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Civil Commitment Law with a Focus on Hospitalized Patients History and Practice in Kansas: Part I and Part II

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PART I

INTRODUCTION

Some patients become noncompliant with treatment or avoid help from their physicians when they are ill.[1] Patients with acute mental illness can suffer from anosognosia, the inability to recognize that they are ill or how severe their illness is. Anosognosia partly can explain their noncompliance leading to further health deterioration, as well as preventable hospitalizations and increased cost of care.[2] Psychiatry is unique in that, a psychiatrist or qualified mental health professional may request involuntary civil commitment and treatment when patients are considered dangerous due to their mental illness.[3] If the patient is adjudicated, or court committed to hospitalization and treatment, the patient loses autonomy to decide about their treatments and the decision-making power is given to another individual, most commonly the patient's physician. Naturally, this loss of autonomy raises ethical considerations. The process of civil commitment has multiple steps and can become confusing to non-psychiatry colleagues.

As a psychiatry resident rotating through inpatient services, much of my time consists of treating patients with severe mental illness. Many of them may have suicidal thoughts, may be unable to care for themselves, or may lose the ability to distinguish real from unreal. Untreated, they could become agitated or aggressive. Without the option of civil commitment and treatment over their objection, many of these patients would never receive any treatment. More than 25% of acutely ill patients on the medical floor are mentally ill.[4] For that reason, it is vital that all branches of medicine have a basic understanding of Kansas Civil Commitment Laws. This report will share how these laws evolved, and how we use them.

Involuntary commitment and treatment over objection laws are governed by individual states, therefore, there is variance in these laws from state to state.[5] These laws are based on two main principles. The first principle is parens patriae, a Latin term that means "parent of the country". It stems from an English common law that assigns government the responsibility to intervene on behalf of citizens who cannot act in their own best interest. A second legal principle, police power, requires a state to protect the interests of its citizens. Conversely, the state has a duty to protect all people within state lines, therefore, being forced to enact statutes that benefit all citizens but may restrict the rights of a few.[6,7]

Historical Perspective

To have at least a basic understanding of current civil commitment procedures, it is important to delve into the history of this law and how it evolved. The first use of involuntary commitment dates long before psychiatry was considered a specialty. Like many aspects of medicine, our first account of this occurring points to the father of medicine, Hippocrates. He was the first to consider that those with mental illness should be held in a secluded, comforting, and therapeutic environment.[8] Throughout time, from early Roman law, the English Middle Ages and until now, physicians have been involved in the civil commitment of patients deemed "mentally unfit". The famous Bedlam Hospital in England first designated a wing for the inpatient care of the mentally insane in 1403.[6]

Many years later, the United States followed by opening many privately funded asylums, leading to the era of institutionalization.[9] The view by many at the time was that patients with mental illness did not have the capacity to make decisions. A distinction between voluntary and involuntary admission did not exist. Nothing more than the presence of mental illness, and a recommendation from the patient's psychiatrist, was sufficient for admission. Prior to the Civil War, commitment was founded upon the doctrine of parens patriae, which propelled coercion of treatment. This led to sane people being wrongfully hospitalized because of greedy relatives or unethical psychiatrists. These claims led to advocating for reform of the civil commitment laws after the Civil War.

The new laws were modeled after the criminal justice system, and they included: jury trials, requirement of examination of the patient by a psychiatrist prior to testimony, and the absence of a psychiatrist's conflict of financial interest.[3] Even though these new laws were more protective of patient's rights, they were not adaptable enough to address emergency situations, and the time required for the legal proceedings delayed needed treatment.

To address this need, individual states developed a new set of laws prior to World War I. These laws allowed short term hospitalization based only on a physicians or police request, without lengthy judicial process, and with the possibility of a court hearing if patient desired.[3] The next important milestone in the governance of civil commitment laws was in 1951. The newly founded National Institute of Mental Health (1949) released the landmark, Draft Act Governing Hospitalization of the Mentally Ill.[10] The document was based on the report of the prestigious Group for Advancement of Psychiatry condemning excessive identification of mental illness and criminality by similarity of procedures. This draft was to provide guidance on how to reform mental health laws in individual states. The document emphasized voluntary admission as preferable, and that involuntary admission should be used only when patient becomes dangerous due to their mental illness, is in need of treatment and care in a psychiatric hospital, lacks insight, and is unable to make reasonable decisions. Urgent hospitalizations would be possible, but if these occurred, the patients had the right to a prompt hearing, legal representation, and participation in their hearing.[10] New laws based on this document decreased excessive criminal regulations and restored the decision-making power psychiatrists had before, without the burden of long legal standards.[3,11]

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Modern Era of Treatment and Pivotal Court Cases

Even with improvement of the laws, there were about 500,000 patients in America's asylums in the 1950s.[9] Serendipitous discovery of chlorpromazine by the French surgeon and neurobiologist Henri Leborit in the early 1950s, and its addition to the established armamentarium of psychiatric treatments, started the modern era of psychiatry. Dr. Leborit hypothesized that chlorpromazine could be used as an anxiolytic for psychiatric patients, since it calmed patients before going into surgery.

Chlorpromazine entered clinical testing and unexpectedly was found to have the most benefit in patients suffering from psychotic disorders, such as bipolar disorder with psychosis and schizophrenia.[12,13] Additionally, some of these patients were able to resume their normal life.[14] With that revelation, the first antipsychotic medication, Largactil® (chlorpromazine), was born. The idea of treating patients in an outpatient setting, who previously were thought to require lifelong hospitalization, seemed much more plausible. In addition, the cost of lifelong hospitalizations, the progression of the civil rights movement with the push for more humane psychiatric care, and the creation of Medicare and Medicaid led to closure of many psychiatric asylums and launched the era of deinstitutionalization. After president Kennedy signed The Community Mental Health Centers Act of 1963, many state hospitals across all of America shut down and the number of inpatients plummeted from over half a million in 1950 to 30,000 by the early 1990s.[3,15]

As mentioned, the laws governing involuntary commitment (involuntary admission) and treatment vary by state. All states recognized that only patients suffering from mental illness may be civilly committed. There are common criteria that are upheld by states, and these criteria were established by several pivotal cases. To meet the treatment needs for mentally ill patients who are not perceived dangerous, the criteria for confinement to the least restrictive setting were established in the case of Lake v. Cameron (1966).[16] This approach enabled more patients to get treatment in partial day hospitals, observation units, or intensive outpatient therapy if they could be treated there safely. The case of Lessard v. Schmidt (1972)[16] established that each patient had the right to due process, which meant that a patient had the right to trial and an attorney. The case of O'Connor v. Donaldson (1975)[17] decided that patients suffering from mental illness who were dangerous may be committed involuntarily, and the case of Addington v. Texas (1978)[16] established that the middle standard of clear and convincing evidence is sufficient proof to satisfy the need for involuntary commitment. This meant that the clinician must present clear and convincing evidence that a patient is a danger to self or others (including self-care failure), is in need of treatment, and lacks the capacity to make informed decisions about the treatment. With these cases, the need for treatment model shifted more to a dangerousness model.[16,17]

For patients who refuse needed treatment and lack the capacity to make reasoned care decisions, but do not suffer from mental illness, medical providers need to rely on advance directives and proxy decision makers such as a durable power of attorney, the patient's guardian, an emergency guardian, or living will if patient is suffering from a terminal condition.[18]

PART II

Kansas Laws, Voluntary versus Involuntary Admission, and Civil Commitment During Hospitalization

Admission to a locked behavioral health unit (BHU) can be voluntary, which is preferred, or involuntary, which is against a patient's will. Patients can be admitted from the emergency department (ED) directly from the patient's outpatient provider, from a medical floor, or from another hospital. Kansas laws governing involuntary admission (civil commitment) and involuntary treatment are outlined under the Probate Code in Chapter 59, Article 29, "Care and Treatment Act For Mentally Ill Persons".[5]

Voluntary Admission

Voluntary admission to a locked BHU is no different from voluntary admission to any other hospital unit. It starts with an evaluation of the patient by a provider and concludes with the determination whether the patient has a mental illness and meets criteria for medical necessity. In other words, the patient's safety can be assured only if the patient is treated in the hospital. A patient signs consent to be admitted, evaluated, and treated in the BHU. According to Kansas Law (KSA 59-2950), a patient can be discharged when he or she reaches the maximum benefit from the hospitalization.[5] In clinical practice, this means that the patient's condition improved to the point that treatments can be continued safely in an outpatient setting.

There are times when a voluntarily admitted patient withdraws their consent to be hospitalized, and requests to be discharged. This usually happens when patients disagree with proposed treatments, believe they are stable for discharge, or have some obligation outside the hospital to which they need to attend. In this case, the patient or patient's guardian must submit a written "Request for Discharge" which is also called a "3-day notice" or "72-hour letter".[5] Unless a patient withdraws this request, the treatment facility has three court working days to either discharge the patient, if the patient is stable for discharge, or to file a petition and seek involuntary commitment of the admitted patient.[5] No medications can be administered to a voluntarily admitted patient without the patient's or patient's guardian consent.

Involuntary Admission

Emergency Detention and Application for Emergency Observation and Treatment

At times, mentally ill patients who are behaving dangerously are brought to the ED by family or a law enforcement officer (LEO). Based on the "police power" principle, Kanas law allows an LEO to detain a person without a warrant[5] and bring that person to the ED for examination by a qualified mental health provider. The evaluation usually has three different outcomes:

a) The patient does not meet the criteria for involuntary commitment or hospitalization and LEO takes the patient to where the patient was picked up,[5]

b) The patient does not meet the criteria for involuntary commitment but meets criteria for hospitalization, and voluntary hospitalization is offered but not enforced, or

c) Patient meets the criteria for involuntary commitment, and involuntary hospitalization is enforced after an "Application for the Emergency Observation and Treatment" ("Application") is filled out by the LEO or medical provider. This application must contain an explanation of why the emergency hospitalization is necessary.[5]

The Application frequently is referred to as an "Emergency Admission and Hold". According to Kansas law, a treatment facility may admit and detain any person presented for emergency observation and treatment upon the written application. This Application expires at 5:00 p.m. on the next working day and the patient will have to be discharged unless he or she is willing to be admitted voluntarily, or a request for temporary custody and mental health petition was filed, or the court orders otherwise.[5] There are occasions when the patient's condition leading to involuntary admission under the "Application" improves so much, that the patient may be discharged prior to expiration of the "Application". A common example of this is when a dangerous patient is admitted involuntarily under the "Application" on Friday or during a holiday, is ready for discharge on Sunday, and the "Application" expires on Monday at 5 p.m. In this case, the patient can be discharged following the same process as is used for the discharge of voluntary patient.

Temporary Custody Order and Petition for Determination of Mental Illness (Mental Health Petition)

A Request for Temporary Custody Order and Petition for Determination of Mental Illness are filed with a court when a patient is admitted either involuntarily or voluntarily, but the patient is refusing necessary treatments or wants to be discharged while they still are considered to be dangerous.[5] Both these written requests can be submitted to the district court at the same time. The first one, the Temporary Custody Order, is a request to keep the patient in the facility against the patient's will prior to the temporary custody hearing. The second one, the Mental Health Petition, is to determine if the patient suffers from mental illness and is subject to involuntary treatment.

The request for Temporary Custody Order must be accompanied with an explanation of why it is necessary for the patient to wait for the hearing in the treatment facility.[5] Upon filing of this request, the court will schedule a hearing within two business days, will notify the patient and petitioner of time and place of the hearing, and will appoint an attorney for the patient if the patient does not have one. The patient and the petitioner are expected to appear and participate in the court hearing, unless the patient's attorney believes that this hearing would be harmful to the patient. In that case, a patient's presence may be waived by the court, unless the patient writes a written request to participate against his attorney's request.

Based on the presented evidence, testimony, and cross examination, the court will determine if:

a) There is probable cause to believe that the patient is mentally ill, and it is in the patient's best interest to stay detained in the facility until trial. The court issues a temporary custody order, which does not include an order to treat unless specifically stated by the judge, or the trial is advanced.

b) There is probable cause to believe that the patient is mentally ill, but it is not in the patient's best interest to stay detained in the facility until trial. The court may release the patient with stipulations.

c) There is not probable cause to believe that the patient is mentally ill. The court terminates the proceedings and releases the patient.

Filing of a Mental Health Petition with the district court will trigger several preliminary orders.[5] In similar fashion to a temporary custody order, the court will order: (1) the time and place of the trial, (2) LEO to notify the patient personally about the petition being filed, (3) the patient to appear at the hearing, (4) an appointed attorney to consult with the patient and represent the patient in all proceedings, and (5) a qualified mental health provider to write the mental health evaluation. This evaluation must state whether the patient is a mentally ill person subject to involuntary commitment, and what is the least restrictive setting to protect the patient and others. The evaluation is submitted to the court at least three days prior to trial. Additionally, the law allows to reschedule a court hearing for a later date (continuance) if there is good cause (e.g., illness) or earlier date (advancement) if that is in the best interest of all. If all needed information is provided to the court early, the civil commitment hearing may be advanced to the time of temporary custody hearing.

Trial

An officer will serve the written notification of the date and place of the trial to the patient, and the petitioner (provider) also will be notified. The date is set anywhere between 7 to 14 days after filing, or within 30 days if the patient requested a jury trial.[5] The trial most commonly occurs in the hospital, and the patient's presence may be waived the same way as in a temporary custody hearing. The main purpose of this trial is to determine whether there is clear and convincing evidence the patient suffers from a mental illness due to which he or she is likely to be a danger to self or others and incapable of making an informed decision about care and treatment. Both patient and petitioner are afforded the opportunity to be present, put on the witness stand and cross-examined by attorneys representing both parties. The final decision to commit the patient lies in the hands of the judge, or the jury if a jury trial was requested. Based on presented evidence, testimony, and cross examination, the judge or jury will determine:

a) There is clear and convincing evidence the patient suffers from a mental illness and is in need of care and treatment in the hospital. This means that the patient remains hospitalized, and medications may be administered against patient's will. This order usually expires in three months,[5] or upon discharge from the hospital or transfer of the patient out of the court district. The petitioner may request for the order to be transferred from the hospital to another inpatient or outpatient care facility.

b) There is not clear and convincing evidence the patient suffers from mental illness and is not in need of care and treatment. The court will release the patient and terminate proceedings.

Any time an involuntary patient has a hearing where the case is advanced and/or the patient has a trial, and the patient is ordered to receive treatment, the court must send a copy of the order to the Kansas Bureau of Investigation (KBI) within five days. The KBI enters this information to the appropriate databases, including the database which prohibits patients from owning firearms.[5] When an involuntary patient is discharged from the hospital, the hospital notifies the court to terminate proceedings and notify the KBI, unless the treatment order was transferred to outpatient care. A patient who is no longer committed to treatment may file a petition for restoration of the ability to legally possess a firearm. If a patient signs a waiver to get treated, the court orders the treatment, however, this order is not sent to the KBI and the patient retains their right to own/possess a firearm.

CONCLUSIONS

Psychiatric disorders can change a patient's perception of reality, make them behave dangerously, and severely can impair their capacity to make rational decisions, including those about their own treatment. During times of patient instability and common uncooperativeness, it is difficult to navigate ethically between letting patients make decisions autonomously versus making decisions for them in a way patients do not like but will benefit from in the long run. This is where civil commitment laws come in. These laws provide rules and procedures that ensure a patient has proper due process when it is proven there is clear and convincing evidence that a mentally ill patient has lost the capacity to make rational decisions and poses harm to self or others, and that these imposed treatments have a good chance to restore a patient's capacity and safety in the future.

Due to the particular wording of commitment statutes, or infrequent exposure to these laws (as would be true for our non-psychiatrists), civil commitment and when to use a proxy decision maker remains a confusing topic. By reviewing the evolution and details of these laws, we hope to add clarity to this matter. It is important to remember that many of these laws differ from state to state, and do not travel across state lines. Therefore, it is always recommended to speak with local law professionals or hospital staff knowledgeable in this area.

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