MENTAL HEALTH POLICY IN THE UNITED STATES

CIVIL COMMITMENT[1]

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Abstract: This lecture provides an overview of three forms of civil commitment—involuntary inpatient commitment, involuntary outpatient commitment (often called "assisted outpatient treatment"), and civil commitment of sex offenders. I review the debates about the use of these coercive interventions including (1) what the criteria should be for forced hospitalization, (2) whether and under what conditions there should be mandated outpatient treatment, and (3) what procedural protections are necessary. I also note that the debates about involuntary inpatient and outpatient treatment of people with mental illness draw from two ideological points of view. One stresses the responsibility of society to protect people with disabling mental illness and to protect the community from potential dangers. The other point of view stresses the fundamental right to liberty and the importance of attempting to engage people with serious mental illness voluntarily in services that could be of benefit to them. I note that the effectiveness of involuntary commitment is a critical and arguable question. Do court mandates make a difference in comparison to extensive outreach and the provision of comprehensive services? In addition, I explore the debate about using psychiatric hospitalization to extend the incarceration of sex offenders past the end of their sentences. Is this a legitimate way of protecting society from dangerous individuals or is it an illegitimate abuse of involuntary hospitalization to punish people for crimes they might commit in the future?

The right to liberty is fundamental to a democratic society, but it is not absolute. There are various circumstances under which government has the authority to limit a person's right to live as s/he chooses. Obviously, people are not free to commit crimes, and the government has the authority to incarcerate people against their will if they are convicted of committing certain crimes. Liberty may also be legitimately constrained for children and adolescents, who presumably have not yet reached the "age of reason". It may also be constrained to protect society in extreme circumstances. Famously, yelling "fire" in a crowded theatre is not protected by the right to free speech. Interestingly, quarantine of people with certain contagious diseases against their will is sometimes a legitimate power of government, although that authority has been challenged during the pandemic when

people have been allowed not to wear masks, not to isolate, not to take vaccines, etc. When is it the job of government to persuade people to behave in the public interest? When is it to force people to behave safely? An interesting question for another time.

What about mental illness? Commitment of people with serious mental illnesses to psychiatric hospitals/asylums against their will goes back centuries. Is it legitimate? The criteria for commitment, the processes through which it is done, who has the authority to order it, and what services need to be provided for people who are committed are all subjects of ongoing debate.

In this lecture, I will discuss three forms of civil commitment—involuntary inpatient commitment, involuntary outpatient commitment (often called "assisted outpatient treatment"), and civil commitment of sex offenders.

INVOLUNTARY INPATIENT COMMITMENT

According the Cornell Legal Information Institute, ***"Involuntary civil commitment*** *is the admission of individuals against their will into a mental health unit. … In the case of mental illness, dangerousness to self or others defines the typical commitment standard, with almost all states construing the inability to provide for one's basic needs as dangerousness to self. In terms of process, every state provides for a hearing, the right to counsel, and periodic judicial review, while most states have statutory quality standards for treatment and hospitalization environment*." [2]

Criteria for Commitment: Since the Donaldson Decision[3] of the Supreme Court in 1975,[*] it has been clear that being mentally ill, even being psychotic, does not in and of itself legally justify involuntary incarceration in a psychiatric hospital. Through this and other court decisions, dangerousness to self or others has become the key standard for involuntary inpatient commitment. But there is an ongoing debate about the meaning of "dangerousness".

Ideological "protectionists" (my term for those on one side of the debate) generally believe that currently the standard of dangerousness

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[*] According to this decision: "A State cannot constitutionally confine, without more, a non-dangerous [mentally disabled] individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends…." A quarter century later, the Court went a step further. In the Olmstead Decision of 1999, it noted that it is possible for government to provide (or pay for the provision of) support services that make it possible for people with mental disabilities to survive safely in the community even without help from family or friends, and it required the states to provide such supports, including decent housing within limits of affordability.

is interpreted too narrowly as meaning imminent danger—i.e., being actively assaultive, homicidal, suicidal, or at risk of death due to lack of self-care. They argue that more people should be hospitalized because they have a "grave disability" and are at risk of not being able to "survive safely" in the community, and they want it to be clear that "grave disability" is a form of dangerousness. In addition, protectionists sometimes argue that non-dangerous people should be involuntarily hospitalized if (1) they have a serious mental illness that will predictably result in their becoming dangerous to self or others in the future, (2) they refuse treatment, and (3) treatment that will help them is available in a hospital.

Ideological "libertarians" (also my term) generally want to limit the use of involuntary inpatient commitment to only those who are currently and imminently dangerous. They oppose involuntary hospitalization of people who are not dangerous now even if they have a serious mental illness, are at risk of eventually becoming dangerous to self or others, and presumably could benefit from treatment that they refuse.

Libertarians also have argued effectively (see Rivers vs Katz [4]) that people who are involuntarily hospitalized do not automatically lose their right to refuse treatment and that forcing them to take medication is a separate matter from involuntary hospitalization.

Protectionist views arise from their distress about the terrible circumstances in which some people with serious mental illness live. Just think, they argue, about people living outdoors in considerable danger. Shouldn't they be picked up and hospitalized for their own good in keeping with the *parens patrie* role of government? In addition, they generally believe that people with serious mental illness who are living on the streets could have far better lives if they got treatment and that, therefore, they should be forced to get treatment.

Libertarians generally think that government should remove a person from the community only if the risks are severe. Their views rest on respect for the right to liberty, tolerance for the hazards of liberty, lack of confidence in the ability of psychiatrists to predict deterioration and dangerousness, concern about the limited effectiveness and harmful side-effects of psychiatric treatment, and distress about the abusive history of state psychiatric hospitals.

Procedural protections

Legal decisions about involuntary commitment have not only spelled out criteria for commitment but also have laid out due process requirements.

Due process is a Constitutional right, but under the law due process requirements vary with the potential severity of punishment and the extent of deprivation of liberty. For example, violators of traffic laws are entitled to a hearing, but they are cursory, do not require a jury, etc. In contrast, those who are accused of a serious crime that may result in incarceration are entitled to a jury trial and prosecutors must prove guilt beyond a reasonable doubt.

To understand the protections that are now provided, it's important to keep in mind how easy it was to institutionalize someone in the past. For example, a man could bring his wife (or vice versa) to a nearby state institution and claim that she was insane. If the superintendent of the institution was persuaded (or induced) to agree, the spouse could be incarcerated for an indefinite period of time. This sort of abuse is now illegal and far less likely because involuntary commitment requires a hearing and a judicial order.

Due process requirements vary by state but generally include:

- A limited list of people who can legitimately ask for examination to determine mental illness
- Determination of mental illness and dangerousness by at least one but generally two physicians
- A hearing before a judge
- Representation by a lawyer of one's choice or a mental health legal service (similar to a public defender)
- Court authorization for commitment based on "clear and convincing evidence"[5]
- Separate court authorization for involuntary administration of psychiatric medication
- Respect for patients' rights (see e.g., NYS OMH statement on the rights of inpatients)[6].

<u>INVOLUNTARY OUTPATIENT COMMITMENT</u> (IOC)

As deinstitutionalization unfolded and even after community support services were made available, it became clear that there is a sizable population of people with serious and persistent mental illness who will not use treatment services that they presumably need to live safely in the community. This includes people who deny that they have a mental disorder, who do not believe that treatment works or believe that it is dangerous, who find it humiliating to go to a mental health program, who have suffered abuse in psychiatric hospitals, etc. Some of these people are able to lead lives that they find satisfying without endangering themselves or others. Some of them go through ups and downs, with repeated periods of deterioration of functioning, especially when they discontinue medication. Some become

dangerous to self or others eventually and are involuntarily committed to a hospital from time-to-time.

Often their parents or other responsible family members as well as mental health providers who know them become very distressed when nothing can be done to prevent their predictable slide into dangerousness. IOC was developed to be able to intervene before the person with serious mental illness reaches rock bottom again. It is specifically for people who do not meet the standard of dangerousness required for involuntary inpatient commitment but who have a history of rejecting treatment and eventual deterioration into dangerousness to self or others.

Most states now have laws that permit involuntary outpatient commitment, which is often referred to as "assisted outpatient treatment" (AOT). These laws vary from state to state, but all of them permit mental health professionals and others to ask a court to mandate outpatient treatment pursuant to a comprehensive treatment plan for a person living in the community who is showing signs of deterioration and is likely to eventually become dangerous.

Procedural protections noted above for inpatient commitment also apply for the most part to outpatient commitment.

Failure to comply can result in being picked up by a law enforcement agency and taken involuntarily to a hospital for observation to determine the need for involuntary inpatient commitment. If the patient does not meet criteria for involuntary inpatient commitment, s/he must be released.

IOC is highly controversial. Many claims are made regarding the benefits of IOC. These include the general claim that people ordered into outpatient treatment get treatment that is helpful to them and prevents a predictable slide into dangerous dysfunction.[7] In addition, claims are made that people in AOT are less likely to be hospitalized[8], less likely to be homeless[9], less likely to be arrested[10], and less likely to be violent to self or others[11].

Despite claimed benefits, opponents of, and skeptics about, IOC argue that it generally violates the right to live freely in the community unless a crime has been committed or there is evidence of clear and present dangerousness. In addition, they argue, IOC violates the right to refuse treatment except in dire circumstances, and its justification rests on a questionable prediction that a person will become dangerous. Thus, opponents of IOC argue, forcing a non-dangerous person to accept treatment constitutes a kind of preventive detention, which is unconstitutional in the U.S.

In addition, opponents argue that there is little to no evidence that IOC works.[12, 13, 14, 15] Yes, they say, there is some evidence that people in IOC do better than people who are not, but that only proves that people who get comprehensive mental health treatment and support services usually do better than people who get no services. It does not prove that the court mandate, which is the essence of IOC, does anything to improve outcomes compared to efforts to reach out to and engage people who reject ordinary treatment. Most people, it is argued, who do not go for treatment on their own are likely to accept services and supports if they are offered services that they want such as housing and if services are provided at ordinary places in the community rather than in mental health service facilities.

CIVIL COMMITMENT OF SEX OFFENDERS [16]

20 states and the District of Columbia use involuntary commitment to confine sexual offenders after they have served their sentences in prison. They have processes through which some sexual offenders are diagnosed with a mental condition such as "mental defect" and found to be dangerous because they are likely to re-offend. Once found mentally defective and dangerous, they can be placed in a secure psychiatric facility for an indefinite period. Some states provide the alternative of outpatient commitment.

This use of psychiatric hospitals has been extremely controversial, but state and federal laws permitting it have been found constitutional by the Supreme Court.[17,18]

Commitment of sexual offenders arises from the widespread but possibly erroneous perception that sexual offenders are highly likely to re-offend. [19] There must be a way to protect society from these dreadful people, it is argued. Since criminal law provides only limited sentences, commitment appears to be the only way to provide adequate protection.

Those who object argue that:

- Incarceration after serving out one's sentence for an offense because a person is "likely" to re-offend is effectively preventive detention—punishment in anticipation of a crime, which is unconstitutional.

- It is inappropriate to use psychiatric hospitals to punish criminals.

- This should be purely a criminal justice matter. If sexual offenses call for longer sentences, that should be provided in criminal law, not through a phony process of finding someone mentally ill and dangerous.

- Using psychiatric hospitals to indefinitely detain sexual offenders lends credibility to the myth that most people with mental illness are dangerous.

- Increasing the number of people in psychiatric hospitals will drive up costs in the mental health system and draw desperately needed resources away from people who really have mental illness.

- Men of color are far more likely than white men to be incarcerated after their sentence is over, as are men who abuse men rather than women, another example of discrimination due to race and to sexual orientation.[20]

For all of the reasons noted above, I personally opposed the passage of a law establishing civil commitment of sexual offenders in NYS. At that time I, and others, were very concerned that, in addition to the fundamental injustice of it, civil commitment of sexual offenders would syphon off funding for other mental health services and overwhelm state facilities. That does not appear to have happened, although it would be interesting to see a formal evaluation.

Nationwide, it is also not clear to me what the impact of civil commitment of sexual offenders has been. The use of hospitalization to prolong detention of sexual offenders has been in effect in the United States at least since the 1990s, when it was ruled constitutional by the Supreme Court. Similar laws go as far back as the 1930s. What has been the consequence? According to the Williams Institute of UCLA Law School, as of 2019 there were 6,300 sexual offenders detained in psychiatric hospitals, [21] which is, by my calculation, about 5% of all patients in psychiatric inpatient treatment and a whopping 20% of patients in public psychiatric hospitals.[22] In NYS each patient reportedly costs about $175,000 per year.[23] Let's guess that the average cost across the country is $150,000. That would mean that civil commitment of sexual offenders costs about $1 billion a year, far less than 1% of total mental health spending in the United States.

So, from an ideological point of view civil commitment of sexual offenders may be a very big deal; but from a pragmatic point of view in the larger scheme of things, it may not be a major concern at all. What do you think?

Coercion vs. Outreach and Engagement

The debate about how extensively coercive interventions should be used and how effectively outreach can result in voluntary engagement in services is at the heart of the schism that divides the mental health advocacy community against itself. In my opinion, it vastly limits the effectiveness of advocacy to improve the mental health system. Hopefully a new generation of advocates will find a way to bridge the ideological divide.[24]

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