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A Guide to Involuntary Commitment in Delaware

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Theoretical and Historical Background

U.S. citizens are entitled to a constitutionally protected right to privacy that permits an individual to dictate whether he or she will accept or refuse any recommended medical treatment. In that regard, a citizen with sound mind may rightfully refuse medical interventions despite any potential personal harm or unrealized therapeutic benefit the refusal would carry. Associated with that constitutional right of privacy is the legal presumption that every adult possesses a sound mind, or the mental competence, to independently engage in medical decision making. As with most legal rights, there are limitations and circumstances that would permit the curtailment of such privacy rights in order to provide treatment against a person's will.

U.S. state jurisdictions have the authority to involuntarily commit citizens with acute mentally illness to treatment facilities under two broad authorities, *parens patriae* and police power. *Parens patriae* refers to the power of the state to care for its citizens and to commit individuals who are incapable of caring for themselves to institutions. That state power stems from the governmental authority held by English kings to act as "general guardian to all infants, idiots, and lunatics"[1] and was first applied to the mentally ill in the U.S. through the 1845 Massachusetts Supreme Judicial Court decision, In re Oakes.[2] In addition to helping care for those who unable to care for themselves, *parens patriae* is used by the state to protect the community from dangerous individuals.

A state jurisdiction's police power refers to the authority to take necessary steps to protect the general welfare of the public and to attend to society's interests above the interests of a private citizen. The 1905 U.S. Supreme Court decision, Jacobson v. Commonwealth of Massachusetts,[3] recognized states' constitutional authority to exercise its police power by upholding a state law that required citizens to be vaccinated for smallpox. It is the police power that permits involuntary commitment of acutely mentally ill citizens to prevent dangerous behaviors towards themselves or others.

It is instructive to examine the development of case law in the area of civil commitment. In Lake v. Cameron,[4] a 60 year old female was found wandering the streets of Washington, DC suffering from mild dementia and was being held awaiting a civil commitment hearing. There was concern from examining psychiatrists that she "is a danger to herself in that she has a tendency to wander among the streets…" The court found that an exploration of alternatives to involuntary hospitalization must be pursued, such as home care services or community mental health. This ruling places a limitation on the use of civil commitment to ensure that less restrictive alternatives are examined prior to deprivation of liberty that accompanies involuntary hospitalization.

The case of Lessard v. Schmidt[5] reinforced the need to examine less restrictive alternatives, while also requiring that individuals facing civil commitment proceedings be entitled to due process rights similar to those of criminal proceedings. These rights include effective and timely notice of the reason for detainment, limits on detention without probable cause and/or commitment hearings and right to counsel.

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In O'Connor v. Donaldson,[6] the U.S. Supreme Court examined whether "a finding of mental illness alone" justifies custodial confinement by the state. In that case, the court held that "there is no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom." This requirement of dangerousness is an important component of the Delaware Civil Commitment Statute, as will be discussed in greater detail below.

Another important component of civil commitment, the legal burden of proof, was established in Addington v. Texas.[7] It was held that the burden of proof for civil commitment is one "that strikes a fair balance between the rights of the individual and the legitimate concerns of the state" and concluded that "clear and convincing" evidence was the appropriate burden of proof for civil commitment.

Commitment Process for the State of Delaware

In the State of Delaware, a civil commitment procedure allows for the involuntary confinement of individuals with mental health problems at risk of dangerousness. In order for this to occur, the person must be evaluated and thought to be an acute risk to himself or others. Such procedure is intended to allow for treatment of underlying mental illness in order to reduce the likelihood of harm and protect vulnerable persons. This process can involve the individual, mental health professionals, concerned friends or family members, and portions of the legal system.

However, such confinement is extremely serious, given the restriction of liberty and potential impact on an individual's life. Steps are also in place for discontinuing confinement allowing for release back into the community or other treatment settings at any point along the trajectory. This paper serves a review of the process in the State of Delaware, adapted from the 16 Delaware code § 5001 statute,[8] in order to educate individuals who are not familiar with its intricacies.

Any party with concern for an individual's dangerousness can initiate the process by bringing the person (hereafter, "the patient") to an emergency room or by contacting law enforcement. If law enforcement is concerned for underlying mental health problems, they can also bring the patient to an emergency room. At this point, a certified mental health screener will evaluate the patient for concerning symptoms or signs of an underlying mental illness that may lead to dangerous behavior by way of serious bodily harm. This mental health screener may be either a A) psychiatrist or a B) licensed mental health professional, unlicensed mental health professional under supervision of a psychiatrist, or another physician. If the screener falls under category B, she must be credentialed by the State of Delaware Department of Health and Social Services to assess and evaluate mental health problems in an emergency setting.

The evaluation may be performed in a medical or dedicated psychiatric emergency room. If the individual is deemed to be in need of emergency mental health services and is unwilling or lacks capacity (that is, lacks the ability to coherently understand the risks and benefits) to sign himself into a hospital, an emergency detention is put in place by documenting the patient's alleged mental health problems and dangerous behaviors.

After this, the patient is transported to a designated psychiatric facility for further observation and potential treatment. This also means that an individual may not be involuntarily committed to a medical facility.

Within twenty-four hours of this transfer, a psychiatrist must decide whether to involuntarily admit the patient to the hospital. In order to do so, the psychiatrist must certify that the person

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appears to have a "mental condition," is unable or unwilling to accept offered voluntary treatment, poses a "present threat…of being dangerous to self or dangerous to others," and cannot be treated through "less restrictive alternatives," such as outpatient treatment. This certification allows for another forty-eight hours of detainment known as "provisional admission" to allow for additional assessment and treatment. It is important to note that at no point during this process does alcohol or drug intoxication, dementia, or intellectual disability constitute a mental condition that may be subject to involuntary detainment.

The next steps in this process are known as the "probable cause" complaint and hearing. The hospital files a request for involuntary civil commitment with the courts. Another certification of mental condition, dangerousness, and appropriateness of treatment setting and its involuntary nature occurs. Within eight business days, a mental health court hearing establishes whether there is probable cause for continued involuntary detention based on these grounds. During this and subsequent legal proceedings, the patient has the right to an attorney, to present and discover evidence, and to have direct and cross examination of witnesses.

If probable cause is not found, the patient may be discharged back to the community on his own recognizance or ordered to outpatient treatment over objection. The court may order this level of outpatient supervision if the patient has a "documented mental condition," is "reasonably expected to become dangerous to self or dangerous to others or otherwise unlikely to survive safely," is refusing or unable to voluntarily participate in the recommended treatment plan, and has either a history of documented nonadherence to treatment recommendations or poses an extreme danger given recent actions. Thus the requirement for outpatient commitment essentially differs from inpatient detainment regarding imminence of dangerousness and the presence of nonadherence to treatment plans.

If the patient was detained in the hospital rather than discharged at the "probable cause hearing," only then may she be considered involuntarily committed for legal purposes. After this point would the patient be prohibited from possessing a firearm. The following step is an involuntary inpatient commitment ("IIC") hearing held within eight business days. At this second hearing, the patient may be kept in the hospital if the conditions for the probable cause hearing continue to be met regarding mental health difficulties, dangerousness, and appropriateness of treatment setting and involuntariness. Importantly, the legal burden of proof is raised from the previous probable cause standard to now requiring the more substantial clear and convincing evidence of the need for involuntary commitment. The burden to prove this falls on the institution. For comparison, probable cause is the standard used to obtain a warrant for arrest or property search, while clear and convincing evidence is required of a person's wish for removal of life support.

If involuntarily committed, the patient is then kept at the hospital for continued treatment for a period no longer than three months without a follow-up hearing. Otherwise, he may be discharged with or without involuntary outpatient treatment. Of note, in neither setting does treatment does not imply medication, as a separate procedure must take place. As such, a patient who is involuntarily committed may refuse medications unless in emergency situations or if ordered by the courts.

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5. Lessard v. Schmidt 349 f. supp. 1078, 26 (1972).
6. O'Connor v. Donaldson 422 U.S. 563, 11 (1975).
7. Adddington v. Texas 441 U.S. 418, 10, 12 (1979).
8. 16 Delaware code § 5001 located at http://delcode.delaware.gov/title16/c050/index.shtml

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