allaTitle Page

**State Involuntary Commitment Statutes: How Can Policy Reflect Patient-Centered Care**

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Abstract

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**Abstract**

An estimated 10.4 million adults (18 years or older) in the United States live with a serious and persistent mental illness (SPMI). Individuals with SPMI are at risk of experiencing debilitating symptoms that make them lose touch with reality, which may place themselves or others in danger. Consequently, individuals with SPMI are oftentimes subjected to involuntary commitment, where an individual is adjudicated by a court to complete mental health treatment, against the individual’s will. Studies show that involuntary commitment is associated with a greater likelihood of treatment non-adherence, jail time, suicide attempts, longer hospitalization stays, rehospitalization, and decline in social functioning. However, other studies have found positive outcomes involved patients who were able to engage in their treatment and build a good relationship with providers, despite being involuntarily committed**.** It is of public health significance to investigate involuntary commitment policies and procedures that override individual liberties, and potentially worsen the quality of life for individuals who already belong to a vulnerable population. Two research questions are addressed in this essay. 1) What are the standard practices and policies at the state level in the United States regarding involuntary evaluation or admission for individuals experiencing a mental health crisis? 2) How can current state practices be altered to align with the patient-centered care model? This essay found that the majority of states have adopted broader statutes, providing states with more authority to compel individuals into mental health treatment. Therefore, efforts to change involuntary commitment laws should incorporate practices that help individuals with SPMI engage in the process. Several examples of how to operationalize patient-centered care in the context of treating individuals who are involuntarily committed are included in the findings.

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# Introduction

In 2016, it was estimated that 10.4 million adults (18 years or older) in the United States live with a serious and persistent mental illness (SPMI)(National Institute of Mental Health, 2017). This population experiences numerous challenges due to their illness that affect their ability to maintain a social support network, financial stability, housing security, and an overall sense of positive well-being. As a result, they are often involved in the criminal justice system and/or compelled into treatment from mental health institutions. In the latter case, the practice is generally known as involuntary commitment where an individual is adjudicated by a court to complete treatment, against an individual’s will, until a mental health professional deems it is no longer necessary. If the individual agrees to the treatment, this is referred to as voluntary commitment.

## Population at Risk

SPMI constitutes a wide range of mental health disorders that meet diagnostic criteria as defined by the *Diagnostic Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association, 2013). The most common disorders that are associated with SPMI include schizophrenia, schizoaffective disorder, psychotic disorders, major depressive disorders, bipolar disorders, and borderline personality disorder(APA, 2013). Individuals living and/or diagnosed with these disorders may experience hallucinations, delusions, disturbances in the thought process, lack of energy, loss of concentration, sleep deprivation, lack of emotion and motivation, becoming withdrawn from others, and/or loss of interest in life(National Registry of Evidence-based Programs and Practices, 2016). Consequently, these symptoms impact an individual’s ability to complete activities of daily living (e.g., dressing and grooming, toileting, walking, feeding, etc.) and/or instrumental activities of daily living (e.g., managing the following: finances, transportation, meal preparation, home maintenance, communication, medication, etc.)(NREPP, 2016).

As these symptoms manifest and worsen, a person with SPMI is at an increased risk of unemployment, social isolation, financial insecurity, and food insecurity(Goering, Tolomiczenko, Sheldon, Boydell, & Wasylenki, 2002; Patterson et al., 2013; Whitley & Henwood, 2014; Poremski, Woodhall-Melnik, Lemieux, & Stergiopoulos, 2015). Consequently, they are also more likely to become institutionalized, jailed, and/or experience other traumatic events(Goering et al., 2002; Patterson et al., 2013; Whitley & Henwood, 2014; Poremski et al., 2015). Unfortunately, these events further exacerbate their psychiatric symptoms, continuing a cycle of destitution, institutionalization, hospitalization, and/or involvement with the criminal system(Gulcur, Stefancic, Shinn, Tsemberis, & Fischer, 2003; Gilmer, Stefancic, Ettner, Manning, & Tsemberis, 2010). According to a World Health Organization (WHO) 2010 data, mental and behavioral disorders accounted for 13.6% of total U.S. disability-adjusted life years (DALYS), placing it in the top three categories(NAMI, 2010). SPMI diagnoses formed the largest percentage among the mental and behavioral disorders(NAMI, 2010). This evidence further suggests that individuals with SPMI are greatly burdened by their illness.

## Patient-Centered Care

Health systems tout patient-centered care as one of the leading standards for patient management. The Institute of Medicinehas defined it as, “providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions” (2001). Considering that involuntary commitment brings together the fields of law and medicine, it is imperative that policies and legal proceedings related to involuntary commitment meet the standards of medical practice because it can affect the health outcomes of individuals needing mental health treatment.

## Public Health Significance

### Scope of investigation

Individuals with SPMI are at risk of experiencing debilitating symptoms that make them lose touch with reality, which may place themselves or others in danger. Consequently, involuntary commitment primarily affects individuals in this population. It is critical to investigate involuntary commitment policies and procedures that essentially override individual liberties. Namely, the ability of an individual to determine the direction of their life. This essay is an investigation of the current nature of involuntary commitment in the United States to explore potential policy implications. More specifically, how can policies align with the patient-centered care model. The evolution of mental health treatment in the United States will be discussed. Its history will help explain the current barriers to care and circumstances in which involuntary commitment is imposed. Arguments pertaining to individual rights and public safety will be explored within the context of involuntary commitment.

### Research Questions

Considering the severity of health outcomes among individuals with SPMI and the costs of treatment, it is imperative that public health professionals better understand the policies that govern how individuals become hospitalized for mental health treatment, particularly if it is against their own volition. Involuntary commitment is regulated at the state level. However, in practice, it is implemented on the county level. Currently, there are no guidelines for how involuntary commitment is implemented at the county level.

Additionally, regardless of whether an individual is seeking treatment for physical or mental health problems, the standard in today’s healthcare is evidence-based practice. The literature suggests that models such as patient-centered care can lead to better patient outcomes. ­­Studies have not focused on how to apply this practice model in cases of involuntary mental health treatment.At a glance, it would seem that involuntary commitment falls contrary to the overall approach of patient-centered care because it strips individuals of their right to forgo treatment. However, providers still have the ethical duty to provide care that meets the standards of modern healthcare practice. As such, this essay analyzed the patient-centered care model alongside the current involuntary commitment policies.

Two research questions are addressed in this essay. 1) What are the standard practices and policies at the state level in the United States regarding involuntary evaluation or admission for individuals experiencing a mental health crisis? 2) How can current state practices be altered to align with the patient-centered care model?

This essay is organized into the following sections. Chapter 2 provides general background information related to involuntary commitment. It provides a review of the deinstitutionalization movement, the current state of affairs surrounding mental health treatment in communities, barriers to care, legal considerations, and outcomes specific to individuals who have been involuntarily committed. Chapter 3 describes the methodology used for data collection and analysis. Chapter 4 presents the findings from this investigation, detailing the state statutes surrounding involuntary commitment (e.g. characteristics and components of involuntary commitment for each state), and a listing of the dimensions and attributes surrounding patient-centered care. Chapter 5 provides a discussion of the findings from the state statutes with the patient-centered care model, and a list of recommendations on how to better align current statutes and processes of involuntary commitment with operational definitions of patient-centered care.

# Background

Prior to the 1960s, individuals were easily placed under institutional care or confinement under the guise of one’s mental illness. There was no distinction between voluntary and involuntary psychiatric commitment. Historically, individuals with chronic illnesses (e.g. dementia, seizure disorders, mental disability etc.) were taken into these institutions. However, any person who was deemed a danger or burden could be relegated to a warehouse or prison. At its peak in 1953, there were 559,000 individuals in psychiatric inpatient care in the United States (Testa & West, 2010).

The quality of life for an individual in psychiatric inpatient care was generally poor. Lengths of stay were indefinite, but often times would span decades. Furthermore, any actual therapeutic treatment was not guaranteed at these mental asylums. If treatment was provided, it was usually inhumane and ineffective. Prior treatments included lobotomies, metrazol therapy (which induced seizures that regularly resulted in many adverse effects), electroshock therapy, and isolation. The living conditions were unregulated and inadequate. However, around the time of the Civil Rights movement, the injustices and atrocities within the mental health system came to light. What followed was a shift towards creating provisions of legal protections for individuals who were being considered for commitment.

## The Deinstitutionalization Movement

With the advent of psychotropic medications that proved to be very effective in treating symptoms of psychosis (e.g. chlorpromazine, an antipsychotic mediation), and pressure from civil rights activists, the movement for mental health treatment in the community was born. Several court cases limited the practice of placing individuals into inpatient psychiatric treatment against their will (i.e. involuntary commitment). By the 1990s, the population of individuals in psychiatric care declined to 30,000 (Testa & West, 2010).

This mass exodus of individuals leaving mental institutions was of great benefit to some individuals but very detrimental to others. On the one hand, there were individuals who were wrongly placed in institutional settings because of abuse of power and were now released. Other individuals needing treatment were able to receive adequate care and achieve recovery in the community with the advancements in medicine. However, it was highly dependent on the available funding for a given community.

In 1963, President John F. Kennedy signed the Community Mental Health Centers Act to help move individuals from institutions to the community (Testa & West, 2010). However, this alone was not enough to ensure actual funding and infrastructure to cover the massive influx of individuals needing care in the communities. This birthed a large homeless population of individuals with SPMI (Testa & West, 2010; Danzer & Wilkus-Stone, 2015). Unfortunately, the situation has not changed since then. Homelessness continues to be a prevalent issue. A 2016 report by the U.S. Department of Housing and Urban Development (HUD) found there to be 549,928 individuals who experienced homelessness on a given night, with a fourth of them having mental illness.

## Legal Framework Governing Involuntary Commitment

The legal system has played a unique role in transforming the practice of involuntary commitment. With strong support from civil rights activists, a clear shift took place during the 1960s in which the authority of government regarding involuntary commitment shifted from the states’ *parens patriae* powers to the principle of *police power*. The former is defined as the responsibility of the state to “intervene on behalf of citizens who cannot act in their own best interest” (Testa & West, 2010). The latter is defined as the responsibility of “a state to protect the interests of its citizens” (Testa & West, 2010). Consequently, this change meant that laws reflected a stricter definition under which individuals could be taken into treatment against their will.

This shift toward the protection of individual interests was further supported by several landmark Supreme Court cases between 1972 and 2003. Together, these cases expanded the due process rights of individuals with SPMI who undergo involuntary commitment proceedings. The due process clause of the U.S. Constitution states that individuals cannot be deprived of their rights to life, liberty, or property without due process of the law.

In *Humphrey v. Cady* (1972),the Supreme Court determined that involuntary commitment is a curtailment of individual liberty, and the due process clause should also apply to those who are being committed on the grounds of their mental illness (Mrad, 2009; Danzer & Wilkus-Stone, 2015). In another, 1972 decision, *Jackson v. Indiana*, the Court’s ruling limited the length of involuntary commitment (Mrad, 2009; Danzer & Wilkus-Stone, 2015). Additionally, the Court said that due process requires a clear relationship between the commitment order and the purpose and duration of the commitment (Mrad, 2009; Danzer & Wilkus-Stone, 2015).In the latter part of the 1970s, the Supreme Court ruled that individuals cannot continue to be committed if they longer pose a dangerous threat in*O’Connor v. Donaldson* (1975) (Mrad, 2009; Danzer & Wilkus-Stone, 2015). Furthermore, individuals cannot be confined if they are able to live safely by themselves or with the assistance of family members or friends (Mrad, 2009; Danzer & Wilkus-Stone, 2015). Finally, in 1979, in *Addington v. Texas*,the Court ruled that the minimal burden of proof required “clear and convincing evidence” instead of the former “preponderance of the evidence” (Mrad, 2009; Danzer & Wilkus-Stone, 2015). In other words, courts need to meet a more rigorous standard to warrant involuntary commitment, increasing from a 50% to 75% probability.

The court determined in *Washington v. Harper* (1990) that prisoners can be forcibly medicated if they are found to be dangerous or gravely disabled (Mrad, 2009; Danzer & Wilkus-Stone, 2015). Additionally, an administrative proceeding is enough to determine involuntary medication, compared to the prior standard of a hearing with a jury (Mrad, 2009; Danzer & Wilkus-Stone, 2015).

In *Riggins v. US* (1992), ***t***he court maintained that those with mental illness facing criminal charges have the right to refuse antipsychotic medications (Mrad, 2009; Danzer & Wilkus-Stone, 2015). “However, this right can be overturned by a compelling governmental interest in prosecuting serious crimes” (Danzer & Wilkus-Stone, 2015). Additionally, side effects of medication should not pose serious impairment of the individual’s ability to testify and follow trial proceedings, using less intrusive alternatives if available (Mrad, 2009; Danzer & Wilkus-Stone, 2015).

The court maintained, in *Sell v. US* (2002-2003) that the government is allowed to administer drugs against the will of a criminal defendant. However, it must meet the following conditions: “there are legitimate government interests at stake, forced medications are likely to restore competency, no less restrictive alternative is available, and the medications are medically appropriate” (Danzer & Wilkus-Stone, 2015).

The rulings demonstrate a non-linear progression of the rights of individuals with SPMI who are involved in legal proceedings. Following the deinstitutionalization movement, the rulings affirmed several due process rights of individuals with SPMI involved in involuntary commitment. Providing due process rights to individuals follows the *police power* principle, which emphasizes the protection of individual interests. However, the rulings from 1990 – 2003 signal a return to the *parens patriae* principle, which is the belief that states have the responsibility to intervene when individuals cannot act in their own best interest. Since then, it appears that the parens patriae principle continues to guide policymaking regarding involuntary commitment at the state level.

## Definitions of Dangerousness

As mentioned earlier, the courts determined in *O’Connor v. Donaldson* that an individual must pose a danger to themselves or others to warrant involuntary commitment. However, the definition of dangerousness has varied throughout time and by each state. There are three broad categories under which someone is considered a danger.

### Imminent Physical Danger to Self or Others

Under this definition, an individual is considered appropriate for involuntary commitment if they pose a physical threat to themselves or others in the foreseeable future at the time of medical evaluation. This is the narrowest definition of dangerousness. Meaning, it is much harder to meet this criterion in order to get an individual committed for mental health treatment against their will. Generally, this has been the definition states have adopted. Some states specify a timeframe in which a dangerous act might occur. For example, the Pennsylvania statute on involuntary commitment includes that “there is a reasonable probability that death, serious bodily injury or serious physical debilitation would ensue within 30 days unless adequate treatment were afforded” (Treatment Advocacy Center, 2018).

### Grave Disability

The grave disability standard widens the definition of dangerousness. This allows the state to commit individuals who are unable to care for their own basic needs. Some states have a clear definition of what constitutes basic care. For instance, Alaska has adopted the following definition:

‘gravely disabled’ means a condition in which a person as a result of mental illness … is in danger of physical harm arising from such complete neglect of basic needs for food, clothing, shelter, or personal safety as to render serious accident, illness, or death highly probable if care by another is not taken (Treatment Advocacy Center, 2018).

### Need-for-treatment

A need-for-treatment standard is the broadest definition of dangerousness. Therefore, it allows a wider range of circumstances to warrant involuntary commitment of an individual with SPMI. Essentially, this is a return to the *parens patriae* principle. Michigan provides a thorough need-for-treatment definition:

An individual who has mental illness, whose understanding of the need for treatment is impaired to the point that he or she is unlikely to voluntarily participate in or adhere to treatment that has been determined necessary to prevent a relapse or harmful deterioration of his or her condition… (Treatment Advocacy Center, 2018).

## Mental Health Treatment

### Levels of Care

Though this essay focuses on involuntary commitment, which places individuals in an inpatient setting of a psychiatric hospital, readers should also be aware of the various treatment settings that occur in the community. This gives a better understanding of the current treatment landscape for mental health care. In the United States, individuals who are diagnosed with a mental illness and are in need of treatment should receive care in a setting that is least restrictive. Treatment in the community fall into the following four categories—from the most to the least amount of care: 1) residential treatment centers, 2) partial hospitalization programs, 3) intensive outpatient programs, or 4) outpatient treatment.

The levels of care correspond to the amount of resources required for treatment of an individual. Residential treatment is the first step down from inpatient care. These centers provide 24-hour monitoring, and individuals in treatment spend most of their days in various therapy activities. On average, individuals who go into residential treatment centers have a length of stay ranging from thirty to sixty days. Outpatient treatment, the lowest level of care, only requires office visits and no overnight stays. Individuals may only use these services once a week or less.

### Assertive Community Treatment

Assertive community treatment (ACT) is a multidisciplinary and integrated approach to the treatment of individuals with SPMI who are living in the community (Bond, Drake, Mueser, & Latimer 2001). Typically, fully staffed ACT teams are comprised of the following professionals: psychiatrist, nurse, social worker, and rehabilitation counselor (Bond, Drake, Mueser, & Latimer 2001). Treatment is individualized to the needs of the client, and services include treatment of physical and mental conditions—medication management, physical healthcare, symptom control issues, rehabilitation issues, substance use treatment, practical assistance, social services, and family services(Bond et al., 2001).

### Economic Cost

A *Health Affairs* report found that spending for mental health disorders cost an estimated $201 billion dollars in 2013 (Roehrig, 2016). It topped the list as the costliest condition in the United States for that year. It is likely that inpatient services account for a large proportion of mental health spending. Consider the following examples. Despite the fact that inpatient mental health treatment had the lowest user percentage among Medicaid patients in Allegheny County, it was still the highest cost service (Allegheny HealthChoices, Inc., 2017). Schizophrenia, one of the more debilitating mental health diagnoses, affects approximately 1.1 percent of the global population (Zhang et al., 2018). In the United States, the economic burden of schizophrenia amounts to $63 billion dollars annually. This includes roughly “$23 billion (~35%) in excess direct health care costs ($8.0 billion for long-term care; $7.0 billion for outpatient care; $5 billion for medications; and $2.8 billion for hospitalization); $9 billion (~15%) in direct non-health care costs; and $32.4 billion (~50%) in total excess indirect costs” (Zhang et al., 2018).

Given the high costs of treatment and the indirect spending related to mental illness, it is critical that processes that could potentially increase inpatient mental health usage, like involuntary commitment, only involve cases that are warranted and in the best interest of the individual.

## Factors Contributing to Involuntary Commitment

### Lack of Access to Quality Care

Mental health providers regularly work in high stress and sometimes dangerous environments. They engage with individuals who may be suicidal, facing extreme emotional distress, and who may share traumatic life events with them. Researchers found that among mental health providers, 21-67% of individuals experienced high levels of burnout (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012). Consequences related to burnout include negative physical and mental health outcomes for those experiencing it, reduced commitment to the work, negative attitudes, absenteeism and turnover, and job dissatisfaction (Morse et al., 2012; Dreison, Luther, Bonfils, Sliter, & McGrew, 2018). In turn, individuals who are burned out are less likely to provide quality care to their clients (Morse et al., 2012; Dreison et al., 2018).   
 On the consumer side, there are several factors that affect access to quality care. The costs for consumers to receive treatment is a primary concern. In a 2018 report surveying 5,000 American adults, 42% of participants cited the high cost of mental health treatment and poor insurance coverage as the top barriers to care (Cohen Veterans Network & The National Council for Behavioral Health, 2018). Participants also noted long wait times to see a provider (38% waiting longer than one week for treatment) and limited treatment options (46% have had to or know someone who has had to drive more than hour roundtrip to seek treatment).

It is particularly difficult for individuals in rural areas to receive care (Wells, 2018). Individuals in rural areas are more likely to be uninsured, travel longer distances to receive treatment (60% live in mental health professional shortage areas), and have difficulty in recognizing that they or their loved ones have a mental illness (Stewart, 2018; Wells, 2018). Additionally, professionals are less likely to be trained to work in rural areas (Stewart, 2018; Wels, 2018).

### Stigma

Cultural and societal factors, such as stigma related to mental health diagnoses and utilization of mental health services further minimize the likelihood that an individual will seek help. Individuals with SPMI are often looked upon by the general population as dangerous or crazy. It is widely documented how media outlets promulgate the idea of mental illness as the cause for many shootings (Levin, 2001; Montgomery, Metraux, & Culhane, 2013; Varshney, Mahapatra, Krishnan, Gupta, & Deb, 2016; Stone, 2018). However, the idea that individuals with SPMI are violent is unsubstantiated (Levin, 2001). It is more likely that individuals with mental illness are the victims of violence rather than the perpetrator of violence (Levin, 2001; Montgomery et al., 2013; Varshney et al., 2016; Stone, 2018).

Nevertheless, the stigma associated with mental illness appears to limit the funding that goes to behavioral health services on local, state, and federal levels. As a result, the effects of stigma are perpetuated on an individual and institutional level: individuals are less likely to seek mental health treatment because of the perceived and internalized stigma, and institutions and community agencies lack the resources to carry out services effectively (Levin, 2001; Montgomery et al., 2013; Varshney et al., 2016).

### Lack of Adherence to Medication

SPMI has a strong biological component and is highly affected by environmental factors like exposure to stress, poverty, sexual and/or physical abuse, and other forms of trauma (Hopper, Jost, Hay, Welber, & Haugland, 1997). With the onset of psychiatric symptoms, social and cognitive functioning considerably decrease. Worsening symptoms can lead to the degradation of social support and inability to maintain employment (Montgomery et al., 2013).

Treatment for individuals with SPMI involves the use of psychotropic medication. Considering the many challenges facing individuals with SPMI, it is not a surprise that medication adherence is relatively poor among this population (Kane, Kishimoto, & Correll 2013). Non-adherence can be intentional or unintentional (e.g. failing to fill a prescription, stopping medication prematurely, taking the wrong dosage, taking medication at the wrong time, etc.) (Semahegn et al., 2018). Again, internalized and perceived stigma contribute to non-adherence among individuals with SPMI. Consequently, non-adherence lead to poorer health outcomes, including a greater number of visits to the emergency rooms, longer hospital stays, and deterioration of their mental health (Kane et al.; Semahegn et al., 2018).

### Lack of Knowledge Among Healthcare Professionals and Judges

Health professionals engaging with individuals who may require involuntary commitment include physicians, physician assistants, nurse practitioners, nurses, social workers, and technicians. In a study by Holder et al. (2018), health professionals (i.e. physicians, physician assistants, nurse practitioners, nurses, social workers, technicians) working in an emergency department of a South Carolina health system were tested on the state’s involuntary commitment statues. The findings indicated that the majority of professionals achieved less than 50% correct response on true and false questions regarding the South Carolina involuntary hospitalization process (Holder et al., 2018). Similarly, professionals who have the responsibility for initiating involuntary commitment proceedings frequently have limited time to decide whether an involuntary commitment is appropriate, and have limited information to make the determination (McGarvey, Leon-Verdin, Wanchek, & Bonnie, 2013). Altogether, it is questionable whether placement of individuals into involuntary commitment is consistent or warranted. In addition, the operational procedures for involuntary commitment and training of healthcare professionals about its process vary across county and state levels—further complicating this issue.

Similarly, judges who make the final determination regarding whether a person will be committed rely on expert testimony by clinicians. Interestingly, a study by Evans and Salekin (2014) found that the manner in which clinicians communicate risk factors for a given individual influence the probative value of the information communicated. In other words, the communication style made a difference in the extent to which a judge believed an individual’s risk of danger. This is problematic because it demonstrates that judges, who do not necessarily have any mental health training, make determinations based on factors unrelated to the actual evidence.

Combining all of these factors—barriers to care, stigma, symptomatic challenges and individual behavior, and the knowledge base of those making commitment determinations—demonstrate the complex nature of this issue. The individual and subjective factors present their own concerns and challenges, and contribute to the likelihood of whether an individual is committed.

## Experiences and Outcomes of Involuntary Commitment

Researchers have examined the demographic profiles of individuals who experience compulsory treatment. One’s gender (i.e. male), diagnosis (i.e. bipolar, schizophrenia), severity of illness, and low socioeconomic status have been shown to be predictive factors of involuntary commitment (Curley et al., 2016; Canova Mosele et al., 2018; Stone, 2018).

The literature is mixed regarding the outcomes of individuals who are committed on a voluntary versus involuntary basis. Positive outcomes related to involuntary commitment include a reduction in psychotic symptoms, increased cooperativeness with treatment, and improved attitudes toward treatment (Danzer & Wilkus-Stone, 2015). Individuals were more likely to engage and regard involuntary commitment in a positive manner if they perceived that they were respected by hospital staff and were part of the decision-making process regarding their treatment plans (Danzer & Wilkus-Stone, 2015; Seed, Fox, & Berry, 2016). In contrast, other studies show that involuntary commitment is associated with a greater likelihood of treatment non-adherence, jail time, suicide attempts, longer hospitalization stays, rehospitalization, and decline in social functioning (Kallert, Glockner, Schutzwohl, 2008; Testa & West, 2010; Danzer & Wilkus-Stone, 2015; Vannoy, Andrews, & Srebnik 2016; Hung, Chan, & Pan, 2017).

### Patient-Centered Care

Core components of patient-centered care include respecting patient preferences, educating and informing the patient, providing emotional and physical support, coordinating care, providing continuity in care, and involving family and friends (Epstein & Street, 2011). Its objective is to foster an environment in which patients feel empowered and informed in their healthcare treatment.

The PCC model is particularly important in the care and management of individuals with SPMI who are involuntarily committed. When an individual is involuntarily committed, they lose their autonomy, and may perceive and internalize greater stigmatization. Oftentimes, involuntary commitment results in further mental and physical deterioration for individuals with SPMI (Kallert, Glockner, Schutzwohl, 2008; Testa & West, 2010; Danzer & Wilkus-Stone, 2015; Vannoy et al., 2016; Hung et al., 2017). PCC, which aims to engage and empower patients in their treatment, can help ameliorate some of the challenges that accompany involuntary commitment.

A few studies regarding involuntary commitment cited PCC or its components as a way to improve patient engagement and health outcomes for affected populations (Danzer & Wilkus-Stone, 2015; Wyder, Bland, Herriot, & Crompton, 2015). For the example, the study by Danzer & Wilkus-Stone (2015) stated the following:

The interviewed patients also articulated their need for staff to be tactful, transparent, and honest, particularly about the nature of their mental illnesses, treatment options, and the consequences of refusing medication. Such dialogues helped patients develop new insights, reduced patient anxieties, and defused potentially threatening situations. In turn, working alliances developed and promoted trust and hope in the treatment process.

The study by Wyder et al. (2015) investigated how involuntary commitment proceedings were perceived by patients, and how it affected their state of mind. The researchers noted, “it is also possible that the perception of being treated fairly, of clear legal processes, and ‘procedural justice’, has the potential to influence clinical outcomes” (Wyder et al., 2015). *Procedural justice* was defined by the researchers as “fairness,” which involves educating the individual of their rights, and including them in the decision-making process. They added, “patients may perceive [involuntary commitment] as less coercive if they are treated with respect and are afforded procedural justice” (Wyder et al., 2015).

# Methods

In order to answer the first research question: What are the standard practices and policies at the state level in the United States regarding involuntary evaluation or admission for individuals experiencing a mental health crisis? I obtained the statutes regarding involuntary commitment from all fifty states and the District of Columbia from the Treatment Advocacy Center (2018). In reviewing each statue, I paid particular attention to the following characteristics or components in the state standards: criteria for commitment (i.e. how dangerousness is defined), process of commitment (i.e. who is able to initiate proceedings), and whether an assisted outpatient treatment law existed for the given state.

### Criteria for Commitment

As discussed, the statutes fall under three general categories regarding the definition of *dangerousness* of an individual. These definitions stipulate the legal standard of when commitment is permissible. In other words, it is the reason why an individual is being committed. The three general definitions include: (1) posing serious imminent harm to self or others, (2) grave disability, or (3) need-for-treatment. These definitions play a significant role in an individual’s access to treatment. States may include one or more definitions of dangerousness in their statutes. In this essay, only the first two definitions are documented and discussed because identifying the use of the need-for-treatment is difficult to discern because it seemed to be implied in some state statutes but not explicitly written.

### Process of Commitment

Similar to the criteria for commitment, states vary in how they define the procedural components of involuntary commitment. Procedural components include, but are not limited to, how long individuals can be detained before an evaluation or treatment (or otherwise be released), whether a hearing is required before evaluation or commitment, as was who has to sign off on a petition (if anyone). In this essay, I identified who is allowed to petition the court (e.g. family members, only authorized professionals, etc.). An individual who is petitioning the court is asking the court to exercise the authority of compulsory mental health treatment. Defining who can petition the court affects access to treatment and scope of who is affected by involuntary commitment processes. Allowing more individuals to have the capacity to petition the court may increase the likelihood of an individual being involuntarily committed.

### Assisted Outpatient Treatment

During the investigation, it was identified whether or not states included an outpatient commitment law. Outpatient commitment, or assisted outpatient treatment (AOT), allows an individual in crisis to remain in the community but is still mandated to receive treatment through some means of supervision by mental healthcare professionals. AOT has been shown to moderate outcomes related to symptom management if clients are effectively engaged (Testa & West, 2010; Schneeberger et al., 2017; Cripps & Swartz, 2018). Therefore, it was critical in the analysis to identify how many states indicated an AOT option in their commitment statutes. However, it should be noted that the existence of a state statute for AOT does not imply or provide evidence that the option is being utilized to its full extent.

In order to answer the second research question: How can current practices be altered to align with the patient-centered care model? I did the following. First, descriptions of patient-centered care were collected and synthesized. These were gathered from the following sources: grey literature (e.g. federal, state, and local health department resources), as well as peer-reviewed literature through a search using the University of Pittsburgh University Library System, Google Scholar, and other search engines. Specific suggestions of how to operationalize patient-centered care were derived from the respective studies. The following chapter includes a table of definitions and key components of the patient-centered care model.

# Results

## Criteria for Involuntary Commitment

All 50 states, as well as the District of Columbia include a definition of dangerousness as bodily harm to self or others. Forty-six states include some kind of definition of *grave disability* in their criteria for dangerousness, as shown in Table 1. Alabama, Delaware, Maryland, New York, as well as the District of Columbia do not include any kind of *grave disability* definition in their statutes. There was a great deal of variation in the clarity and detail in defining the term. Some cited what constitutes basic needs, like the ability to attain for themselves shelter, food, hygiene. Others, like Alaska, define grave disability as, “to suffer severe and abnormal mental, emotional, or physical distress, and this distress is associated with significant impairment of judgment, reason, or behavior causing a substantial deterioration of the person's previous ability to function independently” (Treatment Advocacy Center, 2018).

Table 1 Criteria for involuntary commitment, by state including the District of Columbia

|  |  |  |
| --- | --- | --- |
| State | Danger to Self or Others | Grave Disability |
| Alabama |  |  |
| Alaska |  |  |
| Arizona |  |  |
| Arkansas |  |  |
| California |  |  |
| Colorado |  |  |
| Connecticut |  |  |
| Delaware |  |  |
| District of Columbia |  |  |
| Florida |  |  |
| Georgia |  |  |
| Table 1 Continued | | |
| Hawaii |  |  |
| Idaho |  |  |
| Illinois |  |  |
| Indiana |  |  |
| Iowa |  |  |
| Kansas |  |  |
| Kentucky |  |  |
| Louisiana |  |  |
| Maine |  |  |
| Maryland |  |  |
| Massachusetts |  |  |
| Michigan |  |  |
| Minnesota |  |  |
| Mississippi |  |  |
| Missouri |  |  |
| Montana |  |  |
| Nebraska |  |  |
| Nevada |  |  |
| New Hampshire |  |  |
| New Jersey |  |  |
| New Mexico |  |  |
| New York |  |  |
| North Carolina |  |  |
| North Dakota |  |  |
| Ohio |  |  |
| Oklahoma |  |  |
| Oregon |  |  |
| Pennsylvania |  |  |
| Rhode Island |  |  |
| South Carolina |  |  |
| South Dakota |  |  |
| Tennessee |  |  |
| Texas |  |  |
| Utah |  |  |
| Vermont |  |  |
| Virginia |  |  |
| Washington |  |  |
| West Virginia |  |  |
| Wisconsin |  |  |
| Wyoming |  |  |

## Petitioning the Court for Evaluation or Treatment

State statutes vary in who can initiate petition proceedings for emergency evaluation or involuntary commitment. Unsurprisingly, peace or law enforcement officers and physicians are most frequently mentioned in regards to who can petition the court for an *emergency evaluation* of an individual who seems to fit the state’s criteria of being mentally ill or a danger to themselves or others. See Table 2. Twenty-three states allow any person to begin the petition proceedings for *emergency evaluation* of another individual who fits the criteria. Twenty-seven states allow any person to initiate the petition proceedings for *involuntary commitment*.

Table 2 Who can petition the court for involuntary commitment, by state including the District of Columbia

|  |  |  |
| --- | --- | --- |
| Initiator | Inpatient Treatment | Emergency Evaluation |
| Any interested person | AL, AR, CT, GA, HI, IL, IA, KS, KY, LA, MD, MI, MN, MS, NH, NM, ND, OH, OR, PA, SC, SD, TX, UT, VA, WV, WY | AZ, AK, CA, CO, GA, IL, IA, MD, MA, MI, MS, MO, NH, NC, PA, SC, SD, TX, UT, VA, WV, WI, WY |
| Advanced practice registered nurse | WA | CT, HI, ID, MD, ND |
| Attorney |  | HI, |
| Attorney General | NJ, RI |  |
| Child of individual | NV, OK, RI, VT | OK, VT |
| Clergy member |  | HI |
| Commonwealth's attorney | KY |  |
| Coroner |  | AK, LA |
| Counselor or therapist |  | CO, FL, MD, NV |
| County attorney | AZ, KY, MT, NE TX |  |
| Crisis team member | WA | CA |
| District attorney | OK, TX |  |
| Examiner | WI |  |
| Facility administrator | FL, ME, MO, RI | MD, NM |
| Facility superintendent | IN, MA, SC, TN |  |
| Friend | ID, IN, KY, VT | AZ, VT |
| Table 2 Continued | | |
| Government employee | ID | HI |
| Grandparent | OK |  |
| Guardian | DC, ID, IN, KY, NV, OK, RI, TN, VT | VT |
| Health officer | IN, OR, TN | ME, MD, OH, UT |
| Hospital or treatment facility | DE | KS |
| Judge |  | LA |
| Law enforcement officer | DC, IN, TN, VT | AL, AZ, AK, CT, DC, FL, HI, IN. KS, ME, MA, NE, NV, NJ, NY, OH, PA, RI, TN, VT, WI, WY |
| Medical director | AZ, CA, ID, MA, RI | ND, RI |
| Mental health coordinator | MO | MO, OR |
| Mental health professional | AK, KY, OK, VT, WA | DE, HI, ND, RI, VT |
| Parent | DC, NV, OK, RI, TN, VT | OK, VT |
| Parole officer |  | OH |
| Peace officer | KY, OK | AL, AZ, AK, CA, CO, GA, ID, IL, IA, KY, LA, MD, MI, MN, MT MO, NH, NM, NY, ND, OK, OR, UT, WA |
| Physician | AK, CA, DC, GA, ID, NV, NY, NC, TN, VT, WA | AL, CA, CT, DE, DC, FL, GA, HI, ID, KY, MD, MA, NV, NM, ND, OH, PA, RI, TN, VT, VA |
| Physician assistant | WA | ID, ND |
| Professional person | CO | CO |
| Prosecuting attorney | ID, IN |  |
| Psychiatric nurse |  | FL, MA |
| Psychiatrist | NJ | AL, DE, ND, OH |
| Psychologist | CA, DC, NV, TN | AL, CT, DC, FL, HI, MD, MA, NM, ND, OH, TN |
| Registered nurse | CA, NV | CO, NV |
| Relative | ID, IN, KY, MS, RI, TN, VT | AZ, MS, OK, VT |
| Sibling | OK, RI |  |
| Social worker | CA, NV | CO, CT, FL, HI, MD, MA, NV |
| Spouse | DC, ID, IN, KY, NV, OK, RI, TN, VT | VT |
| Treatment advocate | OK |  |

## Inclusion of Outpatient Commitment Law

Only four states do not include a provision regarding outpatient commitment (Table 3). These states are Connecticut, Massachusetts, Maryland, and Tennessee. All other states, as well as the District of Columbia have a provision for outpatient commitment.

Table 3 Outpatient commitment law, by state including the District of Columbia

|  |  |
| --- | --- |
| States without provision | CT, MA, MD, TN |
| States with provision | All other US states and the District of Columbia |

## Patient-Centered Care Define and Operationalized

In the current literature, patient-centered care (PCC) is defined in various ways, with varying degrees of similarity. Table 4 lists four different conceptualizations of PCC and the key components or themes of PCC identified by the respective authors. In addition, Table 4 offers examples of how PCC can be operationalized in practice. Three articles specifically focused on PCC as it relates to mental health or psychiatric care (Geller, 2012; Waters & Buchanan, 2017; Maassen, Schrevel, Dedding, Broerse, & Regeer, 2017), while Fix et al. (2017) surveyed a wide variety of healthcare professionals to understand how providers conceptualize PCC. In the Dutch study by Maassen et al. (2017), how patients’ conceptualized PCC was paired with four dimensions of PCC identified in their literature review.

There are two specific components of PCC that each study identified. First is the importance of treating each patient as a unique individual. This means that every patient has unique needs and concerns that should be considered. Treatment cannot be a one-size-fits-all approach. Second, treatment involves shared decision making between the patient and healthcare professional. Doing so engages the patient in the treatment process by providing them the opportunity to voice their preferences and educating them on medication and other treatment options. Lastly, trainings for healthcare professionals that strengthen therapeutic communication skills can support these approaches to PCC.

Several examples of how to operationalize PCC were gathered from the literature review. Two studies noted the need for hospitals to cultivate a culture of PCC that permeates throughout all levels of the organization. Similarly, a PCC approach not only means empowering, educating, and supporting patients, but health professionals, as well. There are many examples regarding patient-provider interactions. Suggestions include active-listening, using empathy, and shared decision-making. Geller (2012) specifically mentioned minimizing the use of seclusion or restraint, and limiting the use of coercive discharge. Other possible procedural accommodations not mentioned in Table 4 are discussed later in this essay.

Table 4 Patient-centered care overview

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Author(s) | Year | Title | Key components of PCC | Operationalizing PCC |
| Geller | 2012 | Patient-centered, recovery-oriented psychiatric care and treatment are not always voluntary | * + - Centrality of individual in the process of treatment planning and implementation     - Shared decision making     - Reasoned risk taking     - Care to include health and wellness, mindfulness, social engagement, and employment | * + - Minimizing the use of seclusion or restraint     - Limiting use of coercive discharge     - Maximizing patient participation when appropriate |
| Fix et al. | 2017 | Patient-centered care is a way of doing things: how healthcare employees conceptualize patient-centered care | * + - Biopsychosocial perspective     - Patient-as-person     - Sharing power and responsibility     - Therapeutic alliance     - Doctor-as-person | * + - Employees seeing patient beyond illness     - Getting to know the patient (hobbies/interests/ goals)     - Provide sufficient support for staff     - View patients as equal partners (active listening, identifying patient goals, etc.)     - Empathy and respect     - Creating a healing atmosphere (intentional about design of space and use of colors)     - PCC as part of organizational culture |
| Waters & Buchanan | 2017 | An exploration of person-centered concepts in human services: a thematic analysis of the literature | * + - Honoring the person     - Being in relationship     - Facilitating, participating, and engagement     - Social inclusion/citizenship     - Experiencing compassionate love     - Being strengths/capacity focused     - Organizational characteristics | * + - Individualized care     - Providing opportunities for shared decision-making or choices     - Active listening and valuing     - Allowing for self-determination and control as much as possible     - Providers to develop relationship with family of patient     - Providing staff with sufficient resources and support to do job |
| Maassen, Schrevel, Dedding, Broerse, Regeer | 2017 | Comparing patients’ perspectives of “good care” in Dutch outpatient psychiatric services with academic perspectives of patient-centred care | * + - Patient-as-person     - Health professional-as-person     - Patient-professional interaction: communication, and shared responsibility and power     - Develop PCC culture within healthcare organization | * + - Treating patient as person, not as a problem     - Using a strengths-based approach to treatment     - Using patient’s experiential knowledge in formulating care plan     - Acknowledging patient preferences and goals can change over time—adjustments might be necessary     - Provider as a knowledgeable, empathetic, active-listener, and non-judgmental during interactions     - Interactions to include discussion of lifestyle, not just pharmaceuticals     - Appropriate use of self-disclosure by provider     - Building trust between provider and patient     - Empowering health professionals to respond to patient needs     - Integration of alternative therapies |

**Table 4 Continued**

# Discussion

The issue of involuntary commitment intersects the fields of law and healthcare. Many proponents of statutes that set the criteria of dangerousness as “imminent physical harm to self or others” are typically those working in the field of law. Arguments for narrower statutes focus on individual liberty and autonomy and point to the negative outcomes associated with involuntary commitment. Conversely, those who argue for broader statutes that, at the very least, allow the grave disability standard, are mostly psychiatrists, therapists, other mental health professionals, as well as family and friends of individuals with SPMI. Their argument lies in the idea that earlier treatment better serves individuals with SPMI because it does not require further deterioration to the point of physical bodily harm to anyone. Again, the literature has shown mixed results in terms of health outcomes related to involuntary commitment. However, studies that have found positive outcomes involved patients who were able to engage in their treatment and build a good relationship with providers, despite being involuntarily committed (Danzer & Wilkus-Stone, 2015; Seed, Fox, & Berry, 2016).

Procedural safeguards, outlined earlier in this essay, were established to protect the rights of individuals with SPMI. However, current state statutes suggest of a return to the *parens patriae* principle, which contends that states have the authority to intervene in order to protect its citizens who cannot act in their own best interest. This essay found that nearly all states include the grave disability standard, and many of them allow any individual to initiate the petition process for emergency evaluation or involuntary commitment (Table 1; Table 2). Moreover, the response from legislators after mass shootings in the last couple of years suggest that laws regarding involuntary commitment will continue to shift towards more states adopting broader statutes (Rosenberg, 2014; Morris, 2018). However, this essay argues that changing involuntary commitment laws should not be centered around gun violence—individuals with SPMI are more likely to be the victims of violence rather than the perpetrators.

Instead, efforts should be focused on establishing a more standard way to approach involuntary commitment proceedings. A critical examination of each state’s statutes demonstrates the high degree of variability in how dangerousness is defined, who plays a role in involuntary commitment (e.g. judges, lawyers, physicians, relatives, etc.), and how the proceedings are carried out (e.g. duration of emergency hold, use of judicial counsel, etc.). Furthermore, how statutes are implemented at the state and county level vary depending on the culture of agencies, knowledge base of actors (lay people, judges, physicians, police officers, nurses, etc.), and other factors.

Efforts to change involuntary commitment laws should incorporate practices that help individuals with SPMI engage in the process. As the literature suggests, when individuals are given a voice, and are treated with respect and dignity, it is more likely to result in positive outcomes even in the case of involuntary commitment. If standards included the application of a patient-centered approach, then individuals with SPMI may feel less threatened from the outset of involuntary commitment proceedings.

This study has identified intervention points throughout the commitment process that could accommodate a more patient-centered approach. For example, some states specified the level of training required for certain professionals to be able to initiate involuntary commitment. Consider if states required all judges and officers to be trained in Mental Health First Aid or have some basic understanding of mental health and illness. Similarly, there are trainings that teach agencies how to develop empathy and provide trauma-informed care (Mahoney, Mulder, Hardesty, & Madan, 2017). Hearings should involve the person of interest, and allow them the opportunity to speak and share their experience.

Additionally, a study by Australian researchers outlined the idea of procedural fairness (Wyder et al., 2015). Not only do legal proceedings on involuntary treatment include a mental health review tribunal composed of a lawyer, psychiatrist, and a community member, but they also ensure that “patients understand that the tribunal is not part of the health system and that it is not ‘on the doctor’s side’” (Wyder et al., 2015). Creating a distinction between a commitment order and treatment may give providers a better chance of creating a therapeutic relationship with the patient.

Within the inpatient hospital setting, after an individual is approved for involuntary commitment, providers should limit the use of restraints and coercive actions, and include patients in decision-making whenever possible. Furthermore, as the literature suggests, administrators should identify ways to support staff working directly with patients to minimize burnout. More importantly, a well-supported team helps ensure that patients are receiving treatment that is empathetic and empowering. Other suggestions of ways to operationalize patient-centered care in the context of involuntary commitment are listed in Table 4.

As this essay discussed, there are other factors that mitigate the use of involuntary commitment, such as stigma and access to quality mental healthcare. Educational programs and campaigns that destigmatize mental health and illness are worthwhile investments that can help individuals with mental health issues feel accepted and embraced by society. Moreover, they promote the use of mental health services and early treatment. Institutional supports that decrease costs for mental health treatment also increase the likelihood of treatment utilization. Lastly, offering incentives for physicians to specialize in psychiatry, as well as providing trainings to treat rural communities can improve the overall quality of care for individuals with mental illness. Together, these efforts can minimize the use of involuntary commitment because individuals receive treatment before serious mental health deterioration occurs.

## Conclusion

In many ways, the mental health system mirrors the population it serves. Often, it lacks institutional support and financial stability. A large proportion of providers in the system are burned out and lacking the mental and emotional capacity to serve its clients. Regardless of where individuals fall on the argument of broader or narrower statutes regarding involuntary commitment, all agree that allocation of resources for mental healthcare are critically needed.

More upstream approaches are essential in order to address the challenges being faced by individuals with SPMI and those who care for them. For example, there is evidence that if a given community has more access and services in the community, utilization of involuntary commitment decreases (McGarvey et al., 2013). This essay provides suggestions on how to integrate the patient-centered approach early on in the involuntary commitment process. Lastly, writing these practices into policy can help ensure that implementation is more uniform, and empowering all individuals to engage in the process.

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