Involuntary Hospitalization of Primary Care Patients

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LESSONS LEARNED AT THE INTERFACE OF MEDICINE AND PSYCHIATRY

The Psychiatric Consultation Service at Massachusetts General Hospital (MGH) sees medical and surgical inpatients with comorbid psychiatric symptoms and conditions. During their twice-weekly rounds, Dr Stern and other members of the Consultation Service discuss diagnosis and management of hospitalized patients with complex medical or surgical problems who also demonstrate psychiatric symptoms or conditions. These discussions have given rise to rounds reports that will prove useful for clinicians practicing at the interface of medicine and psychiatry.

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Have you ever worried about the mental health and well-being of your outpatients and wondered when and how to obtain more extensive psychiatric evaluation and treatment? Have you been uncertain about how to involuntarily admit one of your outpatients for psychiatric treatment? If you have, then the following case vignette and discussion should prove useful.

Involuntary commitment of an outpatient, particularly in the primary care setting, represents an important and challenging issue at the interface of ethics, law, and clinical practice. We present the case of an outpatient for whom involuntary commitment was considered and provide an overview of the approach to the psychiatrically unstable outpatient.

CASE REPORT

Ms A, an increasingly depressed, unmarried 48-year-old woman with a history of treatment-resistant major depressive disorder (ie, an episode of major depressive disorder that does not respond adequately to treatment with 2 different antidepressants), as well as social anxiety disorder, was struggling with low energy and appetite and guilty ruminations (about being a burden to others, particularly her immediate family and her treaters). She had a history of 3 psychiatric hospitalizations, but no suicide attempts, and had no significant medical illnesses. Ms A intermittently responded to combinations of selective serotonin reuptake inhibitors and antipsychotics. She also went to group and individual therapy weekly and diligently attended all appointments.

However, over the past several weeks, Ms A's depressed mood worsened substantially. Her social anxiety increased as well, feeling so anxious about public performances that she, on occasion, did not go to school (she is a graduate student who often has to speak in class). Her neurovegetative symptoms of depression (energy level, appetite, and concentration ability) worsened. Her outpatient psychiatrist started a new antidepressant and gradually raised the dose. He saw Ms A weekly and offered her a voluntary inpatient hospitalization or partial hospitalization in the hopes of increasing the intensity of her treatment; however, she refused these options. Ms A had consistently viewed the relationship with her family and her pets (as well as a fear of pain) as reasons not to attempt suicide. She increasingly felt like a burden to her family, but she continued to deny any intent to harm herself. She agreed to call her physician if she developed thoughts of suicide.

Only 3 days after her last appointment, Ms A failed to show up for scheduled follow-up therapy (individual and group); this was highly unusual for her. Ms A's psychiatrist called to check on her and left a voicemail message. Several hours later, after having not heard from her, the physician filed a Section 12 form (to initiate involuntary commitment in Massachusetts) given his concern for her safety. Ms A was then found (minimally conscious but arousable) by police and emergency medical services at her home. She had overdosed on several medications and alcohol and had left a suicide note. Ms A was brought to the emergency department, where she was treated, medically cleared, and admitted to an inpatient psychiatry facility.

WHAT IS INVOLUNTARY COMMITMENT?

Involuntary commitment, often referred to as civil commitment, represents the legal process of hospitalizing a person against his or her

Clinical Points

- All states have laws and procedures for ensuring that patients with psychiatric illness can be involuntarily evaluated and/or committed, and primary care physicians can involuntarily refer patients for psychiatric evaluation.
- Most states' involuntary commitment laws are based on dangerousness of the patient to self or others.
- Primary care physicians should have a plan to ensure the safety of both the patient and staff if a patient represents a danger to self or others.

stated wishes.[1] State governments, acting under 2 major legal principles, have enacted laws to guide the process of involuntary commitment of patients with psychiatric illness. These 2 legal principles are *parens patriae*, or the responsibility of the state to intervene on behalf of its citizens who cannot act in their own best interest,[2,3] and "police power," or the necessity of the state to broadly protect the interests of its citizens.[2] The *parens patriae* component of government has traditionally been viewed as the basis for the "need for treatment" of patients in commitment, and it fueled most commitments prior to the 1960s, when patients were typically involuntary hospitalized on the basis of their need to be treated, irrespective of the risk to oneself or others. The police power component of government, on the other hand, has been viewed as providing the "dangerousness" criteria for commitment.[2,3]

In the 1960s, a state-by-state movement began to clarify criteria for involuntary commitment, shifting away from *parens patriae* and moving toward commitment being based on an individual's direct risk of harm to self or others or being so "gravely disabled" that he or she could not provide for basic survival needs.[4] This process continued until the landmark Supreme Court case *O'Connor v Donaldson*,[5] which in 1975 established the constitutionality of holding individuals against their will if they represented a direct risk to self or others or were in such a state to be "hopeless to avoid the hazards of liberty."[5,6] (Interestingly, though, this case did not strike down the constitutionality of a *parens patriae* approach.) The US federal government, mostly through rulings by the Supreme Court, has continued to clarify these state-by-state laws over the past 30 years.[2] Over the past 20 years, there has been a gradual shift back toward the *parens patriae* (ie, the need for treatment) approach to involuntary commitment, particularly when supporting involuntary outpatient treatment programs.[4] Involuntary outpatient commitment (wherein a patient is mandated to undergo outpatient psychiatric treatment) is beyond the scope of this article, and all references to involuntary commitment forthcoming represent involuntary commitment to *inpatient* facilities.[7]

Despite clarification of points at the federal level, involuntary commitment continues to remain a state issue, with varying statutes among the states, although most of them are similar; most states codify specific commitment criteria based on dangerousness as a result of mental illness.[2,8] Involuntary commitment in North Carolina (a randomly chosen state), for instance, requires that a person be a danger to "self, others or property" and "explicitly includes reasonable probability of suffering serious physical debilitation from the inability to, without assistance, either exercise self-control, judgment, and discretion in conduct and social relations" or "satisfy need for nourishment, personal or medical care, shelter, or self-protection and safety."[9] Massachusetts, on the other hand (the home state of the authors), requires that a person be a danger to self or others or "be at very substantial risk of physical impairment or injury because he/she is unable to protect himself/herself in the community."[10] Each state's criteria for involuntary hospitalization differs, so physicians should be aware of the criteria in their own state. For practical purposes, and for general practitioners, the criteria for "petitioning" for commitment (ie, sending a Section 12 petition to the police to force a psychiatric evaluation, as in our case) remain the same as those for commitment in general. An Internet search for involuntary commitment laws by state or directly speaking with legal representatives can facilitate knowledge about individual state laws.

HOW DOES THE PROCESS OF COMMITMENT WORK?

In every state, a physician can petition law enforcement personnel to bring a patient to a mental health facility for an evaluation of commitment without the necessity of a judicial hearing,[3] similar to what occurred in our vignette. Most states also allow psychologists and other nonphysician mental health workers (such as social workers) to petition for an evaluation of a patient's commitment. Massachusetts, for instance, allows all licensed physicians, psychologists, nurse mental health clinical specialists, or independent clinical social workers to file for commitment.[11] Police officers may also arrange for a patient to be evaluated against the patient's will in Massachusetts in "an emergency" and if none of the aforementioned providers are available.[11] In some states, such as Maryland, any person may petition a judge to have an individual evaluated, and, if approved by the judge, the person will be brought involuntarily to a facility for psychiatric evaluation.[12] As mentioned, criteria for these petitions typically rest on the same criteria for commitment (ie, dangerousness) per the state, but the petitioner need not list all of the criteria for commitment, as the formal psychiatric evaluation at the facility will determine if the patient meets the criteria.

The initial referral for commitment (as would be done by a primary care physician) does not involve actual civil commitment—that would be done after an evaluation by a psychiatrist and/or a hearing with a judge. A referral for mandatory involuntary psychiatric evaluation, as was done in our case, typically allows the facility to hold a patient for a predetermined amount of time (that is different on a state-by-state basis). Massachusetts, for instance, allows a facility to hold a patient for 72 hours before either a court

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hearing must occur or the patient must be discharged.[11,13] Some states allow for lengthier times of detainment prior to a hearing.[3]

In order to file for involuntary admission (if one is concerned about a patient's mental health or safety), typically, one starts by contacting the police. In Massachusetts, the police require that a physician fax a copy of the Section 12 form, which allows them to detain a patient and bring him or her in for evaluation for involuntary civil commitment.[13] Police officers require a detailed description of the need for assessment (such as whether or not you think the patient has a weapon). States often have varied approaches to this process, and you should become familiar with the approach in your state. If the patient is in your office or clinic, the process will most likely entail calling security and having the patient escorted to an appropriate evaluation facility. Again, details of this process will be situation and state dependent.

WHEN SHOULD A PATIENT BE COMMITTED?

Although the pendulum may be swinging back toward considering the need for treatment in commitment,[4] more than 30 years of legal precedent have established dangerousness as the primary criterion for commitment[1]; this should be the basis for decisions regarding commitment of primary care patients. Therefore, a general approach to commitment of outpatients includes taking expressions of the intent to harm oneself[14] or others seriously or noting substantial impairment by mental illness, all of which should lead to referral for commitment.[15] Although not all states require a physician to commit a patient who has expressed serious suicidal ideation, the standard of care requires this.[8] If a patient expresses serious suicidal ideation and refuses voluntary psychiatric evaluation, unless you have a previously well-established contract with a patient who is chronically suicidal (who would most likely need and have a psychiatrist anyway), then you should file a petition for his or her commitment. If you are filing for a commitment evaluation and the patient is not in your office, is unaware of your filing, and is at acute risk, you should not notify him or her, because this may lead to the patient trying to avoid the police. Since these patients are being evaluated involuntarily, there is therefore no requirement to notify them or their family members. Family members might also notify these patients and help them avoid evaluation.

It is acceptable to break confidentiality (by telling the police about a patient's situation) when filing for commitment, since these patients represent an acute risk to themselves or others, and you are emergently acting in their best interest. Aside from steps necessary to ensure that the patient makes it in for psychiatric evaluation, confidentiality should be respected (ie, it is not necessary to notify or discuss details of the patient's illness with family members when the police are on their way to secure a patient). As in all encounters, when initially beginning treatment, all patients should be made aware of limits of confidentiality, which include your concern for their safety or the safety of others.

Any threats of self-injury should be assessed for seriousness, with particular attention paid to primary psychiatric symptoms, a history of prior attempts, and the means of carrying out the threat to one's life.[1] Other components and risk factors that require assessment include depression and other psychiatric conditions, level of hopelessness, age (since age > 65 years increases risk), gender (men are 4 times more likely to complete suicide), and race (whites are twice as likely to attempt and to complete suicide than are blacks and Hispanics, although American Indians and Alaskans have the highest rates of any ethnic groups in the United States).[16]

In addition to the risk of self-harm, the risk of harm to others is a primary component of involuntary commitment statutes. Patients who express the intent to harm others as a result of mental illness should be referred for commitment. Patients expressing the intent to harm others as a result of antisocial traits or those who do not clearly have a mental illness should be referred to the police, as they are more appropriately managed by the criminal justice system.[1] Studies have revealed that non–mental health physicians as well as psychiatrists poorly predict violence in their patients.[17,18] Nonetheless, society expects physicians to help protect the general public from dangerous individuals.[19] If a patient expresses a desire to hurt someone, this intent should be explored for its seriousness, as well as its connection to mental illness, and the patient's access to means of harm should also be investigated.[1] In a 1976 rehearing of a 1974 California Supreme Court case, *Tarasoff v Regents of the University of California*,[20] the courts established that mental health professionals have a "duty to protect" third parties from harm if a credible threat was expressed by their patient (including by involuntarily hospitalizing the patient).[19–22] Since that time, the original premise of a "duty to warn," rather than to protect, has been applied in some states, and 37 states have adopted *Tarasoff*-like obligations, which apply to mental health professionals.[19] Given the variety of criteria among the states,[19] physicians should become aware of the laws in their state in the event that a patient expresses thoughts of homicide. Difficult cases often require legal consultation and contacting police may be the safest option for anyone expressing serious homicidal intent—the police can be helpful in determining whether charges should be filed or whether the person should be redirected toward psychiatric commitment and what steps the physician should take either way. You have no duty to warn patients that you have contacted the police if you are concerned about potentially violent behavior.

The final point to consider when referring a patient for commitment is whether the patient represents an indirect risk to self secondary to mental illness. This can be a more confusing area, particularly for nonpsychiatrists, so a referral for commitment can be helpful. For example, a patient with severe major depressive disorder may no longer be eating and may become severely malnourished or a person with bipolar disorder and current mania may be wandering into traffic. This is the area in which psychotic patients often fall. Unless

they have clear suicidal or homicidal ideation, psychotic patients who are disorganized, hallucinating, or delusional and unable to care for themselves may be committed under this criterion.

Of note, all patients could be offered voluntary psychiatric assessment and hospitalization, which is preferable to involuntary admission. For calm, insightful, cooperative patients, offering voluntary admission is preferable. If the patient seems to have little insight into his or her illness (ie, they do not think they have an illness at all and see themselves as having no need for help), is potentially agitated or violent, or impulsive and likely to act irrationally in the face of a referral to psychiatric assessment, it is best to not offer voluntary admission and seek involuntary commitment.

HOW ARE THESE PATIENTS MANAGED PRACTICALLY?

There are general approaches to managing patients being referred for involuntary commitment, but specifics will vary based on your clinic practice. You should do everything possible to ensure the safety of these patients. If willing, you can walk the patient to an evaluation facility, ensuring that he or she gets there safely. If available, security should be notified immediately and should stay with the patient until he or she can be transferred to an evaluation center. Security can also help keep the patient from attempting self-harm or from escaping. If possible, the patients could be searched for dangerous weapons or objects and kept on suicide precautions until transfer. If the patient leaves your facility, security can again be notified to track him or her down, if possible. It will likely be more helpful, though, to notify police and go through the process of petitioning for involuntary commitment, since the police can search for the person, including going to his or her home. Calling security is generally more likely in a hospital-based practice.

In community practices, it is also helpful to try to keep the patient in your office while awaiting police arrival. This may involve being vague about your reasoning for keeping the patient in the office, so as not to arouse agitation or escape. If the patient does leave, petitioning, as discussed previously, is recommended. If any patient becomes violent in your office, regardless of cause, it is appropriate to call the police immediately. Safety of the patient, yourself, and staff is a top priority.

WHAT IS THE EMOTIONAL IMPACT OF INVOLUNTARY COMMITMENT ON PATIENTS AND PROVIDERS?

One might imagine that patients—particularly patients with limited insight into their need for psychiatric treatment—may not appreciate being admitted involuntarily. Qualitative studies of patients who have undergone involuntary psychiatric hospitalization reveal that they can develop an internalized sense of self as "mad and bad," resulting in low self-esteem, as well as feeling stigmatized and discriminated against after discharge.[23,24] Involuntary hospitalization has also led patients to feel vulnerable and to feel that their integrity has been violated.[25] These feelings can contribute to the view that hospitalization is unjust and can have a negative impact on their therapeutic relationship with treaters.[25] Because of these concerns, involuntary admissions should be considered carefully and coercion used only in acute crises.[25] The impact of involuntary admissions on these patients is lessened when the process is implemented with respect in a climate of trust, genuine interest, and understanding and when not extended beyond use in the prevention of harm.[25]

Physicians themselves may feel conflicted about sending a patient for involuntary hospitalization. Physicians have long noted that competing demands between obligations to the patient—which most physicians regard as their primary obligation—and obligations to society create conflicted feelings.[26]

The full impact on the therapeutic relationship of involuntary hospitalization cannot be completely predicted. Patients who reflect positively on their involuntary admission (after the fact) have been thankful that their treaters pursued commitment proceedings (this positive association has also been associated with greater insight into one's illness).[27] Others have noted that the majority of patients who persistently perceive their admissions as unjust may continue to harbor negative feelings toward their treaters.[25,28] Although the impact on the therapeutic relationship may be impaired—sometimes permanently—the safety of the patient should take precedence, and referrals for commitment performed, when concerns for safety exist (as outlined previously).

CONCLUSIONS

Primary care patients who present with a serious direct or indirect risk of harm to self or others (as a result of mental illness) should be referred for commitment. Most states base their commitment statutes on this dangerousness criterion, and physicians should be familiar with the laws in their respective states. Diligent attention to psychiatric concerns (particularly with respect to dangerousness) and proper initial assessment, along with contacting authorities and understanding the commitment process, can save lives.

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