CHAPTER TWO

2. LITERATURE REVIEW

2.1 THE INTERNATIONAL PERSPECTIVE ON INVOLUNTARY COMMITMENT

International literature on the subject of involuntary commitment is scarce. Despite the international growth of debate on mental health law, sound data relating to the international practice of involuntary commitment also remain scarce. Only a few countries have published data comparing involuntary commitment in their countries with involuntary commitment in others (31). The causes of dramatic differences in compulsory admission rates or quotas are the varied definitions and methods adopted by the national health departments or statistical bureaux of different nations. The reviewed literature suggests that this subject is a contentious issue in many countries throughout the world; particularly in the United States of America. Furthermore, it indicates that the rates of involuntary placement or treatment of people with mental illness are widely considered to be an indicator of underlying characteristics of national mental health laws or other frameworks (31).

Civil commitment standards tend to influence the type of patient who would be admitted to a mental institution. Segal (32) looked at the patient mix in England, Wales, Italy and the United State of America, and at their civil commitment standards. He found that although the three countries shared a common policy of reducing institutionalisation, their mental health systems differed considerably.

Each country's civil commitment standards defined patient eligibility criteria in accordance with one of two primary dimensions: need for treatment or degree of dangerousness. The differential in selection criteria had resulted in differences between mental health systems, serving different subgroups of the total population. The criteria in England and Wales targeted older women; in the United States, younger men; in Italy, a group balanced in age and sex.

Furthermore, the data on civil commitment for these countries, as analysed by Segal (32), indicate that it is necessary to understand the health and social service system of a country and its cultural context, in order to comprehend the full impact of civil commitment criteria on patient mix. He concluded that regardless of context, however, the substance of the criteria had a clear and specifiable impact on the demographic character of the patient population. In addition to this, patient mix or group composition affected treatment strategies, service outcomes and social context of the in-patient facilities.

Paul S. Appelbaum (7) in his 1997 paper, "Almost a revolution: an international perspective on the law of involuntary commitment", noted that a number of countries had emulated the United States to some degree, in adopting the dangerousness-based commitment criteria. These included countries such as Australia, Belgium, Germany, Israel, The Netherlands, Northern Ireland, Russia, Taiwan, and Canada. Many more countries had altered their civil commitment procedures to increase the procedural protection of patients who were subject to

involuntary hospitalisation, without specifically adopting the dangerousness criterion as the only basis for civil commitment. An example is England/Wales whose 1983 mental health legislation laid down the procedures for post commitment reviews and provided for the commitment of patients who met the criterion of suffering from a mental disorder “of a nature or degree which makes it appropriate for them to receive treatment in a hospital” and in whose case admission was necessary for their own health and safety and the protection of others. The provisions of this legislation in England and Wales are comparable with those of the South African Mental Health Act, No. 18 of 1973, in terms of criteria for certification; except that the South African Act made no provision for post-commitment reviews. These have, however, been catered for in the soon-to-be-implemented Act No. 17 of 2002.

Appelbaum (7) further observed that extensive data from the United States and more limited data from other countries suggested that reforms are generally resisted when they are seen as shifting the focus away from patient treatment needs. When the law fails to reflect widely held moral sentiments, the general practice is to remould it to conform more closely to them. He also noted that a variety of approaches to mental health law are consistent with reasonable protection of civil liberties in a democratic society. The key to understanding the difference between commitment law as written and its practice is to recognise that laws are not self-enforcing. The responsibility for implementation of involuntary hospitalisation is delegated to a variety of participants in the commitment process,

each of whom affects how the law is applied (7). This explains why it is possible to commit patients inappropriately to institutions, despite the requirements of the law.

The United States of America's experience with regard to civil commitment laws deserves special emphasis because it explains the social momentum that propelled legislators to make dramatic changes in the commitment laws. Moreover, debates about the civil commitment laws and their accompanying interventions have gone full cycle. The benefit of hindsight allows for objective assessment of their experience regarding commitment standards and procedures, and of what could be practically achieved with reforms in commitment laws.

Before the late sixties and the early seventies, a mentally ill person in the United States could easily be committed to a mental institution under the *parens patriae* duties of the state and the policing powers of the state could easily be invoked to achieve a similar objective without major problems. These days, however, this can no longer be done unchallenged. The principle of *parens patriae* arose from the perception that the state was the guardian of all of its citizens and, therefore, would have a benevolent interest in caring for those who were unable to look after themselves. The policing powers of the state are based on the duty of the state to protect its citizens and society at large from dangerous individuals (25, 29, 35).

In the early 1970's there was a shift in the U.S. Civil commitment laws and criteria. Changes occurred in three areas: the substantive criteria, the period of

confinement and procedural due process (19,25). First, the legislators changed the substantive criteria for civil commitment from something like being “in need of treatment by reason of mental illness” to something like being “mentally ill and as a result of that illness dangerous to oneself or others”. Thus the dangerousness standard was added as a new requirement for civil commitment (23). The factors that led to this shift included a series of court decisions, which negated the need for treatment criteria in civil commitment as being too vague and broad and potentially leading to inappropriate commitment of individuals. The emergence of strong libertarian movements that advocated on behalf of patients’ rights to liberty and dignity, and against the stigma attached to mental illness, the poor conditions found in the state psychiatric hospitals and the limited treatment options with poor therapeutic outcomes, which prevailed then, also contributed to this shift.

From the liberal civil perspective, the rationale undergirding this change was that people had a right to be different; that it was difficult to distinguish between difference, deviance and mental illness, and that even the presence of significant mental illness did not necessarily entitle the state to abridge liberty. It was anticipated by the advocates for these changes that the purview of civil commitment would be substantially narrowed by the addition of the dangerousness criterion. The dangerousness criteria stipulate that mentally ill persons could only be civilly committed if:

- they posed danger to themselves;
- they might endanger others;

- they were gravely disabled (35).

The legislators then changed the period of civil commitment from an indeterminate period with laws approximating “so long as treatment shall be deemed necessary by the treating physician”, to a relatively determined period. The rationale behind this change was, so the advocates argued, that civil commitment constituted a massive intrusion into liberty and thus, needed to be sharply delimited. The reformers, moreover, believed that the burden of perpetuating civil commitment should be placed explicitly on the state, to ensure that all ambiguities would be resolved in favour of the liberty of the person committed (23). Again, the proponents believed that such change would markedly shorten the duration of the committed person’s hospitalisation. Some hoped that if that period were truncated, more resources would be available to the patient during hospitalisation.

Thirdly, first the legislators, and later the courts, enshrouded commitment laws with a panoply of due process provisions designed to safeguard the rights of those civilly committed (23). The mental health legislation of most states enshrined revisions such as those that:

- required a prompt probability hearing;
- specified thorough judicial review before final commitment;
- endorsed the rights of competent patients to refuse medication;
- endorsed patients’ rights to adequate treatment;
- made provision for the least restrictive alternatives (5,16,35).

> The apparent reasoning behind this increased move towards due process protection was that in commitment hearings, the social momentum favoured the state. With these procedures in place, the reformers believed, unwarranted civil commitment would be curtailed.

Concerns about the shift to dangerousness criteria as the sole basis for civil commitment of mentally ill persons came from a number of sources. These included amongst others clinicians, families of the mentally ill, lawyers and administrators. In 1985 Treffert (35), a physician, observed that the changes in mental health laws, together with due process revisions, meant that in almost every state, jurisdiction governing involuntary hospitalisation of the mentally ill became predicated solely on dangerousness: suicidal threats or behaviour, or homicidal threats or behaviour and inability to meet basic living needs of food, clothing and/or shelter. Provisions for the state use of *parens patriae* powers in the absence of dangerousness narrowly defined were effectively abolished: the pendulum swung entirely to using dangerousness, in terms of imminent physical harm, as the only basis on which the state could infringe upon individual liberty. Treffert felt that the pendulum had swung too far and generally affected adequate treatment of mentally ill. Those concerned generally accepted the need to protect the rights of mentally ill people, while also observing that a number of problems had arisen as a result of this shift. These problems compromised adequate treatment and rehabilitation of the mentally ill.

Concern was expressed about the notion of dangerousness itself: in practice defining what constituted dangerousness was difficult. The courts, in their adjudications on this matter, did not clearly state what they meant and it was left to clinicians to define and assess the degrees of potential dangerousness. To demonstrate the problem, Rachlin (28) reviewed 12 Appellate Court decisions from seven states, selected from published legal literature. His article focused on the degree of dangerousness that experienced judges had found acceptable for commitment. It revealed that different judges had perceived what constituted dangerousness, differently. For example, one court had held that a patient who merely lacked sufficient judgement to protect herself from the hazards of the world demonstrated a serious risk of harm whereas in another, telephonic threats made by a patient, which were said to be not serious, had been nonetheless considered sufficient grounds for commitment after being paired with a psychiatric opinion that she was mentally ill and dangerous.

Yet another court had required proof beyond reasonable doubt, based on physical fact or evidence. In one instance hearsay concerning patient threats to shoot someone had been accepted, even though he had not attempted to carry out the threats and had denied making them. On the basis of the varied approaches used by the courts in determining what constituted dangerousness, Rachlin (28) concluded that “danger like beauty is in the eyes of the beholder” and its practical meaning is not restricted to overtly violent behaviour. He posited further, that

presuppositions about how a judge will adjudicate have no place in clinical decision-making.

Moreover, the view was held that inherent difficulties existed in predicting dangerousness and that even psychiatrists were unable to predict dangerousness accurately. In 1981, Monahan (27,37) concluded that clinicians were wrong in two thirds of their predictions of potential violence. Later, in his appraisal of 1997, he concluded that clinicians had a better than chance ability to predict violence and that epidemiological studies had demonstrated that mental illness was only a modest risk predictor of potential violence. Zito (37) reached a conclusion more optimistic than Monahan's, suggesting that "at least one in two short-term predictions of dangerous behaviour are accurate", that even better predictions were feasible if non-traditional predictors were used and if a specific subset of the mentally ill population were considered.

Reliance on the dangerousness criteria meant that mentally ill persons who were not yet dangerous, unable to make treatment decisions but in need of treatment could not be helped and remained untreated until they had deteriorated to a point of dangerousness, become criminalised and been booked for vagrancy, public disturbance or other offence. They could also remain neglected in the streets and alleys of America and could even die unnoticed while their "rights" remained intact (18,35).

Consequently, dangerousness was blamed in part for homelessness amongst mentally ill populations. A survey of literature suggests that approximately one third to one half of homeless persons were suffering from severe and persistent mental disorders and another third, from disorders related to substance abuse. A considerable overlap between the two categories was found to exist (6).

Futhermore, the reliance on dangerousness criteria backfired in the fight against stigma attached to mental illness. It stigmatized mentally ill people as dangerous although of the mentally ill, only a small number may be dangerous (especially when these are not treated). To demonstrate this a review of relevant literature (27) showed that in 1950, 7.2 percent of respondents to questionnaires related to perceptions associated with mental illness had mentioned violence in describing a person with mental illness, but only 4.2 percent of that subgroup had used “dangerous to self or other” language in their descriptions. In 1996 12,1% of respondents had mentioned violence in their descriptions and 44% of them had used language indicating “dangerousness”. The 44% sub-group accounted for the increased total percentage of respondents associating violence with mental illness.

Clinicians were concerned about the intrusion of due process upon clinical decision-making. They pointed out that “dangerousness” was not necessarily a psychiatric term, nor was it the main focus of clinical practice. They viewed it as a legal concept imposed on them, broadly reducing their role of clinicians concerned with mental illness and potentially converting their functions to those of “jailers” of

dangerous individuals threatening society's safety. They felt that the ethical and effective practice of psychiatry required more than the implementation of police powers of the state and the imposition upon practice of the concept of danger (27). Furthermore, they noted that the procedures for civil commitment were time consuming and costly in terms of the clinicians' and courts' time required and the personnel involved with these procedures. Delayed judgements, inherent in these procedures, meant that patients would remain untreated unless an emergency arose. Treatment delayed was treatment denied.

Lastly, the administrators complained that their hospitals were filled with dangerous individuals. These often had psychopathic personalities, were generally refractory towards therapeutic interventions and lacked treatable mental illness. Their institutions had thus been turned to prisons for preventive detention of persons whom society deemed dangerous and undesirable. In this context, psychiatry had become a tool of social control, expected to identify, raise alarm about, and then detain these individuals (27).

Against the background of difficulties and challenges that had arisen from the shift to the dangerousness criterion for civil commitment, attempts were made to find solutions for them. The first of these came from Stone (15), who suggested use of the following commitment criteria to address the needs of mentally ill people:

- a reliable diagnosis of a severe mental disorder must be made;

- the immediate prognosis for the patient must be one of major distress;
- effective treatment must exist;
- the patient must offer an incompetent refusal of treatment and
- the proposed treatment must meet a test of reasonableness: it must be such that a reasonable person in the same situation would accept the proposal.

Stone's commitment criteria later formed the basis for the American Psychiatric Association's model for law on civil commitment.

In 1983 the American Psychiatry Association (APA) published standards and procedures for civil commitment, approved by its assembly in 1982 (3,35). In summary, under these statutes, involuntary commitment could occur if the person:

- either refused or was unable to consent to voluntary admission for treatment;
- lacked the capacity to make an informed decision concerning the treatment;
- as a result of the severe mental illness, was likely either
    - to cause harm to himself or suffer substantial mental or emotional deterioration or
    - to cause harm to others.

The APA's model, unlike Stone's original proposal retained a modified version of the traditional criteria of dangerousness but added a treatment-oriented criterion that focused on patients' distress and deterioration and required evidence of

incompetence to decide on treatment. These alternative procedures were designed to effect a move away from reliance on dangerousness as the sole commitment criterion. The APA's commitment law was criticized for adding the deterioration standard. Critics felt that it would lead to inappropriate civil commitment of mentally ill persons. It was also criticized for doing away with legal safeguards and for granting immunity to clinicians involved in these procedures (30).

Treffert (35), to address the needs of mentally ill people who were excluded from involuntary commitment by the dangerousness criteria, proposed a fourth criterion for commitment in addition to the three related to dangerousness. This standard, meant to cater for the obviously mentally ill person in need of treatment, incorporated the following conditions:

- The person is unable to make informed decisions regarding treatment and evidences a substantial probability of serious mental illness or emotional deterioration unless treatment is provided and
- is incapable of expressing an understanding of advantages and disadvantages of accepting treatment and alternatives to the particular treatment offered, after advantages and disadvantages and the alternatives have been explained to the individuals.

Another proposal intended to remedy the challenges arising from reliance on the dangerousness criteria included changes in guardianship laws and commitment to outpatient treatment. The guardianship laws in some states were changed to empower the guardian to make treatment decisions on behalf of a mentally ill person. This could happen after the mentally ill person, following examination and a hearing with appropriate due process safeguards, was found to be incompetent and a guardian was appointed for him (6,35). Outpatient commitment in practice mainly targeted those "revolving door" chronically mentally ill patients who had previously been involuntarily committed and stabilized and no longer met the dangerousness criterion for commitment. These patients would soon after release stop their medication and stop going for treatment, which led to relapse and eventually, to their becoming dangerous. To reduce their chances of becoming dangerous and requiring involuntary hospitalisation, outpatient commitment allowed the state to intervene on behalf of these "revolving door" patients by compelling them to receive treatment in their communities to avert the possibility of their becoming dangerous (13).

The literature reviewed above demonstrates difficulties inherent in determining the appropriateness of certification criteria for admission to psychiatric hospitals. It further indicates that subjective influences and perceptions play a role in making such decisions and shows that regardless of fairly defined standards and procedures, reaching consensus about who should be certified for admission to a psychiatric hospital is difficult. This is the experience in many countries in the

world; especially in the USA, where debate around these issues has been rigorous. It is also clear from the literature review, that changing commitment laws does not necessarily lead to the desirable improved care of the mentally ill but may lead instead to more questions than answers. There are unforeseen problems in process and no approach is foolproof. It is through a process of continual engagement amongst clinicians, mentally ill people and their families, legislators, administrators, the justice system and other relevant stakeholders that a reasonable consensus which best approximates the desires and wishes of those concerned can be achieved in an ethical way. In practice, clinicians have to create a balance between protecting the rights of mentally ill people and their treatment needs.