4

Involuntary Hospitalization

Richard D. Milone, M.D.

Few issues in the field of mental health evoke more controversy than involuntary commitment and treatment. Involuntary hospitalization becomes a meeting place for several ethical principles, including some that conflict with one another. These include utilitarianism, beneficence, autonomy, and informed consent, to name a few. This chapter presents these ethical principles as equal bases on which to choose or not choose involuntary treatment for a patient. Below, the principles observed in supporting and opposing involuntary treatment are introduced, followed by a discussion of coercion and recent legal developments that provide context for this issue.

Ethics Principles for Involuntary Treatment

The paragraphs below present opposing ethical viewpoints on involuntary treatment. While the statutes for involuntary hospitalization vary from state to state, it is generally acknowledged that this treatment decision requires two elements: (1) the presence of a severe mental disorder that deprives the individual of the capacity to make treatment decisions; and (2) the likelihood of harm to self or to others. Choosing involuntary hospitalization for a patient who does not meet both of these criteria would be unethical, and often, illegal.

In Favor of Involuntary Treatment

Those who support involuntary treatment for the mentally ill likely uphold the utilitarian principle—that is, through treatment, lessening or

completely removing the barrier that mental illness forces onto an individual will eventually give that individual a better life. This view holds that the temporary deprivation of physical liberty is justified by the eventual good of returned health.

Similarly, the principle of beneficence directs physicians and others to care for individuals incapable of caring for themselves. Supporters of beneficence believe that involuntary hospitalization restores autonomy to the mentally ill through treatment. Further, the argument is made that society has the right to limit an individual's freedom when necessary to protect others from serious harm.

Opposed to Involuntary Treatment

Those opposed to involuntary treatment support the principles of autonomy and libertarianism. Proponents of these principles attest that an individual has a right to exist independently without control by others. In this view, forcing someone into hospitalization is an act of paternalism—that is, "Father [or the authority figure] knows best, and you should do whatever he tells you to do." Further, from these perspectives, liberty is such an important value to society that it transcends all other values—and involuntary hospitalization is a clear infringement of a person's liberty. One passage frequently cited by libertarians to support their position is John Stuart Mill's treatise *On Liberty*:

> [The] only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinions of others, to do so would be wise, or even right. (Mill 1912, p. 15)

Involuntary Treatment and the Issue of Coercion

Can treatment that is coerced be effective and does coercion have any place in medicine, either psychiatry or general medicine? In its publication *Forced Into Treatment: The Role of Coercion in Clinical Practice*, the Group for the Advancement of Psychiatry stated: "Coercion, persuasion, suggestion and direction are legitimate dimensions of both

parenting and treatment, but they require careful scrutiny, and their use demands that the clinician be scrupulously reflective" (Group for the Advancement of Psychiatry 1994, p. 2).

Bloch, Chodoff, and Green quoted the same document by the Group for the Advancement of Psychiatry in their comprehensive text *Psychiatric Ethics* (Bloch et al. 1999). Regarding the place of coercion in the treatment of the mentally ill, Bloch et al. quoted the Group for the Advancement of Psychiatry as follows:

> As we examine these forced-treatment solutions, we found repeatedly that initial coercion can lead to greater freedom....as we researched and studied the exceptions to the original premise that coercion is antithetical to treatment, we began to view coercion not in terms of presence or absence, but in terms of degree and source....Voluntary and forced treatments lie on a continuum with different elements working to strengthen motivation. We believe that optimism in these forced-treatment situations can be justified. We encourage psychiatrists to provide such treatment when appropriate to help the patient progress from a posture of defiance, to compliance, to alliance. (Bloch et al. 1999, p. 431)

In recent years, the argument by Thomas Szasz and others that mental illness is a myth (Szasz 1961) has, for the most part, subsided. New and effective treatments, particularly the advent of safe and effective antidepressant and antipsychotic medications, have improved the lot of the patient and shortened hospitalization. The report in December 1999 from the Surgeon General of the United States (U.S. Department of Health and Human Services 1999) points especially to the efficacy of psychiatric treatment. The Surgeon General's report defines mental disorders as legitimate illnesses that respond to specific treatments, just as other health conditions respond to medical intervention. The question in recent times is less one of whether involuntary hospitalization should take place, but, more, under what circumstances should involuntary hospitalization occur.

Involuntary Hospitalization and the Law

A psychiatrist's decision to use involuntary treatment is made within the parameters of current state law on the issue. Therefore, it is important to remain informed about one's state laws on this topic and any

changes that may occur. State legislatures appear to be moving toward a middle ground that meets the treatment needs of the severely mentally ill, while at the same time preserving their legal rights. Below, a discussion on the government powers that these laws reflect.

The law under which involuntary hospitalization may take place is perhaps best expressed in the preamble to the Constitution of the United States. Two powers are identified: the police power and the *parens patriae* power. First, for the benefit of society, governments are responsible for protecting each citizen from other persons' injurious actions. This is called the police power, and the issue here is dangerousness of the individual and protection of citizens from the individual in question. Second, governments have the power and the duty to protect individuals who cannot do so themselves. This is the principle of *parens patriae*, when governments are the parent of last resort for each citizen. Here, the needs of the individual are of concern, and the issue is a need for treatment. It is important to remember that the *parens patriae* power is a benevolent one regarding the patient, the individual who cannot protect herself; that is, government is responsible for the care of a disabled citizen as loyally as a parent would care for a child.

Shift Toward Dangerousness Standard

The current trend in civil commitment moves away from the *parens patriae* standard toward criteria that make dangerousness to self or to others the principal determinant of eligibility for involuntary hospitalization. Coincidental with this shift has been a marked limitation of the psychiatrist's power to commit an individual to involuntary hospitalization without court approval, and patients have been granted procedural protection similar to that granted to criminal defendants.

Stavis, writing for the Treatment Advocacy Center, reported a celebrated case that demonstrates the shift away from *parens patriae* and toward the dangerousness standard (Stavis 1989). The case, which occurred in New York in 1987, involved Ms. Billie Boggs (a pseudonym for her real name).

> Ms. Boggs was a 44-year-old woman who lived on the public sidewalk of an affluent New York City neighborhood. She was frequently seen by personnel from emergency psychiatric services and was described by them as dirty and disheveled, speaking in sexually oriented rhyme, exposing herself, and smelling of excrement. She also exhibited other erratic behavior such as tearing up money and urinating on it.

New York City Health and Hospitals Corporation sought to have Ms. Boggs involuntarily committed for care and treatment because such treatment was essential for her welfare. This effort by New York City Health and Hospitals Corporation was vigorously opposed on behalf of Ms. Boggs by the New York Civil Liberties Union, which contended that her main problem was homelessness. Both parties agreed that commitment of Ms. Boggs must meet standards showing that the alleged mental illness is potentially dangerous or likely to result in harm to the individual or others. New York City Health and Hospitals Corporation successfully proved that Ms. Boggs was more than merely dysfunctional and proved that her judgment was impaired due to her mental illness. But, at least initially, it was not able to establish her dangerousness, and so she returned to the streets essentially untreated.

Stavis further explained:

> [The] Boggs case illustrates that patients who could truly benefit from mental health treatment will be more unlikely to obtain help because the illness also causes a denial or an unawareness of its own existence. This is unfortunately not consistent with the parens patriae power under which the government is supposed to behave as a parent in helping those who do not have competent decision making ability and who cannot cope with a major aspect or function of life even if there isn't a true imminent danger. It was very arguable whether Ms. Boggs was a danger to herself or others. After all, she existed for more than a year and a half on the streets of Manhattan without sustaining any significant injury or causing any direct harm to anyone. She sustained a pattern in her life including obtaining food, having a primitive sanitary system and having clothing. (Stavis 1989, p. 3)

The effect of this trend away from the *parens patriae* power of government toward the "dangerousness" or police power is to relegate government's benevolent intervention only to those instances in which harm can be foreseen. In a climate in which "dangerousness" prevails as the determinant for involuntary hospitalization, the benefit of merely restoring an individual's mental health, or returning to an individual the ability to care for himself or herself, becomes insufficient reason for the government to invoke its serious power of civil commitment.

Outpatient Involuntary Treatment

In late 1999, New York State enacted legislation that provides for assisted outpatient treatment and certain mentally ill individuals who, in

view of their psychiatric history and current circumstances, are unlikely to survive safely in the community without supervision. The new law, commonly referred to as “Kendra’s law,” was named after a young woman who died after being pushed in front of a New York City subway train by a mentally ill person who had failed to take the antipsychotic medication prescribed for his illness. The law establishes a procedure by which a court can order outpatient treatment as described in a written treatment plan previously approved by the court (New York Mental Health Hygiene Law, Section 9.60).

References

Bloch S, Chodoff P, Green S (eds): Psychiatric Ethics, 3rd Edition. New York, Oxford University Press, 1999

Group for the Advancement of Psychiatry: Forced Into Treatment: The Role of Coercion in Clinical Practice. Washington, DC, American Psychiatric Press, 1994

Mill JS: On liberty, in The World’s Classics, Introductory. London, Oxford University Press, 1912

New York Mental Health Hygiene Law, Section 9.60 (Kendra’s Law, Assisted Outpatient Treatment “AOT”)

Stavis PF: Involuntary Hospitalization in the Modern Era: Is “Dangerousness” Ambiguous or Obsolete? Treatment Advocacy Center, 2300 N Fairfax Drive, Suite 220, Arlington, VA 22201, 1989

Szasz TS: The Myth of Mental Illness. New York, Dell, 1961

U.S. Department of Health and Human Services: Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999. S/N 017-024-01653-5.