The Involuntarily Confined Mental Patient and Informed Consent to Psychiatric Treatment

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There are many traumatic experiences awaiting a person about to be admitted to a mental institution. The new patient faces a totally different environment in which he will probably lose his identity and individuality. In addition—and perhaps more importantly—the new patient suffers a serious loss of many of his personal rights and liberties. Furthermore, the mental patient is sadly neglected by the American public and legal system. He is left to flounder on his own; he is systematically stripped of his rights, and neither society nor the legal system can offer a valid justification for the deprivation of these rights.

In 1972 over 750,000 people were admitted to public and private mental institutions. Over 400,000 of these new patients were placed in public institutions operated by state and county governments. Bertram S. Brown, Director of the National Institute of Mental Health, recently stated that every year approximately two per cent of the population receives some sort of psychiatric or mental care. Furthermore, he predicted that this percentage would continue to grow rapidly.

In fact, one out of every ten Americans will require hospitalization.


2. One commentator has noted:

Although modern psychiatry has demonstrated that individual mental patients differ vastly in their capacities for responsibility, mental hospital commitment in most states automatically strips them en masse of specific civil rights—sometimes of all such rights regardless of capacity. Testimony of Albert Duetsch, Subcomm. on Constitutional Rights of the Senate Judiciary Comm., 87th Cong., 1st Sess., Part I, at 40 (1961), cited in R. Allen, E. Fester, and J. Rubin, Readings in Law and Psychiatry 182 (1968).


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for a mental disorder during their lifetime. Even though many people face possible hospitalization, the general public and the individual mental patient are unaware of the aforementioned loss of rights awaiting a person about to be committed to a mental institution.

In the last ten years legal and medical scholars have begun a movement to reform mental institutions and mental health law. There have been several recent court decisions that have recognized the need for such a reform. For instance, the Supreme Court in *Jackson v. Indiana* implicitly gave its approval to this reform movement when it said:

The particular fashion in which the power [of commitment] is exercised . . . reflects different combinations of distinct bases for commitment sought to be vindicated . . . Considering the number of persons affected, it is perhaps remarkable that the substantive limitations on this power have not been more frequently litigated.

This note will discuss the reasons and the justifications for the loss of the mental patient's right to determine whether he wishes to receive the proposed psychiatric treatment. It will also attempt to determine whether an involuntarily confined mental patient is capable of consenting to or refusing psychiatric treatment provided by an institution and, if the patient is capable, whether the patient should be allowed to exercise this right. The right to refuse or accept treatment offered is generally described as "informed consent." This concept has been recognized by the majority of jurisdictions concerning the typical doctor-patient relationship. A mental patient, however, is denied the right to give his informed consent to treatment once he is committed to an institution.

This note will deal only with the right of the involuntarily con-

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5. Siegel, The Justifications for Medical Commitment—Real or Illusory, 6 W. FOREST INTRA 21 (1969) [hereinafter cited as Siegel].
6. T. SZASZ, LAW, LIBERTY, AND PSYCHIATRY 223-53 (1963) [hereinafter cited as SZASZ].
fined\(^{11}\) mental patient to give his informed consent to treatment. A patient who voluntarily enters a state mental hospital does not encounter the same problems in regard to release as does an involuntary patient. The voluntary patient who becomes dissatisfied with his treatment can leave the institution; in effect, he is exercising his right to refuse treatment.\(^{12}\)

Over forty per cent of the patients admitted to public hospitals in 1972 were admitted as involuntary patients.\(^{13}\) Another ten per cent were placed in these institutions in such a manner that these patients could be deemed to be involuntarily confined.\(^{14}\) All of these patients receive treatment whether or not they desire it. Therefore, a large number of patients in mental hospitals are being denied their right to give their informed consent to treatment.

The presumption made by the legal system and the institutions is that when a person is committed to an institution, he can no longer effectively consent to the psychiatric treatment offered by the hospital. In order to determine the truth of this presumption, this note will first examine the commitment standards in relation to the commitment process and psychiatric diagnosis. Thereafter, the note will discuss whether the person committed must accept the treatment offered by the state even if that person is capable of giving a valid consent, and, in the alternative, whether the state has a right and/or duty to treat a mental patient over his objections. The final section will discuss whether the involuntarily confined patient can meet the criteria necessary for a person to give informed consent.

\(^{11}\) A person is involuntarily confined when he is "judged to be mentally ill" and he is removed "from his normal surrounding to a hospital authorized to detain him." Brakel, supra note 1, at 35.

\(^{12}\) However, a voluntary patient can be denied his freedom if the hospital administrators petition the courts to have him committed as an involuntary patient. See generally Gilboy and Schmidt, Voluntary Hospitalization of the Mentally Ill, 66 NW. U.L. REV. 429 (1971); Benton, Criteria In Civil Commitment Proceedings, 26 U. MIAMI REV. 659, 663-65 (1972) [hereinafter cited as Benton]. Twenty-six states allow for the detention of the voluntary patient if the superintendent thinks it is necessary. During this period the superintendent must initiate commitment proceedings. Brakel, supra note 1, at 23. The Illinois statute reads as follows:

Each voluntary admittee shall be allowed to leave the hospital within five days... after he gives any professional staff member written notice of his desire to leave... unless within said five days a petition and the certificates of two examining physicians... are filed with the court. Ill. REV. STAT. ch. 91½, § 5-3 (1973). However, only nine states require the hospital staff to advise the voluntary patient of his right to leave the institution at any time. Brakel, supra note 1, at 23.

\(^{13}\) Inpatient Services, supra note 3, at Chart—Admissions to State and County Mental Hospital by Legal Status of Admission, Sex, Race and Age—United States, 1972.

\(^{14}\) Id. Three sub-classes were entitled as follows: Non-protesting, Prison Transfers, and Incompetent For Trial. Patients within these three groups are more clearly associated with the involuntarily confined patient than with a patient who voluntarily enters a state hospital.
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Commitment Processes

An examination of commitment standards and statutes is essential to determine what a court decides when it commits a person to a mental institution. Although almost all states have separate commitment and incompetency proceedings, very few mental patients actually receive an incompetency hearing. Therefore, the loss of one's rights must flow from the commitment order. If all commitment procedures clearly determine that a mental patient lacks the ability to give his informed consent, then only those who really need treatment and whose illness prevents them from perceiving this need are actually committed. But, if the commitment process does not conclusively determine that an involuntarily confined mental patient lacks the ability to consent, perhaps people are being committed who need treatment but who are fully capable of determining if they want this treatment.

It is important, therefore, to determine if the commitment process distinguishes between mental illness and total incompetency. If it does not, then many merely "functionally annoying" people are being committed to institutions without a determination being made that they are not capable of consenting to treatment. The mental patients within this group are not committed because of their inability to function; rather, they are committed because their erratic behavior makes other members of society uneasy.

The Commitment Statutes

As previously mentioned, a mental patient is deprived of many of his personal rights upon commitment to a mental hospital. Since the patient, in most cases, suffers a serious loss of his personal freedom, it would logically follow that the commitment standards should be very concise and clear. Furthermore, it would also be logical to conclude that forced hospitalization would be used by the courts only as a last

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15. Brakel, supra note 1, at 250-60.
16. Even those patients who might be totally incapable of giving an informed consent must be protected by a guardian. See text accompanying notes 117 through 118 infra.
17. See text accompanying notes 107 through 118 infra.
18. The author feels that many people are committed to mental institutions not because of their erratic behavior but because their presence makes friends, relatives, neighbors, and co-workers uneasy. These people are capable of functioning in society except for these behavioral quirks. Therefore, these people are "functionally annoying."
resort. However, recent in-depth studies have indicated the opposite. The statutes are so broad and vague that they do not identify "with clarity or precision" which mental illnesses require commitment or the severity of mental illness for which "involuntary hospitalization, with the accompanying deprivation of many personal and civil rights, is justified." Three states, California, New York, and Illinois, accounted for almost twenty-five per cent of the total patient population admitted to public mental hospitals in 1972. Yet the statutes of these three states that prescribe the degree of mental illness necessary for a person to be committed are inordinately vague.

The majority of state statutes advance three standards under which a person may be involuntarily committed to a mental institution: the patient is insane or psychotic; he is either dangerous to himself or others; or he is sick and needs institutional help. While the reasoning that supports these standards may be very persuasive, in reality these standards are very vague and lax. Commitment statutes are felt by many authorities to be totally useless because they do not provide a reasonable basis for determining whether a person should be committed to a mental institution. One commentator views commitment standards as unworkable and unrealistic:

It has been demonstrated, for example, that even such standard tests as being "mentally ill and dangerous to oneself or others"

22. Inpatient Services, supra note 3, at 5.
23. Each of the state statutes set standards for commitment that are so broad that they could be subject to almost any interpretation.

"Person In Need of Mental Treatment," . . . means any person afflicted with mental disorder, . . . if that person, as a result of such mental illness, is reasonably expected at the time the determination is being made or within a reasonable time thereafter to intentionally or unintentionally physically injure himself or other persons, or is unable to care for himself . . .


[H]e may be certified for not more than 14 days of involuntary intensive treatment under the following conditions:

(a) the person is [found], as a result of his mental disorder . . . [to be] a danger to others, or to himself, or gravely disabled.


A "mentally ill person" means any person afflicted with mental disorder to such extent that for his own welfare or the welfare of others, or of the community, he requires care and treatment.

N.Y. MENTAL HYGIENE LAW § 2:8 (McKinney 1951).

or being "mentally ill in need of care, custody or treatment" are frequently worthless as concrete or even general guidelines.26

Some state statutes define the standard for commitment for mental illness by describing the persons as being "mentally ill." In effect, these statutes define the terms for commitment by using the terms themselves in the definition.27

Even the reasoning that underlies the purpose of state commitment statutes is faulty. For example, a large number of statutes call for commitment of a mentally ill person because he is dangerous to himself or others. Forty-four states have statutes that allow the immediate apprehension and incarceration of a mentally ill person who can then be held in advance of a hearing because of his condition. Twenty-seven states have set the standard specifically at "dangerous to self or others."28 Yet most commentators feel that there is no valid basis for the generally held belief that mental patients are more violent or dangerous than other "normal" people. One commentator in attacking this myth stated:

Because of the highly biased reporting, the reader is free to make the unwarranted inference that murder and rape and other acts of violence occur more frequently among former mental patients than among the population at large. Actually it has been demonstrated that the incident of crimes of violence (or of any crime) is much lower among former mental patients than in the population in general.29

In 1967 the American Psychiatric Association agreed with the view held by many commentators that most mental patients are not dangerous. The Association stated that ninety per cent of all mental patients present no danger to people within the community; and, in most cases, they are completely harmless.30 Although there are other groups in society that are far more potentially dangerous than mental

27. Brakel, supra note 1, at Table 3.1; Benton, supra note 12, at 662.
29. SCHEFF, supra note 1, at 72. Other studies have indicated that the overall rate of arrest for mental patients with no prior record of arrest was less than ½ of that of the general population and they were arrested for less serious crimes. Siegel, supra note 5, at 35. See also Hastings, Follow-up Results In Psychiatric Illness, 114 AM. J. PSYCH. 1057 (1959).
patients, mental patients are the only persons singled out by society for preventive detention.\textsuperscript{31}

Thus the commitment statutes fail to provide the courts with an adequate basis for determining if a person should be committed to a mental institution and the reasoning that supports these statutes, in many instances, is inadequate. Yet, despite all these apparent problems, reform of the commitment statutes seems to be moving very slowly. In reality no statutes exist that offer sound and qualitative definitions of mental illness and forced hospitalization, and none are likely to be forthcoming in the near future.\textsuperscript{32}

\textit{The Court Process}

Because of the difficulty involved in interpreting these statutes and the mass influx of commitment cases in recent years, the courts and the medical profession have stressed speed and efficiency rather than taking the time to develop concrete commitment standards.\textsuperscript{33} Furthermore, judges are ill-equipped to deal with the problems that arise when a psychiatrist determines that a person is mentally ill, and to deal with the various issues that arise concerning the adequate treatment that is needed for the individual.

In addition, the judges have willfully or by default allowed psychiatrists to determine whether the person should be committed to a mental institution.\textsuperscript{34} The psychiatrists have eagerly accepted this role. Usually a psychiatrist will first determine what disposition is proper and then will testify in court in such a manner as to assure that his evaluation is followed by the court\textsuperscript{35} even though the final determination concerning the need for hospitalization is supposed to be left to the trier of fact. One commentator indicates that in determining whether a defendant is competent to stand trial, the courts have unequivocally preferred to leave this job to the psychiatrist.\textsuperscript{36} The psychiatrist's opinion, there-

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\item \textsuperscript{31} Ennis, \textit{Civil Liberties and Mental Illness}, \textit{7 CRIM. LAW BULL.} 101, 104-12 (1971) [hereinafter cited as Ennis].
\item \textsuperscript{32} Brakel, supra note 1, at 60.
\item \textsuperscript{33} American Bar Foundation Report, \textit{Hospitalization and the Discharge of the Mentally Ill}, 7-20 (R. Rock, M. Jacobson and R. Janapaul, ed. 1968) [hereinafter cited as Rock].
\item \textsuperscript{34} Consider \textit{id}. at 259:
\begin{quote}
Under these conditions the court becomes essentially ministerial. The judge has neither the objective legal criteria nor the technical training to decide the treatment questions really at stake. \ldots The court decides the central issue indirectly through the choice of medical examiners, a matter in which the court has no special competence and for which it is not responsible to anyone.
\end{quote}
\item \textsuperscript{35} Szasz, supra note 6, at 39-78.
\item \textsuperscript{36} American Bar Foundation Report, \textit{The Mentally Disabled and the Criminal Law} 90-92 (R. Matthews ed. 1970) [hereinafter cited as Matthews]. Matthews
\end{itemize}
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Therefore, plays the major role in deciding whether a person should be committed to a mental institution.\textsuperscript{37}

\textbf{(a) The Psychiatric Interview}

Normally a psychiatric evaluation for the purpose of diagnosis is a time-consuming process. The psychiatrist must have a number of in-depth interviews before he can determine if there is a need for any form of psychiatric treatment.\textsuperscript{38} Since the courts that forcibly commit people to mental institutions rely so heavily on the opinion of the psychiatrist, it only seems logical that a psychiatric diagnosis for the purpose of commitment would be made after all sound psychiatric procedures had been followed. Again the opposite is true. Most psychiatric interviews to determine if commitment is necessary are so brief and pointless that they are practically worthless.

The typical psychiatric examination for the purposes of commitment is conducted without the use of proper psychiatric methodology. Most court-appointed examiners are sadly lacking in formal training and many have little background in psychiatry.\textsuperscript{39} One commentator described the interviews as hurried, with the questions of the examiners coming “so rapidly that the examiner often interrupted the patient, or one examiner often interrupted the other.”\textsuperscript{40} He also noted that the average interview lasted 10.2 minutes during which little could be accomplished by the examining doctor.\textsuperscript{41} For these reasons an unjustified amount of reliance is placed by the court on the psychiatrist’s finding that a person is mentally ill.

\textbf{(b) The Hearing}

At the actual commitment hearings, the courts almost universally rely on the opinion presented by the psychiatrist who performed the examination. One commentator reported in studies of two different Arizona courts that the judges followed the psychiatrist’s opinion in 97.9\% and also notes that court psychiatrists usually make “dispositional diagnoses” of defendants. The psychiatrist decides what disposition he thinks is necessary and “then conforms his answers to the legal questions” to accomplish his goal. \textit{Id.} at 87.

40. SCHEFF, \textit{supra} note 1, at 144.
41. \textit{Id.} Matthews noted that criminal defendants face the same problems in incompetency interviews. The interviews “last only a few minutes” and the reports merely repeat information “drawn from prior records.” Matthews, \textit{supra} note 36, at 84.
96.1% of the cases that were observed. Remarkably, judges fail to question the psychiatrist as to the adequacy of his examination or as to the basis for his decision that a person is mentally ill and in need of commitment. Yet there are a variety of different factors that will definitely affect the outcome of the psychiatrist's report, and that will affect his decision that only commitment will aid the individual in recovering from his mental illness.

The following factors, which are important in determining the adequacy of a psychiatrist's report concerning a defendant's competency to stand trial, are equally applicable to a psychiatric diagnosis that a person is mentally ill and in need of commitment:

- whether the examination is outpatient or inpatient, at a jail, at the office of a psychiatrist, at a court clinic, at a psychiatric hospital or the psychiatric wing of a general hospital, at a short-term institution with a strong therapeutic orientation, or a long-term institution with a strong custodial orientation; whether the doctor works in private practice, in a court clinic, or at a state hospital; the competence, experience, and predisposition of the examiner.

Despite these important factors, judges continue to accept the opinion of the psychiatrist without bothering to ask any of these relevant questions.

The commitment hearing, in most cases, is brief and lacking in formality. Because the court has such a large caseload, it seems to consider the mere handling of such large number of cases to be more important than dealing with the rights of the individual. One commentator reported that in twenty-two hearings observed, the average hearing lasted 1.6 minutes. In Texas the commitment process is more rapid, and the commitment hearings are often held in the hospital. Patients are present in only ten per cent of the observed cases; and each hearing on the average lasts only one and one-half minutes. Most of the attorneys present have never had any contact with their client until the day of the hearing. The Texas commitment process is not an exception—it is the rule.

42. Scoville, supra note 20, at 60. Scheff reported similar results in his study. SCHEFF, supra note 1, at 139.

43. Matthews, supra note 36, at 81. Detre states that in trying to diagnose neurotic disorders the treating physician must rely on his "clinical experience and individual preferences and prejudices" to base a decision on such matter as "whether treatment should be offered and what kind it should be." DETRE, supra note 38, at 231 (emphasis added).

44. SCHEFF, supra note 1, at 135.


46. Scoville's study found that commitment hearings were very brief in Arizona. Scoville, supra note 20, at 38-51. For similar results in different states see Kutner...
The statutes and the courts, therefore, provide little direction in determining who should be committed to a mental institution. On the basis of this inadequate system, an involuntarily confined mental patient can automatically be deemed incapable of consenting to or refusing psychiatric treatment. However, as has been shown, there is nothing within the statutes or commitment processes that can form a proper basis for denying the mental patient this right.

The only area left for examination in the commitment process is the psychiatrist's opinion. It is important to take a brief look at the foundations and formulations that make up a psychiatrist's diagnosis that a person is mentally ill in order to determine if the psychiatrist does, in fact, conclude that a patient is incapable of consenting and if the psychiatrist has a valid basis for making such a decision.

The Psychiatric Diagnosis

A psychiatrist determines if a person is mentally ill and if he should be committed to an institution on the basis of his understanding of the term "mental illness." To facilitate the psychiatrist's diagnosis, his profession has established its own definitions and classifications for mental illness. The psychiatrist, therefore, determines if a person is mentally ill by evaluating the person's conduct in light of the psychiatrist's understanding of his profession's standards and conceptions of mental illness. Consequently, the psychiatrist does not evaluate the person's conduct in light of the legal standards set by state statutes. Moreover psychiatric classification is made to allow the psychiatrist to determine what treatment is necessary to cure the patient. But what do such classifications as schizophrenia really tell the courts about the patient? To determine this factor, this note must examine the basis for the psychiatrist's diagnosis.

Within the field of psychiatry the use of such systems of classifications and the use of various terminology cause considerable difficulties in relation to the actual diagnosis. Different psychiatrists rarely agree on the diagnosis or evaluation made of the same person. Since there who studied Illinois; Kutner, supra note 38. For a detailed study of the states of California, Florida, Michigan, New York and Washington, D.C., see Matthews, supra note 36.

47. T. SZASZ, PSYCHIATRIC JUSTICE 72-74 (1965) [hereinafter cited as SZASZ I]. See Kittrie, supra note 7, at 77-79.


49. Schizophrenia is a group of disorders manifested by characteristic disturbances of mood and behavior. DETRE, supra note 38, at 108-09.

50. Roth feels that psychiatric diagnosis will depend entirely upon who is watching.
are no objective standards within psychiatry, individuals “for whom treatment is desirable but not mandatory” cannot be discerned from the individuals for whom treatment will not be beneficial. Treatment results are rarely similar; therefore, the “answer the patient gets depends upon whom he asks.”

Furthermore, the various categories and classifications of mental illness established by the American Psychiatric Association are unavoidably ambiguous. This ambiguity allows the psychiatrist to place a person into almost any category of mental illness.

Psychiatric nosology is also dependent upon society for its guidelines. Conduct which often determines if a person is mentally ill is defined by the value society places on the conduct. The less society approves of the conduct, the more likely the person’s conduct will be used to designate him as being mentally ill. The basic determination about who is mentally ill, in many cases, is thus made by the people in the general community and not by the psychiatrist, who merely certifies the opinion of the community. As the values of society change, so do the patterns of psychiatric diagnosis. For instance, in the United States psychiatrists have been more willing to make a “diagnosis of schizophrenia” in the last few years.

All of these factors have led to a movement within psychiatry to re-examine and re-evaluate the need for psychiatric nosology. Many psychologists believe, based on a variety of considerations, that include philosophic, legal, therapeutic, and theoretical ones, that such classifications of mental illness are “useless at best and downright harmful, misleading.

Much of contemporary psychiatric and psychological theory is not subject to empirical validation. The basic tenets of psychiatric theory, such as the concept of mental illness itself, are so loosely defined that the same phenomenon may be perceived differently by individual researchers and the same researchers may even describe the same phenomenon differently during different experiments.

Roth, supra note 28, at 403; see also Benton, supra note 12, at 673-75.
51. DETRE, supra note 38, at 62.
53. Salzman believes that mental illness is defined by our religious and moral values. Salzman, Changing Styles In Psychiatric Syndromes, 130 AM. J. PSYCH. 147, 147 (1973). A diagnosis that a person is mentally ill is also a question “calling for a policy or philosophical judgment concerning what kinds of abnormality should be included” in describing mental illness. Weihofen, The Definition of Mental Illness, 21 OHIO ST. L.J. 1, 5 (1960).
55. E. SLATER AND M. ROTH, MAYER-GROSS CLINICAL PSYCHIATRY 238 (3d ed. 1969). Scheff reports that there have been over 5,000 studies done on schizophrenia since 1920, and yet there has been no substantial progress made in understanding this common mental disorder. In fact, many researchers believe that these reports have been approaching the problem from the wrong angle. SCHRUFF, supra note 1, at 7-9.
Even though such nosology has caused a great deal of controversy, the psychiatrist is still required to use this terminology as a basis for deciding whether a person should be forcibly committed. This determination, because it will bring about such serious consequences as forced hospitalization, should be almost errorless to prevent the unnecessary incarceration of any individual. Unfortunately for the prospective patient, the psychiatrist is not always successful in detecting mental illness or the lack of the same. One commentator reported on a study that placed eight “sane” persons in mental institutions. All eight feigned symptoms to gain admission to the institutions, but once they were admitted, they resumed their normal behavior patterns. The eight freely conversed with the attendants and openly took notes of their observations. Only the actual patients within the mental institution knew that the eight volunteers were “normal.” Remarkably, none of the eight had been released as cured by the various institutions when the study reached its conclusion.57

The psychiatrist is further hindered in his diagnosis by the role he plays in the commitment process. In most cases when the psychiatrist renders his diagnosis, he is either working for the people who wish to have the patient committed or he is working for the court which needs his decision to determine if the patient should be committed.58

Furthermore, the commitment process only allows the psychiatrist to recommend that the person be committed to a mental institution. The psychiatrist is not asked to determine that a person is incapable of exercising various rights. Nor is the psychiatrist asked to specify that the person will always be totally incapable of exercising his rights while he is a patient in the mental hospital. Most state commitment statutes do not require the psychiatrist to make such a conclusive judgment at the commitment hearing.59 Moreover, the limited time that the psychiatrist spends with the person renders suspect any determination by the psychiatrist that the person is incapable of giving his informed consent to treatment. At the trial, efficiency is the order of the day; therefore, the psychiatrist does not have a sufficient amount of time to present any conclusive findings to the court. The patient,

56. Rosenhan, On Being Sane In Insane Places, 13 S. CLARA LAWYER 379, 380 (1973) [hereinafter cited as Rosenhan].
57. The average stay within the different mental institutions lasted approximately nineteen days. Id. at 381-86.
58. Szasz I, supra note 47, at 56-61, 72-74.
59. Brakel, supra note 1, at 252-56.
therefore, is sent to a mental institution based on this incomplete diagnosis and court process. The institution decides what treatment it wishes to give to the new mental patient, and then proceeds to treat the patient without consulting him.60

In summary, the commitment process suffers from the uncertainty of the psychiatrist's examination. One psychiatrist might recommend commitment while another might not. The problem is further complicated by the changing values of society which determine what conduct denotes mental illness. Furthermore, the psychiatrist is usually not asked to render his opinion concerning the individual patient's ability to consent to treatment.61 Due to the gradual breakdown in the commitment process, a judgment that requires a person to be institutionalized almost always carries with it a denial of rights that by statute can only be lost at a competency hearing.62 Moreover, the commitment statutes do not provide an adequate basis for determining if a person should be committed. These factors lead to the inescapable conclusion that the commitment process offers no satisfactory basis for determining whether a mental patient is capable of giving his informed consent to treatment.

The only other basis by which a state can claim that the patient must accept the treatment offered, even if the patient is capable of deciding whether he wants the treatment, is the state's commitment power. This note will now examine the sources of the state power that gives it the right to forcibly commit and forcibly treat an individual designated as being "mentally ill."

THE STATE COMMITMENT POWER

As has already been demonstrated, state commitment processes cannot and do not adequately determine if a committed mental patient has the ability to give his informed consent to treatment. In spite of this fact, a person committed to a mental institution is still denied this

60. The treatment of patients in many instances is inadequate, poorly supervised, and possibly presents a danger to the health of the mental patient. Patients are routinely drugged as part of their "treatment program." Yet the fact that a drug produces an alteration in consciousness and a modification of behavior does not justify its administration as a medicine. Roth, supra note 28, at 439. Rosenhan reported that the eight pseudo-patients received a total of nearly 2,100 pills during their stays. The eight received a wide variety of medications suitable for many different forms of mental illness even though each individual had been diagnosed as suffering from only one form of mental illness. Rosenhan, supra note 56, at 395-96. Kittrie feels that the continued use of drugs to alter behavior patterns raises serious moral questions; he views such treatment as tantamount to an execution of the personality of the patient. Kittrie, supra note 7, at 388-91.

61. Most states by statute require separate competency hearings to determine if the patient is capable of exercising certain rights. Brakel, supra note 1, at 255 and Table 8.3.

62. See text accompanying notes 15 through 46 supra.
right; therefore, the power to deny this right is effective upon the patient's commitment but it must be derived from sources that are not within the scope of the commitment hearing. The power to deny this right to the patient is, most probably, derived from the state's power to commit an individual to a mental institution.

The most rational view of this power would be that if a state determines that a person must be committed to a mental institution, the state must also provide treatment for the mental patient. The failure of the state to provide adequate treatment — and thereby the failure of the state to attempt a cure of the patient — would deprive the state of its justification for committing an individual in the first place. \(^6\) Therefore, the state forces treatment on the patient to be able to justify commitment.

To determine if the state has the inherent power to force treatment on an objecting mental patient, an examination of the theoretical justifications of the state's power to commit people to mental institutions is needed. The state as sovereign and guardian of its citizens derives from two sources the power to forcibly commit people who are mentally ill. These sources are generally designated as the police power of the state and the state's power as parens patriae. \(^6\) The state, acting through its police power, has the right to detain citizens who present a danger to themselves or others. This is an inherent power within the state because the state owes a duty to its citizens to preserve order within society. \(^6\) The state as parens patriae has the right to institutionalize those people whose mental disability makes them unable to care for themselves. \(^6\)

**Police Power**

Under its police power the state has a right to commit the dangerously mentally ill; but, at the same time, the state owes a duty to its citizens to commit only those people who the state is absolutely certain present a danger to society. The state, therefore, can act only when

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64. KITTRIE, supra note 7, at 3-14; Benton, *supra* note 12, at 678-89; Nascent, *supra* note 24, at 1138-39.


66. KITTRIE, *supra* note 7, at 8-11, 366-69; SZASZ, *supra* note 6, at 151-53. The justification of parens patriae for the commitment of the mentally ill was developed to deal with the non-dangerous mentally ill individual. Marschall, *supra* note 63, at 40-41.
all other reasonable alternatives to forced commitment have failed. Furthermore, commitment cannot be justified simply because a person is claimed to be dangerous; there must also be a strong possibility that he will commit some violent act. The state must meet these requirements because many individual rights and liberties can be lost when a person is involuntarily confined to a mental institution.

As in the commitment process, the determination that the state should use its police power to commit a person falls squarely on the psychiatrist. Few psychiatrists, however, are adept at determining if a person presents a "danger" to society. In fact, psychiatric prediction has failed miserably in this area. Furthermore, the broad use of the police power against the mentally ill cannot be justified because the mentally ill as a group have not been shown to be more dangerous than any other identifiable group within society. Because of these factors, the police power can only have a limited application in relation to the commitment of the mentally ill.

The justification for the use of the police power against the mentally ill is similar to that offered by the state in incarcerating criminals. Thus, the rationale for incarceration of criminals is that the state owes a duty to protect society from those individuals who are dangerous. These people, therefore, are in prison because they have committed a crime against the members of society. Despite the fact that a criminal is committed for the same reasons as a dangerous mental patient, the prisoner's consent must always be sought by the state when the state wishes to treat the prisoner for an illness. As in the normal doctor-patient relationship, the prisoner's consent must meet the informed consent

67. Kittrie, supra note 7, at 381.
68. There must be strong proof that the individual is dangerous. He must be shown to be particularly violent. As for the person possibly injuring other members of society, "rather rigid criteria of potential violence is needed." Visotsky, Adequacy Of Treatment And Provisions for Methods of Assuring Adequacy of Treatment, cited in THE MENTALLY ILL AND THE RIGHT TO TREATMENT 73-74 (G. Morris ed. 1970) (hereinafter cited as Visotsky).
69. Katz, supra note 63, at 758-59. This is further proven in cases dealing with the criminally insane. Psychiatrists in maximum security hospitals are reluctant to release these people because they are unable to predict with any accuracy that the patients will never commit violent acts again. Psychiatrists know that when they release these people from these institutions the courts rely on their evaluation that the person should be released and they are, therefore, reluctant to certify that a person will never again commit violent acts. Matthews, supra note 36, at 142; Ennis, supra note 31, at 104-12.
70. Studies have indicated that there are very few reliable criteria which determine that any individual might present a danger to other members of society. Criminal recidivists constitute one group whose members can be expected, with a high degree of probability, to commit violent acts against society. And yet, no one suggests that states use their police power to incarcerate these individuals until they can be shown to no longer present a danger to society. Marschall, supra note 65, at 57-58. See text accompanying notes 28 through 32 supra.
Furthermore, the police power could not justify the state's forcible use of medical or psychiatric treatment in an attempt to rehabilitate a prisoner; the prisoner's consent must always be sought in such circumstances.72

Similarly, a mental patient, who is viewed as presenting a danger to society, can only be committed to a mental institution as long as he poses such a threat. This detention by the state is the only justification for the use of the police power. As in the case of the criminal, the mental patient can only lose those rights necessary to maintain his confinement. The state should not use the police power as a justification for forcibly treating the individual mental patient.

Classifying a person as being "dangerously mentally ill" and incarcerating him may be reasonable in order to protect society. The need for such classification and incarceration, however, does not justify the state's forcible treatment of a mental patient. The ability of the patient to consent to treatment must not depend on whether the patient is dangerous to society; rather, it must depend on whether he can validly give his informed consent.

**Parens Patriae**

The state under the theory of *parens patriae* acts in its capacity as sovereign and guardian for various members of society who because of their mental or physical condition are unable to care for themselves.73 The state, therefore, has the duty to care for these people and the duty to protect their interests. Application of the theory of *parens patriae* might allow the state to impose such treatment as is deemed necessary to cure the mental patient. This imposition would be allowable because the patient, due to his mental disability, is unable to recognize his need for such psychiatric treatment. This paternalistic view has allowed the state to impose very painful psychiatric treatment upon a mental patient.74 Such an attitude is best demonstrated by the following statement made in regard to the right of the state to impose shock therapy on a mental patient.

It must be borne in mind that the care, treatment and mainten-

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71. See text accompanying notes 83 through 85 infra.
ance of the mental patient is a governmental function and that the basic considerations in this function are best carried out by the authorized agencies of the Commonwealth, uncontrolled by the dictates of the patient, his friends, relatives or others.\textsuperscript{76}

Therefore, the basic purpose of the state's use of \textit{parens patriae} is to impose treatment that will benefit the mental patient. However, the basic tenets that support this imposition of treatment have never been shown to be true. The state has no adequate basis for determining that a mental patient is capable of deciding whether he wants the offered treatment; the commitment process—the only time when a state makes any determination concerning a mental patient—never reaches the issue of the patient's ability to consent.\textsuperscript{76} Without such a factual justification the state has no basis for relying on \textit{parens patriae} to impose treatment.

In many cases, psychiatric treatment procedures dispute the state's position that forced treatment is better than none at all. The best treatment results are usually achieved when the patient willingly accepts the treatment.\textsuperscript{77} Therefore, the patient is benefited the most when he has the right to accept or reject treatment. This view is closer to the basic premise of \textit{parens patriae} that the state should act for the benefit of the patient. The state should be willing to allow the patient this right; and in this way it will be best achieving its goals.

A further danger of the unlimited application of the \textit{parens patriae} power is that psychiatrists and mental hospital officials become too paternalistic in dealing with the individual patient. The patients, in turn, react to this handling by being "assimilated" into the mental health system and thereby becoming totally "dependent" upon that system.\textsuperscript{78} The whole process is further complicated because the mental institution becomes totally dependent on the mental patient for a variety of needed services. Officials become reluctant to release many patients because these patients perform valuable services at the institution.\textsuperscript{79}

This entire process gradually eliminates the remainder of the patient's

\textsuperscript{75} Position of the Attorney General of the State of Pennsylvania, quoted in J. \textsc{Katz}, \textsc{Experimentation With Human Beings} 715 (1972).

\textsuperscript{76} See text accompanying notes 15 through 62 \textit{supra}.

\textsuperscript{77} See text accompanying notes 128 through 141 \textit{infra}.

\textsuperscript{78} Rock, \textit{supra} note 33, at 225-26. For a further discussion of the possible debilitating effects of long-term commitment see text accompanying notes 133 through 136 \textit{infra}.

\textsuperscript{79} The institution's staff develops a bias that prevents them from releasing the patients in many cases. Those patients who can perform tasks that are essential to the basic operation of the institution are retained the longest. Many large institutions utilize patient labor in jobs that range from menial laundry tasks to the performance of complex tasks in electrical shops. Rock, \textit{supra} note 33, at 228.
rights. The more dependent the patient becomes, the less chance there is of curing him.\textsuperscript{60} The less chance there is of curing him, the longer he stays in the mental hospital. The longer he stays, the more dependent the hospital system becomes on him for his services. The more dependent the institution becomes on the patient, the less likely it is that the institution will release the patient. This cycle is produced and fed by the unlimited application of \textit{parens patriae}. It starts with the denial of the right of the patient to refuse treatment and concludes by effectively depriving the patient of all his rights and his freedom.

The best way to break this cycle is to prevent it from starting. The state, by initially allowing the patient the right to refuse treatment, could create an attitude within the patient and an atmosphere within the mental institution that is very beneficial to the patient's achieving mental health.\textsuperscript{81} It follows, therefore, that the state best serves the interests and needs of the individual mental patient when it allows the capable patient to give his informed consent to the proposed psychiatric treatment. This interpretation of the state's role as \textit{parens patriae} is quite acceptable if involuntarily confined mental patients are capable of giving their informed consent.\textsuperscript{82}

In summary, the state commitment process and the state commitment powers fail to provide an adequate basis for determining whether an involuntarily confined mental patient can give his informed consent. Without such a determination, the state has no foundation for its argument that it must forcibly treat these patients. Thus, the determination of whether or not a patient can consent must be made by applying the informed consent criteria to each individual patient. This note will now look at the various criteria that make up an informed consent and will then try to determine which involuntarily confined mental patients can truly give their consent to the offered psychiatric treatment.

\textbf{INFORMED CONSENT}

\textit{In the normal doctor-patient relationship, the physician is required}

\textsuperscript{60} The general rule of thumb is that the longer the patient stays, the worse his condition becomes.

\textsuperscript{61} Nearly all long-term hospital patients exhibit flatness of response, withdrawal, muteness, and loss of motivation. Once believed to be part of the degenerative process of mental illness, these phenomena are now universally accepted—even by public hospital administrators—as responses to hospitalization itself superimposed on the difficulties of illness. Chambers, \textit{Alternatives To Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives}, 70 Mich. L. Rev. 1107, 1127 (1972).

\textsuperscript{81} For a discussion of the proper atmosphere to be maintained in a mental institution see text accompanying notes 137 through 141 infra.

\textsuperscript{82} See text accompanying notes 107 through 118 infra.
to obtain the consent of the patient before proceeding with any form of treatment. If the physician fails to obtain the patient’s informed consent and proceeds to treat the patient, the doctor could be subject to possible tort liability.83 Likewise, when a person seeks private psychiatric treatment, the psychiatrist is required to obtain the patient’s consent before proceeding with the treatment.84 In fact, no cases have been found that have held that a psychiatrist is not bound by the same informed consent standards as the regular medical practitioner.85

Informed Consent to Psychiatric Treatment and the Courts

The courts in dealing with cases involving a non-institutionalized patient’s informed consent to psychiatric treatment have chosen to ignore the possibility that the patient’s mental illness might have prevented him from properly consenting to the proposed treatment. However, this same factor (the patient’s mental illness) is used as a justification for not allowing the institutionalized mental patient to give his informed consent for similar treatment. For example, in Wilson v. Lehman86 the patient was suffering from moods of depression that were manifested in her physical condition. Her physician recommended that she undergo electro-shock therapy. This treatment involves the passage of electricity through the temples of the patient’s head. The process is very painful and can cause serious physical injury.87 The patient entered the private hospital and underwent the treatment; later she sued, claiming that she had never consented to the treatment.

The patient alleged that she could remember nothing about the therapy while she was in the hospital. Therefore, she could not possibly have given her informed consent to the treatment. The court, however, ruled that her voluntary entrance into the hospital showed that she freely consented to the electro-shock treatment.88 The court did not dis-

83. See cases at note 10 supra. See generally Waltz and Scheuneman, Informed Consent To Therapy, 64 NW. U.L. REV. 628 (1969) [hereinafter cited as Waltz]; Fraser and Chadsey, Informed Consent In Malpractice Cases, 6 WILLAMETTE L.J. 183 (1970) [hereinafter cited as Fraser].


85. Annot., 99 A.L.R.2d 599, 606 (1965). However, in 1970, psychiatric malpractice suits made up only 1.5% of the total number of malpractice suits filed in that year. U.S. DEP’T OF HEALTH, EDUCATION AND WELFARE, PUB. NO. (OS) 73-58, MEDICAL MALPRACTICE: THE REPORT OF THE SECRETARY’S COMMISSION ON MEDICAL MALPRACTICE Table 4 (1973) [hereinafter cited as SECRETARY’S COMMISSION]. Furthermore, no cases have ever been found concerning malpractice of a psychiatrist in relation to psychoanalysis. Dawidoff, supra note 84, at 696.

86. 379 S.W.2d 478 (Ky. Ct. of App. 1964).

87. Redlich, supra note 38, at 337.

88. 379 S.W.2d at 480.
cuss whether the patient's mental illness could have prevented her from giving her informed consent to treatment.

In *Aiken v. Clary* the doctor determined that the patient was a paranoid schizophrenic and recommended that he undergo insulin shock therapy. This treatment involves the injection of insulin in sufficient amounts to induce a comatose state; the patient is then revived. This process is repeated over a period of several days until the psychiatrist can determine that the patient will be more receptive to psychotherapy. After the patient initially refused to undergo the treatment, the physician recommended to the patient's wife that she either convince him to accept the treatment or that she commence commitment procedures because her husband was seriously mentally ill.

The patient finally agreed to the treatment, and he later sued the doctor, claiming that the doctor had failed to warn him of all the risks involved with the treatment. The court reversed and remanded the case to allow the patient to introduce competent medical testimony to prove that the doctor should have warned him of the risks. The court did not decide if the patient's subsequent consent was valid even though the patient's own doctor felt that the patient was so ill that he should be committed to an institution.

Once the patient had been committed, he could have been forced to accept the very treatment for which the doctor had requested his consent before the patient was committed. It seems incredible that the doctor felt the patient could consent to the treatment but, at the same time, if the patient refused the treatment, he should be committed and forcibly treated. Therefore, in the doctor's and the court's mind, the patient's ability to consent was determined, not by the effect the illness had on the patient's capabilities, but by whether the patient was confined to a mental institution.

It seems remarkable that a person suffering from a mental illness could be deemed incapable of giving his informed consent to psychiatric treatment solely because of his status as an involuntary mental patient. There seems to be no logical basis for allowing a private individual the right to give his informed consent to psychiatric treatment while an involuntarily confined mental patient suffering from the same illness can be denied this right.

89. 396 S.W.2d 668 (Mo. 1965).
90. REDLICH, supra note 38, at 336-37.
91. 396 S.W.2d at 671.
92. *Id.* at 676.
Proponents of forced psychiatric treatment for mental patients counter this argument by stating that only those people who are incapable of giving their informed consent are forcibly committed and treated by the states. However, as has already been shown, the present commitment process cannot adequately determine whether a patient is capable of consenting to or refusing the psychiatric treatment. At the same time, the state's theoretical justifications for commitment fail to provide an adequate basis for allowing the state to forcibly treat the mental patient.

Therefore, the person's status as an involuntarily confined patient cannot be the factor that determines whether he can consent to the treatment. As in the two cases just discussed, the courts must look at the circumstances of the individual case in order to determine whether the patient can consent. The proper way to do this would be by applying the informed consent standard to each individual mental patient. Each mental patient must be deemed capable of giving his informed consent until an application of the informed consent standards shows that he lacks this capacity.

Informed Consent Criteria and the Mental Patient

The following criteria form the basis of a valid informed consent to regular medical treatment: ability of the patient to consent; full disclosure of all risks by the treating physician and a consent that is freely given. Application of these criteria has led to the following formulation of informed consent. The patient must be able to make an intelligent choice from among the various courses of possible treatment or to refuse treatment altogether. The doctor must inform the patient of the following: "(1) the diagnosis, (2) the general nature of the contemplated procedures, (3) the risks involved, (4) the prospect of success, (5) the prognosis if the procedure is not performed, and, (6) alternative methods of procedure, if any." Finally, the patient must be free from any coercive influences when he makes his decision based upon the doctor's disclosures.

Analogously, there must be a standard by which one can determine

94. See text accompanying notes 15 through 62 supra.
95. See text accompanying notes 63 through 82 supra.
96. Waltz, supra note 83, at 643-46; Fraser, supra note 83, at 186-87.
97. Secretary's Commission, supra note 85, at 29.
98. Fraser, supra note 83, at 186.
whether a mental patient can truly give his informed consent to treatment. Such a standard, while containing criteria similar to that needed to form a general informed consent, must take into consideration the involuntarily confined mental patient's environment. The standard should be tailored to meet the patient's abilities and to overcome his shortcomings. In the past, the American legal system has been willing to adopt certain rules formulated to deal with the problems presented by a person's mental disability. For example, several different tests have been developed to determine whether a mentally ill person is responsible for his actions.

In criminal law the courts have established tests to determine whether a person is competent to stand trial\textsuperscript{100} or whether a person can be held criminally responsible for his acts, if, at the time of their performance, the person was mentally ill.\textsuperscript{101} As for incompetency to stand trial, the diagnosis of a mental disorder is not in and of itself sufficient to warrant a finding of incompetency. The mental disorder must cause an impairment in judgment regarding the specific issues involved.\textsuperscript{102}

In contract law a mentally ill person is bound by his contract if he possessed "sufficient mind or reason to comprehend the nature, terms and effect of the contract in issue."\textsuperscript{103} A few jurisdictions declare that a person is incompetent to contract upon his commitment to a mental institution. Therefore, any contracts made after the commitment proceedings are void. But most states require an independent finding—through a separate hearing—that the mentally ill person is incompetent to make a contract.\textsuperscript{104}

A testator who is mentally ill can make a will as long as he knows the nature and extent of his property and the natural objects of his


\textsuperscript{101} There are several different tests to determine if the defendant was insane at the time he committed the crime. One of the most prevalent ones is stated as follows: A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks adequate capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of the law. \textit{Model Penal Code} § 4.01 (1962).

\textsuperscript{102} Redlich, \textit{supra} note 38, at 713.

\textsuperscript{103} Turley v. Turley, 374 Ill. 571, 575, 30 N.E.2d 64, 66 (1940); Harris v. Rivard, 64 Wash. 2d 173, 175, 390 P.2d 1004, 1006 (1964); Page v. Prudential Life Ins. Co. of America, 12 Wash. 2d 101, 108, 120 P.2d 527, 531 (1941).

\textsuperscript{104} Brakel, \textit{supra} note 1, at 304-05.
bounty; and as long as he is capable of relating these factors together to make his intended disposition of property.\textsuperscript{105} As in the case of making a contract, some states equate hospitalization of a person with general incompetency, but most states do not apply this rule.\textsuperscript{106} These states require an independent hearing to determine if the person is competent to make a will.

Therefore, commitment for a mental disability alone does not prevent a mental patient from validly executing a contract or drawing a will. The mental patient need only meet the stated criteria for each act. Thus, if our legal system has established tests for mentally ill people in regard to certain forms of their conduct, there seems to be no logical reason why similar standards cannot be developed to allow an involuntarily confined mental patient to consent to or to refuse the proposed treatment.

\textbf{Ability}

A growing number of commentators feel that mentally ill individuals are perfectly capable of making a rational and understanding decision with regard to the psychiatric treatment offered by a mental institution.\textsuperscript{107} While the patient might not be capable of making these decisions at all times, almost all involuntarily confined mental patients experience periods of "lucidity" during which they should be allowed to make these decisions.\textsuperscript{108} As previously mentioned, most commitment proceedings fail to determine if the patient is able to give an informed consent and, therefore, these capabilities of the patient are never fully explored at the hearing. If the patient is fully advised, and he is deemed capable of making rational decisions, there is no valid reason for not allowing him to make his own decision. In reality, patients cannot decide whether they want the proposed treatment because nobody bothers to ask them.

It should suffice to note that the "mental patient" often does not, in fact, know "what he is letting himself in for." But, in our view, this is not because he is incompetent or stupid, \ldots but because the psychiatrist does not tell him what he intends to do for him.\textsuperscript{109}

\begin{itemize}
  \item Brakel, supra note 1, at 305-06.
  \item Ferleger, supra note 7, at 471-73; Szasz, supra note 6, at 149-53; Kaplan, \textit{Civil Commitment "As You Like It"}, 49 Bos. L. REV. 14, 22 (1969) [hereinafter cited as Kaplan]. \textit{See generally} Kittrie, supra note 7; T. Szasz, \textit{The Myth of Mental Illness} (1961); Ennis, supra note 31.
  \item Siegel, supra note 5, at 31; Rosenhan, supra note 56, at 389-90.
  \item Alexander and Szasz, \textit{From Contract to Status Via Psychiatry}, 13 S. CLARA LAWYER 537, 552 n.70 (1973).
\end{itemize}
Therefore, these commentators feel that if a capable mental patient is adequately informed of the proposed treatment, he should be allowed to make a rational choice of whether to accept treatment or to reject it.

Psychiatrists recognize that many forms of mental illness do not render a person totally incompetent. The exercising of certain rights, like consent to treatment, should not depend upon the form of the patient's illness, but rather, should depend upon the effect the illness has on the patient's ability to understand the problems connected with his treatment. Therefore, a judgment that a person should be committed must not include a denial of all rights unless there is a specific finding that the patient is totally incompetent. Thus, the view that a mental patient may be unable to consent to psychiatric treatment because he is unaware of what is going on around him and the view that the mental patient is incapable of free choice “may only be an illusion, an illusion that is without any foundation.”

Furthermore, since the psychiatrist spends such little time in determining what the mental patient’s capacities are, any judgment by an examining psychiatrist that a patient is incapable of giving his informed consent to treatment must automatically be suspect. Unless a psychiatrist makes an in-depth examination of the patient that allows him to conclude that the patient is totally incapable of giving his informed consent, it must be concluded that the patient is capable of giving his informed consent to the proposed psychiatric treatment because the psychiatrists has no basis for reaching the opposite conclusion.

The actions of many patients, once they are committed, indicate that they are fully aware of the environment that surrounds them: an indication that they are capable of making rational decisions. These mental patients actively manipulate their environment; they make every effort to convince the hospital staff that they are responding to treatment and that they are achieving goals established for them by the hospital. This phenomenon occurs irrespective of the actual effectiveness of the treatment offered by the mental institution. The rising number of voluntary mental patients also indicates an ability on the part of many mentally ill people to choose between treatment and freedom.

111. Visotsky, supra note 68, at 72-73.
112. Lipsius, Judgments of Alternatives to Hospitalization, 130 AM. J. PSYCH. 892, 892 (1973); see also E. Goffman, Asylums (1961) [hereinafter cited as Goffman].
113. Ennis, supra note 31, at 104.
a patient is capable of making such choices and coping with his envi-
ronment there is no reason why he cannot be deemed capable of giving
his informed consent to treatment.

Several state statutes also indicate that mental patients, in general,
are fully capable of giving their informed consent to medical treat-
ment.114 These statutes require the institution to seek the consent of
the patient before any regular medical treatment can be administered.
The Illinois statute reads as follows:

Surgery may be performed on patients only if the consent of the
patient, of the parent of a patient under 18 years of age, or the
 guardian of any patient is first obtained but if an emergency exists
and the life of the patient is threatened, consent need not be ob-
tained. . . .115

It would seem anomalous, therefore, that mental patients can be
deemed capable of consenting to regular medical treatment, but incap-
able of consenting to psychiatric treatment. This is especially true be-
cause there are many forms of regular medical treatment that would
require a greater deal of mental capacity on the part of the mental
patient to understand than do certain forms of institutionalized psychia-
tric care. To resolve this and other problems within the Nebraska
Mental Health Code, one commentator has proposed that the mental
patients be allowed to refuse any treatment offered by the mental insti-
tution at any time.116

These factors indicate that there is a high degree of probability that
many involuntarily confined mental patients have the ability to consent
to or to refuse any treatment offered by an institution. From the above
passages the following criteria can be derived that can serve as guides
for determining if the mental patient has the ability to consent: the
patient must have the ability to rationally understand the nature of the
treatment, the risks involved and the need for such treatment.

These criteria are similar to the criteria necessary for a general in-
formed consent to medical treatment. However, the only different re-
quirement is that the mental patient need not be able to give his consent
at all times during his hospital stay. As long as the patient has periods
when he is lucid, he should be deemed capable of consenting, and his
consent can only be requested during this period. A consent given

114. Brakel, supra note 1, at Table 5.3.
115. ILL. REV. STAT. ch. 91 1/2, § 1-8 (1973). The California and New York
statutes allow the patient to refuse certain types of psychiatric treatment. CAL. WELF.
AND INSTNS CODE § 5325 (West Supp. 1971); N.Y. MENTAL HYGIENE LAW § 15.03
(b) (McKinney 1972).
116. Kaplan, supra note 107, at 44.
at any other time cannot be valid for the simple reason that the patient
gave the consent when he lacked the ability. Furthermore, if a patient
does not have the ability to consent during his stay, then the consent
of his guardian must be sought.

If the informed consent concept is going to be properly applied to
the involuntary mental patient, the psychiatrist and the mental institu-
tion can no longer force treatment on the patient even if the patient
cannot give his consent. In the normal doctor-patient relationship
it is the right of the patient or the patient's guardian, and not the right
of the doctor, to decide whether to pursue a particular course of treat-
ment.\footnote{117}

There is no valid reason why this guardianship principle cannot be
applied to the involuntarily confined patient's relationship with the
treating psychiatrist. Most states have provisions for the appointment
of guardians for mental patients who are deemed incapable of dealing
with their property.\footnote{118} Therefore, there seems to be no reason why
a guardian cannot be appointed to accept or to refuse treatment on
behalf of the patient if the patient is not capable of giving his informed
consent to the proposed treatment at all times during his stay at the
mental institution.

The guardian should be allowed to seek the independent advice of
a psychiatrist who is not a member of the institution's staff. In this
way the guardian would be able to properly protect the interests of
the incompetent mental patient.


disclosure of risks

A patient's consent to medical treatment is not valid unless the phy-
sician has advised the patient of the risks that will accompany the pro-
posed treatment, including all collateral risks that might affect the
patient's decision.\footnote{119} Consent that is based upon a full disclosure
of risks is required because of the fundamental belief that every person
has the right to know what is happening or will happen to his body
and a right to participate in any decision affecting it.\footnote{120} Therefore,
it is the duty of the treating psychiatrist to disclose to the mental patient
all the risks that are inherent in the proposed treatment.

\footnote{117}{See generally Rock, supra note 33; A. Duetsch, The Mentally Ill In America (2d ed. 1969); M. Gutmacher and H. Weihofen, Psychiatry and the Law (1952).}
\footnote{118}{Brakel, supra note 1, at 250-65.}
\footnote{119}{Walz, supra note 83, at 630.}
\footnote{120}{Secretary's Commission, supra note 85, at 74-75. Judge Cardozo's often-}
When this standard is applied to the mental institution setting, two problems develop. First, the relationship between the doctor and his patient is sharply contrasted by the relationship between the state-appointed psychiatrist and the involuntarily confined mental patient. This latter relationship lacks the fiduciary qualities of the former. The psychiatrist is primarily the agent of the state and secondarily the treating doctor of the mental patient. The psychiatrist, therefore, is placed in a difficult position because the state, his employer, has placed the patient in the mental institution because of its decision that the patient needed treatment. The psychiatrist must avoid the temptation of not disclosing certain risks to the patient because of the psychiatrist's fear that the patient will refuse the treatment. If the psychiatrist falls into the temptation of not informing the patient of the risks involved with the treatment, the patient cannot give a valid consent to the treatment. Any treatment by the psychiatrist in such cases could make him liable to the patient for any injuries the patient might suffer from the treatment.

In order for the psychiatrist to avoid this pitfall, he must make a full and free disclosure of the risks involved to the mental patient. He must advise the mental patient as if the patient were not confined in an institution, and he must give the patient the same advice as if he were treating him in his office. The psychiatrist should view the patient as a private citizen with a right to determine what he wants to do with his body.

In the normal doctor-patient relationship, the treating physician's duty to disclose risks does not require the physician to disclose every conceivable risk, no matter how remote, that is involved with the proposed treatment. The courts, in general, have required the treating physician to disclose only those reasonable consequences that a reason-
able medical practitioner would disclose under similar circum-
stances. If the procedure is new and unorthodox, the doctor is
required to explain this factor to the patient and to advise the patient
that there are unknown risks involved with the proposed treat-
ment.

The application of this latter part of the disclosure of risk standard
to the mental institution setting raises a second problem for the treating
psychiatrist. The use of several types of psychiatric therapy—drug
therapy, shock therapy and lobotomies—can cause many possibly harm-
ful side effects. In particular, drug therapy, the most prevalent form of
psychiatric treatment, causes many painful side effects and can possibly
cause permanent damage to the physical system. The possible
side effects vary from patient to patient, and also depend a great deal
upon how often the patient has been treated with the same drug in
the past. Therefore, in many cases, the psychiatrist will not be
able to tell in advance exactly what possible risks might face the mental
patient. In order to protect himself, the psychiatrist must disclose those
risks that a reasonable psychiatrist would disclose under similar circum-
stances.

Once it has been determined that the patient has the capacity to give
his informed consent to the proposed psychiatric treatment and that
the patient has been warned of the relevant risks involved with the treat-
ment, then it must be determined if the involuntarily confined mental
patient can freely give his consent to treatment within an institutional-
ized setting.

Consent Freely Given

The involuntarily confined mental patient must be freely able to de-
cide whether he wishes to accept the treatment offered by the institu-

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124. Natanson v. Kline, 183 Kan. 393, 403, 350 P.2d 1093, 1106 (1960); Woods
court stated that the test for determining whether a particular risk or peril must
be disclosed is its materiality to the patient's decision. Therefore, all risks potentially
affecting his decision must be disclosed. 464 F.2d at 785-90.
But see Waltz who argues that a patient can never consent to unknown risks in any
treatment. Waltz, supra note 83, at 632-35.
126. The aforesaid types of therapy have a wide range of side effects that
cannot be covered in depth in this note. An example of possible side effects from
the use of the drug phenothiazene used to treat schizophrenia, will demonstrate the
possible risks involved in the use of drugs to treat mental patients. The drug can cause
minor forms of temporary paralysis, convulsive seizures, abnormal tension and possible
catatonic states. DETRE, supra note 38, at 535-91.
127. For a detailed discussion of the use of drugs in treating mental patients see DETRE, supra note 38, at 528-634; Wexler, supra note 26, at 298-99.
tion. This is an essential element of any informed consent. When applying this part of the informed consent concept to the mental patient, the following problems might arise because of the institutionalized environment in which the mental patient is placed.

Most forms of psychiatric treatment require that the patient freely accept the treatment and that the patient be willing to cooperate with the psychiatrist. A cooperative patient will aid the psychiatrist in treating the patient and will make the patient's recovery much easier. For these essential reasons the psychiatrist and the mental institution must make sure that there are no coercive factors operating on the patient's free will that might negate his consent to treatment.

The first dilemma facing the involuntarily confined mental patient is presented by the role the psychiatrist plays at the mental institution. The psychiatrist is both the doctor and the evaluator. As the doctor, the psychiatrist will directly seek the consent of the mental patient concerning the proposed treatment. As the evaluator, however, the psychiatrist is the one who determines when the patient is to be released from the institution. The patient, therefore, is faced with the complex problem of withholding his consent for treatment from the very person who determines when he is to be released and what privileges he will have during his stay at the mental institution.

Furthermore, the psychiatrist represents to the mental patient one of the last memories that the patient has of contact with the outside world. The new patient may be desirous of holding on to all the remaining features of his past freedom. He will be quite "susceptible to the influence and suggestions" of the psychiatrist. The burden of overcoming these factors will fall squarely on the psychiatrist. He must recognize the problems that face a new mental patient with regard to the patient's being able to freely give his informed consent. The treating psychiatrist is obligated to do all he can to ascertain that the mental patient's consent was voluntarily given before he can proceed with any treatment.

The very environment of a mental institution can exert coercive influences on the involuntarily confined mental patient. The individual patient, in most cases, almost totally losses his identity and his individu-

128. See text accompanying notes 95 through 99 supra.
129. Dawidoff, supra note 84, at 697-98; A.P.A., supra note 30, at 1459.
130. KITTIE, supra note 7, at 101; REDLICH, supra note 38, at 200-05; Shestack, supra note 122, at 8-9.
131. SZASZ, supra note 6, at 169-70; see generally Ferleger, supra note 7.
132. Ferleger, supra note 7, at 451.
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ality upon his admission to the mental institution. He feels "powerless and gradually loses his confidence" as he is continually exposed to the "depersonalization of the mental institution."\footnote{133}

One commentator convincingly captures the total feeling of frustration and hopelessness that may overcome the new mental patient:

[T]he new patient finds himself stripped of many of his accustomed affirmations, satisfactions and defenses, . . . . Here one begins to learn about the limited extent to which a conception of oneself can be sustained when the usual setting of supports for it are suddenly removed.\footnote{134}

Within the mental institution, the mental patient gradually develops a whole new self-image. As more and more decisions are made for him, he adopts the image that hospitalized mental patients are "losers, sufferers, and victims."\footnote{135}

The existing institutional structure totally supports the patient's new self-image. Patients are expected to follow all orders given to them without questioning these orders.\footnote{136} The institution will release the mental patient only if he shows a willingness to obey the rules. Therefore, the patient's desire for release could effect his decision concerning the offered treatment. It is within this setting that a mental patient would be expected to voluntarily consent to treatment. While this is indeed a grim picture, it is not totally impossible for a mental patient to give his consent freely. The institution and the psychiatrist will have to recognize the right of the patient to refuse treatment. Once they recognize that the patient does have this right, they will have to make every possible effort to make sure that the patient freely consents.

One of the primary goals of the earlier-mentioned reform movement is to enlarge the rights and responsibilities of the individual mental patient within the mental institution. The more the psychiatrist and the mental institution are made aware of these rights, the more freedom the patient will have. In effect, he will be freed from the coercive elements of the institution, and he will be able to freely consent to treatment.\footnote{137} If the psychiatrist and the institution are reluctant to grant these rights to the patient, appropriate legal action must be taken to protect the rights of the patient.

\footnote{133}{Rosenhan, supra note 56, at 394-98.}
\footnote{134}{GOFFMAN, supra note 112, at 148.}
\footnote{135}{R. Rubenstein and H. Laswell, THE SHARING OF POWER IN A PSYCHIATRIC HOSPITAL 5 (1966) cited in J. KATZ, EXPERIMENTATION WITH HUMAN BEINGS 231 (1972).}
\footnote{136}{Visotsky, supra note 68, at 66.}
\footnote{137}{Shestak spoke of setting up an "administrative procedure act" that would pre-}
Such action was taken in *Wyatt v. Stickney.* The guardians of mental patients and the employees of Alabama's Bryce State Hospital filed a class action suit alleging that the constitutional rights of the patients were being violated because the sub-standard facilities of Bryce did not provide adequate treatment for the patients. Judge Johnson gave the state of Alabama six months to remedy the Bryce situation. At the end of the six-month period the state of Alabama had failed to take the necessary action. Judge Johnson proceeded to formulate a detailed set of proposals that the Alabama authorities had to follow to correct the conditions at Bryce.

As part of the guidelines the court adopted a patients' bill of rights which required that the mental patients in Bryce be free "from excessive medication;" that the patients not be subject "to experimental research without their express consent;" and that the mental patients not be subject to "lobotomy, electro-convulsive treatment, and aversive reinforcement conditioning" without the "express and informed consent" of the mental patient after he has had time to consult "with counsel or [the] interested party" of his choice. These standards are a recognition by the *Wyatt* court that the mental patient in most instances is fully capable of deciding what he wants to do with his body. The adoption of these and similar proposals by mental institutions will allow the involuntarily confined mental patient an opportunity to freely give his informed consent to treatment.

**CONCLUSION**

The commitment process, the commitment criteria, the methods of psychiatric diagnosis and the theoretical justification of the state commitment powers offer the state no reliable basis for determining that the involuntarily confined mental patient cannot give his informed consent to psychiatric treatment offered in mental institutions. The determination as to whether a mental patient can give his consent must be made by applying the relevant informed consent criteria to each individual mental patient. Therefore, the psychiatrist and the mental insti-

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139. 325 F. Supp. at 786.
140. 344 F. Supp. at 380.
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tution must first determine if the patient can and did consent properly to the proposed psychiatric treatment. The following criteria can be used by the institution and the psychiatrist to determine if the mental patient did give his informed consent to the treatment:

1. The patient must have periods of lucidity during which he is capable of rationally understanding the need for the treatment, the risks involved, and the nature of the proposed treatment; and

2. The treating psychiatrist must have disclosed to the patient, when the patient was able to understand, all direct and collateral risks that a reasonable psychiatrist would disclose under similar circumstances; and

3. The patient must have consented when free from any coercive influences.

The re-establishment of the patient's right to consent to or refuse treatment is part of the process of restoring as many rights to the mental patient as is possible. The psychiatrist and the mental institution must be made to reorder their priorities in order to establish a more considered opinion as to what is best for the patient. It is hoped that the recognition that each individual mental patient might be able to give his informed consent will facilitate this re-ordering.

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142. Of course, if the mental patient is not capable of giving his informed consent, the approval of the patient's guardian must be sought before the treatment can be administered. See text accompanying notes 117 through 118 supra.

143. The state of New York has adopted a legislative scheme that allows mental patients to retain as many of their rights as possible. Notwithstanding any other provision of law, no person should be deprived of any civil right, if in all other respects qualified and eligible, solely by reason of receipt of services for a mental disability nor shall the receipt of such services modify or vary any civil right of such person. . . .

N.Y. MENTAL HYGIENE LAW § 15.01 (McKinney 1972).