Psychiatrists' Opinions About Involuntary Civil Commitment: Results of a National Survey

Robert A. Brooks, JD, PhD

This article presents results of a national survey of psychiatrists in the United States about involuntary civil commitment. The questionnaire, created by the researcher, asked respondents about their knowledge of and support for various legal standards surrounding inpatient and outpatient commitment. Data from 739 members of the American Psychiatric Association indicated support for relatively limited definitions of mental disorder for purposes of commitment and relatively limited legal grounds for commitment. Respondents frequently gave inaccurate responses about the grounds for commitment in their states, as well as whether involuntary outpatient commitment is allowed in their states. A comparison of results with prior surveys of psychiatrists is provided, and policy implications are discussed.

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Involuntary civil commitment laws provide for the forceful detention and commitment to an institution by judicial means of persons with mental illnesses who meet certain further criteria. These particular criteria vary from state to state and have also been subject to historical trends. Until the late 1960s many states, operating under their *parens patriae* powers, allowed for the commitment of persons who had a mental illness and simply needed treatment. Beginning with California in the late 1960s, states began to tighten the criteria for civil commitment in response to reports of abuses, in concern for civil liberties, and in the recognition that, in some circumstances, prolonged inpatient treatment could have harmful consequences.[1] In addition, federal policy began to encourage community-based treatment for persons with serious mental disorders. All states adopted some form of the "dangerousness" standard under their police powers, and many states also provided for commitment of persons with mental illnesses who were unable to meet their basic needs (referred to herein as the grave-disability standard).[2]

Contrary to expectations, admissions to psychiatric hospitals in some states actually increased following the tightening of civil commitment criteria, while the length of such hospitalizations decreased. This revolving-door phenomenon involved persons with serious mental illnesses, particularly those described as the "young adult chronic patient,"[3] who were repeatedly hospitalized after psychiatric crises or who were transinstitutionalized into the criminal justice system.[4,5] States responded in two ways. First, some retooled their commitment statutes by adopting an additional criterion for commitment based on "deterioration" or "relapse." Several such statutes specifically focused on the person with prior histories of hospitalization who appeared to be heading toward dangerousness. Second, some states expanded involuntary outpatient treatment, with the stated effort to provide community-based alternatives to hospitalization or by providing follow-up treatment to lengthen the interval between lapses.

Throughout these debates about the appropriateness of specific commitment criteria, psychiatrists have played a central role. Psychiatrists are medical doctors with the authority to prescribe medications for mental illnesses and are the primary care providers for persons with severe mental illnesses,[6] who are most likely to be subject to involuntary commitment. Psychiatrists make decisions on admissions and discharges, and also frequently provide expert testimony in civil commitment cases. They are perceived as holding the most power in the commitment

Dr. Brooks is Assistant Professor, Department of Criminal Justice, Worcester State College, Worcester, MA. Address correspondence to: Robert A. Brooks, JD, PhD, Worcester State College, 486 Chandler St., Worcester, MA 01602. E-mail: rbrooks@worcester.edu

process—in fact, sometimes observers see courts as "rubber stamps" of psychiatrists' testimony,[7–9] although this has not been a universal finding.[10]

More broadly, the American Psychiatric Association is the developer and publisher of the Diagnostic and Statistical Manual of Mental Disorders (now the DSM-IV-TR).[11] In addition, psychiatrists have been identified as a key constituent "interest group" in the formation of mental health policy, including the content and provisions of civil commitment laws.[12] For example, the American Psychiatric Association regularly takes positions on mental health matters, including those involving civil commitment.[13,14]

However, not much is known about individual psychiatrists' recent views about involuntary civil commitment. The last comprehensive national survey directed to psychiatrists on the topic occurred more than 25 years ago,[15] although some recent research has focused on more local populations, such as psychiatrists in particular states.[16] The current research sought to update knowledge about the opinions of psychiatrists through a survey based on a national random sample of members of the American Psychiatric Association.

Most prior U.S. surveys about psychiatric hospitalization were conducted in the 1970s and 1980s and focused on two aspects: the commitment process and patients' rights after commitment (with the majority focusing on the latter). Surveys about commitment used various sampling methods directed at a variety of populations (including attorneys, psychiatrists, psychologists, and social workers). Surveys addressed to psychiatrists have included a national random sample,[15] and one that surveyed eight psychiatrists from each state.[17] Others have directed surveys to psychiatrists within a single state,[16,18] while some research has involved semistructured interviews of clinical practitioners within a single institution.[19] Such surveys emphasized different aspects of the commitment process, including: support for involuntary commitment and for various grounds for involuntary commitment; accuracy of responses about various aspects of commitment law; and support for procedural protections, both during the commitment process and after hospitalization. Other research[20,21] has focused more on the clinician's decision-making process than on their opinions *per se*.

Methods

Respondents and Procedure

A questionnaire created by the researcher was mailed to 1500 members of the American Psychiatric Association (APA), including 1000 APA general members and 250 members from each of two APA membership sections (Emergency Psychiatry and Suicide/Self-Injury) whose members were thought to have had more experience with involuntary commitment. The first and second waves of questionnaires were mailed in August and October 2001, respectively. Each mailing included a cover letter explaining that the research process had been approved through the institutional review process at American University and assuring the participants' confidentiality. Seven hundred thirty-nine surveys were completed and returned by respondents—an initial return rate of 49.3 percent—and 20 surveys were returned as undeliverable. Twenty-three surveys were returned uncompleted with notations indicating that the respondent was not interested, was ill, or was retired. The useable surveys thus produced a return rate of 48.4 percent. Other researchers who have surveyed psychiatrists about psychiatric hospitalization have reported response rates ranging from 25 to 60 percent.[15,16,18,22,23]

The survey instrument was written by the researcher. The relevant questions for the purpose of this article included questions relating to inpatient and outpatient commitment laws. Respondents were first asked what they thought were the grounds for inpatient commitment in their states. They had the following eight choices: dangerous to oneself, dangerous to others, inability to care for oneself, relapse of severe and chronic mental illness, addiction to alcohol, addiction to drugs other than alcohol, sexual predator status, and other. Later in the survey, a question asked what the law should be, based on these same eight choices. Another question asked which mental illnesses should be included in a civil commitment statute. Respondents were also asked whether their states allowed outpatient commitment, and if they believed their state did not, whether they supported outpatient commitment. Questions relating to the respondents' experiences with commitment were also included. Last, a group of classifying questions was presented that included sex, race/ethnicity, education, years of experience, state of residence, and age.

Legal Research

The legal research involved a compilation of all states' and the District of Columbia's inpatient and outpatient civil commitment statutes as of late 2001. Commitment based on mental illness as well as on drug and alcohol addiction was included in the research. The relevant statutes were located in a local law library and were photocopied, collected, and coded. In those states that did not provide for commitment for "grave disability," a search of judicial decisions was also performed to determine whether the state's appellate courts had interpreted "danger to self" to include commitment for "grave disability." Results of this research were cross-checked with that of other researchers to increase reliability and inconsistent results were noted and rechecked for accuracy.

Research showed that as of the fall of 2001, every jurisdiction allowed for involuntary inpatient commitment of persons who had a mental illness and were dangerous to themselves or others, although the various statutes differed in how they defined both mental illness and dangerousness. Forty-nine of the jurisdictions also included some variation of grave disability, 45 through legislation and 4 through court decisions. Sixteen states had enacted legislation allowing commitment based on the concept of illness relapse or deterioration. In 2001, only one state (South Carolina) allowed involuntary inpatient commitment of a person with a mental illness who simply "needed treatment." Eleven states allowed inpatient commitment based on drug addiction alone (without evidence of dangerousness), and eight states allowed commitment based on alcohol addiction alone. Forty-one states and the District of Columbia allowed some form of involuntary outpatient treatment.

Results

Demographic Findings

Most (83.2%) of the respondents were white, 9.0 percent were Asian or Pacific Islander, 4.0 percent were Hispanic, and 2.5 percent were African American. Respondents were mostly (77.5%) men. The median age was 53 years. The median number of years licensed was 21. Respondents reported the following employment settings: private practice (41.9%), teaching (17.9%), government care/treatment facility (15.4%), hospital (6.1%), clinic (4.7%), research (3.0%), and other (11.1%).

The sample population included APA members from all states except Wyoming (Table 1, column 3). There were responses from 49 of the 51 states and the District of Columbia, with New York ($n = 56$), Massachusetts ($n = 48$), California ($n = 47$), Illinois ($n = 42$), and Pennsylvania ($n = 40$) having the largest number of respondents. There was only one respondent from each of the states of Montana and Hawaii, and there were no respondents from New Mexico or Wyoming (Table 1, column 4). Among the regions (according to U.S. Census Bureau classifications),[26] 29.3 percent ($n = 203$) were from the Northeast, 25.4 percent ($n = 178$) were from the North Central region, 40.0 percent ($n = 217$) were from the South, and 14.3 percent ($n = 101$) were from the West.

Experience With Involuntary Commitment

Nearly 62 percent of respondents had had direct experience with involuntary commitment in the preceding 24 months. Of those who had had experience, 77.4% had been involved in the commitment of a current patient, and 23.4% had been involved in the commitment of a former patient. Many respondents (40.8%) had provided expert testimony, and more than a quarter (28.7%) had been involved in some other way. (Many respondents who checked the "some other way" category indicated that they had been involved through their administrative function.) Those in private practice reported significantly less experience with inpatient commitment ($\chi^2 = 17.410$, $p < .0001$; $\gamma = -0.317$) compared with all other respondents; however, 52.9% of those in private practice had had some experience with involuntary commitment in the prior 24 months. While involvement was common, the overall percentage of respondents' patients involved in inpatient hospitalization was very small—the median was just 0.03% of all patients (the mean value was 0.1%). Nearly all (96.7%) of the respondents who had experience with commitment were involved in inpatient proceedings, whereas only 26.5% were involved in outpatient commitment.

Defining Mental Illness

Respondents were asked which mental disorders ought to be included when defining mental illness for the purpose of a commitment statute. (Respondents could choose more than one response.) The most favored response was psychosis (62.9%). The major-

Table 1 U.S. Psychiatrists, APA Sample Population, and APA Sample, by State

State	Percentage of U.S. Psychiatrists (*n*)*	Percentage of APA Sample Population (*n*)	Percentage of APA Sample (*n*)
AL	0.75 (298)	0.60 (9)	0.56 (4)
AK	0.16 (63)	0.27 (4)	0.42 (3)
AZ	1.35 (539)	0.60 (9)	0.56 (4)
AR	0.50 (198)	0.74 (11)	0.56 (4)
CA	13.44 (5,352)	7.41 (111)	6.55 (47)
CO	1.67 (667)	1.20 (18)	1.81 (13)
CT	2.46 (981)	2.20 (33)	2.51 (18)
DE	0.25 (101)	0.47 (7)	0.56 (4)
DC	0.93 (370)	1.27 (19)	1.53 (11)
FL	4.53 (1,806)	2.47 (37)	2.23 (16)
GA	2.18 (868)	1.94 (29)	2.09 (15)
HI	0.55 (217)	0.20 (3)	0.14 (1)
ID	0.20 (80)	0.27 (4)	0.56 (4)
IL	3.87 (1,540)	6.81 (102)	5.85 (42)
IN	1.22 (486)	2.27 (34)	1.81 (13)
IA	0.51 (205)	1.20 (18)	1.81 (13)
KS	0.82 (328)	0.74 (11)	0.70 (5)
KY	0.98 (392)	1.00 (15)	0.97 (7)
LA	1.29 (514)	0.93 (14)	0.70 (5)
ME	0.52 (209)	0.60 (9)	0.70 (5)
MD	3.43 (1,366)	4.81 (72)	5.29 (38)
MA	5.18 (2,063)	7.28 (109)	6.69 (48)
MI	2.87 (1,143)	2.27 (34)	2.65 (19)
MN	1.32 (526)	3.14 (47)	2.92 (21)
MS	0.43 (171)	0.40 (6)	0.56 (4)
MO	1.41 (560)	1.27 (19)	0.84 (6)
MT	0.20 (76)	0.20 (3)	0.28 (2)
NE	0.38 (151)	0.67 (10)	0.84 (6)
NV	0.34 (134)	0.27 (4)	0.28 (2)
NH	0.53 (212)	1.13 (20)	1.39 (10)
NJ	3.53 (1,405)	2.94 (44)	2.51 (18)
NM	0.63 (249)	0.13 (2)	0.00 (0)
NY	14.44 (5,750)	8.41 (126)	7.80 (56)
NC	2.45 (974)	5.01 (75)	5.33 (38)
ND	0.18 (71)	0.53 (8)	0.56 (4)
OH	2.88 (1,147)	4.54 (68)	4.87 (35)
OK	0.66 (262)	0.40 (6)	0.56 (4)
OR	1.06 (424)	0.93 (14)	1.25 (9)
PA	5.09 (2,026)	5.27 (79)	5.57 (40)
RI	0.53 (213)	0.93 (14)	0.97 (7)
SC	1.14 (453)	2.14 (32)	2.79 (20)
SD	0.12 (49)	0.13 (2)	0.14 (1)
TN	1.34 (535)	1.07 (16)	0.97 (7)
TX	4.71 (1,877)	3.54 (53)	2.65 (19)
UT	0.48 (192)	0.53 (8)	0.56 (4)
VT	0.37 (149)	0.87 (13)	0.97 (7)
VA	2.31 (920)	2.94 (44)	2.51 (18)
WA	1.84 (731)	2.07 (31)	2.51 (18)
WV	0.38 (152)	0.53 (8)	0.97 (7)
WI	1.48 (590)	2.23 (34)	2.23 (16)
WY	0.10 (40)	0.00 (0)	0.00 (0)
Total	99.99 (39,825)	99.77 (1,498)	99.38 (718)

Data are percentages. Columns do not total to 100% due to rounding.
*Data were computed using a 1999 estimate of psychiatrists per capita per state from the U.S. Department of Health and Human Services,[24] and U.S. population in 2000 from U.S. Census Bureau.[25]

ity favored inclusion of bipolar disorder (54.0%) and major depression (51.9%), but respondents did not support a definition of "all disorders in the DSM-IV" (35.8%), or one that included either antisocial personality disorder (11.3%) or other personality disorders (16.8%).

Table 2 Combined Cross-Tabulations Showing Respondents' Acccuracy With Respect to Five Grounds for Commitment

State Law Status in 2001	Believes the Ground Is the Law	Believes the Ground Is Not the Law	Total (*n*)
Grave disability is grounds*	70.7	29.3	100.0 (690)
Grave disability is not grounds*	61.5	38.5	100.0 (13)
Relapse is grounds†	19.0	81.0	100.0 (116)
Relapse is not grounds†	9.4	90.6	100.0 (586)
Sexual predator status is grounds‡	11.3	88.7	100.0 (320)
Sexual predator status is not grounds‡	4.2	95.8	100.0 (382)
Alcohol addiction is grounds§	37.2	62.8	100.0 (86)
Alcohol addiction is not grounds§	10.0	90.0	100.0 (617)
Drug addiction is grounds‖	20.0	80.0	100.0 (145)
Drug addiction is not grounds‖	9.0	91.0	100.0 (558)

*Pearson $\chi^2 = 0.518$, $p = 0.472$; Goodman-Kruskal gamma = 0.203 (Several cells were sparse, and so the χ^2 statistic is suspect).
†Pearson $\chi^2 = 9.100$, $p = 0.003$; Goodman-Kruskal $\gamma = 0.386$.
‡Pearson $\chi^2 = 12.660$, $p < 0.0001$; Goodman-Kruskal $\gamma = 0.487$.
§Pearson$\chi^2 = 48.070$, $p < 0.0001$; Goodman-Kruskal $\gamma = 0.683$.
‖Pearson $\chi^2 = 14.062$, $p < 0.0001$; Goodman-Kruskal $\gamma = 0.435$.

Grounds for Commitment

All respondents believed "dangerous to oneself" and "dangerous to others" were grounds for commitment in their states. Most respondents (70.6%) believed "inability to care for oneself" (grave disability) was grounds for commitment. A much smaller percentage of respondents believed that illness relapse (11.0%), alcohol addiction (13.4%), or drug addiction (11.2%) were grounds. Nearly all of the respondents wanted a commitment law that includes dangerousness to self and dangerousness to others as grounds. A substantial majority (89.6%) also wanted grave disability to be grounds. A bare majority (51.6%) favored illness relapse, while smaller percentages supported commitment for drug addiction (22.3%), alcohol addiction (22.0%), or for classification as a sexual predator (26.1%).

Outpatient Commitment

Respondents were asked whether they believed their states allowed involuntary commitment on an outpatient basis. A majority (53.5%) believed that their states allowed involuntary outpatient commitment, while 28.1 percent believed their states did not allow it, and 18.4 percent said they did not know. Respondents who did not answer "yes" to the question were then asked if they supported a state law to allow it. More than two-thirds (68.8%) of the respondents supported passage of a law allowing outpatient commitment, while 13.8 percent opposed such a law, and 17.5 percent had no opinion.

Accuracy About Commitment Law

All respondents were correct in believing that danger to self and danger to others were grounds for commitment in their states. Because all states allowed commitment based on dangerousness, and respondents were all correct, the following discussion applies to the remaining grounds. Respondents were less accurate as to alcohol addiction (83.5%), addiction relapse (78.8%), drug addiction (76.4%), grave disability (70.1%), and sexual predator status (57%). However, the accuracy rate is perhaps better explained by examining the percentage of correct responses both as to whether the particular ground was the law or was not the law, in each case, rather than on overall accuracy. Table 2 shows the combined cross-tabulation results for each of the grounds, showing whether a particular ground was or was not the law in each state (rows) by whether respondents believed each ground to be the law (columns). For example, most respondents (70.7%) were correct in believing grave disability was a ground for commitment in their states when it was a ground; however, the majority (61.5%) of respondents also believed grave disability was the law when it was not (Table 2). For the remaining grounds, when the ground was the law in their states, a relatively small percentage of respondents were correct in believing that the ground was the law. For example, where sexual predator status was grounds for commitment, only 11.3 percent of respondents believed such a commitment was per-

Table 3 Acuracy of Responses About IOC

State Law Status in 2001	Believes IOC Is Allowed	Does Not Believe IOC Is Allowed	Does Not Know	Total (*n*)
State allows IOC	59.86	22.36	17.78	100.00 (568)
State does not allow IOC	26.32	52.63	21.05	100.00 (133)
Total (*n*)	53.50 (375)	28.10 (197)	18.40 (129)	

Data are percentages. Pearson $\chi^2 = 58.435$, $p < 0.0001$, Goodman-Kruskal $\gamma = 0.325$.

mitted (Table 2). However, when the ground did not provide a basis for commitment, respondents were overwhelmingly correct when they said it did not. For example, in states in which sexual predator status is not a ground for commitment, 95.8 percent of respondents knew that it was not. Accuracy as to whether a ground was not the law appears to be largely due to relatively few respondents' believing that grounds apart from dangerousness and grave disability were permissible grounds for commitment. For example, only 7.4 percent of all respondents believed that sexual predator status was grounds for commitment, but nearly half (45.6%) of respondents lived in one of the 17 states that allowed commitment on such a basis in 2001.[27,28] Nonetheless, while respondents were not highly accurate, for each of the grounds (with the exception of grave disability), respondents were significantly ($p \leq .003$) more likely to be correct than not (Table 2).

Most respondents (59.9%) in states where outpatient commitment is allowed were correct in their responses (Table 3). In states where outpatient commitment is not allowed, a bare majority (52.6%) of respondents were correct in saying that their states did not allow outpatient commitment.

Results showing the respondents' accuracy should be interpreted with caution, for the reasons presented in the Discussion section.

Discussion

The particular wording of commitment statutes is often the subject of much contention. Respondents supported a relatively limited definition of mental disorder for purposes of commitment, as psychiatrists did in the latest national survey.[15] As to grounds, nearly all respondents favored "danger to self" and "danger to others," and nearly 90 percent favored the grave-disability standard. In the last national survey,[15] support for the grave-disability ground was more limited, with a mean score in support of 4.3 of a possible 7.0. It appears that 90 percent support was stronger than 4.3 of 7.0; however, it is difficult to compare yes/no responses to those given according to a Likert-like scale. For example, some respondents in this study who checked the "inability to care for self" box may have only weakly supported that ground. If the current results could be read as increased support, this may be due to the widespread adoption of the grave-disability standard into most states' laws—whether by amendment or court decision—in the interim period. Analysis of the data reported elsewhere[29] shows that respondents who believed grave disability (as well as each of the other grounds) was a ground in their states were significantly more likely to want that ground to be law. Greater support for grave disability may also be due to its increased use, estimated by some to be the most used ground for commitment.[30]

There was only tepid support (51.6%) among respondents for the "relapse" standard. A study in 1969[17] found that only 10 percent of responding psychiatrists supported commitment based on mental illness alone. By the late 1970s, 48 percent of the psychiatrist respondents favored commitment based solely on mental illness.[15] While the percentages in that study and in the current study are similar, the questions were worded differently, with the question in the current questionnaire being much more specific ("relapse of a severe and chronic mental illness"). A similar percentage supported commitment based on mental illness in a 1980 study[31] (50% of the respondents in Connecticut and 35% percent in the District of Columbia); however, the mental illness in that survey was identified as psychosis. Thus, it could be surmised that respondents would be less supportive of the broader mental illness standard than were psychiatrists in that study. In contrast, it could also be assumed, given the similar percentages in the three studies, that psychiatrists have a similar concept of mental illness when it comes to a basis for commitment (i.e., that it must be serious, akin to psychosis).

The lack of clear support for the illness-relapse ground should be of interest to those considering expanded grounds for commitment. While illness relapse alone is not strictly correlated to the criteria found in some state statutes, which link "deterioration" more explicitly to a potential recurrence of dangerousness, it appears that APA members are clearly divided about expanding grounds for commitment. Considering that the APA itself has supported similar expanded grounds for inpatient commitment,[13] and more recently has supported expanded grounds for outpatient commitment,[32] there is a question as to how closely the APA's official views reflect those of its members in this controversial area. Questions about such a possible disconnect have been raised before.[33]

The respondents showed a clear lack of support for commitment for alcohol addiction (22.0%) and drug addiction (22.9%). (A study of psychiatrists from England and Wales[34] found less than 10% support for commitment among psychiatrists in those countries.) This result appears to show a decline in support since the last national study,[15] which reported the mean response from psychiatrists favoring commitment based on alcoholism and drug addiction to be 3.9 of a possible 7.0. Cautions about comparing yes/no responses to those on a Likert-like scale apply here as well. In addition, responses may not be comparable because of the differing forms of the questions. In the prior study,[15] the question about substance abuse was asked in the following way: "When mental illness is used as a criterion for civil commitment, this phrase should include. . ." (Ref. 15, p 271); thus, when respondents chose "alcoholism" or "drug addiction," they were not necessarily endorsing commitment solely on that basis, but were only voting to include those categories in the list of disorders making one eligible for commitment. A person with a substance disorder would still have to meet the requirements of the commitment statute, whether that is danger to self, grave disability, or simply the ability to benefit from treatment, as a result of the substance abuse. Here, respondents were presented with substance addiction as the sole criterion for involuntary treatment. Respondents might have been more in favor of treatment if substance abuse had been presented as a type of mental illness, with other conditions (such as dangerousness) necessary for commitment.

As discussed earlier, respondents were given seven choices of grounds for commitment, not including other. The choice "mentally ill only" or "mentally ill and could benefit from treatment" was not provided, given that only one state (South Carolina) apparently allowed involuntary commitment on such expansive grounds in 2001. It was thus presumed that APA members would not favor commitment on this basis. However, in response to a hypothetical question not reported in the current data, respondents showed a tendency (mean = 4.05) to override a strict commitment statute and to hospitalize a person involuntarily who was described as "mentally ill and could benefit from treatment." This suggests that perhaps there remains significant support for this most expansive commitment ground. It is of course impossible to tell from this survey if respondents' tendencies to support commitment for mental illness show only a personal preference, a professional preference, or a desire for actual legal change.

Overall, respondents' tendencies to support relatively limited grounds for commitment may be related to respondents' ambivalence about the use of involuntary commitment. In response to a question (not reported above), respondents were slightly more likely to agree than disagree (mean = 3.59) that "use of involuntary commitment against a patient damages the psychiatrist/patient relationship." The perception that legal coercion is inconsistent with a positive therapeutic relationship might (at least in part) lead some psychiatrists to favor limited grounds for commitment. Of course, there are many other reasons that psychiatrists might favor limited grounds. Some may rely on traditional libertarian notions of individual freedom, while others may feel that patients do not derive much (or as much) benefit from treatment that is legally coerced, particularly in the area of substance abuse.[16]

The respondents' knowledge of the law may also be of some concern (Tables 2, 3), and thus more education about the contents of the law may be in order. However, it is also true that respondents showed the greatest familiarity with the grounds that they were most likely to encounter in practice (dangerousness to self or others) and were least likely to be correct about the ground of sexual predator status, which is used infrequently and almost always in connection with impending release of a sex offender from incarceration. Commitment procedures based on substance abuse alone are also apparently seldom used. The grave-disability ground, while widely used in commitment proceedings,[30] may be more com-

mon in public sector practice, in which most respondents were not involved. Generally, psychiatrists may rely more on clinical perceptions of need for commitment than the grounds provided in the exact wording of state statutes.

The respondents also were imperfect in their knowledge of whether their states provided for outpatient commitment. In those states allowing outpatient commitment, almost 60 percent of respondents were correct in saying that their states allowed it (almost 18 percent did not know), while in those states where outpatient commitment was not allowed, just over 50 percent were correct in saying that their states did not allow it, and almost 20 percent said they did not know (Table 3). This result is of some concern. The merits of outpatient commitment are debatable. Some[34] claim it unnecessarily expands the umbrella of commitment, while others[35] believe it may actually reduce the number of inpatient commitments. However, it is probably desirable, from the viewpoint of both policy and practice, if psychiatrists are at least aware of its legal status and availability in their states.

However, caution should also be exercised in interpreting these results, because whether respondents were correct or incorrect about certain grounds is somewhat difficult to ascertain, for several reasons. First, respondents may have answered the question as to what their state code provides, intentionally not taking into account the rulings of state courts. (For example, the grave-disability standard has been incorporated into "dangerousness" or "injury" to self by several state appellate courts.) In addition, respondents were given limited choices that they may have believed did not accurately reflect their states' laws. In particular, the illness-relapse ground was expressed as "relapse of a severe and chronic mental illness," whereas some states have crafted their statutes in terms of "deterioration." Last, actual practices in some states or localities may provide for commitment on certain grounds (such as grave disability) when the grounds are not explicitly included in the statute, and appellate courts have not yet ruled on the matter. In addition, the exact meaning of "outpatient commitment" may have been unclear. Some states use the term "involuntary outpatient treatment" and some commentators (and some respondents) have expressed discomfort using the term "commitment" to apply to outpatient treatment, even if it is involuntary. In addition, even when allowed by statute, the availability of involuntary outpatient treatment may vary considerably by locale.[35]

Several limitations concerning potential bias should be considered. First, APA members may not be representative of all psychiatrists. However, approximately 85 percent of U.S. psychiatrists are APA members, and studies have found APA members' sociodemographic and training characteristics to be similar to those of U.S. psychiatrists as a whole, taken from the American Medical Association's Masterfile.[36] A second point of concern is that APA members (and psychiatrists generally) are concentrated in certain states (and urban areas within those states). For example, the top eight states in the number of questionnaires returned (New York, Massachusetts, California, Maryland, North Carolina, Illinois, Ohio, and Pennsylvania) accounted for 47.95 percent of the total returns (two states were not represented at all; Table 1). One study[17] avoided this problem by selecting eight psychiatrists from each state; however, this method creates a data analysis problem by not using a national random sample. Thus, care should be taken in using the data in particular states supposedly to show the psychiatrists' point of view. Nevertheless, it should be noted that other research concerning this data set[29,37] has found limited significant relationships involving respondents' opinions by geographic region.

Another potential element of bias involves the decision to oversample two APA membership sections: Suicide and Emergency Psychiatry. The members in these sections were thought likely to have had more experience with involuntary commitment and therefore to be more likely to respond to the survey. However, response rates for the three groups—APA general members (46.6%), Emergency Psychiatry section (46.4%), and Suicide section (50.8%)—did not reach statistical significance. In addition, the section members had very few statistically significant differences with general members in survey responses, and contrary to expectations, did not have significantly more experience with commitment.

A similar concern may arise from the decision to survey APA members even though a different group of psychiatrists (such as hospital directors or members of the American Association of Community Psychiatrists) may have had more experience with commitment. However, prior studies involving involuntary commitment[15,17,23] have also surveyed APA members, and other surveys[16,22,31]

have used general membership lists from state psychiatric associations. Surveying APA members allows for a more direct comparison between the results of those prior surveys and the results of this research. In addition, the APA is the most prominent psychiatric organization in the United States and occasionally takes policy positions regarding involuntary commitment. Surveying APA members tests the fit between the APA's official stance and the opinions of its members. In addition, as mentioned, a significant majority (61.8% overall) of respondents had been involved in some way in a commitment proceeding in the prior 24 months. (In comparison, a study of Illinois psychiatrists[16] reported that 62% of respondents had been involved in a commitment proceeding in the prior 5 years.)

Nevertheless, it could be imagined that opinions of psychiatrists who regularly treat the involuntarily committed could differ from those of psychiatrists who treat few such patients. For example, there are widespread reports of clinicians' frustration with the "revolving door" of psychiatric readmissions. Thus, it might be predicted that psychiatrists with greater commitment experience would favor less stringent commitment criteria. However, it is also possible that the same psychiatrists might favor expanded outpatient treatment and community monitoring rather than less strict inpatient commitment grounds. In the current survey, there were no statistically significant differences between amount of experience (when coded as either a two- or three-level variable) and any of the questions reported herein. Another area of concern is that, while the usable return rate compares favorably with similar research, it is nevertheless below that considered ideal in survey research.[38] However, there were no statistically significant differences between the two waves of respondents on any questions reported herein. Thus, it can be fairly concluded that a further wave of mailings would not have significantly altered responses.

Conclusions

Discovering the views of psychiatrists about involuntary commitment is important because psychiatrists provide information and opinions to legislators and others in crafting legislation, and survey research lets us know where psychiatrists stand on these matters. It is important to present opinions publicly and to identify areas of controversy to encourage discussion. State laws beginning in the 1960s tended toward greater rights for subjects of civil commitment and also tightened definitional criteria. More recently, states have begun to make involuntary commitment easier (for example, by introducing the "relapse" or "deterioration" ground, and by expanding outpatient commitment), perhaps out of a sense that reforms had gone too far. These respondents tended to support relatively limited commitment criteria.

More study regarding what psychiatrists perceive as grounds for commitment is warranted. The choices provided in this study could be expanded to include more bases for commitment. For example, choices might include more specific deterioration grounds as well as a "mental illness only" type ground (given respondents' tendency to agree to override a strict statute and involuntarily commit a person who is "mentally ill and could benefit from treatment"). Studies of other groups involved in the commitment process—such as psychologists, social workers, masters-level counselors, members of consumer groups, the public, and mental health lawyers—would also add to the body of knowledge about opinions concerning commitment. The last surveys were published in the 1970s and 1980s, and surveys of judges' opinions about commitment are particularly scarce. Such research would further clarify the differences between the views of APA members and other stakeholders and would show where each group's responses lie on the continuum of opinion of interested parties. Research may also explore the attitudes of those psychiatrists who are most heavily involved in the commitment process.

More research is warranted regarding the relationships concerning more macro-level variables regarding clinicians' opinions about commitment. Published[29] and unpublished[37] research from these data suggests that state-level variables (such as region of the country and state political climate) have few significant relationships with survey responses. It may be that psychiatrists' professional affiliation has a stronger effect than that of state-level variables, or it may be that the particular state-level variables chosen for the larger analysis in this study[37] were inappropriate or were insufficiently sensitive.

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