

DEPRIVATION OF LIBERTY AND THE PSYCHIATRIC PATIENT: INVOLUNTARY CIVIL COMMITMENT AND TREATMENT

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December 19, 2001

Introduction & Overview of the Problem

Each year in the U.S. about one million persons are civilly committed to hospitals for psychiatric treatment (Durham, 1996, p. 17). As Kellogg (1997) notes, civil commitment refers to the “proceedings directing confinement of a mentally ill or incompetent person for treatment” (p. 342). Civil commitment may be either “voluntary” or “involuntary”. In its purest form, “voluntary” commitment means that a patient makes a free and unconstrained choice to enter a psychiatric facility for treatment *and* that the patient, once admitted, has the freedom to discharge himself. In practice, “voluntary” commitment is rarely purely voluntary. The patient who voluntarily commits himself generally does not retain full control over his care and treatment once admitted and may encounter certain procedural and administrative barriers to discharging himself. A little more than two-thirds of all civil commitments each year in the U.S. are classified as “voluntary” commitments (McFarland, Brunette, Steketee, et al., 1993, p. 46; Durham, 1996, p. 17).

About one-third of the annual total of one million commitments (or around 300,000) in the U.S. is classified as “involuntary” commitments. In the case of involuntary commitments, neither the patient nor his parent/guardian consent to hospitalization. Instead, in involuntary commitment, the state (through the courts) orders confinement of a patient for evaluation, treatment or custodial care. The state’s decision to hospitalize (or compel to outpatient treatment) the patient against

his/her will is generally made based on the assessment that the person poses a threat to himself and/or others in the community and/or is unable to care for himself in the community (Kellogg, 1997, p. 443). In contrast to voluntary patients, the involuntary patient lacks the freedom to discharge himself (including the freedom to discharge himself “against medical advice”), at least for the statutorily limited duration of his confinement. The involuntary patient is also distinguished from the voluntary patient in his even more limited ability to make decisions about his own treatment. In some jurisdictions, and under certain conditions, the involuntary patient may lack the right to refuse specific medication treatment even though such treatment is medically risky (Appelbaum, 1994; Arrigo & Tasca, 1999).

At its core, involuntary civil commitment involves “a conflict between the government’s interest in safety and an individual’s interest in freedom” (Durham, 1996, p. 18). Involuntary commitment and involuntary treatment also represents a significant abridgement of the individual’s civil liberties. The Group for Advancement of Psychiatry (1994) argues that “the issue of involuntary treatment brings into conflict two significant and persistent American values: autonomy and paternalism” (p. 36). Involuntary hospitalization and/or treatment represent an assault on individual liberty and on the individual’s right to autonomy. Schopp (2001) defines liberty as “the absence of rule-imposed limits on freedom of action within a political system”, and notes that liberty is “a narrower concept than freedom” since “liberty involves only a lack of legal constraints, but freedom requires the absence of any constraints from personal sources” (pp. 67-68). Autonomy, when used to identify a right, “refers to a right to self-determination within a sphere of personal sovereignty. The individual who holds this right enjoys discretionary authority within this sphere in that his or her competent, voluntary decision is necessary and sufficient to settle matters falling within the scope of this right” (Schopp, 2001, p. 69).

This paper provides an overview and analysis of the deprivation of individual liberty encompassed in the process and act of involuntary civil commitment and related involuntary treatment. The focus of this paper is confined to involuntary civil commitments arising within the community. While involuntary civil commitment of sexual predators and other convicted criminals as well as involuntary psychiatric treatment of prisoners constitutes analogous deprivations of liberty in the realm of psychiatry and law, this investigation is limited to the problems posed by involuntary civil commitments.

Rational for Involuntary Treatment: *Police Powers & Parens Patriae*

There are two primary justifications made by the state for the deprivation of liberty caused by the involuntary hospitalization/treatment of patients. As described by the Group for the Advancement of Psychiatry (1994):

The first of these justifications is a *police powers doctrine* based on a society's perception of its need and right to protect its members, both individually and collectively, from the dangerous actions of people who will not or cannot exert self-control. The second is a *parens patriae doctrine*, or the concept of benevolent paternalism, under which society accepts an obligation to protect its incapacitated members from the consequences of their incapacities (p. 30).

Schopp (2001) explains how the police powers and *parens patriae* doctrines intrude on individual liberty, as well as the political/legal framework for the limitations on these doctrines:

The *parens patriae* and police powers represent traditional sources of authority for government intrusion into individual action and limitation on individual liberty. As such, they presuppose a legal system reflecting general principles of political morality that support some relatively broad range of individual liberty....the broader legal structures in the U.S. and other liberal societies institutionalize liberal principles of political morality that support a broad range of individual liberty that includes liberty from physical confinement or unwanted treatment..the *parens patriae* and police powers represent certain well-established exceptions to a broad presumption of individual liberty... (p. 75).

Changing Legal Approaches to Civil Commitment

Prior to the 1830s and the opening of the country's first state mental institutions, there was little official separation between mental and physical illness. The problematic mentally ill – i.e., those who were particularly disruptive or whose behavior was well outside the social norm – were generally confined in jails or poorhouses. In the mid-19th century, social reformers such as Dorothea Dix argued for development of a system to care for the mentally ill and to remove them from the inhumane conditions in jails and poorhouses. The response was the construction of “asylums” – places where the mentally ill could retreat from the stresses of the outside world (Appelbaum, 1994, p. 19). Appelbaum (1994) explains that “commitment was predicated simply on a mentally ill person's requiring care...Entry was designed to be as simple as possible, and it was essentially left in the hands of family and physicians wherever practicable...coercion was viewed as essential if needed treatment was to be obtained” (p. 20). Changes in some of the procedural aspects of commitment occurred periodically over the decades in response to the existing political/social climate. Greater oversight to commitment was applied during times when the public attention was focused on the potential abuse of civil liberties in asylums while in other eras, when concern about social disorder and crime prevailed, procedures were loosened to allow for speedy commitment.

By the early 20th century, law enforcement personnel had become integrally involved in the commitment process. Appelbaum (1994) notes that in the late 1930s “it was estimated that 64% of patients were transported to state hospitals by law enforcement personnel” and that police could detain individuals and arrange for their hospitalization for up to 140 days without any kind of hearing (p. 21). Durham (1996) notes that the mental asylums were seen as remedies for a wide variety of social problems, including mental illness, poverty and crime. The number of people

detained in asylums far exceeded the number of people held in jails and prisons around the country.

By the late 1940s, however, asylums were no longer viewed as a panacea for society's ills. Indeed, the nation's many asylums were increasingly portrayed in the media as "snakepits" and breeding grounds for crime and disease, including mental illness (Durham, 1996; Appelbaum, 1994). In the 1950s and 1960s, a combination of legal trends and advances in psychiatry set the stage for the "deinstitutionalization" of the mentally ill. Treatment of the chronically and seriously mentally ill changed forever in the early 1950s with the development of the first generation of anti-psychotic medication (e.g., thiorazine) (Arrigo & Tasca, 1999, p. 2). In many cases, these new drugs effectively controlled the symptoms of psychosis. They thus allowed for the possibility that the mentally ill could be freed of the need for extended periods of confinement and maybe even lead productive lives in the community. Despite their "miraculous" therapeutic effects, the first generation anti-psychotics also caused a broad range of side effects, some of which could prove permanently disabling (one of the most troubling side effects is tardive dyskinesia, an incurable movement disorder characterized by unpleasant and uncontrollable facial tics) or even fatal. In addition to the concerns over dangerous side effects, there were charges that in many cases, hospital staffs were administering these drugs for their own convenience – i.e., so that patients would be docile, sleepy and easy to control. Not surprisingly, patients and their advocates began to object to the over-use and misuse of these drug (Arrigo & Tasca, 1999, p. 4). These objections occurred in an era when the federal government was beginning to pay increasing attention to the state laws and practices that abridged individual civil liberties (e.g., school segregation, voting laws, etc.).

“Deinstitutionalization” – the transfer of thousands of mentally ill from public and private mental institutions to care in community settings – had already begun by the early 1960s. It was during the 1970s, however, that the entire philosophy and structure of the mental health care system in the U.S. was transformed. Throughout most of the 20th century, civil commitment procedures had been based on a fairly broad interpretation of the government’s *parens patriae* duties and powers. The 1960s saw the reemergence of the police powers doctrine with a new stress on use of a legal versus medical model in the decision to involuntarily commit individuals. This was first codified in California’s Lanterman-Petris-Shirt Act (1969), which limited civil commitment to the ‘dangerously’ mentally ill (Group for Advancement, 1994, p. 31).

On the national level, the most important shift came in the 1972 Wisconsin case of *Lessard v. Schmidt* holding that “the risk of violence to self or others must be established, with such dangerousness being demonstrated by a recent overt act plus the substantial probability of recurrence” (Group for Advancement of Psychiatry, 1994, p. 31). Citing the libertarian philosopher John Stuart Mill, the Court in *Lessard* ruled that “the state’s legitimate powers are limited to preventing harm to others under its police powers and to preventing imminent harm to oneself under a very narrow reading of its powers as *parens patriae*” (Appelbaum, 1994, p. 27). Shortly after the verdict in *Lessard*, states across the country revised their commitment laws and procedures to reflect adherence to a strict standard of “dangerousness” wherein involuntary commitments were allowed only in cases where the person was found to be both mentally ill and in *immediate* (as indicated by a recent overt act) danger of harming himself and/or others. In addition, most states shortened the duration that involuntary patients could be held without additional hearings and tightened their procedures on conservatorship and permanent commitments.

“Deinstitutionalization” represented a dramatic restructuring of mental health in the U.S. The most obvious effects of deinstitutionalization included a dramatic decline in the total number of mental health inpatients, a smaller but no less significant drop in the number of mental hospitals, and a dramatic decline in the median length of stay. Between the mid-1950s and 1980, the number of mental health inpatients dropped from more than 510,000 to 154,000 (Teplin & Voit, 1996, p. 284). In 1937, the average length of stay in U.S. mental hospitals was an astonishing 9.7 years (Durham, 1996, p. 20). According to one major study reported by Teplin & Voit (1996), by 1954 average length of stay had dropped to six months in public mental institutions; by 1975, the average length of stay had fallen to just 25 days (p. 284).

By the early 1980s, states had begun to retreat from the strict standard of dangerousness for involuntary commitment adopted in the early 1970s. Prominent psychiatrists such as Darryl Treffert argued that patients were “dying with their rights on” and that the right to refuse treatment should not be construed as a “right to rot” (Arrigo & Tasco, 1999, p. 6). Washington State led the way in 1979 when it revised its civil commitment laws to make involuntary hospitalization easier to accomplish.

The Washington state revisions came in the wake of a highly publicized murder case involving the murder of a wealthy Seattle couple by their next door neighbor – a mentally ill man who had recently been denied voluntary hospitalization (Durham, 1996, p. 27). The move in Washington and elsewhere to broaden commitment authority resulted in an expansion of commitment criteria to include involuntary hospitalized based on “grave disability” or “need for treatment” as assessed by mental health professionals. In more recent years, there has been a more concerted “backlash” against deinstitutionalization, spearheaded not so much by persons concerned about the need to make it easier for persons who needed

treatment to get treatment, but rather by those concerned about the connection between mental illness, homelessness and violent crime. The movement for loosening the laws on civil commitment has been given extra impetus by a number of highly publicized murders committed by deinstitutionalized mentally ill offenders (e.g., the subway killings in New York City) (Durham, 1996; Appelbaum, 1994).

Another recent development has been the expansion of involuntary outpatient civil commitment structured in one of three formats: 1) conditional release from inpatient hospitalization; 2) civil commitment to an outpatient program as a less restrictive alternative to hospitalization; and 3) commitment to an outpatient program based on less stringent criteria than for inpatient commitment (Malloy, 1996, p. 41). Currently, forty states have outpatient civil commitment laws (Watnik, 2001, p. 1190). In most cases, states have passed outpatient civil commitment laws both to improve economic efficiency of their civil commitment programs (it is obviously cheaper to treat within the community) and/or in response to violent crimes and the desire to make it easier to compel mentally ill people to undergo treatment. New York's "Kendra's Law" – named after a 32-year old Manhattan woman (Kendra Webdale) who was pushed in front of a subway train by a schizophrenic man who had stopped taking his medication – provides a prime example of the latter (Schmemann, 1999; Perez-Pena, 1999).

Possible Solutions to the Problem

There is little question that involuntary civil commitment constitutes an abrogation of individual liberties on several levels. Those, who are not only involuntarily detained, but also subject to involuntary medical treatment suffer the severest deprivation of liberties. Szasz (1998) has argued convincingly that there are significant disparities in legal status between patients with psychiatric illness and patients with non-psychiatric illnesses, including those patients with closely related

neurological illnesses. The latter has a right not only to refuse hospitalization, but also to refuse medical treatment once hospitalized and a right to make decisions about medical treatment based on informed consent.

A number of court cases in the 1970s confirmed an involuntary patient's right to refuse medical treatment based on the patient's Eighth Amendment right to freedom from cruel and unusual punishment and the patient's Fourteenth Amendment due process guarantee (Arrigo & Tasca, 1999, p. 5). From a legal standpoint, these rights are unchallengeable except in the case of a finding of incompetence. Involuntary civil commitment does *not* in itself constitute a presumption of incompetence (finding a person incompetent is a fairly lengthy legal process), however, once found incompetent, an individual's right to refuse treatment is compromised and overshadowed by the physician's duty to treat (Arrigo & Tasca, 1999, p. 5).

Research studies have demonstrated that competent involuntary patients are often denied the right to refuse treatment in psychiatric institutions that following a "treatment-driven" versus "rights-driven" approach to patients' right to refuse treatment. Szasz (1998) cites the example of one Virginia investigation of 350 admissions of which 45 patients attempted to refuse treatment – none of them were successful since "psychiatrists exercised their discretion to promptly treat all patients who refused treatment" (p. 1213). While involuntary outpatient civil commitment is often presented as a "less restrictive" alternative to "traditional" inpatient commitment, it can be argued that outpatient commitment is in many cases *more restrictive* and more of an imposition on individual liberties since it involves protracted restrictions (often for an indefinite period) on multiple facets of the individual's life as well as mandatory drug treatment.

It could be argued that following a period of involuntary treatment, the individual whose liberty and autonomy is initially abrogated may actually come to enjoy greater freedom and/or prevent the loss of additional liberty. In the midst of psychosis, the individual arguably loses his or her autonomy as a consequence of the debilitating effects of untreated disease. Relatedly, the maladaptive behaviors associated with debilitating untreated disease may inevitably lead to the permanent loss of liberty, should the psychotic person engage in criminal behavior ultimately resulting in his incarceration (e.g., the schizophrenic man who pushed a young woman into the path of the subway train). On the other hand, if the same person undergoes a relatively brief deprivation of liberty, receives treatment and regains the mental capacity to function in society, he or she would have greater liberty and autonomy than would have been possible with untreated illness.

At the same time, it must be recognized that the state has both an interest and a duty to protect its citizenry. That is to say, in some cases, involuntary treatment is not only “for the good of the patient” but also for the “good of society”. Although only a small percentage of mentally ill people commit violent acts, it is well established that the severely mentally ill are more likely to commit violent acts – including homicide – than people who are not mentally ill. It is notable that as a group, former involuntary mental patients have an arrest rate up to 28 times higher than the rate of the general population for assault or homicide (Durham, 1996, p. 20). In many cases, the severely mentally ill do in fact represent a danger to themselves. Recent estimates suggest that each year, about 20% of the 2.3 million adult Americans with bipolar disorder and about 10% of the 2 million adult American schizophrenics commit suicide (Watnik, 2001, p. 1187).

On the other hand, it remains true today as it did during the early 20th century era of asylums that the vast majority of patients who are confined involuntarily are

locked up not because they represent any particular danger to themselves or others but rather because they *make people uncomfortable*. The majority of the involuntary patients are schizophrenics whose behavior is at minimum, often socially inappropriate. A large proportion of the involuntary patient population is comprised of racial/ethnic minorities (particularly African-American). A majority of those confined involuntarily are poor by almost any standards used to define poverty. The severely mentally ill population is thus a particularly vulnerable group who under different circumstances (i.e., circumstances unrelated to mental illness) might actually be given greater protection to ensure the preservation of their basic civil liberties.

The review of literature suggests that there are no easy solutions to the problem of the conflicting state and individual interests encompassed in involuntary civil commitment. The APA has established its own recommended criteria for involuntary treatment based loosely on Alan Stone's "Thank You Theory" of civil commitment (which emphasizes patients' need for treatment, incapacity to make decisions, likelihood of benefiting from treatment, and reasonable expectation of being grateful for treatment) (Group for Advancement of Psychiatry, 1994, pp. 44-46). Others, such as Schopp (2001), take a much narrower view, arguing that there is *no* justification for *parens patriae* civil commitment in the absence of incompetence (p. 79). Szasz (1998) argues in favor of the elimination of involuntary civil commitment altogether, maintaining that neither police powers nor *parens patriae* can justify the abrogation of civil liberties entailed in involuntary treatment. Szasz (1998) would not excuse or ignore the crimes committed by the mentally ill, nor would he belittle threats of violence made by persons from this group. Instead, he would have them treated the same as the non-mentally ill: prosecuted as criminals. The Bazelon Center for Mental Health Law has proposed a model law that would

create a legal “right” to mental health services and empower all people with serious mental illnesses to obtain mental health services on a voluntary basis, thus theoretically precluding the need for involuntary treatment (“Bazelon model law...” 2001, p. 1).

Ultimately, we are forced to conclude once again that there are no easy solutions. There are times when the state’s interest (either from a police powers or *parens patriae* approach) should prevail and other times when the individual’s interest in liberty should prevail. As the APA’s Group for the Advancement of Psychiatry (1994) observed “sometimes involuntary psychiatric treatment is necessary, can be effective, and can lead to freedom from the constraints of illness” whereas “conversely, tight restrictions against coercive treatment can have disastrous consequences” (p. 43).

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