AT LAW

Holding the Guardrails on Involuntary Commitment

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In November 2022, New York City Mayor Eric Adams issued a directive authorizing first responders to transport people experiencing mental health crises to hospitals for evaluation and possible involuntary hospitalization if they display "an inability to meet basic living needs, even when no recent dangerous act has been observed."[1] He characterized the city's new approach as a necessary response to the increasing number of people with serious mental illness living on the streets. A few weeks later, Mayor Ted Wheeler of Portland, Oregon, expressed a similar view, arguing that "it's time to consider lowering the threshold for civil commitments and forc[ing] the city's most vulnerable to get mental health help against their will."[2]

These mayors are right to be concerned about the rise in the number of people with mental illness who are experiencing homelessness, but expanding the use of involuntary commitment is a dangerous response. Even putting aside the obvious impracticability of the mayors' proposals—there are not enough psychiatric beds to meet existing demand, let alone an increase in admissions[3]—there is no evidence that involuntary commitment offers long-term benefits, and quite a few reasons to predict that expanding its use will affirmatively cause harm. The proposals also ignore the fact that most people diagnosed with mental illness retain decision-making capacity. The proposals are simply additional examples of how our society continues to deny people diagnosed with mental disorders rights considered fundamental in all other areas of health care.

States' Legal Authority to Involuntarily Commit People for Their Own Benefit

States' authority to subject people with mental illness to involuntary hospitalization rests on two distinct sources of authority: the police power, which enables states to enact laws to preserve public health and safety, and the *parens patriae* power, which allows states to protect people who are unable to care for themselves.[4] The police power applies when the person sought to be hospitalized is determined to be dangerous to others, while the *parens patriae* power applies when the goal is to protect the individual herself. In the 1975 case of *O'Connor v. Donaldson*,[5] the Supreme Court held that the Constitution does not permit states to confine people involuntarily "if they are dangerous to no one and can live safely in freedom."[6]

As a constitutional matter, a *parens patriae* commitment does not necessarily require proof that an individual is actively harming herself. In *Donaldson*, the Supreme Court observed that a person "is literally 'dangerous to himself' if for physical or other reasons he is helpless to avoid the hazards of freedom either through his own efforts or with the aid of willing family members or friends."[7] Some state mental health statutes recognize this possibility by defining the concept of *danger to self* to include the inability to provide for food, clothing, shelter, or other basic necessities.[8] Other states take a different approach, authorizing the commitment of such people by defining them as having a mental disorder that renders them "gravely disabled."[9] However, in light of the constitutional standards governing involuntary commitment, the Washington Supreme Court has interpreted its "gravely disabled" standard to require the same "risk of danger of serious harm" as involuntary commitment based on "danger to self."[10] Relying on this decision, an intermediate appeals court in Washington found that a statute authorizing the involuntary commitment of alcoholics was unconstitutionally overbroad because it did not limit commitments to individuals at substantial risk of serious injury in the near future.[11]

Most involuntary commitment statutes require proof of an "imminent" or "substantial" risk of danger,[12] but the

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Supreme Court has never explicitly held that this standard is constitutionally required. Some statutes apply a different standard when commitment is sought because of an individual's inability or unwillingness to care for herself. For example, Indiana's mental health statute authorizes the involuntary commitment of a person who, as a result of mental illness, "is in danger of coming to harm" because of "an obvious deterioration of that individual's judgment, reasoning, or behavior that results in the individual's inability to function independently."[13] In contrast, for people who pose an active danger to themselves or others, the statute requires a "substantial risk" that the person will cause harm.[14] The different formulations of these two provisions imply that a person could be found "in danger of coming to harm" without the need for a showing that the danger is substantial.

In most states, *parens patriae* commitments are limited to people at risk of death or serious physical injury, but a few states authorize the involuntary commitment of individuals at risk of nonphysical harm. For example, Alaska allows the involuntary commitment of an individual who, as a result of an untreated mental illness, "will . . . suffer or continue to suffer severe and abnormal mental, emotional, or physical distress [that] . . . is associated with significant impairment of judgment, reason, or behavior causing a substantial deterioration of the person's previous ability to function independently."[15] In 2022, Utah amended its mental health law to incorporate a similar provision.[16]

Benefits and Risks of Involuntary Commitment

Involuntary hospitalization can be life saving for people who are actively suicidal or engaging in behaviors that are immediately life-threatening. However, there is no evidence that it provides lasting benefits once the immediate crisis has abated. Indeed, according to a 2022 systematic review, "[T]he data do not show a trend of improvements and do not seem to exclude the possibility of worse compliance [with treatment] after compulsory hospitalization."[17]

One reason for the limited effectiveness of involuntary commitment is that the experience can be traumatic, leading to mistrust in the health care system and long-term avoidance of mental health services. In one study of young people subjected to involuntary commitment, many participants reported that the experience made them unwilling to disclose suicidal feelings or intentions, even when they continued to receive mental health services after leaving the hospital.[18] The impact of coercion on trust may be especially significant for members of racial minority groups, who already have "low trust in psychiatric institutions and late engagement with services in situations of need."[19]

In addition, hospitalization itself can exacerbate some individuals' symptoms. Life in a psychiatric hospital "is rife with adverse experiences that could be suicidogenic for vulnerable persons."[20] This risk is greater for those who have been forced into treatment. According to one study, the perception of having been coerced into psychiatric hospitalization is an independent risk factor for making a suicide attempt after being released from the facility.[21] Similarly, individuals who have been involuntarily committed for substance use disorder face a higher risk of relapse and overdose, particularly when they are confined in facilities that do not provide medication-assisted treatment.[22]

Beyond medical risks, involuntary hospitalization can result in a host of negative collateral consequences, including loss of housing or employment[23] and barriers to obtaining professional licenses.[24] In many cases, involuntary commitment can also have significant financial repercussions, as "patients may be held financially liable for care they did not authorize and even actively refused."[25] In addition, the fact that an individual has been civilly committed may be introduced as negative evidence of character or credibility in civil litigation.[26]

It should not be surprising that the risks associated with involuntary commitment are not spread equally among all segments of society. Individuals who identify as Black, multiracial, or another race other than White are significantly more likely to be subjected to involuntary psychiatric hospitalization than those who identify as White.[27] The risk of being involuntarily hospitalized is also positively associated with individual-level and community-level economic deprivation.[28] More broadly, scholars have argued that the standards and procedures used to determine who should be considered for involuntary hospitalization "reinforce the systems, structures, practices, and policies of structural oppression and white supremacy."[29]

Parens Patriae Commitments as Mental Health Exceptionalism

One of the most disturbing aspects of the push for a greater use of involuntary commitment for people who do not pose an imminent danger to themselves or others is that it reinforces a two-tiered system of legal protections, under which people with mental illnesses are denied rights considered fundamental in all other areas of medical care. Outside the mental health context, individuals have a near-absolute right to refuse medical interventions; except for limited situations involving prisoners[30] and criminal defendants,[31] a refusal of care can be overridden only if the individual is found to lack decision-making capacity.[32] For an individual who lacks capacity, the law generally requires decisions to be grounded in the person's previously expressed wishes and values to the greatest extent possible.[33] Moreover, decisions are typically made by a family member or other person close to the patient, with resort to the courts limited to situations where there is no available surrogate or a conflict arises as to the best course of care.[34]

In contrast, only about a quarter of states condition *parens patriae* commitments on a finding that the individual lacks decision-making capacity.[35] In other states, individuals can be involuntarily hospitalized based solely on the fact that they have a mental illness and are engaging in behavior that is considered contrary to their welfare. A few state statutes pay lip service to the principle of respecting individual choices, but they do so in a way that distorts the principle of informed consent beyond recognition. For example, Iowa's statute requires a finding that an individual, because of a mental illness, "lacks sufficient judgment to make responsible decisions with respect to the person's hospitalization or treatment."[36] The implication is that individuals' decisions will be respected if they are consistent with the recommendations of health care providers, but if an individual objects to being hospitalized, the decision can be challenged as "irresponsible" and therefore ignored.

The unstated premise of these laws appears to be that, if a person has been diagnosed with a mental illness and is not taking care of herself adequately, her ability to make informed decisions is necessarily compromised. However, a diagnosis of mental illness does not imply a lack of decision-making capacity.[37] Only about half of patients hospitalized with an acute episode of schizophrenia have impaired decision-making capacity; for other mental health diagnoses, the percentage of patients with incapacity is even lower.[38] People who have the capacity to make their own health decisions are entitled to decide for themselves whether they want to be hospitalized, at least in situations when the state's police power is not implicated. This is true even if their choices might appear to be objectively unwise. For example, it is well established that Jehovah's Witnesses have the right to refuse blood transfusions, even when doing so is highly likely to be fatal.[39] The right to make one's own health care decisions includes the right to make choices that most others would not.

Even in the minority of states that limit *parens patriae* commitments to individuals who have been found to lack decision-making capacity, no state requires judges to consider whether the individual would choose to be hospitalized if she had the capacity to do so. The law simply presumes that anyone who meets the standards for commitment will be better off in a hospital, despite the fact that psychiatric hospitalization is by no means benign. In addition, unlike health care decisions not involving mental illness, courts play the primary role in deciding whether someone should be hospitalized for her own benefit, rather than serving as a backup for resolving conflicts or making decisions when no one is available to speak on the patient's behalf.

Moving Forward

There are better ways to address the rise in the population of unhoused people with mental disorders than expanding the use of involuntary commitment for people who pose no danger to others and are not in an immediately life-threatening situation. Chief among these is providing sufficient resources for sustainable housing. Research shows that supportive housing programs are an effective way to ensure that people with mental illness are not forced to live on the streets.[40] Strengthening community-based mental health support services must also be a priority.[41]

At the same time, states should take a hard look at existing legal standards governing *parens patriae* commitments, which for too long have denied individuals diagnosed with mental disorders the basic legal protections that apply in other areas of health care. One model worth considering is Northern Ireland's innovative legislation on health care decisions, the Mental Health Capacity Act of 2016. That law establishes a uniform standard for imposing nonconsensual health care interventions, without any distinction between mental health disorders and other conditions in which capacity might be compromised. In general, the act conditions deprivations of liberty and other involuntary interventions on a finding that the individual lacks decision-making capacity and the proposed intervention is in her best interests. Moreover, it emphasizes that judgments about the person's best interests must be made with "special regard" for the person's "past and present wishes and feelings," as well as "the beliefs and values that would be likely to influence [the person's] decisions if [she] had capacity."[42] A weakness of the act is that it does not adequately address individuals who pose an imminent risk to others because of a mental health condition; courts' authority to require such people to be hospitalized is limited to people who have been convicted of an offense punishable by imprisonment.[43] Nonetheless, the act provides a framework that, with some modifications, would be useful for eliminating the pernicious mental health exceptionalism that underlies mental health laws throughout the United States.

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5. 422 U.S. 563 (1975).

6. Ibid.

7. 422 U.S. 563, at 575.

8. See, e.g., S.D. CODIFIED LAWS § 27A-1-1(7)(b).

9. See, e.g., LA. REV. STAT. ANN. § 28:2(13).

10. In re Detention of LaBelle, 107 Wn.2d 196, 728 P.2d 138 (Wash. 1986).

11. In re Treatment of Mays, 116 Wn.App. 864, 68 P.3d 1114 (2003); see also In re N.N., 146 N.J. 112 (1996) (which states, "The parens patriae power to authorize involuntary commitment is generally restricted to instances in which the individual poses a danger to self"); Colyar v. Third Judicial Dist. Court, 469 F. Supp. 424 (D. Utah 1979) (stating, "[A]n individual who is not a danger to himself cannot be involuntarily committed under the parens patriae power").

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14. Ind. Code Ann. § 12-7-2-53.

15. Alaska Stat. § 47.30.915(9).

16. Utah Code Ann. § 26B-5-301(24)(f).

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27. T. Shea et al., "Racial and Ethnic Inequities in Inpatient Psychiatric Civil Commitment," *Psychiatric Services* 73, no. 12 (2022): 1322-29.

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31. Sell v. United States, 539 U.S. 166 (2003).

32. K. L. Cerminara, "Cruzan's Legacy in Autonomy," *SMU Law Review* 73 (2020): 27-46.

33. M. Wright, "Dementia, Autonomy, and Supported Healthcare Decision Making," *Maryland Law Review* 79 (2020): 257-324.

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