has appeared in public at an increasing rate over the last century in galleries, media, and publications. Some see this as positive, and that this can be an avenue for individuals to reintegrate into society; however, others view this as an avenue to emphasize the difference between those who have mental illness and the general public, adding to the stereotype of the “mad artist.”

Early experiences with the art of the mentally ill included use of their art for diagnostic or interpretative purposes. In the 20th century, exhibits of such work began to appear, labeled as “outsider art” or “schizophrenic art.” Some of the largest collections of art created by those who had mental illness are unattributed work by hospitalized patients who were killed by the Nazi regime. However, many modern artists who experience mental illness join cooperative ventures that combat stigma and are in line with a recovery orientation, providing people opportunities for empowerment, emotional expression, social inclusion, and personal agency as they add to the culture of visual arts.

Visual arts are also used in modern therapeutic environments, and many modalities of psychiatric treatment include some version of art therapy. A new therapeutic movement includes the use of art designed to focus on the therapeutic relationship and the process of art creation and communication. These art programs are designed as part of psychosocial rehabilitation, and those participating in these programs have indicated that involvement has had a positive effect on their recovery. Research indicates that involvement with creative expression can be useful, increasing a sense of empowerment and self-validation.

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Voluntary Commitment

Voluntary commitment takes place when a person provides informed consent to be admitted to a psychiatric hospital or residential mental health unit for the purposes of psychiatric assessment and treatment. Criteria for admission as a voluntary patient vary between jurisdictions, but often include some or all of the following: the person is diagnosed as having a mental disorder, the person is considered suitable for voluntary commitment and/or has the potential to benefit from treatment, the person understands the nature and implications of the request for voluntary commitment, the person is willing to sign a voluntary admission form or to consent verbally to admission, and the person must be capable of requesting discharge. As an additional criterion, in some jurisdictions, the patient must be at risk of harm to self or others.

Persons who are under voluntary commitment are free to withdraw consent to admission, refuse consent to different treatments, and/or leave the facility at any time. However, different legal or administrative policies may delay this process or usurp this right. The person’s capacity to consent may have an impact on their ability or their substitute decision maker’s ability to consent to voluntary admission. Applications for involuntary commitment may be used to detain persons who lack capacity or withdraw consent to admission and treatment prior to any attempt to leave the facility. In some jurisdictions, voluntary commitment is defined within mental health legislation,

See Also: Art and Artists; Creativity; Movies and Madness; Stereotypes.

Further Readings


whereas in many jurisdictions it is not, although jurisdictions are moving in the direction of embedding such definitions within statutes. The vast majority of psychiatric inpatients are voluntary. Voluntary commitment is preferred and encouraged by most hospitals and practitioners over involuntary commitment, although any benefits to patient agreement may be outweighed by the experiences of coercion and lack of legislative safeguards attached to voluntary commitment.

**Treatment**

Once voluntary commitment takes place, the inpatient may be subjected to a variety of forms of treatment, usually psychotropic medication, but also electroshock (ECT), individual therapy, and group therapy. Voluntary patients maintain the right to stop any of these treatments by withdrawing consent, or to refuse some or all forms of treatment at any time. Consenting to voluntary admission to hospital does not serve as blanket consent to all treatment. Voluntary patients must be given the right to consent or refuse consent, or withdraw consent after giving consent, to different forms of treatment. Varying between jurisdictions, voluntary patients may or may not be subjected to restraint.

In order to be able to agree to admission and treatment, a person who is voluntarily committed must be informed and aware of their voluntary status and must be informed of their right to withdraw consent and leave the hospital at any time, as an ethical standard. In addition, information must be given to the person that details their assessment and treatment, and they must be given the opportunity to ask and receive answer to any questions they may have about the committal. In order for informed consent to be considered genuinely voluntary, it must be free of coercion or constraints, including force, pressure, duress, deceit, and fraud. If these elements of informed and noncoerced consent are not all present, the commitment represents an infringement on personal and civil liberties and is involuntary.

In some jurisdictions, patients who are assessed to lack capacity to consent are not permitted to commit themselves voluntarily, as they are understood to be unable to agree to admission or to make well-reasoned decisions for themselves. However, in some jurisdictions, substitute decision makers are able to sign them in as voluntary patients on their behalf. In other jurisdictions, patients who present themselves for voluntary commitment, and are deemed to require such treatment, are not assessed for capacity unless they refuse or withdraw consent at some point during their admission.

Children, who are deemed unable to consent because of age, with specific age limits varying between jurisdictions, can be voluntarily admitted by parents, guardians, or care givers. In Australia, this voluntary committal of children by those with parental rights is allowable only if the child does not actively resist admission, thus allowing children to refuse consent (but not to consent) to voluntary admission.

**Withdrawal or Refusal of Consent and Request for Discharge**

Voluntary patients in principle retain the right to withdraw their consent to admission and/or treatment, or to refuse consent to treatment at any time. As such, the request to be discharged is an inherent right of all voluntary patients, regardless of jurisdiction. However, there are various differences between jurisdictions in terms of the amount of time it may take to be released once a request for discharge is made and the steps needed to be released, if release takes place at all. For example, most facilities maintain the right to detain a voluntary patient requesting discharge from four hours in some jurisdictions up to 72 hours in others. This delay allows time for assessment and change of status application to involuntary commitment or facilitating aftercare planning prior to the patient leaving. However, in some jurisdictions where the detainment allowance time is very short, such as in New Zealand, practitioners may fill in involuntary admissions forms at the time that patients are undergoing voluntary commitment, in order to help speed up the involuntary committal process if the voluntary patient attempts to discharge him- or herself.

This process, although expedient, is unethical and counter to involuntary commitment rules, which generally require current, rather than post-dated assessments. Other administrative rules, varying between jurisdictions, include filling out request for discharge forms, signing discharge against medical advice (AMA) forms,
obtaining passes, obtaining leaves of absence, being assigned particular privilege levels, and/or obtaining permission from practitioners. These administrative rules may be embedded in statute or may simply be based on local facility policy. The signing of forms, and in particular the AMA forms, is designed to limit liability of the hospital and practitioners if the discharged patient causes harm to self or others after discharge. In some jurisdictions, voluntary patients who discharge themselves without following the administrative rules or without informing practitioners are deemed to have absconded and will be returned to the facility by police. As such, although request for discharge is a right of voluntary patients, the administrative rules and delays in being discharged ensures that patients deemed to require treatment are not allowed to leave.

In some jurisdictions, refusing treatment as a voluntary patient may be sufficient grounds to change a patient's status from voluntary to involuntary; however, in most jurisdictions, the criteria are more exacting and may include all or some of the following: the person is diagnosed with a mental disorder, the person is deemed lacking capacity to consent, the person is a danger to self or others, the person is at risk of serious physical impairment or substantial mental or physical deterioration, the person demonstrated improvements from treatment in the past, and the person is deemed unsuitable for voluntary commitment. Involuntary patients may become voluntary patients upon request and in meeting the criteria, or in some jurisdictions, this may automatically happen once the timeline of their involuntary admission expires.

Coercion
Coercion may be defined as any threat of action or actual action that compels someone to conduct themselves in a way that is inconsistent with their wishes. Although there is the illusion of choice attached to voluntary commitment, many voluntary patients will attest to the many elements of forced admission and forced treatment attached to their “voluntary” inpatient experiences. Attempts to be discharged may be met with threats of involuntary commitment, absconding may be met with police involvement in being forcibly returned to hospital, pro re nata (PRN) medication is often served up by nurse demand or insistence, and acts of persuasion, forceful arguments, and emotional guilt trips may be used to gain consent to engage in group work—a few examples of the arsenal of coercive techniques used by practitioners to gain compliance to treatment and to ensure that the person does not leave the hospital. This is in addition to the coercion or “persuasive powers” that may be used to obtain consent to voluntary commitment in the first instance. This attests to the need to understand both voluntary and involuntary commitment as consisting of blurred forms of psychiatric coercion, rather than understanding them as dichotomous instances of noncoercive and coercive forms of commitment.

The research literature demonstrates that many voluntarily committed patients regard their status as one that has involved coercive force rather than being genuinely voluntary. However, what constitutes coercion or undue pressure is not understood or experienced the same by all voluntarily committed patients. Not all patients feel forced at the same points within the process of admission and treatment as others. There is a great variability in experiences of coercion as voluntary patients. Some strategies and forms of the experiences of coercion, ranging from at the point of referral, at the point of admission, and after admission, include threat of involuntary commitment, overt force, gentle persuasion, threat of incarceration, threat of apprehension of children, outright or implicit deceit, punishments, constraints, verbal persuasion, not being listened to, not being given adequate information about treatment and alternatives and instead having their treatment decided for them, not being told if they were voluntarily or involuntarily admitted and leaving them with no knowledge of their status or their rights, being denied permission to leave, enforced medication, physical force, and physical restraint. All of these issues raise questions regarding ethical standards, social control, power relations, and accountability within psychiatric institutions when people are under voluntary commitment.

In many jurisdictions, voluntary commitment lacks the safeguards that are attached to the due process protections of involuntary commitment status. However, it remains the preferred mode of admission to hospital, with its benefits proffered as being less coercive, stigmatizing, and adversarial;
more participatory, timely, and respectful of autonomy, decision making, and choice, as well as leading to more successful treatment outcomes. Critics of voluntary commitment remain unconvinced by these claims. Instead, the downside of voluntary commitment is understood to outweigh any possible benefits. These include lack of safeguards against coercion, abuse, and assault; lack of legal representation or judiciary review; fewer opportunities for release; fewer procedural rights; no means of external redress; and the overriding threat of involuntary detainment. The lack of a legal safety net for voluntary patients is seen to leave people vulnerable to the coercion that is known to accompany voluntary commitment. By choosing voluntary over involuntary commitment, the hospitals benefit from removal of the adversarial nature of legal system involvement in the committal and treatment process.

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See Also: Commitment Laws; Compulsory Treatment; Informed Consent; Patient Rights; Right to Refuse Treatment.

Further Readings

Vulnerability

Vulnerability considers the susceptibility, or fragile state or condition, of a population group in regard to a social impact or health condition. Vulnerability can be based on race, gender, income, education, or geographic region (i.e., nation, or urban versus rural). Vulnerable populations may be more at risk because of social limitations such as poverty and lack of education, and because of certain social and environmental factors such as pollution, community violence, health impacts such as obesity, and other behavioral and mental health outcomes. Vulnerable populations are also more likely to be susceptible to a range of social conditions that predict health and well-being as a result of social inequality.

Although vulnerability to certain health conditions and outcomes may be genetic or inherited, such as schizophrenia, oftentimes vulnerable populations experience lower social status (based on education or resources) and have less or limited access to power. Populations may experience vulnerability in various social arenas such as in education, politics, safety and crime, and health. Racial or ethnic minorities, women, sexual minorities, and populations residing in certain regions may experience more vulnerability based on their social situation.

Overall, vulnerability reflects the social status of a group of people that experience a range of poor health and social outcomes as a result of their low social and socioeconomic status. Because there is a high correlation between race and ethnicity and gender and socioeconomic status and power, minorities and women are more likely vulnerable to social conditions (i.e., poverty and lower education) and adverse health outcomes than other populations.

Race

Racial ethnic minority groups are often more vulnerable to a range of social and health effects. Research has explored different outcomes for racial and ethnic groups across a range of indicators compared to whites. Outcomes often vary across health, crime rates (including victimization from crime and criminal charges), educational level, economic well-being, and access to political power. Also, racial ethnic minorities, particularly