Voluntary Inpatient Psychiatric Hospitalization:
“Voluntariness” and Punishment

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Class of 2012

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VOLUNTARY INPATIENT PSYCHIATRIC HOSPITALIZATION: “VOLUNTARINESS” AND PUNISHMENT

By Elizabeth Ferguson

INTRODUCTION

The inherent coercive nature of most “voluntary” inpatient psychiatric hospitalizations—especially during the hospital admissions phase—poses a danger to mental health care consumers’ civil liberties, specifically the right to be free from restraint and imprisonment without due process of law. Without a more appropriate, patient-focused approach to psychiatric inpatient hospital admissions—free from coercion—such hospitalizations will continue to wrongfully and unconstitutionally punish the status of being mentally ill. As a starting point, psychiatric hospitals should strongly consider developing and utilizing evidence-based guidelines as standard of care during inpatient admission.

The first section of this paper focuses on the roles of voluntariness and coercion in the admission process of psychiatric inpatient hospitalization. Issues including doctor/hospital preferences for voluntary admission, the mental capacity to consent to voluntary hospitalization, and coerced consent are thoroughly analyzed. The second section of this paper illustrates how inpatient psychiatric hospitalizations can often punish the mentally ill. The justification for criminal punishment served by hospitalization, the punishment of status, and the similarities of psychiatric confinement to criminal incarceration are discussed. The final section of this paper recommends making the voluntary psychiatric admission process more judicious by proposing specific guidelines to ensure informed consent is reached.
VOLUNTARINESS AND COERCION IN INPATIENT ADMISSIONS

The implications of imposing voluntary status on patients admitted to a psychiatric hospital are of great importance from both a legal and medical standpoint.¹ A significant difference exists in voluntary versus involuntary hospitalization; however, the lines are often blurred at the admission stage. Involuntary hospitalization occurs when a judge commits a patient following an administrative hearing. Legal representation, a right to be present, and the right to cross-examine witnesses, and present one’s own witnesses are part of due process protection for involuntary patients.² However, people confined to a psychiatric hospital under voluntary legal status never see an impartial judge or have the benefit of counsel—they are committed without any benefits of due process protections.³ Many patients are coerced to “voluntarily” consent to hospitalization, and are therefore deprived of liberty without due process of law. This illustrates the potential quandary associated with “voluntary” psychiatric hospital admission.

In New York, “the director of any hospital may receive as a voluntary patient any suitable person in need of care and treatment, who voluntarily makes a written application therefor [sic].”⁴ Under the New York Mental Hygiene Law, to be “suitable” for admission as a voluntary patient, the patient must be notified and have the ability to understand (1) that the hospital to which he/she is requesting admission is a hospital for the mentally ill, (2) that he/she is making an application for admission, and (3) the nature of the voluntary status and the provisions governing release or conversion to involuntary status.⁵ In New York, if a voluntary patient gives notice in writing to the director of the hospital regarding his/her desire to leave the hospital, the director must promptly release the patient. However, if there are reasonable grounds for belief that the patient may be in need of involuntary care and treatment, the director can keep the
patient for a period not to exceed seventy-two hours from receipt of such notice. Before the expiration of this seventy-two hour period, the director must either release the patient or apply to the court for an order authorizing the involuntary retention of the patient. When such an involuntary commitment proceeding is initiated the state has the burden of proving the need of involuntary hospitalization by clear and convincing evidence.

A. The Preference for Voluntary Admission

Both the psychiatric profession and the courts prefer and encourage voluntary admission. They believe the patient who recognizes his/her condition and voluntarily undertakes therapy is more likely to be rehabilitated than a patient forced to undergo treatment involuntarily. Further, involuntary admission forces the doctor and patient into an adversarial relationship, which can potentially undermine the therapeutic alliance and adversely affect the patient’s treatment. According to medical professionals, the benefits of voluntary admission over those of involuntary commitment include a greater level of patient involvement and responsibility in their individual treatment decisions. And when no necessity exists for a hearing for involuntary commitment, doctors no longer have to spend time informing the court of other lesser restrictive treatment options.

Even the New York legislature recommends that mental health professionals encourage mentally ill individuals to apply for voluntary treatment in a psychiatric hospital. According to the Mental Hygiene Law, all state and local officers (in relation to the mentally ill) are required to advise any person suitable for psychiatric inpatient treatment to apply for voluntary admission.
The fact that voluntary admission avoids the stigma associated with an involuntary commitment by a court emphasizes the preference for voluntary status. Due to the community stigmatization involved in a legal finding of incompetence, patients committed involuntarily may come to view themselves in a way that can possibly worsen their condition. Labeling a person as “incompetent,” itself, may be psychologically damaging, setting up a self-fulfilling prophecy that exacerbates an individual’s mental health problems.

Formal involuntary commitment proceedings require significant psychiatric resources, further supporting the preference for voluntary admission. Doctors and hospital staff find the overall involuntary commitment process too time consuming. These healthcare professionals must prepare and attend court, as well as submit a detailed treatment plan to the court, which takes away time from their professional practice. With voluntary commitment, as soon as the patient signs the voluntary form, the healthcare professional can send it on to the court and avoid any further negotiations with the legal body.

The preference for voluntary admission also avoids the problem of the doctor’s counter transference reactions to the patient who refuses voluntary admission. When patients refuse to consent to treatment, they often elicit intense antagonism among their caregivers.

The preference for voluntary admission has consequences though, as the importance of individual liberty and autonomy cannot be understated. Because psychiatric hospitalization dampens such autonomy, the contra position emphasizes the necessity that involuntary commitment serves to protect individual rights and liberties. Reasons offered against voluntary admission include the potential for patient abuse, coercion, fewer discharge opportunities, lack of an adversarial process, no attorney representation, and no maximum length of stay. Further, due to the less complicated administrative and treatment procedures involved for voluntary...
patients, doctors and hospital staff may coerce patients to elect voluntary status.\textsuperscript{20} By electing such voluntary status, patients may unknowingly agree to restrictions of liberty and thereby give up the right to be discharged on demand.\textsuperscript{21}

\textit{B. Capacity to Consent to Voluntary Hospitalization}

Since people who are admitted to psychiatric hospitals are “mentally ill,” it raises the issue of competence to consent to such hospitalization. \textit{Zinermon v. Burch} controls on the issue of the mentally ill’s capacity to consent to voluntary admission. The case involved a Florida mental patient who signed forms requesting voluntary admission to various mental hospitals. However, the patient later alleged that he was heavily medicated, disoriented, and suffering from psychotic delusions at the time of his first admission and was not competent to give informed consent under Florida’s voluntary admission law.\textsuperscript{22} Burch alleged that the hospital’s failure to initiate an involuntary placement procedure established by Florida law denied him his constitutionally guaranteed right to due process.\textsuperscript{23} The Court held that the hospital should have allowed only patients who were competent to consent to have the option of voluntary admission.\textsuperscript{24} With this ruling the Supreme Court upheld the importance of “voluntariness” in the voluntary admission process by emphasizing that voluntary admission must meet the standards of consent established by state statute, or else a hearing is required prior to hospitalization.\textsuperscript{25} \textit{Zinermon} ensures that patients are not deprived of a substantial liberty interest without either valid consent or an involuntary placement hearing.

All \textit{Zinermon} requires is that the state have predeprivation procedural safeguards in place to protect a patient’s liberty interest; however, the Court did not specify what those safeguards should be.\textsuperscript{26} In New York, the law requires that to be suitable for voluntary admission the patient
must be notified and have the ability to understand (1) that the hospital to which he/she is requesting admission is a hospital for the mentally ill, (2) that he/she is making an application for admission, and (3) the nature of voluntary status and the provisions governing release or conversion to involuntary status.27

The MacArthur Treatment Competence Study identified four legal standards for determining competence. The first and least stringent consists of the ability to communicate choice, which presupposes the capacity to make a knowing, intelligent choice. Under this standard, when patients are unable to reach a decision or to indicate to their caregivers what course of treatment they desire, they uniformly will be considered incompetent.28

The ability to understand relevant information—the second and most common legal standard for competence—emphasizes the importance of patients’ comprehension of information related to the issue at hand.29 The information that must be understood must be disclosed to the patient under informed consent law.30 In New York, the Mental Hygiene Law requires that to be suitable for voluntary status, the patient must have the ability to understand (1) that the hospital to which he/she is requesting admission is a hospital for the mentally ill, (2) that he/she is making an application for admission, and (3) the nature of voluntary status and the provisions governing release or conversion to involuntary status.31

The ability to appreciate the nature of the situation and its likely consequences, the third legal standard identified by the study, requires patients’ ability to apply the information and understand the stakes of their own situation.32 This standard addresses a patient’s classic lack of insight regarding his/her psychiatric condition, such as a voluntary patient’s refusal to be admitted to the hospital because he/she denies that he/she suffers from a mental illness.
The ability to evaluate information rationally, the fourth and final legal standard for competence to consent, emphasizes patients’ ability to employ logical processes to compare the benefits and risks of treatment options. In this case it would be whether to apply for voluntary admission. The rationality to which this standard refers primarily addresses the logic in processing information, not necessarily the choice eventually made.

The standard for competency to consent in New York integrates the first two standards described in *The MacArthur Treatment Competence Study*: ability to communicate choice and ability to understand relevant information. The New York standard incorporates the ability to communicate choice because the Mental Hygiene Law requires that the patient request admission to a hospital for the mentally ill. This communicates choice, as the request for admission involves a “choice” to be hospitalized for a mental illness.

The New York Mental Hygiene Law incorporates the ability to understand relevant information by requiring that the patient seeking admission have the ability to understand (1) that he/she is requesting admission to a hospital for the mentally ill, (2) that he/she is making an application for admission to such a hospital, and (3) the nature of voluntary status and the provisions for release or changing status to involuntary. While these elements of understanding are relevant, they do not include all the important aspects of voluntary admission. An important aspect not provided for by the statute could be the fact that release from the hospital depends on a doctor’s determination that the patient no longer suffers from a mental illness and no longer poses a danger to himself or others.

The last two aspects of competency to consent under *The MacArthur Treatment Competence Study*—the ability to appreciate the nature of the situation and likely consequences, and the ability to evaluate information rationally—are absent from New York’s Mental Hygiene
Law. By not informing a patient of the substantial loss of liberty incurred by seeking admission to the hospital, he/she cannot truly appreciate the nature and consequences of the situation. The third requirement under New York’s Mental Hygiene Law, that the patient must understand the nature of voluntary status and the provisions governing release, partially addresses the issue of appreciating the nature of the situation, but does not adequately address the consequences of such hospitalization. Likely consequences may include the stigma of being an inpatient on a locked psychiatric unit or the possible inability to achieve a timely discharge.

Lastly, no provision exists in New York’s Mental Hygiene Law that implicates a patient’s ability to evaluate information rationally. A provision of this nature might include a requirement that the patient being admitted be able to explain the perceived risks and benefits of an inpatient psychiatric hospitalization.

In the absence of a well-developed legal standard for determining competence to consent to voluntary hospitalization, the admitting physician lacks the ability to execute the first step in the admission process (evaluation of capacity to consent), and ultimately risks a subsequent finding that the “voluntary” admission was in fact void of voluntariness. The stakes in this situation are high. For instance, a patient may elect voluntary status and by so doing he/she unknowingly waives his/her right to a hearing to contest commitment and also waives fundamental constitutional rights, including the right to liberty itself. Ensuring the capacity and competence to consent to voluntary hospitalization is essential; otherwise such hospitalization results in the loss of liberty without the guaranteed benefit of due process of law.
C. When Voluntariness Is Defeated: Coercion in the Admission Process

Often patients admitted to psychiatric hospitals “voluntarily” are actually coerced in some way during the admission process to give their “voluntary consent” to treatment. Merriam Webster defines “voluntary” as: “(1) proceeding from the will or from one’s own choice or consent; (2) unconstrained by interference; (3) done by design or intention; (4) of, relating to, subject to, or regulated by the will; (5) having power of free choice; (6) provided or supported by voluntary action; (7) acting or done of one’s own free will without valuable consideration or legal obligation.”

On the other hand, Merriam Webster defines “coerce” as: “(1) to restrain or dominate by force; (2) to compel to an act or choice; (3) to achieve by force or threat.” Coercion occurs when individuals lose their true decision-making power. Coercion may come in the form of threats, pressure, persuasion, manipulation, or deception, ultimately depriving the person of autonomous choice. The Nuremberg Code defines its standard of coercion as “the knowing consent of an individual or his legally authorized representative, so situated as to be able to exercise free power of choice without undue inducement or any element of force, fraud, deceit, duress, or other form of constraint or coercion.” A consequence of coercion manifests itself when physicians do not allow patients to participate in treatment decisions. When this occurs, patients often do not comply with medical advice.

The concept of voluntariness relates to the moral right to decision-making autonomy. Autonomy serves as an important principle rooted in the liberal Western tradition of individual freedom and choice, both for political life and for personal development. A person acts autonomously only if he/she acts (1) intentionally, (2) with understanding, and (3) without
controlling influences. Respect for a patient’s autonomy during the admission process plays a major role in whether the patient perceived his decision to be coerced or not.

A patient’s voluntary or involuntary legal status often does not correlate with the level of coercion perceived by the patient during the admission process. Frequently, patients with voluntary legal status experience coercion upon admission to the hospital. A significant percentage of legally “voluntary” patients experience coercion, and a significant percentage of legally “involuntary” patients believe that they freely chose to be hospitalized. Admitting physicians often threaten that if the patient does not sign the voluntary admission form and assent to the psychiatric hospitalization, then the admitting physician will involuntarily commit the patient against his will. As a result of such a threat, doctors and hospital staff communicate to the patient that involuntary admission will be bad for him/her and may likely result in a longer confinement. The MacArthur Coercion Studies indicate that in 49 percent of voluntary cases someone other than the patient initiated coming to the hospital, 44 percent attributed the idea to be admitted to someone else, and 39 percent believed that they would have been involuntarily committed if they had not “volunteered” to be hospitalized. Whereas with patients having the legal status of involuntary, 22 percent reported that it was their idea to come to the hospital for help, 20 percent say they had initiated the admission, and 35 percent did not perceive themselves as having been coerced into the hospital. This incongruence highlights a basic problem with the admission of “voluntary” patients to psychiatric hospitals.

The MacArthur Coercion Studies also measure the presence or absence of four different circumstances in which others may have influenced the decision about hospitalization (pressures). The pressures include: (1) persuasion (“Did anyone try to talk you into going to the hospital or being admitted”); (2) inducement (“Did anyone offer or promise you something”); (3)
threats (“Did anyone threaten you”); and (4) force (“Did anyone try to force you”).\textsuperscript{47} The studies showed that about half of the patients reported no pressures of any type (46 percent). However, 38 percent reported efforts to persuade them and 19 percent reported the use of force.\textsuperscript{48} Only 9 percent reported threats and only 4 percent an inducement.\textsuperscript{49} The studies then divided these pressures into “positive” pressures (those which sought to show that patients would be better off if they were admitted) and “negative” pressures (those which would indicate to patients that they would be worse off if they resisted admission).\textsuperscript{50} The positive pressures included persuasion and inducements, while the negative pressures comprised threats and force.\textsuperscript{51} The vast majority (89.5 percent) of people reporting that they had been subjected to negative pressures (threats and force) scored a 4 or 5 on a 0 to 5 scale of perceived coercion.\textsuperscript{52} Only 10.2 percent of patients who reported being subjected only to positive pressures (persuasion and inducements) felt they were similarly coerced.\textsuperscript{53} This reflects a portion not significantly different from that of people who reported no pressures at all (8.3 percent).\textsuperscript{54} The remaining 35 percent that scored a 4 to 5 on the perceived coercion scale reportedly experienced both positive and negative pressures.\textsuperscript{55} These findings illustrate that positive pressures do not appear to cause an increased level of perceived coercion, and seem to actually mitigate the effect of negative pressures.\textsuperscript{56} When negative pressures are applied alone, 89.5 percent of people reported feeling very coerced.\textsuperscript{57} However, when patients experience both positive and negative pressures, only about one-third (35.3 percent) reported feeling very coerced.\textsuperscript{58} Therefore, the utilization of positive pressures in the admission process can decrease the level of perceived coercion felt by the patient. But the question remains, do these positive pressures really negate overall coercion in the admission process, or are they simply friendlier forms of coercive acts to get patients to submit to what the doctor ultimately wants. If these
positive pressures operate to defeat decisional autonomy, then coercion results, compromising voluntariness in the admission process. Yet, if the focus centers solely on perceived coercion, then applying positive pressures may be a tool for doctors to use to gain informed, voluntary consent to hospitalization. The sacrifice of decisional autonomy seems to be the touchstone for achieving voluntary, informed consent. Coercion acts as a burden on decisional autonomy whether perceived or not. In evaluating the true voluntariness of consent, any type of coercion can effectively render such a decision involuntary. Thus, any coercion in the admission process ultimately defeats voluntariness.

The MacArthur Studies on Coercion also evaluated psychiatric patients’ perceptions of how they were treated by others during the hospital admission process.\textsuperscript{59} They termed this measure “procedural justice.”\textsuperscript{60} The researchers concluded that the coercion a patient experiences during hospital admission does not relate to his/her demographic characteristics.\textsuperscript{61} Rather, the amount of coercion a patient experiences strongly relates to a patient’s belief about the justice of the process by which he/she was admitted.\textsuperscript{62} A patient’s beliefs that others acted out of genuine concern, treated him/her respectfully, and afforded him/her a chance to tell his/her side of the story, are associated with low levels of experienced coercion.\textsuperscript{63} A physician can curtail the perception of coercion by simply validating a patient’s experiences and giving that patient a voice by respecting his/her decision-making autonomy and including him/her in the admission process. However, coercion in the admission process, whether perceived or not, ultimately defeats voluntariness. In this situation the issue becomes whether an admitting physician’s empathetic bedside manner merely hides coercion or if it actually eradicates it.

In the context of negotiating voluntary admission, as mentioned above, admitting physicians often resort to the threat of involuntary commitment when patients express resistance
to signing a voluntary consent form. Szasz explains that “voluntary mental hospitalization” truly operates as a type of involuntary mental hospitalization. He states that involuntary mental hospitalization results when a person feels forced to sign himself in as a voluntary patient under the threat of commitment. And, ultimately, once admitted to the hospital as a voluntary patient, he/she may not be able to freely leave the facility when desired.\(^64\) Such a scenario subjects a patient to “no-option” coercion.\(^65\) The *MacArthur Coercion Studies* refers to this as a lack of procedural justice.

This lack of procedural justice parallels the defense of duress in criminal law. Duress involves an unlawful threat that causes a defendant to reasonably believe that the only way to avoid imminent death or serious bodily injury is to engage in conduct that violates the criminal law.\(^66\) The rationale behind the duress defense suggests that the defendant should be excused when he/she “is the victim of a threat that a person of reasonable moral strength could not fairly be expected to resist.”\(^67\) By recognizing an excuse for a person who committed a crime in fear of death or serious bodily injury, the criminal law ratifies the similar idea that a person coerced or tricked into signing voluntary consent forms for admission to a hospital should not be classified under voluntary legal status.

For admission of a psychiatric patient to be truly voluntary, informed consent must be free from coercion, undue influence, and duress. Informed consent goes beyond autonomous authorization when given (1) with substantial understanding, (2) in substantial absence of control by others, (3) intentionally, and (4) authorizing a physician to admit the patient to a psychiatric hospital for treatment.\(^68\) For a more functional and complete understanding of informed consent, a policy-oriented concept of consent must be added to the notion of autonomous authorization. Under a policy-oriented approach to authorization, the consent must be obtained through
procedures that satisfy the rules and requirements defining a specific institutional practice in health care. This type of consent focuses on regulating the behavior of the consent-seeker (e.g., the admitting physician) and establishing procedures and rules for the context of consent. The policy-driven version of informed consent generally requires that authorization and consent take the form of rules focusing on disclosure, comprehension, the minimization of potentially controlling influences, and competence.

Understanding necessary for autonomous action requires informed consent. To achieve complete understanding of an action, a person must fully comprehend all of the relevant propositions (those that contribute in any way to obtaining an appreciation of the situation) that correctly describe (1) the nature of the action, and (2) the foreseeable consequences and possible outcomes that might follow as a result of performing and not performing the action. Without this understanding voluntary informed consent cannot be achieved. The concepts of autonomous authorization, effective consent, and understanding, inform the admitting physician’s recommended guidelines for admission found in the appendix of this paper.

THE CRIMINALIZATION & PUNISHMENT OF THE MENTALLY ILL THROUGH INPATIENT PSYCHIATRIC HOSPITALIZATIONS

A. Introduction

In the eyes of the law, confinement, regardless of how it is justified, is deprivation of liberty. It may be just or unjust, but it is loss of liberty. This is what makes coerced psychiatric “care” similar to law enforcement and punishment for crime, and different from medical care and treatment for disease. At the same time, the psychiatrist’s legally and socially validated claim that his coercion is treatment, not punishment, makes psychiatric coercion appear to be similar to health care and unlike imprisonment for crime.
Confinement and coercion give inpatient psychiatric hospitalization a controversial character similar to criminal punishment. This section discusses how the justifications for (criminal) punishment are also served by psychiatric “incarceration” and treatment; how inpatient hospitalization functions as a punishment for being mentally ill; and how psychiatric hospitalization operates according to an economy of suspended rights, similar to criminal punishment.

B. Psychiatric Hospitalization Serves the Justifications for Punishment

The five justifications for why we, as a society, punish, include: (1) retribution; (2) deterrence (general and specific); (3) incapacitation; (4) denunciation; and (5) rehabilitation. These justifications for punishment are usually thought of in relation to penal objectives in the criminal law. However, I argue that psychiatric inpatient hospitalization (confinement) operates as another type of incarceration that punishes in a similar way to that of criminal incarceration.

Retribution, in a justification sense, consists of the idea that a person deserves proportional punishment, but only as a penalty for a past crime. Moral retributivists agree that criminals deserve their punishment because they freely willed their past crime, but some also believe that pain and suffering in punishment should be imposed for the criminal’s sake, in effort to make him/her “whole” again. But pure retributivists reject any benefits ensuing from the criminal’s punishment, as the punishment operates neither for the criminal’s sake nor society’s. The thought here illustrates that a criminal deserves and society demands punishment regardless of benefit or lack thereof.

In regard to psychiatric hospitalization, we presume that incarceration or confinement to the hospital—the deprivation of liberty—acts as punishment. The “crime” amounts to the
precipitating event that leads the patient to the hospital. Often, this event will be a suicide attempt or a form of dangerous behavior, such as a person in a psychotic state jumping into a random car at a stop light and ordering the driver to drive (assumedly to escape his/her paranoid delusions). The patient is committed and confined to a psychiatric unit. Retributivism would support this act of confining or incarcerating a person because of their “bad” state of mind, which thereby led to their bad behavior. The comparison goes a step further in that the length of a person’s hospitalization may largely depend on the precipitating event that brought them to the hospital in the first place. This speaks to the proportionality of the “crime” to the “punishment.”

Additionally, the precipitating event that initially led the patient to the hospital affects the intensity of how uncomfortable his/her experience might be. Doctors and hospital staff may respond to the patient in a way that reflects their approval or disapproval of the precipitating event. For instance, a patient admitted to the hospital because he entered a stranger’s car, demanding her to drive to escape his delusions, may be treated with less sympathy and care as someone in the hospital because of a suicide attempt following a severe traumatic experience.

Society approves “locking these people up” because they deserve it since they committed the “crime” (whether the “crime” is a suicide attempt or dangerous psychotic behavior). The retributive idea that prison life should be tougher for serious felons and relatively more comfortable for less serious offenders rings true in the psychiatric sense as well. In psychiatric inpatient units there are levels of access or freedom that a patient can achieve through good behavior. By achieving a higher level a patient can gain perks like supervised grounds privileges. Patients whose precipitating event or “crime” was less serious usually achieve these levels faster. Also, similar to administrative segregation in prison, a psychiatric hospital may sentence an
unruly patient to seclusion in an empty room similar to a jail cell presumably until the patient ceases being unruly.

Defining the essence of deterrence, Cesare Beccaria said in 1764, “The purpose of punishment, therefore, is no other than to dissuade the criminal from doing fresh harm to his compatriots and to keep other people from doing the same.” Deterrence embodies the pressure of discouraging certain behavior by fear of punishment. Deterrence assumes that most people are rational calculating maximizers and as such they will conduct a cost benefit analysis, which will influence their behavioral decision-making. General deterrence prevents the public from doing a certain wrong because they have witnessed what happens to a person who has done such wrong (e.g., that he/she goes to jail). Specific deterrence acts as pressure on the actual person who has been punished. The prisoner, once released, carries with him painful memories of his prison experiences, which continues to haunt him, pressuring him to avoid criminality in the future.

Deterrence has a direct application to psychiatric confinement. Painful memories of the loss of liberty and autonomy deter the patient from engaging in the “wrong” activity that landed them in the hospital (like a suicide attempt). General deterrence results from discouraging society from engaging in “criminal” behavior (e.g., dangerous or suicidal behavior) because it could result in a person being incarcerated in a psychiatric hospital. On the other hand, like prison, a psychiatric hospitalization could lead to patients exchanging tips and ultimately learning more effective means to commit a suicide so that next time they are successful. While psychiatric confinement may be less viewable to the public eye than criminal punishment, when the patients leave the hospital and tell stories of their confinement people may take greater notice.

Incapacitation involves the removal of a person who has committed a criminal act from society to prison. Prison incapacitates by protecting society from the criminal. The
incapacitation achieved by imprisonment correlates to psychiatric confinement. Protecting the patient from himself and society operates as the key purpose of a psychiatric inpatient hospitalization—evidenced by making “dangerousness” a controlling factor in the admission stage of the hospitalization. Psychiatric confinement mirrors quarantine where patients are incarcerated for the greater good—to protect society.

Denunciation functions as a form of communal expression of disapproval of certain actions.\(^8\) In general, such an expression of disapproval acts as a deterrent, but the deterrent effect exists only secondarily to the expression.\(^4\) We disapprove of murder so we denounce it by making it a crime to commit such an act. Similarly, we disapprove of suicidal behavior so we denounce it by making it an offense, which leads to the punishment of psychiatric confinement.

“Rehabilitation—or reformation—essentially consists of the acquisition of attitudes, values, habits, and skills by which an ‘enlightened’ criminal comes to value himself as a member of society in which he can function productively and lawfully.”\(^8\) As applied to psychiatric confinement, rehabilitation perhaps once functioned as a key purpose of inpatient psychiatric hospitalization. During the age of institutionalization, prior to the civil rights movement, the goal of inpatient psychiatric care was to treat the actual mental illness instead of merely incapacitating a person for safety reasons. But even now after the deinstitutionalization movement, where temporary hospitalization focuses on incapacitating a person rather than treating him, psychiatric hospitals operate under the guise of treatment by incorporating minimal group therapy designed to “rehabilitate” the patient and prepare him for life outside of the hospital.

Similar to criminal incarceration, psychiatric incarceration through inpatient hospitalization serves all the justifications of punishment, which leads to the conclusion that
psychiatric confinement functions as a form of punishment. As such there has been widespread criminalization of the mentally ill.

C. Kansas v. Hendricks: What is Punishment

The Supreme Court in *Kansas v. Hendricks* found that “civil” commitment after imprisonment under the state’s sexually violent predator act does not amount to criminal punishment because it implicates neither of the two primary objectives of criminal punishment – retribution and deterrence. The Court found that the act’s purpose was not retributive because it did not affix culpability for prior criminal conduct and that such conduct was instead used solely for evidentiary purposes to demonstrate that a “mental abnormality” or mental illness existed or to support a finding of future dangerousness necessary for civil commitment. The Court found that the act did not function as a deterrent because the persons committed under the act are, by definition, suffering from a “mental abnormality” that prevents them from exercising adequate control over their behavior and as such, these persons are unlikely to be deterred by the threat of confinement.

While the Court finds that retribution and deterrence are not formal purposes of a civil commitment statute, this may not be the case functionally. Punishment may not be the primary purpose of psychiatric commitment, but it has become the de facto reality of inpatient psychiatric hospitalization. The culpability for previous criminal conduct may not be an explicit purpose of a civil commitment statute, but psychiatric confinement functions as to apportion blame on the patient for the precipitating event that brought him/her to the hospital. In fact, accepting responsibility for being confined in the hospital may be considered an integral step in the patient’s “treatment” plan, ultimately bringing him/her closer to discharge.
Further, the Court in *Hendricks* argues that deterrence cannot be achieved in civil commitment by assuming that the mentally ill cannot be deterred. While this may be true for sex offenders who suffer from volitional impairments with an inability to control their actions, it does not ring true for all mentally ill persons *per se*. Mental illness exists on a spectrum and to presume that all persons suffering from a mental illness cannot be deterred is sanism at best. Specific deterrence can be achieved among some patients when they are confined to a psychiatric hospital and deprived of basic personal liberties, such as the freedom to go outside or the freedom to shave in privacy. The unpleasantness of experiencing psychiatric hospitalization stays with them and likely affects their decisions and actions moving forward. Previously confined patients who share their stories with others who suffer from mental illness may achieve general deterrence as well.

While retribution and deterrence are not explicit purposes of civil commitment statutes, these justifications for punishment have become the de facto reality for those confined to a psychiatric hospital.

**D. Punishing the Status of Being Mentally Ill**

*Black’s Law Dictionary* defines a status crime as “a crime for which a person is guilty by being in a certain condition or of a specific character.” The criminal law operates to punish acts, as punishment for being of a particular status is unconstitutional under the Eighth Amendment of the Constitution. The common maxim in criminal law requires that “the evil doing mind must move the evil doing hand.” This implies that a culpable mental state (*mens rea*) must be present at the time the criminal act (*actus reus*).
In 1962 the Supreme Court held in *Robinson v. California* that imprisonment solely for the crime of being addicted to a narcotic violates the Eighth Amendment’s prohibition of cruel and unusual punishment. In *Robinson*, a California law made the status of narcotic addiction a criminal offense. The Court held that such a law violated the cruel and unusual punishment clause because addiction should be classified as an “illness” and California was attempting to punish people based on being in this state of illness, rather than for any specific act. Ultimately, *Robinson* prohibits criminalizing or penalizing any behavior not a product of free will.

By accepting the increasingly punitive character of psychiatric confinement, the issue becomes one of criminalizing the status of being mentally ill. Mental illness is just that, an illness. A person who chooses not to take his medication does not choose to be mentally ill, he continues to be mentally ill while medicated or unmedicated—the medication just helps manage the symptoms. Detaining a person in a psychiatric hospital for the “offense” (e.g., the precipitating event leading to hospitalization) is akin to punishing the patient for his mental illness. The solution to this blatant criminalization of the mentally ill requires reformulation of how we treat mental illness. As previously mentioned, psychiatric hospitals no longer operate under the sole guise of treating the patient. They have become holding cells for people until they can be safely discharged back into the community. Even medicating the patient functions in a way to stabilize him/her and procure speedy discharge. Requiring the least restrictive alternative to inpatient psychiatric hospitalization will likely result in more affordable outpatient community care. Such outpatient community care, where appropriate, will lessen the existing burden on the mental health system and provide consumers of mental health care with treatment tailored to their individual needs (as opposed to locking them up and merely observing them).
Both criminal punishment and psychiatric confinement represent an economy of suspended rights in effort to quell bad behavior. Similar to the perks of good behavior in prisons, psychiatric hospitals have a system of levels in place whereby each patient can attain more rights. For instance, when a patient achieves “level 3,” he/she may have supervised grounds privileges. Like administrative segregation in prison, a psychiatric hospital may sentence an unruly patient to seclusion in an empty room similar to a jail cell. By further suspending the patient’s right of movement, the hospital effectively punishes “bad” behavior. Finally, similar to prisons where inmates can get jobs inside as a reward for good behavior, inpatients can also attain employment working on the ward based on good behavior during confinement.
APPENDIX

Admitting physicians should follow the protocol below when making the decision to admit a patient voluntarily:

1. **Assess Capacity**
   a. Is the patient a minor or of legal age to give informed consent?
   b. Is the patient on any medications that might render consent invalid?
   c. Is the patient capable of communicating choice?
   d. Does the patient understand all the information relevant to inpatient hospitalization?
   e. Does the patient appreciate the nature of his/her situation and the likely consequences?
   f. Does the patient have the ability to evaluate information rationally?

2. **Ensure Understanding**
   a. Does the patient understand that he/she is making an application for admission to a hospital for the mentally ill?
   b. Does the patient understand that if admitted he/she will be an inpatient with restraints on his/her liberty of movement?
   c. Does the patient understand that he/she may request to leave the hospital at anytime and the hospital must release him/her within 72 hours or else start procedures for involuntary commitment?
   d. Does the patient understand that if he/she requests release, he/she may be denied and committed involuntarily?

3. **Do Not Threaten**
   a. Do not indicate that if the patient does not sign the voluntary consent form that you, the doctor, will commit him/her involuntarily.
   b. Do not threaten that any legal action will be brought against the patient if he/she does not consent to inpatient hospitalization.
   c. Do not inform the patient that anything bad will happen to him/her as a result of not giving voluntary consent for hospitalization.

4. **Describe Risks and Benefits of Voluntary Hospitalization**
   a. What are the inherent risks of inpatient psychiatric hospitalization? Might the loss of autonomy make his/her condition worse?
   b. What are the inherent benefits of inpatient psychiatric hospitalization? Might the incapacitation help to keep the patient safe from harming himself/herself or others?

5. **Describe Alternatives to Hospitalization (Including Risks and Benefits)**
   a. Is outpatient care a realistic alternative to inpatient hospitalization?
      i. Partial hospitalization programs?
      ii. Intensive outpatient programs?
   b. Does the community where you are located have outpatient programs? Are there any openings in these programs?
   c. What are the risks and benefits of outpatient treatment versus inpatient “treatment”?
      i. Do outpatient programs provide enough safety planning to prevent suicide or harm to others?
      ii. Do outpatient programs preserve patient dignity and autonomy in a more meaningful way than inpatient hospitalization?

Id.

1. Id.

2. Id.

3. Id.


5. N.Y. MENTAL HYG. LAW § 9.17 (a) (McKinney 2011).


8. Stone, *supra* note 1, at 27 (discussing the preference for voluntary psychiatric treatment).

9. Id. at 28.

10. Id. at 43.

11. N.Y. MENTAL HYG. LAW § 9.17 (a) (McKinney 2011).


13. Id. at 165.

14. Id.


16. Id.


18. Id.

19. Halverson, *supra* note 12, at 166 (discussing the position that involuntary commitment is necessary to protect rights).


21. Id.


23. Id.

24. Id.


27. N.Y. MENTAL HYG. LAW § 9.17 (a) (McKinney 2011).


29. Id.

30. Id. at 110.

31. N.Y. MENTAL HYG. LAW § 9.17 (a) (McKinney 2011).

32. Appelbaum & Grisso, *supra* note 28, at 110 (discussing the legal standards for competence of the mentally ill to consent to treatment).

33. Id.

34. Id.


39. Id. at 1149.

40. Id. at 1160.

41. FADEN & BEAUCHAMP, *supra* note 37, at 7.
42 Id. at 238.
44 Id. at 18.
45 Id.
46 Id. at 17.
47 Id.
48 Id. at 18.
49 Id.
50 Id. at 19-20.
51 Id. at 20.
52 Id. at 21.
53 Id. at 21-22.
54 Id. at 22.
55 Id. at 21.
56 Id. at 22.
57 Id.
58 Id.
59 Id. at 16.
60 Id.
61 Id. at 26.
62 Id. at 26-27.
63 Id. at 27.
64 Thomas S. Szasz, Voluntary Mental Hospitalization: An Unacknowledged Practice of Medical Fraud, 287 NEW ENG. J. MED. 277, 277 (1972) (discussing the involuntary nature of “voluntary” admission to a mental hospital).
65 RESEARCH IN COMMUNITY AND MENTAL HEALTH, supra note 43, at 84.
67 Id.
68 FADEN & BEAUCHAMP, supra note 37, at 278.
69 Id. at 280.
70 Id.
71 Id. at 282.
72 Id. at 252.
75 Id. at 1167.
76 Id. at 1167-68.
77 Id. at 1170.
78 Id. at 1174.
79 Id.
80 Id. at 1192.
81 Id. at 1187.
82 Id.
83 Id. at 1235.
84 Id.
85 Id. at 1197.
87 Id. at 362.
88 Id.
89 BLACKS LAW DICTIONARY 320 (8th ed. 2005).
91 Id.