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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

Donald H. Stone, J.D.*

ABSTRACT

This Article will examine the reverse trend in civil commitment laws in the wake of recent tragedies and discuss the effect of broader civil commitment standards on the care and treatment of the mentally ill. The 2007 Virginia Tech shooting, the 2011 shooting of Congresswoman Giffords, and the 2012 Aurora movie theatre shooting have spurred fierce debates about the dangerousness of mentally ill and serve as cautionary tale about what happens when warning signs go unnoticed and opportunities for early intervention missed. This piece will explore the misconception about the role medication and inpatient civil commitments should play in prevention of dangerousness and undermine the belief that we can medicate away the needs of the mentally ill. The adverse effect civil commitments can have on individuals’ long-term recovery, future employment prospects and overall mental, physical, emotional and economic stability can be far-reaching; so minimum due process protections must be carefully guarded. The contention is that civil commitment decisions should be based on concrete evidence that the individual is an imminent danger to self or others and not on a psychiatrists’ speculation about future deterioration absent coerced treatment. Statistical data, collected from a survey of 100 psychiatrists, will be examined to determine what 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. Finally, this Article will outline how “need for treatment” and “grave disability” provisions in commitment standards have stripped away due process protections for the mentally ill and discuss ways mental health advocates can fight back to reverse this troubling movement in commitment laws.

* © 2011 Donald H. Stone. Donald H. Stone, Professor of Law, University of Baltimore School of Law, B.A., Rutgers University; J.D., Temple University School of Law. Professor Stone gratefully acknowledges his research assistant, Catherine Seward Jackson, a 2012 graduate of the University of Baltimore School of Law, for her outstanding legal research in the preparation of this Article.
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 uncontested psychiatrist expert opinions have on the outcome? How imminent should danger to self or others be? Will we permit legislatures and pro-treatment advocates to stretch the civil commitment standard until all due process protections are gone? What impact do more relaxed commitment standards have on the level of care that patients with mental illness receive? Why should disability advocates and members of the legal community alike be alarmed by this regressive trend toward more permissive commitment?

There is a backlash among mental health advocates who are questioning the long-term efficacy of psychiatric medication for the treatment of persons with severe mental illness. 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 through 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 about 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 mental illness and increase community treatment resources. State and federal courts, recognizing that civil commitment was a significant curtailment of liberty interests, established procedural limitations to the previously unchallenged practice of committing mentally ill persons for treatment purposes under *parens patriae* powers. Following landmark Supreme Court decisions, most states adopted a stricter criterion for civil commitment, requiring, at a minimum, a showing of "dangerousness."\(^4\)

Unfortunately, several decades later the pendulum has swung in the opposite direction. Legislatures, with the broad support of medical community, have moved to expand the definition of "dangerousness" back to what it was prior to the 1960s. Only eight states still define dangerousness solely as a "danger to self or others."\(^6\) Forty-two states have criteria broader than dangerousness that usually include either a "grave disability"\(^7\) or "need for treatment"\(^8\) provision. These expanded criteria give judges broad discretion to make civil commitment decisions.


\(^5\) *Id.* at 224. In a national survey, completed by over 700 psychiatrists, 90% 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% supporting such grounds in 1969.


\(^7\) *Id.* (stating that 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).

\(^8\) *Id.* (stating that "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 twenty-six of the forty-two states with some sort of broader commitment criteria have "need for treatment" language in their statutes).
and overvalue the role of medication adherence in the treatment of mental illness. These provisions allow for the commitment of non-dangerous individuals based on a presumption that, if left untreated, future harm will likely ensue.

Three recent tragedies, and the public discourse that followed, may help to explain the reversal of long fought protections for people with mental illnesses. The 2007 Virginia Tech shooting, the 2011 shooting of Congresswoman Giffords, and the 2012 Aurora movie theatre shooting were three very high profile cases in which the media focused its discussions on the mental health of the shooters. There was a tumultuous debate about the dangerousness of persons with mental illness when warning signs go unnoticed and there is a 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 persons with mental illness who may be dangerous in the future.9

This Article will examine the regressive trend in civil commitment laws and the effect of that trend on the care and treatment of persons with mental illness. 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 should justify the curtailment of persons’ liberty when there is no clear evidence that serious physical harm to the individual or to others is imminent.

This Article will examine statistical data from a survey of 100 psychiatrists in order to better understand what evidence is most significant to psychiatrists in commitment recommendations and highlight the impact of state standards and types of hospital facilities on psychiatrists’ testimony at civil commitment proceedings.10

I. PROCEDURAL DUE PROCESS PROTECTIONS FOR PERSONS WITH MENTAL ILLNESS

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

Prior to the early 1970s, the civil commitment of persons with mental illness went largely unchallenged in the courts. State courts committed many people with mental illnesses under parens patriae

9 For example, in the wake of Virginia Tech shooting, Virginia changed statute from requiring evidence of imminent danger to only a substantial likelihood person would cause physical harm to self or others. VA. CODE ANN. § 37.2-808, 809 (West 2011).
10 See infra Appendix A: Donald H. Stone, Involuntary Commitment Survey of Psychiatrists (2011) [hereinafter Stone, Survey].
powers, asserting that they were in need of treatment.\textsuperscript{11} The Supreme Court in \textit{Jackson} v. \textit{Indiana} extended due process protection to respondents in civil commitment proceedings, mandating that there be a reasonable relationship between the purpose of civil commitment and the nature and duration of commitment.\textsuperscript{12} The Court expanded these protections in \textit{O'Connor} v. \textit{Donaldson},\textsuperscript{13} restricting states' ability to confine non-dangerous individuals who are capable of surviving safely in freedom.\textsuperscript{14} 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."\textsuperscript{15} The Court held that the state's interest in providing care to the unfortunate was not a sufficient justification to confine a person with a mental illness against his will, even if it ensured him a higher standard of living.\textsuperscript{16}

The Court elevated the burden of proof for civil commitments in \textit{Addington} v. \textit{Texas}, requiring the state to prove by clear and convincing evidence that the person is mentally ill, dangerous to either himself or others, and in need of confined therapy.\textsuperscript{17} The Court explained that the clear and convincing standard of evidence is a balance of the patient's interest to not be involuntarily confined and the state's \textit{parens patriae} power to provide care for its citizens who are unable to care for themselves.\textsuperscript{18} The Court weighed heavily the liberty interests of individuals to make independent treatment decisions and the stigma that can result after a person has been committed to a mental hospital.\textsuperscript{19} 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."\textsuperscript{20} The Court chose to increase the burden of proof to stress to the factfinder the importance of the decision and to reduce the likelihood that courts would order inappropriate commitments.\textsuperscript{21} These landmark decisions served as guideposts for civil commitment laws across the country as states revised their statutes to comply with the Court's holdings.
B. CHALLENGES TO STATE CIVIL COMMITMENT STANDARDS: INDIVIDUAL CHALLENGES MET WITH INCONSISTENT SUCCESS

Despite the protections outlined by the Supreme Court, the disturbing trend seen in the "need for treatment" and "grave disability" statutes permits confinement based on an expectation of deterioration and possible future harm that is largely based on questionable presumptions about persons with mental illness. These exceptions to the requirement of dangerousness represent a complete erosion of the due process rights articulated by the Court.22

There is much disagreement among state courts about what is a constitutionally permissible commitment standard. State courts have interpreted minimum due process differently. The handling of challenges made to "need for treatment" provisions in Alaska and Wisconsin reflects that variance. Despite similarities in the content of the statutes, the Wisconsin Supreme Court upheld the state's "need for treatment" provision, while the Alaska Supreme Court struck down its state's provision.

The Alaska Supreme Court, in Wetherhorn v. Alaska Psychiatric Institute, explicitly adopted the O'Connor standard in holding that the definition of "gravely disabled" is constitutional only if narrowly construed to require a level of incapacity so substantial that the respondent is incapable of surviving safely in freedom.23 In Alaska, a person was thought to be gravely disabled if, as a result of his or her mental illness, the person was in danger as a result of the neglect of basic needs or personal safety or would suffer severe or abnormal mental, emotional, or physical distress if not treated.24

The Wisconsin Supreme Court went the opposite direction in In re Commitment of Dennis H,25 rejecting the idea that dangerousness must be "based upon a finding of recent overt act, attempt or threat to do substantial harm to oneself or another" and that there must remain an immediate danger at the time of the hearing.26 In Dennis H., the Wisconsin Supreme Court affirmed the constitutionality of a lower standard for dangerousness.27 The challenged provision of Wisconsin's involuntary commitment statute, dubbed the "fifth standard," allows for the commitment of a person with mental illness who will "suffer severe mental, emotional, or physical harm that will result in the loss of the

22 See O'Connor v. Donaldson, 422 U.S. 563, 575 (1975); see also Addington, 441 U.S. 418.
24 Id. at 376 (quoting ALASKA STAT. § 47.30.915(7) (2012)).
25 647 N.W.2d 851 (Wis. 2002).
27 See Dennis H., 647 N.W.2d 851.
individual's ability to function independently in the community or the loss of cognitive or volitional control over his or her thoughts or actions" if left untreated. 28 The Wisconsin Supreme Court held that even if there is no foreseeable risk of self-injury or suicide, a person is still dangerous if he or she is "helpless to avoid the hazards of freedom." 29 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. 30

The addition of "need for treatment" provisions to civil commitment laws reflects a troubling supposition that persons with mental illness who are not on medication are inherently dangerous. The need for treatment standard upheld by the court in In re Commitment of Dennis H. 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 commitment should not justify the deprivation of a person's freedom. New laws like those adopted and upheld in Wisconsin, however, do just that, redefining dangerousness to include "need for treatment" language.

Despite setbacks in some courts, there have been many victories for disability advocates. 31 The Florida Appellate Court in Boller v. State held that the commitment of a woman who refused to take her psychotropic medication was unconstitutional. 32 The court followed the well-settled rule that refusal to take medication, despite deteriorating mental condition, does not justify involuntary commitment. 33 The court held that 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 that there is a substantial likelihood that in the near future she will inflict serious bodily harm on herself or another, as evidenced by recent behavior. 34 The requirement that the patient exhibit recent dangerous behavior rather than simply refuse to take medication establishes that the danger standard is fundamental and necessary to comply with constitutional substantive due process requirements. Speculation as to the significance of medication refusal should not be a

28 Id. at 857 (quoting Wis. Stat. Ann. § 51.20 (West 2011)).
29 Id. at 863 (quoting O'Connor v. Donaldson, 422 U.S. 563, 574 n.9 (1975)).
30 Id. at 862–63.
31 See State v. M.A.B., 157 P.3d 1256, 1259 (Or. Ct. App. 2007) (finding that the refusal to take medication was not sufficient, by itself, to prove an inability to provide for basic needs); see also State v. T.R.O., 145 P.3d 350, 353 (Or. Ct. App. 2006) (holding that a particularized threat is necessary for involuntary commitment).
33 Id.
34 Id. at 409–10.
component of the evaluation of a person's need for involuntary hospitalization. Recent dangerous behavior should form the basis of clear and convincing evidence of danger in commitment proceedings.

In a similar case, Carolyn Blue refused to take her medication and faced civil commitment in Florida. The court reversed the involuntary commitment, holding that although her condition was deteriorating, the evidence lacked the specificity needed to establish that there was a substantial likelihood that in the near future she would inflict serious bodily harm on herself or another person. Mere speculation that a person's refusal of medication will cause her to harm others was insufficient to warrant involuntary commitment. The requirement that there be a substantial likelihood that in the near future the person with mental illness will inflict bodily harm on herself or another person is essential to adequately safeguard the right of patients with mental illness to make independent treatment decisions.

In New Jersey, when a judge asked a psychiatrist what her basis was for believing that the respondent, 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. In another case, the Appellate Division of the New Jersey Superior Court held that to justify an involuntary commitment, it is necessary to show more than a potential for dangerous conduct. The court in In re Commitment of J.R. describes "danger to self" by reason of mental illness as threatened or attempted suicide or serious bodily harm or behavior that indicates that the person is unable to satisfy his or her need for nourishment, essential medical care, or shelter to such an extent that it is probable that substantial bodily injury, serious physical debilitation, or death will result within the reasonably foreseeable future. The requirement of immediacy of the danger, coupled with the substantial risk based on recent specific acts or threats of dangerous behavior, should protect against medication refusal being used as the primary justification for involuntary commitment.

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36 Id.; see also Lyon v. State, 724 So. 2d 1241, 1242 (Fla. Dist. Ct. App. 1999) (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).
40 Commitment of J.R., 916 A.2d at 467.
II. ROLE OF MEDICATION NONADHERENCE ON CIVIL COMMITMENT DECISIONS

Should the role of government expand to authorize and sanction the involuntary confinement of a person with mental illness 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" that many psychiatrists provide starts and ends with recommending that patients take pharmacological tablets. Whether a patient arrives at a psychiatric hospital with a laundry list of prescribed medications and is assessed by doctors as over-medicated, or he arrives in the refusal mode, without the list of pills, screaming "you can't make me take those pills," the evaluating psychiatrist's treatment plan at the admissions unit of the hospital remains rather consistent: Let us replace those old, less effective medications with some new and improved ones, or let us immediately start the newly-admitted patient on a drug regimen and see what happens.

One should not be surprised that psychiatrists use the wait-and-see approach to bolster the purported need for continued hospitalization when the civil commitment hearing day arrives. Psychiatrists commonly tell judges at commitment hearings that the need to adjust medication type and dosage justifies continued commitment. Continued confinement is necessary, according to the testifying psychiatrist, to ensure the safety of the patient. The hospital will invariably ask the judge to sign off on the civil commitment order to permit the treating psychiatrist to "wait and see." The patient will continue to be confined against his or her will despite a lack of tangible evidence that the person poses a danger to himself or herself or others in the community. Such a decision is based on a misguided belief that only patients who are properly medicated are no longer dangerous.

When a patient is involuntarily committed to a psychiatric hospital based on non-compliance with medication, the patient faces the possibility of being forced to take medication against his or her will.\(^{41}\) It is well established that a person may refuse other kinds of medical

\(^{41}\) See Md. Code Ann., Health-Gen. § 10-708(b) (West 2012) (stating that 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).
treatment even if at risk of death.\textsuperscript{42} The state's interest in protecting a person from harm to self is relatively low where the acts or omissions do not cause injury.\textsuperscript{43} Despite this recognition, there is an odd assumption that courts should treat forced medication for mental illness differently. The assumption that an untreated person's mental condition will decompensate without intervention until the individual eventually becomes dangerous is highly speculative. It is possible that the individual may not decompensate and will, like many individuals with mental illness, recover even without ongoing treatment.\textsuperscript{44}

Confinement for the purpose of providing treatment, one could argue, is a laudable purpose. However, if the reason for commitment is the refusal of a person with mental illness to comply with a medication regimen 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 person with mental illness could be subject to involuntary confinement simply because of a voluntary decision to refuse to take prescribed antipsychotropic medications. However, once the person is confined to a hospital, such medication could not be forcibly provided without a showing of dangerousness, and 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 refusal of treatment will result in a person engaging in harmful

\textsuperscript{42} See Stamford Hospital v. Vega, 674 A.2d 821, 832 (Conn. 1996) (stating that a patient's refusal of blood transfusions was in keeping with the deeply rooted common law right of bodily integrity, and the hospital's interests in preserving the 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, 667 (Fla. Dist. Ct. App. 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} See \textit{In re} Duran, 769 A.2d 497, 503, 504 (Pa. 2001).


\textsuperscript{45} See Dep't of Health & Mental Hygiene v. Kelly, 918 A.2d 470, 471–72 (Md. 2007) (holding in a forced medication case that the hospital must prove that the patient presents a danger in the hospital if not medicated, not just in the community were he to be released); see also Enis v. Dep't. of Health & Social Servs., 962 F. Supp. 1192, 1194 (W.D. Wis. 1996).

conduct or being unable to provide for his basic physical needs. 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 degree of dangerousness resulting from medication noncompliance.

The Substance Abuse and Mental Health Services Administration (SAMHSA) examines mental health treatment in the United States. 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 problem. The type of mental health services received ranged from prescription medication (11.1%) and outpatient services (6.9%) to inpatient treatment (1%).

There are several explanations for the fact that 5.5 million adults with mental illness are 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 that treatment would not help (10.3%), and fear of being committed or having to take medicine (7.2%).

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47 See 405 ILL. COMP. STAT. § 5/1-119 (2010). The Illinois commitment statute states in pertinent part 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. Id.


49 Id. In 2007 there were 24.3 million adults in the U.S. with serious psychological distress. Results from the 2007 National Survey on Drug Use and Health: National Findings, DEP’T OF HEALTH & HUMAN SERVS., SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., & OFFICE OF APPLIED STUDIES (Sept. 4, 2008), http://www.oas.samhsa.gov/NSDUH/2k7NSDUH/2k7results.cfm#Ch8.

50 Results from the 2007 National Survey on Drug Use and Health, supra note 49 (using 2007 data).

51 2003 National Survey on Drug Use & Health: Results, DEP’T OF HEALTH & HUMAN SERVS., SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., & OFFICE OF APPLIED STUDIES, (June 3, 2008), http://www.oas.samhsa.gov/nhsda/2k3nshu/2k3Results.htm#toc (using 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. Id.
The reasons for medication noncompliance are complicated and profound. Side effects of anti-psychotic and anti-depressants medications are often severe and significant. Anti-psychotic medications can carry serious side effects, including the following: myocarditis (fatal heart condition), changes in cardiac electrical impulses, sedation, agranulocytosis (decrease in white blood cells), diabetes, and serious weight gain. Other side effects include sexual dysfunction, suppression of REM sleep, muscle tics, fatigue, emotional blunting, and apathy. Additionally, the risks and stigma associated with forced involuntary treatment, including feelings of alienation, disaffection, adverse impact on the therapeutic psychiatric-patient relationship, 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.” In addition, a 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% of responders exhibit long-term cognitive symptoms of apathy, inattentiveness, forgetfulness, word-finding difficulty, and mental slowing, and over 40% of the responders experienced physical symptoms of fatigue and sleepiness/sedation. Dr. Maurizio Fava and his colleagues concluded from this data that the long-term symptoms of patients with major depressive disorder are both side

54 Bruce J. Winick, Mandatory Treatment: An Examination of Therapeutic Jurisprudence, 75 NEW DIRECTIONS FOR MENTAL HEALTH SERVS. 27, 30 (1997).
56 Id.
57 Id.
effects of the antidepressants and the residual symptoms of the mental illness. 58

Persons with mental illness sometimes also refuse medication because they are in denial and taking medication would serve as an admission that they do indeed have a highly stigmatized disorder that can be long-lasting and disabling. 59 Resistance to medication may also be a battle for autonomy and control. 60 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. 61 Society places a stigma on mental illness and receiving medications for one’s mental illness is an acknowledgement of the illness, which carries the stigma.

Even those persons with mental illness who willingly take their medication may still have low levels of energy and are often plagued by anxieties and depression, unable to hold a job, and forced to live life in poverty. 62 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. 63

When a person with mental illness 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 and recognize the benefits of medication; 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 rails 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 chemical imbalances in the brain and that psychiatric medication can improve the patients’ mental health. Whitaker

58 Id. at 1757.
60 Id.
61 Id.
62 Id.
63 Id.
claims the precise causes of mental disorders are unknown. Whitaker asserts that psychiatrists embraced the chemical imbalance theory of mental disorders “because it ‘set the stage’ for them to ‘become real doctors.’” As doctors of internal medicine had their antibiotics, “now psychiatrists could have their ‘anti-disease’ pills too.”

Whitaker similarly cites studies suggesting that anti-psychotic medication may have a negative impact on the overall course of the illness and might cause a worsening of the illness. Whitaker cites a number of studies that refute the notion that drugs fix chemical imbalances in the brain. Whitaker believes that psychiatry grossly exaggerates 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.

There is a growing chorus of voices 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 anti-psychotics were making patients “more biologically vulnerable to psychosis” and asked whether the cure was worse than the disease. Whitaker points to a study demonstrating that patients with schizophrenia had long-term recovery rates of 40% off medication and only 28% suffered from psychotic symptoms. In contrast, only 5% of those taking anti-psychotic medication were in recovery and 64% were actively psychotic. Another alarming statistic is the skyrocketing growth in population of persons diagnosed with schizophrenia in psychiatric hospitals between 1955 and 2008. The study blamed the fourfold increase on drug treatment, coinciding with the arrival of the medication Thorazine.

Whitaker warns that antipsychotic medication may actually make some patients with diagnoses of schizophrenia more vulnerable to future relapses than would be the case in the natural course of the illness. Whitaker asserts that drugs were increasing the likelihood that a person who suffered a psychotic break would become chronically ill. He goes on to say that initial exposure to neuroleptics puts patients on a path to

64 Whitaker, supra note 53, at 332.
65 Id. at 78.
66 Id. at 191.
67 Id. at 307–09.
68 Id. at 334.
69 Id. at 114.
70 Id. at 115–16.
71 Id. at 120.
72 Id. at 104.
73 Id.
lifelong drug dependence and relapse suffered by patients withdrawn from antipsychotics was drug-related and not the result of the return of the disease. Swedish physician Lars Martensson agreed in 1984 at the World Federation of Mental Health Conference in Copenhagen, stating that "the use of neuroleptics is a trap . . . it is like having a psychosis-inducing agent built into the brain."

Whitaker has put the spotlight on the need to reexamine the misuse of medication in the treatment of persons with mental illness. Advocates should push the dialogue to alternative forms of non-drug treatment options and recognize the limits of medication in the treatment of mental illness. States should repeal and courts should overturn the "grave disability" and "need of treatment" standards. Advocates should demand that concrete and specific evidence of current dangerous behavior be 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 understand the reasons for medication noncompliance. Judges should appreciate that not all people with mental illness who refuse their medication lack insight into their illness, and that refusal to take one's medicine is not necessarily emblematic of a dangerous person.

III. 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 support 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, the conventional wisdom was that clinicians were rather poor at predicting future violence in individuals with mental disorders. In general, studies showed that clinicians were 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 experience was not appreciably better than flipping a coin. According to a clinical study on

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74 Id. at 106.
75 Id.
76 Id. at 107 (internal citation omitted).
predicting risk of physical violence of patients with psychotic symptoms, the most significant factor is a past history of physical aggressive behavior. Furthermore, studies indicate that clinicians vastly overestimate the incidence of violence in released patients.

To provide empirical data on the views of psychiatrists about the civil commitment standard in their state and to determine how they evaluate different evidence in making their decisions, this author surveyed a diverse group of one hundred psychiatrists from twenty-six states. The respondents were from a variety of settings, public and private, inpatient and outpatient, rural, urban, and suburban, with forty-three of the respondents having testified in 100 or more civil commitment hearings. Twenty-six of the respondents were from states with a strict dangerous criteria for civil commitment, twenty-six were from states with a “grave disability” provision, and forty-seven were from states with a “need for treatment” provision in their civil commitment laws. The empirical data contained in this Article is submitted to serve as a backdrop for purposes of illuminating and comparing the significance that various presenting behaviors of the mentally ill persons have for psychiatrists.

The survey included a series of questions about how psychiatrists evaluate whether a person is a danger to self or others. In the first set of

80 M. Neil Browne & 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, 1174 (2008) (stating that 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).
81 See Stone, Survey, supra note 10 (unpublished web-based survey conducted by the author, original survey on file with author). The survey questions and answer choices are 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 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.
82 Id.
83 Id. One respondent did not complete demographic information and his responses are not included in data comparing responses by commitment statutes.
84 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.
questions, there was a hypothetical about a forty-year-old-patient, described as carrying a diagnosis of major depressive disorder and 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 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 fifty percent 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.86

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.87 Interestingly, a greater percentage of psychiatrists from states with strict dangerousness standard found clear and convincing evidence for civil commitment than the psychiatrists from states with broader standards.88

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86 Id. at Hypothetical 1.
87 Id. at Question 3; see also Stone, Results, supra note 86.
88 Stone, Results, supra note 86 (stating that 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).
89 Id.
The respondents were asked to categorize each of the patient’s presenting behaviors as providing (1) minimal support, (2) some support, (3) strong support, (4) clear and convincing evidence, or (5) being irrelevant to their finding of the patient’s dangerousness. The fact that the patient was talking about overdosing on aspirin was the most significant factor to all of the psychiatrists surveyed, with 50% classifying the statement as clear and convincing evidence of dangerousness. Ninety percent said it provided strong support or clear and convincing evidence for their decision. 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% of the psychiatrists. 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% or more of the psychiatrists.

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90 Id.
91 See Stone, Survey, supra note 10, at Questions 2 and 3.
92 Id.; see also Stone, Results, supra note 86.
94 Id.
The value the individual psychiatrists placed on the highest ranked behaviors varied depending on 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, a larger percentage of the psychiatrists from states with a broader criteria ranked those behaviors that are less explicitly dangerous, such as wandering late at night, leaving food on the stove, hearing voices, decline in daily living activities, and refusal to take psychotropic medication as significant.

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95 See id. at Question 2; see also Stone, Results, supra note 86.
97 Id.
98 Id.
Breakdown of the Most Significant Behaviors by Commitment Standards

Graph 4: Most Significant Behaviors by Commitment Standards

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 less than 40% of the psychiatrists.

Least Significant Behaviors to Psychiatrists

Graph 5: Least Significant Behaviors

99 Id.
100 See id. at Question 2; see also Stone, Results, supra note 86.
Given the concerns of many psychiatrists about the danger of medication non-compliance, it is noteworthy that 98% 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 medication refusal. 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 significant in psychiatrists’ recommendations should provide some comfort to mental health advocates.

Although the data indicates that psychiatrists do not weigh medication non-compliance as heavily in predicting dangerousness, a patient’s decision to forego psychotropic medications to treat his mental illness is still given considerable weight in the determination as to whether an individual is capable of living safely in the community, particularly where combined with a past history of dangerous behaviors.

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102 See id. at Question 8 (showing medication non-compliance alone satisfies clear and convincing evidence of dangerousness); see also Stone, Results, supra note 86.

103 See Stone, Survey, supra note 10, at Question 2; see also Stone, Results, supra note 86.


105 Id.

106 See id. at Question 8 (showing medication non-compliance alone satisfies clear and convincing evidence of dangerousness); see also Stone, Results, supra note 86.
when off of medication. 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. A slightly higher margin of psychiatrists from “need for treatment” or “gravely disabled” states (53%) found medication non-compliance as significant in their commitment decisions compared with 46% of psychiatrists from states with a strict dangerous criteria.

### Graph 7: Comparison of Medication Non-Compliance

Questions 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 the patient became non-compliant with psychotropic medication and did exhibit dangerous behavior six months earlier. After the patient was hospitalized in a psychiatric facility, he resumed taking medication but went off his medication again two or three weeks later.

A decisive majority of psychiatrists (79%) agreed with the statement: “There are no specific examples of recent dangerous behavior, it is premature to recommend involuntary civil commitment at this time.” An even larger majority found that there was not clear and convincing evidence of danger to self or others, with only 12% believing that the

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107 See Stone, Survey, supra note 10, at Question 2; see also Stone, Results, supra note 86.
109 Id.
110 Id.; see also Stone, Results, supra note 86.
112 Id. at Hypothetical 2.
113 See id. at Question 6; see also Stone, Results, supra note 86.
facts met that level of evidence of danger to self or others. The different standards for civil commitment explain the variance. Some states do not require recent dangerous behavior to civilly commit someone. In those places, the state can use civil commitment as a preventive measure.

Hypo 2: "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.

Graph 8: Premature to Commit Where No Recent Dangerous Behavior

Hypothetical 2: Clear and Convincing Evidence of Dangerousness

Yes; 12%

No; 88%

Graph 9: Clear and Convincing Evidence of Dangerousness

114 See Stone, Survey, supra note 10, at Question 7; see also Stone, Results, supra note 86.

115 See Stone, Survey, supra note 10, at Question 6; see also Stone, Results, supra note 86.
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. 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. 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.” 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, said 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 [sic] when a client will deteriorate” but encouraged the patient to receive community treatment, accept in home services, and remain medication compliant to prevent inpatient treatment.

Graph 10: Insufficient Evidence for Commitment

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116 See Stone, Survey, supra note 10, at Question 7; see also Stone, Results, supra note 86.
117 See Stone, Survey, supra note 10. Eleven out of the twelve respondents who answered “yes” to Question 7 were from states with either a “need for treatment” and/or a “grave disability” provision.
118 Id.
119 Id.
120 Id.
121 See id. at Question 6; see also Stone, Results, supra note 86.
However, many psychiatrists still perceive that their role is to predict violence and many view hospitalization as an 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 treatment is good predictor of future success.” One psychiatrist so sure of his prediction stated, “HE HAS (sic) OR IS GOING TO HAVE A RELAPSE.” This belief that psychiatrists can so easily predict dangerousness 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 successful at treating mental illness and preventing future harm.

The most scientific predictions of dangerousness are based on thorough examination, diagnosis of mental symptoms, past patterns of behavior, and probabilistic assessments; however, these predictions are still wrong nearly as often as they are right. Given the speculative nature of predicting dangerousness and the liberty interests at stake,

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122 See Stone, Survey, supra note 10, at Question 7; see also Stone, Results, supra note 86.
123 See Stone, Survey, supra note 10, at Question 6; see also Stone, Results, supra note 86.
125 Id.
126 Charles W. Lidz 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).
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.

IV. 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 that 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 caused when psychiatrists testify in favor of involuntary confinement, and they indicated that legal coercion 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 that the commitment criteria have been met.

Is the harm to the therapeutic relationship worth the benefits of civil commitment? Are we better off as a society having laws that make it easier to confine non-dangerous persons with mentally illness? Studies indicate that the answer is probably “no.”

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

130 Id.
131 Id.
132 Id.
The length of confinement in a psychiatric inpatient facility is rather short, driven by insurance policies, high costs, and the belief that the purpose of involuntary confinement is to deal with an acute, emergency situation. Accordingly, the effectiveness of involuntary confinement in promoting the long-term wellbeing of a person with mental illness is questionable and the social stigma attached to being involuntarily committed is profound. In addition, even if a treatment team is successful in forcibly medicating a patient within the hospital, it is common to see the patient refuse to take the psychotropic medication upon discharge into the community. The revolving door from community to inpatient hospitalization and back to the community is not an efficient or effective method of treating persons with mental illness or preventing future violence.

The push to enhance community-based mental health services is an important and vital step in humanely treating persons with mental illness. However, the trend unfortunately appears to be toward increasing the number of persons eligible 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 for their opinions on the ease or difficulty of inpatient civil commitment in their states and if they have seen a change in the past five years. The majority of the psychiatrists (51%) indicated that commitment laws in their states were about the same, 26% indicated that it had become more difficult, and 23% said that it had become easier to commit.133 Interestingly, a greater percentage of psychiatrists from states with strict dangerousness criteria found that it had gotten easier to commit individuals than those from states with broader criteria.134

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133 Stone, Results, supra note 86; see Stone, Survey, supra note 10.
134 See Stone, Survey, supra note 10; Stone, Results, supra note 86 (stating that 29% of psychiatrists in states with strict dangerous criteria and 21% of psychiatrists from states with broader criteria indicated that it is easier to commit people to hospitals than five years before).
In addition, a greater proportion of psychiatrists who work primarily in inpatient facilities found that it had gotten easier to commit than those...
who do not work in such facilities. Interestingly, many psychiatrists expressed that the changes in the ease or difficulty of committing a person were largely based on outside factors such as the shortages of beds making it more difficult to commit. 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 and others more liberal. 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.”

The average length of stay at a nonfederal short-stay hospital for psychoses in 2009 was 7.5 days overall and 11.2 days for

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137 Stone, Results, supra note 86 (giving the demographic information used to compare responses of psychiatrists who indicated they worked predominately in an inpatient or outpatient setting, 22% of respondents from inpatient (n=21) facilities and 14% of respondents from outpatient facilities (n=59) indicated that it is easier to commit people to hospitals than five years before. Data from persons that worked at both equally or left demographic question blank not included in this data).

138 Id.; see Stone, Survey, supra note 10, at Question 9.


140 Id.

141 Id.
schizophrenia.\textsuperscript{142} This marks a decrease in the length of stay from 12.2 days in 1990.\textsuperscript{143} In a study of the average length of inpatient stays for schizophrenia, depression, and bipolar disorder between 1996 and 2000 in Pennsylvania,\textsuperscript{144} the length of stay decreased for all three 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{145} This study found that patients with public insurance (Medicaid or Medicare) had the longest length of stay and individuals with HMOs had the shortest.\textsuperscript{146}

In the \textit{Stone Survey}, 45% of the psychiatrists indicated that the length of stay for inpatient treatment is too short, and only 16% believed that the length of stay is too long.\textsuperscript{147} Interestingly, there was a significant split in opinion about the appropriateness of the average length of stay between outpatient and inpatient psychiatrists. Not one inpatient psychiatrist believed that the average length of inpatient treatment is too long, but 20% of psychiatrists who work at outpatient facilities believed that to be the case.\textsuperscript{148} Most outpatient psychiatrists found that treatment stays in inpatient facilities were too short, explaining that there were not enough resources in the community to meet the acute needs of some of their patients. Many psychiatrists attributed the short stays to fiscal pressures, blaming insurance companies and bed shortages.\textsuperscript{149}

\textsuperscript{142} Nat'l Ctr. for Health Statistics, National Hospital Discharge Survey: Average Length of Stay and Days of Care - Number and Rate of Discharges by First-Listed Diagnostic Categories (2009).  
\textsuperscript{145} Id.  
\textsuperscript{146} Id.  
\textsuperscript{147} See Stone, Survey, supra note 10, at Question 10; see also Stone, Results, supra note 86.  
\textsuperscript{148} See Stone, Survey, supra note 10; see also Stone, Results, supra note 86.  
\textsuperscript{149} See Stone, Survey, supra note 10, at Question 10; see also Stone, Results, supra note 86.
There was also a significant difference in responses between people who work in public hospitals versus private hospitals, with more

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151 See id.; see also Stone, Results, supra note 86.
psychiatrists in public hospitals finding the length of stay to be too long.152

![Graph 17: Length of Stay (Public vs. Private)](image)

**Graph 17: Length of Stay (Public vs. Private)**

V. RECOMMENDATIONS

Given the liberty interests at stake in civil commitment decisions, it is imperative that both the commitment laws and actions taken by people involved in the commitment process ensure the due process rights of mentally ill persons are respected. For those individuals who have a mental illness and are 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 shows

152 See Stone, *Survey*, supra note 10, at Question 10; see also Stone, *Results*, supra note 86 (giving the 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).

that 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 have not yet reached the 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 persons with mental illness who are acutely dangerous at the time of the commitment. The purpose of the commitment should only be to stabilize patient and return him 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.

7. Expand funding for outpatient mental health treatment services.

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 shortsighted to believe inpatient hospitalization is a magic bullet to protect the public from persons with mental illness who are deemed dangerous. 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 do not address the long-term care needs of persons with mental illness.

There must be a collaborative approach to fixing the civil commitment laws and addressing the mental health needs of persons with acute mental illness. 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 his 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 are essential to
alleviating the shortages of inpatient hospital beds needed to appropriately treat the population of persons with mental illness who are considered dangerous. 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.
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>
</tr>
</thead>
<tbody>
<tr>
<td>Decline in activities of daily living (bathing, dressing, poor hygiene)</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating 50% of meals</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refusal to take psychotropic medication</td>
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<tr>
<td>Spoke of feeling sad</td>
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<td></td>
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<tr>
<td>Talking about overdosing on aspirin</td>
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<tr>
<td>Fired from job</td>
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<tr>
<td>Self-injurious minor scratches &amp; bruises</td>
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<tr>
<td>Poor sleeping habits</td>
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<td></td>
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<tr>
<td>Hearing voices</td>
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<tr>
<td>Found wandering late at night on the other side of town</td>
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<tr>
<td>Refusal to attend group therapy sessions</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Vague threats to harm neighbor</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Left food on stove</td>
<td></td>
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</tr>
</tbody>
</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
- 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

**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.


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.

Please explain.

______________________________________________________________

______________________________________________________________
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.