

INVOLUNTARY TREATMENT: HOSPITALIZATION AND MEDICATIONS

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1. Why is involuntary hospitalization necessary?

Although the number of involuntary hospitalizations relative to total psychiatric admissions has decreased considerably in the United States from 90% in 1949 to 55% in 1980, civil commitment of the mentally ill remains a frequent route for inpatient treatment. A majority of persons suffering from severe mental illness show **limited insight** into their illness. Schizophrenic patients, in particular, may show no recognition that they have a mental illness or need treatment. Depressed patients who are unable to envision hope or recall a better time may be suicidal and unwilling to seek treatment. Manic individuals who have become markedly grandiose and deny that they have any kind of problem or illness that needs treatment may display behaviors that put themselves or others in danger. Other patients may recognize their symptoms as part of an illness, but disagree with and refuse recommended treatment.

Untreated depression, mania, and psychosis can have devastating effects on both the affected individual and those around him or her: suicide, assaults on others, inadvertent tragedies stemming from delusional thinking, financial and social ruin, and inability to adequately care for one's own needs. Because insight often is lacking, civil commitment may be initiated by others who witness or are the brunt of concerning behavior, whether they be family members, police, or mental health providers.

2. What is the legal basis for involuntary commitment?

The state's authority to commit individuals stems from two legal theories; *parens patriae* and the police power of the state.

Parens patriae, which literally means "parent of the country," provides the sovereign power with authority to protect citizens who, for reasons of mental or physical disability or because they are unsupervised minors, cannot adequately protect or care for themselves. Intervention by the state is indicated for individuals who are deemed unable to make rational decisions for themselves, including the mentally ill who are "gravely disabled" or suicidal. The state also is obligated to make the decision that is in the best interest of the individual and most clearly reflects the choice that the individual would have made if he or she were competent to do so.

The legal theory **police power** provides the state with the authority to act for the protection of society and the general welfare of its citizens. In the process of such protection, isolation and confinement of dangerous individuals may be necessary. Not only the criminal element and persons with highly contagious diseases may be detained, but also the mentally ill who are a risk to others. Whereas *parens patriae*

provides for the protection of the individual, police power generally is invoked on behalf of society against the individual.

3. Who can be involuntarily hospitalized?

The legal standards specifying the criteria for civil commitment vary widely from state to state, and may have changed in some states since the publication of this book. The clinician must be aware of the specific criteria for his or her own state. The presence of a **mental illness** is a prerequisite for civil commitment. Other criteria frequently include **dangerous behavior** toward self or others, **grave disability**, and the **need for treatment**. Over the past three decades there has been a general shift among most states from standards based on the individual's need for treatment to standards that require the person to be considered dangerous to self or others. However, some states have recently modified their statutes to allow for involuntary hospitalization of persons who are in need of treatment but are not imminently dangerous to themselves or others.

Less common criteria used by some states include: the responsiveness of the mental illness to treatment and the availability of appropriate treatment at the facility to which the patient will be committed; refusal of voluntary admission; lack of a capacity to consent to or refuse psychiatric treatment or hospitalization; future danger to property; and involuntary hospitalization as the least restrictive alternative.

4. What disorders does the term mentally ill include?

The legal definition of the term mental health, as spelled out in each state's statutes, varies considerably. Except for Utah, the statutes do not include specific psychiatric diagnoses, but instead define mental illness in terms of its effects on the individual's thinking or behavior. Some definitions are rather vague; for example, in the District of Columbia mental illness means "a psychosis or other disease which substantially impairs the mental health of a person." Most definitions include some deleterious effect of the illness. For example, in Georgia mentally ill "shall mean having a disorder of thought or mood which significantly impairs the judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life." Some definitions are qualified by a reference to the need for treatment. Hawaii's statute specifies that a mentally ill person has "psychiatric disorder or other disease which substantially impairs the person's mental health and necessitates treatment or supervision." Many definitions include aspects of dangerousness. Oregon's statute declares that a mentally ill person is "a person who, because of a mental disorder, is either (a) dangerous to himself or others; or (b) unable to provide for his basic personal needs and is not receiving such care as is necessary for his health or safety."

5. Is someone with a developmental disability considered mentally ill?

Although developmental disability (mental retardation) is described in the Diagnostic and Statistical Manual of Mental Disorders, 4th ed. (DSM-IV), it typically is not considered a mental illness for the purposes of civil commitment. Many statutes completely exclude mental retardation from their definition of mentally ill, whereas others note that such a disorder may not constitute mental illness but does not preclude a comorbid mental illness. A few statutes specifically include mental retardation per se.

6. Are other diagnoses excluded in the definition of mentally ill?

In a few state statutes, the definition of mentally ill specifically excludes other disorders, most commonly alcoholism, drug addiction, and epilepsy. Some exclude "simple intoxication" with either alcohol or drugs. A small number exclude sociopathy, severe personality disorders in general, senility, and organic brain syndrome. Some statutes specifically *include* alcoholism and drug addiction. Maine's statute includes "persons suffering from the effects of the use of drugs, narcotics, hallucinogens or intoxicants, including alcohol, but not including mentally retarded or sociopathic persons."

7. What is grave disability?

The exact definition of grave disability varies from state to state. In general, the term refers to an inability to care adequately for one's own needs. In some states, a person is gravely disabled if he or she cannot care for basic needs without the assistance of others, even if family or friend are currently providing such care. In other states, the person must be without basic needs of food, clothing, shelter, or essential medical care.

8. What are the differences between emergency detention, observational institutionalization, and extended commitment?

Each has a specific purpose, although there often is considerable overlap. All states provide for some form of *emergency detention*, in which the intent is immediate psychiatric intervention to treat what is currently, or soon to become, an emergency situation. Emergency detention allows for an initial psychiatric assessment and at least temporary treatment for an individual who, for example, has presented a danger to self. Some states include statutes that provide for *observational institutionalization*. A person satisfying the appropriate criteria may be hospitalized so that the treatment staff and psychiatrist may further observe him or her to determine the diagnosis and to provide limited treatment. Formal procedures for *extended commitment* can be found in nearly every state. Such commitment allows for continued psychiatric treatment of individuals who meet one or more of the state's specific criteria (usually dangerousness to self or others or grave disability; less common criteria are discussed above) but would otherwise refuse treatment.

9. Who can initiate involuntary hospitalization?

The specifics of which professionals or persons may initiate civil commitment vary among states, and usually within a state depending on the type of commitment sought (e.g., emergency detention or extended commitment). In general, the application for emergency detention is less formal and extended commitment more formal; observational commitment (where available) is somewhere between.

Emergency detention generally may be initiated by another adult, usually a family member or friend who has witnessed the person's deterioration and dangerous behavior. The police also frequently initiate the process, although some states require judicial approval before the person can be detained. A number of states provide for medical certification; that is, an evaluation from a physician stating that the person meets the statutory criterion is adequate to proceed with hospitalization.

Application for **observational commitment** often may be made by any citizen with good reason, although some states limit the application to physicians or hospital personnel. Most states require court approval.

The procedure to request **extended commitment** is the most formal and usually more detailed than the applications for other forms of commitment. In general, one or more of a specific group of people may complete the appropriate forms to request involuntary treatment. Although this group may include spouses, relatives, friends, guardians, and public officials, it typically is limited to physicians, hospital superintendents, and other mental health professionals, such as certain licensed social workers and nurses. Even in states that allow for other persons to initiate commitment, generally only a physician can extend commitment beyond the initial period. Often the application must be accompanied by a certificate or affidavit from a physician in which the person's psychiatric presentation, pertinent history, recent behavior warranting commitment, initial diagnosis, and recommendations for treatment are described in detail. Some states require statements from two physicians or an additional statement from a psychologist, mental health board or similar designee. In virtually all states extended commitment is a judicial process. A hearing is scheduled, and either a judge or a jury decides whether to uphold the request.

10. How long does involuntary hospitalization last?

- Emergency detention is designed to provide for an assessment of a dangerous situation. It is generally limited to a brief period, usually 3–5 days; the period ranges from only 24 hours in a few states to 20 days in New Jersey.
- The length of an observational commitment, in states that allow it, varies from 48 hours in Alaska to 6 months in West Virginia. Before the expiration of the emergency or observational commitment, the patient must either agree to voluntary hospitalization or be discharged; otherwise, civil commitment proceedings must be initiated.
- Extended commitment also is limited; 6 months is a typical period. If at the end of that period the treating psychiatrist recommends continued involuntary treatment, application for further extension of civil commitment may be made. Again the length of time is finite, often 1½–2 times longer than the initial commitment. The

possibility for renewal at the end of each period continues as long as it is requested and the patient continues to meet the statutory criteria.

11. Is mental commitment possible on an outpatient basis?

Yes. Many states explicitly provide for outpatient commitment, whereas others simply do not prohibit the extension of civil commitment to outpatient programs. In states with statutes that specifically address outpatient commitment, the length of commitment generally is limited but somewhat longer than for inpatient commitment. The specific criteria and procedures are similar to those for inpatient commitment and likewise vary from state to state. The goal of outpatient commitment may be continued involuntary treatment in a less restrictive setting than the inpatient unit, or an attempt to avoid inpatient treatment for a patient whose condition is deteriorating. If the patient fails to comply with the conditions of treatment, rehospitalization is indicated.

12. Which patients are appropriate for outpatient commitment?

Patients appropriate for outpatient commitment include those who have shown a good response to psychiatric medications in the past, but are **noncompliant** with medications and other aspects of treatment without continued coercion. Involuntary outpatient treatment also is indicated for patients who require considerable **structure** to their lives and support from others to maintain adequate functioning outside the hospital. For outpatient commitment to be realistically tenable, the facility, often a mental health center, should be capable of adequate outreach. Also needed is a high degree of cooperation and communication between the courts authorizing commitment and the outpatient programs, as well as between the outpatient and inpatient facilities.

13. What are the rights of patients who have been involuntarily hospitalized?

Persons involuntarily hospitalized maintain a number of rights, some of which are specifically related to the commitment proceedings and come under the rubric of due process. Such rights usually include notice of commitment, objection to confinement, representation by an attorney, presence at the commitment hearing, trial by jury, independent psychiatric examination, and change to voluntary status. Additional civil rights of the mentally ill, regardless of their legal status, generally include humane care and treatment; treatment in the least restrictive setting; free and open communication with the outside world via telephone or mail; meetings with visitors, particularly their attorney, physician, or clergy; confidentiality of records; possession of their own clothing and money; payment for any work done in the hospital; absentee ballot voting; and being informed of such rights. Many of these rights may be temporarily restricted by the staff if deemed necessary (e.g., while the patient is in restraints or seclusion).

14. Can an involuntary patient be treated?

Treatment cannot be forced. However, involuntary admission does not preclude treatment either. Many patients, despite being hospitalized on a civil commitment, are both amenable

and receptive to treatment. They may disagree that they need to be in a hospital, but ironically they do not disagree that they need treatment. It is important to continue to educate patients who deny the need for treatment about their condition, psychiatric diagnosis, and treatment options. The refusal for voluntary hospitalization and voluntary treatment should be sought, explored, and discussed to foster a therapeutic alliance.

Simple education or addressing concerns of the patient may allow him or her to decide to sign into the hospital voluntarily and/or to agree to treatment. Severe psychosis, mania, or depression, of course, may result in an impasse that requires the court or judge to decide. However, many patients who are initially brought into the hospital involuntarily may later be willing to sign themselves into the hospital and actively participate in their treatment.

Note that the same therapeutic approaches that help to foster a therapeutic relationship with voluntary patients also help to engage involuntary patients in treatment.

15. May involuntarily hospitalized patients refuse to take medications?

Generally, yes. A majority of states consider all patients, even mentally ill patients hospitalized involuntarily, competent to make personal decisions, including whether to take psychotropic medications, unless they are specifically found legally incompetent by a court of law. Most states provide that an involuntary patient's refusal of medications may be overridden only by court hearing. Many states allow a legally appointed guardian to consent for the patient. A small number of states specifically recognize the right of voluntary patients to refuse medications.

Although a patient's refusal to take medications may stem from delusional thinking or a denial that anything is wrong, the reasons also may be based in reality. The patient may have previously had an intolerable side effect to the medication in question. It is essential to explain the recommended pharmacologic treatments, including expected benefits and possible adverse effects, and to explore fully the reasons behind the patient's refusal. Negotiation and compromise, such as using an alternate medication of the same class or initiating the medication at a lower dose, may be helpful and allow for treatment to proceed.

16. What is the difference between involuntary medications and emergency medications?

Emergency medications are ordered acutely by the treating psychiatrist or physician for a patient who is considered imminently dangerous to self or others, either physically or psychologically, and refuses to take the medications freely. Examples of such situations include the dehydrated and delirious manic patient who is already in restraints but continues to thrash about and bang his or her head against the bed frame. Emergency medications should work acutely (e.g., neuroleptics and benzodiazepines as opposed to antidepressants and mood stabilizers) and must target the serious presenting symptoms. The clinical need for emergency medications must be reassessed frequently, from every several hours to every 24 hours. Often a second opinion about the appropriateness of the emergency

medications must be obtained from another physician. Emergency medications usually are limited to a few days.

Involuntary medications are granted by a court in nonemergent situations. Mentally ill persons who require chronic administration of medication and yet have minimal insight into their need may warrant involuntary medications. The treating psychiatrist or physician generally applies for the administration of involuntary medications with an accompanying affidavit supporting the opinion that the patient is mentally ill and incompetent to participate in treatment decisions, and that the medications are clinically indicated. The statement also may need to review the patient's prior noncompliance with medication and expected benefit and potential side effects.

Some states direct that involuntary medications can be requested only for patients who are currently under a civil commitment. The criteria for involuntary medications vary from state to state, but commonly include such aspects as incompetence to participate in decisions about treatment and expected clinical deterioration or dangerous behavior to self or others without the medications.

Court-ordered involuntary medications are time-limited, often lasting only as long as the patient's civil commitment or for a period set by the judge. Extension beyond that time requires a reappraisal of the patient's condition, response to treatment, and likelihood of future compliance.

17. Can electroconvulsive therapy be given involuntarily?

Many states have provisions in their statutes that specifically allow for refusal of electroconvulsive therapy (ECT). If the person is considered incompetent, then a court order or a guardian's consent is required. If the situation is viewed as a life-threatening emergency, some states allow for ECT to be administered without consent of either the patient or a guardian; however, such consent or a court order should be obtained as soon as possible. Often a second opinion about the appropriateness of treatment and the person's competency to consent also must be obtained. Some states limit the use of ECT to certain psychiatric disorders or age groups; some also limit the number of treatments that can be administered to a patient each year.

18. What are the proper indications for seclusion or restraints?

Both seclusion and restraints generally are viewed as appropriate and sometimes necessary parts of inpatient psychiatric treatment, given the proper indications. Restraints are defined as the physical incapacitation of the person, either in total or in part, by tying him or her securely to a bed or chair, frequently with leather straps. Seclusion refers to the placement of an individual in isolated confinement. A seclusion room typically is small, securely built, and unfurnished or minimally furnished, with a lockable door. The door usually has a small window for viewing the patient or a mounted camera for close monitoring.

The most common clinical indications for the use of such external constraints are (1) **prevention of serious injury to self or others** when other treatment techniques are unsuccessful or inappropriate and (2) **prevention of serious physical damage to the inpatient unit or marked**

disruption of the ward. Other less common reasons include their use as part of a specific behavior therapy program, or at the patient's own request.

19. What are the legal constraints on the use of seclusion and restraints?

Most states have either specific statutes or administrative rules that regulate the use of restraints. About one-half of states have similar regulations for the use of locked seclusion. In general, the use of restraints and seclusion requires a physician's written order; is limited in duration (often to 24 hours); and must be accompanied by frequent monitoring of the patient's condition, usually by the nursing staff, with documentation of the assessment and reasons for continued seclusion or restraints. If seclusion or restraints are necessary beyond the initial period, a physician must conduct a direct examination, sign another written order, document the behaviors that necessitate continued external constraints, and establish that such measures are the least restrictive intervention. When restraints or seclusion have been used for several consecutive days, a mandatory review by the medical director or superintendent is common.

20. Which is the most restrictive intervention: seclusion, restraints, or involuntary medication?

There is no clearly established hierarchy of intrusiveness. The choice of the most appropriate treatment of a violent psychotic patient varies with the situation, and different clinicians may give opposing views.

21. Who can authorize psychiatric admission of children?

Statutes detailing the psychiatric admission procedures for children often are convoluted and vary widely. In general, children (i.e., legal minors) are considered legally incompetent. This includes incompetence to make a decision about psychiatric hospitalization. The past two decades have seen a number of changes with increased recognition by many states of certain rights of due process for minors. Most states continue to allow a child's parent or guardian to approve admission to a psychiatric hospital regardless of the child's wishes. They also often provide that a child may not be discharged from a mental hospital without authorization from the parents. A number of states have statutes that provide for parentally authorized admission for younger children (up to the age of 13 or 14 years), but older minors have the rights of due process, including a hearing and counsel, either automatically or if they protest their hospitalization.

Once hospitalized, the minor's continued need for inpatient treatment must be reviewed periodically, from every 10 days (in Arizona) to every 60 days in other states. Most states now permit older children to admit themselves voluntarily into a psychiatric hospital. The minimal age ranges from 12 years in Georgia to 17 years in Florida. When a child refuses admission for psychiatric hospitalization and the state does not allow for parental consent, emergency commitment proceedings must be initiated.

22. Do the criteria for civil commitment of children differ from those for adults?

The clinical indications for the commitment of minors may differ from those for adults in particular states. In general, if a child is suicidal or homicidal or has a severe mental illness, he or she may satisfy criteria for involuntary hospitalization. Some state statutes include “being in need of treatment,” which allows admission of children who do not respond adequately to intensive outpatient intervention. As with the statutes for adults, the specific criteria and procedures vary markedly among states.

Usually a psychiatrist must conduct an examination to determine the appropriate services for the child. The assessment must include an interview with the child alone and a thorough review of the child’s history. The evaluation should use as many possible sources of information as possible, such as parents, school, and social agencies.

23. Can a child’s parents authorize involuntary psychotropic medication?

Many states consider a parent’s consent for psychiatric treatment adequate to overrule a minor’s refusal to take medication. However, if the treatment is considered unusual or hazardous, such as electroconvulsive therapy or high doses of medications, parental consent may be inadequate; in such cases, the clinician should obtain authorization from a court.

24. May a patient who was admitted voluntarily and then wishes to leave be converted to an involuntary patient?

Yes. When a person who has admitted him- or herself voluntarily wishes to be discharged against the recommendation of the physician and treatment team, the staff are provided time to assess whether the patient meets criteria for civil commitment. If such criteria are met, the process of emergency detention must be initiated at once.

25. What is the difference between incompetence and civil commitment?

Competence is divided into legal competence and clinical competence. *Legal competence* refers to a declaration by a court of law that the person is unable to manage adequately his or her assets or to make decisions about personal care and welfare. All adults, including those with severe mental illness, are presumed legally competent until found otherwise. *Clinical competence*, also called decision-making capacity, refers to the ability to comprehend a situation and the consequences of decisions and to communicate such comprehension to others. It refers to a particular question and depends on the patient’s understanding and the risks of the proposed intervention. A person may be considered incompetent in one sphere but not another; e.g., the person may be competent to concur with psychiatric hospitalization, but incompetent to consent to ECT.

Patients may be subject to *civil commitment* because they fulfill the particular criteria in that state; e.g., they have a

mental illness that renders them markedly delusional with paranoia and suicidal thoughts. However, if they fully understand the risks and benefits of a particular treatment or procedure, whether it is receiving medications, having their teeth pulled, or having surgery for gallstones, they remain competent to accept or refuse, regardless of the decision they make. Conversely, an individual with dementia or mental retardation may not have a major psychiatric illness requiring hospitalization but still be clinically incompetent to make a particular decision.

26. Can mentally ill patients who appear to be incapable of understanding their legal rights with regard to hospitalization be admitted voluntarily?

For the most part, unless someone has already been declared legally incompetent, he or she is presumed to be legally competent to make decisions about personal welfare, including psychiatric admission. Some states, however, specify that a patient’s decision for voluntary admission must be competent. In such states, the patient would require civil commitment.

27. Can alcoholics and addicts be involuntarily treated?

It depends upon the state in question. Less than two-thirds of the states have laws allowing for involuntary treatment of alcoholics, and fewer have provisions for drug addicts. Definitions of alcoholism and drug addiction generally include loss of control of intake and imminent risk for self-harm as criteria for civil commitment.

28. Is the person who initiated involuntary hospitalization liable for false imprisonment?

A patient claiming to have been negligently hospitalized may seek malpractice litigation for false imprisonment. Such litigation is rare because of the legal protections that ensure due process. **Important guidelines for clinicians** involved in civil commitments include the following: they should (1) be familiar with both the commitment statutes of their state and the appropriate administrative policies for their facility; (2) act in good faith; (3) conduct a comprehensive psychiatric examination of the person in question; (4) complete all aspects of the necessary commitment forms; (5) describe the specific behaviors and symptoms that support the presence of mental illness and the need for treatment, including behaviors fulfilling commitment criteria such as dangerousness; (6) outline the recommended treatment for the person’s condition with consideration for the least restrictive setting; and (7) obtain consultation for equivocal cases.

29. Will managed care cost-containment change civil commitment laws?

The potential conflict between the focus on cost reduction by managed care companies and the focus on control of dangerous patients by the courts is currently being played out in many states and likely will result in civil commitment law modification in the future.