

CIVIL COMMITMENT IN THE UNITED STATES

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ABSTRACT

This article reviews the academic literature on the psychiatric practice of civil commitment. It provides an overview of the history of involuntary psychiatric hospitalization in the United States—from the creation of the first asylum and the era of institutionalization to the movement of deinstitutionalization. The ethical conflict that the practice of involuntary hospitalization presents for providers, namely the conflict between the ethical duties of beneficence and respect for patient autonomy, is presented. The evolution of the United States commitment standards, from being based on a right to treatment for patients with mental illness to being based on dangerousness, as well as the implications that the changes in commitment criteria has had on patients and society, are discussed. Involuntary hospitalization of patient populations that present unique challenges for psychiatry (e.g., not guilty by reason of insanity acquittees, sex offenders, and individuals with eating disorders, substance use disorders, and personality disorders) is discussed. Finally, an overview of outpatient commitment is provided. By reading this article, one will learn



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the history of involuntary psychiatric hospitalization in the United States and gain an understanding of the ethical issues that make civil commitment one of the most controversial practices in modern psychiatry.

INTRODUCTION

Many people with psychiatric illnesses spend much of their lives struggling with disorders that affect the most fundamental aspects of the human experience—their perceptions of themselves and the world in which they live. The perceptual distortions caused by disorders of mood, thought, and cognition can interfere with a person's functioning to such a severe degree that treatment is critical to the safety of the affected individual and of others. For example, a person with depression may see him- or herself as worthless and, in his or her despair, make efforts to end his or her life. A woman in a manic state, acting in accordance with a grandiose belief of indestructibility, may engage in erratic, unsafe driving that puts her life, as well as the lives of other drivers, in jeopardy. Someone with schizophrenia may become overwhelmed by paranoid delusions and hallucinations that command him or her to act violently against others. And an individual suffering from dementia may become so out of touch with his or her basic needs that the individual fails to provide him- or herself a level of nourishment and self care that is necessary for survival.

Despite the clear need for psychiatric intervention in cases such as these, providing necessary treatment to persons with mental illnesses is often not an easy task. Unfortunately, the same disorders that impair a person's mood, thoughts, and functioning also impair his or her insight and judgment, making refusal of care common in psychiatry. Hospitalization is often a critical first step in initiation of psychiatric care. For this reason, involuntary hospitalization, or civil commitment, has been a mainstay of psychiatric care since the inception of our field. It continues to be a

mainstay of treatment even today, although provisions for outpatient involuntary treatment have been created in an effort to avoid hospitalization when possible yet ensure that individuals get the care that they need.

ETHICAL ISSUES IN INVOLUNTARY HOSPITALIZATION

Our society defines the role of the physician in terms of our professional responsibilities to patients. Physicians' professional responsibilities are derived from the ethical principles of medical practice dating back to the time of Hippocrates.¹ The first and foremost principle of medical ethics is the principle of nonmaleficence—the physician's duty to “do no harm.”^{1,2} One way that physicians can avoid harming patients is by showing respect for their autonomy (i.e., by allowing patients to make their own decisions regarding whether to accept or reject recommended medical care). Physicians are also bound by a professional obligation to help patients. This duty is prescribed by the ethical principle of beneficence,^{1,2} which requires that doctors provide to patients services that will benefit them.

Psychiatrists often encounter cases in which patients are in grave need of treatment yet adamantly refuse to cooperate with the provision of the necessary treatment. In these cases, psychiatrists face the challenge of weighing their professional obligations of nonmaleficence and beneficence in deciding whether to hospitalize patients against their wishes. When an individual is suffering from a severe mental illness that grossly distorts his perception of reality, it is often clear that he or she has lost the usual capacity for making decisions in his or her best interest. In this case, the individual is not truly autonomous, and the decision to override his or her expressed wishes in favor of hospitalization and treatment to benefit the patient and restore autonomy does not cause much conflict for the psychiatrist. In other cases, involving, for example,

patients with eating disorders, substance abuse disorders, and personality disorders, which do not necessarily grossly impact individuals' reality testing, the weighing of ethical obligations can be a very difficult task.

THE STATE'S ROLE IN INVOLUNTARY HOSPITALIZATION

Fortunately, psychiatrists do not struggle alone or without guidance when making the difficult decision of recommending involuntary hospitalization. State governments—acting on the basis of two major legal principles—have enacted laws defining the standards for involuntary treatment, which serve as guidelines for physicians confronted with patients who are refusing hospital admission.

There are two main legal principles that underly the state's interest in the process of civil commitment. The first of these is *parens patriae*. *Parens patriae* is a Latin term that means “parent of the country.” It refers to a doctrine from English common law that assigns to the government a responsibility to intervene on behalf of citizens who cannot act in their own best interest.^{3,4,13-16} A second legal principle, police power, requires a state to protect the interests of its citizens.^{4,5,13-16} Whereas physicians have a duty to people other than our patients in only very narrow circumstances (those involving a clear and imminent threat to an identifiable person or persons),⁶ the state, on the basis of police powers, has a duty to consider the welfare of all people living within its boundaries. Because of this obligation to all citizens, the state has the right to write statutes for the benefit of society at large, even when providing this benefit may come at the cost of restricting the liberties of certain individuals.⁵

INSTITUTIONALIZATION OF THE MENTALLY ILL

In 1403, London's Bedlam Hospital, which had been in operation since the mid-1200s, began operating an asylum for the provision of inpatient

care to people with mental illnesses.^{4,7} Several centuries later, inpatient psychiatric facilities started to emerge in the United States.⁴ Prior to the inception of American asylums, people with mental illness were relegated to prisons and shelters for the poor. In these settings, the

distinction between voluntary and involuntary admissions to psychiatric hospitals; all admissions were involuntary. Furthermore, because many institutions operated on private funding, it was quite possible for families to purchase the confinement of unwanted relatives.⁸ When patients

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mentally ill were warehoused to ensure the safety of the community and were not offered treatment of any kind.⁸ Between 1817 and 1824, four privately funded asylums were established in the northeastern states of Connecticut, New York, Massachusetts, and Pennsylvania.^{7,9} Subsequently, public asylums were opened in the southern United States,⁹ and the widespread establishment of state-run mental institutions soon followed.⁸ Most persons who ended up in American asylums were patients suffering from dementia, seizure disorders, diseases involving paralysis, or advanced neurosyphilis. These individuals were incurable by the available treatments of the day. Asylums thus became long-term homes for chronic patients whose care consisted of restraint, sedation with medications, such as bromides and chloral hydrate,⁷ or experimental treatment with opium, camphor, and cathartics.⁹ These treatments were neither effective in curing patients nor did they affect a level of improvement that could render patients able to survive outside the facilities. Populations in America's asylums swelled to more than 500,000 during the 1950s,⁴ with an all time high of 559,000 United States psychiatric inpatients in 1953.⁹

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were eventually released from asylums, they often found that they had lost many of their civil rights (e.g., their property and custody rights).⁴ The case of Mrs. Elizabeth Packard illustrates how problematic the civil commitment standards of the time were. Mrs. Packard was committed to a Jacksonville, Illinois, asylum in 1860 at the behest of her husband who was a clergyman.¹⁰ Mr. Packard initiated the hospitalization of his wife to punish her for having an unclean spirit,¹⁰ a decision that he based on her exploration of spiritual traditions outside the Presbyterian faith.⁴ Mrs. Packard was diagnosed with "moral insanity" and held involuntarily in the hospital for three years before ultimately being declared sane. Once released, Mrs. Packard learned that she had lost custody of her children and ownership of her property. She filed a lawsuit for wrongful confinement and won. She then devoted her life to promoting change in civil commitment laws.⁴

It was the legal standards for civil commitment in 1860 that allowed Mrs. Packard to be hospitalized. The standards of the day required only that the presence of mental illness and a recommendation for treatment be established to prove that admission of a person to a psychiatric hospital against his or her will was necessary.⁸⁻¹³ The assumption prevailed that inpatient care was of benefit to patients with mental illness.⁸ The admissions process was

easy;⁴ there were no established procedural barriers to stand between a prospective psychiatric inpatient and the doorway of the asylum. Patients were presumed incapable of making decisions, and commitment was based on a need for treatment.⁸ State commitment standards during this time were based on the doctrine of *parens patriae*—the government's obligation to provide for the incapacitated.⁴ For these reasons, coercing patients to comply with prescribed therapies was considered to be acceptable.

In response to abuses of civil commitment, such as the injustice that Mrs. Packard suffered, 20th century America saw a shift in the standards for involuntary hospitalization. States changed civil commitment laws to put legal protections in place to protect the right to liberty of the person being considered for commitment. These legal protections included the potential inpatient's right to a trial, with attorney representation, prior to psychiatric admission.⁸ Stricter commitment standards were imposed,^{8,13} and the decision-making power was taken from the hands of medical professionals and placed in the hands of judges and magistrates.¹³

While these changes were made to better protect the rights of people with mental illnesses, there were problems. Many times, individuals served short terms of imprisonment while awaiting the completion of the required procedural standards. For example, a person may have waited in jail for days because an attorney was not immediately available to represent them in a precommitment trial, and he or she may have waited even longer for the precommitment trial to occur. Psychiatrists and mental health advocates protested the standards, which they saw as extreme and harmful to patients. In 1951, the National Institute of Mental Health (NIMH) published the "Draft Act Governing Hospitalization of the Mentally Ill." The Act functioned to restore psychiatrists' decision-making power on the issue

of civil commitment to its prior state, unburdened by lengthy legal procedures.⁸

DEINSTITUTIONALIZATION

Another important event occurred in 1950. During the same time that the NIMH was successful in advocating for a public view of commitment as a necessary step to treatment, new medications were invented that challenged the assumption that institutionalization was necessary for the care of patients with mental illness. In this year, novel medications called antipsychotics arrived on the market.^{4,8,11} Chlorpromazine was invented and sold under the trade name Thorazine. The medication was so effective in treating psychosis that the idea of community-based outpatient treatment of individuals who were previously considered to be lifelong hospital cases seemed plausible.⁹

By 1960, state hospitals were being widely criticized. They were portrayed as places where “little effective treatment” was administered. They were described as run-down archaic establishments that simply housed the mentally ill.⁸ The United States government created Medicare and Medicaid in that year, and as a result society assumed a shared responsibility to pay for the care of people suffering from mental disorders.¹¹ Americans started to believe that the cost of caring for the mentally ill in institutions was not worth the limited benefit that could be seen as a result of institutionalization.⁸ Additionally, the civil rights movement, which was gaining momentum in the United States at that time, lent to the public push for the abandonment of mental institutions in favor of more humane psychiatric care.⁴ American President John F. Kennedy signed the Community Mental Health Centers Act in 1963 as a means of facilitating the transitioning of patients from inpatient psychiatric hospitals out into communities.¹¹ As a result of all of these factors, deinstitutionalization began. Huge numbers of state hospitals were closed all across the United States.⁷⁻¹² The number of

psychiatric inpatients declined precipitously from a high of more than 550,000 in 1950 to 30,000 by the 1990s.⁴

SHIFT TO DANGEROUSNESS CRITERIA AS THE STANDARD FOR CIVIL COMMITMENT

Along with the civil rights movement and deinstitutionalization came a shift in the legal standard for civil commitment away from a need-for-treatment model to a dangerousness model. In 1964, Washington, DC, instituted a standard for civil commitment that established that a person must be determined to have a mental illness before he or she could be hospitalized against his or her will. Second, the person had to pose an imminent threat to the safety of him- or herself or others or be shown to be “gravely disabled,” meaning that he or she could not provide for the necessities for basic survival.⁸ The district did not define the terms of the statute concretely, leaving some room for interpretation. However, it is commonly interpreted that dangerousness refers to physical harm to self (suicide) or physical harm to others (homicide), and that the requirement for imminence means that the threat must be likely to occur in the close future.¹³ California adopted a similar statute five years later.⁸ One by one, other states followed suit until the prevailing

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standard for civil commitment in the United States required the presence of dangerousness as a result of mental disease.^{8,13,16,17} Currently, there are only a few states that do not follow the trend. Delaware requires only proof that a person is not able to make “responsible choices” about

hospitalization or treatment for that person to be committed. Iowa’s statute mandates only proof that a person is likely to cause “severe emotional injury” to people who are unable to avoid contact with him (e.g., family members).¹⁷

Each state’s civil commitment criteria also still reflect standards set forth in an important Supreme Court case—O’Connor v. Donaldson—in 1975.¹³ This case involved a man named Kenneth Donaldson who was diagnosed with paranoid schizophrenia and was held in a psychiatric hospital against his will for 15 years. When his release was repeatedly denied by the psychiatrist in charge of his care, despite the fact that he had not shown any evidence of suicidality or intentions to harm others, Mr. Donaldson argued to the court for restoration of his freedom. The case was eventually heard by the Supreme Court, who determined that Mr. Donaldson should be released. The Supreme Court laid out acceptable criteria for holding patients against their will. Justices stated that a mentally ill individual must either present a known risk of harm to him- or herself or others, be in such a state that he or she would be “hopeless to avoid the hazards of freedom,”¹³ or in need of psychiatric treatment. The court seemed to embrace the dangerousness model for civil commitment; however, they did

also find that individuals with mental disorders could not be kept in institutions “without more.”^{8,13,18} The word “more” is generally believed to refer to treatment.⁴

In addition to the redefinition of criteria for involuntary hospitalization, there was also a shift in procedural

standards for civil commitment that granted potential psychiatric inpatients greater procedural safeguards.^{4,8,13-15} States continued to allow patients to be admitted directly to hospitals against their wishes;

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however, they determined that this could only be done for a short, pre-determined period of time that varied by state from two days to approximately two weeks. After that time, patients were entitled to a hearing before the court to determine whether their involuntary commitment should continue.⁴ Patients were also guaranteed that they would have legal representation at their commitment hearings.

Another aspect of civil commitment proceedings that was defined at this time was the issue of burden of proof, or the degree to which the evidence presented convinces the trier of fact that his decision is correct. There are three standards of proof that can apply when decisions are made in court. The highest standard of proof is "beyond a reasonable doubt." This standard requires that the trier of fact be convinced of his decision without any reservations that would be expected of a reasonable person. It applies in criminal cases. The lowest standard of proof is by a "preponderance of the evidence," and it requires only that the trier of fact be certain that her decision is more likely to be correct than incorrect. It applies in civil suits. The third standard of proof allows decisions to be made based on "clear and convincing evidence," which is defined as being greater than a preponderance of evidence, but less

than beyond a reasonable doubt. An important Supreme Court case in 1978, *Addington v. Texas*, considered the following question: "Which standard of proof does the person requesting involuntary hospitalization

of a psychiatric patient have to meet to satisfy the court that the patient meets criteria for commitment?"^{4,8,13,19}

Frank Addington was a man with a long history of psychotic illness who had been hospitalized numerous times in the past.¹³ His mother filed a case requesting that he be committed indefinitely because he assaulted her in the past. Her request was granted and Mr. Addington appealed this decision because the court committed him based on a standard of clear and convincing evidence, the mid-level standard of proof. He argued that the evidence against him should have been required to reach the highest standard of proof, beyond a reasonable doubt.^{8,13} The Supreme Court disagreed with Mr. Addington and supported the ruling of the lower court.¹⁹ The justices opined that because psychiatry was a field dealing with the inexact science of predicting future risk, the standard of beyond a reasonable doubt was so burdensome that it would serve as a barrier to the hospitalization of many patients who were in clear need of care.¹³

In 1966, another important legal case occurred that underscored dangerousness as the key criteria for involuntary hospitalization of psychiatric patients by establishing a right to less confining treatment for nondangerous patients. This was the case of *Lake v. Cameron*, which was presented before a Washington, DC, appeals court in 1966.⁴ Catherine

Lake was a woman with mental illness who had been hospitalized against her will and kept involuntarily at St. Elizabeth's psychiatric hospital for many years, despite not showing any evidence of dangerousness to herself or anyone else. She desired freedom and petitioned the district for her release.^{4,17,20} The court determined that all patients who were not dangerous "should not be confined if a less restrictive alternative is available."²⁰ To this day, because of this ruling, psychiatrists who complete emergency evaluations are required by law to recommend the least restrictive level of treatment that will meet the needs of nondangerous psychiatric patients.¹⁶

UNINTENDED CONSEQUENCES OF BASING CIVIL COMMITMENT ON DANGEROUSNESS RATHER THAN A NEED FOR TREATMENT

Although the shift toward strict dangerousness criteria for civil commitment was based on the honorable intentions of protecting the rights of individuals with mental illnesses and ensuring that they received effective treatment delivered in the least socially disruptive settings, serious unintended negative consequences have occurred. Because an inpatient stay is often the first step in treatment for people with mental illness, one consequence of the shift toward dangerousness criteria has been compromised access to psychiatric care for nondangerous individuals with mental illness who need but are refusing treatment. Under treatment-driven criteria for commitment, these persons would have gained access to the system through hospitalization on an involuntary basis if necessary. However, under standards based on dangerousness, the medical system will not intervene against a person's wishes until he or she becomes suicidal, physically violent, or grossly unable to perform activities of daily living. Through interviews of mothers of individuals with mental illness, Copeland learned that current civil commitment criteria force relatives to watch their loved ones go through

progressive stages of psychiatric decompensation before they can get them any help at all.²¹

Furthermore, since the tightening of criteria for involuntary psychiatric hospitalization, the United States has seen a trend of persons with mental illness being marginalized to unsafe and inappropriate settings. Since deinstitutionalization, there has been a tremendous increase in America's population of people with mental illness who are living on the streets.^{8,22,23} The latest estimates by the United States' Substance Abuse and Mental Health Services Administration reveal that up to 25 percent of our country's homeless population is made up of individuals with mental disorders, despite the fact that only approximately six percent of the general population suffers from mental illness.²³

Individuals with mental illness are not only overrepresented in our nation's homeless population, but they are overrepresented among the United States' correctional population as well. Since the 1970s, coincident with deinstitutionalization and reform of civil commitment standards toward dangerousness criteria, the trend of "criminalization of the mentally ill" has occurred.²⁴ It is currently estimated that, among our country's prison inmates, there is a 10- to 25-percent prevalence of mental illness.^{22,24} Many of these mentally ill inmates are nonviolent offenders,⁸ a fair number of whom were convicted of survival crimes (e.g., theft of food or trespassing for shelter) related to limitations in social functioning and ability to meet basic needs because of chronic mental illness.²⁵ It has been shown that people with mental illness are arrested more often than people without mental illness that encounter law enforcement under similar circumstances. Additionally, persons who have been civilly committed in the past have a higher likelihood of arrest than persons with histories of voluntary psychiatric hospital stays. One reason that police cite as a motivating factor for taking people with mental disorders into criminal custody rather than to hospital

emergency rooms is that the justice system is a more likely route through which long-term care can be achieved. It is unfortunate, but this is a direct result of the decreased average length of involuntary hospitalization that has occurred because of the shift to dangerousness criteria for civil commitment. Involuntary hospitalization has become a quick and limited fix for acute and severe mental pathology rather than a step toward long-term psychiatric care.²⁵

SPECIAL POPULATIONS

There are several special populations of people with mental illness that fall at the intersection between psychiatry and law. These individuals present unique challenges to psychiatry and are often subject to civil commitment.

The first such population consists of persons with mental illness who have histories of breaking laws during episodes of mental illness and are found by the court to be not guilty by reason of insanity (NGRI). The American public may view the insanity defense critically due to a widespread belief that it provides an easy route for criminals to avoid social punishment.²⁶ In reality, insanity acquittees are not quickly released to society. Although these persons are technically acquitted by the justice system, they are almost always subsequently remanded to the medical system with the expectation that they will receive psychiatric care.

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This expectation is met through civil commitment, and insanity acquittees remain hospitalized until they can prove that they have been sufficiently psychiatrically rehabilitated to no longer pose a risk to society.²⁷ The process of release from commitment for persons found NGRI can be very lengthy and complicated, and the

time acquittees spend in psychiatric facilities may exceed the term of the jail sentence that they would have served if found guilty of the crime that they committed.^{26,27}

In fact, the issue of length of commitment after a court finding of NGRI went before the Supreme Court of the United States in 1983. In the case of *Jones v. United States*, a man who had been arrested for the misdemeanor-level crime of attempted petty larceny entered an insanity plea. He was found NGRI by the court and subsequently civilly committed. After he had been hospitalized for more than 12 months, the maximum possible term of incarceration for misdemeanor offenses, he went back to the court asking to be released. He presented the argument that he should not be involuntarily hospitalized for a longer period than he would have spent in jail. The court rejected Mr. Jones's argument.^{4,28} The justices ruled that, because a finding of NGRI was technically an acquittal, the length of the "hypothetical criminal sentence" was irrelevant to the determination of the length of involuntary hospitalization.²⁸ The Supreme Court set a standard with this ruling that persons committed after findings of NGRI could be hospitalized against their will for an indefinite period of time, regardless of the maximum length of time that could be served if they were convicted.^{4,28,29}

A second group that presents a challenge at the interface of

psychiatry and law is sex offenders. There is a deeply ingrained and intense fear of victimization by sexual predators among the American public. This has led to an extraordinary number of socially and legally sanctioned means of social control of persons with histories of committing sexual crimes. As a society, we label

these individuals “sex offenders” and control them with a variety of measures, including mandated public registry participation, restriction of housing and employment opportunities, and civil commitment. Sexually violent predator (SVP) commitment laws exist in the legal statutes of 20 states as well as in federal law.³⁰ These laws allow civil commitment of individuals who have been convicted of sexually violent crimes provided that they have been diagnosed with a mental illness and are judged to present a risk to the general public because of their diagnoses.³¹

Several cases that challenged SVP commitment laws were adjudicated by the United States Supreme Court. The issue of whether post-release civil

conditions leading to commitment were untreatable, commitment could last indefinitely.^{4,30,31} Five years later, in 2002, another case challenging Kansas’s practices of civil commitment of sex offenders was brought to the Supreme Court. The case of *Kansas v. Crane* again upheld the constitutionality of the commitment of individuals who had committed violent sex crimes.³⁰ The justices deciding this case also ruled that an evaluator’s judgment that a person has an impaired ability to control his behavior stemming from a “mental abnormality or personality disorder” could suffice for establishing the presence of mental disorder required for civil commitment.^{30,33}

SVP commitment laws are very controversial and have strong

that the end of public safety does not justify the unethical means used to achieve it.³⁰

On the other hand, SVP commitment laws also have strong supporters. Those in favor of the laws believe that disorders of aberrant sexual behavior are largely untreatable and that individuals suffering from them pose a great risk to innocent citizens.^{4,31} Individuals who support civil commitment of sex offenders point out that, even with the best hormonal and behavioral treatments, there is still some degree of recidivism. Grossman et al³⁴ published a review of current literature on outcomes after treatment of sex offenders, through which the authors found that existing hormonal and behavioral treatments for sex offenders were effective in decreasing recidivism by 30 percent over a seven-year follow-up period. Given this data, supporters of SVP commitment laws serve an important function in protecting society from individuals who may still be dangerous.

With regard to a personality disorder, antisocial personality disorder, which predisposes individuals to dangerousness, there is controversy regarding the issue of civil commitment. Psychiatrists disagree about whether this diagnosis alone should be grounds for commitment, and there have been conflicting legal decisions on the matter. The Supreme Court ruled through *Kansas v. Hendricks* that a personality disorder could be grounds for keeping a sexual predator civilly committed.^{31,36} However, in the case *Foucha v. Louisiana* a different ruling was made. In this case, Terry Foucha committed the offenses of aggravated burglary and illegal discharge of a firearm while under the influence of psychosis, which was later determined to have been drug-induced. When he was no longer psychotic, he petitioned for his release on the basis that he was not mentally ill. Psychiatrists evaluated Mr. Foucha and opined that he had antisocial personality disorder and that he would likely present a danger

The American Psychiatric Association formally opposed SVP [sexually violent predator] commitment laws,³⁰ and a large number of psychiatrists over the years have expressed professional concerns that these laws mandate physicians to serve the inappropriate, nonclinical function of incarcerating persons with criminal pasts in facilities that were established for treatment of psychiatric disorders.⁴

commitment of sex offenders who have completed prison sentences violated the protection from double jeopardy guaranteed by the Constitution was considered by the Supreme Court in the 1997 case *Kansas v. Hendricks*. This case involved Mr. Hendricks, a man with pedophilia and a history of child molestation who had been civilly committed in Kansas after serving a jail sentence for his crimes. He requested his release based on his belief that he was then being punished twice for one crime.³² The Court determined that civil commitment by definition was a psychiatric intervention rather than a punishment, and therefore, states had the right to involuntarily hospitalize even those individuals who had already served time for crimes arising from sexual disorders. Additionally, the Court determined that if sexual

opponents. The American Psychiatric Association formally opposed SVP commitment laws,³⁰ and a large number of psychiatrists over the years have expressed professional concerns that these laws mandate physicians to serve the inappropriate, nonclinical function of incarcerating persons with criminal pasts in facilities that were established for treatment of psychiatric disorders.⁴ Additionally, many individuals classified as sex offenders, (e.g., those who have committed rape) do not clearly meet criteria for any *Diagnostic and Statistical Manual of Mental Disorders* diagnosis. A common diagnosis among committed sex offenders (second only to pedophilia) is paraphilia, not otherwise specified. Critics of civil commitment of sex offenders argue that providers are using catch-all diagnoses to justify the continued deprivation of liberty, and

to others if discharged.³⁵ The case went to the United States Supreme Court, which determined that antisocial personality disorder did not qualify as a diagnosis of mental illness because of which a person could be involuntarily hospitalized, and that Foucha should be discharged.^{35,36}

Individuals with eating disorders are another population that presents special challenges to psychiatrists, especially when the issue of involuntary hospitalization arises. Eating disorders carry high mortality rates. A 1995 study reported that the mortality rate for patients with anorexia was nearly six percent per decade.³⁸ A subsequent meta-analysis published in 2009 reported that eating disorders had crude mortality rates between 3.9 and 5.2 percent.³⁸ Death occurs not only from medical complications of chronic starvation and purging behaviors (self-induced vomiting and laxative abuse), but also from suicide.³⁷⁻³⁹ Patients with eating disorders also show a large degree of reluctance toward and refusal of treatment.⁴⁰ Despite the potential lethality of the disorders, the fact that an inpatient setting is often the most appropriate setting for weight restoration and intense psychiatric treatment, and the commonality of treatment refusal among those with the disorders, commitment of individuals with eating disorders is uncommon. It is notable that within the extensive literature on eating disorders, there is scant mention of the role of civil commitment in their treatment, and that the *Practice Guidelines on Eating Disorders* published by the American Psychiatric Association gives no concrete guidelines on commitment of patients with eating disorders.⁴¹

There are many reasons why civil commitment of patients with eating disorders is a challenge for United States psychiatrists. A primary reason is that many psychiatric providers are not certain about whether an eating disorder qualifies as a "severe mental disease or defect."⁴¹ There is a common impression throughout the United States that eating disorders are not serious mental disorders.³⁹

Furthermore, patients with eating disorders can often hide the extent to which their thought processes and judgment are impaired by perceptual disturbances regarding body image and weight. The typical patient with anorexia, for example, is not the picture of an obviously certifiable patient, but that of a well-spoken, seemingly put together young woman.⁴⁰ Providers may find it difficult to assert that patients with eating disorders pose an imminent risk of harm to themselves. Chronic starvation is not typically considered to be a suicidal behavior, and even providers who see this behavior as suicidal do not necessarily see it as imminently life threatening. Although many states have statutes that allow for commitment of patients whose behavior renders them gravely disabled, the behavior has to be so disabling as to create an imminent risk of harm to the patient. Currently, even among mental health providers who specialize in eating disorders, there is no clear consensus about what clinical signs indicate that this imminent risk exists.⁴¹

Patients who abuse substances are another special population in our discussion of civil commitment practices in the United States. Individuals with substance use disorders have illnesses that pose a high mortality risk to them. Substance abusers have a high degree of treatment reluctance and often refuse residential treatment even when critically necessary for their survival. Furthermore, patients with substance dependencies do not demonstrate clear evidence of thought disorder. Just as these factors contribute to a relatively low rate of civil commitment of patients with eating disorders, they contribute to a relatively low rate of civil commitment for patients with addictions. As of the year 2001, 11 of the 50 states had commitment statutes that allowed for involuntary hospitalization of individuals based solely on the presence of drug dependence (without even the presence of dangerousness), and in eight states commitment of

individuals based solely on the presence of alcohol dependence was allowed.⁴² Researchers found, however, that in states where these statutes existed only 20 percent of psychiatrists believed that substance dependence as a diagnosis fulfilled criteria for civil commitment.⁴²

One area in which compulsory residential treatment of persons with addictions is often employed is in the field of forensic psychiatry. In 1961, California passed legislation allowing for involuntary hospitalization of narcotic-addicted individuals who had been arrested for drug-related crimes. New York passed its own law allowing for civil commitment of persons with opioid dependence in 1962. Subsequently, in 1966, Congress passed the Narcotic Addict Rehabilitation Act (NARA), a federal law that allowed for commitment of persons with addictions to narcotics. Currently, there are many states with systems in place that allow persons convicted of drug offenses to go to treatment as an alternative to going to jail. Research has shown that these individuals, who are coerced into treatment, have just as favorable outcomes as do voluntary patients.⁴³

Although NARA does allow for compulsory treatment of drug abusers who have not been convicted or even charged with legal offenses, in practice, most involuntary hospitalization of substance abusers occurs within the forensic psychiatric population. This is an area of controversy. Advocates of drug treatment argue that because involuntary treatment is as effective as voluntary treatment, commitment should be used more often in treating addictions. However, because of limited access to programs and a widely shared belief that resources should be prioritized for people who truly want to be in recovery of their own accord, the practice of committing addicted individuals who have not broken laws is rare.⁴³

OUTPATIENT CIVIL COMMITMENT

Outpatient civil commitment is a relatively modern trend in the United

States. In contrast to inpatient civil commitment, which involves separation of a mentally ill person from society through placement behind a locked door, outpatient civil commitment allows people suffering from mental disorders to remain in their communities. It is an alternative means of mandating the treatment of individuals who could potentially become dangerous to themselves or others without forcing them to be hospitalized.

Although by the year 1999, outpatient commitment had been around for decades, the state of New York brought national attention to this issue with the passage of Kendra's Law. The impetus for Kendra's Law was the occurrence of a tragedy in New York City—a man

commitment must be diagnosed with a mental disorder. Second, the individual needs to clearly be in need of treatment and have a history of poor insight regarding his need for care leading to periods of treatment nonadherence. This in turn indicates that he would not be likely to reliably access psychiatric care on a voluntary basis. Third, there must be evidence indicating that the individual is likely to decompensate into a state that would prove dangerous to him or herself or others if treatment nonadherence were to occur.⁸ If the criteria are met, the individual can be mandated to outpatient psychiatric treatment, however, not necessarily forced to take prescribed medications.^{4,8}

The benefit of outpatient

The benefit of outpatient commitment comes with the monitoring of committed individuals and the requirement of adherence with outpatient mental health visits. Persons who are civilly committed to the outpatient mental health system are easier to involuntarily hospitalize at earlier stages of psychiatric deterioration because they are carefully managed by the community mental health system.

with untreated schizophrenia shoved a young woman into the path of a city subway, causing her untimely death. The law enacted outpatient commitment standards for the state of New York with the hopes of preventing similar tragedies from occurring in the future. The state passed the law to ensure that persons with mental illness who were in need of treatment that would prevent them from becoming dangerous in society got the treatment they needed.⁴

Currently, outpatient commitment statutes exist in most states.⁸ The goal of these statutes is to ensure that psychiatric care is provided to individuals who have a need not only for mental health services but also for supervision.⁴ Outpatient civil commitment depends on several criteria. First, the individual considered for outpatient

commitment comes with the monitoring of committed individuals and the requirement of adherence with outpatient mental health visits. Persons who are civilly committed to the outpatient mental health system are easier to involuntarily hospitalize at earlier stages of psychiatric deterioration because they are carefully managed by the community mental health system. Families also often find it easier to access needed care for mentally ill relatives who are subject to outpatient commitment.²¹ Outpatient commitment results in fewer arrests of people with mental illness.²⁵ Additionally, outpatient commitment has been shown to be effective in improving patients' psychiatric outcomes,⁴⁴ decreasing rates of hospitalization and lengths of inpatient psychiatric stays,^{44,45} as well as increasing participation in community psychiatric treatment.^{44,45}

CONCLUSION

Living with a mental illness can be a difficult experience because of the effects that the disorders can have on the perception of reality and the distortion of an individual's judgment. These alterations may place the patient and others in danger. The practice of civil commitment—involuntary hospitalization of a patient—predates the profession of psychiatry itself, however remains a controversial part of psychiatric practice.

Often involuntary hospitalization is the first step in establishing psychiatric treatment for individuals who are desperately in need of mental health services, and the original commitment standards in the United States reflected the recognition of a right to treatment for individuals with mental disorders. However, abuse of treatment-based standards led, in some cases, to institutionalization of individuals without mental disease whose hospitalization could benefit unprincipled spouses or relatives. The United States movement of deinstitutionalization during the civil rights era, with concurrent shift in commitment standards to standards based on dangerousness, was meant to protect psychiatric patients from unjust violations of autonomy. This shift created different problems, including a shift of people with mental illness from asylums to prisons, and creation of an epidemic of homelessness among persons with mental disorders. Today, we still face the challenge of striking a balance between assuring that patients have access to psychiatric care, through involuntary hospitalization if necessary, without allowing the practice of psychiatry to be used as a force for social control.

The United States Supreme Court has addressed the issue of civil commitment in numerous landmark cases. In deciding *O'Connor v. Donaldson*, *Addington v. Texas*, and *Lake v. Cameron*, the Court established the criteria for and burden of proof needed to justify civil commitment, and established a right to treatment in the least restrictive

environment for patients facing hospitalization against their will. The Court has also answered questions about the purpose of involuntary hospitalization, not only for typical psychiatric patients, but for special populations such as sex offenders (Kansas v. Hendricks) and NGRI acquitters (Jones v. United States) as well. Despite the progress the Supreme Court has made in resolving the controversies surrounding civil commitment, many controversies remain. Areas in which consensus is needed regarding civil commitment include personality disorders, eating disorders, and substance use disorders.

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