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Confine is Fine: Have the Non-Dangerous Mentally Ill Lost Their Right to Liberty? An Empirical Study to Unravel the Psychiatrist's Crystal Ball

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CONFINE IS FINE; HAVE THE NON-DANGEROUS MENTALLY ILL LOST THEIR RIGHT TO LIBERTY? AN EMPIRICAL STUDY TO UNRAVEL THE PSYCHIATRIST’S CRYSTAL BALL

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I. INTRODUCTION

In determining that a mentally ill person requires civil commitment to an inpatient psychiatric hospital, how much discretion should judges have? How much influence should psychiatrist uncontested expert opinions have on the outcome? How imminent should danger to self or others be? How far will we permit legislatures and pro-treatment advocates to stretch the civil commitment standard before all due process protections are gone? What impact do more relaxed commitment standards have on the level of care of patients with mental illness? Why should disability advocates and members of the legal community alike be alarmed by this backward moving trend?

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There is a backlash among mental health advocates who are questioning the long-term efficacy of psychiatric medication for the treatment of the severely mentally ill. Does a magic bullet really exist to treat persons with mental illness? Might there be rational and valid reasons for patients to refuse certain medication or treatment? How we as a society respond, both in terms of the profession of treating psychiatrists who choose to institute commitment proceedings against patients with mental illness under a “grave disability” or “need for treatment” standard and the judges who are asked to make determinations at civil commitment hearings will speak volumes to the weight we give to the liberty interests of individuals with mental illness.

In the late 1960s, there was broad consensus that the present treatment of persons with mental illness was inhumane and in need of change. There was a national push to deinstitutionalize people with mentally illness and increase community treatment resources. State and federal Courts, recognizing that civil commitment was a significant curtailment of liberty interests\(^1\), established procedural limitations to the

\(^1\) Addington v. Texas, 441 U.S. 418 (1979). Jackson v. Indiana, 406 U.S. 715 (1972); Humphrey v. Cady, 405 U.S. 504 (1972); In
previously unchallenged practice of committing mentally ill persons under parens patriae powers for treatment purposes.²

Following landmark Supreme Court decisions, most states adopted a stricter criterion for civil commitment, requiring at a minimum a showing of “dangerousness”.³

Unfortunately, several decades later the pendulum has switched in the opposite direction and legislatures, with the broad support of medical community⁴, have moved to expand the

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⁴ Id. At 224 (In a national survey, completed by over 700 psychiatrists, 90 percent of respondents wanted grave disability to be at least one of the grounds for civil commitment. Fifty-two percent supported commitment standard based on mental illness alone, an increase from only 10 percent supporting such grounds in 1969).
definition of dangerousness back to what it was pre-1960s. Only eight states still define dangerousness solely as a “danger to self or others”.\(^5\) Forty-two states have a criterion broader than dangerousness that usually includes either a “grave disability”\(^6\) or “need for treatment”\(^7\) provision. This expanded criteria gives judges broad discretion to make civil commitment decisions and overvalues the role of medication adherence in treatment of mental illness. These broad provisions allow for the commitment of non-dangerous individuals based on a presumption that if left


\(^6\) Id. (Grave disability provision is an additional criteria adopted in most states that allows for commitment where a person because of their mental illness is unable to care for their basic needs).

\(^7\) Id. (“Need for Treatment” provisions are a third criteria for civil commitment based on either the person’s inability to provide for needed psychiatric care, inability to make an informed medical decision or need for intervention to prevent further psychiatric or emotional deterioration. Currently 26 of the 42 states with some sort of broader commitment criteria have “need for treatment” language in their statutes).
untreated future harm will likely ensue.

Two recent tragedies, and the public discourse that followed, may help to explain the reversal of long fought protections for the mentally ill. The 2007 Virginia Tech shooting and the 2011 shooting of Congresswoman Giffords were two very high profile cases where the mental health of the shooters was highly discussed by the media. There was a tumultuous debate about the dangerousness of mentally ill persons when warning signs go unnoticed and lack of proactive intervention. Following these tragedies, many state legislatures have moved to loosen the requirements for civil commitment to make it easier to commit potentially future dangerous mentally ill persons.\(^8\)

This article will examine the reverse trend in civil commitment laws and the effect on the care and treatment of mentally ill persons. It will take a critical look at the presumption that medication and inpatient hospitalization are effective means of preventing dangerous behavior and examine whether psychiatrists’ predictions of future dangerousness

\(^8\) See VA Code Ann. § 37.2-808 and § 37.2-809 (West 2011) (Virginia in the wake of Virginia Tech shooting changed statute from requiring evidence of imminent danger to only a substantial likelihood person would cause physical harm to self or others).
should justify the curtailment of person’s liberty where there is no clear evidence that serious physical harm to the individual or to others is imminent.

Statistical data from a survey of 100 psychiatrists will be examined to better understand what evidence is most significant to psychiatrists in commitment decisions and highlight the impact state standards and types of hospital facilities have on psychiatrists’ testimony at civil commitment proceedings.⁹

II. PROCEDURAL DUE PROCESS PROTECTIONS FOR THE MENTALLY ILL

A. LAYING THE FRAMEWORK: SUPREME COURT OUTLINES MINIMUM DUE PROCESS PROTECTIONS

Prior to the early 1970s the civil commitment of mentally ill persons went largely unchallenged in the courts. Many people with mentally illness were committed under parens patriae powers because they were in need of treatment.¹⁰ The Supreme Court in Jackson v. Indiana extended due process protection to civil commitments of persons with mental illness, mandating that there be a reasonable relation between the purpose of civil commitment and the nature and duration of commitment.¹¹


¹⁰ Bagby, effects of legislative reform, supra, at 45

¹¹ 406 US 715 (1972)
expanded these protections in *O’Connor v. Donaldson*\(^\text{12}\), restricting states ability to confine non-dangerous individuals who are capable of surviving safely in freedom.”\(^\text{13}\) The Court stated that the “mere presence of mental illness does not disqualify a person from preferring his home to the comforts of an institution”.\(^\text{14}\) The Court held that the state’s interest in providing care to the unfortunate, even if ensuring them a higher standard of living, was not a sufficient justification to confine a mentally ill person against their will.\(^\text{15}\)

The Court in *Addington v. Texas* elevated the burden of proof for civil commitments, requiring the state to prove by clear and convincing evidence that: the person is mentally ill; dangerous to either self or others and in need of confined therapy.\(^\text{16}\) The Court explained that the clear and convincing standard for evidence is a balance of the patient’s interest to not be involuntarily confined, and the state's *parens patriae* power to provide care to its citizens who are unable to care for

\(^\text{12}\) 422 U.S. 563 (1975).

\(^\text{13}\) *Id.* at 576.

\(^\text{14}\) *Id.* at 575

\(^\text{15}\) *Id.*

\(^\text{16}\) 441 U.S. at 429.
themselves. The Court weighed heavily the liberty interests of the individuals to make independent treatment decisions and the stigma that can result after a person has been committed to a mental hospital. Given the loss of liberty and the stigma of civil commitment, the Court stated that the factfinder should commit an individual only on “a showing that the individual suffers from something more serious than is demonstrated by idiosyncratic behavior.” The Court chose to increase the burden of proof to stress to the factfinder the importance of the decision and reduce the likelihood that inappropriate commitments will be ordered. These landmark decisions served as a guidepost for civil commitment laws across the country as states revises their statutes to bring in line with the Court’s holdings.

B. CHALLENGES TO STATE CIVIL COMMITMENT STANDARDS: INDIVIDUAL CHALLENGES MET WITH INCONSISTENT SUCCESS

Despite the protections of a mentally ill person as outlined by the Supreme Court, the disturbing trend seen in the “need for treatment” and “grave disability” statutes permits

17 Id. at 426-27
18 Id. at 426
19 Id. at 425-426
20 Id.
confinement based on an expectation of deterioration and possible future harm that is largely based on presumptions about persons with mental illness. These exceptions to the requirement of dangerousness represent a complete erosion of the substantive due process rights articulated by the Court. 21

There is much disagreement among state courts about what is a constitutionally permissible commitment standard and state courts have interpreted the minimum due process differently. An example of such disparity can be seen in the handling of challenges made in Alaska and Wisconsin of “need for treatment” provisions. Despite similarities in the content of the statutes, Wisconsin Court upheld the state’s need for treatment provision, while Alaska’s Supreme Court struck down the provision.

In Wetherhorn v. Alaska Psychiatric Institute, Alaska’s Supreme Court explicitly adopted the O’Conner standard in invalidating a provision of Alaska’s civil commitment statute that permitted involuntary commitment of gravely disabled persons who are at risk of substantial deterioration of the individual’s ability to function independently. 22 In Alaska, a person was determined to be gravely disabled if as a result of

21 See O’Connor, 422 U.S. 563; See also Addington, 441 U.S. 418.

22 156 P.3d 371 (Alaska 2007)
their mental illness the person was in danger due to neglect of basic needs or personal safety or will if not treated suffer severe or abnormal mental, emotional or physical distress.\textsuperscript{23} The Court insisted on the need for a finding that the person presents some danger to herself and that the impairment results in a substantial deterioration.\textsuperscript{24}

The Wisconsin Supreme Court’s decision went the opposite direction in \textit{Commitment of Dennis H}, \textit{rejecting the holding by the U.S. District Court in Lessard v. Schmidt}, that dangerousness must be “based upon a finding of recent overt act, attempt or threat to do substantial harm to oneself or another” and must remain an immediate danger at the time of the hearing\textsuperscript{25}. The Wisconsin Court affirmed the constitutionality of a lower standard for dangerousness.\textsuperscript{26} The challenged provision of

\begin{itemize}
\item \textsuperscript{23} \textit{Id.} at 371 (Roslyn Wetherhorn was found to be gravely disabled and challenged the constitutionality of the statute).
\item \textsuperscript{24} \textit{Id.}
\item \textsuperscript{25} 349 F. Supp. 1078 (E.D. Wisc. 1972)
\item \textsuperscript{26} \textit{See In re Commitment of Dennis H.}, 647 N.W.2d 851, 854 (2002) (Mentally ill person with schizophrenia challenged the grave disability statute because it allowed involuntary commitment based on a finding of a substantial probability of something less than physical harm).
\end{itemize}
Wisconsin involuntary commitment statute, dubbed the “fifth standard,” allows for the commitment of a mentally ill person who left untreated will “suffer severe mental, emotional, or physical harm that will result in the loss of the individual's ability to function independently in the community or the loss of cognitive or volitional control over his or her thoughts or actions.”\textsuperscript{27} The Wisconsin Court held that even if there is no foreseeable risk of self-injury or suicide, a person is still dangerous if he is helpless to avoid the hazards of freedom.\textsuperscript{28} To justify involuntary commitment, the level of incapacity of the gravely disabled person should be so substantial that the person is incapable of surviving safely in freedom.\textsuperscript{29}

The addition of “need for treatment” provisions to civil commitment laws indicates a troubling supposition that mentally ill persons without medication are de facto dangerous. The need for treatment standard upheld by the Court in the Commitment of Dennis should be unsettling to all advocates who subscribe to the belief that substantive due process requires a showing of dangerousness by clear and convincing evidence. Simply demonstrating that a person might benefit from involuntary civil

\textsuperscript{27} Wis. Stat. Ann. § 51.20 (West 2011)

\textsuperscript{28} Dennis H., 647 N.W.2d at 863.

\textsuperscript{29} Id. At 862
commitment should not justify one’s deprivation of freedom. However, new laws like those adopted and upheld in Wisconsin Courts do just that, redefining dangerousness to include “need for treatment” language.

Despite setbacks in some courts there have been many victories for disability advocates.\(^\text{30}\) The Florida Appellate Court, in *Boller v. State*, held that the commitment of a woman who refused to take her psychotropic medication was inappropriate.\(^\text{31}\) The Court followed the well-settled standard that refusal to take medication, despite deteriorating mental condition, does not justify involuntary commitment.\(^\text{32}\) The Court held that there must be clear and convincing evidence that without treatment, the patient would pose a real and present threat of substantial harm to herself or a substantial likelihood that in the near future she will inflict serious

\(^{30}\) See *State v. M.A.B.*, 157 P.3d 1256, 1259 (Or.App., 2007) (refusal to take medication not sufficient, by itself, to prove an inability to provide for basic needs); See also *State v. T.R.O.*, 145 P.3d 350 (2006) (Court of Appeals of Oregon holding that a particularized threat is necessary for involuntary commitment).

\(^{31}\) 775 So. 2d 408 (2000)

\(^{32}\) *Id.*
bodily harm on herself or another, as evidenced by recent behavior.\(^{33}\) The essential requirement that the recent dangerous behavior should be present, rather than simply a refusal to take medication, proves the danger standard is fundamental and necessary to comply with the constitutional substantive due process requirements. Speculation as to the significance of medication refusal should be removed from the evaluation of a person’s need for involuntary hospitalization. Recent dangerous behavior should form the basis of clear and convincing evidence of danger for consideration of the need for hospitalization.

In a similar case, Carolyn Blue refused to take her medication and faced civil commitment in Florida.\(^{34}\) The Court reversed the involuntary commitment, holding that although her condition was deteriorating the evidence lacked specificity that there was a substantial likelihood that in the near future she would inflict serious bodily harm on herself or another person.\(^{35}\) Mere speculation that a person’s medication refusal will cause

\(^{33}\) Id.

\(^{34}\) Blue v. State, 764 So. 2d 697 (2000)

\(^{35}\) Id., see also Lyon v. State, 724 So. 2d. 1241 (requiring the specifying of self-neglect to establish real and present threat of substantial harm to her well-being when patients were not on medication).
her to harm others was viewed as insufficient to warrant involuntary commitment.\textsuperscript{36} The requirement that there be a substantial likelihood that in the near future the mentally ill person will inflict bodily harm on herself or another person to warrant involuntary confinement is essential to adequately safeguard the right of patients with mental illness to make independent treatment decisions.\textsuperscript{37}

In New Jersey when a psychiatrist was asked by the judge her basis for believing that the mentally ill patient, J.R., may stop taking his medication and present a danger to others, the doctor could not provide any specific incidents of assaultive behavior that occurred while the individual was living without medication in the community.\textsuperscript{38} New Jersey Superior Court held that to justify an involuntary commitment, it is necessary to show more than a potential for dangerous conduct.\textsuperscript{39} The New Jersey Court describes “danger to self” by reason of mental

\begin{itemize}
  \item \textsuperscript{36} Henson v. State, 801 So. 2d 316 (2001).
  \item \textsuperscript{37} Id.; see also Tavares v. State, 871 So. 2d 974 (Fla. Dist. Ct. App. 2004) (reversing commitment because the court failed to include facts of danger to self or others).
  \item \textsuperscript{38} In re Commitment of J.R, 916 A.2d 463(N.J. Super. A.D., 2007)
  \item \textsuperscript{39} In re Commitment of Raymond S.,623 A.2d 2491(N.J. Super.A.D., 1993).
\end{itemize}
illness as the person has threatened or attempted suicide or serious bodily harm or has behaved in such a manner as to indicate that the person is unable to satisfy his need for nourishment, essential medical care or shelter so it is probable that substantial bodily injury, serious physical debilitation or death will result within the reasonably foreseeable future. The immediacy of the danger, coupled with the substantial risk based on recent specific acts or threats of dangerous behavior, should protect against the medication refusal, being used as the primary justification for involuntary commitment.

III. ROLE OF MEDICATION NONADHERENCE ON CIVIL COMMITMENT DECISIONS

Should the role of government shift and expand to authorize and sanction the involuntary confinement of a mentally ill person who articulates a refusal to comply with a psychiatrist’s order of medical treatment? Does the rejection of a treatment plan that includes psychiatric medication warrant an ambulance ride to the nearest psychiatric hospital for evaluation and treatment? It appears that the “treatment” provided by many psychiatrists starts and ends with the consuming of pharmacology tablets. Whether a newly arriving patient to a psychiatric hospital has an accompanying laundry list of prescribed

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40Commitment of J.R., 916 A.2d at 529.
medications and is assessed as over-medicated by some or arrives in the refusal mode, without the list of pills and screaming “you can’t make me take those pills”, the treatment plan ordered by the evaluating psychiatrist at the admissions unit of the hospital remains rather consistent. Let’s replace those old less effective medications with some new ones that are improved versions of the old or let’s immediately start the newly admitted patient on a drug regiment and see what happens.

One should not be surprised that the wait and see approach announced by psychiatrists is used to bolster the need for further hospitalization when the civil commitment hearing day arrives. Common arguments given to the judge at the hearing are: the patient needs a week or two in the hospital because a new medication has just been started and we are still trying to stabilize the patient on the new medications; I need to wean the patient off the medication they were previously on and then start new medications, then monitor the effects, adjust the dose upward and retain the patient until the medication is at the proper therapeutic dose; the patient has been refusing to take their medication as prescribed and so we have been unable to stabilize the patient. According to psychiatrists continued confinement is necessary, according to the testifying psychiatrist, to ensure the safety of the patient. The judge will invariably be asked to authorize and sign off on the civil
commitment order to permit the treating psychiatrist to “wait and see.” The patient will continue to be confined against their will despite a lack of tangible evidence that the person poses a danger to themselves or others in the community. Such a decision is based on a misguided belief that only when a patient is medicated are they no longer a danger.

When a patient is involuntarily committed to a psychiatric hospital based on non-compliance with medication, once hospitalized, the patient faces forced medication against their will.\textsuperscript{41} It has long been recognized that in the physical medical care arena, a person may refuse medical treatment even if at risk of death.\textsuperscript{42} The state’s interest in protecting a person

\textsuperscript{41} See Md. Code Health General § 10-708 (West 2012) (Medication may be administered to an individual who refuses the medication, in an emergency, on the order of a physician where the individual presents a danger to the life or safety of the individual or others; or in a nonemergency, when the individual is hospitalized involuntarily or committed for treatment by order of a court and the medication is approved by a panel under the provisions of this section).

\textsuperscript{42} See Stamford Hospital v. Vega, 674 A.2d 821, 832 (Conn., 1996) (patient’s refusal of blood transfusions was in keeping with the deeply rooted common law right of bodily integrity, hospital's
from harm to self is relatively low where the acts or omissions do not cause injury.\textsuperscript{43} Despite this recognition there an odd assumption that forced medication for mental illness should be treated differently. The assumption that an untreated person’s mental condition will decompensate without intervention until the individual eventually becomes a danger of serious harm is highly speculative. It is possible that the individual may not decompensate and will like many mentally individuals recover even without ongoing treatment.\textsuperscript{44}

The confinement for the purpose of providing treatment, one could argue, is a laudable purpose. However, if the reason for commitment is a mentally ill person’s refusal to comply with interests in preserving patient's life and in protecting ethical integrity of medical profession were insufficient to take priority over patient's rights); see also St. Mary’s Hospital v. Ramsey, 465 So.2d 666, (Fla.App. 4 Dist.,1985)(upholding a patient’s constitutional right of privacy, freedom to choose and a right of self-determination in her decision to refuse a blood transfusion).

\textsuperscript{43} In re Duran, 769 A.2d 497, 503 (PA 2001).

\textsuperscript{44} Andrew W. Kane, Essentials of Involuntary Civil Commitment Assessment for Mental Illness, in ESSENTIALS OF FORENSIC PSYCHOLOGICAL ASSESSMENT, 136-164 (Marc J. Ackerman, 1999).
medication in the community and confinement is for the purpose of treatment, ergo medication, the purpose is without meaning. Without a demonstration of imminent danger in the community, a mentally ill person could be subject to involuntary confinement simply because of a voluntary decision to refuse to take antipsychotropic medications prescribed. However once the person is confined to a hospital, without a showing of dangerousness in the hospital setting such medication could not be forcibly provided and so such a person could languish there without treatment.\textsuperscript{45}

Where proponents of involuntary commitment based on need for treatment maintain that coerced care is preferable to no care, the freedom from physical confinement by the state where an individual poses no danger to self or others is still the guiding constitutional principal for states.\textsuperscript{46} States applying a need for treatment standard do so under the guise that such

\textsuperscript{45} \textit{Department of Health and Mental Hygiene v. Kelly}, 397 MD 399 (2007) (the Court held in a forced medication case that the hospital must prove that the patient presents a danger in the hospital if not medication, not just in the community were he to be released); see also \textit{Enis v. Dept. of Health and Social Services}, 962 F. Supp 1192 (W.D. Wisc. 1996).

\textsuperscript{46} See \textit{O’Connor}, 422 U.S. 563.
refusal of treatment will result in a person engaging in harmful conduct or an inability to provide for one’s basic physical needs.\(^47\) However, the connection between mental illness and the need for involuntary admission is attenuated and relies on several inferences about the nature of mental illness, the role of psychotropic medication in responding to mental illness and the dangerousness resulting from noncompliance to medication.

The Substance Abuse and Mental Health Services Administration (SAMHSA) examines mental health treatment in the United States.\(^48\) SAMHSA’s National Survey on Drug Use and Health (NSDUH) found in 2008 that 58.7% of adults in the U.S. with a serious mental illness received treatment for a mental health

\(^47\) See 405 ILCS 5/1-119 (Illinois commitment statute states in pertinent part states that a person subject to involuntary admission on an inpatient basis includes a person with mental illness who: refuses treatment or is not adhering adequately to prescribed treatment; is unable to understand his or her need for treatment; and if not treated on an inpatient basis, is reasonably expected, after such deterioration,” to meet the dangerous or gravely disabled criteria).

\(^48\) Use of Mental Health Services and Treatment Among Adults, National Institute of Mental Health (March 30, 2012) http://www.nimh.nih.gov/statistics/3use_mt_adult.shtml
problem. The type of mental health services received ranged from prescription medication (11.1%) outpatient services (6.9%) to inpatient treatment (1%).

Several explanations are provided for the 5.5 million mentally ill adults not receiving treatment, including cost or insurance issues (45.1%), not feeling a need for treatment or thinking the problem could be handled without treatment (40.6%), not knowing where to go for service (22.9%), perceived stigma associated with receiving treatment (22.8%), lack of time (18.1%), belief treatment would not help (10.3%), fear of being committed or having to take medicine (7.2%).

The reasons for medication noncompliance are complicated and profound. Side effects of anti-psychotic and anti-depressants medications are often severe and significant. The Anti-psychotic medications can carry serious side effects, including: myocarditis (fatal heart condition), changes in

49 Id. (In 2007 there were 24.3 million adults in the U.S. with serious psychological distress).
50 Id. (2007 data).
51 Id. (2003 data. it is also noted that adults who used illicit drugs in the past year were more than twice as likely to have a serious mental illness as adults who did not use an illicit drug).
cardiac electrical impulses, sedation, agranulocytosis (decrease in white blood cells), diabetes, and serious weight gain.\textsuperscript{52} These side effects also include sexual dysfunction, suppression of REM sleep, muscle tics, fatigue, emotional blunting, and apathy.\textsuperscript{53} Additionally, the risks and stigma associated with forced involuntary treatment include feelings of alienation, disaffection, adverse impact on the therapeutic psychiatric-patient relationship\textsuperscript{54} and loss of control over one’s life, often undercut the recovery process.

A study by Bolling & Kohlenberg of 161 outpatients with Major Depressive Disorder (MDD) who had completed a course of treatment with a selective serotonin reuptake inhibitor (SSRI) antidepressant found that one fifth complained of "apathy," and one fourth complained of "loss of creativity".\textsuperscript{55} In addition, a

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\textsuperscript{54} Bruce J. Winick, \textit{Mandatory Treatment: An examination of Therapeutic Jurisprudence,} 75 New Directions for Mental Health Services 27, 30-41(1997).
\textsuperscript{55} Maurizio Fava, Lesley M. Graves, Franco Benazzi, Margaret J.
\end{flushleft}
significant population complained of cognitive side effects, including "poor concentration" (17.4%), "loss of ambition" (16.1%), "memory loss" (13.0%), and "problem-solving difficulties" (9.9%).

In a long-term study of persons with major depressive disorder on antidepressant therapies, by Dr. Maurizio Fava of the Department of Psychiatry, Depression, Clinical and Research Program at Massachusetts General Hospital, found that more than 30% exhibit long-term cognitive symptoms of apathy, inattentiveness, forgetfulness, word-finding difficulty, mental slowing and over 40% of the responders experienced physical symptoms of fatigue and sleepiness/sedation. Dr. Maurizio Fava and her colleagues concluded from this data that the long-term symptoms of patients with major depressive disorder are both side effects of the antidepressants and the residual symptoms of the mental illness.56

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56 Id. at 1757.
Persons with mental illness sometimes also refuse medication because they are in denial and taking medication would serve as an admission they do indeed have a highly stigmatized disorder that can be long lasting and disabling. Resistance to medication may also be a battle for autonomy and control. Such individuals feel that their lives have been so controlled by doctors, nurses and families, and that controlling the intake of medications is the only power they have left. Society places a stigma on mental illness and receiving medications for one’s mental illness is an acknowledgement of the illness, which carries a societal stigma.

Even those mentally ill persons who willingly take their medication may still have low levels of energy and they are often plagued by anxieties and depression, unable to hold a job, and forced to live life in poverty. They see no hope for love or marriage and life may not appear much better when they are on medication than when they are off.

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57 Agnes Hatfield, Medication Non-Compliance, Schizophrenia.com
http://www.schizophrenia.com/newsletter/997/997noncom.htm

58 Id.

59 Id.

60 Id.

61 Id.
When a mentally ill person appears before a judge to determine if involuntary civil commitment is necessary and appropriate, what is the relevance of the refusal to take psychotropic medication, standing alone, on the showing of danger to self or others? There is a preference shown toward medication compliance, whereby patients acknowledge their illness, recognize the benefits of medication, and a compliant attitude equates with cooperation and adjustment. However, should noncompliance with medication equate with signs of danger, permitting a judge to authorize involuntary commitment because the indication is the patient lacks contact with reality, is unable to acknowledge their illness, is unable to seek assistance and thus poses a danger to self or others?

In his masterful book, Anatomy of an Epidemic, Robert Whitaker rallies against the psychiatric and drug industry that has given rise to mental illness in America. Whitaker challenges the deep-seated belief that mental illness is a result of a chemical imbalance in the brain and that psychiatric medication prescribed can improve the patients’ mental health. Whittaker claims the precise causes of mental disorders are unknown.\(^\text{62}\) Whitaker asserts psychiatrists embraced the chemical-imbalance theory of mental disorders because it set the stage for them to

\(^{62}\) Whittaker, supra. at 332.
become “real doctors”, as doctors of internal medicine had their antibiotics, now psychiatrists could have their “anti-disease” pills too. 63

Whitaker similarly finds that anti-psychotic medication have a negative impact on the overall course of the illness64 and can cause a worsening of the illness.65 Whitaker cites a number of studies that refute the notion that drugs fix chemical imbalances in the brain.66 Whitaker believes that psychiatry grossly exaggerate the value of new drugs, silences critics and keeps the story of poor long-term outcomes hidden. His goal is to break up the psychiatry and drug company partnership that seeks to expand the market for psychiatric drugs.67

There is a growing voice ringing the iatrogenic process bell, claiming that doctors, through their choice of medical treatment, inadvertently induce the disease of mental illness. Yale psychiatrist Thomas McGlashan wondered whether antipsychotics were making patients “more biologically vulnerable to psychosis,” and asking whether the cure was worse

63 Id. at 78.
64 Id. at 191.
65 Id.
66 Id. at 307-90
67 Id. at 334
than the disease.\textsuperscript{68} Whitaker points to a study that demonstrates patients with schizophrenia had long-term recovery rates at 40 percent off medication and only 28 percent suffered from psychotic symptoms. In contrast, only 5 percent of those taking anti-psychotic medication were in recovery and 64 percent were actively psychotic.\textsuperscript{69} Another alarming statistic is the skyrocketing growth in population of persons diagnosed with schizophrenia in psychiatric hospitals between 1955 and 2008, blaming the fourfold increase on drug treatment, coinciding with the arrival of the medication Thorazine.\textsuperscript{70}

Whitaker warns that antipsychotic medication may actually make some schizophrenic patients more vulnerable to future relapses than would be the case in the natural course of the illness.\textsuperscript{71} Whitaker asserted that drugs were increasing the likelihood that a person who suffered a psychotic break would become chronically ill.\textsuperscript{72} He goes on to say initial exposure to neuroleptics put patients onto a path where they would likely

\textsuperscript{68} Id. at 114
\textsuperscript{69} Id. at 116
\textsuperscript{70} Id. at 120
\textsuperscript{71} Id. at 104
\textsuperscript{72} Id.
need the drugs for life\textsuperscript{73} and relapse suffered by patients withdrawn from antipsychotics was not from the disease returning but drug related.\textsuperscript{74} A Swedish physician by the name of Lars Martensson agreed, in 1984 at the World Federation of Mental Health Conference in Copenhagen stated “the use of neuroleptics is a trap...it is like having a psychosis-inducing agent built into the brain.”\textsuperscript{75}

Whitaker has put the spotlight on the need to reexamine the misuse of medication in the treatment of persons with mental illness. Advocates should all push the dialogue to alternative forms of non-drug treatment options and recognize the limits of medication in the treatment of mental illness. The “grave disability” and “need of treatment” standards should be removed. Advocates should demand that concrete and specific evidence of current dangerous behavior is the only admissible evidence used to support civil commitments. Judges, presented with persons with mental illness facing civil commitment should be open minded and willing to understanding the reasons for medication noncompliance. Judges should appreciate that not all people with mental illness who refuse their medication lack insight

\textsuperscript{73} \textit{Id.} 106

\textsuperscript{74} \textit{Id.}

\textsuperscript{75} \textit{Id.} at 107 (citation omitted)
into their illness and refusal to take one’s medicine should not be seen as an emblematic of a dangerous person.

IV. CHALLENGES TO PREDICTING DANGEROUSNESS: STATISTICAL REVIEW AND ANALYSIS OF PSYCHIATRISTS RECOMMENDATIONS IN CIVIL COMMITMENT DECISIONS

When psychiatrists are called upon to offer expert testimony at civil commitment hearings they must explain how the patient’s presenting behaviors supports their belief that the patient poses a danger to self or others and requires inpatient treatment. The factors the psychiatrist considers in evaluating and predicting whether a person is dangerous are often debated and discussed, however most scholars would agree that such a task is largely speculative. For years, clinicians were considered to be rather poor at predicting future violence in individuals with mental disorders. In general, clinicians were thought to be right a third of the time in predicting whether an individual with mental illness would be involved in future violence. The standard conclusion was that relying on clinical

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experience was not appreciably better than flipping a coin.77
According to a clinical study on predicting risk of physical
violence of psychotic patients, the most significant factor is a
past history of physical aggressive behavior.78 However, studies
indicate that clinicians vastly overestimate the incidence of
violence in released patients.79

To provide empirical data on the viewpoint of psychiatrists
about the civil commitment standard in their state and to
determine how they evaluate different evidence in making their
decisions a diverse group of 100 psychiatrists from 26 states

77 Edward P. Mulvey, Ph.D., Assessing the Likelihood of Future
Violence in Individuals with Mental Illness: Current Knowledge
78 Mamore, et al. Predictors of violent behavior among acute
psychiatric patients: Clinical study, 62 Psychiatry and Clinical
Neurosciences 247(2008)
79 M. Neil Browne and Ronda R. Harrison-Spoerl, Putting Expert
Testimony in Its Epistemological Place: What Predictions of
Dangerousness in Court Can Teach Us, 91 Marq. L. Rev. 1119
(2008)(clinicians estimated 50% to 80% of offenders would engage
in a serious aggressive act, the actual rate of violence was in
the 12% to 15% range).
were surveyed.\textsuperscript{80} The respondents were from a variety of settings, public and private, inpatient and outpatient, rural, urban and suburban, with 43 of the respondents having testified in 100 or more civil commitment hearings.\textsuperscript{81} Twenty-six of the respondents were from states with a strict dangerous criteria for civil commitment, 26 were from states with a “grave disability” provision, and 47 were from states with a “need for treatment”

\textsuperscript{80} See Donald H. Stone. Involuntary Commitment Survey of Psychiatrists. (2011) [hereinafter “Stone, Survey”] (unpublished web-based survey conducted by the author, original survey on file with author, survey questions and answer choices reproduced infra at Appendix A. The invitations to participate in the survey were distributed to American psychiatric associations throughout the country. Survey respondents indicated they practiced law in Alabama, Alaska, California, Colorado, Connecticut, Delaware, Hawaii, Indiana, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New York, Ohio, South Dakota, Texas, Utah and Wyoming).

\textsuperscript{81} Id.
provision in their civil commitment laws.\textsuperscript{82} The empirical data\textsuperscript{83} contained in this article is submitted to serve as a backdrop for purposes of illumination and comparison of the significance of various presenting behaviors of the mentally ill person have on psychiatrists.

The psychiatrists surveyed were asked to respond to a serious of questions about how they evaluate whether a person is a danger to self or others.\textsuperscript{84} In the first set of questions, respondents were provided with a hypothetical about a 40 year-old-patient, described as carrying a diagnosis of major depressive disorder, living alone. The psychiatrists were told that during the past two to three weeks the patient presented with the following behaviors: (1) refusal to attend group therapy sessions; (2) vague threats to harm neighbor; (3) fired

\textsuperscript{82} Id. (one respondent did not complete demographic information and responses are not included in data comparing responses by commitment statutes).

\textsuperscript{83} Donald H. Stone. Results of Involuntary Commitment Survey of Psychiatrists. (2011) [hereinafter “Stone,Results”] (unpublished data on file with the author)(The percentages cited in this article represent the percentage of valid responses to each question, which exclude participants who did not respond).

\textsuperscript{84} Id
from job; (4) hearing voices (5) poor sleeping habits (6) self-injurious minor scratches & bruises; (7) decline in activities of daily living (bathing, dressing, poor hygiene); (8) eating 50% of meals; (9) left food on stove; (10) spoke of feeling sad; (11) refused to take psychotropic medication; (12) talked about overdosing on aspirin; and (13) found wandering late at night on the other side of town, who they were not currently treating, met the criteria for involuntary commitment.\textsuperscript{85}

The psychiatrists were asked whether they believed that the patient, given the evidence, was dangerous. Eighty percent of respondents found that under these facts there was clear and convincing evidence of dangerousness to warrant involuntary commitment.\textsuperscript{86} Interestingly, under a greater percentage of psychiatrists from states with the strict dangerousness standard found clear and convincing evidence for civil commitment than the psychiatrists with a broader standard.\textsuperscript{87}

\textsuperscript{85} See Stone, Survey, supra note 80, at Hypothetical 1.

\textsuperscript{86} Id. at Question 3; See also Stone, Results, supra note 83.

\textsuperscript{87} Stone, Results, supra note 83 (demographic information used to compare responses of psychiatrists from states with dangerous standard and those from states with a grave disability or “need for treatment” provision).
The respondents were asked to categorize each of the patient’s presenting behaviors as either providing minimal support, some support, strong support, clear and convincing evidence or not relevant in their evaluation of the patient’s

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88 Id.

89 Id.
dangerousness.\textsuperscript{90} The fact that the patient was talking about overdosing on aspirin was the most significant factor to all of the psychiatrists surveyed, 50 percent classifying it as clear and convincing evidence of dangerousness; and 90 percent said it provided strong support or clear and convincing evidence in their decision.\textsuperscript{91} The evidence that the patient had been found wandering late at night on the other side of town and had left food on the stove was also considered to be compelling evidence to over 70 percent of the psychiatrists.\textsuperscript{92} Hearing voices, decline in activities of daily living, vague threats to harm neighbor, and refusal to take psychotropic medication were also ranked as significant to 50 percent or more of the psychiatrists.\textsuperscript{93}

\textsuperscript{90} See Stone, Survey, supra note 80, at Question 2.

\textsuperscript{91} Id.; See also Stone, Results, supra note 83.

\textsuperscript{92} Id.

\textsuperscript{93} Id.
The value the individual psychiatrists placed on the highest ranked behaviors varied depending on what the commitment standard of the psychiatrist’s state of practice. The behaviors that were most overtly dangerous in nature, overdosing on aspirin and threats to harm neighbors, were ranked as clear and convincing evidence of dangerousness or strong support by a greater percentage of psychiatrists from states with the strict dangerous criteria than among the psychiatrists from states with broader commitment criteria. Conversely, those behaviors that are less explicitly dangerous, such as wandering late at night, leaving food on the stove, hearing voices, decline in daily

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94 See Stone, Survey, supra note 83, at Question 2; See also Stone, Results, supra note 87.

95 Id.; See also Stone, Results, supra note 87.

96 Id.
living activities and the refusal to take psychotropic medication, were ranked as significant by a larger percentage of the psychiatrists from states with a broader criteria.\textsuperscript{97}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{breakdown_of_most_significant_behaviors_by_commitment_standards.png}
\caption{Graph 4: Most Significant Behaviors by Commitment Standards\textsuperscript{98}}
\end{figure}

The patient’s other presenting behaviors (refusal to attend group therapy sessions, speaking of feeling sad and poor sleeping habits) were considered to provide clear and convincing evidence of dangerousness or strong support to 40 percent or less of the psychiatrists.\textsuperscript{99}

\textsuperscript{97} Id.

\textsuperscript{98} Id.

\textsuperscript{99} See Stone, Survey, supra note 80, at Question 2; See also Stone, Results, supra note 83.
Given the concerns of many psychiatrists about the danger of medication non-compliance, it is noteworthy that 98 percent of the psychiatrists surveyed indicated that they disagreed with the statement that “medication non-compliance alone satisfies clear and convincing evidence of dangerousness”. According to the psychiatrists surveyed, the refusal to take psychotropic medications is not as significant to psychiatrists as other behaviors. They considered six factors more significant than

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100 Id.
101 See Stone, Survey, supra note 80, at Question 8 (Medication non-compliance alone satisfies clear and convincing evidence of dangerousness); See also Stone, Results, supra note 115.
102 See Stone, Survey, supra note 80, at Question 2; See also Stone, Results, supra note 83.
medication refusal.\textsuperscript{103} The fact that concrete examples of dangerous behaviors such as wandering late at night, talking about overdosing on aspirin, and leaving the stove on were more valuable in psychiatrists’ recommendations should provide some comfort to mental health advocates.\textsuperscript{104}

\begin{figure}[h]
\centering
\includegraphics[width=0.5\textwidth]{graph6.png}
\caption{Graph 6: Medication Non-Compliance\textsuperscript{105}}
\end{figure}

Although the data indicates that medication non-compliance is not weighed as heavily by psychiatrists in predicting dangerousness, a patient’s decision to forego psychotropic medications to treat their mental illness is still given

\textsuperscript{103} Id.
\textsuperscript{104} Id.
\textsuperscript{105} See Stone, Survey, supra note 80, at Question 8 (Medication non-compliance alone satisfies clear and convincing evidence of dangerousness); See also Stone, Results, supra note 83.
considerable weight in the determination whether an individual is capable of living safely in the community, particularly where combined with a past history of dangerous behaviors when off of medication.106 Fifty-one percent of the psychiatrists surveyed ranked the patient’s refusal to take medication as either providing strong support or clear and convincing evidence of dangerousness.107 A slightly higher margin of psychiatrists from “need for treatment” or “gravely disabled” states (53 percent) found medication non-compliance as significant in their commitment decisions compared with 46 percent of psychiatrists from states with a strict dangerous criteria.108

106 See Stone, Survey, supra note 80, at Question 2; See also Stone, Results, supra note 83.

107 Id.

108 Id.
Question 6 and 7 of the survey addressed the weight given to a patient’s refusal of medication where there is a history of medication non-compliance and violent behavior. In the second hypothetical the patient did not exhibit any physically dangerous behavior but six months ago the patient became non-compliant with psychotropic medication and did exhibit dangerous behavior. After the patient was hospitalized in a psychiatric facility, he resumed taking medication but 2–3 weeks ago went off his medication again.

A decisive majority of psychiatrists (79 percent) agreed with the statement: “there are no specific examples of recent dangerous behavior, it is premature to recommend involuntary

\[\text{Graph 7: Comparison of Medication Non-Compliance}^{109}\]

\[\text{Comparison of Psychiatrists who Ranked Medication Non-Compliance as Clear and Convincing Evidence or Strong Support for Civil Commitment}\]

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109 Id; See also Stone, Results, supra note 87.

110 See Stone, Survey, supra note 80, at Question 6 and 7.

111Id. at Hypothetical 2.
An even larger majority found that there was not clear and convincing evidence of danger to self or others, with only 12 percent believing that there was evidence of danger to self or others. The difference can be explained by the different standards for civil commitment. Some states do not require recent dangerous behavior to civilly commit someone, that civil commitment can be used as a preventive measure.

112 See Stone, Survey, supra note 80, at Question 6; See also Stone, Results, supra note 83.
113 See Stone, Survey, supra note 80, at Question 7; See also Stone, Results, supra note 83.
Graph 8: Premature to Commit Where No Recent Dangerous Behavior\(^{114}\)

Graph 9: Clear and Convincing Evidence of Dangerousness\(^{115}\)

\(^{114}\) See Stone, Survey, supra note 80, at Question 6; See also Stone, Results, supra note 83.

\(^{115}\) See Stone, Survey, supra note 80, at Question 7; See also Stone, Results, supra note 83.
The weight psychiatrists give to medication non-compliance is alarmingly higher in states where the civil commitment standard is less than a strict dangerous criterion.116 All but one of the psychiatrists, who disagreed with the statement that it was premature to commit, came from states with a need for treatment or grave disability statute.117 One respondent who supported the decision to recommend commitment in the second hypothetical, stated that although “the patient does not exhibit suicidal or homicidal ideation he is clearly gravely disabled. His condition can only be expected to worsen if the patient is allowed to continue without adequate psychiatric care.”118 This answer contrasts with responses from psychiatrists in states with the dangerous criteria. A psychiatrist from a state with a dangerous criteria, explaining why it was premature to commit explained that the patient “is at risk for becoming ill and dangerous, but she is not dangerous now.” Another psychiatrist from a state with a “grave disability” provision cautioned that “psychiatrists cannot predict future behavior or timing when a

116 Id. (11 out of the 12 respondents who answered “yes” to question 7 were from states with either a “need for treatment” and/or a “grave disability” provision).

117 Id.

118 Id.
client will deteriorate,” but encouraged the patient receive community treatment, in home services and medication compliance to prevent inpatient treatment.\textsuperscript{119}

\begin{figure}[h]
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\includegraphics[width=0.5\textwidth]{graph10.png}
\caption{Graph 10: Insufficient Evidence for Commitment\textsuperscript{120}}
\end{figure}

\textsuperscript{119} Id.

\textsuperscript{120} See Stone, Survey, supra note 80, at Question 6; See also Stone, Results, supra notes 83 and 87.
However, many psychiatrists still perceive that their role is to predict violence and view hospitalization as intervention to prevent persons from deteriorating to the point that they might become dangerous to themselves or others. A psychiatrist from Missouri stated that as psychiatrists, “we are held by the public to a higher standard than law enforcement...[w]e are expected to make reasonable efforts to foresee and prevent harm”. Another psychiatrist remarked: “[p]ast evidence of dangerousness is best predictor of future harm. Success in prior

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121 See Stone, Survey, supra note 80, at Question 7; See also Stone, Results, supra notes 83 and 87.

122 See Stone, Survey, supra note 80, at Question 6; See also Stone, Results, supra notes 83 and 87.
treatment is good predictor of future success”\textsuperscript{123}. One psychiatrist so sure of his prediction stated: “HE HAS OR IS GOING TO HAVE A RELAPSE”\textsuperscript{124}. This belief that dangerousness can be so easily predicted and that forced medical treatment will prevent future harm is misguided and is in conflict with the reality that hospitalization and forced treatment are not proven to be any more successful at treating mental illness and preventing future harm.

The most scientific predictions are based on thorough examination, diagnosis of mental symptoms, past patterns of behavior and probabilistic assessments, however they are still wrong nearly as often as they are right\textsuperscript{125}. Given the speculative nature of predicting dangerousness and the liberty interests at stake, commitment decisions must be based on concrete evidence of recent acts or threats of physical violence either to self or others to decrease the number of false positive predictions.

\textsuperscript{123} \textit{Id.}

\textsuperscript{124} \textit{Id.}

\textsuperscript{125} Charles W. Lidy et al, The Accuracy of Predictions of Violence to Others 269 JAMA 1007, 1010 (1993) (recognizing that clinicians are relatively inaccurate at predicting future violence).
V. DANGEROUS TRENDS IN CIVIL COMMITMENT LAWS: STATISTICAL ANALYSIS OF EASE OF COMMITMENT AND LENGTH OF STAY

In addition to predictions by psychiatrists being highly speculative and unreliable, some experts find the use of clinicians to predict violence detracts from patients care, interferes with critical decision-making and hampers the administration of justice. In Robert A. Brooks’ survey of 739 members of the American Psychiatric Association about civil commitment laws, psychiatrists acknowledged the conflict in the psychiatrist/patient relationship by their testifying in favor of involuntary confinement and they indicated that legal coercion of treatment is inconsistent with building a positive therapeutic relationship. The therapeutic relationship between patient and treating psychiatrist is oftentimes jeopardized where the patient’s psychiatrist is called upon to divulge confidential and protected communications at the civil commitment hearing in order to prove commitment criteria met.

Is the harm to the therapeutic relationship worth the benefits of civil commitment? Are we better off as a society,

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127 Brooks, Psychiatrists’ Opinions, supra at 225.
having laws that make it easier to confine non-dangerous mentally ill? Studies indicate, probably not. 128

According to the MacArthur Risk Assessment, a multidisciplinary study following more than 1,000 individuals discharged from psychiatric hospitals, violent behaviors are most prevalent following discharge from inpatient treatment.129 The Study found that most of the violent behavior occurred shortly after the individuals’ discharge from the hospital.130 The study revealed that violent incidents dropped off markedly after about twenty weeks back in the community.131

The length of confinement in a psychiatric inpatient facility is rather short, driven by insurance policies, high costs, and the belief that involuntary confinement is to deal with an acute and emergency situation. Accordingly, the effectiveness of involuntary confinement to the long-term wellbeing of a mentally ill person is questionable and the social stigma attached to being involuntarily committed against


129 Id.

130 Id.

131 Id.
one’s will is profound. In addition, even if a treatment team were successful in forcibly medicating a patient within the hospital, it is common to see the patient refuse to take the psychotropic medication upon discharge to the community. The revolving door from community to inpatient hospitalization and back to the community is not an efficient or effective method of treating mentally ill or preventing future violence.

The push to enhance community-based mental health services is an important and vital step in humanely treating the mentally ill. However, the trend unfortunately appears to be a desire to increase the number of eligible persons for involuntary hospitalization despite evidence that frequent short-term hospitalizations cause more harm than good.

A. DATA ANALYSIS OF TRENDS IN COMMITMENT LAWS AND LENGTH OF STAY OF CIVIL COMMITMENTS

The Stone Survey asked psychiatrists their opinion on the ease or difficulty of inpatient civil commitment in their state and if they have seen a change in the past 5 years. Majority of the psychiatrists (51 percent) indicated that commitment laws in their states were about the same, 26 percent indicated that it had become more difficult and 23 percent said that it has become
easier to commit. Interestingly, a greater percentage of psychiatrists from states with strict dangerousness criteria found that it has gotten easier to commit individuals than those from states with broader criteria.

Graph 12: Ease or Difficulty of Civil Commitment

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132 See Stone, Survey, supra note 80, at Question 9; See also Stone, Results, supra notes 83.

133 Id.; See also Stone, Results, supra notes 87. (29 percent of psychiatrists in states with strict dangerous criteria and 21 percent of psychiatrists from states with broader criteria indicated that it is easier to commit people to hospitals than 5 years before).

134 See Stone, Survey, supra note 80, at Question 9; See also Stone, Results, supra notes 83.
Graph 13: Breakdown of Ease of Commitment by Standard

In addition, a greater proportion of psychiatrists who work primarily in inpatient facilities found that it has gotten easier to commit than those who do not. Interestingly, many expressed that the changes in the ease or difficulty to commit a

135 See Stone, Survey, supra note 80, at Question 9; See also Stone, Results, supra notes 83 and 87.

136 Id. (demographic information used to compare responses of psychiatrists who indicated they worked predominately in an inpatient or outpatient setting, 22 percent of respondents from inpatient (n=21) facilities and 14 percent of respondents from outpatient facilities (n=59) indicated that it is easier to commit people to hospitals than 5 years before. Data from persons that worked at both equally or left demographic question blank not included in this data).
person was largely based on outside factors such as the shortages of beds making it more difficult to commit.\textsuperscript{137} Some expressed that the ease of commitment largely depended upon the jurisdiction and the judges in the area, with some judges more strict about the criteria with others more liberal.\textsuperscript{138} Some psychiatrists expressed frustration with commitment laws, lawyers, and judges that they felt sometimes obstructed patients ability to obtain needed treatment blaming the strict dangerous criteria and “limiting emphasis on the deteriorating mental health condition of patients” for causing “an undue burden on the mental health professional in providing the best and appropriate care.”\textsuperscript{139}

\textsuperscript{137} See Stone, Survey, supra note 80, at Question 9; See also Stone, Results, supra notes 83 and 87.

\textsuperscript{138} Id.

\textsuperscript{139} Id.
The average length of stay at a nonfederal short-stay hospital for psychoses in 2009 was 7.5 days, 11.2 days for Schizophrenia. This marks a steady decrease in the length of stay from 12.2 days in 1990. In a study of the average length of in-patient stays for schizophrenia, depression, and bipolar disorder between 1996-2000 in Pennsylvania. The length of stay

140 Id.

141 National Hospital Discharge Survey: 2009 table, Average length of stay and days of care – Number and rate of discharges by first-listed diagnostic categories.


decreased for all 3 conditions between 1996 and 2000 dropping from 11.3 days to 7.6 days for depression, 19.0 to 12.7 days for schizophrenia and 13.9 to 9.4 days for bipolar disorder.\textsuperscript{144} This study found that patients with public insurance (Medicaid or Medicare) had the longest length of stay and individuals with HMO’s had the shortest.\textsuperscript{145}

In the Stone Survey, forty-five percent of the psychiatrists indicated that the length of stay for inpatient treatment is too short, and only 16 percent believe the length of stay is too long.\textsuperscript{146} Interestingly, there was a significant split in opinion about the appropriateness of the average length of stay between outpatient and inpatient psychiatrists, not one outpatient psychiatrist believing the inpatient treatment is too long, compared to 20 percent of psychiatrists who work at outpatient facilities.\textsuperscript{147} Most outpatient psychiatrists found that treatment in inpatient facilities was too short, explaining that there were not enough resources in the community to meet the acute needs of some of their patients. Many psychiatrists

\textsuperscript{144} Id.
\textsuperscript{145} Id.
\textsuperscript{146} See Stone, Survey, supra note 80, at Question 10; See also Stone, Results, supra note 83.
\textsuperscript{147} Id.; see also Stone, Results, supra note 137.
attributed the short stays to fiscal pressures, blaming insurance companies and bed shortages.\textsuperscript{148}

\begin{figure}
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\includegraphics[width=0.5\textwidth]{psychiatrists_opinions.png}
\caption{Psychiatrists Opinions on the Average Length of Civil Commitments}
\end{figure}

\textbf{Graph 15: Length of Civil Commitments}\textsuperscript{149}

\begin{figure}
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\includegraphics[width=0.5\textwidth]{length_of_stay.png}
\caption{Length of Stay (Inpatient vs. Outpatient)}
\end{figure}

\textbf{Graph 16: Length of Stay (Inpatient vs. Outpatient)}\textsuperscript{150}

\textsuperscript{148} See Stone, Survey, supra note 80, at Question 10; See also Stone, Results, supra note 83.

\textsuperscript{149} Id.

\textsuperscript{150} Id.; see also Stone, Results, supra note 137.
There was also a significant difference in responses between people who work in public hospitals versus private hospitals, with more psychiatrists in public hospitals finding the length of stay to be too long.\textsuperscript{151}

\begin{figure}
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\includegraphics[width=\textwidth]{graph17.png}
\caption{Length of Stay (Public vs. Private)}
\end{figure}

VI: RECOMMENDATIONS

Given the liberty interests at stake in civil commitment decisions it is imperative that both the commitment laws and

\textsuperscript{151} See Stone, Survey, supra note 80, at Question 10; See also Stone, Results, supra note 83 (demographic information used to compare responses of psychiatrists who indicated they worked primarily in private or public settings; 20 respondents were from private settings, 75 were from public settings and 5 were other and not included in the data reported for purposes of this question).

\textsuperscript{152} Id.
actions taken by people involved in the commitment process ensure the due process rights of mentally ill persons are respected. For those individuals who are mentally ill and in need of treatment, the challenge is to provide the needed care and treatment in the least restrictive setting appropriate to meet their needs. The individual’s right to be treated in a humane setting with due process protections should be balanced against the safety interests of the community.

The following are recommendations to guide state legislatures in developing and implementing an involuntary civil commitment statute:

1. Require a demonstration of imminent danger of physical harm to the life of the individual or others.

2. Require that imminent danger can only be found where clear and convincing evidence at the time of the hearing that: (a) there is an imminent risk of serious physical harm to the individual or others.

3. Clear and convincing evidence of dangerousness can only be concrete evidence of recent actions or threats of physical harm to self or others. Evidence of recent acts or threats of emotional harm should not satisfy this requirement.

4. Individuals who are deteriorating but not yet reached level of causing serious physical harm shall not be subjected to involuntary civil commitment.
5. Establish a policy that inpatient civil commitment should only be used to deal with mentally ill persons who are acutely dangerous at the time of the commitment. The purpose of the commitment should only be to stabilize patient and return them to the community.

6. Establish as a policy that the lack of medication in and of itself should never warrant civil commitment without a showing of clear and convincing evidence of dangerousness.

   Expand funding for outpatient mental health treatment services.

VII. CONCLUSION

There continues to be pressure on psychiatrists to err on the side of caution when it comes to recommending inpatient hospitalization. However, it is short sighted to believe inpatient hospitalization is a magic bullet to protect the public from the dangerously mentally ill. The mistaken belief that medication noncompliance is an accurate predictor of future dangerous behavior is impeding a long-term solution to addressing the needs of the growing population with acute mental illness. The watered down “grave disability” or “need for treatment” standards make it easier to commit individuals but does not address the long-term care needs of mentally ill.

A collaborative approach to fixing the civil commitment laws and addressing the mental health needs of the acutely
mentally ill. We should all take a collective deep breath and review the goals of involuntary civil commitment, balancing the need to protect the individual and community from serious harm and the civil liberty interests at stake in confining a mentally ill person against their will. Community based treatment programs need to be supported and more fully appreciated. A return to a strict “dangerous” standard, requiring a showing of imminent danger to self or others, and a focus on improving the community based mental health services is essential to alleviating the shortages of inpatient hospital beds needed to appropriately treat the dangerously mentally ill population. Finally, judges must base their civil commitment decisions on concrete evidence of dangerous behavior and stop relying on the psychiatrist’s crystal ball prognosis of future deterioration.
APPENDIX A:

Question 1. Please fill-in the following demographic information:

What is your job title? ________________________________

In what state do you practice? _________________________

How would you classify the area where you practice (rural, suburban urban)? _______________________________________

How many years have you been a psychiatrist? 
________________________________________________________

What type of facility do you practice (public or private)?
________________________________________________________

What type of patients do you primarily come in contact with (mostly inpatient, mostly outpatient, both equally)?
________________________________________________________

How many involuntary commitments have you provided testimony or evidence in? ________________________________
Survey Instructions

Please read Hypothetical 1 and 2. Answer each question based on your state's standard for in-patient civil commitment of a person with a mental illness.

In answering the questions below, assume that the patient is Pat Brown, a 40 year-old-patient who carries a diagnosis of major depressive disorder, lives alone, and you are not currently treating the patient but are asked to make a recommendation on whether Pat should be involuntarily committed to an in-patient facility.

Some of the questions in the survey will ask you about the weight you would give to different factors in deciding whether or not civil commitment is appropriate. I understand that in practice, your decision is based on a combination of factors whereby the totality of all factors determines the outcome. However, for purpose of this survey, I am attempting to determine the weight you would give to each individual factor in your decision.
Hypothetical 1

During the past two to three weeks Pat Brown presented with the following behaviors. Pat has eaten fifty percent of meals, left food on the stove on three occasions resulting in smoke filling the apartment, has spoken with neighbors about feeling sad and is talking about taking an overdose of over the counter aspirin. Pat’s activities of daily living have declined over the past two to three weeks, refusing to bathe, dress and exhibiting poor hygiene. Again, the past two to three weeks, Pat was exhibiting poor sleeping habits and found wandering late at night on the other side of town, confused, without a reasonable explanation for being there. Over the past two to three weeks, Pat has refused to take prescribed psychotropic medication for the diagnosed mental disorder and has refused to attend recommended group sessions at a local mental health clinic.

Additionally, Pat has made a few vague threats to harm the next-door neighbor, complaining about loud music. Pat has self-injurious minor scratches and bruises, and acknowledges hearing voices. In the past two to three weeks, Pat was recently fired from for excessive lateness and was referred to you for a consult to determine the appropriateness of in-patient psychiatric treatment.
**Question 2.** Please classify the strength you would give to each of the following factors in deciding whether or not to recommend the involuntary commitment of Pat to an in-patient hospital or treatment facility.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Clear and Convincing</th>
<th>Strong Support</th>
<th>Some Support</th>
<th>Minimal Support</th>
<th>Not Relevant</th>
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<tr>
<td>Decline in activities of daily living (bathing, dressing, poor hygiene)</td>
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<tr>
<td>Eating 50% of meals</td>
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<td>Refusal to take psychotropic medication</td>
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<td>Spoke of feeling sad</td>
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<td>Talking about overdosing on aspirin</td>
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<td>Fired from job</td>
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<td>Self-injurious minor scratches &amp;</td>
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<td>bruises</td>
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<td>Poor sleeping habits</td>
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<td>Hearing voices</td>
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<td>Found wandering late at night on the other side of town</td>
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<td>Refusal to attend group therapy sessions</td>
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<td>Vague threats to harm neighbor</td>
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<td>Left food on stove</td>
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</table>

**Question 3.** If you were asked to testify in the in-patient civil commitment hearing of Pat Brown, would you find that there is clear and convincing evidence of dangerousness to warrant involuntary commitment?

_____ Yes, there is clear and convincing evidence of dangerousness.

_____ No, there is not clear and convincing evidence of dangerousness.
Please explain.

Question 4. If you answered yes to question three, please indicate which evidence you gave the greatest weight and which the least?

Most Relevant

_____ Decline in activities of daily living (bathing, dressing, poor hygiene)
_____ Eating 50% of meals
_____ Refusal to take psychotropic medication
_____ Spoke of feeling sad
_____ Talking about overdosing on aspirin
_____ Self-injurious minor scratches & bruises

_____ Poor sleeping habits
_____ Fired from job
_____ Hearing voices
_____ Found wandering late at night on the other side of town
_____ Refusal to attend group therapy sessions
_____ Vague threats to harm neighbor
_____ Left food on stove.
Least Relevant

_____ Decline in activities of daily living (bathing, dressing, poor hygiene)

_____ Eating 50% of meals

_____ Refusal to take psychotropic medication

_____ Spoke of feeling sad

_____ Talking about overdosing on aspirin

_____ Fired from job

_____ Self-injurious minor scratches & bruises

_____ Poor sleeping habits

_____ Hearing voices

_____ Found wandering late at night on the other side of town

_____ Refusal to attend group therapy sessions

_____ Vague threats to harm neighbor

_____ Left food on stove.

Please explain.

________________________________________________________________
________________________________________________________________

Question 5. Based on the hypothetical, do you think there are less restrictive treatment options available that are consistent with the welfare and safety of Pat?

_____ Yes.

_____ No.

Please explain.

________________________________________________________________
________________________________________________________________

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Hypothetical 2

Six months ago Pat became non-compliant with psychotropic medication, exhibited dangerous behavior, was hospitalized in a psychiatric facility and upon discharge resumed taking medication. About 2–3 weeks ago Pat again went off the medication and was brought before you for an evaluation to determine if Pat should be involuntarily committed in a psychiatric hospital for care or treatment. At the point of your evaluation, there are no specific examples of dangerous behavior being exhibited, however the concern is Pat is again off the psychotropic medication.

Question 6. Since there are no specific examples of recent dangerous behavior, it is premature to recommend involuntary civil commitment at this time.

_____ I agree with this statement.
_____ I disagree with this statement.

Please explain.

______________________________

Question 7. Based on the facts in hypothetical 2, would you find that there is clear and convincing evidence of danger to self or others necessary for the involuntary in-patient commitment of Pat Brown?

_____ Yes.
_____ No.
Please explain.

________________________________________________________________________

________________________________________________________________________

General Questions:

Please answer the following questions based on your perception of the current involuntary commitment laws and practices in your state.

**Question 8.** Medication non-compliance alone satisfies clear and convincing evidence of dangerousness.

_____ I agree with this statement.

_____ I disagree with this statement.

Please explain.

________________________________________________________________________

________________________________________________________________________

**Question 9.** Over the past 5 years, what is your understanding about the “ease or difficulty” of involuntarily committing a mentally ill person to an in-patient psychiatric hospital for care or treatment?

_____ Easy to involuntarily commit.

_____ Difficult to involuntarily commit.

_____ About the same.
Question 10. Over the past 5 years, what is your understanding about the “length of stay” of those individuals involuntarily confined to an in-patient psychiatric hospital for care or treatment?

_____ Just right.

_____ Too long.

_____ Too short.

Please explain.