

23 CIVIL COMMITMENT

As with most issues where psychiatry and the law intersect, the statutes that regulate civil commitment vary substantially from state to state. As a practicing psychiatrist, you'll want to familiarize yourself with your jurisdiction's civil commitment law. Most states should have this information available online, and the Treatment Advocacy Center has information on all the states at its website at <http://www.treatmentadvocacycenter.org/LegalResources/statechart.htm> . There are general issues and potential problems common to most states, and we'll discuss those here.

COMMITMENT PROCEDURES AND TYPES

Emergency Commitment

Most states have provisions for a short-term emergency commitment until a formal determination can be made. The length of the emergency commitment may vary from just seventy-two hours in one state to as many as fifteen days in another. The grounds for emergency holds are generally that the patient is mentally ill and poses a threat to himself or others. Some states require that the threat be "substantial" and "imminent."

The procedures for initiating an emergency commitment also vary greatly. There are no general rules as to who may file the petition, where it should be filed, or how the patient is to be taken into custody. Again, you must consult your state statutes.

State laws also differ as to the requirement for a probable cause hearing and the timing of such a hearing. The purpose of a probable cause hearing is to determine whether there is substantial evidence that the patient meets the criteria for involuntary hospitalization. If she does, the patient can be hospitalized until a more formal determination takes place. In states that have probable cause hearings, there is generally no provision for short-term commitment. Once probable cause has been found, the emergency commitment continues until a formal commitment determination is made.

Short-Term Commitment

A number of states have provisions for short-term as well as emergency commitments. The length of time of these short-term commitments also varies greatly, from fourteen days in California to sixty in New York. A patient held in New York, however, can request a hearing at any time during those sixty days,

and if the court fails to find him “in need of retention,” he’ll be released. Although these short-term commitment statutes require greater procedural protection than those for emergency commitments, the initial responsibility for the decision is still vested in the hospital rather than the court. The standards for short-term commitments are not as rigorous as those for long-term retention.

Long-Term Commitment

In virtually every state, a patient cannot be involuntarily committed on a long-term or indefinite basis unless a court (or, occasionally, an administrative agency) determines that he meets the substantive criteria of the state’s law. Although the procedures vary, in most states a patient can’t be committed without a hearing. While some states still authorize indefinite long-term commitments, this is now generally out of favor, and is precluded in many states. Instead, a periodic review of the patient’s continuing need for commitment is usually required. The frequency of these reviews varies.

Commitment of Minors

Because the laws vary so widely, if you work with children and adolescents you definitely need to familiarize yourself with your state’s provisions for the “voluntary” hospitalization of minors. In some states the minor is given a degree of veto power over “voluntary” admissions, in others parents can only commit a child under a certain age voluntarily. In still other states, the minor and the parent must sign the application for commitment. If the child refuses, the parents must initiate involuntary commitment. Check your state law.

SUBSTANTIVE STANDARDS FOR LONG-TERM COMMITMENT

Commitment of the mentally ill has traditionally been justified as the exercise of two of the state’s powers: 1.) *parens patriae*, which rests on the state’s interest in caring for and protecting those who cannot care for themselves; and 2.) police power, or the state’s power to protect its citizens from potential harm or danger from others. At present, civil commitment laws have much more to do with police power than *parens patriae*. The most common standards for civil commitment are:

- **Mental Illness:** All states currently consider mental illness to be a prerequisite of commitment. While some states delineate what specific psychiatric disorders qualify, others are less clear. Most require that the patient’s illness “substantially impair” her functioning to the point where protection or care and treatment are required. Again, you need to familiarize yourself with the state statutes.

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- **Dangerousness:** Dangerousness to oneself or others is currently the most common substantive ground for long-term commitment. Although states vary as to the exact definition, *danger to others* is generally defined as risk of substantial physical harm, or injury, to another person or persons. Some states require that this danger be imminent, or immediate, while others go so far as to demand that there be a judicial finding of an overt act that indicates the danger.

Dangerousness to oneself is accepted in all states as grounds for commitment, but while some may only require that you demonstrate an individual's extreme neglect of his basic needs, others demand evidence that the patient is "gravely disabled." It is relatively safe to say that proof that a patient is unable to provide for his own food, shelter, and clothing would adequately define "dangerousness to self" anywhere in the United States.

- **In Need of Treatment:** The commitment of a person because she is "in need of care and treatment" rather than because of a perceived danger to herself or others falls under the traditional *parens patriae* standard and is now much less common. A number of courts have even questioned whether the involuntary commitment of a nondangerous person is consistent with due process. However, some states still specifically permit involuntary commitment for this cause.
- **Additional Requirements:** Several states apply additional standards for involuntary commitment. Some states:
 1. Require that a patient be advised of, and given the opportunity for, voluntary commitment.
 2. Condition involuntary commitment on a determination that the patient is likely to benefit from the treatment he'll receive as an inpatient, or that his disorder is at least susceptible to treatment.
 3. Require that the person committed lack the capacity to make reasoned treatment decisions for herself.
 4. Require that the commitment in a hospital will be the "least restrictive alternative" or "least restraint" that will meet a patient's needs.

LIABILITY FOR WRONGFUL COMMITMENT

The most important safeguards for you in avoiding liability for a commitment decision are to conscientiously abide by the commitment procedures mandated by your state and to conduct adequate patient examinations. If you reasonably

follow the required procedures in good faith, chances diminish that a court will find you liable for wrongful commitment.

A number of courts have held that a psychiatrist participating in commitment proceedings is immune from liability. They reason that the therapist is performing a quasi-judicial function and, like a judge, should be able to make the decision without fear of liability. In some jurisdictions, however, this immunity is granted only if the psychiatrist and patient do not have a doctor-patient relationship.

PRACTICAL POINTERS

- Be sure state commitment laws are known and correctly followed.
- Be familiar with the substantive criteria for commitment in your state, such as the legal definitions of *mentally ill* and *dangerousness*.
- Always document that the patient refused voluntary commitment before involuntary procedures were invoked.
- Be sure the decision to commit is made only after an adequate examination or on the basis of compelling clinical evidence.
- Be especially circumspect in considering requests to commit made by a third party.