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American Psychiatric Association

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Mental Competency and Mental Hospitals

Ewing H. Crawfis, M. D., LL.B.*

PSYCHIATRISTS GENERALLY ARE AWARE that there is not necessarily any relation between competency and hospitalization for mental illness. The consensus seems to be that these two things should be considered entirely separately. Many patients may need mental hospital care, without having suffered any impairment of their competency. My personal estimate is that 75% of all patients admitted to the average mental hospital could be considered to be competent. Also, it is well to keep in mind that an individual may require a guardian because of incompetency due to a mental disorder, but not require hospitalization in a mental hospital.

Unfortunately, this distinction is not readily recognized by many attorneys and courts. It is also sometimes forgotten by psychiatrists. There are many factors which tend to foster the impression that hospitalization in a mental hospital is equivalent to loss of competency. This paper is being written to bring attention to the problem and to plead for corrective action.

In a number of states, the process of commitment, or the language of either the particular statute court order, makes commitment of a mental patient to a mental hospital an automatic adjudication of incompetency. This is true even though guardianship is not provided for at the same time. The specific effect of commitment upon an individual's competency will vary from state to state. I have made no effort to determine statistics on this for various states, for this particular paper, but I would point out that such information as to his own state's practice in this regard should be worthwhile knowledge for any attorney. It is, of course, imperative that the physician on the staff of a mental hospital have such knowledge at his disposal.

In Ohio, the competency of a patient in a state mental hospital is specifically covered by Revised Code, Section 5123.57.¹ All patients who are hospitalized by commitment are considered

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¹ O. G. C., Sec. 1890-68 (Competency of patient).

to be incompetent. Voluntary admissions, and sane epileptics (presumably by medical certification), are excepted. It should be pointed out that the statute provides that a contract, deed, or other instrument can be executed by a patient if it has been approved and allowed by the court committing him, and is substantiated by an order entered on the journal of said court. To my knowledge, this provision is little known, and seldom, if ever, used. Since it also provides that a certified copy of such order shall be attached to such contract, deed, or instrument, it is quite cumbersome and apparently is generally ignored. The statute also provides that it applies to patients who have been placed on trial visit from the State Hospital. In actual practice, it is ignored except in real property transactions. Here, the usual procedure is to discharge the patient from the rolls of the hospital before the expiration of the normal trial visit period, or to advise delay of the transaction until the trial visit has been completed and the patient has been discharged.

The status of the patient's competency while in the hospital is of importance. But of much greater interest to the patient is the effect of his release from the hospital. If the physician is to be of help in advising and counseling patients who are ready to be released from the hospital, he must have specific information on the subject, particularly as to the practice and procedure in his own state. Obviously, attorneys who are retained in such cases should be informed as to such matters.

The statutes relating to discharge may alter, by the procedure prescribed, the intent or effect of other provisions of law relating to the hospitalized mentally ill patient. The situation in California provides a good example of this situation. The language of the statutes² indicates that the commitment procedure is entirely separated from the determination of competency, and that commitment means only that the patient is in need of hospitalization and treatment. The Supreme Court of California has ruled that the patient's competency is not affected, unless guardianship action has occurred.³

This approach is, of course, consistent with the enlightened psychiatric viewpoint. However, the sections of the statutes relating to discharge set up a procedure for the restoration of competency. They provide for the issuance of a discharge certificate

² California W. & I. Code, Sections 5040 and 5100.

³ Application of Jackson *ex parte* Zanetti, 34 Calif. 2d 136, 208 P. 2d 657 (1949).

by the Department of Mental Hygiene.⁴ A copy of the discharge certificate may be filed with the clerk of the court of the county from which the patient was committed. If the certificate of discharge indicates recovery, the filing has the same legal force and effect as a judgment of restoration to capacity. If the certificate does not indicate recovery, it does not have this effect.

I shall discuss below the legal versus the medical implications of the terms "improved" and "recovered." The point to be made here is that these California sections clearly imply that commitment is equivalent to an adjudication of incompetency, notwithstanding the previous sections and the court decision. In the procedures and practices relating to discharged patients, the implication destroys the effect of the statute separating commitment and competency. In actual practice, this situation most commonly becomes important in those instances when discharged patients are involved in transactions concerning real property. If a certificate of recovery has not been filed, then the formal court action of judgment in restoration to capacity is insisted upon before the discharged mental patient can convey title to real property. It is my impression that a similar situation exists in other states, in regard to certification of recovery upon discharge acting as the equivalent to restoration to capacity.

The Ohio section (Section 5123.50)⁵ specifically states that a discharge, as "recovered," shall operate as a restoration to competency; a discharge, as "improved," shall not operate as a restoration. There is also a section (Section 5123.51)⁶ which provides that a person previously adjudicated to be mentally ill, feeble-minded, or epileptic, may file an application in the probate court to determine whether such person is then competent. However, if the person has been committed to a state institution, he shall not be permitted to file such application until he has been discharged from the institution. Therefore, this section seems to provide only an opportunity for the patient to raise the issue of competency in case he is discharged as improved. But there is still another sentence in Section 5123.50 which is important. It states that such discharge, as recovered or improved, shall not operate as a termination of an existing legal guardianship, but may be received in evidence in a proceeding to terminate such guardianship. I would emphasize here, that while our patients

⁴ Calif. W. & I. Code, Secs. 6728-29-30.

⁵ O. G. C., Sec. 1890-63 (Discharge of patient).

⁶ O. G. C., Sec. 1890-63a (Procedure to procure adjudication of competency).

ordinarily assume that discharge from the hospital restores all of their rights, from the above it can be seen that this is not true and that further action on their part may be necessary.

As in Ohio, in other states there is a legal distinction as to the terms "recovered" and "improved." The term "recovered" is regarded as being the legal equivalent to "sane," or competent, or "restored to capacity." The term "improved" is any condition short of this, and carries the implication of lack of capacity.⁷

However, in determining the condition at time of discharge, the evaluation of the patient is a medical and psychiatric one, rather than on the basis of the patient's legal status or competency. The statistical manual of the American Psychiatric Association is ordinarily referred to in such situations, in order that statistics of one state can be compared with others on a common nationwide basis. The manual has two pertinent statements on this subject.

1) "The individual's pre-illness capacity, in terms of occupational and social adjustment, will be used as a base line for estimating the degree of impairment." Note that the term "capacity" here is not the capacity nor competency commonly used in legal terminology.

2) The term "no impairment" or "recovered" as described in the manual is as follows: "This term will be used whenever there are no *medical* reasons for changing employment or life situation." Another favored psychiatric term—"remission"—meaning abatement of the symptoms of disease, but implying that the basic disease process is still present—is not used in the manual in this particular section. There is no term in legal terminology which has any equivalent status to remission. Yet patients are frequently discharged from mental hospitals with a notation of being in remission.

It is my impression that state hospital psychiatrists are rather conservative in discharge evaluation, and that the term "improved" is favored over "recovered," even though the patient may have returned to his former social situation and employment. Also, for purposes of statistical evaluation, remission is commonly interpreted as "improved" rather than "recovered." This has been particularly noticeable since the adoption of the present revision of the nomenclature and the issuance of the manual in 1952. I presume that the revision was based upon the

⁷ See, Black's Law Dict., 1440 (4th ed., 1951)—"recover"; Webster's New Collegiate Dict., 419 (2d ed., 1949)—"improve."

belief that hospitalization and competency would be clearly and separately considered. Unfortunately, the changes in the statutes of the states have not kept pace.

Under this system (APA Statistical Manual) the diagnosis of mental illness includes the complementary evaluation elements of—

- (a) external precipitating stress
- (b) pre-morbid personality and disposition
- (c) degree of psychiatric impairment.

There is a tendency to include the pre-morbid personality and disposition in the consideration of discharge condition on the basis of a permanent defect caused by the psychiatric disorder, rather than to use it as part of the base line for estimating whether or not the patient has returned to his pre-illness status and condition.

The essential point that I would like to emphasize is that the evaluation of the hospitalized mental patient at the time of discharge is a medical and psychiatric one, with little or no consideration as to his legal status in regard to competency. Unfortunately, however, in many instances his legal rights are involved in this procedure, with injustices and inconvenience to the patient.

For the ordinary adult, there is a presumption in law that he is competent. Once he has been determined to be incompetent, this condition is presumed to exist until there has been a judicial determination to the contrary, or until it has been affirmatively demonstrated that such is no longer the case. The absence of such a positive judicial finding puts the patient at a disadvantage. In the case of the patient who is discharged as "recovered" with notification to the court, and a change in the official record, competency is restored. However, in the case of the patient who is discharged as "improved," or in which the hospital does not notify the court, the presumption continues, even though the patient may return home, resume his business, and conduct himself just as he did before hospitalization. He may even obtain a driver's license and drive his car, or register and vote, without being challenged. Should a contract that he subsequently makes be attacked, or the question of his competency be raised in some way, the burden of proof has now shifted to him to demonstrate his competency.

As previously referred to, many discharged patients become aware of this situation only when they attempt to convey title

to real property. It should also be re-emphasized that this situation does not apply in those cases in which the patient is admitted on a voluntary basis, or on medical certification in which no judicial procedure has occurred. Unfortunately only a small percentage of mental patients are admitted on such basis—the majority still being committed by the courts.

I have made two recommendations to psychiatrists on the staffs of state hospitals, who are considering patients for discharge.

(1) I believe that a more liberal attitude in relation to the use of the term "recovered" is justified. One of the devices recommended is an effort on the part of the psychiatrist to determine the competency of the individual patient at the time he is being considered for discharge. A specific notation is then made so that both a medical and legal evaluation result. If the patient is regarded as competent and able to manage his own affairs, he is classified as "recovered" for the purpose of the discharge record, and the report to the court.

It is pointed out that competency is not a static concept, and that criteria vary. Obvious variants which may be encountered are the capacity to make a will as compared with the criteria for competency in operating a business. Or a person may be sufficiently competent to purchase food and clothing and to meet simple responsibilities, but not sufficiently competent to manage a complex business. A senile person who has managed a complex business for a number of years may be competent to continue managing it, more or less out of habit, although an equally senile person who has never had similar experience would not be so competent. Each case must be determined individually on the basis of the particular patient's mental condition and the circumstances of the situation in which he will be placed. It is clear that in following such a plan, the psychiatrist must enlarge his knowledge of the criteria for competency.

(2) I feel that the psychiatrist should be informed as to the statutes and the procedure in his own state, with particular reference to those governing the discharge of mental patients. He should consult a lawyer for this information, or get a legal opinion. Usually, in the case of state hospitals, this can be obtained from the attorney general's office. If it is found that commitment by the court is the equivalent to a determination of incompetency in the state, the hospital staff should establish a

procedure by which they notify the committing court of the discharge of the patient, and of his status on discharge.

The statutes should be amended so that problems of hospitalization for mental illness are clearly and specifically separated from competency. The determination of competency should remain a legal matter, and should not be involved in medical situations primarily related to hospitalization and treatment.

Ohio Rev. Code, Section 5123.57: The section on competency of patients should be amended so that: (a) Where hospitalization is achieved by commitment or upon court order, the findings in regard to capacity shall be specifically limited to "Lack of sufficient insight or capacity to make responsible decisions with regard to his hospitalization," and so that

(b) It specifically indicates that every patient retains his civil rights unless he has been adjudicated incompetent and has not been restored to legal capacity.

Ohio Rev. Code, Section 5123.50: The section on discharge of patients should be amended so that: (a) Language referring to the terms "recovered" and "improved" is deleted, leaving the phraseology that the patient may be discharged when he can be released without danger to others, and with benefit to himself, and so that

(b) The sentence with reference to discharge operating in relation to competency be deleted entirely.

I hope that the members of the legal profession in Ohio and in other states will interest themselves in this problem, and that the needed changes in the statutes, as described above, will be accomplished.