

Danger to Self or Others



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An important legal question is: when may a court force someone into involuntary psychiatric treatment? Additionally, when may a court force someone into involuntary psychiatric treatment when the patient coherently disagrees? The following sections provide an overview of the law and standards of dangerousness and behavioral health disorders, involuntary treatment, expert testimony requirements, and limitations on evidence due to privileges and confidentiality.

4.1 LAW AND STANDARDS

4.1.1 Dangerousness and Behavioral Health Disorders

This section explains the history of the involuntary treatment standard and the influence of Supreme Court decisions of the dangerousness standard.

The United States Constitution provides that no person shall be deprived of his or her liberty without the due process of law by the federal government.¹ However, persons with mental disorders present a unique challenge to due process application. While persons with mental disorders are guaranteed constitutional protections, the Supreme Court and state regulations have allowed for the government to assert its *parens patriae* powers to make decisions on behalf of the mentally ill under limited circumstances.

During the late eighteenth and into the early nineteenth century, persons with mental disorders were regularly institutionalized by physicians without judicial oversight.² However, by the mid-nineteenth century, states began adopting various and differing precursors to modern civil commitment laws.³ Thereafter, requirements for involuntary treatment lessened during the Great Depression, when, for example, many states abolished jury trials for involuntary treatments.⁴ However, in the 1960s and 1970s, advocates fought back against the lessened requirements and pushed for more adequate constitutional safeguards.⁵

The modern history of involuntary treatment arguably began in 1975 with the Supreme Court's decision in *O'Connor v. Donaldson*.⁶ In *O'Connor*, a patient, diagnosed with paranoid schizophrenia, was civility committed to confinement in a state-run mental hospital for nearly 15 years.⁷

¹ U.S. Const. Amend. V.

² Dan Moon, *The Dangerousness of the Status Quo: A Case for Modernizing Civil Commitment Law*, 20 WIDENER L. REV. 209, 212 (2014).

³ *Id.*

⁴ *Id.*

⁵ *Id.*

⁶ *O'Connor v. Donaldson*, 422 U.S. 563 (1975).

⁷ *Id.*

Although the patient repeatedly demanded release claiming that he was not dangerous, not mentally ill, and not receiving treatment, the hospital refused to discharge him.⁸ In response, the patient brought an action alleging that the hospital had intentionally and maliciously deprived him of his constitutional right to liberty.⁹ Ultimately, the Supreme Court held that in order to constitutionally commit and confine an individual, the state must show that the person is either dangerous to himself or others and that the person is not capable of living safely under the supervision of willing and responsible family members or friends.¹⁰ Furthermore, the Supreme Court reaffirmed that the nature and duration of involuntary treatment must be reasonably related to its purpose.¹¹ Although the Supreme Court has heard other involuntary civil commitment cases throughout the years, the Supreme Court has demonstrated a reluctance to alter the dangerousness standard. However, subsequent cases have sought to further clarify the dangerousness standard.

For example, in *Addington v. Texas*, the Supreme Court addressed the standard of proof necessary for involuntary treatment cases.¹² The Supreme Court held that the due process guarantees of the Fourteenth Amendment require a clear and convincing standard of proof in a state involuntary treatment proceeding.¹³ Clear and convincing evidence that a person has a mental disorder and evidence that hospitalization is required because the person poses a danger to himself or others.¹⁴ The Supreme Court reasoned that the clear and convincing evidence standard strikes a fair balance between the rights of the individual and the legitimate concerns of the state.¹⁵

In *Olmstead v. L.C.*, the Supreme Court held that unjustified segregation of persons with disabilities constitutes discrimination and is in violation of the Americans with Disabilities Act.¹⁶ Individuals institutionalized with mental disorders or disabilities are protected under the Americans with Disabilities Act and have the right to be placed in a community setting if the following three conditions are met.¹⁷ First, the State's treatment professionals must determine that the community placement is appropriate.¹⁸

⁸ *Id.* At 565

⁹ *Id.*

¹⁰ *Id.* At 576

¹¹ *Id.* At 575; *Jackson v. Indiana*, 406 U.S. 715, 738 (1972).

¹² *Addington V. Texas*, 441 U.S. 418 (1979).

¹³ *Id.* At 427.

¹⁴ *Id.*

¹⁵ *Id.* At 431.

¹⁶ *Olmstead v. L.C.*, 527 U.S. 581 (1999).

¹⁷ *Id.*

¹⁸ *Id.* At 587.

Second, the transfer from institutional care to a less restrictive setting must not be opposed by the individual, and, third, the placement must be reasonably accommodated, taking into account the resources available to the state and the needs of others with mental disorders of disability.¹⁹ The Supreme Court reasoned that the “institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable of or unworthy of participating in community life.”²⁰ The Supreme Court further provided that “confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.”²¹

Involuntary treatment generates a negative stigma that attaches to a person regardless of the merits or clinical severity of a mental disorder. The Supreme Court recognizes this stigma in *Vitek v. Jones*, where it held that adequate procedural protections such as notice, an adversary hearing, and provision of counsel are required before a prisoner may be transferred to a mental health facility.²²

The states have applied the dangerousness holdings, set forth by the Supreme Court in *O'Connor* and *Olmstead*, in different ways.²³ For example, some states include the inability to care for oneself in the dangerousness standard while other states strictly define dangerousness based on the immediacy of the threat of physical violence to the individual or others in the community.²⁴ Nevertheless, there is very little variation among the states in application of the “legitimate state interest” standard as defined by the Supreme Court in *O'Connor*. Involuntary treatment must serve a legitimate state interest and both the interest and the reasons for committing an individual must be disclosed to an appropriate tribunal.²⁵ As such, state statutes limit the length of involuntary confinement to prevent unnecessary commitment, and most statutes limit the length to one year and allow for judges to assign shorter commitments when appropriate.²⁶

4.1.2 Involuntary Treatment

Involuntary treatment is an umbrella term for any form of forced intervention, such as involuntary inpatient commitment or hospitalization, involuntary outpatient commitment, and forced medication.

State governments have enacted laws that define the standards for involuntary treatment. States may involuntarily detain and treat individuals with a mental disorder under either their police power or the *parens patriae* doctrine.

¹⁹ *Id.*

²⁰ *Id.* At 600.

²¹ *Id.* At 601.

²² *Vitek v. Jones*, 445 U.S. 480, 492 (1980).

²³ Moon, *supra*, at 210.

²⁴ *Id.* At 218-23 (comparing dangerousness factors in different states); see also Elizabeth A. McGuan, *New Standards for the Involuntary treatment of the Mentally Ill: “Danger Redefined,”* 11 Marq. Elder’s Advisor 181, 203-06 (2009); see *Olmstead v. L.C.*, 527 U.S. 581, 587 (1999).

²⁵ *O'Connor v. Donaldson*, 422 U.S. 583, 580 (1975) (Burger, C.J., concurring).

²⁶ Moon, *supra*, at 213.

In order to detain a person under police power, there must be a finding of mental disorders and dangerousness to self or others. As such, police power is used to protect the public from harm. Under the *parens patriae* doctrine, the state can assert its interest in caring for an individual who is unable to care for himself. As such, the *parens patriae* doctrine is used to protect the individual from harming himself or others.

The Supreme Court described involuntary civil commitment as a “massive curtailment of liberty” that warrants due process protection and provides that, as a result, courts must carefully balance between state authority and individuals’ due process rights.²⁷ While, historically, patients were afforded minimal rights,²⁸ modern courts now recognize and protect the rights of persons with mental disorders under the Due Process Clause of the Fourteenth Amendment. No state shall “deprive any person of life, liberty, or property, without due process of law.”²⁹ Several courts have ruled that involuntary treatment must be administered in the “least restrictive” means,³⁰ and some state statutes mandate use of the least restrictive alternative.³¹

Generally, states can confine an individual if it is shown by clear and convincing evidence that the individual has a mental disorder that poses a danger or risk of harm to self or others. Some of these statutes even allow involuntary civil commitment as evidenced purely by the person’s consumption of alcohol or other intoxicating drugs and the risk that continuing use of that substance will cause harm to the person. Because the *parens patriae* power of the states is implicated in involuntary treatment, the state legislatures are a more appropriate venue for change than the Supreme Court.

In addition to inpatient civil commitment, many states have statutes permitting outpatient commitment, or assisted outpatient treatment (AOT). AOT is the practice of court-ordering an individual with a mental disorder to adhere to a specific program of outpatient treatment as a condition of remaining in the community. AOT is often included in a court order that includes both inpatient treatment and AOT.

AOT received national attention in 1999 with New York’s passage of Kendra’s Law.³²

²⁷ *Humphrey v. Cady*, 405 U.S. 504, 509 (1972).

²⁸ See Sheldon Gelman, *Looking Backward: The Twentieth Century Revolution in Psychiatry, Law, and Public Mental Health*, 29 Ohio N. U. L. Rev. 531 (2003).

²⁹ U.S. Const. amend XIV § 1.

³⁰ See e.g., *DeAngelas v. Plaut*, 503 F. Supp. 775, 780-81 (D. Conn. 1980) (holding state statute unconstitutional “insofar as it fails to require findings... that commitment of the accused is the least restrictive alternative”); *Eubanks v. Clarke* 434 F. Supp. 1022, 1028 (E.D. Pa. 1977) (“Due process requires that the state place individuals in the least restrictive setting consistent with legitimate safety, care and treatment objectives.”) *Stamus v. Leonhardt*, 414 F. Supp. 439, 452-53 (S.D. Iowa 1976) (Finding state law unconstitutional for “failing to require that less restrictive alternatives be considered prior to ordering full-time hospitalization”).

³¹ See, e.g., Ariz Rev. Stat. § 36-540(B) (“The court shall consider all available and appropriate alternatives for the treatment and care of the patient. The court shall order the least restrictive treatment alternative available.”); 450 Ill. Comp. Stat. Ann. 5/3-811 (“The court shall order the least restrictive alternative for treatment which is appropriate.”).

³² 1999 NY Laws 408.

Kendra's Law was enacted after a man with untreated schizophrenia shoved a young woman into the path of a subway train, causing her death. The law outlines outpatient commitment standards and was enacted to ensure that individuals with mental disorders would receive the treatment they needed. As of 2015, every state except Connecticut, Maryland, Massachusetts, New Mexico, and Tennessee have enacted statutes that authorize AOT.³³

There are two basic approaches states use to define AOTs eligibility criteria.³⁴ The first approach provides separate, distinct criteria for AOT and inpatient commitment . Under this approach, the inpatient criteria focuses on the person's current dangerousness while the AOT criteria pertains to individuals who are not dangerous but have a documentable history of treatment non-compliance resulting in bad outcomes. The second, more common, approach treats all commitment as a unitary process with a single set of criteria. Under this approach, the court chooses the type of commitment, either inpatient or AOT, that is the least restrictive alternative meeting the person's particular needs.

Violation of AOT court orders generally leads to a re-evaluation of the individual's need to be involuntarily committed to the hospital.³⁵ The court order will be amended with the same procedural safeguards as the original order.

Research has shown that the use of AOT has reduced the number of arrests of people with mental disorders.³⁶ Additionally, AOT has been shown to improve patient' psychiatric outcomes, decrease hospitalization rates, decrease length of inpatient psychiatric stays, and has increased the rate of participation in community psychiatric treatment.³⁷

4.1.3 Forced Medication and Restraint

Persons with mental disorders, in certain limited circumstances, may be forcibly medicated. Forced medication is not implicit in involuntary treatment because of statutes restricting the authority to use this procedure. Several courts have ruled that involuntary medication may only be administered in emergency situations.³⁸

³³ Treatment Advocacy Center, *Assisted Outpatient Treatment Laws*, available at <http://www.treatmentadvocacycenter.org/solution/assisted-outpatient-treatment-laws>.

³⁴ See Treatment Advocacy Center, *Mental Health Commitment Law: A Survey of the States* (2014). Available at <http://www.tacreports.org/storage/documents/2014-state-survey-abridged.pdf>.

³⁵ *Id.*

³⁶ *Id.*

³⁷ *Id.*

³⁸ See, e.g., *Steel v. Hamilton Country Cmty. Mental Health bd.*, 736 N.E.2d 10, 21 (Ohio 2000) (in order to administer involuntary medication court must find that "the patient does not have the capacity to give or withhold informed consent regarding his/her treatment"); *State ex rel. Jones v. Gerhardstein*, 416 N.W.2d 883, 894 (Wis, 1987) ("While dangerousness may legitimately justify the state's authority to involuntarily commit an individual, it does not justify the abrogation of the individual's right of informed consent with respect to psychotropic drugs.").

An individual who satisfies the criteria for involuntary hospitalization does not necessarily meet the criteria threshold for involuntary medication.³⁹ For example, an individual involuntarily committed because he is a danger to his own safety cannot be forcibly medicated unless the treatment has not diminished the individual's dangerousness.⁴⁰

In addition to these statutory restrictions, other restrictions may apply in the context of guardianships and powers of attorney. In these situations, in order to forcibly medicate an individual with mental disorders by substituted judgment, it must be shown that the individual, if competent, would have chosen that course of treatment. The substituted judgment standard of decision-making for individuals who are incompetent mandates that someone who is incompetent to consent to medical treatment may be administered only those treatments that a surrogate decision-maker concludes the incompetent person would choose, if he were competent.⁴¹

When making its analysis of what the patient would want, the court considers the individual's values and preferences pertaining to the specific treatment and the medications.⁴² In particular, a great deal of attention is given to the side effects.⁴³ Historically, psychotropic drugs and anti-psychotic medications that physicians prescribed to involuntary committed patients had severe and dangerous side effects. Many cases involving the right to refuse forced medication focused on the debilitating side effects that came along with the psychotropic drugs.⁴⁴ However, since the 1990's, psychiatrists have had access to new drugs which not only better treat symptoms of psychiatric disease, but also exhibit a lower frequency of side effects than the older drugs.

Furthermore, psychiatric advance directives allow individuals to specify what treatments they do and do not wish to receive should they become incompetent.⁴⁵ All states have statutes that recognize the validity of advance directives for medical treatment.⁴⁶

³⁹ See Ariz. Rev. Stat. § 36-540(B) ("The court shall consider all available and appropriate alternatives for the treatment and care of the patient. The court shall order the least restrictive treatment alternative available."); III. Comp. Stat Ann. 450 5/3-811("The court shall order the least restrictive alternative for treatment which is appropriate."); Dora W. Klein, *Autonomy and Acute Psychosis When Choices Collide*, 15 Va. J. SOC. POL'Y & L. 355, 377 (2008).

⁴⁰ See e.g., *Myers v. Alaska Psychiatric Inst.*, 138 P.3d238, 248 (Alaska 2006); *In re K.K.B.*, 609 P.2d 747, 751 (Okla. 1980) ("IF there is no emergency, hospital personnel are in no danger; the only purpose of forcible medication in these circumstances would be to help the patient. But the basic premise of the right to privacy is the freedom to decide whether we prefer to be helped, or to be left alone.").

⁴¹ See Wash. Rev. Code Ann. § 71.05.217 ("If the patient is unable to make a rational and informed decision about consenting to or refusing the proposed treatment, the court shall make a substituted judgment for the patient as if he or she were competent to make such a determination"); Mass. Gen. Laws Ann. 201 § 14(c) (mandating a substituted judgment standard); *In re C.E.*, 641 N.E.2d 345, 355 (III. 1994) (providing that the substituted judgment standard "requires the parties to inquire into the values and preferences of the patient and attempt to make a decision as the patient would, were he competent").

⁴² *In re Guardianship of Roe*, 421 N.E.2d 40, 52, 57 (Mass. 1981).

⁴³ *Id.* At 53-55

⁴⁴ Moon, *supra*, at 231.

⁴⁵ See Justine A. Dunlap, *Mental Health Advance Directives: Having One's Say*, 89 KY. LJ 327-345 (2000).

⁴⁶ Kellen Rodriguez, *Suing Health Care Providers for Saving Lives*, 20 J. Legal Med. 1, 3 (1999)

4.1.4 Expert Testimony Requirements

Whether an individual presents a danger to himself or others generally turns on expert testimony, which is largely presented by psychiatrists.⁴⁷ In general, although there are some variations among the states, the factual threshold for the testifying psychiatrist is lower than that required in a Daubert hearing. However, strict adherence to statutory processes and procedures is mandatory.

An ongoing treatment relationship between the testifying psychiatrist and mentally ill person is not required in order to render an opinion as to the individual's potential for future violence to himself or others. Instead, a single examination conducted immediately before and pursuant to the civil commitment hearing is a sufficient basis for the expert's opinion of the individual's dangerousness.⁴⁸ Moreover, courts can even accept expert opinion testimony of the individual's potential for future dangerousness to self or others when the testifying psychiatrist has never even examined nor spoken to the accused, and the sole ground for forming the expert opinion is hypothetical questions posed to the expert.⁴⁹

4.1.5 Limitations on Evidence Due to Privileges & Confidentiality

Significant negative social stigma attaches to persons undergoing psychiatric treatment or involuntary treatment. As such, mental health records and psychotherapy treatment records are protected in a variety of ways, which include ethical obligations of providers, licensing statutes, the potential for civil liability based on negligence, the right of privacy, and testimonial privileges.⁵⁰ However, there are limits to this confidentiality and protection when there is a clear danger of a person doing harm to himself or others, such as the psychotherapist-patient privilege and other privacy rules.

In *Jaffee v. Redmond*, the Supreme Court recognized a new privilege in federal courts for confidential communications between a psychotherapist and his patient.⁵¹ The Supreme Court held that the patient's private interest in confidentiality is significant because successful psychotherapy depends on the patient's willingness to discuss "facts, emotions, memories, and fears," which if publically disclosed "may cause embarrassment or disgrace."⁵² This privilege advances important private and public interests. However, the Supreme Court mentioned one explicit exception to the privilege in a footnote which stated that disclosure of patient-psychotherapist communications may be allowed to prevent or lessen the serious imminent threat of harm to the patient or others.

⁴⁷ See *Addington v. Texas*, 441 U.S. 418, 429 (1979); see also William Hoffman Pincus, *Note: Civil Commitment and the 'Great Confinement' Revisited: Straightjacketing Individual Rights, Stifling Culture*, 36 Wm. & Mary L. Rev. 1769 (1995).

⁴⁸ *In re Brown*, 493 A.2d 447, 449-50 (N.H. 1986).

⁴⁹ See Fed. R. Evid. 703 (the advisory committee note specifically includes hypothetical questions as a permissible basis of opinion at trial).

⁵⁰ See *supra* Section 4.1.2 Involuntary Treatment; see also Steven R. Smith, *Medical and Psychotherapy Privileges and Confidentiality: On Giving With One Hand and Removing With the Other*, 75 KY. L.J. 473, 480 (1986).

⁵¹ *Jaffee v. Redmond*, 518 U.S. 1 (1996).

⁵² *Id.* at 10.

Additionally, the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule provides patients with privacy rights and protections with respect to their health information, which includes important controls over how the patients' health information is used and disclosed by health plans and health care providers. These protections are especially important when sensitive information is concerned such as mental health information. However, the Privacy Rule does provide exceptions to the protections and does allow protected health information to be shared in certain limited circumstances.

The Privacy Rule permits a health care provider or covered entity to disclose necessary information about a patient to law enforcement, family members of the patient, or other persons when the provider or covered entity believes that the patient presents a serious and imminent threat to himself or to others.⁵³ As such, when a health care provider or covered entity believes in good faith that a warning is necessary to prevent or lessen a serious and imminent threat to the health or safety of the patient or others, the Privacy Rule allows the provider or covered entity to alert those persons who are reasonably able to prevent or lessen the threat. However, the information released should always be strictly limited to information that is specifically needed to take the appropriate precautions.

The Privacy Rule also permits covered entities, such as hospitals, to disclose certain protected health information, including the date and time of admission and discharge, in response to a law enforcement official's request, for the specific purpose of locating or identifying a suspect, fugitive, material witness, or missing person.⁵⁴

Many states enacted similar statutory schemes which address, and often require, disclosure of patient information to prevent or lessen the risk of imminent harm to the patient or to others.

Furthermore, under the Federal law, 42 C.F.R Part 2 governs the confidentiality of drug and alcohol abuse treatment and prevention records.⁵⁵ These regulations set forth requirements applicable to certain federally assisted substance abuse treatment programs limiting the use and disclosure of substance abuse patient records and identifying information.

⁵³ See 45 C.F.R. § 164. 512(j).

⁵⁴ See 45 C.F.R. § 164-512(f)(2).

⁵⁵ See *infra* Chapter 5: Privacy, Security and HIPAA.

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