

Mental Health Law and Civil Commitment: Litigation and the Need for Further Reform

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I. Introduction

It has been nearly nine years since there have been any significant changes to mental health laws governing civil commitments in the Commonwealth of Massachusetts. Those changes instituted procedural rather than substantive amendments to the civil commitment process. Following the trend of prior reforms, emphasis remained on patients' due process rights in the context of expanding enumerated patients' rights and more stringent filing requirements.¹ Existing patient rights in the civil commitment process seemed strengthened with reduced periods for filings designed to speed up the process and improve outcomes for patients. Since then there has been some progress and there have been some pitfalls. Additionally, there is still a need for substantive reform in the practice of mental health law and civil commitments, particularly as it relates to the non-dangerous patient. This article briefly summarizes the modern history of civil commitment in the Commonwealth of Massachusetts, the most recent reforms, and the continuing practical shortcomings in existing mental health law litigation and the treatment of non-dangerous patients facing commitment.

II. History Of Modern Mental Health Law And Civil Commitments

Chapter 123 of the General Laws of Massachusetts was intended to make mental health laws and regulations adaptable to changing conditions and to advances in methods

of care and treatment of the mentally ill.² Modern mental health law has rapidly advanced since the late 1960's and early 1970's. Prior to that time, the prevailing point of view toward mentally ill patients was vividly captured by the holding in *Inhabitants of Amherst v. Inhabitants of Shelburne*, where the Supreme Judicial Court ("SJC") stated, "[a] commitment of a lunatic to a hospital by a judge need not be in open court, nor be recorded."³ Mental illness, in general, was something that was repressed and not discussed in public. The stigma of psychiatric hospitalization to the individual patient, and derisive terms such as "lunatic", "insane asylum" and "demonic possession" were commonly used and accepted regarding the mentally ill. This view broadly pertained to all mentally ill patients, even those considered not dangerous. The focus of modern mental health law has centered on the patient's rights to due process rather than treatment. This focus has evolved from the government's strict *parens patriae* approach – where the state, acting in its role as parent for those in need, serves as the decision-maker for the patient from commitment through treatment – to the more relaxed approach of individual liberty. The development of due process regarding modern civil commitment provides for the patient, where possible, to decide for him or herself the need for admission to a mental health facility and treatment.

The law has increasingly recognized due process rights of mental health patients who have been admitted involuntarily to a mental health facility.⁵ This increased emphasis

on civil rights arose in response to mental health confinement horror stories which were discovered to exist as recently as several decades ago.⁶ Further, coinciding with the civil rights movement as well as advances in modern medicine helped place more of an emphasis on due process. Significant changes in mental health law have evolved as a result, including the landmark decision by the United States Supreme Court in *O'Connor v. Donaldson*.⁷ *O'Connor* established a dangerousness standard for commitment of the mentally ill.⁸ Massachusetts, in the decision in *Thompson v. Commonwealth*, adopted the standard in *O'Connor*.⁹ In *Thompson*, the SJC made it clear that the dangerousness standard elucidated in *O'Connor* would apply to Massachusetts civil commitment proceedings, stating that the Commonwealth cannot constitutionally confine a non-dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.¹⁰ The SJC recently affirmed the primacy of due process in its recent decision in *Newton-Wellesley Hospital v. Magrini*.¹¹ There, the SJC further extended procedural protections to patients by stating a broader interpretation of a patient's right to an emergency hearing under the commitment statute, pointing out that attempts by the hospital to circumvent the statutory scheme were precisely what the statute was intended to prohibit.¹²

III. The Most Recent Statutory Changes

In 1998, the Massachusetts Department of Mental Health (DMH)

promulgated regulations creating a patient's bill of rights detailing a number of specific obligations a facility had to offer and apprise a patient of, adding due process protections.¹³ In 2000, Acting Governor Swift signed into law an amendment to G.L. c. 123, § 12 which significantly reduced the amount of time a psychiatric facility could hold a patient without the necessity of petitioning for intervention/action by the courts.¹⁴ Governor Mitt Romney signed a further amendment in 2004 modifying the timeframes slightly but not significantly altering the impact of the 2000 legislation.¹⁵

Prior to the two most recent amendments, a psychiatric facility could hold a patient under Section 12 for a period of up to ten (10) days before having to file a petition for civil commitment with the District Court.¹⁶ This period was reduced to four (4) days by the 2000 amendment and then three (3) days in 2004.¹⁷ Prior to the amendments a hearing had to be scheduled within fourteen (14) days of a petition being filed.¹⁸ The 2000 amendment lowered this period to four (4) days and then extended it to five (5) days under the 2004 amendment.¹⁹ Both in theory and in practice, the state of the law before the amendments allowed facilities and psychiatrists sufficient time to evaluate mentally ill patients to determine the degree of their mental illness and what risks and/or dangers a patient posed to himself, herself or others. The net effect of the amendments reduced the timeframe for an evaluation from up to twenty-four (24) days down to eight (8). The twenty-four (24) day period most often times resulted in a patient's discharge prior to hearing, particularly in those instances where patients were compliant

with treatment recommendations and/or a more appropriate setting/placement became available. In practice the more stringent requirement of filing a petition for commitment within three (3) days has resulted in the filing of more commitments and placed a strenuous burden on facilities and psychiatrists which in some respects, although captioned in favor of patient's civil rights, has been detrimental to the facilities' ability to treat the patient's illness.²⁰

No one argued vehemently against shortening the existing timeframe for filing as proposed by the 2000 amendment. However, the significance in the reduction increased the pressure on psychiatrists and psychiatric facilities, already overburdened and underfunded, to assess the mental illness and dangerousness of a patient with little or no additional information beyond the patient's presentation. Practitioners were more accustomed to using the longer period of time allotted before passage of the amendment to gather historical and medical information on the patient or to simply observe the patient in the Mental Health Unit in order to make a more practical assessment or proper diagnosis of the patient's mental illness, the patient's substantial likelihood of harm to himself, herself or others, and the appropriate treatment.

The result of the changes in the law with respect to psychiatric admissions was an increase in the number of petitions filed and the number of petitions actually heard by the courts.²¹ While the intent of the amendments – placing more emphasis on the patients by affording him or her more rights – was correct with universal concurrence, the impact of the amendments made it more dif-

ficult for the patient to receive effective care and treatment for his or her mental illness. By mandating use of a criminal standard for a civil commitment process of a mentally ill patient, the illnesses of the patient is secondary to the procedural aspects of filing a petition for civil commitment based upon a shorter timeframe. The three (3) day filing timeframe heightens the inherent sense of distrust of involuntarily confined, mentally ill patients by fostering a more adversarial process between the patient and caregivers.

The barrier to treatment is profound when the psychiatrist in the psychiatric facility, already perceived as the enemy, is now confirmed as the same upon the filing of the petition. Further exacerbating the adversarial nature of the psychiatrist-patient relationship is the requirement that a psychiatrist inform the patient that any information he or she shares with the psychiatrist may be used in a commitment hearing against the patient.²² The ability of the psychiatrist to develop a relationship with his or her patient and to garner the patient's trust has been hindered by the process. Once the petition is filed, counsel is appointed for the patient, and the facility and the patient are now adversaries in litigation, with conflicting goals. The expressed goal of patient's counsel is to obtain a patient's release under any circumstances, whether in the patient's best interests or not.²³ The opposing side consists of the psychiatrist in the psychiatric facility, with the help of counsel, seeking to treat a patient in what it perceives to be in the patient's best interests. In the middle is the court trying to navigate through the adversarial process and in much less time.

IV. Civil Commitment Practice

Where medicine has made significant advances in the care and treatment of the mentally ill, the law has not progressed as swiftly particularly as it relates to litigation. This lag has effectively counteracted medical advances by treating civil commitments in some ways as analogous to criminal proceedings. There is general agreement that a patient involuntarily confined to a mental health facility should be afforded civil rights equivalent to or greater than those of a criminal defendant. The law needs to more adequately address the purpose and timeframe of confinement associated with a civil commitment. Specifically, a civil commitment should not be seen as equivalent to a criminal proceeding and punitive but rather a civil one with the goal of effective treatment and discharge.

Equating civil commitment in its broader sense with criminal confinement has confused the process for all the parties involved and unnecessarily increased stigmatization of the mentally ill. Part of the conflation of civil and criminal processes is due to the similarity of nomenclature and criteria in statutes and regulations. In practice terms, the statutory and regulatory terminology creates the misperception of mental illness than is the actual practice in the courts. The headings of the pertinent sections under Chapter 123 reference proceeding to commit dangerous persons.²⁴ These same sections are the bases upon which facilities seek to commit non-dangerous patients categorizing such patients as "dangerous" due to the degree of their impairment.²⁵ More specifically, the statute provides for the court to find the likelihood of

serious harm if there is a very substantial risk of physical impairment or injury to the person himself as manifested by evidence that such person's judgment is so affected that he is unable to protect himself in the community and that reasonable provision for his protection is not available in the community.²⁶ The statute makes little distinction between being dangerous to oneself and being unable to live safely in the community.²⁷

In theory, the standard of proof on the mental health facility in a civil commitment is the same as the burden on the state in a criminal trial, proof beyond a reasonable doubt.²⁸ Under this most stringent of burdens, one would presume that a majority of non-dangerous patients would prevail in a civil commitment proceeding. It is this writer's experience, however, that it is the facility which prevails on nearly every occasion. This is due at least in part to the court acting more as arbiter/mediator in commitment hearings with recognition of the need for treatment in deference to due process rights. The court has shown in case after case that it will hear all of the evidence taking into account what is in the patient's best interests and balancing the patient's opposition to confinement with his or her need for treatment. The court purportedly takes this position as a matter of practical need because of the inherent conflict of either confining a patient to a mental health facility or releasing him or her to the community without services which in nearly all cases they appear to need. The court is not being dismissive of the patient's civil rights, but rather is sensitive to addressing those rights without the necessity of repeat involuntary confinement of a patient who is mentally ill; thereby consuming further resources for

adversarial litigation rather than focusing on effective treatment and possibly shorter terms of confinement.

There are those who profess strict adherence to patients' civil rights and advocate for discharge from the hospital in every instance.²⁹ These advocates have opined that there is a lack of due process afforded to involuntary confined mentally ill patients.³⁰ They cite the location of the hearing (usually at the hospital), the patient's appearance at the time of hearing, and the fact that the patient may be medicated at the time of hearing as factors weighing against a patient's release rather than affording the patient a fair opportunity to be heard in accordance with due process.³¹ Patients are afforded a number of procedural remedies under Chapter 123, many of which are analogous to those available in a criminal matter.³² However, these same advocates when appointed to represent a mentally ill patient, often fail either to seek an independent psychiatric exam or, even when an independent psychiatric exam is obtained, fail to advocate in the patient's best interests when the independent psychiatric examiner agrees with the facility. Such advocacy, although zealous and part of counsel's charge, is arguably not in the patient's best interests and, in many cases, is detrimental based on the stigma of the findings relative to the adversarial hearing process.

The process typically subjects the patient to an order of commitment with the stated findings that the patient is mentally ill and a danger to himself, herself or others.³³ This is in opposition to the patient's need for treatment exacerbated by the patient's view of his/her treating psychiatrist as an adversary and

not as a therapist.³⁴ There is a direct contradiction between the law in practice and effective medical treatment for the mentally ill. In its strictest sense, the law cannot favor treatment of mentally ill patients because treatment is subjugated to due process.³⁵ As stated by Justice Learned Hand, litigation is one of the worst things that can happen to a person except for illness and should be dreaded.³⁶ Respondents in civil commitment proceedings must unfortunately confront both these troubles simultaneously. Due process, though important, presents a barrier to treatment because it forces all parties in the mental health setting to engage in litigation.

V. The Need For Further Reform

Advances in psychiatric medicine as well as safeguards by law have relegated the idea of locking up patients who are mentally ill and throwing away the key, as discussed in the civil context herein, to an antiquated notion. Even with these advances, medicine, particularly psychiatric medicine, is still nowhere near an exact science. Any focus on mental health law has waxed and waned depending on the political climate and the ever increasing competition for funding. Most often, the issue is not addressed until such time as a sensational, catastrophic event such as the Virginia Tech shooting occurs. The issue of reform with regard to civil commitments has been out of vogue for the greater part of this decade.³⁷ Therefore, there is still a need for reform with respect to mental health law and civil commitments with an emphasis on treatment of the patient without sacrificing due process rights.

One remaining area for reform is the role of a less restrictive alternative placement in commitment proceedings. This criterion has not been clearly defined by the Legislature or courts, and guidance from DMH is lacking. Most other jurisdictions have implemented this protection through authorizing other forms of involuntary treatment beyond simply inpatient commitment and some of which are referenced herein.

In Massachusetts, the legal criteria for civil commitment are several.³⁸ The patient must be determined to have a mental illness.³⁹ The patient must demonstrate a substantial likelihood of harm to himself or herself or others if discharged or must be so impaired that they are deemed a very substantial likelihood of harm to themselves if discharged.⁴⁰ Lastly, there must not be any less restrictive alternative settings to commitment.⁴¹ Of these criteria for commitment, the most confusing is the last, a determination whether there are any less restrictive alternative settings to commitment. There are not many alternatives, if any, particularly where the patient presents as a substantial likelihood of harm to himself or others. The term “less restrictive alternative setting” is ambiguous and vague, and neither the Legislature, nor the courts, nor DMH has taken occasion to define or clarify this term. Courts have stated the facility must find the least burdensome means of restraint that will protect the patient and others from physical harm, while providing rehabilitation for the patient.⁴² The practical aspect is that facilities petitioning for involuntary commitment are doing so because they had insufficient time to properly evaluate a patient’s fitness for discharge, or they simply

have no place for a patient clearly in need of treatment to go to.

Numerous other jurisdictions have been able to carve out a less restrictive alternative to involuntary in-patient commitments. A large number of states have adopted or incorporated into their mental health law legislation the concept of involuntary outpatient commitment.⁴³ Unlike inpatient commitment, outpatient commitment has been defined as a judicial order entered pursuant to a state’s civil commitment scheme, which compels a person to participate in mental health programs and to comply with a court-approved treatment regimen outside of the walls of a mental institution.⁴⁴ This eliminates, at least temporarily, the concerns associated with any “massive curtailment” of the patient’s liberty.⁴⁵ Another novel concept, most recently employed in the state of Wisconsin, has modified the criteria for commitment to include care based on a patient’s need for mental health services.⁴⁶ This modified commitment standard allows for a maximum inpatient treatment period of thirty (30) days.⁴⁷ Massachusetts allows for commitment for up to six (6) months for a first commitment and an even longer period subsequently. It then requires the patient to be discharged to conditional outpatient treatment.⁴⁸ The Wisconsin statute has a number of other criteria and procedural safeguards which need to be met but the idea offers an alternative to the prolonged periods of commitment authorized by statute in many states, including Massachusetts.⁴⁹

VI. Conclusion

The concepts described above offer a buffer to the adversarial process of involuntary inpatient commitment which may soften the stigma

associated with commitment, including a court declaration of mental illness. Perhaps the time for these concepts has arrived in Massachusetts. The current state of the law, subsequent to the statutory changes and the ever-increasing liability exposure for psychiatrists and mental health facilities, has seen the number of civil commitment petitions filed annually since 2000 more than double.⁵⁰ Clinicians' increasing liability for the violent actions of their patients, even before the most recent amendment, has forced evaluations to err on the side of commitment.⁵¹ The concepts, such as outpatient commitment, can be adopted in Massachusetts, affording patients not only more due process rights, but also a likely reduction in inpatient involuntary commitments in a manner beneficial to the patient, the psychiatric facility and the court.

1 G.L. c. 123, §§ 7 & 12.

2 G.L. c. 123, § 2.

3 77 Mass. 107 (1858).

4 Stavis, Paul F., "Civil Commitment: Past, Present and Future", *Quality of Care News*, Issue 64 (1995).

5 See generally, *Humphrey v. Cady*, 405 U.S. 504 (1972); *O'Connor v. Donaldson*, 422 U.S. 563 (1975); *Thompson v. Commonwealth*, 386 Mass. 811 (1982); *Newton-Wellesley Hospital v. Magrini*, 451 Mass. 777 (2008).

6 See *O'Connor*, *supra* (non-dangerous patient held for 15 years without treatment).

7 *Id.*

8 *Id.*

9 386 Mass. 811 (1982).

10 *Id.* at 816, quoting *O'Connor v. Donaldson*, *supra*, at 576.

11 451 Mass. 777 (2008).

12 *Id.* at 784.

13 104 CMR 27.00 *et seq.*

14 St. 2000, C.249, §5.

15 St. 2000, c. 249, §§ 4 to 8.

16 St. 1992, c. 379, § 29.

17 St. 2000, c. 249, §§ 4 to 8.

18 St. 1992, c. 379, § 29.

19 St. 2000, c. 249, §§ 4 to 8.

20 Robert D. Miller, Ph.D., "Grievances and Law Suits Against Public Mental Health Professionals: Cost of Doing Business?", *Bull. Am. Psychiatry Law* 20:4 (1992).

21 *Id.*

22 *Commonwealth v. Lamb*, 365 Mass. 265 (1974).

23 Committee for Public Counsel Services Performances Standards 1; see also Note 18, *supra*.

24 G.L. c. 123, §§ 7 & 12.

25 *Id.*; see also generally G.L. c. 123, § 1.

26 G.L. c. 123, § 1.

27 See J. Parry, "Involuntary Civil Commitment in the 90's", 18 *Mental & Physical Disability L. Rep.* 320, 324 (1994).

28 *Commonwealth v. Nassar*, 380 Mass. 908 (1980).

29 Note, The Search for Due Process in Civil Commitment Hearings: How Procedural Realities Have Altered Substantive Standards, 61 *Vanderbilt Law Review* 959 (2008).

30 *Id.*

31 *Id.*

32 G.L. c. 123, §§ 5 & 9.

33 G.L. c. 123, § 8.

34 It is the treating physician who provides the substantive testimony against his patient.

35 Note, *supra* at note 18.

36 Fred R. Shapiro, "The Oxford Dictionary of American Legal Quotations" 304 (1993), quoting "The Deficiencies of Trials to Reach the Heart of the Matter", *Lectures on Legal Topics* 89, 105 (1926).

37 Joseph D. Bloom, M.D., "Thirty-Five Years of Working with Civil Commitment Statutes". *J. Am. Acad. Psychiatry Law* 32: 430-9 (2004).

38 G.L. c. 123, §§ 1 & 8; *Commonwealth v. Nassar*, 380 Mass. 908 (1980).

39 G.L. c. 123, § 8.

40 G.L. c. 123, §§ 1 & 8.

41 *Commonwealth v. Nassar*, 380 Mass. 908 (1980).

42 *Id.* at 918.

43 Elizabeth Dickinson Furlong, "Coercion in the Community: The Application of Rogers Guardianship to Outpatient Commitment", 21 *New Eng. J. on Crim. & Civ. Confinement* 485 (1995).

44 *Id.* at 486.

45 *Newton-Wellesley v. Magrini*, 451 Mass. 777, 784 (2008).

46 1995 Wis. Act 292.

47 *Id.*

48 *Id.*

49 G.L. c. 123, § 7.

50 The Boston Municipal Court had approximately 58 civil commitment petitions filed in 2000. As of December 1, in excess of 121 petitions had been filed for 2008.

51 Robert D. Miller, Ph.D., "Grievances and Law Suits Against Public Mental Health Professionals: Cost of Doing Business?", *Bull. Am. Acad. Psychiatry Law* 20:4 (1992).