Statutory Definitions of Mental Illness for Involuntary Hospitalization as Related to Substance Use Disorders

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Objective: **In New York City, individuals gravely disabled by substance use disorders repeatedly present to emergency rooms yet rarely remain in treatment for more than several days and often sign out against medical advice. Although these individuals are at high risk of death and often lack the capacity to make treatment decisions, the laws in New York State are unclear about whether substance use disorders qualify as mental illnesses for the purpose of involuntary hospitalization. To better understand the national landscape of civil commitment law, with a specific focus on substance use disorders, a review was conducted of mental health statutes in all 50 states and the District of Columbia (D.C.).** ***Methods:*** **Two independent reviewers examined all state mental health statutes using LexisNexis and Westlaw search engines.** ***Results:*** **A total of 22 states, including D.C., do not reference substance use disorders in their statutory definitions of mental illness. Of the 29 that do, eight include substance use disorders and 21 explicitly exclude them. In addition, nine states have separate inpatient commitment laws specifically addressing substance use disorders.** ***Conclusions:*** **Civil commitment statutes vary greatly by state in terms of clarity and specificity regarding which mental illnesses are included for the purpose of involuntary hospitalization. Mental health professionals and policy makers should discuss whether individuals gravely disabled by substance use disorders, a complex and vulnerable population, should be more widely included under standard civil commitment law. (*Psychiatric Services* 65:634–640, 2014; doi: 10.1176/appi.ps.201300175)**

Although the great majority of individuals with substance use disorders never require civil commitment for involuntary hospitalization for treatment, there is a subpopulation of patients with complex conditions for whom addiction is so gravely disabling that they are unable to make rational treatment decisions or care for themselves independently, necessitating a higher level of care. In New York City, for example, there is a subpopulation of individuals with substance use disorders who repeatedly present to public hospital emergency rooms, never stay in treatment for more than several days, and often sign out of the hospital despite clinical recommendations otherwise, and never stay in either inpatient or outpatient treatment for more than several days. These patients have become chronically homeless and socially isolated. They have a multitude of untreated chronic medical conditions despite having hundreds of hospital admissions and accruing immense hospital costs; the minimum annual mortality rate in this subpopulation is 8.6%, or roughly 20 times the age-adjusted rate (1).

In the United States, civil commitment language typically permits involuntary hospitalization of individuals with mental illness for one of three purposes: suicidal danger to self, homicidal danger to others, or danger to self as a result of grave disability, which prevents an individual from being able to secure basic necessities such as food, clothing, or shelter. As with patients who have decompensated schizophrenia or severe and immobilizing depression who meet dangerousness criteria, individuals with severe substance use disorders may be considered eligible in some U.S. states for involuntary hospitalization when they become gravely disabled.

In New York State, the definition of mental illness for civil commitment purposes (MHL § 1.03) is very broad and allows for considerable discretion. However, the law does not reference substance use disorders. Although many clinicians may have assumed that substance use disorders did not qualify as committable mental illnesses, no case law existed until 1995 to guide interpretation. *In the Matter of Michael S.* is a case that came before a Westchester County, New York, court in 1995 (2). In this

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case, a father and doctor had petitioned a lower court to involuntarily admit an opiate-addicted patient for treatment. The lower court dismissed the complaint, writing, "There is no medical evidence to equate mental illness with drug addiction." A second court did not comment on this matter until 2010. In *Lawlor v. Lenox Hill Hospital,* a patient brought a medical malpractice claim against Lenox Hill Hospital alleging that Lenox Hill failed to psychiatrically evaluate and involuntarily treat a patient who had been medically admitted for alcohol-related injuries (3). The court again dismissed the complaint, stating, "Alcoholism is not considered a mental illness under [New York State statute] and a person cannot be involuntarily confined under that statute solely for treatment of alcoholism." A subsequent case has now relied on *Lawlor,* excluding "alcoholism" as a committable mental illness (4). These court rulings, however, have limited precedential authority and are not applicable throughout the state—or even throughout New York City. The rulings give little clarification as to what qualifies as a mental illness in New York State.

The ambiguity surrounding criteria for the commitment of addicted persons in New York may hinder clinician attempts to treat this complex population. State statutes that do not explicitly comment on substance use disorders within their definitions of mental illness for civil commitment may complicate efforts by families and providers to secure inpatient treatment for appropriate patients. Consequently, in many states it is legally difficult—or frequently believed by practitioners to be difficult (5,6)—to hospitalize patients gravely disabled by substance use disorders who do not agree to treatment.

History

In the 1845 court ruling *In the Matter of Josiah Oakes* (7), Judge Shaw of Massachusetts heralded "the great law of humanity" as the justification for temporarily restricting the liberties of persons with mental illness for the purpose of treatment. Building on English Common Law, the ruling helped develop the state interest of *parens patriae*, or caring for persons who are unable to care for themselves (8). Over the course of the mid-19th century, all states subsequently developed mental hygiene laws with civil commitment statutes that allow for the involuntary hospitalization of individuals with mental illness (9).

Until the 1960s, these statutes were relatively vague (often simply stating that anyone who was "insane" and "needed treatment" could be involuntarily committed) and left much of the decision making about hospitalization in the hands of physicians (10). Committed patients (all of whom were hospitalized because at the time outpatient commitment did not exist) were considered to be globally incompetent (that is, without any rights or ability to manage any of their affairs, including medical decisions), and mental illness alone was considered sufficient for confinement (11). In 1961, the publication of *The Mentally Disabled and the Law* (12) marked a watershed moment for the legal profession's burgeoning influence over the treatment of persons with mental illness (13). A series of sweeping societal and legal reforms followed, further inspired by civil rights movements (14). By the early 1970s, virtually all states had narrowed their criteria for involuntary hospitalization and placed more of an emphasis on dangerousness rather than need for treatment (10)—so much so that the American Psychiatric Association countered with the 1983 Model State Law in an attempt to renew emphasis on the need for treatment (15). Since the 1980s, several states have widened their criteria beyond imminent dangerousness to include risk of severe deterioration and general inability to care for self (10). Throughout this period, revisions were made to procedural rights, whereas substantive definitions of what met criteria for a mental illness remained essentially the same.

Coincident with the development of "traditional" mental hygiene laws over the past 150 years was the evolution of "drug dependence laws" that addressed the treatment of people with alcohol or drug dependence outside the traditional civil commitment process for mental illness (16). The notion of addiction as a disease or illness rather than simply criminal or immoral behavior first entered the public consciousness in the mid-1800s, originating from Temperance Movement literature questioning whether alcohol was "irresistible" for some people (17). Between the 1860s and 1890s, at least 14 states passed commitment statutes for addiction, and 50 "inebriate hospitals" were constructed across the nation (17). By the 1910s, there was interest at the federal level in committing addicted persons to inpatient treatment, as indicated by the Harrison Narcotic Act of 1914, which prompted the creation in 1935 of a national treatment center in Lexington, Kentucky, run by the U.S. Public Health Service.

It was not until the 1960s that some states and physicians once again began to treat addiction as a mental illness under the law. From the mid-1960s through the 1970s, roughly 20 states developed separate commitment procedures for persons with substance use disorders (18). Among these states, commitment was often limited to outpatient or residential treatment, such as therapeutic communities, and was frequently in lieu of a criminal trial or was implemented after conviction (18). Thus many states have had two sets of commitment laws for hospitalization: one for patients with (dangerous) mental illnesses and another for those with substance use disorders.

The debate within the medical community over the nature and treatment of substance use disorders during this period increased in intensity. In a landmark 1968 case from the U.S. Supreme Court, *Powell v. Texas*, Justice Marshall wrote, "there is no agreement among members of the medical profession about what it means to say that 'alcoholism' is a 'disease,' " which raised the concern that "therapeutic commitment" for "indigent public inebriates" entailed the risk that they would be "locked up" for an indefinite period because of the limited available evidence that alcoholism could be cured or even effectively treated (19).

The lack of consensus within the medical community has thus served as

a backdrop for the ongoing creation of inconsistent state statutes regarding addiction and civil commitment. Three editions of *The Mentally Disabled and the Law* have been published—in 1961, 1971, and 1985 (12, 20,21). A review of these editions indicates that there was little consistency among states in handling the commitment of persons with substance use disorders in the latter half of the 20th century. Although it appears that several states that permitted commitment for both alcohol and drug use disorders in 1961 continued to do so in 1985, few other trends can be identified. [Three U.S. maps in an online data supplement provide an overview of states that permitted commitment to institutionalization or hospitalization—that is, not residential or outpatient commitment—for alcohol and or drug use disorders in 1961, 1971, and 1985.]

Methods

To better understand the national landscape, civil commitment statutes for involuntary hospitalization in all 50 states and the District of Columbia (D.C.) were reviewed to assess for trends that might help guide further discussion about this important interface between mental health practice and the law. Our primary goal was to compile a comprehensive list of all statutory definitions of mental illness as related to involuntary hospitalization, with a specific focus on any mention of substance abuse or dependence. Two authors with experience in teaching and writing about mental health law (SC and EBF) reviewed all state mental health statutes as of April 11, 2013, by using LexisNexis and Westlaw search engines. Civil commitment and, if applicable, separate addiction-related inpatient commitment statutes were reviewed. The definition of mental illness for the purpose of involuntary hospitalization was identified and interpreted in three ways: including substance use disorders, excluding substance use disorders, or not referencing substance use disorders. Although case law was occasionally used to help interpret particularly complicated statutes, a thorough review of all case law and administrative regulations was outside the scope of this review.

Results

A total of 22 states, including D.C., do not reference substance use disorders in their statutory definitions of mental illness (Table 1). Of the 29 that do, eight explicitly include substance use disorders and 21 explicitly exclude them as qualifying mental illnesses for the purpose of commitment. Nine states have separate, additional inpatient commitment laws specifically permitting involuntary hospitalization for substance use disorders (two of which are states that otherwise exclude substance use disorders in their definitions of mental illness). In sum, 17 state statutes appear to explicitly permit involuntary hospitalization for substance use disorders either by inclusion of substance use disorders in definitions of mental illness or through separate inpatient commitment laws. An additional 15 state statutes do not reference substance use disorders such that, short of prevailing case law or administrative regulation, they appear to passively permit involuntary hospitalization. [A flow diagram and a U.S. map illustrating these findings are included in the online data supplement.]

Definitional language varies greatly from state to state in terms of clarity and specificity. For instance, Washington State (§ 71.05.020) defines a "mental disorder" vaguely as "any organic, mental, or emotional impairment which has substantial adverse effects on an individual's cognitive or volitional functions." In contrast, Oregon's (ORS § 426.495) mental illness definition ("Chronic schizophrenia, a chronic major affective disorder, a chronic paranoid disorder or another chronic psychotic mental disorder") is more specific.

Some states clearly exclude or include substance use disorders in their mental illness definitions. Alabama's statute [§ 22–52–1.1 (1)] specifically excludes substance use disorders ("Mental illness, as used herein, specifically excludes the primary diagnosis of . . . substance abuse, including alcoholism"). Whereas Tennessee (§ 33–1-101) specifically includes alcoholism or drug dependence ("Mentally ill individual means an individual who suffers from a psychiatric disorder, alcoholism, or drug dependence").

Among the ten states that have separate commitment laws for substance use disorders, language regarding substance use disorders varies even more than that defining mental illness. This may in part reflect the frequent conflation (for either medical or legal purposes) of intoxication, substance abuse, and addiction and a historical carryover of distinguishing alcohol dependence from other drug dependence.

Discussion

We believe this compilation to be the first of its kind for at least the past two decades. Civil commitment statutes affect clinical practice because clinicians assess dangerousness and hospitalization criteria partly on their understanding of existing legal criteria (22). The ambiguity and inconsistency of statutory language may complicate such efforts.

State statutes regarding the hospitalization of persons with substance use disorders have largely remained stagnant since the 1970s despite progress in understanding the etiology and neurobiological pathology of substance use disorders. An abundance of evidence now associates addiction with changes in brain structure and function that persist well beyond the cessation of drug use and detoxification (23–27). Unlike views prevalent in the 1970s, expert views on substance use disorders among addiction researchers and clinicians are now consistent in describing substance use disorders as chronic brain diseases. Importantly, addiction is not simply a neurologic disease but a mental illness. It changes fundamental aspects of an individual's personality—cognition, emotions, and behaviors—that implicate decision-making capacity and self-determination (28–30). Research on treatment effectiveness has also grown considerably. By 1990 several authoritative reviews emerged spanning tens of thousands of patients enrolled in federally funded studies demonstrating that treatment leads to significant and enduring declines in drug use (31,32). Subsequently, the 1990s Drug

Table 1

Inclusion or exclusion of substance use disorders in state laws defining mental illness for the purpose of involuntary hospitalization

State	Current relevant law	Status of substance use disorders in the definition of mental illness[a]	Separate commitment law permits involuntary hospitalization[b]
Alabama	Alabama Health, Mental Health and Environmental Control Law § 22–52–1.1(1)	Excluded	
Alaska	Alaska Welfare, Social Services and Institutions Law § 47.30.915(12)	Excluded	§ 47.37.190(a)
Arizona	Arizona Revised Statutes § 36–501	Excluded	
Arkansas	Arkansas Code of 1987, Ann. § 20–47–202	Excluded	
California	California Welfare and Institutions Code § 5008 and 5585.25	Included[c]	
Colorado	Colorado Revised Statutes Ann. CRSA § 27–65–102	Not referenced	§ 27–81–112 (alcohol only)
Connecticut	Connecticut General Statutes § 17a–495	Excluded	
Delaware	16 Delaware Code § 5001	Not referenced	
Florida	Florida Statutes § 394.455	Excluded	
Georgia	Georgia Code Ann., § 37–1–1	Not referenced	OCGA § 37–7–81
Hawaii	Hawaii Revised Statutes § 334–1 and § 334–60.2	Not referenced[d]	
Idaho	Idaho Code § 66–317	Not referenced	
Illinois	405 Illinois Compiled Statutes 5/1–129	Excluded	
Indiana	Indiana Code Ann. § 12–7–2–130	Included	
Iowa	Iowa Code § 229.1	Not referenced	§ 125.75
Kansas	Kansas Statutes Ann. 59–2946	Excluded	
Kentucky	Kentucky Revised Statutes § 202A.011	Not referenced	
Louisiana	Louisiana Laws Revised Statutes 28:2	Excluded	
Maine	34-B Maine Revised Statutes § 3801	Included	
Maryland	Maryland Health-General Code Ann. § 10–101	Not referenced	
Massachusetts	Massachusetts General Laws 123 § 1	Not referenced[e]	123 § 35
Michigan	Michigan Compiled Laws § 330.1100d	Excluded	
Minnesota	Minnesota Statutes § 253B.02	Excluded	
Mississippi	Mississippi Code Ann. § 41–21–61	Excluded	§ 41–31–3
Missouri	Missouri Revised Statutes 630.005	Excluded	
Montana	Montana Code Ann. § 53–21–102	Excluded	
Nebraska	Nebraska Revised Statutes § 71–908	Included	
Nevada	Nevada Revised Statutes 433A.115	Excluded	
New Hampshire	New Hampshire Revised Statutes § 135-C:2	Excluded	
New Jersey	New Jersey Statutes Ann. 30:4–27.2	Not referenced[f]	
New Mexico	New Mexico Statutes Ann. 1978, § 24–7B–3	Not referenced	
New York	New York Mental Hygiene Law §§ 1.03 (20), 1.03(3)	Not referenced	
North Carolina	North Carolina General Statutes § 122C–3	Not referenced	§ 122C–285
North Dakota	North Dakota Century Code § 25–03.1–02	Included	
Ohio	Ohio Revised Code § 5122.01	Not referenced	
Oklahoma	43A Oklahoma Statutes Ann. § 1–102 & § 1–103	Included	
Oregon	Oregon Revised Statutes § 426.495	Excluded	
Pennsylvania	50 Pennsylvania Statutes § 4102	Not referenced	
Rhode Island	Rhode Island General Laws 1956, § 40.1–5–2	Not referenced	
South Carolina	South Carolina Code Ann. § 44–17–410	Not referenced[e]	SC Code Ann. § 44–52–10
South Dakota	South Dakota Codified Laws § 27A–1–1	Excluded	
Tennessee	Tennessee Code Ann. § 33–1–101	Included	
Texas	Texas Mental Health Code § 571.003	Excluded[g]	
Utah	Utah Code Ann. § 62A–15–602	Not referenced	
Vermont	18 Vermont Statutes Ann. § 7101	Not referenced	18 VSA § 8402 ("drug addicts" only)
Virginia	Virginia Code Ann. § 37.2–100 & 37.2–800	Included	
Washington	Revised Code of Washington § 71.05.020	Not referenced	
Washington, D.C.	Washington D.C. Code § 21–501	Not referenced	
West Virginia	West Virginia Code § 27–1–2 and § 27–5–4	Not referenced[d]	

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State	Current relevant law	Status of substance use disorders in the definition of mental illness[a]	Separate commitment law permits involuntary hospitalization[b]
Wisconsin	Wisconsin Statutes Ann. 51.01	Excluded[g]	
Wyoming	Wyoming Statutes § 25–10–101	Excluded	

[a] Rather than "mental illness," some states use terms such as "mental disorder," "mental disability," or "mental condition."
[b] Separate law specifically permits commitment of persons with substance use disorders.
[c] California does not define mental disorder; however, its definition of grave disability for the purposes of hospitalization of persons with mental disorders explicitly includes "chronic alcoholism." There is no reference to other drug dependence.
[d] Involuntary commitment of persons with substance use disorders is allowed in addition to persons with mental illness.
[e] State does not define mental illness.
[f] New Jersey statutes state that involuntary hospitalization is not allowed for "simple" intoxication unless there are severe complications but do not explicitly reference substance use disorders.
[g] Alcoholism excluded but other substance use disorders (that is, illicit drug dependence) not referenced

Abuse Treatment Outcome Study provided evidence regarding which aspects of addiction treatment were most effective, ultimately emphasizing the importance of retention in treatment (33,34). Most recently, the literature has evolved to demonstrate that coerced treatment for substance use disorders can, in some cases, be as effective as voluntary treatment (35–39). As with other serious mental illnesses, involuntary hospitalization may be a necessary tool that allows clinicians to fully stabilize, assess, and plan (for example, arrange for mobile outreach or intensive case management) for these patients with complex conditions (1).

There is limited literature on the subject of psychiatrists' knowledge of and attitudes toward commitment criteria. However, the few available studies have repeatedly found that surveyed psychiatrists are often not familiar with the specific criteria and procedures contained in their state's statutes (5,22,40–42). In addition, some researchers have found that nonrespondents (that is, those who do not reply to surveys) are even less familiar with the criteria than respondents (43). It is also not uncommon for psychiatrists to be influenced by nonlegal criteria, such as logistical constraints involving bed availability, workload, overcrowding, and a lack of less restrictive alternatives, despite statutory guidelines to the contrary (44–46).

Conversely, in states where civil commitment is permitted for substance use disorders, it is often not used (8,47–49). A 2006 American Psychiatric Association poll of its members (N=739) concluded that 99% of psychiatrists agreed with commitment for "dangerousness," but only 22% agreed with commitment for substance use disorders (41). Although these findings do not comment on psychiatrists' attitudes about commitment for dangerous ("gravely disabled") persons with substance use disorders, they do highlight that in the broader mental health community there is disagreement about whether substance use disorders should be treated, legally, in the same manner as other severe mental illnesses.

We recognize that there are significant concerns, ideologically, logistically, and financially, with any standardization of civil commitment and, possibly, with any expansion, especially in areas of the country with relatively limited resources. First, as already mentioned, there is no clear agreement in the health care community about the best treatment practices for individuals who have gravely disabling substance use disorders. We see debate as an opportunity for addiction specialists to strive for best practices in this area.

Second, and perhaps even more important in our current era of cost containment, widening the scope of persons who qualify for inpatient hospitalization to include gravely disabled individuals with substance use disorders may further stress the already limited number of hospital beds. It is possible, however, that shifting dollars to longer-term inpatient care or stabilizing patients to transition them to less restrictive levels of care (such as residential or assertive community treatment) may actually improve overall system efficiency and cost-effectiveness. Additional resources are clearly needed for more effective early interventions that prevent the degree of deterioration that necessitates such a high level of care. It is hoped that implementation of the Affordable Care Act will expand such funding.

Third, with approximately half of states already permitting (explicitly or passively) inpatient commitment for persons with substance use disorders, one may ask why the option of involuntary hospitalization for gravely disabled substance users across all states would change the standard of care. We acknowledge that statutory language and the realities of clinical practice may not be closely aligned. However, we suggest that excluding substance use disorders from the statutory definition of mental illness for involuntary hospitalization is both scientifically outdated and may withhold a potentially life-saving treatment option from an extremely vulnerable population.

Conclusions

Laws represent the combined efforts of our elected leaders and our peers to balance the rights of individuals in society against the rights of society as a whole. Over the past 50 years, these great laws of humanity have had increasing influence on the practice of psychiatry related to conflicts

between individual autonomy, provider authority, and state power. Yet most psychiatrists have a limited understanding of relevant state statutes guiding practice related to involuntary hospitalization, particularly with regard to substance use disorders.

Civil commitment statutes related to involuntary hospitalization, especially definitions of mental illness and the inclusion or exclusion of substance use disorders, are important legal tools for psychiatrists to use in making treatment decisions. In the case of individuals who are gravely disabled by substance use disorders, involuntary hospitalization may save their lives. Since the 1980s, *DSM-III* and its progeny, in concert with findings from the past two decades of neuroscience and clinical research, identify substance use disorders in the same category as serious mental illnesses such as schizophrenia and bipolar disorder. Yet the 50 states and D.C. continue to largely address substance use disorders—at least in terms of statutory provisions—as voluntary, self-directed behavior and separate from typical models of treatment for mental illness and from the practice of involuntary hospitalization.

These concerns clearly warrant more empirical evidence regarding cost-effectiveness, duration of treatment effect, and the impact of statutory language on clinical practice. Because of recent advancements in clinical practice and research, we advocate for further exploration and discussion among psychiatrists, policy makers, and legal professionals.

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Submissions Invited for Column on Integrated Care

The integration of primary care and behavioral health care is a growing research and policy focus. Many people with mental and substance use disorders die decades earlier than other Americans, mostly from preventable chronic medical illnesses. In addition, primary care settings are now the gateway to treatment for behavioral disorders, and primary care providers need to provide screening, treatment, and referral for patients with general medical and behavioral health needs.

To stimulate research and discussion in this critical area, *Psychiatric Services* has launched a column on integrated care. The column focuses on service delivery and policy issues encountered on the general medical–psychiatric interface. Submissions are welcomed on topics related to the identification and treatment of (a) common mental disorders in primary care settings in the public and private sectors and (b) general medical problems in public mental health settings. Reviews of policy issues related to the care of comorbid general medical and psychiatric conditions are also welcomed, as are descriptions of current integration efforts at the local, state, or federal level. Submissions that address care integration in settings outside the United States are also encouraged.

Benjamin G. Druss, M.D., M.P.H., is the editor of the Integrated Care column. Prospective authors should contact Dr. Druss to discuss possible submissions (bdruss@emory.edu). Column submissions, including a 100-word abstract and references, should be no more than 2,400 words.