients who have an impaired capacity to consent to voluntary hospitalization but who do not meet the criteria for involuntary civil commitment. Such an approach should be attentive to (and seek to minimize) the potential for coercion or abuse these patients may face and should be designed to maximize the self-determination of which they are capable. Some patients whose disabilities are chronic but episodic may be able to provide adequate consent through the use of advance directives, although the use of such instruments—especially by persons with mental disabilities—is relatively rare.²⁴ Others may be able to participate in the decision-making process if the criteria by which their competence is assessed are defined to require only minimal functionality.²⁵ But patients who are assisted by third-party decision makers—particularly those with court-appointed guardians—should be able to gain access to inpatient psychiatric treatment without running the gauntlet of involuntary civil commitment, if the substantive standards and procedural requirements put in place by state law can be made adequate to insure that the third-party decision makers are acting with respect for the values held by these patients and, to the extent possible, are seeking to serve their best interests.

Part II of this Article recounts the long history of the development of involuntary civil commitment law and practice in the United States and the more recent development of voluntary inpatient admissions. It also explores the role that informed consent plays in voluntary hospitalizations and the due process considerations regarding consent introduced into

23. See, e.g., MD. CODE ANN., HEALTH—GEN. § 10-708(b)(2) (LexisNexis 2013) (providing right to refuse medication); *id.* § 10-803 (providing for release of voluntary patient).

24. See generally Linda L. Emanuel et al., *Advance Directives for Medical Care—A Case for Greater Use*, 324 NEW ENG. J. MED. 889 (1991); Ardath A. Hamann, *Family Surrogate Laws: A Necessary Supplement to Living Wills and Durable Powers of Attorney*, 38 VILL. L. REV. 103, 125–34 (1993). In the context of persons with mental illness, see Halverson, *supra* note 4, at 182; Bruce J. Winick, *Advance Directive Instruments for Those with Mental Illness*, 51 U. MIAMI L. REV. 57 (1996); cf. Rebecca S. Dresser, *Ulysses and the Psychiatrists: A Legal and Policy Analysis of the Voluntary Commitment Contract*, 16 HARV. C.R.-C.L. L. REV. 777 (1982) (describing and criticizing “voluntary commitment contracts” by which chronically mentally ill persons could commit to consent to future inpatient treatment when their illness would prevent their providing voluntary consent).

25. See Francine Cournos et al., *Report of the Task Force on Consent to Voluntary Hospitalization*, 21 BULL. AM. ACAD. PSYCHIATRY & L. 293, 298–300 (1993); Rael Jean Isaac & Samuel Jan Brakel, *Subverting Good Intentions: A Brief History of Mental Health Law “Reform”*, 2 CORNELL J.L. & PUB. POL’Y 89, 115–16 (1992) (describing APA Task Force’s recommended “easy-to-meet” standard for consent, under which “patient expressing agreement with admission and treatment in any way, verbal, behavioral or written, and displaying some minimal understanding of where he is and why, would meet the competency requirements for admission and initial treatment”).

this area by the United States Supreme Court's decision in *Zinermon v. Burch*.²⁶ Part III takes up the topic of guardianships and the related question of how incompetency—the threshold requirement for the appointment of a guardian—is defined. Part IV reviews the variety of approaches adopted by states for regulating the authority of guardians to provide consent for inpatient treatment. Part IV then concludes with an analysis of the interests in tension and offers a framework for an effective statutory approach to the area.

II. VOLUNTARY INPATIENT ADMISSION, INVOLUNTARY CIVIL COMMITMENT, AND THE PROBLEM OF CONSENT

The practice of permitting the voluntary psychiatric hospital admission of persons with mental disabilities did not become widespread in the United States until the last quarter of the twentieth century.²⁷ While the first state law governing voluntary admissions was enacted in Massachusetts in 1881, and while over half of the states had statutes regulating the practice by 1924, few patients with mental disabilities were admitted as inpatients on their own initiative.²⁸ Even as late as the decades following World War II, only about 10% of psychiatric inpatients were voluntarily admitted.²⁹ In the 1970s, however, the practice became much more common, accounting for a majority of mental hospital admissions in many jurisdictions.³⁰

Today, voluntary admission laws are in force in virtually every state, and voluntary patients make up more than 50% of the population in specialized mental hospitals and about 85% of the population in psychiatric units of general hospitals.³¹ The law in a number of states sets out a preference for voluntary hospitalization over involuntary civil commitment,³² and “almost all mental health professionals, and probably a majority of the mental health bar, favor the retention of voluntary admissions as the most frequently used means of ingress to a psychiatric hospital.”³³

26. 494 U.S. 113 (1990).

27. See GUTHEIL & APPELBAUM, *supra* note 1, at 48.

28. See BRAKEL ET AL., *supra* note 3, at 177–78.

29. See GUTHEIL & APPELBAUM, *supra* note 1, at 48.

30. See *id.*

31. See SLOBOGIN, RAI & REISNER, *supra* note 3, at 857.

32. See BRAKEL ET AL., *supra* note 3, at 178; Stone, *supra* note 4, at 29 (describing statutory preference for voluntary admission in Minnesota, New York, Louisiana, and Florida).

33. GUTHEIL & APPELBAUM, *supra* note 1, at 49. The modern trend has been for states to enact parallel statutes governing the voluntary admission of developmentally disabled persons and individuals with substance use disorders as well as patients with mental illness. In some states,

[T]he “voluntary” admission procedures for developmentally disabled persons are not so much identical as analogous to those for the mentally ill. These procedures are sometimes labeled “administrative,” permitting the developmentally disabled person to apply for himself if he is of age and competent but providing for application by the parent or guardian

This increase in the rate of voluntary admissions for persons with mental disabilities has taken place within the context of a public mental health system in the United States that has been focused, for most of the past two centuries, primarily on involuntary commitment.³⁴ In order to frame further consideration of voluntary admissions for persons under guardianship, therefore, attention to the course of development of involuntary commitment law and practice in the United States is due.

A. *The Development of Civil Commitment Law and Practice*

The first civil commitment statutes were enacted in American states in the late eighteenth century.³⁵ By the middle of the nineteenth century, the practice of civil commitment had become somewhat common, in part due to a growing perception—fostered by the founding of the American Psychiatric Association (APA) and the advocacy of Benjamin Rush and others—that effective “scientific” techniques for treating mentally ill persons were available.³⁶

The ensuing path of this history of involuntary treatment for persons with mental disabilities is anything but linear. A number of commentators have described the historical record as “cyclical” or marked by the swinging of a “pendulum” between the poles of paternalist concern for those with mental illness and other mental disabilities on the one side, and an opposing libertarian pole animated by fears of government (and physician) overreaching and centered on the values of individual autonomy and self-determination on the other.³⁷ The libertarian impulse was first expressed in the period immediately following the Civil War, when patients’ rights advocates raised concerns that some idiosyncratic individuals were being unnecessarily targeted for involuntary commitment by others who found their religious beliefs or political opinions to be excessively “novel.”³⁸ Particularly troubling stories also emerged about malevolent husbands who arranged to have their wives committed for reasons of simple convenience.³⁹ During the 1860s and early 1870s, these crusaders persuaded a number of states to enact procedural protections in the civil commitment context that included a right to counsel and trial by jury.⁴⁰

when he is not, in which case the procedure is—by our definition—not voluntary.

BRAKEL ET AL., *supra* note 3, at 179.

34. See SLOBOGIN, RAI & REISNER, *supra* note 3, at 701–09.

35. See BRAKEL ET AL., *supra* note 3, at 14.

36. See SLOBOGIN, RAI & REISNER, *supra* note 3, at 702.

37. See *id.* at 701–04. See generally ALBERT DEUTSCH, *THE MENTALLY ILL IN AMERICA: A HISTORY OF THEIR CARE AND TREATMENT FROM COLONIAL TIMES* (2d ed. 1949).

38. See SLOBOGIN, RAI & REISNER, *supra* note 3, at 703.

39. See, e.g., BRAKEL ET AL., *supra* note 3, at 15 (describing involuntary commitment of Mrs. E.P.W. Packard in Illinois by petition of her husband and her subsequent campaign to reform mental health law).

40. See SLOBOGIN, RAI & REISNER, *supra* note 3, at 703.

The pendulum swung back in the direction of paternalist interventionism during the Progressive Era of the late nineteenth and early twentieth centuries. Reformers, influenced by Dorothea Dix and others who had worked tirelessly to expand the resources available for the mentally disabled, showed a renewed interest in providing care and treatment for persons with mental illness, which in turn led to an increased “medicalization” of procedures for their civil commitment.⁴¹ These efforts gained momentum following World War II, as new treatment technologies—including modern psychotherapy, psychosurgery, electro-convulsive therapy, and early pharmacotherapies—became available.⁴² In the period between the 1940s and the early 1970s, consistent with this increasingly medicalized approach, hearings before juries or judicial officers were replaced in many jurisdictions by “lunacy commissions” or physicians’ boards, and dangerousness criteria disappeared in favor of “in need of treatment” standards for involuntary admission.⁴³ More voluntary admission statutes also began to appear during this period.⁴⁴

Beginning in the late 1960s and early 1970s, the pendulum swung once more, this time in a libertarian direction. In addition, for the first time, a significant percentage of patients with mental disabilities were voluntarily admitted for inpatient treatment.⁴⁵ Influenced by the civil rights movement and by a broad rethinking by both policymakers and the lay public of the mid-century commitment to a paternalistic “rehabilitative ideal,”⁴⁶ the libertarian reforms of the 1970s produced widespread statutory revisions that refocused civil commitment criteria on dangerousness, as opposed to amenability to or need for treatment, and reintroduced legalized procedural protections such as a right to counsel, heightened burdens of proof, and the like.⁴⁷

41. *See id.*

42. *See id.*

43. *See* GUTHEIL & APPELBAUM, *supra* note 1, at 40.

44. *See* BRAKEL ET AL., *supra* note 3, at 177–78.

45. *See id.* at 178.

46. For a classic account of the rise and fall of rehabilitative practice and theory in the twentieth century, see FRANCIS A. ALLEN, *THE DECLINE OF THE REHABILITATIVE IDEAL: PENAL POLICY AND SOCIAL PURPOSE* (1981). *See also* Richard C. Boldt, *Rehabilitative Punishment and the Drug Treatment Court Movement*, 76 WASH. U. L.Q. 1205, 1218–45 (1998).

47. *See* SLOBOGIN, RAI & REISNER, *supra* note 3, at 703–04. Perhaps the most influential state statutory reform of this period was the Lanterman-Petris-Short Act, passed by the California legislature in 1967. *See* CAL. WELF. & INST. CODE § 5000 (1981). The California law, which served as a model for statutory revisions in a number of other states, “made dangerousness to self or others the core criteria for commitment, defined these criteria relatively narrowly, and provided extensive procedural protections.” SLOBOGIN, RAI & REISNER, *supra* note 3, at 704. State legislative reform was supported in a number of jurisdictions by state court and lower federal court decisions, articulating the beginnings of a constitutional jurisprudence based on the due process clause. *See, e.g.*, Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972); Wyatt v. Stickney, 344 F. Supp. 373 (M.D. Ala. 1972).

The libertarian individual rights reforms of the 1970s combined with a dramatic increase in the use of psychotropic medications—which were first introduced in the 1950s—fueled a process of “deinstitutionalization” that reduced the census of public and private psychiatric hospitals throughout the final decades of the twentieth century.⁴⁸ Thus, while more than 550,000 patients were in public mental hospitals on any given day in the mid-1950s, that number had dropped to roughly 130,000 patients by the mid-1980s.⁴⁹ Contained within this declining population of inpatients receiving care and treatment for mental illness, however, was a steadily increasing percentage of voluntary patients. As the *parens patriae* rationale for hospital admission largely was excised from the laws and policies governing involuntary commitment,⁵⁰ and as involuntary confinement essentially became limited to the dangerous mentally ill, it was only natural that clinicians, concerned family members, and others increasingly would come to rely on voluntary admissions as a means of providing access to inpatient services for patients with significant mental disabilities who did not present an imminent threat to themselves or to others. In addition, the underlying values of patient autonomy and self-determination that animated much of the effort toward civil commitment reform were consistent with a new emphasis on voluntary hospitalization that was said to enlist the patient in decision making about his or her own care, and that, at least superficially, permitted the patient to retain some control over the nature and duration of his or her hospitalization.⁵¹

B. *Voluntary Inpatient Admission: Coercion and Choice*

In truth, while the restrictions imposed on involuntary commitment standards and the increased legalization of commitment procedures, on

48. This process of deinstitutionalization was linked with the community treatment movement, which had led to the passage of the Community Mental Health Centers Act by Congress in 1963. The idea behind the community treatment movement was that many persons with mental disabilities could be treated effectively with psychotropic medications and other services as outpatients in a network of new community mental health centers (CMHCs) that were supposed to be constructed and staffed, in part, through new federal government resources. While a number of CMHCs were built, the full network of facilities was never completed and the level of staffing and services envisioned never fully supported and never achieved. See SLOBOGIN, RAI & REISNER, *supra* note 3, at 706. A number of commentators critical of deinstitutionalization place special emphasis on the failure of the community treatment movement in their accounts of this failed policy. See, e.g., Robert Bernstein & Tammy Seltzer, *Criminalization of People with Mental Illnesses: The Role of Mental Health Courts in System Reform*, 7 UDC/DCSL L. REV. 143 (2003); see also Marc F. Abramson, *The Criminalization of Mentally Disordered Behavior: Possible Side-Effect of a New Mental Health Law*, 23 HOSP. & CMTY. PSYCHIATRY 101 (1972).

49. See BRAKEL ET AL., *supra* note 3, at 47.

50. See *id.* at 24; GUTHEIL & APPELBAUM, *supra* note 1, at 39–40.

51. See Stone, *supra* note 4, at 27 (explaining that voluntary admission “respects individual autonomy” and “allows the patient the legal right to request release”).

the one hand, and the growth of voluntary admissions, on the other, were interconnected phenomena; the relationship between involuntary and voluntary admission was, and is, exceedingly complex. The simple notion that most voluntary patients act relatively free from coercion when they elect to enter the hospital, and the paired idea that involuntarily committed patients generally express a “knowing, overt resistance” to their admission, are both overstated.⁵² As Brakel points out, “[i]n the vast majority of involuntary *and* voluntary cases, it is the family or relatives who move toward, pressure for, or insist on commitment.”⁵³ As a consequence, he reports, “[i]n many instances where it orders commitment, the state’s judicial machinery merely formalizes and sanctions a decision arrived at by the family and the family doctor.”⁵⁴ At the same time, he explains, “[t]he phenomenon of a freely derived, fully conscious, voluntary decision to enter a mental facility (particularly a public facility) is as rare as knowing, overt resistance to involuntary commitment.”⁵⁵ This is so, because in many cases, voluntary patients are “already in some form of official custody” when they “elect” hospitalization, and their choice in that respect is often made with “the threat of involuntary commitment as the principal means of persuasion.”⁵⁶

It is, perhaps, because of the coercive features present within many voluntary mental hospital admissions that state law generally imposes restrictions on the practice that are not ordinarily present in the case of voluntary hospital admissions for other health-care services. State laws typically contain detailed provisions setting out the process by which an individual may elect to enter an inpatient mental health treatment facility, the criteria under which that application for admission is to be assessed by hospital personnel, and the rights and restrictions (particularly on requesting discharge from the hospital) that apply once the voluntary pa-

52. See BRAKEL ET AL., *supra* note 3, at 32.

53. *Id.*

54. *Id.* Of course, this account assumes that the patient has an engaged family or support group and is being cared for by a family physician. Increasingly in recent years, however, many severely mentally ill patients come into (or re-enter) the public mental health system as homeless or nearly homeless individuals, often alienated from family and friends and without ongoing links to health care or other social service providers. In such cases, the patient is just as likely to come into the treatment system by way of the criminal justice system as through the efforts of family and friends. See Bernstein & Seltzer, *supra* note 48, at 143.

55. BRAKEL ET AL., *supra* note 3, at 32.

56. Janet A. Gilboy & John R. Schmidt, “Voluntary” Hospitalization of the Mentally Ill, 66 NW. U. L. REV. 429, 430 (1971); see also Stone, *supra* note 4, at 36 (“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.”).

tient is admitted.⁵⁷ Even the designation of an admission as “voluntary” oversimplifies the variety of ways in which a patient can enter an inpatient psychiatric facility without going through the involuntary commitment process. Thus, in some states, a voluntary admission can result either from the applications of patients themselves, or from the application of a designated third-party decision maker, such as a court-appointed guardian or an individual authorized by a properly executed advanced directive.⁵⁸ Moreover, in most states, the governing statutes distinguish between “pure” voluntary admissions, a status that permits the patient to leave the hospital whenever he or she wishes, and “conditional” voluntary admission (sometimes also referred to as “formal” admission), under which the patient is prohibited from leaving prior to the passage of a period of time (usually several days) after providing notice to hospital officials of an intention to leave.⁵⁹

C. *The Zinermon Decision and the Problem of Informed Consent*

However conceived, the notion of voluntarily seeking admission for inpatient treatment in a psychiatric facility fairly implies that the patient has exercised some sort of choice. In the case of other health-care services, including general medical inpatient treatment, patients must provide informed consent.⁶⁰ The laws in some states governing voluntary admission into mental hospitals and other psychiatric inpatient settings reflect this general principle and require that informed consent be obtained before a patient can be admitted.⁶¹ In many other states, however, no explicit consent requirements are set out in the governing statutes.⁶² This patchwork of differing state law standards for consent also characterized the state of the law in 1990 and formed the background for the

57. See BRAKEL ET AL., *supra* note 3, at 177.

58. Brakel takes the position that admissions accomplished at the request of a third-party decision maker should not be labeled as “voluntary,” but that terminology does appear in other descriptions of the practice. See *id.*

59. See GUTHEIL & APPELBAUM, *supra* note 1, at 49.

60. The requirement of informed consent for medical treatment is often traced to Justice (then Judge) Benjamin Cardozo’s opinion in *Schloendorff v. Society of New York Hospital*, 105 N.E. 92, 93 (N.Y. 1914), where the court stated: “Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault, for which he is liable in damages.” *Id.* See generally A.D. Nieuw, *Informed Consent*, 12 MED. & L. 125 (1993).

61. See, e.g., 405 ILL. COMP. STAT. 5/3-400 (2014) (setting out consent requirement for voluntary admission in Illinois Mental Health and Developmental Disabilities Code); N.Y. MENTAL HYG. LAW § 9.17 (McKinney 2014) (governing requirement of informed consent); see also *In re Gardner*, 459 N.E.2d 17, 20 (Ill. App. Ct. 1984) (holding that individual who lacked capacity to provide informed consent for inpatient treatment could not be admitted by his guardian).

62. For a general discussion of the state statutes governing voluntary hospitalization, see *infra* notes 142–235 and accompanying text.

United States Supreme Court's discussion of voluntary psychiatric admission in its decision in *Zinermon v. Burch*.⁶³

In *Zinermon*, the Court's primary focus was on a technical question concerning whether a federal civil rights claim for damages under § 1983 could be brought against hospital officials who had treated the plaintiff as a voluntary patient, notwithstanding his disoriented psychotic condition upon admission. The underlying events had taken place in Florida, one of a minority of states whose law did (and still does) require that voluntary patients provide competent informed consent for admission.⁶⁴ The narrow question addressed by the Justices was whether, given this statutory requirement, the patient Burch was entitled as a matter of federal due process to be screened for competency before being admitted as a voluntary patient. Given that he was "hallucinating" and believed he was "in heaven," and thus, by all accounts, was not able to provide competent informed consent,⁶⁵ Burch's argument was that his admission should have been sought through Florida's involuntary civil commitment process. That process would have provided him with an adversarial hearing, a right to counsel, and all of the other procedural safeguards associated with the legalized approach to commitment that had become the norm throughout the United States by 1990.⁶⁶ Under then-existing § 1983 law, this narrow question turned on whether Florida's requirement of informed consent had been foreseeably and routinely violated in practice, and whether a post-deprivation remedy could be made available or whether a pre-deprivation determination of competency was necessary to protect the underlying state-law-based liberty interest.⁶⁷

Writing for a five-person majority, Justice Blackmun held that "[i]t is hardly unforeseeable that a person requesting treatment for mental illness might be incapable of informed consent, and that state officials with the power to admit patients might take their apparent willingness to be admitted at face value and not initiate involuntary placement procedures."⁶⁸ Therefore, he explained, Burch and other patients like him were entitled to some screening for competence before being voluntarily admitted as

63. 494 U.S. 113 (1990).

64. At the time *Zinermon* was decided, the Florida statute required that a patient voluntarily give "express and informed consent to evaluation or treatment," or, in the alternative, that "a proceeding for court-ordered evaluation or involuntary placement [be] initiated." See *id.* at 122 (quoting FLA. STAT. § 394.463(1)(d) (1981)). Currently, the statute requires: "The patient . . . shall be asked to give express and informed consent to placement as a voluntary patient, and, if such consent is given, the patient shall be admitted as a voluntary patient; or [] A petition for involuntary placement shall be filed . . ." FLA. STAT. § 394.463(i)(3)-(4) (2014).

65. See *Zinermon*, 494 U.S. at 118-19.

66. See *id.* at 124.

67. See Paul A. Nidich, *Zinermon v. Burch and Voluntary Admissions to Public Hospitals: A Common Sense Proposal for Compromise*, 25 N. KY. L. REV. 699, 702-03 (1998); see also Winick, *supra* note 4, at 174-77.

68. *Zinermon*, 494 U.S. at 136.

psychiatric inpatients.⁶⁹ The majority did not detail what a constitutionally adequate preadmission procedure might look like, although the tenor of Blackmun’s discussion suggests that a judicial hearing likely would not be necessary and that a standardized assessment of competence by clinicians at the hospital might suffice.⁷⁰

The broader question lurking in the case—which the Justices chose not to resolve explicitly, given the procedural posture in which the matter came to the Court—was whether all voluntary patients in state facilities must provide some sort of informed consent and, if so, whether they therefore have a constitutional right to some preadmission process by which their competence to provide that consent is evaluated. Dicta in Justice Blackmun’s opinion has led one commentator to conclude that the Court’s view was that “all voluntary patients should be screened for competence before hospitalization.”⁷¹ This broader suggestion is grounded in Blackmun’s discussion of the liberty interest held by psychiatric inpatients.⁷² Perhaps, however, the majority’s suggestion—that a preadmission assessment of a patient’s capacity is required by the due process clause of the Fourteenth Amendment, even in states without an explicit statutory requirement of informed consent—was a function of the extent of the deprivation in Burch’s case. The majority opinion goes to some lengths to catalogue the specific circumstances of Burch’s hospitalization, including the fact that he remained in the state hospital for five months. As Justice Blackmun put the point: “Burch’s confinement at [Florida State Hospital] for five months without a hearing or any other procedure to determine either that he validly had consented to admission, or that he met the statutory standard for involuntary placement, clearly infringes on [his] liberty interest.”⁷³

In any event, in the period immediately following the Supreme Court’s decision in *Zinermon*, its implied message, however inchoate, that voluntary patients must be competent to consent to inpatient admission, attracted the attention of key stakeholders in the field. Most particularly, it caught the attention of the APA, which promptly put in place a task force to address the question.⁷⁴ At the time, nearly three-quarters of all inpatient psychiatric admissions in the United States were voluntary.⁷⁵

69. *See id.*

70. *See* Paul S. Appelbaum, *Voluntary Hospitalization and Due Process: The Dilemma of Zinermon v. Burch*, 41 HOSP. & CMTY. PSYCHIATRY 1059, 1060 (1990).

71. *See id.*

72. One writer has referred to this as the “‘hidden agenda’ of the majority” opinion in *Zinermon*. Nidich, *supra* note 67, at 704. This reading of the case, he suggests, “as requiring informed consent before a state hospital can accept a request for voluntary admission is certainly on the minds of those involved in this process.” *Id.*

73. *Zinermon*, 494 U.S. at 131.

74. *See* Stone, *supra* note 4, at 42.

75. *See* Appelbaum, *supra* note 70, at 1060; *see also* SLOBOGIN, RAI & REISNER, *supra* note 3, at 857.

Available research on the capacity of these patients to meet a rigorous standard of informed consent indicated that the great majority of these patients were incapable of understanding and rationally processing even fairly basic information about inpatient psychiatric admission.⁷⁶ If the alternative route of involuntary civil commitment were to become the primary means by which inpatient psychiatric admissions were achieved, massive new adjudicative resources would be required. In their absence, the courts, lawyers, and administrative personnel available to operate a vastly expanded civil commitment system would be overwhelmed.⁷⁷ In addition, many of the former voluntary patients who now would have to be involuntarily committed might be prevented from receiving inpatient treatment because, while less than fully competent, they would not likely be found imminently dangerous to themselves or to others.⁷⁸

The Task Force, motivated by all of these considerations, concluded that “strong policy interests support the establishment of a low threshold for competence in this situation.”⁷⁹ The “undemanding threshold” they adopted was made up of two competencies, the ability to “communicat[e] choices” and the ability to understand “that he/she is being admitted to a psychiatric hospital or ward for treatment, and [] understand[] release from the hospital may not be automatic”⁸⁰ No additional requirements often associated with competency determinations—such as the ability to rationally weigh costs and benefits or to evaluate a decision free from false beliefs—were included in the Task Force’s recommendations.⁸¹

Even this diminished set of requirements endorsed by the Task Force might have been too demanding, had they been rigorously applied. However, they have not been, at least not consistently.⁸² Given the circumstances, it is easy to see why this has been so. In research conducted a few years after the Task Force recommendations were issued, Norman

76. One widely cited study, for example, found that “60 percent of the sample [of schizophrenic patients] consented to treatment even though only 15 percent fully understood what they were consenting to” Grossman & Summers, *supra* note 2, at 206. The authors concluded that their “results suggest that only a small portion of schizophrenics may be able to give fully informed consent as required by law,” and thus “there is a serious discrepancy between legal requirements and the capacity of schizophrenic patients.” *Id.*

77. See Appelbaum, *supra* note 70, at 1060; see also GUTHEIL & APPELBAUM, *supra* note 1, at 50–51.

78. See Stone, *supra* note 4, at 37.

79. Binyamin C. Appelbaum, Paul S. Appelbaum & Thomas Grisso, *Competence to Consent to Voluntary Psychiatric Hospitalization: A Test of a Standard Proposed by APA*, 49 PSYCHIATRIC SERVS. 1193, 1193 (1998).

80. Cournos et al., *supra* note 25, at 299–300.

81. See GUTHEIL & APPELBAUM, *supra* note 1, at 216.

82. Although written before *Zinerman* was decided, the following remains an apt description of ongoing practice: “Many clinicians are not aware of the right of competent patients to refuse treatment and will inform them that they ‘must’ sign themselves into the hospital. Few therapists on the other hand will reject the agreement of a patient to treatment, even if he is clearly incompetent.” GUTHEIL & APPELBAUM, *supra* note 1, at 37 (citation omitted).

Poythress and his colleagues designed a study in which they distinguished between “weak” and “strong” models of informed consent. The question they addressed was similar to that confronted by the Task Force: “how stringent should the test of capacity be in screenings anticipated by the *Zinerman* dicta?”⁸³ Instead of focusing on the strong model of consent—which was defined to include “fairly extensive disclosure” about the legal rights waived by voluntary admission, the procedures for discharge, and the “adverse social costs (e.g., stigma) potentially attendant to hospitalization”—Poythress and colleagues measured participants’ performance on a “relatively non-demanding” test that had been designed by the Treatment Competence Subgroup of the MacArthur Foundation’s Research Network on Mental Health and the Law.⁸⁴ The study found that, even on this more limited test of competence, over 60% of the voluntary patients they tested “demonstrated impaired capacity to consent”⁸⁵

D. *The Alternative of Guardians and Other Third-Party Decision Makers*

Perhaps in recognition of the tension between the law’s systemic preference for voluntary admissions on the one hand and the limited capacity of many psychiatric inpatients to provide fully informed consent on the other, both the *Zinerman* majority and the APA took the position that guardians or other properly authorized third-party decision makers might be relied upon to provide the consent needed for admission. Thus, in his majority opinion in *Zinerman*, Justice Blackmun noted that protections for due process might include “appointment of a guardian advocate to make treatment decisions”⁸⁶ The APA had endorsed the use of third-party surrogate decision makers even before *Zinerman*, and in its assessment of the issue after *Zinerman*, the APA’s Task Force elaborated, by stating that such surrogates might include guardians, family members, or others authorized by state law to make decisions on behalf of the impaired patient.⁸⁷

83. Norman G. Poythress et al., *Capacity to Consent to Voluntary Hospitalization: Searching for a Satisfactory Zinerman Screen*, 24 BULL. AM. ACAD. PSYCHIATRY & L. 439, 441 (1996).

84. *See id.* at 441–42, 447.

85. *See id.* at 447. The research participants were 120 persons initially brought to “crisis stabilization units” (CSU) in Florida. *See id.* at 442–43. Half of the subjects had been involuntarily admitted following assessment by a psychiatrist and half had been “permitted to sign into the CSU as voluntary treatment patients [. . .].” *Id.* at 443. Surprisingly, even more of the voluntary patients failed the minimal competency test used by the researchers than did the involuntary patients. *See id.* at 447. The authors speculate that this might have been the result, in part, of the psychiatrists’ practice of denying patients who refused to consent to take psychotropic medications the opportunity to be admitted as voluntary patients. *See id.* at 448–49. The suggestion here is that some number of these refusers may actually have had more capacity to process information than did those patients who agreed to treatment and were admitted voluntarily. *See id.* at 449.

86. *Zinerman v. Burch*, 494 U.S. 113, 134 (1990).

87. *See Halverson, supra* note 4, at 172–73.

It is not difficult to understand why substitute decision makers are an attractive alternative in this setting. As noted, an expansive reading of the *Zinermon* majority opinion, that takes seriously the full implications of Justice Blackmun's dicta, creates a potential gap in the treatment system of considerable moment. As Donald Stone has explained:

Mentally ill persons who are incapable of giving informed consent to admission may not necessarily meet the statutory standard for involuntary placement. . . . 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.⁸⁸

One potentially effective solution to this problem is to rely on eligible third-party decision makers. These substitute decision makers could be appointed by a court (usually in the role of guardian or conservator), identified in advance by the patient through a properly executed advance directive,⁸⁹ or authorized by state statutes that empower family members or others close to the individual.⁹⁰ Advance directives are not widely used for mental health treatment; consequently, third-party decision makers arranged by the patient are infrequently available.⁹¹ A number of states permit other designated third-party decision makers to provide consent for psychiatric treatment without special court approval.⁹² An additional group of states expressly prohibits surrogates from making these treatment decisions, absent judicial authorization.⁹³ In most jurisdictions, however, the law with respect to the authority of third-parties other than guardians or conservators is unsettled, at best.⁹⁴ By a process of elimination, therefore, court-appointed guardians become an important potential resource in many jurisdictions for managing the decision-making process by which inpatient psychiatric treatment might be arranged for those persons with mental disabilities who are unable to provide adequate informed consent on their own. Unfortunately, with some notable exceptions, the law in many states governing the power of guardians to arrange for the psychiatric hospitalization of their adult wards without utilizing the full process for involuntary civil commitment is underdeveloped, confused, or

88. Stone, *supra* note 4, at 37.

89. See Winick, *supra* note 24, at 57.

90. See Halverson, *supra* note 4, at 173.

91. See *id.*

92. See *id.* at 174.

93. See *id.*

94. See *id.* at 173–75.

inadequate. Before turning to a consideration of that body of law, however, a brief discussion of guardianships more generally, and of the difficult issue of incompetency that ordinarily triggers the appointment of a guardian, is in order.

III. INCOMPETENCY AND GUARDIANSHIP

A. *The Presumption of Competency*

For the most part, adults over the age of eighteen are presumed competent to manage their own affairs, including making health-care treatment decisions.⁹⁵ The most commonly employed mechanism for overcoming the standing presumption of competency is a judicial hearing, at which a finding of general incompetency or incompetency with respect to a specific decision or function may result in the court's appointment of a general or limited guardian.⁹⁶ This reliance on judicial hearings to determine incompetency is a relatively recent development. Before the 1960s, the legal status of incompetency was most often established by way of a different legal presumption contrary to the ordinary presumption of adult competence, which was triggered by the involuntary commitment (and sometimes even voluntary hospitalization) of an individual with a mental disability.⁹⁷ In most jurisdictions, this presumption of incompetency was irrebuttable; thus, a determination that an individual was subject to civil commitment was the "equivalent of a finding of general incompetency"⁹⁸ As time went along, some states adjusted this rule to make psychiatric hospitalization the basis for a rebuttable rather than irrebuttable presumption of incompetency.⁹⁹ Nevertheless, the great majority of patients who were hospitalized for mental illness or other mental disabilities were deemed incompetent and thus lost the power to enter into contracts, to initiate lawsuits, to marry or divorce, to decide where to live, and to consent to medical care.¹⁰⁰

More recently, a great many clinicians and legal advocates have concluded that mental illnesses and other mental disabilities that are severe enough to warrant inpatient treatment do not necessarily render patients entirely incapable of making all significant decisions or otherwise participating in a variety of daily activities associated with managing their own affairs.¹⁰¹ As a result, the irrebuttable presumption that a person subject to involuntary commitment (or voluntary hospitalization) is generally in-

95. See Bruce J. Winick, *The Side Effects of Incompetency Labeling and the Implications for Mental Health Law*, 1 PSYCHOL. PUB. POL'Y & L. 6, 41 (1995).

96. See BARBARA A. WEINER & ROBERT M. WETTSTEIN, LEGAL ISSUES IN MENTAL HEALTH CARE 287-90 (1993).

97. See GUTHEIL & APPELBAUM, *supra* note 1, at 222.

98. See *id.*

99. See *id.*

100. See SLOBOGIN, RAI & REISNER, *supra* note 3, at 940.

101. See GUTHEIL & APPELBAUM, *supra* note 1, at 223; WEINER & WETTSTEIN, *supra* note 96, at 116.

competent has been abrogated, replaced either by a rebuttable presumption of incompetence or, more commonly, by the ordinary background norm that all adults are presumed competent until found otherwise by a court of appropriate jurisdiction.¹⁰² As a rule, the determination of general incompetency is now legally distinct from the decision to civilly commit an individual for inpatient treatment.¹⁰³ As civil commitment increasingly has come to be centered on the state's police power interest in restraining and treating patients whose mental disability poses a danger to themselves or to others,¹⁰⁴ the state's *parens patriae* interest in caring for those who are incapable of caring for themselves increasingly has become concentrated in the judicial process by which incompetency (and guardianship) are determined.¹⁰⁵

The now common presumption that patients subject to psychiatric hospitalization should be deemed competent unless a court makes contrary findings is, of course, relevant to the *Zinermon* dicta suggesting that voluntary patients must be capable of providing consent for admission.¹⁰⁶ Depending on the definition of competency one employs, however, research suggests that a significant portion of the population of voluntary patients in mental hospitals and specialized psychiatric units likely cannot engage fully in the cognitive process by which information relevant to the hospitalization decision must be evaluated in order to meet a standard of fully informed consent.¹⁰⁷ Some states now routinely require voluntary patients, involuntary patients, or both to be screened for competency, and some routinely petition the appropriate court for the appointment of a guardian when the patient is determined to be incapable of providing the necessary consent either for admission, in the case of voluntary patients, or for other treatment decisions such as the administration of psychotropic medications, in the case of involuntary patients.¹⁰⁸ There are significant limitations on the resources available to support such a widespread

102. See GUTHEIL & APPELBAUM, *supra* note 1, at 222–23.

103. See *id.* at 223.

104. See BRAKEL ET AL., *supra* note 3, at 26–27.

105. See GUTHEIL & APPELBAUM, *supra* note 1, at 222–23; see also BRAKEL ET AL., *supra* note 3, at 370.

106. A very different approach pertained in the 1950s, when the National Institute of Mental Health took the position that voluntary psychiatric patients need not be competent to consent to hospitalization. See NAT'L INST. OF MENTAL HEALTH, A DRAFT ACT GOVERNING THE HOSPITALIZATION OF THE MENTALLY ILL, PUBLIC HEALTH SERV. PUB. NO. 51 (1951), available at <http://catalog.hathitrust.org/Record/006203370>. Paul Appelbaum reports that this decision led many states to adopt the same approach. See Appelbaum, *supra* note 70, at 1060. The governing assumption for this policy was that “the benefits of voluntary hospitalization, including a presumed acknowledgment of a need for treatment, a stronger alliance with treatment personnel, and avoidance of the stigma of court hearings, should not be denied non-objecting patients, even if they would not meet ordinary competence criteria.” *Id.*

107. See Grossman & Summers, *supra* note 2, at 206.

108. See GUTHEIL & APPELBAUM, *supra* note 1, at 223.

use of guardians for all patients who might be regarded as incompetent, at least according to some reasonably demanding conception of competency, not the least of which is the limited availability of persons willing and able to serve in that capacity.¹⁰⁹ As noted above, there are also important legal restrictions on the authority of guardians in many jurisdictions to perform as substitute decision makers in order to provide the consent needed, at least in the case of approving voluntary psychiatric hospitalization.¹¹⁰

B. *Determining Incompetency*

Incompetency, which ordinarily is the standard by which a guardianship is authorized,¹¹¹ is subject to significant contest, both as to its definition and its legal significance.¹¹² The range of important legal consequences that flow from a finding of incompetency by a court turns on a constellation of criteria that may not be entirely appropriate when clinicians seek to evaluate the competency of patients for other purposes, including questions of medical management or treatment.¹¹³ A classic discussion of the factors relevant to evaluating competency—originally developed by Paul Appelbaum and Loren Roth for the purpose of determining the capacity of individuals with mental disabilities to consent to research—provides useful tools for considering both legal and clinical competency and has become a common starting point for commentators in this field.¹¹⁴ Originally conceived as a hierarchy of capacities, Professor Appelbaum subsequently suggested that each of the four categories of functionality he and his colleague identified might apply differently and might hold independent significance, depending on the individual circumstances presented by any particular individual whose competency is to be assessed.¹¹⁵ Logically, however, for most purposes, the four areas of capacity they describe form a set of criteria of apparent ascending importance.¹¹⁶

The first is the capacity to evidence a choice.¹¹⁷ Ordinarily, even severely mentally disabled individuals are able to communicate their agree-

109. *See id.* at 224–25.

110. For a further discussion of the various legal restrictions on the authority of guardians, see *supra* notes 9–14 and accompanying text.

111. Although, “[t]he trend in the law has been to abandon the term *incompetent* and refer to the person as *incapacitated* or *disabled*, since this is less pejorative.” WEINER & WETTSTEIN, *supra* note 96, at 282.

112. *See* GUTHEIL & APPELBAUM, *supra* note 1, at 215–16; Winick, *supra* note 95, at 6.

113. *See* GUTHEIL & APPELBAUM, *supra* note 1, at 215; WEINER & WETTSTEIN, *supra* note 96, at 116; *cf.* Roca, *supra* note 2, at 1177.

114. *See generally* Paul S. Appelbaum & Loren H. Roth, *Competency to Consent to Research: A Psychiatric Overview*, 39 ARCHIVES GEN. PSYCHIATRY 951 (1982).

115. *See* Paul S. Appelbaum & Thomas Grisso, *Mental Illness and Competence to Consent to Treatment*, 19 L. & HUM. BEHAV. 105, 110 (1995).

116. *See* SLOBOGIN, RAI & REISNER, *supra* note 3, at 932.

117. *See* Appelbaum & Roth, *supra* note 114, at 952–53.

ment or disagreement with a proposed decision, though the basis for that assent or refusal may not always be entirely rational or grounded in objective fact. Occasionally, however, a patient is either entirely incapable of communication, or provides a mix of verbal and/or nonverbal signals that are so inconsistent that a clear indication of the patient's choice is impossible to discern. For the most part, though, relatively few incompetency determinations are based on this first sort of incapacity.¹¹⁸

The second set of functional capacities identified by Appelbaum and Roth are more consequential and govern the analysis in a greater number of cases. They relate to an individual's ability to understand the facts central to a proposed decision or task.¹¹⁹ These capacities are largely cognitive in nature. Where a particular choice is contemplated, the required matters that must be understood include the options open to decision and the respective costs and benefits of electing one or another of these options.¹²⁰ In the case of decision making with respect to medical care, this sort of factual understanding includes a clear comprehension of the proposed intervention, the likelihood of success, the risks and potential side effects associated with the treatment, and the available alternative options along with their risks and potential benefits.¹²¹

The level of detail and complexity of the information deemed essential for a competent decision varies considerably, depending on the subject under consideration and the judgment of the evaluator.¹²² Beyond the question of detail and complexity, Appelbaum and Roth helpfully divide this second category of functional capacity into two sub-categories that further refine the assessment process. The first sub-category goes to the individual's basic "ability to understand" relevant facts, while the second concerns the individual's more refined capacity to demonstrate "actual understanding" of those facts.¹²³ An evaluator might determine that a patient has the basic ability to understand the facts bearing on a decision by exploring whether he or she has a grasp of facts of a similar order or level of complexity, or perhaps by asking him or her to identify relevant information on a written list of alternatives.¹²⁴ The more demanding question is whether the patient can exhibit "actual understanding" by re-

118. *See id.*

119. *See id.* at 953–54.

120. *See id.*

121. *See* GUTHEIL & APPELBAUM, *supra* note 1, at 219 ("The patient ought to have the ability to understand the proposed interventions, including their risks, benefits, and the possible alternatives. For example, an acutely psychotic patient should understand that psychotropic medication carries the risk of dystonic reactions . . . ; that the benefit is the probable resolution of the psychotic episode; and that alternatives include psychotherapy and milieu therapy, and possibly ECT, but that at least the two former alternatives carry a lower short-term success rate than does medication.").

122. *See* Roca, *supra* note 2, at 1195.

123. *See* Appelbaum & Roth, *supra* note 114, at 953.

124. *See* Poythress et al., *supra* note 83, at 951.

peating back information he or she has been given, by paraphrasing that information in his or her own words, or by showing some comprehension of the consequences of the choices that are available.¹²⁵

Closely related to the demonstration of an actual understanding of essential facts is the third functional capacity described by Appelbaum and Roth, the ability to apply that information in a "rational" process of deliberation.¹²⁶ Other writers, most prominently Michael Moore, have elaborated on the central role that "practical reasoning" plays in assessing an individual's moral agency. In its most essential form, this practical reasoning—or rational deliberation—requires the decision maker to go through a process of weighing the relative costs and benefits of competing choices in order to arrive at a decision.¹²⁷ This practical reasoning is said to have moral significance, in part because the very process of assigning weight to these various costs and benefits necessarily draws upon the individual's foundational normative commitments and value structure.¹²⁸

In any event, a system in which competency is evaluated according to an individual's capacity to engage in the rational manipulation of information must contend with several challenges. The first follows from the moral significance assigned by Moore and others to the process of practical reasoning. By definition, the assessment of another's rationality is highly subjective, precisely because the judgment that another has arrived at a rational decision likely turns, at some level, on agreement between the assessor and the decision maker with respect to the relative weights assigned to the risks and benefits of the choices under consideration.¹²⁹ Beyond the problem of subjectivity, the rational manipulation criterion also runs into potential difficulty when the patient being evaluated holds false beliefs with respect to one or more facts that enter into the practical reasoning process.¹³⁰ Appelbaum and Roth point out that the law has long

125. See Appelbaum & Roth, *supra* note 114, at 953–54.

126. See *id.* at 954.

127. See Michael S. Moore, *Causation and the Excuses*, 73 CALIF. L. REV. 1091 (1985); see also MICHAEL S. MOORE, *LAW AND PSYCHIATRY: RETHINKING THE RELATIONSHIP* 9–112 (1984).

128. See Gary Watson, *Free Agency*, in *MORAL RESPONSIBILITY* 84 (John Martin Fischer ed., 1986).

129. See Appelbaum & Roth, *supra* note 114, at 954. This point has been pressed with particular vigor by Duncan Kennedy, who has argued that the decision to overrule another's choice cannot be explained by a neutral conception of capacity, because "the question of capacity is hopelessly intertwined with the question of what the other wants to do in this particular case." Duncan Kennedy, *Distributive and Paternalist Motives in Contract and Tort Law, with Special Reference to Compulsory Terms and Unequal Bargaining Power*, 41 MD. L. REV. 563, 644 (1982). For Kennedy, the focus of some commentators and courts on the ability of an individual to undertake a rational decision-making process is effectively a cover for an underlying paternalism (perhaps necessary under the circumstances) of acting contrary to the wishes of the individual, in order to protect what another determines to be the incapacitated person's best interests. See *id.* at 642–46.

130. See GUTHEIL & APPELBAUM, *supra* note 1, at 218 (stating that determining patient's ability rationally to manipulate information requires examination of "the

treated the presence of “insane delusions” as adequate grounds for a finding that an individual lacks contractual or testimonial capacity, thus providing a basis to invalidate a contract or will executed on the basis of such false beliefs.¹³¹ But individuals with mental illness or other mental disabilities may suffer impairments that impact the rationality of particular choices or behaviors without affecting their cognitive processes more globally. Because “the impact of delusions, for example, may be limited to a discrete area of mental functioning,” the fact that a patient holds false beliefs relating to one set of issues may not be relevant to his or her capacity to assess the relative risks and benefits of a proposed course of action unrelated to his or her thought disorder.¹³² The question in such cases, then, is whether the individual should be regarded as competent to make the decisions and manage the portions of his or her affairs unaffected by the cognitive dysfunction caused by the mental disability.¹³³

The fourth competency identified by Appelbaum and Roth is the ability to “appreciat[e] the nature of the situation.”¹³⁴ Appreciation, they explain, is distinct from factual understanding in that it requires the individual to possess the ability to apply the abstract information he or she has been provided to a concrete circumstance, most commonly the individual’s immediate situation.¹³⁵ It is one thing, for example, to understand that the rules governing voluntary admission formally limit patients’ ability to leave the hospital without providing forty-eight hours’ notice; it is quite another for patients to appreciate that staff will stop them if they attempt to walk out the front door of the hospital. Beyond the application of abstract knowledge to concrete circumstances, the capacity of apprecia-

basic components of the patient’s mental status: orientation, memory, intellectual functioning, judgment, impairment in rationality (hallucinations and delusions), and alterations of mood”).

131. See Appelbaum & Roth, *supra* note 114, at 952–56. Elyn Saks takes a somewhat different approach. She has endorsed a standard for determining competency to consent to treatment that requires the patient to possess a level of factual understanding in which he or she harbors no “patently false beliefs” about that information, but does not require any demonstration of an ability to rationally manipulate the information. See generally Elyn R. Saks, *Competency to Refuse Treatment*, 69 N.C. L. REV. 945 (1991).

132. See Appelbaum & Roth, *supra* note 114, at 954.

133. Robert Roca explains that assigning a diagnosis of, for example, schizophrenia, bipolar disorder, or dementia, while relevant to an assessment of competency to consent, does not “in and of itself, invariably impl[y] incompetency.” Roca, *supra* note 2, at 1187. This is so, he continues, because the cognitive impairment or thought disorder associated with the diagnosed illness or condition may have no relationship to the particular decision (or task) for which the competency assessment is being made. See *id.* In such instances, where the impairment does not “imply global decisional incapacity,” it may be possible for the clinician (and thus a court) to conclude that the individual remains competent with respect to the particular choice at issue. See *id.*

134. See Appelbaum & Roth, *supra* note 114, at 954–56.

135. See *id.*

tion also entails the integration of cognition and affect.¹³⁶ In a different context, the drafters of the American Law Institute's (ALI) Model Penal Code provision governing the insanity defense recognized this insight when they altered the common law *M'Naghten* test for criminal defendants asserting a defense of insanity. Under the ALI test, the inquiry is not what a criminal defendant "knew" about the facts relevant to the offense, which was the prevailing common law standard, but whether the defendant was able to fully "appreciate" the significance of that information.¹³⁷ In explaining this shift in emphasis, the Model Penal Code drafters observed that appreciation of the wrongfulness of one's conduct entails a mature understanding of and emotional connection with its consequences.¹³⁸ Clearly, requiring an individual to have this sort of appreciation, particularly regarding the decision whether to agree to enter an inpatient facility for mental health treatment, is a demanding standard for many patients with acute mental disabilities. If this capacity were part of the matrix necessary for legal competency, and if due process were understood to require informed consent measured in such a fashion, many patients who would otherwise be admitted as voluntary patients would lose that opportunity and would be limited to involuntary hospitalization, outpatient treatment, or no treatment at all.

The Appelbaum and Roth competency criteria, taken as a whole, are focused on the process by which a decision is made and not on the outcome of that decision-making process. One could also assess competency, however, by evaluating outcomes, with little or no attention to the process through which information supporting a choice has been obtained and weighed. This fundamental distinction between a process-based approach and an outcomes-centered approach to competency determinations is crucial in shaping the law governing adult guardianship.¹³⁹

136. *See id.*

137. *See* MODEL PENAL CODE § 4.01 (Official Draft 1962) (Mental Disease or Defect Excluding Responsibility).

138. *See* MODEL PENAL CODE § 4.01 cmt. (Official Draft and Revised Comments 1985).

139. *See* SLOBOGIN, RAI & REISNER, *supra* note 3, at 947. In a slightly different context, Robert Roca has offered the following example, which helps to illuminate this key distinction:

Consider an elderly man who refuses to stop smoking despite severe progressive obstructive pulmonary disease. His physicians inform him that he is hastening his demise by continuing to smoke. He retorts that he does not believe smoking is harming him and that in fact he relaxes and breathes more comfortably when he smokes. His choice is unwise, unreasonable, and at odds with general knowledge about the relationship between smoking and pulmonary disease. A psychiatric evaluation is requested and reveals no evidence of dementia, major depression, or any other capacity-compromising psychiatric syndrome. His refusal to accept commonly-held beliefs about the relationship between smoking and lung disease might lead ardent anti-smokers to question his "competency," and this challenge might be sustained if there were no requirement for the demonstration of a disabling psychiatric disorder.

The traditional state law approach governing the appointment of guardians for incompetent adults has focused on whether the individual is capable of making decisions that produce reasonable outcomes. More recently, a number of states have adopted an alternative approach, developed as part of the Uniform Probate Code (UPC), which shifts the emphasis from reasonable outcomes to the soundness of the individual's decision-making process itself. In response to a concern that the UPC's process-based approach is too subjective, a third alternative has appeared in some states that centers on the capacity of the individual to undertake specific tasks having to do with essential functions such as housing, health care, and nutrition.

An adult under guardianship could have considerable actual capacity to participate in the decision to seek inpatient treatment, could be only partially impaired, or could be largely incapable of usefully contributing to that decision-making process, depending upon which of these legal regimes for the appointment of a guardian the court has employed. Moreover, a ward might express agreement with the inpatient placement, express no opinion, or make clear his or her opposition to the plan. The authority of a guardian to arrange a voluntary admission ought to reflect an assessment of both the ward's capacity for engaging in the decision-making process and producing reasonable outcomes. In some instances, where the ward is capable of reasonable judgment and has communicated his or her agreement with inpatient admission, the guardian should be permitted to exercise considerable discretion. In other instances, where the ward is more severely impaired and/or has not conveyed agreement with the inpatient placement, judicial oversight will be essential. The legal formula for managing this complex relationship between adult wards and their guardians facing a hospitalization decision ordinarily will derive from the statutes governing voluntary admissions together with the state law setting out the powers of guardians. This Article now turns to a consideration of that body of law.

Roca, *supra* note 2, at 1188.

From a process-based point of view, it would be difficult, though not impossible, to conclude that the smoker in the above example is incompetent. His belief that smoking is not harming his health is a false belief judged against objective medical evidence, and under a rigorous version of the process approach, one might argue that his capacity to rationally assess the relevant evidence is therefore impaired. Virtually all of the other process-focused criteria identified by Appelbaum and Roth, however, point in the other direction. The elderly patient is clearly communicating his choice, understands (and probably appreciates) all of the other facts relevant to the decision, and has applied that understanding in the process of weighing his options. A more paternalistic outcomes-based perspective, on the other hand, might well support the conclusion that the elderly smoker is incompetent, given that his choice is clearly not in his objective best interest.

IV. SEEKING A BALANCE OF INTERESTS: A REVIEW OF STATE LAWS

The authority of a court-appointed guardian to consent to voluntary inpatient psychiatric treatment for his or her ward varies from state to state. In some jurisdictions, the guardian's authority turns on whether the ward has objected to the proposed hospitalization, has indicated consent, or has failed to protest the admission. Often, the guardian's ability to authorize inpatient treatment depends on how state law views the ward's capacity following the guardian's appointment. Thus, the ward may categorically be regarded as legally incompetent under state law by virtue of the court's appointment of a general guardian, or the ward may be understood as having partial decision-making capacity to the extent that he or she can in fact make a reasonable choice with respect to hospitalization, notwithstanding the court's prior guardianship decision.¹⁴⁰ In addition, state laws vary on whether a patient subject to voluntary psychiatric hospitalization must be capable of giving informed consent. This variation in state law reflects, in part, ongoing uncertainty about whether the Supreme Court's majority decision in the *Zinerman* case made the capacity to provide such consent (or some lesser degree of decision-making competence, as suggested by the APA Task Force recommendations) a requirement of federal due process.¹⁴¹

In more than a half-dozen states, a guardian may provide consent for the voluntary psychiatric hospitalization of his or her adult ward. In Georgia, for example, guardians have broad decision-making authority under the guardian powers statutes and the voluntary commitment law that together appear to provide a sufficient foundation for providing consent to inpatient care.¹⁴² In Maine, a guardian may provide consent unless the adult ward objected at an earlier time when he or she had capacity, in which case court approval for inpatient psychiatric treatment is required.¹⁴³ North Carolina's guardian statute is especially broad, providing

140. See, e.g., *Pima Cnty. Pub. Fiduciary v. Superior Court for Pima Cnty.*, 546 P.2d 354, 355 (Ariz. Ct. App. 1976) (discussing and quoting *In re Sherrill's Estate*, 373 P.2d 353 (Ariz. 1962) (in banc)).

141. See *supra* notes 71–74 and accompanying text.

142. See GA. CODE ANN. § 37-3-20 (2014) (authorizing guardian to make application for ward's voluntary commitment); see also *id.* § 29-4-21(a)(3) (“[T]he appointment of a guardian shall remove from the ward the power to . . . [c]onsent to medical treatment”); *id.* § 29-4-23(a)(2) (allowing guardian to “give any consents or approvals that may be necessary for medical or other professional care, counsel, treatment, or service for the ward”).

143. Under Maine's guardian powers statute, a guardian is authorized to provide consent for medical and other care or treatment: “A guardian may give or withhold consents or approvals related to medical or other professional care, counsel, treatment or service for the ward.” ME. REV. STAT. ANN. tit. 18-A, § 5-312(a)(3) (2013). However, if a guardian's decision is against the wishes of his or her ward, as expressed by the ward when the ward had capacity, then court approval is necessary. See *id.* § 5-806; see also *Guardianship of Boyle*, 674 A.2d 912, 915 (Me. 1996) (“The guardian of an incapacitated person has the same powers that ‘a parent has respecting [the parent's] unemancipated minor child,’ unless

the guardian with the power to “give any consent or approval that may be necessary to enable the ward to receive medical, legal, psychological, or other professional care, counsel, treatment, or service”¹⁴⁴ In South Dakota, if the ward “presents” to a psychiatric facility, the ward’s guardian may provide consent for voluntary inpatient treatment.¹⁴⁵

The statutory provisions in Wisconsin governing the provision of psychiatric treatment for an incompetent adult suggest a similar approach. With respect to healthcare generally, the Wisconsin guardian powers statute makes clear that a guardian has:

[T]he power to give an informed consent to the voluntary receipt by the guardian’s ward of a medical examination, medication,

modified by court order. This authority includes the giving or withholding of consent or approval related to medical care.” (alteration in original) (citation omitted) (quoting ME. REV. STAT. ANN. tit. 18-A, § 5-312(a)) (citing ME. REV. STAT. ANN. tit. 18-A, §5-312(a)(3))).

144. See N.C. GEN. STAT. § 35A-1241(a)(3) (2013). North Carolina’s guardian powers statute provides, in pertinent part:

(a) To the extent that it is not inconsistent with the terms of any order of the clerk or any other court of competent jurisdiction, a guardian of the person has the following powers and duties:

(3) The guardian of the person may give any consent or approval that may be necessary to enable the ward to receive medical, legal, psychological, or other professional care, counsel, treatment, or service; provided that, if the patient has a health care agent appointed pursuant to a valid health care power of attorney, the health care agent shall have the right to exercise the authority granted in the health care power of attorney unless the Clerk has suspended the authority of that health care agent The guardian of the person may give any other consent or approval on the ward’s behalf that may be required or in the ward’s best interest. The guardian may petition the clerk for the clerk’s concurrence in the consent or approval.

Id. § 35A-1241(a), (a)(3). Significantly, in directing the guardian’s decision making with respect to the ward’s place of abode, the statute sets out a preference for residences that are not treatment facilities and for treatment facilities that are community-based. Nevertheless, the authority to consent to inpatient psychiatric treatment is not expressly foreclosed by the statute:

(2) The guardian of the person may establish the ward’s place of abode within or without this State. . . . The guardian also shall give preference to places that are not treatment facilities. If the only available and appropriate places of domicile are treatment facilities, the guardian shall give preference to community-based treatment facilities, such as group homes or nursing homes, over treatment facilities that are not community-based.

Id. § 35A-1241(a)(2).

North Carolina’s voluntary admissions statute authorizes a health care agent/surrogate to provide proxy consent, but it does not address the authority of a guardian in that regard. See *id.* § 122C-211. Nevertheless, it appears that the guardian powers statute controls in the absence of an agent/surrogate.

145. See S.D. CODIFIED LAWS § 27A-8-18.1(1)–(4) (2014) (“If a person eighteen years of age or older presents for admission to an inpatient psychiatric facility and meets the requirements . . . but the facility director or administrator determines that the person is incapable of exercising an informed consent to the admission, then the person may be admitted upon exercise of a substituted informed consent: [] [b]y a guardian . . . [or other possible surrogate decision makers].”).

including any appropriate psychotropic medication, and medical treatment that is in the ward’s best interest, if the guardian has first made a good-faith attempt to discuss with the ward the voluntary receipt of the examination, medication, or treatment and if the ward does not protest.¹⁴⁶

With respect to consent for inpatient treatment particularly, Wisconsin law authorizes the guardian of an incompetent adult to provide consent for the voluntary admission of the ward to an inpatient treatment facility in cases where the ward does not indicate a desire to leave the facility, if general statutory procedures for voluntary admission are followed.¹⁴⁷

Statutes in Michigan permit the guardian of an adult ward to authorize inpatient psychiatric treatment if the patient “assents,” although this power is limited to “formal” voluntary admissions.¹⁴⁸ In Missouri, a guardian can consent to voluntary hospitalization for thirty days, after which a court order is required.¹⁴⁹ In North Dakota, a guardian of an adult can consent to voluntary psychiatric hospitalization for up to forty-five days without an authorizing court order.¹⁵⁰

146. WIS. STAT. ANN. § 54.25(2)(d) (West 2014).

147. *See id.* § 51.10(8) (“An adult for whom, because of incompetency, a guardian of the person has been appointed in this state may be voluntarily admitted to an inpatient treatment facility if the guardian consents after the requirements of sub. (4m)(a)1. are satisfied or if the guardian and the ward consent to the admission under this section.”).

148. *See* MICH. COMP. LAWS § 330.1415 (2014). Section 330.1411, on the other hand, deals with informal voluntary admissions and indicates that only patients themselves can apply to be admitted in this fashion. *See id.* § 330.1411. *But see id.* § 330.1415 (governing formal voluntary admissions). While almost identical, section 330.1415 provides:

[A]n individual 18 years of age or over may be hospitalized as a formal voluntary patient if the individual executes an application for hospitalization as a formal voluntary patient or the individual assents and the full guardian of the individual, the limited guardian with authority to admit, or a patient advocate authorized by the individual to make mental health treatment decisions under the estates and protected individuals code executes an application for hospitalization and if the hospital director considers the individual to be clinically suitable for that form of hospitalization.

Id. (citations omitted) (citing MICH. COMP. LAWS §§ 700.1101–700.8102; 1998 Mich. Pub. Acts 386).

149. *See* MO. ANN. STAT. § 632.120 (West 2014) (permitting guardian to make application for voluntary hospitalization of ward). *But see id.* § 475.120(5) (placing limit on guardian’s ability to have ward admitted: “No guardian of the person shall have authority to seek admission of the guardian’s ward to a mental health or intellectual disability facility for more than thirty days for any purpose without court order except as otherwise provided by law.”).

150. *See* N.D. CENT. CODE § 30.1-28-12(2) (2013) (“[N]o guardian may voluntarily admit a ward to a mental health facility or state institution for a period of more than forty-five days without a mental health commitment proceeding or other court order.”). The negative implication is that a guardian may voluntarily admit a ward to a treatment facility for forty-five days or less. The Supreme Court of North Dakota has considered whether this guardian powers statute applies in

In more than a dozen states, by contrast, the law is settled that a guardian is not authorized to consent to voluntary psychiatric hospitalization if the ward either has not provided or is incapable of providing informed consent. In these states, the guardian seeking inpatient treatment for his or her ward ordinarily will be required to initiate an involuntary commitment process. States in this category include Alaska,¹⁵¹ Illinois,¹⁵²

the case of a ward admitted to a care facility (a locked dementia unit), and has concluded, based on legislative history, that it does not. *See In re Guardianship/Conservatorship of Van Sickle*, 694 N.W.2d 212, 218–21 (N.D. 2005). The guardian in *Van Sickle* was permitted to place his ward in this facility without first obtaining a court order. *See id.* The clear implication of this holding is that, in circumstances in which the ward is to be admitted to a psychiatric facility as opposed to a care facility, for a period longer than forty-five days, the guardian will be required to obtain an authorizing court order.

151. *See* ALASKA STAT. § 13.26.150(e), (e)(1) (2014) (prohibiting guardians from placing wards in psychiatric facilities: “A guardian may not [] place the ward in a facility or institution for the mentally ill other than through a formal commitment proceeding under [Alaska Stat. §] 47.30 in which the ward has a separate guardian ad litem . . .”).

152. *See* 755 ILL. COMP. STAT. ANN. 5/11a-17(a) (West 2014) (“A guardian of the person may not admit a ward to a mental health facility except at the ward’s request as provided in Article IV of the Mental Health and Developmental Disabilities Code and unless the ward has the capacity to consent to such admission as provided in Article IV of the Mental Health and Developmental Disabilities Code.”). This provision is consistent with the Illinois Appellate Court’s decision in *In re Gardner*, in which the court held that a guardian cannot authorize the admission of a non-consenting ward to a mental health treatment facility as a voluntary patient. *See In re Gardner*, 459 N.E.2d 17, 20 (Ill. App. Ct. 1984). The ward in *Gardner* lacked the capacity to provide informed consent for inpatient treatment, but was not dangerous. *See id.* at 18. The court, although recognizing that the ward would not be subject to hospitalization under the involuntary commitment statute, nevertheless refused to allow the guardian the authority to consent to voluntary inpatient treatment. *See id.* at 20; *see also In re Guardianship of Muellner v. Blessing Hosp.*, 782 N.E.2d 799, 802 (Ill. App. Ct. 2002) (“[A] trial court may not grant a guardian the power to admit a nonconsenting ward to a mental health facility for treatment as a voluntary patient.” (citing *In re Gardner*, 459 N.E.2d at 20)).

Maryland,¹⁵³ Montana,¹⁵⁴ New York,¹⁵⁵ Pennsylvania,¹⁵⁶ Texas,¹⁵⁷ and the District of Columbia.¹⁵⁸

153. *See* MD. CODE ANN., EST. & TRUSTS § 13-708(b)(2) (LexisNexis 2014) (setting out functions of guardians and providing the “right to custody of the disabled person and to establish his place of abode within and without the State, provided there is court authorization for any change in the classification of abode, except that no one may be committed to a mental facility without an involuntary commitment proceeding as provided by law”).

154. *See* MONT. CODE ANN. § 53-21-111 (2013). While Montana’s voluntary admission statute is silent as to whether a guardian can make an application to have a ward admitted, it does contain an informed consent requirement that suggests that the patient must provide informed consent. *See id.* Additionally, the guardian powers statute appears to limit a guardian’s ability to place a ward in an inpatient psychiatric facility. *See id.* § 72-5-321. Although it permits a guardian to give consent for medical and other care, and generally provides that the guardian of an adult ward has the same powers that parents have with respect to the care of their children, the statute then goes on to limit this power in the mental health context:

A full guardian or limited guardian may not involuntarily commit for mental health treatment or for treatment of a developmental disability or for observation or evaluation a ward who is unwilling or unable to give informed consent to commitment . . . unless the procedures for involuntary commitment set forth in Title 53, chapters 20 and 21, are followed.

Id. § 72-5-321(5).

155. *See* N.Y. MENTAL HYG. LAW § 81.22(b)(1) (McKinney 2014) (“No guardian may: [] consent to the voluntary formal or informal admission of the incapacitated person to a mental hygiene facility” (informal admission refers to voluntary admission)); *see also id.* § 9.13 (governing voluntary admissions but not authorizing a guardian to provide consent or make application); *id.* § 9.17 (providing informed consent requirements but not authorizing a guardian to provide proxy consent).

156. *See* 20 PA. CONS. STAT. § 5521(f) (2013) (setting out the “[p]owers and duties not granted to [a] guardian”). Section 5521(f) provides: “The court may not grant to a guardian powers controlled by other statute, including, but not limited to, the power: [] [t]o admit the incapacitated person to an inpatient psychiatric facility or State center for the mentally retarded.” *Id.* In addition, the Pennsylvania statutes governing voluntary hospitalization do not contain any language that can be construed to authorize guardian consent. *See* 50 PA. CONS. STAT. §§ 4402, 4403, 7201, 7203.

157. *See* TEX. ESTATES CODE ANN. § 1151.051(c)(4) (West 2014) (providing that guardians have “power to consent to medical, psychiatric, and surgical treatment other than the inpatient psychiatric commitment of the ward”). However, the statute qualifies this provision:

Notwithstanding Subsection (c)(4), a guardian of the person of a ward has the power to personally transport the ward or to direct the ward’s transport by emergency medical services or other means to an inpatient mental health facility for a preliminary examination in accordance with Subchapters A and C, Chapter 573, Health and Safety Code.

Id. § 1151.051(d).

Thus, under Texas law, a guardian can arrange for his or her ward to be transported to a psychiatric facility for evaluation, but is not empowered to consent to inpatient treatment. The voluntary admissions statutes are also consistent with the position that a guardian cannot provide the requisite consent. *See* TEX. HEALTH & SAFETY CODE ANN. § 572.001, 572.002 (West 2013).

158. *See* D.C. CODE § 21-2047(b)(4) (2012) (providing that, among other powers, guardians may “[c]onsent to medical examination and medical or other

In Washington state, guardians may not arrange inpatient psychiatric treatment for wards who are unwilling or unable to give informed consent, unless the procedures for involuntary commitment are followed.¹⁵⁹ This statute, in effect, codifies the holding of the Court of Appeals of Washington in *In re Guardianship of Anderson*.¹⁶⁰ In *Anderson*, the court construed an earlier guardian powers provision to require the consent of the ward for a voluntary admission, notwithstanding clear statutory language that “permit[ted] public or private health facilities to accept ‘any person . . . suitable . . . for care and treatment as mentally ill, or for observation as to the existence of mental illness, . . .’ who applies for admission individually or through their court-appointed guardian”¹⁶¹ The *Anderson* court explained that the hospitalization of an incapacitated individual under this section without his or her informed consent would constitute “involuntary incarceration,” which is only permissible under the state’s police powers through the involuntary civil commitment process.¹⁶² The guardian in *Anderson* had twice sought to have his ward committed under the involuntary civil commitment process, but he had failed because the lower court did not find that the ward was a danger “to self or others.”¹⁶³ The Court of Appeals made clear that it would permit inpatient treatment under these circumstances only if a factual basis were established supporting either a finding of dangerousness or that the non-consenting ward was “gravely disabled.”¹⁶⁴

While the guardians of incompetent adults in Massachusetts at one time did have the authority to consent to inpatient mental health care, they no longer are permitted to do so.¹⁶⁵ The evolution of Massachusetts

professional care, treatment, or advice for the ward”). *But see id.* § 21-2047.01 (limiting guardians’ power in the mental health treatment context). Section 21-2047.01 states that:

A guardian shall not have the power: . . . [t]o consent to the involuntary or voluntary civil commitment of an incapacitated individual who is alleged to be mentally ill and dangerous under any provision or proceeding occurring under Chapter 5 of Title 21, except that a guardian may function as a petitioner for the commitment consistent with the requirements of [the involuntary civil commitment statute]”

Id. § 21-2047.01(4) (emphasis added).

159. *See* WASH. REV. CODE § 11.92.043(5) (2014) (providing additional duties of guardian: “No guardian, limited guardian, or standby guardian may involuntarily commit for mental health treatment, observation, or evaluation an alleged incapacitated person who is unable or unwilling to give informed consent to such commitment unless the procedures for involuntary commitment set forth in chapter 71.05 or 72.23 RCW are followed.” (emphasis added)).

160. 564 P.2d 1190 (Wash. Ct. App. 1977).

161. *Id.* at 1192 (second, third, and fourth alterations in original) (quoting WASH. REV. CODE ANN. § 72.23.070 (repealed 1985)).

162. *See id.*

163. *Id.* at 1191.

164. *Id.* at 1192.

165. *See* MASS. GEN. LAWS ANN. ch. 190B, § 5-309(f) (West 2014) (“No guardian shall be given the authority under this chapter to admit or commit an incapacitated person to a mental health facility or a mental retardation facility”).

law on this question is instructive, in part because of the shadow cast by a changing understanding over the past forty-five years of the rights associated with involuntary commitment in the state.¹⁶⁶ Before 1977, the guardian of an adult ward could commit the ward to a mental health facility without prior court approval, and such a commitment was treated as a voluntary admission.¹⁶⁷ In 1977, the state legislature enacted a statute "regulating the powers of guardians to admit or commit wards to mental health or retardation facilities without the consent of the wards."¹⁶⁸ The new statute required judicial approval before an inpatient placement was permitted on the consent of the guardian and required the court to find that such a placement would be in the ward's "best interests."¹⁶⁹ The 1977 revisions also required that the ward be present at the hearing at which best interests were adjudicated and that counsel be provided if the ward was indigent.¹⁷⁰

In *Doe v. Doe*,¹⁷¹ the Supreme Judicial Court of Massachusetts took up the question of what was required under this "best interests" standard, particularly in instances in which the ward had not joined in the guardian's application for a voluntary admission.¹⁷² Under the circumstances of that case, the court held that a showing of a "likelihood of serious harm," which was also a required element for involuntary commitment in the state, would be necessary before judicial approval would be appropriate for a guardian seeking the voluntary admission of a ward.¹⁷³ The court arrived at this conclusion expressly because "commitment pursuant to [the guardian powers statute] produces the same loss of freedom and the same label of mental illness as commitment under [the involuntary commitment statute]."¹⁷⁴ Thus, in order to insure that a voluntary inpatient admission approved by a guardian without the ward's consent would not be permitted as an end-run around the state's involuntary commitment statute, the court concluded that essentially the same finding of dangerous-

166. In 1970, the state's involuntary commitment statute was completely revised. See generally MASS. GEN. LAWS ANN. ch. 123 (West 2014). A person is subject to commitment under the revised provision if he or she is found to be mentally ill and his or her discharge would create a "likelihood of serious harm." *Id.* ch. 123, § 12.

167. See *Doe v. Doe*, 385 N.E.2d 995, 998 (Mass. 1979) (discussing and citing *Russell v. Russell*, 147 N.E.2d 954 (Mass. 1958); *Denny v. Tyler*, 3 Allen 225, 227 (Mass. 1861); *Allis v. Morton*, 4 Gray 63 (Mass. 1855)); see also MASS. GEN. LAWS ANN. ch. 123, § 10(a).

168. 1977 Mass. Acts ch. 567.

169. See *id.*

170. See *id.*

171. 385 N.E.2d 995 (Mass. 1979).

172. See *id.* at 999.

173. See *id.* at 1000. In effect, the court held that the statutory requirement of "best interests" could only be established, in cases in which the ward had withheld consent, by a showing that his or her discharge from inpatient care would create a "likelihood of serious harm."

174. *Id.* at 1001.

ness to self or others required for involuntary commitment was impliedly required by the guardian powers statute's "best interest" standard.¹⁷⁵ Eventually, this skeptical intuition, reflected in the court's construction of the state's guardian powers statute, was enacted into the statute itself, which now flatly prohibits guardians from consenting to the voluntary hospitalization of their wards without regard to any assessment of "best interests" or dangerousness.¹⁷⁶

Significantly, while it appears that a guardian may not place an adult ward in a mental health inpatient facility on a voluntary basis in Massachusetts, the state's Supreme Judicial Court has indicated that an individual's health care proxy agent may accomplish precisely the same result, at least under certain identified circumstances.¹⁷⁷ In *Cohen v. Bolduc*,¹⁷⁸ the court construed Massachusetts's health care proxy statute to permit such a voluntary admission, so long as the principal does not object to the placement or revoke the proxy instrument.¹⁷⁹ The Massachusetts statute permitting individuals to give advance directives for health-care decisions permits a proxy decision maker to arrange treatment for both physical and mental disorders.¹⁸⁰ The *Cohen* court acknowledged that the statute is not explicit about whether "treatment" for mental disorders includes inpatient hospitalization, but it concluded that both the State's interest in promoting patient autonomy and self-determination and the broad statutory terms support the conclusion that a health-care proxy agent can consent to such a voluntary placement if the principal does not object.¹⁸¹ Thus, in

175. *See id.*

176. *See* MASS. GEN. LAWS ANN. ch. 190B, § 5-309(f) (West 2014). There remains some tension in the statutory provisions governing the voluntary hospitalization of adult wards in Massachusetts. The voluntary admissions statute contains language suggesting that guardians can apply for the voluntary commitment of their wards under certain circumstances. *See* MASS. GEN. LAWS ANN. ch. 123, § 10 (West 2014) ("The application may be made . . . by the guardian of a person on behalf of a person under his guardianship."); *see also id.* § 11 (suggesting that guardians have some authority to apply to have their wards voluntarily admitted).

177. *See* MASS. GEN. LAWS ANN. ch. 190B, § 5-309(e) (providing that guardians may not revoke the ward's health care proxy without court order and "[i]f a health care proxy is in effect, absent an order of the court to the contrary, a health-care decision of the agent takes precedence over that of a guardian").

178. 760 N.E.2d 714 (Mass. 2002).

179. *See id.* at 718–23.

180. *See* MASS. GEN. LAWS ANN. ch. 201D, §§ 1, 5 (West 2014).

181. *See Cohen*, 760 N.E.2d at 720. The court pointed out that, under the Massachusetts statute, the principal is permitted to revoke the proxy decision maker's authority even after a medical determination of incapacity has been made, and, in any event, the "principal's wishes will *always* prevail over those of her agent, unless a judicial determination of her incapacity is obtained." *Id.* at 722. In instances in which the principal does object to inpatient psychiatric treatment, the court was clear that the same interests in autonomy and self-determination exercised earlier in the proxy-granting document also operate in the withdrawal of the proxy decision maker's authority to consent to the voluntary placement. *See id.* at 723–24. The court, however, left open the question of whether, under the Massachusetts statute, a judicial determination that the principal "lacks capacity to make

Massachusetts, a health care proxy agent may be authorized to consent to voluntary psychiatric hospitalization if the patient is non-objecting, but if the patient objects, the agent would have to obtain a court order or resort to the involuntary commitment process.¹⁸²

This distinction between an objecting versus a non-objecting patient, which is key in Massachusetts for determining whether a health care proxy agent will be accorded the authority to consent to inpatient psychiatric treatment, is central as well to determining the authority of guardians of adult wards in a number of other states. In these states, the power of a guardian to authorize voluntary inpatient treatment turns on whether the ward has objected to the placement rather than on whether the ward has affirmatively provided informed consent. In Colorado, for example, a guardian who wishes to arrange for the voluntary admission of his or her ward must first demonstrate that the ward either agrees to or does not object to the placement. Even when the ward consents or fails to object, the guardian still must notify the court within ten days of placing the ward in an inpatient facility. If the ward does object, the guardian must utilize the state’s involuntary commitment process.¹⁸³ In Ohio, a guardian may consent to voluntary psychiatric hospitalization unless the ward or another

health care decisions” should permit the proxy to provide substitute consent. *Id.* at 723. The court did indicate that, in the ordinary case, the proxy decision maker’s exercise of judgment should, in the first instance, be “in accordance with an ‘assessment’ of her ‘wishes,’ or, if her wishes are unknown, an ‘assessment’ of her ‘best interests.’” *Id.* at 721 (quoting MASS. GEN. LAWS ANN. ch. 201D, § 5).

As part of its discussion of this issue, the court reported on the approaches taken in a number of other states with advance directive/health care proxy statutes. In ten states, the law permits advance directives for mental health treatment but prohibits both voluntary and involuntary commitments under these directives. *See id.* at 718. Three states allow such directives but prohibit only involuntary commitment, and “[e]ight states allow commitment only if expressly authorized by the principal” in the proxy-granting document. *See id.* at 718–19. Four other states require that a separate document be executed in order to permit the health care proxy agent to consent to commitment. *See id.* at 719; *see also* Winick, *supra* note 24, at 57; *cf.* Dresser, *supra* note 24, at 777.

182. *See Cohen*, 760 N.E.2d at 723–24.

183. *See* COLO. REV. STAT. ANN. § 15-14-315(1)(d) (West 2014) (providing that a guardian may “[c]onsent to medical or other care, treatment, or service for the ward”). *But see id.* § 15-14-316(4) (providing limitation that “[a] guardian may not initiate the commitment of a ward to a mental health care institution or facility except in accordance with the state’s procedure for involuntary civil commitment”). Furthermore, section 15-14-316 makes clear that “[n]o guardian shall have the authority to consent to any such care or treatment against the will of the ward.” *Id.* If the ward consents, however, then his or her guardian appears to have authority to voluntarily admit the ward. *See id.* § 27-65-103(1) (“[A] ward . . . may be admitted to hospital or institutional care and treatment for mental illness by consent of the guardian for so long as the ward agrees to such care and treatment. Within ten days of any such admission of the ward for such hospital or institutional care and treatment, the guardian shall notify in writing the court that appointed the guardian of the admission.”).

“interested party” objects or the court has specifically withdrawn this authority.¹⁸⁴

In a number of states, the statutes setting out the power of guardians to make decisions on behalf of their wards provide for the guardians’ authority to consent to health-care services, make housing and other residential decisions, and obtain other human services. Frequently, these statutes do not specifically address whether these general powers include the authority to consent to voluntary psychiatric hospitalization. States in this group include Alabama¹⁸⁵ and West Virginia.¹⁸⁶ Kentucky also falls within this general category, although guardians in Kentucky whose wards are developmentally disabled are expressly permitted to consent to voluntary hospitalization.¹⁸⁷ In New Mexico, a guardian is authorized to consent to

184. See OHIO REV. CODE ANN. § 5122.02(B) (LexisNexis 2013) (authorizing guardian to provide consent: “[T]he application also may be made . . . on behalf of an adult incompetent person by the guardian or the person with custody of the incompetent person.”); *id.* § 2111.13(C) (“A guardian of the person may authorize or approve the provision to the ward of medical, health, or other professional care, counsel, treatment, or services unless the ward or an interested party files objections with the probate court, or the court, by rule or order, provides otherwise.”).

185. See ALA. CODE § 26-2A-108 (2013) (conferring broad decision-making authority upon guardians: “[A] guardian of an incapacitated person is responsible for health, support, education, or maintenance of the ward . . .”). In addition, this statute makes clear that the powers permitted to a guardian of an adult ward are the same as those of a guardian of a minor, which include the ability to “[c]onsent to medical or other professional care, treatment, or advice for the ward” and to “establish the ward’s place of abode within or without this state” (if consistent with court order). *Id.* § 26-2A-78(c)(2), (4) (detailing powers held by minor’s guardian); see also *id.* § 22-52-51 (conferring upon guardians authority to make application to have wards admitted for psychiatric observation and diagnosis); *id.* § 22-52-53 (authorizing a guardian to request that his or her ward—who was voluntarily admitted at some earlier time—be discharged). Taken together, these statutes can reasonably be interpreted as conferring authority upon guardians to consent to the voluntary inpatient treatment of their wards.

186. See W. VA. CODE ANN. § 44A-3-1(a) (LexisNexis 2014) (providing that guardians are “responsible for obtaining provision for and making decisions with respect to the protected person’s support, care, health, habilitation, education, therapeutic treatment, social interactions with friends and family”). Section 44A-3-1 does not specifically address the placement of wards in inpatient care or the requirement of their consent for medical/mental-health decisions. The state’s voluntary commitment statute, however, does suggest that an individual patient’s consent may be required and that a guardian cannot provide it. See 2013 W. Va. Acts ch. 128 (codified at W. VA. CODE ANN. § 27-4-1); see also W. VA. CODE ANN. § 27-4-4.

187. See KY. REV. STAT. ANN. § 387.065(3)(b) (West 2014) (allowing guardian to “[c]onsent to medical or other professional care, treatment, or advice for the ward”); see also *id.* § 387.660(3) (granting guardians authority to “give any necessary consent or approval to enable the ward to receive medical or other professional care, counsel, treatment or service”). Particularly relevant in this statute is a provision directing that a guardian must notify the court within thirty days if the guardian “places a ward in a licensed residential facility for developmentally disabled persons . . .” *Id.* § 387.660(1). Another provision also provides that individuals with intellectual disabilities may be placed in an Intermediate Care Facility for Persons with Intellectual Disabilities by their guardians on a voluntary basis. See *id.* § 202B.021.

voluntary admission for purposes of evaluation only.¹⁸⁸ And in California, special statutory provisions governing wards with severe substance use disorders and others who are “gravely disabled” permit a conservator to provide consent for voluntary hospitalization,¹⁸⁹ but the guardians of persons with mental illness or other mental disabilities that are chronic but not persistent are not so authorized.¹⁹⁰

Guardians in several other states are permitted to consent to voluntary hospitalization if they obtain specific authorization from the probate court that approved their appointment in the first instance or another court of appropriate jurisdiction. States in this category include Kansas¹⁹¹

188. See N.M. STAT. ANN. § 45-5-312(B)(3) (LexisNexis 2014) (“[A] guardian may consent or withhold consent that may be necessary to enable the incapacitated person to receive or refuse medical or other professional care, counsel, treatment or service.”). However, a guardian may only present his or her ward for evaluation for inpatient mental health treatment. See *id.* § 43-1-14(B) (“A guardian appointed under the Uniform Probate Code, an agent or surrogate under the Uniform Health-Care Decisions Act or an agent under the Mental Health Care Treatment Decisions Act shall not consent to the admission of an individual to a mental health care facility. If a guardian has full power or limited power that includes medical or mental health treatment or, if the individual’s written advance health-care directive or advance directive for mental health treatment expressly permits treatment in a mental health care facility, the guardian, agent or surrogate may present the person to a facility only for evaluation for admission . . .”).

189. See CAL. WELF. & INST. CODE § 6000(a)(1) (West 2014) (authorizing conservators to make application for voluntary admission: “[T]he application shall be made voluntarily by the person . . . or, if he is a conservatee with a conservator . . . by his conservator.”). “Any such person received in a state hospital shall be deemed a voluntary patient.” *Id.*; see also *id.* § 5358(a) (“When ordered by the court after the hearing required by this section, a conservator appointed pursuant to this chapter shall place his . . . conservatee who is gravely disabled . . . in the least restrictive alternative placement, as designated by the court. . . . The placement may include a medical, psychiatric, nursing, or other state-licensed facility, or a state hospital, county hospital, hospital operated by the Regents of the University of California, a United States government hospital, or other nonmedical facility approved by the State Department of Health Care Services or an agency accredited by the State Department of Health Care Services, or in addition to any of the foregoing, in cases of chronic alcoholism, to a county alcoholic treatment center.”).

190. See CAL. PROB. CODE § 4652 (West 2014).

191. See KAN. STAT. ANN. § 59-3075 (2014) (conferring upon guardians general authority to consent to treatment when necessary). But, the statute makes clear that a guardian is not permitted “to place the ward in a treatment facility” unless the guardian obtains court authorization under the appropriate procedures. See *id.* § 59-3075(e)(9), see also *id.* § 59-3077 (outlining requisite procedures, referred to in section 59-3075(e)(9), for guardians to place wards in treatment facilities). One such procedural requirement is the provision of a lawyer for the incapacitated ward. See *id.* § 59-3077(c)(3). Kansas’s voluntary commitment statute confirms that a guardian must obtain court approval in order to consent to his or her ward’s placement in a mental health facility: “[I]f such person has a legal guardian, the legal guardian may make such application [for voluntary admission] provided that [] the legal guardian is [able] to obtain authority to do so pursuant to [Kan. Stat. Ann. §] 59-3077 . . . then only in accordance with the provisions thereof.” See *id.* § 59-29b49; see also *In re Guardianship & Conservatorship of Royston*, 276 P.3d 838 (Kan. Ct. App. 2012) (confirming need for court order).

and Tennessee.¹⁹² Relatedly, a guardian in Mississippi may provide consent to inpatient psychiatric care but must first obtain the approval of the court and the facility director.¹⁹³

The legal standard (and criteria) governing the decision of a court to authorize a guardian to give consent to inpatient treatment often is not specified by statute. In practice, the standard is likely to be somewhat different from the standard (and associated criteria) governing involuntary civil commitment decisions in the relevant jurisdiction.¹⁹⁴ In Arizona, however, the criteria for determining judicial approval of a guardian seeking inpatient mental health treatment for a ward are spelled out in some detail. Arizona Statute section 14-5312.01 elaborates the ability of a guardian to provide informed consent in the mental health context. It authorizes a guardian to consent to psychiatric treatment, provided it takes place outside a “level one” facility (i.e., a psychiatric hospital).¹⁹⁵ For placement in a level one facility, the guardian must obtain a court order and comply with other notice requirements and procedural provisions.¹⁹⁶ Before issuing such an order, the court must find on clear and convincing evidence that the ward is “incapacitated as a result of a mental disorder . . . and is likely to be in need of inpatient mental health care and treatment within the period of the authority granted”¹⁹⁷ Moreover, the court

192. See TENN. CODE ANN. § 33-6-201 (2014) (listing decision makers who are eligible to consent to voluntary inpatient hospitalization where individual lacks capacity). This includes a conservator, provided the “court has expressly granted authority to apply for the person’s admission to a hospital or treatment resource for mental illness or serious emotional disturbance” *Id.* § 33-6-201(a)(3).

193. See MISS. CODE ANN. § 41-21-103 (2013) (providing that guardians can make application for voluntary commitment of their wards, provided guardians obtain court authorization). In addition, to be admitted, the patient must meet the facility director’s requirements. See *id.* The relevant statutory language is as follows:

A person with an intellectual disability or with mental illness who is married or eighteen (18) years of age or older and who has a legal guardian or conservator may be admitted to a treatment facility upon application of his or her legal guardian or conservator if authorization to make the application has been received from the court having jurisdiction of the guardianship or conservatorship and the following has occurred:

- (a) An investigation by the director that carefully probes the person’s social, psychological and developmental background; and
- (b) A determination by the director that the person will benefit from care and treatment of his or her disorder at the facility and that services and facilities are available. The reasons for the determination shall be recorded in writing.

Id. § 41-21-103(3).

194. *But see Doe v. Doe*, 385 N.E.2d 996, 1001 (Mass. 1979). In *Doe*, the Supreme Judicial Court of Massachusetts held that the “best interests” standard, then applicable under the statute governing judicial authorization of a guardian to consent to inpatient treatment, required a showing of “likelihood of serious harm,” the same showing needed for involuntary civil commitment in the state. See *id.*

195. See ARIZ. REV. STAT. ANN. § 14-5312.01 (2012).

196. See *id.* § 14-5312.01(A).

197. *Id.* § 14-5312.01(B).

must consider “the cause of the ward’s disability and the ward’s foreseeable clinical needs” and must “limit the guardian’s authority to what is reasonably necessary to obtain the care required for the ward in the least restrictive treatment alternative.”¹⁹⁸ Finally, the court must find that the evidence is supported by the opinion of a licensed mental health expert and must “limit the duration of the guardian’s authority to consent to inpatient mental health care and treatment and include other orders the court determines necessary to protect the ward’s best interests.”¹⁹⁹

Once a guardian in Arizona has received judicial authorization to arrange inpatient treatment for the ward, a range of additional notice and procedural requirements comes into effect. Within forty-eight hours after placement, the guardian must give notice to the ward’s attorney.²⁰⁰ If requested by the attorney, the court must then hold a hearing within three days on the appropriateness of the placement.²⁰¹ In addition, the treatment facility is directed to “assess the appropriateness of the ward’s placement every thirty days and [to] provide a copy of the assessment report to the ward’s attorney.”²⁰² Within twenty-four hours after the treatment facility receives a written request from the ward seeking release, a change in placement, “or a change in the type or duration of treatment, the facility [must] forward this information to the ward’s attorney.”²⁰³ Finally:

The ward’s guardian shall place the ward in a least restrictive treatment alternative within five days after the guardian is notified by the medical director of the inpatient facility that the ward no longer needs inpatient care. The ward, a representative of the inpatient treatment facility, the ward’s attorney, the ward’s physician or any other interested person may petition the court to order the facility to discharge the ward to a least restrictive treatment alternative if the guardian does not act promptly to do so.²⁰⁴

This highly regulated system by which a guardian is permitted to obtain judicial approval for inpatient mental health treatment of a ward exists in Arizona alongside an equally restrictive judicial interpretation of the state’s guardian powers provisions as they relate to voluntary hospital admissions. In *Pima County Public Fiduciary v. Superior Court for Pima County*,²⁰⁵ the Court of Appeals of Arizona was faced with a statute then in place governing voluntary admissions that contained language that “[i]f

198. *Id.* § 14-5312.01(C).

199. *Id.* § 14-5312.01(B), (C).

200. *See id.* § 14-5312.01(D).

201. *See id.*; *see also id.* § 36-536 (entitling all persons facing court-ordered treatment to appointment of counsel).

202. *Id.* § 14-5312.01(E).

203. *Id.* § 14-5312.01(G).

204. *Id.* § 14-5312.01(I).

205. 546 P.2d 354 (Ariz. Ct. App. 1976).

the person making voluntary application is under guardianship, the application shall be signed by the guardian.”²⁰⁶ On the one hand, the court, relying on prior case law suggesting that an individual under guardianship should not be prevented from “performing the acts of which he is in fact capable,”²⁰⁷ indicated that if such a person “is capable of making a decision to be admitted to a mental health treatment agency,” he or she should be permitted to do so, provided his or her guardian also signs the appointment.²⁰⁸ This portion of the opinion is consistent with the statutory language expressly directing the guardian to sign the application for voluntary admission, although the court suggested that “voluntary” as used in the statute, “must refer to the voluntary act of the ward and not the voluntary act of the guardian.”²⁰⁹

On the other hand, in the same opinion, the court went on to explain that a ward under guardianship is an “incapacitated person,” as defined under Arizona law, and therefore by definition is “not competent to make an application for admission to the state hospital and could not make a voluntary application” under the relevant statute.²¹⁰ A contrary conclusion, explained the court, would not be consistent with the requirements of due process and thus would not “pass constitutional muster.”²¹¹ The court distinguished a California statute permitting a conservator to place his or her conservatee in a hospital, on the grounds that the California statute required prior judicial approval of the conservator’s authority and a determination that the conservatee was “gravely disabled.”²¹² Absent such a prior judicial finding, explained the Arizona court, the decision of a guardian to approve inpatient treatment would not constitute an appropriate voluntary admission.²¹³ Thus, although the *Pima County* court’s analysis is somewhat ambivalent, the best understanding of the court’s position—and the conclusion most consistent with current statutory requirements—is that a guardian seeking inpatient treatment for his or her ward must obtain judicial approval, provide notice to the ward’s attorney, and follow the other procedural requirements designed to insure that the ward will be treated in the least restrictive placement available to meet his or her needs.

A. *Legislative Balancing*

The Arizona approach, which permits the hospitalization of an adult ward on the initiative of a guardian so long as substantive statutory criteria

206. *See id.* at 356 (quoting ARIZ. REV. STAT. § 36-518).

207. *Id.* at 355 (quoting *In re Sherrill’s Estate*, 373 P.2d 353, 356 (Ariz. 1962) (in banc)).

208. *Id.*

209. *Id.*

210. *Id.* at 357.

211. *Id.* at 356.

212. *See id.* at 357.

213. *See id.*

are met and procedural requirements are satisfied, provides a sensible balance of the competing interests in this area. On the one hand, by requiring judicial approval of the placement based on clear criteria for decision, as well as notice to the ward’s counsel, the likelihood that a ward will be hospitalized unnecessarily over his or her objection is minimized. On the other hand, permitting incompetent adults to receive such care if the court finds that the statutory requirements have been met, even if they are unable to provide fully informed consent, insures that some individuals who may not meet the standard for involuntary commitment can still receive the benefits of inpatient treatment.

A similar balancing of interests is reflected in the approach adopted in New Hampshire. Section 464-A:25 of the state code sets out two alternative paths by which a guardian can arrange for inpatient care for a ward. Following the first path, a guardian “may admit a ward to a state institution with prior approval of the probate court if, following notice and hearing, the court finds beyond a reasonable doubt that the placement is in the ward’s best interest and is the least restrictive placement available.”²¹⁴ The second path permits the guardian to arrange an inpatient placement without prior court approval, but seeks to safeguard the ward’s autonomy, self-determination, and liberty interests by imposing a rigorous set of procedural protections to insure that the arrangement is monitored going forward. A guardian following the second path must obtain the written certification of a physician or psychiatrist and must submit written notice, with reasons for the placement, to the probate court within thirty-six hours of the inpatient admission.²¹⁵ The probate court is obligated under the statute to evaluate the sufficiency of the notice by determining whether the admission is in the ward’s best interest and is the least restrictive placement available. The court then must appoint counsel for the ward and must notify the ward of that appointment.²¹⁶ Counsel is given a limited period in which to file a report and request a hearing.²¹⁷ If a hearing is scheduled, it is the guardian’s burden to show beyond a reasonable doubt that the inpatient admission is in the ward’s best interest and is the least restrictive placement available.²¹⁸ Finally, the statute sets presumptive time limits on the inpatient hospitalization (no more than sixty days for any single admission and no more than ninety days in any twelve-month period), beyond which court approval is required, and authorizes the ward

214. N.H. REV. STAT. ANN. § 464-A:25(I)(a)(1) (LexisNexis 2014).

215. *See id.* § 464-A:25(I)(a)(2); *see also In re Guardianship of R.A.*, 920 A.2d 1213 (N.H. 2007) (providing example of guardian employing second path for voluntarily arranging inpatient placement for ward).

216. *See* N.H. REV. STAT. ANN. § 464-A:25(I)(a)(3).

217. *See id.* § 464-A:25(I)(a)(4) (giving counsel five days from date of appointment to file report and request hearing).

218. *See id.* § 464-A:25(I)(a)(5).

or the ward's counsel to request a hearing "at any time" during the placement.²¹⁹

In Oregon, guardians also are permitted to arrange inpatient mental health treatment without prior court approval, although they are required to provide notice to the court and to interested parties who may then request a court hearing. While Oregon's guardian powers statute generally authorizes a guardian to "consent, refuse consent or withhold or withdraw consent to health care . . . for the protected person," the statute makes clear that this power is subject to the State's Health Care Decisions Act governing other health care agents.²²⁰ In addition, the law sets out further limitations on a guardian's authority with respect to inpatient admissions. It provides that "[b]efore a guardian may place an adult protected person in a mental health treatment facility, a nursing home or other residential facility, the guardian must file a statement with the court informing the court that the guardian intends to make the placement."²²¹ The statute also imposes other procedural requirements, including the provision of notice to an enumerated list of interested persons with instructions on how they may object.²²² Once these notice requirements are met, "[t]he guardian may thereafter place the adult protected person in a

219. *See id.* § 464A:25(I)(a)(6), (7).

220. *See* OR. REV. STAT. § 125.315 (2013).

221. *Id.* § 125.320(3)(a).

222. *See id.* § 125.320(3). Section 125.320(3) provides:

Before a guardian may place an adult protected person in a mental health treatment facility, a nursing home or other residential facility, the guardian must file a statement with the court informing the court that the guardian intends to make the placement. . . .

(b) Notice of the statement of intent must be given in the manner provided by [OR. REV. STAT. §] 125.065 to the persons specified in [OR. REV. STAT. §] 125.060(3).

(c) In addition to the requirements of paragraph (b) of this subsection, notice of the statement of intent must be given in the manner provided by [OR. REV. STAT. §] 125.065 by the guardian to the following persons:

(A) Any attorney who represented the protected person at any time during the protective proceeding.

(B) If the protected person is a resident of a nursing home or residential facility, or if the notice states the intention to place the protected person in a nursing home or residential facility, the office of the Long Term Care Ombudsman.

(C) If the protected person is a resident of a mental health treatment facility or a residential facility for individuals with developmental disabilities, or if the notice states the intention to place the protected person in such a facility, the system described in [OR. REV. STAT. §] 192.517 (1).

(d) In addition to the requirements of [OR. REV. STAT. §] 125.070 (1), the notice given to the protected person must clearly indicate the manner in which the protected person may object to the proposed placement.

(e) The guardian may thereafter place the adult protected person in a mental health treatment facility, a nursing home or other residential facility without further court order. If an objection is made in the

mental health treatment facility, a nursing home or other residential facility without further court order.”²²³

In Minnesota, the Uniform Probate Code, as adopted, charges guardians with the duty to consent to “necessary medical or other professional care, counsel, treatment, or service . . . [other than] psychosurgery, electroshock, sterilization, or experimental treatment of any kind” that a ward may require.²²⁴ The statute further provides, however, that a ward “may not be admitted to a regional treatment center” (i.e., a state mental health treatment facility) by the guardian except following a hearing under the state’s involuntary civil commitment law or for outpatient services.²²⁵ In the mid-1990s, a Minnesota Supreme Court Task Force was charged with considering how to manage persons who, though incompetent to provide informed consent, were “not resisting the proposed [inpatient] treatment.”²²⁶ The Task Force recommended that “a new option, other than Civil Commitment, should be available for persons who are in need of mental health treatment, not resisting treatment, but [who] are incompetent to give informed consent to treatment or admission.”²²⁷ Specifically, the Task Force proposed, and the state legislature adopted, a system by which substitute consent can be provided, in the first instance by an individual designated as a health care power of attorney through an advance directive, or in the alternative by the local county mental health authority or its designee.²²⁸ By further statutory amendment in 2001, the state legislature authorized courts to appoint a different “substitute decision maker” if no health care power of attorney has been named and if the designated local agency is unable or unwilling to provide consent.²²⁹ Presumably, under this provision, a guardian may receive court appointment as a “sub-

manner provided by [OR. REV. STAT. §] 125.075, the court shall schedule a hearing on the objection as soon as practicable.

(f) The requirement that notice be served on an attorney for a protected person under paragraph (c)(A) of this subsection does not impose any responsibility on the attorney receiving the notice to represent the protected person in the protective proceeding.

Id.

223. *Id.* § 125.320(3)(e).

224. *See* MINN. STAT. ANN. § 524.5-313(c)(4)(i) (West 2014).

225. *See id.* § 524.5-313(c)(1).

226. *See* Halverson, *supra* note 4, at 177 (discussing and citing MINN. SUP. CT. RESEARCH & PLANNING OFFICE, STATE COURT ADMIN., ADVISORY TASK FORCE ON THE CIVIL COMMITMENT SYSTEM 35 (1996) [hereinafter MINN. CIVIL COMMITMENT TASK FORCE], available at [http://www.mncourts.gov/Documents/0/Public/administration/AdministrationFiles/Civil%20Commitment%20Task%20Force%20ADM10-8046%20\(formerly%20C4-94-1646\)/1996-01-17%20Civil%20Commitment%20Task%20Force%20Rpt.pdf](http://www.mncourts.gov/Documents/0/Public/administration/AdministrationFiles/Civil%20Commitment%20Task%20Force%20ADM10-8046%20(formerly%20C4-94-1646)/1996-01-17%20Civil%20Commitment%20Task%20Force%20Rpt.pdf)).

227. *Id.* (quoting MINN. CIVIL COMMITMENT TASK FORCE, *supra* note 226, at 35) (internal quotation marks omitted).

228. *See id.*; *see also* MINN. STAT. ANN. § 253B.04, subd. 1a.

229. *See* MINN. STAT. ANN. § 253B.04, subd. 1b.

stitute decision maker” and thereby obtain the authority to consent to inpatient treatment for his or her ward.²³⁰

Neither the voluntary admissions statute nor the special provision governing substitute decision making sets out the duties of the entity—county agency, family member, or guardian—designated as the substitute decision maker.²³¹ The statute does, however, provide criteria for determining whether such authority should be conferred by the court, as well as procedures for overseeing the ward’s inpatient admission. Thus, in cases where no health care power of attorney has been named in an advanced directive and in which the local mental health agency or its designee has not provided consent, “the person who is seeking treatment or admission, or an interested person acting on behalf of the person, may petition the court for appointment of a substitute decision maker who may give informed consent for voluntary treatment and services.”²³² In evaluating such a petition, the court is directed to consider two criteria: first, whether “the person demonstrates an awareness of the person’s illness, and the reasons for treatment, its risks, benefits and alternatives, and the possible consequences of refusing treatment;” and second, “whether the person communicates verbally or nonverbally a clear choice concerning treatment that is a reasoned one, not based on delusion, even though it may not be in the person’s best interests.”²³³ Once the authority of a substitute decision maker to approve an inpatient admission is granted, “the person [the ward in the case of a guardian] or any interested person acting on the person’s behalf may seek court review within five days for a determination of whether the person’s agreement to accept treatment or admission is voluntary.”²³⁴ Moreover, the statute requires that the patient be informed in writing that he or she may leave the facility within twelve hours of making such a request.²³⁵

230. The Minnesota Voluntary admissions statute clearly contemplates that a guardian may receive court authorization to provide substitute consent for voluntary admission. *See id.* § 253B.04, subd. 1(c)(2) (“Legally valid substitute consent may be provided by a . . . guardian or conservator with authority to consent to mental health treatment . . .”).

231. *See Halverson, supra* note 4, at 183–84.

232. MINN. STAT. ANN. § 253B.04, subd. 1b.

233. *Id.* § 253.04, subd. 1a(b)(1)–(2). These are the same criteria for decision that the statute sets out to guide the decision of the designated local mental health agency. *See id.*; *see also id.* § 253.04, subd. 1b (noting same criteria should be used to evaluate petition for a substitute decision maker as laid out for evaluating designated mental health agencies in subdivision 1a(b)).

234. *Id.* § 253B.04, subd. 1a(e). This statutory right to seek judicial review of the voluntariness of a patient’s agreement to an inpatient placement applies both to admissions approved by a substitute decision maker and to admissions in which the patient himself or herself provided consent. *See id.*

235. *See id.* § 253B.04, subd. 2. Under this same section, an individual receiving inpatient treatment for chemical dependency is entitled to release within seventy-two hours of making such a request. *See id.*

B. *Managing the Tension Between Incompetency and Partial Capacity*

The ambivalence exhibited by the Arizona appellate court in *Pima County*, with respect to whether an adult under guardianship might possess sufficient agency to make a voluntary decision to enter inpatient treatment, is instructive. If it were to turn out that some wards are capable of participating in this sort of decision making—either by providing actual consent or by communicating agreement with a guardian’s decision short of fully informed consent—then perhaps the reluctance of many jurisdictions to permit the voluntary hospitalization of adults under guardianship might be ameliorated. Some writers take the position that all wards admitted for inpatient treatment by a guardian should be regarded as entering involuntarily, presumably because the very fact of their being under guardianship requires a judicial finding that the ward is incompetent.²³⁶ Ultimately, the Arizona court in *Pima County* seemed to settle on this position when it concluded that the decision of the guardian to approve inpatient treatment could not constitutionally be permitted under the state’s voluntary admissions statute, because the ward’s prior adjudication as an “incapacitated person” necessarily constituted a judicial finding that he lacked “sufficient understanding or capacity to make or communicate responsible decisions concerning his person.”²³⁷ Earlier in the opinion, however, the *Pima County* court appeared to recognize that a finding of legal incompetence, even if based on expert evidence of the ward’s impaired decision-making ability, need not be treated the same as a determination that the individual entirely lacked “clinical (*de facto*) competence or decision-making ability.”²³⁸ According to this understanding, even a ward with a judicially appointed guardian should not be prevented from “performing the acts of which he is in fact capable.”²³⁹ Moreover, said the court, if such an individual were to agree to inpatient treatment, that agreement would be “the voluntary act of the ward and not the voluntary act of the guardian.”²⁴⁰

In order to make some sense of this tension between the categorical legal determination of incompetency often associated with the appointment of a general guardian and the partial functional understanding of capacity or incapacity more often employed by clinicians in practice, some

236. See BRAKEL ET AL., *supra* note 3, at 179. For purposes of this discussion, I am assuming a general guardianship. Many states have adopted statutory preferences for limited guardianships, when appropriate, but some observers have reported that this “least restrictive alternative” approach is underutilized even in those jurisdictions that formally appear to require it. See SLOBOGIN, RAI & REISNER, *supra* note 3, at 948.

237. See *Pima Cnty. Pub. Fiduciary v. Superior Court for Pima Cnty.*, 546 P.2d 354, 357 (Ariz. Ct. App. 1976) (quoting ARIZ. REV. STAT. ANN. § 14-5101(1)) (internal quotation marks omitted).

238. See WEINER & WETTSTEIN, *supra* note 96, at 116.

239. See *Pima Cnty.*, 546 P.2d at 355 (quoting *In re Sherrill’s Estate*, 373 P.2d 353, 356 (Ariz. 1962) (in banc)).

240. See *id.*

attention should be directed to the various legal tests that courts use in making guardianship determinations.²⁴¹ One long-standing approach focuses on whether the individual is capable of making decisions that produce reasonable outcomes. State statutes that reflect this approach typically require a showing that the person is not capable of caring for himself or herself, or providing for his or her family, in order for a guardian to be appointed.²⁴² A second approach, now followed in many states, was developed as part of the UPC. This approach shifts the court's focus from reasonable outcomes to the regularity of the individual's decision-making process itself.²⁴³ Under the UPC approach, a person with mental disabilities may be adjudged incompetent if shown to be impaired in the ability to engage in the cognitive process of rationally weighing the risks and benefits of competing choices.²⁴⁴ It was this standard, ultimately, that the *Pima County* court relied on in determining that an adult under guardianship in Arizona could not voluntarily elect inpatient treatment.²⁴⁵

The UPC process-based approach has been criticized for the subjective judgment it requires courts to make in determining whether an individual's thought processes are "rational" and for its consequent susceptibility to abuse.²⁴⁶ In response to this critique, in recent years, some states have developed yet a third approach, which shifts the focus away from process and back toward a consideration of outcomes. Unlike the reasonable outcomes approach, however, this new "functional approach" directs the court's analysis to specific decision-making tasks that an individual might be called upon to undertake with respect to housing, health care, and the like, and requires the individual's dysfunction to be demonstrated through specific evidence indicating imminent risk.²⁴⁷

Clearly, the decision of a court to find an individual legally incompetent and in need of a guardian can carry a range of different meanings, depending upon which of these measures of incompetency the court has employed. Thus, an adult adjudicated incompetent under the functional approach because he or she suffers from a delusion specific to one important choice—say the decision whether to undergo treatment with psychotropic medications—but whose mental processes are otherwise not globally impaired, stands in a very different position than does another individual found by a court to be incompetent under the UPC approach because he or she is broadly impaired in his or her capacity to engage in a practical reasoning process. More to the point, the assumption that an individual under guardianship is categorically incapable of usefully con-

241. See generally Phillip Tor, Note, *Finding Incompetency in Guardianship: Standardizing the Process*, 35 ARIZ. L. REV. 739 (1993).

242. See *id.* at 743; see also BRAKEL ET AL., *supra* note 3, at 371.

243. See UNIF. PROBATE CODE art. 5 (2010).

244. See SLOBOGIN, RAI & REISNER, *supra* note 3, at 946.

245. See *Pima Cnty.*, 546 P.2d at 357.

246. See SLOBOGIN, RAI & REISNER, *supra* note 3, at 946–47.

247. See *id.* at 946 (discussing N.H. REV. STAT. ANN. § 464-A:2).

tributing to his or her guardian’s decision making with respect to inpatient treatment fails to take seriously the various distinct competencies that may (or may not) be impacted by even severe mental illness or other significant mental disabilities, as well as the different degrees of relevance that each of these competencies holds to such a decision.²⁴⁸

The substantive standards adopted in Arizona, New Hampshire, and Minnesota for judicial authorization or review of a guardian’s decision to arrange inpatient treatment, together with the notice and other procedural requirements reflected in these states’ laws, provide useful tools for evaluating and supervising this work.²⁴⁹ In reviewing these statutes, certain basic policy choices stand out. First, should judicial authorization be required in advance of any decision to place an adult under guardianship in an inpatient mental health setting, or is some combination of the patient himself or herself, the guardian, and involved mental health professionals a sufficient team for making the initial determination? Second, regardless of whether the determination is made by clinicians or by judicial actors, what level (or kind) of functional competency should be required of a patient who either seeks to provide consent or at least to assent to a guardian’s decision to elect inpatient treatment?²⁵⁰ And third, how should the law deal with adults under guardianship who withhold consent or perhaps even communicate a desire not to be admitted to an inpatient setting?

With respect to the first question, many of the same concerns identified by those who challenge the general preference for voluntary inpatient admission over involuntary commitment are relevant to an approach that permits guardians to elect inpatient treatment for their wards without a prior judicial hearing. Thus, worries over the potential for abuse, coercion, and the lack of an adversary process are all present in a system that permits guardians to provide consent without first being required to demonstrate through a judicial proceeding that such a placement is in the ward’s interest and is necessary for his or her well-being.²⁵¹ On the other side, some argue that a requirement that the guardian obtain formal judicial approval in advance would be costly and unnecessary, particularly in jurisdictions in which the guardian’s judgment as to the necessity and utility of inpatient treatment must be supported by one or more mental health professionals, often through the submission of a written assessment to that effect.²⁵² In addition, it is argued, a guardian has “already been

248. See Roca, *supra* note 2, at 1191.

249. See *supra* notes 195–219, 224–35 and accompanying text.

250. On the distinction between “assent” and “consent” to admission or treatment, see Stone, *supra* note 4, at 32 (explaining that assent “requires acquiescence, a tacit acceptance, or non-response such as silence,” while consent “requires a competent patient’s active and voluntary acceptance of a prescribed course of treatment”).

251. See Halverson, *supra* note 4, at 166; Stone, *supra* note 4, at 33.

252. See, e.g., N.H. REV. STAT. ANN. § 464-A:25(I)(a)(2) (LexisNexis 2014).

appointed by a court [as] an appropriate person to provide informed consent,” and thus should not be obliged to obtain “additional judicial review” for the hospitalization decision.²⁵³ Finally, advocates for this position point out that the costs associated with delaying the provision of treatment are likely to outweigh the benefits of preventing what is likely to be a low potential for abuse.²⁵⁴

In light of these competing considerations, Donald Stone has concluded that a “middle ground” may well suffice to guard against the dangers of coercion or abuse he perceives as “common in psychiatric hospitals[’]” inpatient admissions practices.²⁵⁵ This middle ground does not mandate a prior judicial hearing, but it does require that the individual be provided counsel as a condition for being voluntarily admitted. Under Stone’s proposal, which would apply to all voluntary admissions and not just those approved by a guardian, the attorney would have an obligation to interview the individual and to conduct a thorough investigation. If, after this interview and investigation, the attorney were to conclude that his or her client “is capable of knowingly and voluntarily admitting himself [or herself] into the hospital, the patient should be permitted to exercise this option without judicial review.”²⁵⁶

Critics of Stone’s middle ground approach point out that attorneys “typically lack prior knowledge of the patient or the patient’s social or medical history,” and moreover that “a competency determination is hardly something that is within an attorney’s professional knowledge.”²⁵⁷ These concerns may or may not be accurate, depending in part on whether the jurisdiction maintains a cadre of specialized attorneys with subject matter expertise and, at least for chronic patients, some prior relationship with their clients. In any event, the essential advantages of Stone’s proposal might be realized through a state law process something like that in place in New Hampshire and Oregon. Recall that in New Hampshire, a guardian is permitted to arrange an inpatient placement without prior court approval, but the guardian must obtain the written certification of a physician or psychiatrist and must submit written notice, with reasons for the placement, to the probate court within thirty-six hours of the inpatient admission.²⁵⁸ This permits a guardian to arrange inpatient care without delay, but sets into motion a legal process that reduces the potential for abuse. The New Hampshire approach imposes some supervisory duties on the probate court, which must review the guardian’s filing in order to determine whether the admission is in the ward’s best interest and is the least restrictive placement available. As with Stone’s

253. Halverson, *supra* note 4, at 167.

254. *See id.*

255. Stone, *supra* note 4, at 34.

256. *Id.* at 34–35.

257. Halverson, *supra* note 4, at 167.

258. *See* N.H. REV. STAT. ANN. § 464-A:25(I)(a)(2) (LexisNexis 2014); *see also In re Guardianship of R.A.*, 920 A.2d 1213 (N.H. 2007).

approach, counsel must be appointed for the ward.²⁵⁹ Within a relatively short window of time, the lawyer must then interview the client and conduct an investigation, leading to the filing of a report and a possible hearing. If such a hearing is scheduled, the court must find beyond a reasonable doubt that the inpatient admission is in the ward's best interest and is the least restrictive available.²⁶⁰

On balance, this sort of hybrid approach, which permits the guardian to approve inpatient hospitalization but also triggers a judicial review process along with attorney consultation and investigation, appears to strike a sensible balance between the concerns present in this area. Even if such a system were put in place, however, a further question arises as to the kind of functional competency that should be required of a patient whose guardian has arranged inpatient treatment. Some jurisdictions, of course, require informed consent before a voluntary placement is permitted, even for individuals under guardianship.²⁶¹ Stone defines such consent as requiring “a competent patient's active and voluntary acceptance of a prescribed course of treatment following . . . full disclosure of associated risks and benefits”²⁶² At the other extreme, some argue that mere “*assent* to retention by the facility” should suffice, in which case “acquiescence, a tacit acceptance, or non-response such as silence” could be a sufficient basis for permitting the inpatient admission.²⁶³ The best approach is one in which some reasonable assessment of the functional capacity of the ward to contribute to the decision-making process is used to determine the level of involvement required to permit the guardian to arrange an inpatient admission. Such a sliding scale of competency could be implemented as a way of operationalizing a best interests standard for approval of the guardian's decision.²⁶⁴

As noted above, in Arizona, the substantive criteria governing the decision of a court to authorize a guardian to approve inpatient treatment include whether the ward is “incapacitated as a result of a mental disorder . . . and is likely to be in need of inpatient mental health care and treatment within the period of the authority granted,” as well as “the cause

259. See N.H. REV. STAT. ANN. § 464-A:25(I)(a)(3).

260. See *id.* § 464-A:25(I)(a)(4), (5).

261. See, e.g., 405 ILL. COMP. STAT. ANN. 5/3-400 (West 2014) (setting out consent requirement for voluntary admission in Illinois Mental Health and Developmental Disabilities Code); N.Y. MENTAL HYG. LAW § 9.17 (McKinney 2014) (governing requirement of informed consent); see also *In re Gardner*, 459 N.E.2d 17, 20 (Ill. App. Ct. 1984) (holding that individuals who lack capacity to provide informed consent for inpatient treatment cannot be admitted by their guardians).

262. Stone, *supra* note 4, at 32.

263. See *id.*

264. See Lawrence A. Frolik & Linda S. Whitton, *The UPC Substituted Judgment/Best Interest Standard for Guardian Decisions: A Proposal for Reform*, 45 U. MICH. J.L. REFORM 739, 750–51 (2012) (setting out “Substituted Judgment-Best Interest Continuum Model” for guardian decision making).

of the ward's disability and the ward's foreseeable clinical needs."²⁶⁵ While these criteria are appropriate considerations for purposes of monitoring the decision of the guardian to elect inpatient hospitalization, they do not provide a basis for assessing whether the ward has contributed sufficiently to this decision in light of his or her actual ability to do so. Importantly, however, the Arizona statute also requires the court to "limit the duration of the guardian's authority to consent to inpatient mental health care and treatment and include other orders the court determines necessary to protect the ward's best interests."²⁶⁶ This additional provision, centered on a best interests analysis, does begin to offer some basis for evaluating the capacity of the adult under guardianship to play a role in the decision-making process. Similarly, in New Hampshire, if a judicial hearing is held, it is the guardian's burden to show beyond a reasonable doubt that the inpatient admission is in the ward's best interest and is the least restrictive available.²⁶⁷

A best interests requirement can be understood as: (1) an injunction to the decision maker to select a course of action based upon his or her own judgment of the best outcome for the subject, all things considered; (2) a requirement that the decision maker base the choice on an assessment of what the subject would want if he or she were able to make a competent decision; or (3) a requirement that the decision maker develop a choice that is consistent with the long-term values and commitments of the subject as revealed or expressed through conduct or prior statements.²⁶⁸ In the *Doe* case, the Massachusetts Supreme Judicial Court construed the state's then-existing statutory best interests requirement to contain an additional related feature, which is of particular assistance in thinking about the question of the ward's capacity to participate in the decision-making process itself. The court explained that, in cases in which the ward is capable of formulating or expressing a preference, the ward's "stated preference" with respect to the proposed inpatient admission "must be treated as a critical factor in the determination of his 'best interests.'"²⁶⁹ Moreover, explained the court, this reading of the role that the ward's expressed preferences should play in evaluating his best interests should apply notwithstanding the fact that the ward "failed to understand his mental condition and his need for treatment . . ."²⁷⁰

Returning to the four domains of competency identified by Appelbaum and Roth,²⁷¹ we can now begin to construct a matrix for guiding the

265. See ARIZ. REV. STAT. ANN. § 14-5312.01(B), (C) (2012).

266. See *id.* § 14-5312.01(C).

267. See N.H. REV. STAT. ANN. § 464-A:25(I)(a)(4)–(5) (LexisNexis 2014).

268. See GUTHEIL & APPELBAUM, *supra* note 1, at 226; see also Frolik & Whitton, *supra* note 264, at 751–52.

269. See *Doe v. Doe*, 385 N.E.2d 995, 1000 (Mass. 1979).

270. See *id.*

271. For a discussion of the Appelbaum and Roth criteria, see *supra* notes 114–39 and accompanying text.

evaluation of the best interests of an adult under guardianship in light of his or her functional capacity to contribute to a decision to seek inpatient treatment. The first, most basic competency is the capacity to evidence a choice. While the number of adults under guardianship who are entirely unable to communicate their agreement or disagreement is likely to be small, such individuals do present from time to time.²⁷² Clearly, these wards are not capable of contributing in any fashion to the decision to seek inpatient treatment. For those who do not meet the statutory standard for involuntary commitment because there is insufficient evidence of danger to others or to themselves, these individuals will be foreclosed from obtaining the advantages of inpatient care if their guardians are not permitted to provide consent on their behalf.²⁷³ While some argue that these individuals should receive care in the community as outpatients if they are not civilly committable, the reality in most localities is that adequate outpatient services often are unavailable or nonexistent.²⁷⁴ The position of the Massachusetts court in *Doe* with respect to such individuals is that a doctrine of substituted judgment may be appropriate.²⁷⁵ Of course, the basis for a substituted judgment can be relatively “objective” and based on the guardian’s own views about the costs and benefits of inpatient admission, or more closely tailored to the choice that the ward would have made were he or she able to do so.²⁷⁶ A properly devised statutory scheme in which the guardian’s judgment is subject to subsequent judicial scrutiny according to sensible substantive criteria—like those articulated in the Arizona statute—together with a rigorous requirement that the ward be placed in the least restrictive setting appropriate to his or her needs,²⁷⁷ is likely to be the most effective system for insuring that a process of substitute judgment is implemented appropriately.²⁷⁸

A far greater number of adults under guardianship are likely to have the ability to evidence a choice and some further functional capacity within the second category of competency described by Appelbaum and Roth.²⁷⁹ These individuals may possess the cognitive capacity to understand the basic facts of their condition and of the proposed institutional placement, but may not be able entirely to comprehend the full import of those facts or the consequences of the choice that is being made by the guardian on their behalf to approve inpatient treatment. Whether these

272. See Appelbaum & Roth, *supra* note 114, at 952–56.

273. See Stone, *supra* note 4, at 37.

274. See SLOBOGIN, RAI & REISNER, *supra* note 3, at 706–07.

275. See *Doe*, 385 N.E.2d at 1000.

276. See GUTHEIL & APPELBAUM, *supra* note 1, at 226.

277. See, e.g., ARIZ. REV. STAT. ANN. § 14-5312.01(B), (C) (2012).

278. As noted in the text, some writers take the not unreasonable position that patients who are incompetent in this sense should be admitted only as involuntary patients. Given the competing interests at stake, however, I have concluded that a system of judicially supervised voluntary admissions is the preferable approach.

279. See Appelbaum & Roth, *supra* note 114, at 952–56.

individuals' cognitive capabilities are limited to a basic understanding of essential information or extend to an "actual understanding" of those facts and their likely consequences,²⁸⁰ their expressed preferences should be accorded some weight in the evaluation of their best interests. The more cognitive facility they demonstrate, the greater deference a reviewing court should accord their views. Thus, a guardian who is acting consistent with the articulated preferences of a ward with *some* cognitive purchase on the circumstances of the decision should be more likely to receive court approval than a guardian whose ward has been unable to engage even in that minimal level of participation in the decision-making process. This should be the case even in many instances in which the ward's thinking includes some distorted or false beliefs, although the more centrally those false ideas implicate the very decision to be made, the more problematic they will be as counting in favor of the decision being approved by the court.

The next category of functional capacities identified by Appelbaum and Roth relates closely to the UPC's approach to defining the line between competency and incompetency.²⁸¹ This third category goes to the individual's ability to undertake a "rational" process of deliberation. In the context of a decision to approve inpatient treatment, this sort of rational deliberation would include consideration of the relative advantages and disadvantages of inpatient care and of reasonably available alternatives.²⁸² As noted earlier, an assessment of rationality may be difficult if the ward assigns values to the competing costs and benefits that are wildly divergent from those identified by others evaluating his or her competency.²⁸³ Here again, if the ward holds false beliefs that are directly relevant to his or her calculation of the competing options, the weight a reviewing court should accord his or her conclusions ought to be reduced accordingly. Nevertheless, an individual who demonstrates a basic ability to assess relevant information in order to generate a preference that reflects his or her essential values ought to be treated as a significant partner in the decision-making process, and, if that preference is consistent with the judgment of the guardian, it ought to shore up considerably the claim of the guardian to be acting in the ward's best interests.

The final area of competency identified by Appelbaum and Roth is the ability to "appreciate[e] the nature of the situation."²⁸⁴ This capacity—to apply information to new circumstances in order to formulate a plan of action or a solution to a problem and to engage that process of application in both the affective and cognitive domains—is the most de-

280. *See id.*

281. *See* UNIF. PROBATE CODE art. 5 (2010).

282. *See* Appelbaum & Roth, *supra* note 114, at 954.

283. For a discussion of the differences between the process-based and outcomes-centered approaches to competency, see *supra* note 139 and accompanying text.

284. *See* Appelbaum & Roth, *supra* note 114, at 954–56.

manding of the measures of competency in Appelbaum and Roth's typography of functional abilities. It is not inconceivable that an individual with mental illness or other mental disability may have this capacity, even though he or she may also harbor distorted or false beliefs. While the presence of false beliefs may diminish somewhat the weight given to his or her judgment, the fact that an individual is able to appreciate in this rich sense the circumstances surrounding his or her hospitalization should count heavily in the court's assessment. If an adult under guardianship possessed of this sort of appreciation of his or her situation expresses a preference that is in accord with the judgment of the guardian, the claim that the consent is voluntary is substantially strengthened.

Of course, a ward may also express either clear or implied opposition to a guardian's plan to arrange inpatient care. In such cases, the tension between the judgment of the guardian and the wishes of the ward creates real problems in terms of the coherence of treating such an admission as voluntary. One could take the position that anything short of affirmative consent, or at least passive assent, renders the guardian's choice in favor of inpatient treatment involuntary and therefore necessarily implicates the civil commitment standards and procedures that govern all involuntary inpatient commitments.²⁸⁵ The problem with this move, as noted earlier, is that it may make it impossible to provide inpatient treatment to a non-cooperating ward whose mental illness or other disability does not create a sufficient danger to self or others to satisfy the involuntary commitment standard.²⁸⁶ In the best of all worlds, this gap would be closed through the provision of clinically appropriate outpatient services. In most jurisdictions, however, the network of community-based mental health resources is less than fully adequate to meet this need. Arguably, a jurisdiction's failure to provide a complete continuum of outpatient care should not drive the development of a distorted doctrinal approach to voluntary admissions. At least for adults under guardianship who are capable of expressing a preference and who indicate that they oppose an inpatient placement, therefore, important interests in patient autonomy and self-determination ought to counsel in favor of defaulting to the rigorous requirements of the involuntary civil commitment regime.

V. CONCLUSION

The conventional view is that there are two methods by which a guardian, family member, or other proxy decision maker might make a judgment on behalf of an impaired individual.²⁸⁷ First, the proxy decision maker could reach a decision based on the best interests of the ward. Ordinarily, this approach is characterized as "neutral or objective" because it is not based on the ward's particular viewpoint regarding the matter for

285. See, e.g., *In re Gardner*, 459 N.E.2d 17 (Ill. App. Ct. 1984).

286. See Stone, *supra* note 4, at 37.

287. See GUTHEIL & APPELBAUM, *supra* note 1, at 226–27.

decision.²⁸⁸ In truth, however, a best interests assessment is still a judgment resting on a particular perspective, precisely because it involves the proxy decision maker acting on the basis of his or her own best judgment as to the ward's well-being.²⁸⁹ The alternative approach is more frankly subjective, in that it requires the proxy decision maker to determine what the ward would have wanted in the situation had he or she been able to decide for himself or herself.²⁹⁰

For adults under guardianship facing the prospect of an inpatient admission, a better approach than either of these conventional alternatives standing alone is to integrate these formally distinct ways of thinking about proxy decision making, so that the best interests of the ward are construed to include a consideration of the ward's likely preferences as well as a more objective determination of the advantages and disadvantages of the proposed inpatient placement. Taken in this fashion, a best interests determination would subsume an assessment of clinical factors with respect to the ward's amenability to treatment, suitability for alternative outpatient care, and the like, as well as a consideration of the ward's preferences expressed at the moment or in the past.

Statutes governing the "voluntary" admission of adults under guardianship should be revised to require that proxy decision makers and reviewing courts employ this modified conception of best interests. They should also contain procedural requirements that, while acknowledging the guardian's authority to make an initial determination, insure effective subsequent judicial supervision of the inpatient placement, in order to guarantee that the ward's needs are met in the least restrictive setting appropriate and in a fashion that is most consistent with the ward's capacity for self-determination.

288. See WEINER & WETTSTEIN, *supra* note 96, at 290.

289. Cf. Kennedy, *supra* note 129, at 563.

290. See WEINER & WETTSTEIN, *supra* note 96, at 291.