Ethics and Boundaries: Legal and Professional Standards in Mental Health
Pt 1

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Disclosure

- Dr. Mays is not on any drug advisory boards, paid for doing drug research, or otherwise employed, funded, or consciously influenced by the pharmaceutical industry or any other corporate entity.
- No off label uses of medications will be discussed unless mentioned in the handout and by the presenter.
- No funny business.

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A Brief Review of Ethical Decision Making…

- Link to video:
- https://youtu.be/F2tjrl04wGY

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Agenda

- This workshop will explore how the law and professional standards relate to each other around certain areas of professional conduct. These areas are:
  - Informed consent
    - Right to refuse treatment
  - Civil Commitment
    - History and Wisconsin Standards
    - Delusion-like beliefs
  - Informed consent for psychotherapy

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Legal History of Consent

- The concept of informed consent began as a way for physicians to protect themselves from charges of battery by their patients. (Battery is a legal term meaning harmful or offensive contact of one person to another. It is concerned with the right to have one's body left alone by others.) Prior to 1957, it was generally accepted that consent was implied by virtue of simply going to a doctor's office, giving a history, submitting to an examination.

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Informed Consent

- A number of social forces shape our attitudes toward informed consent:
  - ethical conflict between paternalism and patient autonomy
  - the Nuremberg Code for research
  - medical consumerism
  - civil rights

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Case Law

- **Salgo v. Leland Stanford, Jr. Univ. Board of Trustees (1957), CA**: A patient with a spinal cord injury secondary to lumbar aortography claimed that he had not been informed of the risks of the procedure. The court ruled physicians would be liable if they withhold facts that are "necessary to form the basis of intelligent consent."
- **Natanson v. Klein (1960), KS**: A female patient claimed to have been inadequately informed of the risks of radiation treatment after a mastectomy, during which she received radiation burns. The amount of information disclosed was defined as that which a "reasonable medical practitioner" would disclose under similar medical circumstances

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Case Law

- **Canterbury v. Spence (1972)**: Washington DC: Jerry Canterbury was a young man with back pain who eventually saw Dr. Spence, a neurosurgeon for treatment. Dr. Spence told Mr. Canterbury's mother that the degree of seriousness of a laminectomy was "not any more than any other operation." While recovering from the surgery on the first day, despite orders to stay in bed, Canterbury got up to use a bedpan, slipped and fell to the floor. Shortly thereafter he became paralyzed from the waist down. He sued, claiming that Dr. Spence had not informed him of the risks of the operation. The Court of Appeals held that Dr. Spence did not reveal the risk of paralysis from the operation, even though it was slight. The scope of the doctors' communications to the patient should depend on the patient's need for information – what a "reasonable person" would find material to clinical decision making.

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Wisconsin Case Law

- Jandre v. Wisconsin Injured Patients and Families Compensation Fund (2012), WI
- The question for the court was whether a physician who had been found not negligent in treatment could be found negligent for failing to inform the patient of the availability of alternative, diagnostic tests that could lead to other diagnoses. (The diagnosis was Bell's Palsy. The patient subsequently had a stroke.) The three justice majority applied a "reasonable patient standard" and found that the physician could be held liable for the failure to inform.

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Response to Jandre

- The concern was that physicians would need to order tests for conditions that they did not believe the patient had, if the patient learned about them and insisted on them. As a response, the Wisconsin legislature revised Wis Stat 448.30. This statute sets a new "reasonable practitioner" standard rather than the old "reasonable patient" standard.

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Wis Stat 448.30

- "Any physician who treats a patient shall inform the patient about the availability of reasonable alternate medical modes of treatment and about the benefits and risks of these treatments. The reasonable physician standard is the standard for informing a patient under this section. **The reasonable physician standard requires disclosure only of information that a reasonable physician in the same or similar medical specialty would know and disclose under the circumstances."**

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Introduction

- It is sometimes difficult for health care providers to appreciate that our society gives primary recognition to an individual's right to choose what is done to his body, even if the choice results in death.
- The notion that an institutionalized mentally disabled person has a right to refuse treatment is one of the most controversial issues in psychiatry, often pitting the mental health profession against the legal profession.

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Historical Perspective

- 1850 - 1960: *Parens patriae* model - the state acts as a benevolent parent. If you are involuntarily committed for a mental illness, you will be treated for that illness.
- 1960 - 2003: Criminal rights/police power model - the state has a right to confine an individual based on "dangerousness." In addition, citizens need protection from those who would violate their rights. The state provides this protection through "due process" procedures.

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Historical Perspective

- In the criminal rights model, the only acceptable rationale for depriving someone of his liberty is if he presents a danger to himself or others. The state has no "interest" in treating someone against his will as long as he is not dangerous.

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Competencies

- Concurrent with the evolution of the "criminal rights" model, growth of community mental health treatment, and the need for mental health clients to be able to sign leases and other contracts, created a need to "debundle" various competencies from one another, e.g. a client might be competent to sign a lease but not able to manage his funds. "Global incompetence" became less common and desirable.

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Preparing the Ground

- These two trends - a movement away from a *parens patriae* model and the notion of global incompetence, as well as issues with psychotropic medication, the growth of legal activism and individual rights, the popularized writings of Szasz and Laing, and a general distrust of institutions, prepared the ground for the court cases concerning the right to refuse treatment.

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Medical Cases of Treatment Refusal

- **App. Of the Pres. and Dir. of Georgetown (1964):** 25 year old mother, Jessie Jones, a Jehovah's Witness, lost 2/3 of her blood due to an ulcer. Her husband refused the blood transfusion. Judge Wright visited the hospital, determined that her place in Heaven would be assured if he ordered the transfusion, which he did. The family sued and lost.
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- **Cruzan v. Director, Missouri DMH (1990):** A young woman was in a persistent vegetative state for 7 years following a car accident. Caretakers wanted to withdraw the treatment. The Supreme Court said that Louisiana could require that there be a clear statement of preference from the patient of a desire that treatment be terminated.

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The Psychiatric Wrinkle

- Legal competence to refuse lifesaving treatment is presumed - the physician must prove otherwise. But in psychiatric settings, a desire to die is considered *prima facie* evidence of a mental disorder, providing justification for treatment.
- Nationally, we have developed a consensus that patients may reasonably refuse treatments that can only keep them alive, not restore them to health. The courts have even recognized treatment refusals in patients who were incurable but not near death (ALS, quadriplegia.) These refusals are not framed as suicide.

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Suicide vs. Letting Nature Take Its Course

- These decisions are characterized as "letting nature take its course." This right has not been extended to psychiatric patients, even in those who cannot be treated to health. In psychiatric cases, the burden of proof shifts to the patient to prove he is competent.

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Some Definitions (Am Med Assoc)

- Euthanasia: the administration of a lethal agent by another person for the purpose of relieving intolerable and incurable suffering. Where legally permitted (Netherlands, Belgium, Colombia, Luxemburg), it follows strict guidelines and requires informed consent)
- Physician assisted suicide: the physician facilitates a patient's death by providing the means or information for the patient to perform the life-ending act, e.g. prescribes medicines for an overdose. (It is illegal and unethical in the US for a physician to administer the means of death, e.g. give a lethal injection.) Assisted suicide is legal in Switzerland, Germany, Japan, Canada, and the US states of Washington, Oregon, Colorado, Vermont, Montana, Wash DC, and California.

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Some Definitions

- Withholding or withdrawing life-sustaining treatment: the disease causes the death (mechanical ventilation, renal dialysis, artificial nutrition and hydration.) Not considered euthanasia by AMA.
- Terminal sedation: high doses of sedatives are given to render the patient unconscious in order to relieve suffering until the patient dies from the disease.
- Principle of double effect: distinguishes between the intention with which an action is performed and the consequences it produces. (It is logically hard to defend, but explains which behaviors people generally believe are permissible and which are not.)

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Physician-Assisted Death: History

- 1991: Dr. Jack Kevorkian has his license revoked in MI
- 1991: Dr. Timothy Quill article in the New England Journal of Medicine concerning providing a lethal dose of barbiturate to a 45 year-old leukemia patient.
- 1997: The US Supreme Court found a New York state ban on physician assisted suicide constitutional. States have a legitimate interest in preventing suicide and there is "no constitutional right to die."
- 1997: Oregon becomes the first state to legalize Physician Assisted Death (The Death With Dignity Act) The law specifies the patient must be terminal and prohibits euthanasia. As of 202 more than 2,500 people have received prescriptions and 1,657 people have died from ingesting the medications. 75% had cancer, followed by neurological disease (11%) and respiratory disease (6%).

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Physician-Assisted Death: History

- 2008: Washington becomes the second state to legalize PAD. Since then Vermont (2013), California (2015), Colorado (2016), Dist of Col (2017), Hawaii (2018), New Jersey (2019), and Maine (2019) have legalized PAD. In 2009 a state Supreme Court ruling in Montana legalized PAD in that state.
- 2019: The American Medical Association holds that PAD is fundamentally incompatible with the physician's role as a healer." This view is not shared by other medical societies (e.g. The American Public Health Association.)

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Physician Assisted Death (PAD

- All US jurisdiction require an oral and written request for the prescription and a subsequent reiteration of the oral request. The written request must be signed and dated by the patient and witnessed by 2 individuals attesting that to the best of their knowledge the patient is capable, acting voluntarily, and not acting under coercion.
- A terminal illness is incurable and irreversible and will probably result in death within six months. The attending physician makes this decision and a consulting physician must affirm it.
- All jurisdictions require the attending physician and a consulting physician to attest that the patient is competent.

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Physician Assisted Death

(*Psych News* May 18, 2018)

- Data suggest that the actual practice of PAD is very difficult to maneuver by terminally ill patients and only a small number end up qualifying. Many who do qualify end up not taking the medication. Patients who qualify for PAD are not looking forward to dying, but rather want to feel that they can control the timing and manner of death.
- Most opposition to PAD comes from people who are concerned that the law may become more lenient – the slippery slope – rather than objections to the law as it now stands.
- 218 patients died by PAD in 2017. 80% were older than 65. 77% had cancer, 7% had ALS. 90% died at home, 91% were in hospice care. The most reported end of life concerns were inability to participate in meaningful activities, loss of autonomy, and loss of dignity.

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Physician Assisted Death and Mental Illness

- Presently (2017), six states and Washington DC allow physician-assisted death for people with terminal illnesses (death within 6 months.) Several countries allow physician-assisted death for patients with significant and intractable suffering, even if the illness is not terminal. These broader criteria have opened the door for people with mental disorders to ask for this intervention.
- Belgium and the Netherlands allow euthanasia for people with mental illnesses. According to recent statistics from Belgium, of the 2,000 euthanasia deaths every year, 40 are psychiatric patients. One clinic may be responsible for up to 40% of these.

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The Mental Health Dilemma

- Recently, Canada has considered whether to allow physician-assisted death in the case of significant suffering in a non-terminal illness. When the interpretation of the law was broadened to allow competent adults to seek physician-assisted death, one person with solely a mental illness chose to die. The legislature re-examined the issue and at this point, the legal issues are unresolved. The problem is balancing the finality of death with the often transient nature of mental illnesses.

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The Arguments

- Some psychiatric conditions cause intense distress and are unresponsive to treatment. 20% of depression is considered treatment resistant, for instance. However, in many studies, treatment resistance often improves when a systematic approach to treatment is taken.
- Furthermore, demoralization and hopelessness are often symptoms of the mental disorder itself, leading to a rejection of treatment options and a desire to die. Determining competence in such cases is difficult. Clinicians report many examples of people who very rationally refuse treatment and express a wish to die, only to change their minds, once the depression has lifted.

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The Arguments

- Given that many people in the United States have limited access to good mental health care, it is possible that more patients would have access to medical assistance in dying than in medical assistance for treating their mental illness. What impact might the fact that mental health systems are often overwhelmed with clients, and family members are similarly overwhelmed and burned out with persistently mentally ill family members, have on these types of decisions?
- The American Psychiatric Association has adopted a statement opposing physician-assisted death for psychiatric patients.
- It is worth noting that in countries that allow psychiatric patients to seek death, the number of patient deaths is increasing yearly.

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Different Points of View

- Research shows that non-psychiatric physicians tend to underestimate a patient's quality of life and desire for treatment. On the other hand, psychiatrists tend to over-diagnose incompetence due to depression in treatment refusal situations.

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The Consensus

- When hopelessness and helplessness are not present, or not clearly of psychological origin, it is important to be capable of validating a patient's wish to die.
- When depression clouds competence, it is important to consult advance directives and other past information, as well as treat the depression. Optimal medical and psychiatric treatment should be given before the right to refuse treatment is accepted.

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The Courts' Point of View

- The courts regard psychotropic medication as a special kind of treatment because:
  - slanted view of side effects
  - potential for limiting personal thought
  - misuse for staff convenience
  - use for control and punishment

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The Mental Health Point of View

- Mental health professionals are concerned that if their ability to prescribe is restricted:
  - the most effective treatment will not be provided
  - hospitalizations will be prolonged and custodial in nature
  - seclusion and restraint will increase
  - inpatient violence will increase
  - resources will be diverted to the courts

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The Constitutional Basis of Refusal: freedom of religion/thought

The courts have held that freedom of religion is one of the most important guarantees of the Constitution. This has been upheld even if the person is incompetent.

- **Winters v. Miller (1971):** New York - First suit involving a mentally ill person's right to refuse medication. A 59 year old long time Christian Scientist, admitted to Bellevue Hospital in 1968, refused blood pressure and medication. She was given IM medication. The Court said that she could not be given medication because she had not been found legally incompetent.

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The Constitutional Basis of Refusal:

Liberty interests – right to privacy and freedom from bodily intrusion

- **Rennie v. Klein (1983):** New Jersey –In December 1977, John Rennie, a committed mental patient at Ancora Psychiatric Hospital in New Jersey, with a long history of involuntary hospitalizations and a diagnosis of schizophrenia and bipolar disorder, filed suit alleging that the hospital's practice of forcibly medicating him with psychotropic drugs in the absence of an emergency was unconstitutional. The District Court held that only when the government shows some strong countervailing interest can the right to refuse treatment be qualified. The District Court set up an elaborate scheme for protecting the patient, including a special review panel - a very "doctor friendly" decision. The Supreme Court eventually heard the case, and remanded it back to the Court of Appeals based on:
- **Youngberg v. Romeo** (1983). "…whenever, in the exercise of professional judgment, such an action is necessary to prevent the patient from endangering himself or others" medication may be forced on a dangerous mentally ill client.

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The Rogers Cases

- Rogers v. Okin (1983) MA
- Mills v. Rogers (1982)
- Guardianship of Richard Roe III (1981) MA
- Rogers v. Commissioner of the Department of Mental Health (1983)

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The Rogers Cases

- **Rogers v. Okin (1983):** Massachusetts – Began as a class action suit on behalf of patients at Boston State Hospital who were receiving forced medication over their objections in non-emergency situations. The Court of Appeals said "a person has a constitutionally protected interest in being left free by the state to decide for himself whether to submit to the serious and potentially harmful medical treatment that is represented by the administration of antipsychotic drugs." In emergency situations (imminent threat of harm with no less intrusive alternative available) medication may be given once. Otherwise, the court must determine and respect competency.
- **Rogers** went to the Supreme Court as:
- **Mills v. Rogers (1982)**, but Massachusetts Supreme Court had just decided
- **Guardianship of Richard Roe III (1981)** MA: in which a noninstitutionalized patient was found to be incompetent and his father appointed guardian. The father sought authority to consent to the forcible administration of antipsychotic medication. This was denied, except in the case of an emergency.

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The Rogers Cases

- A judge, not a guardian, must exercise "The substituted judgment" of an incompetent. Only an overwhelming state interest would call for a judge to go against what the patient would have wanted. The court must look at:
- 1) the expressed preference of the patient regarding treatment
- 2) the patient's religious beliefs
- 3) the impact on the patient's family
- 4) the side effects of treatment
- 5) the prognosis without treatment
- 6) the prognosis with treatment.
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The Rogers Cases

- **Rogers** was sent back to Massachusetts in light of this decision. The case was returned as:
- **Rogers v. Commissioner of the Department of Mental Health (1983):** A committed patient is competent until judicially found incompetent. Forced medication violates the patients' right to free speech and free formation of ideas - even psychotic ones. (Treatment is allowed in an emergency.) When the patient is found incompetent, the judge uses substituted judgment. This is essentially the "one punch=one shot rule." ($8,100,000 in the first year - all to attorneys - none to patient care.)

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Other Cases

- **Perry v. Louisiana (1991):** LA – The Supreme Court was asked whether a death row prisoner had the right to refuse antipsychotic medicine that would render him competent to be executed. The Supreme Court remanded the case back to Louisiana, who held that State law would forbid such treatment.
- **Riggins v. Nevada (1992):** NV – Murderer claimed he heard voices, wanted to stop Mellaril during his trial to show his unmedicated state. Lower court refused, he was convicted and appealed. The US Supreme Court supported the right of a defendant pleading insanity to refuse antipsychotic drugs during his trial.

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Wisconsin Law

- Until 1972, the civil commitment of mentally ill individuals was legally simple: a person needed to be mentally ill and "appropriate" for inpatient care. In Wisconsin, "appropriate" meant that the person was a proper subject for custody and treatment. This was a determination base on a subjective opinion of a psychiatrist. In practice, having a mental illness was enough to support a commitment. In emergencies, a mentally ill person could be held for 5 – 145 days before any sort of hearing.

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From the Milwaukee Journal Sentinel Obituary, 4/26/2015

- Lessard was born in Ingram, Wis., the daughter of a lumberjack and a midwife. She moved to West Allis in the early 1950s and taught first grade. But the school district fired her several years later when she refused to teach what she considered to be an inferior reading program.
- Later, she was fired from Marquette University for mismanaging a reading-instruction program for education majors. She sued and was offered compensation, but Lessard refused to accept money, saying she wanted her job back and an apology.
- She became obsessed and began calling Marquette sometimes hundreds of times a day, insisting that officials rehire her. The university called the police to try to get her to stop. When the West Allis police arrived at her apartment, Lessard imagined that they were "goons" from President Richard Nixon's administration coming to kill her, and she fled out her bedroom window, dangling from the sill.

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Wisconsin Law

- **Lessard v. Schmidt (1972):** Alberta Lessard was taken in to custody in front of her residence in West Allis, WI, and taken to a mental health center. Judge Seraphim issued an order permitting the confinement of Miss Lessard for an additional ten days. Thereafter, on November 4, 1971, Dr. George Currier filed an "Application for Judicial Inquiry" with Judge Seraphim, stating that Miss Lessard was suffering from schizophrenia and recommending permanent commitment.

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The Case

- At this time Judge Seraphim ordered two physicians to examine Miss Lessard, and signed a second temporary detention document, permitting Miss Lessard's detention for ten more days from the date of the order. This period was again extended on November 12, 1971. Neither Miss Lessard nor anyone who might act on her behalf was informed of any of these proceedings. Judge Seraphim signed an order appointing Daniel A. Noonan, an attorney, as guardian *ad litem* for Miss Lessard. Miss Lessard, on her own initiative, retained counsel through the Milwaukee Legal Services.

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The Case

- At the November 24 hearing before Judge Seraphim, testimony was given by one of the police officers and three physicians and Miss Lessard was ordered committed for thirty additional days. Judge Seraphim gave no reasons for his order except to state that he found Miss Lessard to be "mentally ill."

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The Lawsuit

- Lessard claimed that Wisconsin denied her due process of law in the following respects: in permitting involuntary detention for a possible maximum period of 145 days without benefit of hearing on the necessity of detention; in failing to make notice of all hearings mandatory; in failing to give adequate and timely notice where notice is given; in failing to provide for mandatory notice of right to trial by jury; in failing to give a right to counsel or appointment of counsel at a meaningful time; in failing to permit counsel to be present at psychiatric interviews; in failing to provide for exclusion of hearsay evidence and for the privilege against self-incrimination;

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The Lawsuit (cont)

- (Wisconsin denied due process) in failing to provide access to an independent psychiatric examination by a physician of the allegedly mentally ill person's choice; in permitting commitment of a person without a determination that the person is in need of commitment beyond a reasonable doubt; and in failing to describe the standard for commitment so that persons may be able to ascertain the standard of conduct under which they may be detained with reasonable certainty.

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What Does the Supreme Court Say?

- The United States Supreme Court requires only that an individual be mentally ill and dangerous in order to be committed. The states are to determine what dangerous means.

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The Wisconsin Finding

- The court held that the Wisconsin civil commitment procedures did not provide adequate due process rights to those who were committed and ordered numerous safeguards be instituted, including adequate notice, the right to counsel, availability of the privilege against self-incrimination, and a speedy hearing.
- The court held that only a compelling state interest (interpreted as dangerousness) could justify the denial of fundamental liberty.

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The 1976 Wisconsin Mental Health Act

- In addition to procedural changes, this act specified 3 standards of dangerousness that could lead to civil commitment:
- 1) **Self-Injury**: recent threats, attempts at suicide, serious bodily harm
- 2) Substantial probability of physical **harm to others**: recent overt act of violence
- 3) **Impaired judgment**: recent acts or omissions that demonstrated a **substantial probability of physical impairment or injury to self** (walking around barefoot in a blizzard)

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The 1980 Amendment

- The Wisconsin legislature added a Fourth Standard of dangerousness, referred to as the "grave disability" provision. This states that a person may be committed if they are **unable to satisfy their basic needs** of nourishment or self-care, and without treatment of the mental illness, the person faces a substantial probability of death.
- There is some overlap with the 3rd standard of impaired judgment. In practice, this provision allowed for the continuing commitment of people who were not in danger while treated, or confined, but would become unable to take are of themselves if treatment were stopped.

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The 1995 Amendment: The 5th Standard

The Wisconsin legislature added a 5th Standard of Dangerousness for civil commitment: if, due to a mental illness, a person is unable to understand the advantages, disadvantages, or alternatives to a particular treatment (**incompetent**), or is unable or unwilling to apply them to his situation, **and requires such treatment to prevent severe mental, emotional, or physical harm, and will not be able to function independently in the community or will lose cognitive control.**

The statute does not require the person pose a substantial and direct risk of harm, nor does it rely on grave disability.

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The 5th Standard

This standard focuses on whether the individual has a history of similar symptoms as measured by at least one previous civil commitment.

It widens the definition of "dangerousness."

It is geared toward prevention.

It is the first standard that links involuntary hospitalization to mandatory treatment.

It provides help to those who have fallen through the cracks.

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5th Standard Challenge

- **State v. Dennis H (2002):** Dennis H's father, a psychiatrist, filed a 3-party petition in Milwaukee County Court to have his son committed. Dennis was diagnosed with schizophrenia and was refusing to take his medication. In the past this had led him to be hospitalized for renal failure secondary to rapid weight loss and dehydration. The petition stated that Dennis was dangerous under the Fifth Standard.
- Dennis argued that the 5th Standard was unconstitutionally vague, was overbroad, and violated his right to equal protection and due process (the Lessard argument.)

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The Wisconsin Supreme Court

- The Wisconsin Supreme Court upheld the statute. While Dennis claimed that the standard was simply a restatement of what a mental illness is, the court opined that the standard required a heightened degree of impairment than just having a mental illness. The court further stated that the standard is met only when individuals have a mental illness, they are incapable of making treatment decisions, and there is substantial probability that they will need treatment to prevent further disability, including being unable to obtain services, and they will suffer severe mental emotional, or physical harm.
- The standard does not apply if there services in the community and the person would avail themselves of the services.

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The Wisconsin Supreme Court

- The court showed a willingness to accept the 5th Standard definition of dangerousness: the effects that severe and persistent mental illness have on a person's ability to live independently and make informed treatment decisions.
- The court rejected the Lessard reasoning that dangerousness includes only behavior that upsets the public, directly involves police intervention, or is life threatening. The court indicated that the distinction between emotional harm and physical harm is not important if the results are behaviors that lead directly to a person's inability to survive in the community.

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Wisconsin Commitment Law

- be a danger to self/others as evidenced by recent acts/threats;
- be substantially probable to have physical impairment/injury to self as evidenced by recent acts/omissions;
- be unable to satisfy basic needs for nourishment, medical care, shelter or safety so that substantial probability of imminent death, serious physical injury, serious physical debilitation or serious physical disease; (Fourth Standard)
- or
- be substantially unable to make informed treatment choice, needs care or treatment to prevent deterioration, and
- be substantially probable that if untreated will lack services for health or safety and suffer severe mental, emotional or physical harm that will result in the loss of ability to function in community or loss of cognitive or volitional control over thoughts or actions (Fifth Standard)

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Wisconsin Law

- **Roberta S. v. Waukesha (1992):** A guardian lacks authority to forcibly detain a ward or enter premises or give medication. This must be done under a commitment law, after a finding of dangerousness. This stopped the use of medical guardianship for the purposes of involuntary treatment.
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- **Stensvad v. Reivitz et. al. (1985):** the court of Wisconsin held that there was a right to refuse treatment, but it could be overcome by legitimate state interest as long as professional judgment was exercised. "Civil commitment is for custody, care and treatment, and …that nonconsensual treatment is what involuntary commitment is all about."
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Wisconsin Law

- **Enis v. Dept. of Health and Social Services (1996):** WI Bob Enis was found NGRI for murder, diagnosed with psychotic Disorder, NOS. He contended that the State could not override his choice to refuse antipsychotic medication, even if he were found to be incompetent, unless he was also a danger to himself or others. The court agreed that his liberty interests were violated by forced administration of medications without a finding of dangerousness, and that his equal protection rights were violated unless he is granted the same mechanism for reviewing medications as is afforded civilly committed patients. In other words, the same rights granted **Harper**, were granted to incompetent patients. No involuntary treatment unless there is dangerousness. Adequate protection made be provided by the existence of a medical review board.

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Summary

- Both involuntary and voluntary patients have a right to refuse treatment.
- Both competent and incompetent patients are allowed due process hearings regarding their right to refuse treatment.
- There are three relevant models:
  - psychiatric or advisory committee decision maker
  - substituted judgement (court appointed)
  - competency and commitment are bundled together

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Summary

- For all practical purposes the right to refuse treatment has become the right to object and have the treatment decision reviewed. When judges are asked to think like physicians, they act like physicians.
- 25-50% of inpatients will refuse medication at some time. These refusals will be based on delusions, side effects, or anger at the doctor/healthcare system.
- Research shows, the less formal the process, the more likely the patient will get what he wants.

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Special Cases

- Electroconvulsive therapy: courts are very reluctant to approve this without the patient's consent
- Seclusion and Restraint: contentious
- Behavior Modification: is behavior modification treatment? (think of a level system on a psychiatric unit)
- Psychosurgery

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Summary

- Drugs that are given in an emergency can be given for as long as the emergency exists, but not an entire hospitalization.
- Mentally ill patients probably do not have the right to refuse blood work or a PE. Competent, voluntary patients can refuse. More invasive procedures should involve the court.
- There is no law that requires a hospital to keep a voluntary patient who is refusing treatment.

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Summary

- The right to refuse treatment does not include the right to choose your caregiver in a public institution. Psychiatric assessment and treatment must be acceptable, not ideal.

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Components of Informed Consent

- Information: how much is enough?
- Voluntariness (very difficult to measure)
- Competence
  - Choosing
  - Understanding
  - Reasoning
  - Appreciating

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Exceptions to Informed Consent

- Emergencies (implied consent)
- Therapeutic Privilege (it is in the patient's best interest to forego the normal consent procedure)
- Waiver (consent belongs to the patient and he/she may give it up)
- Incompetence (need for a substitute decision maker)

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Consent for Psychotherapy

- Psychoanalysts resisted informed consent for therapy because they believed that talking about the process of the therapy would interfere with the transference. Later, psychotherapists claimed that the nature of their treatment was such common knowledge in the culture that there was nothing new to say, and in any case, there were no risks that could be identified for the patient. As for alternatives, it was assumed that the patient had already considered those before seeing the therapist.

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Consent for Psychotherapy

- The first court case was **Osheroff v. Chestnut Lodge (1982)**, in which a physician was hospitalized at Chestnut Lodge in Rockville Maryland for depression, and treated with a psychoanalytic approach only, without antidepressants, without result, for many months. This case was settled out of court.

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Consent for Psychotherapy

- Consent for psychotherapy is essential not just ethically, but also clinically. Clients who are involved in the planning and direction of therapy have a better outcome than those who don't.

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Guidelines for Therapy

- Be clear about the difference between historical truth (what actually happened) and narrative truth (what the client experienced as happening.)
- Adhere to the ethical duty of neutrality – the obligation to avoid intruding on the client's life or beliefs or values.
- Document and consult.
- Do not use hypnosis and sodium amytal in therapy if litigation is a possible outcome.

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Treater Versus Expert

- The role of treater versus expert witness is clinically and ethically incompatible.
- The clinician's duty to do no harm may be in jeopardy if the clinician is testifying in an adversarial setting like a courtroom.
- The treater's willingness to accept the client's point of view as true is in conflict with the expert's need to investigate

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Consent for Psychotherapy

- Therapists may assume that most patients seeking treatment are familiar with the basic goals of and practices involved in psychotherapy. This is not necessarily the case.
- Keep in mind that the capacity to consent is not all or none, but a continuum. It is not based on diagnosis, and it is not static.
- Patients in crisis may need to stabilize before the informed consent conversation makes sense. Also, it may not be clear how much treatment the managed care company is going to support until several weeks into the therapy.

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Informed Consent in Mental Health

- Your clinic probably requires your clients to sign a consent form before they even enter your office. These documents are designed to release the clinic from legal liability. You should still have the conversation about informed consent.
- Information includes:
  - Appointment schedule, fees
  - Length of sessions, treatment duration
  - Treatment objectives
  - Therapeutic techniques
  - Confidentiality/ third parties (reminders should be given in session)

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Informed Consent in Mental Health

- Err on the side of over-disclosing.
- Informed consent is an ongoing process.
- Document all conversations about consent. Consent is best documented not by a signed form, but by a progress note.
- A competent patient has the right to accept all, part, or none of the treatment offered.

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