U.S. involuntary mental health commitment statutes: Requirements for persons perceived to be a potential harm to self

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The civil commitment statutes of all 50 states and the District of Columbia were reviewed to determine: (1) What is required for a person who is believed to be at serious and imminent risk of self-harm to be eligible for involuntary hospitalization; and (2) Whether an attempt to involuntarily hospitalize was required or was merely an option when the requirements found in number 1 were met. The analysis revealed that nearly 85% of the jurisdictions require dangerousness to self to be the result of a mental illness, and only two jurisdictions mandate attempts at involuntary commitment if a person is deemed to be an imminent harm to self. These results have implications for practice with individuals who are suicidal.

The literature on the appropriate course of action when faced with a suicidal client is fairly consistent: Intervene in some manner to prevent an escalation of the person's apparent desire to kill him or herself or, if necessary, do something to prevent a potentially lethal action from occurring (e.g., Bongar, 1991; Bongar, Maris, Berman, & Litman, 1992; Jobes & Berman, 1993). There are many clinical courses of action available to the professional, including increasing the length or frequency of sessions, voluntary hospitalization, or even breaking confidentiality to alert significant others of the perceived danger (Bongar et al., 1992; Schutz, 1982). If the therapist, preferably in consultation with an experienced colleague (Bongar, 1993), believes that the risk is such that the client is in imminent danger of hurting him or herself upon leaving the clinician's office, then the professional can try to have the person involuntarily hospitalized (Bongar, 1991; Bongar et al., 1992).

There are several potential problems with involuntary commitment, including the person not being admitted due to what occurs during the assessment at the unit (Comstock, 1992) or hospitalization exacerbating the client's condition (Pauker & Cooper, 1990). Some authors (e.g., Comstock, 1992) have talked about such issues and examined factors that may contribute to the effective or ineffective use of involuntary commitment as an intervention to prevent suicide. Two aspects of the involuntary hospitalization scenario that should be vitally important early on in the clinician's decision-making process have not been sufficiently examined: (1) When is a client statutorily eligible for involuntary commitment,
and (2) Whether an attempt at involuntary commitment is an option or is required for the treating therapist. The answers to these questions have obvious implications for the courses of action considered by the clinician.

METHOD

This investigation was designed to address the two areas just outlined. Each state's statutes, as well as those of the District of Columbia, that describe an aspect of the involuntary commitment process were examined to determine, to the degree possible given the way the different laws are written, two things: (1) What is required for a person who is believed to be at serious and imminent risk of self-harm to be eligible for involuntary hospitalization, and (2) whether an attempt to involuntarily hospitalize was required or was merely an option when the requirements found in number I were met. In addition, the definitions that pertained to the involuntary commitment statutes were examined to determine if the requirements found in answering the first question were described in sufficient detail for the therapist to know who would meet each aspect. The focus was on danger to self due to suicidality or other forms of active self-harm, not as a result of grave disability, and no consideration was given to harm to others.

RESULTS

A tabular summary of results is contained in Table 1. Although several different statutes for each jurisdiction were reviewed, in some cases it was not possible to determine whether a mental health professional was required to attempt to involuntarily commit an individual who was believed to be at serious, imminent risk of self-harm or if such an action was merely an option. Assessing the other questions of concern was more straightforward, although still not without problems.

Regarding the minimal requirements for a person to be eligible for involuntary commitment, 43 of the 51 jurisdictions reviewed required that the risk of self-harm be as a result of a mental illness. Seven others merely stated concurrent danger and mental illness but did not specify that the risk arise from the mental disorder and the last one gave contradictory requirements—some places the requirements listed the criterion separately but in at least one other statute the dangerousness needed to be the result of the mental illness. Nearly all the states also required that the person be in need of treatment, that hospitalization would be a benefit to the person, and that there were no less restrictive alternatives. Some added that the person needed to be deemed incapable of making reasoned decisions about the need for treatment. All but seven jurisdictions provided at least a minimal definition of mental illness, mental disorder, or mentally ill person. Explicit descriptions of what constituted dangerousness to self were present in 34 jurisdictions.

Regarding whether an attempt to involuntarily commit a person who has apparently met the statutory requirements for such an intervention is required or is merely an option for the therapist, firm data could only be gathered from 26 jurisdictions. Of these, 24 indicated that if the requirements were met the therapist "may" decide to try to have the person involuntarily committed but they did not specify that the clinician "shall" take such actions. The other two had provisions that mandated an attempt at involuntary hospitalization. Missouri's statute (632.300, emphasis added; see also New Jersey statute 2A:62A-16) incorporates both an option and a requirement, depending on the circumstances:

If, as the result of personal observation or investigation, the mental health coordinator has reasonable cause to believe that such person is mentally disordered and, as a result, presents a likelihood of serious harm to himself or others, the mental health coordinator may file an application with the court having probate jurisdiction pursuant to the provisions of section 632.305; provided, however, that should the mental health coordinator have reasonable cause to believe, as the result of personal observation or

investigation, that the likelihood of serious harm by such person to himself or others as a result of a mental disorder is imminent unless the person is immediately taken into custody, the mental health coordinator shall request a peace officer to take or cause such person to be taken into custody and transported to a mental health facility in accordance with the provisions of subsection 3 of section 632.305.

Of the 25 jurisdictions where the optional/requirement question could not be answered, 12 had statements that said a member of the public "may" attempt to involuntarily hospitalize but there was no information on mental health professionals; in the other 13, no concrete information was given for any non-law enforcement/judicial person.

Table not reproduced: TABLE 1

DISCUSSION

The purpose of this review was to determine what conditions must be met before a person could be a candidate for involuntary hospitalization due to risk of suicide, with a focus on the mental illness and dangerous to self components, and once such circumstances were deemed met whether the treating therapist was required to seek commitment or if such an action was only an option. Given common clinical wisdom, the results are counter-intuitive.

However, before reviewing the results it is important to discuss the limits to the analysis undertaken in this paper. The focus of the review was on the statutory duty of the therapist, based solely on an analysis of state definitional and civil commitment statutes. A professional must also conform to the standards of care that have been established and these may arise from: a different statute, negligence cases addressing wrongful death or failure to diagnose and treat to the standards of the profession, and complaints and proceedings through a licensing board. In addition, the civil commitment statutes themselves might give rise to duties that are broader, narrower, or different than they appear on the face of the statutes because state courts may have interpreted them in a manner that provides for duties that differ from those that might appear in the text in isolation. It is important to recognize that what is being examined here are only the requirements found in the statutory language without addressing these additional sources that might alter the legal obligations. Notwithstanding these caveats, the results of the review have important implications for the decision-making process clinicians should use when working with clients who are suicidal.

Minimal Requirements for Involuntary Hospitalization

Many authors (e.g., Bednar, Bednar, Lambert, & Waite, 1991; Hoge & Appelbaum, 1989; Stromberg & Stone, 1983) have traced the changes in involuntary commitment standards over the past several decades and have stated that one of the primary reasons that jurisdictional laws have changed from merely focusing on mental illness and a perceived need for treatment to an emphasis on dangerousness to self or others was the U.S. Supreme Court case of O'Connor v. Donaldson (1975). Here the Court held that "A finding of 'mental illness' alone cannot justify a state's locking up a person against his [or her] will and keeping him [or her] indefinitely in custodial confinement" (p. 575), and later that "a State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself [or herself] or with the help of willing and responsible family members or friends" (p. 576). Lower courts and jurisdiction legislatures apparently interpreted these statements and others in the case to mean that dangerousness to self or others was a necessary additional requirement to the presence of mental illness (however, such interpretations may be incorrect; see Schopp, 1998).
The American Psychiatric Association (Stromberg & Stone, 1983) developed a "Model State Law on Civil Commitment of the Mentally Ill" to provide jurisdictions with some guidance that was consistent with the common court interpretations but also responded to the needs of people with mental illness. In order to be eligible for civil commitment under the model, a person had to meet four criteria: (1) have a severe mental disorder, (2) lack capacity to make a reasoned treatment decision, (3) have a treatable condition, and (4) be likely to harm self or others. Hoge and Appelbaum (1989) reported that they believed the Model State Law had been very influential as jurisdictions revised their statutes.

The impact of the Model State Law was clearly evident by the time Bednar and colleagues (1991) summarized commitment laws in terms of six requirements: "(1) mental illness, (2) dangerousness to self or others or grave disability, (3) refusal to consent, (4) treatability, (5) lacks capacity to decide on treatment, (6) hospitalization is the least restrictive treatment" (p. 209). Given the results of the present review, it would appear as if this generalization still holds true today. Although all six of these requirements deserve comment, the following discussion will focus on the first two, with a brief mention of capacity.

Every state and Washington, DC, specifies that in order to be qualified for involuntary commitment a person must have a mental illness and be dangerous to self. Further, nearly 85% of the jurisdictions require that the dangerousness be the result of the mental illness. These results indicate that suicidality by itself should not be sufficient to trigger consideration of involuntary commitment nor should it be enough to get a person admitted to a locked unit. Further, even if a mental illness is present, the potential for self-harm must be caused by the disorder, it cannot merely be concomitant to it. These aspects of the laws have been ignored in discussions of hospitalization yet they could have important implications on the courses of action considered by therapists.

Given the fact that high percentages of people who die by suicide are believed to have a mental illness, especially clinical depression (Blumenthal, 1990; Bongar, 1991), it may not be hard to meet the requirements that the suicidality be causally linked to a disorder. Further, depending on how broadly a statute defines mental illness, it may not take a Diagnostic and Statistical Manual (American Psychiatric Association, 1994) diagnosis of severe major depression or schizophrenia for a person to qualify (e.g., Iowa [229.1]: "Mental illness' means every type of mental disease or disorder"). However, in other states (such as Arkansas [20-47-202]: "Mental illness' refers to a substantial impairment of emotional processes, or of the ability to exercise conscious control of one's actions, or the ability to perceive reality or to reason, when the impairment is manifested by instances of extremely abnormal behavior or extremely faulty perceptions"), unless the clinician can document that the person meets the criteria for significant mental disorder, such as schizophrenia, involuntary commitment should not be attempted (see also, Amchik, Wettstein, & Roth, 1990; Bednar et al., 1991). The Arkansas definition appears to have been influenced by the Model State Act, which defines "severe mental disorder" as "an illness, disease, organic brain disorder, or other condition that (1) substantially impairs the person's thought, perception of reality, emotional process, or judgment or (2) substantially impairs behavior as manifested by recent disturbed behavior" (Stromberg & Stone, 1983, p. 312; it is notable that on p. 313 the authors use Arkansas' 1971 definition as an example of an "unsuitably vague" description of mental illness). However, Stromberg and Stone note that "severe mental disorder' corresponds roughly to a psychotic disorder," although they also state that "under exacerbating circumstances, other disorders could meet the standard" (p. 313). This may raise questions about the degree to which suicidal ideation believed to be resulting from major depression may make a person committable or whether the depression will need psychotic features.

In any event, based on this review of laws as they are written, it should be clear that even if one believes that suicidality in and of itself means that a person has a mental illness, more must be documented and
proved to one or more examiners or a judge before involuntary hospitalization can take place. In practice, there is the possibility that anyone who attempts suicide may be committed based solely on the presumption that the attempt itself supports a diagnosis, such as major depression.

In addition, some jurisdictions make it even more difficult for a person to be involuntarily committed as a result of concern about self-harm through their definitions of what constitutes acceptable evidence of danger (Amchin et al., 1990; Bednar et al., 1991). The Model State Act (Stromberg & Stone, 1983) provides a detailed definition which appears to have influenced most of the jurisdictions, the first part of which is relevant to the present discussion (the rest relates to grave disability and deteriorating mental or physical conditions): "Likely to cause harm to himself [or herself] or to suffer substantial mental or physical deterioration' means that, as evidenced by recent behavior, the person (1) is likely in the near future to inflict substantial physical injury upon himself" (pp. 302-303). The commentators emphasize a point that is not explicit in the model but has been incorporated into statutes-"commitments are justified only if it can be predicted that the person will soon harm himself [or herself], and this likelihood is due to his [or her] severe mental disorder" (p. 303). They indicate that in order to satisfy the "likely" portion of the model, there will need to be evidence of "a recent, credible threat of or attempt at self-mutilation or suicide, accompanied by a mental state indicating a likely recurrence" (p. 303).

One final requirement may make it all but impossible, in theory, for anyone except the most severely impaired individuals to be involuntarily committed. Some jurisdictions follow the model and require that the person be incapable of making reasonable treatment decisions. According to Stromberg and Stone,

"lacks capacity to make an informed decision concerning treatment" means that the person, by reason of his [or her] mental disorder or condition, is unable, despite conscientious efforts at explanation, to understand basically the nature and effects of hospitalization or treatment or is unable to engage in a rational decisionmaking process regarding such hospitalization or treatment, as evidenced by inability to weigh the possible risks and benefits. (p. 301)

The commentators note that "A person lacks capacity if, due to his [or her] mental disorder or condition, he [or she] cannot understand the basic nature and effects of the proposed hospitalization or treatment. A person does not lack capacity simply because he for she] refuses treatment" (p. 301, emphasis added). Further,

The definition requires inability to engage in any rational process .... Rational modes of thinking may be unusual, eccentric, or even inconsistently related to reality .... An individual afflicted with a severe mental disorder may be unable to pay attention to and assimilate information, or his disorganized thoughts may preclude him from engaging in anything resembling a rational process. Only this type of patient lacks capacity under the Model Law. (p. 302; emphasis added)

Such a requirement, even if interpreted merely to mean that a person must be unable to assess a decision to suicide, places severe restrictions on who may be considered eligible for involuntary hospitalization as a result of potential harm to self. As has been reviewed elsewhere, a diagnosis of a mental disorder, even schizophrenia or severe major depression, is not sufficient to conclude that a person is mentally incapacitated (Grisso & Appelbaum, 1998; see also Litman, 1986). Thus, in these places the clinician not only needs to do a suicide risk assessment but, upon finding that there is serious danger of the client harming him or herself and determining that involuntary commitment may be the best option, the therapist will then have to do a capacity assessment before actually determining if a client is eligible for hospitalization. Perhaps this is why only a few jurisdictions have actually added such a requirement to their laws.
Is an Attempt at Involuntary Commitment Required or Optional

Hoge and Appelbaum (1989) stated that "commitment statutes are permissive, not mandatory—that is, they allow clinicians to initiate the commitment process in appropriate cases, but do not compel them to do so" (p. 611). The results of the present investigation are notable because they support Hoge and Appelbaum’s claim, but in doing so they run counter to the prevalent clinical belief that when a person is deemed to be at serious risk of self-harm then the therapist is mandated by law to try to get the individual involuntarily committed if there are no acceptable less drastic alternatives. In only two jurisdictions (Missouri and New Jersey) were there explicit provisions that made attempted commitment mandatory. In every other state, as well as in Washington, DC, attempts at involuntary hospitalization are either optional for mental health professionals, optional for all interested persons (without special mention of clinicians), or unclear about when there may be a requirement and to whom such a mandate may apply.

It must be noted, however, that although there may not be a clear statutory requirement in most jurisdictions to try to involuntarily hospitalize a client who is considered to be imminently suicidal, clinicians must still follow the standard of care within the profession (see Bongar, 1991). Some jurisdictions actually tell clinicians in their statutes what they expect the standard to be (e.g., Massachusetts [123 s. 1]; New Jersey [2A: 62A-16]). New Jersey’s statute includes initiating involuntary commitment as one of the ways to meet the duty to protect standard of care (c2) "Initiating procedures for involuntary commitment of the patient to a short-term care facility, a special psychiatric hospital or a psychiatric facility"). The message in New Jersey clearly is that preventive action is expected and the standard of care would indicate that some sort of preventive action is necessary, but whether involuntary hospitalization is the answer is an open question.

Implications

The clinical implications of this review are at least six-fold:

1. The vast majority of mental health professionals do not have a statutory duty to try to involuntarily hospitalize even seriously suicidal clients most of the time.

2. In nearly 85% of the jurisdictions, therapists must be able to document how a client’s condition meets the state’s definition of mental illness (or mental disorder) and how the person’s potential for self-harm (if defined in the statutes) is a result of this mental disorder.

3. Clinicians must review and be familiar with the involuntary commitment statutes of the particular jurisdiction in which they are practicing. If the statute is unclear or incomplete, a knowledgeable risk management attorney should be consulted and the recommendations of the attorney documented, and then followed.

4. Regardless of the jurisdiction in which they work, therapists should take each situation on a case-by-case basis and not make a blanket assumption that a given intervention is or is not legally required; however, the interventions used should be consistent with the standard of care for working with people who are suicidal.

5. "The standard of care for work with suicidal clients is to evaluate the client carefully and weigh the pros and cons of each available clinical course of action from the standpoint of what, in the judgment of the clinician, is in the best interests of the client." 3

6. Clinicians should thoroughly document their decisions, using risk management oriented notes (Bongar, 1991), and clearly indicate how the course of action taken is consistent with both the standard of care and statutory requirements.

Footnotes:

1. However, a subsequent review of approximate state-by-state involuntary commitment rates did not reveal a consistent pattern. For example, although Arkansas' rate (12.03/100,000) was indeed lower than Iowa's (21.06/100,000), both were lower than the national average (24.24/100,000). This would seem to indicate that the strictness of the definition of mental illness is not the overriding factor influencing commitment rates.

Alaska reported that no one was involuntarily committed at the end of 1994 (the last year for which complete data are available). The next lowest rate was Tennessee with 2.26/100,000, while the District of Columbia had the highest rate at 143.19/100,000 (rates of other states are available from the author upon request). The Tennessee definition does not appear overly restrictive ("Mentally ill individual' means an individual who suffers from a psychiatric disorder, alcoholism, or drug dependence, but excluding an individual whose only mental disability is mental retardation") while, in comparison, the DC definition does not appear excessively broad ("Mental illness' means a psychosis or other disease which substantially impairs the mental health of a person"). A reviewer noted that the DC rate may be high because people who traveled to the District to harm an elected official were picked up by the police.

2. The inclusion of "self-mutilation" here is presumed to be because this is an example of behavior that could, in some instances, cause "substantial physical injury" as is necessary in the Model State Act, not because of evidence linking such actions with suicidality.

3. This definition of the standard of care is from an anonymous reviewer of an earlier version of this article. I could not improve upon the phrasing so I decided to quote it. I am sorry I cannot give due credit to the person who provided it.

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