

Clinical Implications of Violence Risk After Civil Commitment in Florida

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In their article, Swanson and colleagues examine the long-term risk of firearm-related and other violent crime in a large population of adults with serious mental illnesses following a gun-disqualifying involuntary civil commitment, compared with similar individuals who were evaluated for commitment but released or voluntarily admitted and with a third group with no holds or commitments. They build on prior research from a sample of individuals from public behavioral health systems of two large counties in Florida. This commentary provides further context for their research by highlighting additional factors related to mental health in the state of Florida. Understanding recent legislation regarding the medical privacy of firearm owners, mental health spending, trends in involuntary examinations, and related firearm laws in Florida will contribute to describing the backdrop of the current study. While Swanson's research proposes greater policy implications, this commentary will examine the direct impact on the practice of clinical psychiatrists.

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The involuntary psychiatric examination of a patient with mental illness is a solution for a short-term problem, namely the safety of the patient or others. Although all states and Washington, D.C., have legal mechanisms to hold a patient in a health care facility for treatment or stabilization without consent, these statutes, collectively referred to as "emergency hold laws," vary greatly with regard to who can initiate the hold as well as the duration, criteria, and regulation of the hold.¹ Depending on the jurisdiction, statutes allow emergency holds or treatment when a person is a danger to self or others due to mental illness, a danger to self or others without specifying if mental illness is the cause, gravely disabled or unable to meet basic needs, or has recently attempted suicide.

Dangerousness criteria are often interpreted as imminently dangerous. In my experience as a psychiatric resident testifying in civil commitment hearings on a psychiatric inpatient unit (in Maryland), it was not uncommon for a patient to be released because

the court disagreed that the safety of the patient presented an immediate crisis. For example, some patients who made a suicide attempt but no longer endorsed suicidal thoughts when in the hospital were found to no longer meet criteria for civil commitment and were thus immediately released. Other patients who were involuntarily examined due to acute psychosis may also have been released at the weekly civil commitment hearing despite ongoing psychosis, again from a perceived lack of imminent dangerousness. As residents, we often wondered if these patients were released due to our inexperienced testimony, the preferences of the administrative law judge presiding over the hearings, or simply because too many patients were inappropriately being held and the proper response was to release them.

Like mental health laws in other states, the Florida Mental Health Act, also known as the Baker Act, has provisions for involuntarily examining and holding a patient.² Swanson and colleagues' current investigation³ studied a population of adults with major mental illness from two large Florida counties between 1998 and 2011. Their analysis focused on individuals who were either disqualified from owning guns following civil commitment or were evaluated but released or voluntarily admitted, thus retaining their gun rights. As the authors note, an important caveat

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is that the study was conducted in a single state. Although they state the reason for the caveat is the “unusually high number of short-term holds for examination not resulting in involuntary commitments” (Ref. 3, p 11), this is but one important limitation for the location of the study’s sample population. There are additional considerations that should be elucidated to understand the state of mental health care in Florida. Having practiced in Florida for 10 years, I will present other contextual factors before considering the direct impact on the practice of clinical psychiatrists.

First, physicians in Florida were embroiled in a six-year legal battle from 2011 to 2017 about the ability to ask patients about firearms ownership. In 2012, I wrote with colleagues⁴ about a recently enacted Florida law governing medical privacy concerning firearms (Fla. Stat. 790.338), which appeared to bar physicians from being able to ask patients about firearms ownership unless safety was an immediate concern. In 2015, the 11th Circuit Court of Appeals upheld the law in a 2–1 decision.⁵ The law directed that a health care practitioner or facility “may not intentionally enter any disclosed information concerning firearm ownership into the patient’s medical record if the practitioner knows that such information is not relevant to the patient’s medical care or safety, or the safety of others” (Ref. 4, p 399). Then in an “unusual step” (Ref. 6, p 648) later in 2017, the 11th Circuit Court of Appeals withdrew their opinion before they voted on the plaintiffs’ request for a rehearing *en banc* and wrote a new decision⁷ striking down the law, with two judges now acknowledging that the law infringed on physician’s First Amendment rights. Florida officials did not appeal that ruling. Before the resolution of this appeal, Florida physicians, especially psychiatrists, were uncertain how to proceed with what many considered important questions regarding safety evaluations and preventive care. Guidance on whether to ask patients if they owned firearms varied greatly depending on who was asked: colleagues, administrators, ethicists, general counsel, or the state psychiatric group. Although the law is now silenced in Florida, the question remains whether other states will be discouraged from adopting similar gag laws and when next the greater political and social debate in the United States over firearms will affect medical practice.

A second contextual factor for Swanson’s study population in Florida is to understand the limits of mental health spending in the state. Using national

survey data, Mental Health America’s Annual State of Mental Health report (considering 15 measures) ranked Florida as 32nd in the United States.⁸ This indicates a higher prevalence of mental illness and lower rates of access to care. In 2010 (near the end of the study), Florida ranked 49th in mental health spending per capita at \$39.55.⁹ Per capita mental health spending varies greatly across the country; for example, Maine spends over 10 times more than does Florida.¹⁰ Limited mental health resources and funding present a significant challenge to practicing psychiatry in Florida.

While Swanson is correct that Florida has a high number of short-term holds for examination in comparison to the number of involuntary commitments, a third factor to consider are trends in the use of involuntary examinations in the state.¹¹ Involuntary examinations in the entire state of Florida increased by 16.26 percent from fiscal year 2013–2014 to fiscal year 2017–2018. The sample population from Swanson’s study was composed of adults from Miami-Dade and Pinellas counties. From fiscal year 2013–2014 to fiscal year 2017–2018, Miami-Dade County had a 19.57 percent increase in involuntary examinations with a 6.22 percent population increase, and Pinellas County had a 25.78 percent increase in involuntary examinations with a 3.82 percent population increase. The use of involuntary examinations in the two counties of the study population have increased more than the rest of the state. In general, the use of involuntary examinations is clearly on the rise in Florida, more than doubling (115.31% increase) in the 17 years from fiscal year 2001–2002 to fiscal year 2017–2018.

Notably, psychiatrists are not the individuals most commonly initiating involuntary examinations in Florida. In fiscal year 2017–2018, 51.67 percent of involuntary examinations for Florida residents were initiated by law enforcement, 46.31 percent by professional certificate, and 2.02 percent by *ex parte* order.¹¹ Of the involuntary examinations initiated by professional certificate, 68.04 percent were initiated by a nonpsychiatrist physician, followed by 9.28 percent by a psychiatrist. The remainder of involuntary examinations were initiated by licensed clinical social workers, licensed mental health counselors, clinical psychologists, psychiatric nurses, licensed marriage and family therapists, and physician assistants. Law enforcement officers and physicians who are not psychiatrists are initiating the majority of involuntary examinations in Florida.

Another factor to help understand the context and implications beyond what Swanson and colleagues³ have described is to know that not all U.S. citizens are required to register their firearms. As of January 2019, while six states and the District of Columbia required individuals to register their ownership of certain firearms with local law enforcement agencies, eight states prohibited the creation of such registries except in limited circumstances.¹² Florida is one of the states prohibiting registration of firearms, stating that such registration is “an instrument that can be used as a means to profile innocent citizens and to harass and abuse American citizens based solely on their choice to own firearms and exercise their Second Amendment right to keep and bear arms as guaranteed under the United States Constitution.”¹³ Exceptions to this provision requiring registration in Florida include recording firearms used in committing any crimes or reported as stolen, and for any person convicted of a crime. Florida’s prohibition of gun registration exists despite the number of guns in the state. In 2019, Florida ranked second in the number of guns registered (432,581) in the United States, behind Texas with 725,368.^{14,15} After the 2018 shooting at Marjory Stoneman Douglas High School in Parkland, Florida, however, Florida passed several gun safety bills (SB 7026 – Marjory Stoneman Douglas High School Public Safety Act),¹⁶ including raising the minimum age to purchase firearms to 21 years (although minors between 18 and 21 are not prohibited from possessing a firearm),¹⁷ requiring a three-day waiting period,¹⁸ and creating an extreme risk protection order law.¹⁹

Finally, Florida is also one of the states that have expanded the federal prohibitions of selling firearms to those adjudicated mentally defective or civilly committed beyond the Brady Act to a broader population.²⁰ In 2013, Florida enacted a law that if a patient had a voluntary admission following an involuntary examination, then the physician may certify that the patient is an imminent danger to self or others and that the patient would have been involuntarily treated if the patient did not agree to voluntary treatment.²¹ The patient receives written notice before agreeing to voluntary treatment that the patient may still be prohibited from purchasing a firearm.

Swanson’s study³ builds on prior research.²² I have no criticism of the current methods, results, or conclusions. Instead, I hear the voice of one of my favorite attending physicians who always asked students

after they presented research articles during rounds: “What does this mean for our patient?” While I admire my mentors and colleagues who share their expertise to shape the public policy related to mental health, I remain puzzled as to whether there is a direct, practical impact of this research for the clinical psychiatrist who treats patients and worries about future risk of violence.

Let us consider a case example of an individual who is likely similar to those in the sample population: a 25-year-old man with a diagnosis of schizophrenia is brought to an emergency room in Florida for an involuntary examination (i.e., the Baker Act), which was initiated by law enforcement for concerns that the patient was acutely psychotic with thoughts of harming himself and others. Most psychiatrists have evaluated a patient meeting this description numerous times. Depending on a number of risk factors, the psychiatrist evaluating this patient in an emergency room is faced with a fundamental (but complex) decision to admit or discharge. If the individual is admitted, the inpatient psychiatrist must evaluate, treat, and determine how long the patient should remain hospitalized. Further, the patient may be offered the opportunity to sign in as a voluntary patient or continue under involuntary legal status, and then the treatment team may continue with civil commitment. This sequence is a common clinical course in psychiatry.

The study by Swanson *et al.*³ offers a robust analysis of the risk of violent crimes based on short- and long-term hold but provides little guidance to the psychiatrists who may interact with the case patient. Given that “gun-involved crime arrests occurred less frequently than expected in persons who experienced involuntary commitment” (Ref. 3, p 12), clinicians may be prompted to consider extended hospitalizations to mitigate risk. Increased hospitalization duration might afford more time to adjust medications, monitor for side effects and adherence, obtain collateral information, and construct a more comprehensive discharge plan. Certainly, lengthier hospitalizations have obvious disadvantages, including loss of liberties and the financial burden, which cannot be ignored. If the extended hospitalization was due to involuntary commitment, then the individual would incur a legal disability to purchase or possess firearms in Florida. Even an individual allowed to sign in voluntarily in Florida may also be prohibited from purchasing firearms. Swanson *et al.* suggest that our case patient might have

improved outcomes regarding risk of gun-related crimes: “Involuntary commitment and the hospital treatment that accompanies it can exert a protective effect in regard to gun-involved violent crime in particular, including homicide” (Ref. 3, p 12). Further, “having a record of either a short-term hold or a record of involuntary commitment significantly increased the risk of future arrest for any violent crime, compared with having neither of these statuses” (Ref. 3, p 9).

While Swanson *et al.*³ analyzed the long-term risk of violence arrests for these individuals, they provide little assistance to the psychiatrists who are in their clinics, emergency rooms, or hospitals faced with the decision whether to initiate an involuntary examination, to release the patient after a short-term hold, to proceed with civil commitment, or to continue with a voluntary hospitalization. The problem is that the involuntary examination is for mitigating the imminent risk, treating the patient in the least restrictive setting, attending to the safety of the individual and the public, respecting patient autonomy, minimizing harm to the patient, and prioritizing resources. The decision when and how to use a short-term psychiatric hold is focused on the current clinical situation and, at most, the near future. The psychiatrist making these complex clinical decisions is not well situated to consider the risk of violent crimes six to seven years in the future, i.e., the duration of the study period.

The current work reminds us of the many challenges that exist in our profession in the United States. Our health care system is broken, patients with mental illness are discussed in partisan debates, and funding affords few resources for a disenfranchised population. The stigma of mental illness runs rampant in discourse that separates an ever-growing list of people into “us” versus “them.” I propose that the research by Swanson *et al.*,³ however, suggests opportunities to improve mental health treatment in a way perhaps more immediate than influencing public policy surrounding civil commitment and firearm legislation. According to the American Psychiatric Association’s Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry:

Section 3: A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient (Ref. 23, p 2).

Section 7.2: Psychiatrists may interpret and share with the public their expertise in the various psychosocial issues that may affect mental health and illness (Ref. 23, p 9).

First, there is an obvious need to provide training and education to physicians who are not psychiatrists on the use of involuntary examinations. Psychiatrists have opportunities for direct interactions with non-psychiatrists through in-service trainings, participating in collaborative models, and serving on hospital committees. Second, there is a need to increase the number and variety of comprehensive services available to our patients so that clinicians have more choices than simply to admit or discharge. On local and regional levels, psychiatrists can advocate and lead these program developments for improved crisis-response teams, residential services, intensive outpatient programs, and partial hospitalization programs. Third, psychiatrists may consider forensic opportunities to evaluate firearm rights restoration for persons under mental health prohibition, especially considering the increasing rates of involuntary examinations. Resources are available to guide those unfamiliar with these cases.^{24,25} Finally, psychiatrists have a role in spreading the scientific message about violence and mental illness, taking the opportunity to advocate for our profession and to speak with colleagues and the community about this burgeoning body of research.

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