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# Healing Hands



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**Involuntary Commitment:  
Ethics at the Nexus of Mental  
Health Care and Homelessness**

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## I. Introduction

In November, the Mayor of New York City announced that emergency services would be focusing on a new city-wide effort to remove people suffering with severe mental illness from the streets of the city and place them in psychiatric care facilities. In his speech announcing the initiative, Mayor Eric Adams said, “The common misunderstanding persists that we cannot provide involuntary assistance unless the person is violent... This myth must be put to rest. Going forward, we will make every effort to assist those who are suffering from mental illness and whose illness is endangering them by preventing them from meeting their basic human needs.”<sup>1</sup>

This announcement prompted a fresh round of public debate on the topic of involuntary commitment (IC). Some observers have applauded the city’s acknowledgment of the link between inadequate mental health care and homelessness, while others have expressed concern that efforts such as these cannot be comprehensive unless they are undertaken in conjunction with expanded access to housing and other services. Others note that chronically-underfunded mental health care systems need investment and reform in order to respond effectively to an influx of patients. Still others have expressed concern that civil liberties may be violated with the implementation of this policy, since the updated policy seems to expand the conditions under which involuntary commitment may be undertaken;<sup>2</sup> whereas previous guidance suggested that a person had to pose an immediate danger to themselves and/or others, this new policy leaves much more leeway for interpreting what “immediate danger” means, and allows more actors than before, including police officers, to make that assessment on the spot and respond accordingly.<sup>3</sup>

For health care providers working with people experiencing homelessness, involuntary commitment has long been one of the thorniest debates in the field. Involuntary commitment occurs in challenging contexts where clinicians are attempting to balance their commitment to saving lives with their responsibility for protecting the autonomy of their patients, who are already experiencing complex vulnerabilities. Dr. Catherine Crosland, Medical Director of Emergency Response Sites for Unity Health Care, Inc., in Washington, DC, sums up the dilemma like this:

“ I approach this topic very cautiously, as I think most providers in my situation do, because we absolutely want to respect the freedom and autonomy of our patients, and we want our patients to have the opportunity to live the happiest and healthiest lives that they can. We certainly don’t want to medicalize or criminalize homelessness, and using IC or civil commitment (CC) as a solution to homelessness is not at all the answer. All of us take it very seriously if we get to that point. So it’s one of the biggest moral dilemmas that we grapple with on a daily basis—you want to respect someone’s moral autonomy but it is painful to see someone who is living in terrible conditions and lacks insight into a mental illness that is ravaging them.”

- Dr. Catherine Crosland

Moreover, many clinicians struggle with the decision to utilize involuntary commitment because it does not always result in a meaningful change for the patient; it is common for a patient in crisis to be held in a hospital for 72 hours, then released back onto the street without a plan for long-term care. For this reason, says one care provider, “IC is one of the most difficult moral dilemmas that we face on a near-daily basis. On one hand, it’s hard to see someone you care about living in difficult situations and you want to give them the meaningful opportunity for health and well-being. On the other hand, we don’t want to put people in handcuffs for any reason, especially because within current systems, there may not be a meaningful intervention.” Because of these difficulties, involuntary commitment is generally understood within the field to be a last-resort measure, to be utilized only when a person’s life is at risk.

This issue of Healing Hands aims to unravel some of the difficulties at the core of the conversation about involuntary commitment. We will first look at the landscape of mental illness and homelessness in the United States, then some of the key issues and quandaries involved in involuntary commitment. We’ll discuss some interpersonal practices and communication strategies that clinicians can incorporate to lessen the trauma involved in involuntary commitment, and look at some considerations for structural and systemic change.

## II. Mental Illness and Homelessness

The relationships between mental illness, homelessness, substance use, and incarceration are incredibly complex, and often oversimplified in public discourses. Mental illness and substance use disorders are linked in complex ways, and are both drivers



*“Another Winter Will Come” by Misha, PhotoVoice Digital Exhibit, Healthcare Without Walls, Wellesley, MA*

## II. Mental Illness and Homelessness (cont.)

and results of homelessness. The following statistics for the United States illustrate the breadth of the mental health challenge faced by the country:

- **1 in 5 adults—43.8 million or 18.5%—experiences mental illness in a given year**
- **Among the 20.2 million adults who experienced a substance use condition, 50.5% (10.2 million adults) had a co-occurring mental illness**
- **1 in 5 youth aged 13-18 (21.4%) experiences a severe mental health condition at some point during their life; for children aged 8-15 that estimate is 13%**
- **46% of homeless adults staying in shelters have a mental illness and substance use disorder**
- **20% of state prisoners and 21% of local jail prisoners have a recent history of a mental health condition**
- **70% of youth in juvenile justice systems have at least one mental health condition**
- **60% of all adults and almost 50% of all youth ages 8-15 with a mental illness received no mental health services in the previous year<sup>4</sup>**

The United States' underfunded mental health care systems are inaccessible for many people and unaffordable for others. Moreover, a symptom of many mental health challenges is an inability to perceive risk accurately, which may result in increased resistance to treatment opportunities that are offered. An estimated 50% of individuals with schizophrenia and 40% with bipolar disorder have symptoms of anosognosia, or "lack of insight"—"a symptom of severe mental illness experienced by some that impairs a person's ability to understand and perceive his or her illness. It is the single largest reason why people with schizophrenia or bipolar disorder refuse medications or do not seek treatment. Without awareness of the illness, refusing treatment appears rational, no matter how clear the need for treatment might be to others."<sup>5</sup> Care providers who work with people experiencing homelessness are therefore often in contact with individuals dealing with untreated mental health conditions, which may co-occur with and aggravate physical health issues and socioeconomic difficulties.

Mental illness is in many cases a life-or-death issue. Public conversations—including the recent conversations in New York City—often center this part of the conversation around the public safety risk posed by people living with mental illness and in conditions of homelessness. Research does indeed indicate that improved access to mental health care lowers homicide rates,<sup>6</sup> but it is also important to mention that people experiencing homelessness experience heightened rates of violence—making them more likely to be victims of a violent crime than perpetrators of a violent crime— as well as increased risk of suicide or death from health conditions, exposure, and other factors related to homelessness.<sup>7</sup>

## II. Mental Illness and Homelessness *(cont.)*

**Dr. Dave Iverson** is the Director of Psychiatry at the Colorado Coalition for the Homeless, and a Senior Instructor of Psychiatry at the University of Colorado School of Medicine. He notes that in order to fully understand the current mental health care landscape, it is necessary to back up a number of decades. History tells us that in 1955 there were 340 public psychiatric beds available per 100,000 U.S. citizens, but by 2005, the number shrunk to 17 beds per 100,000 persons.<sup>8</sup> Dr. Iverson explains:

“The United States embarked on de-institutionalization starting in the 1960s and culminating with aspects of the Civil Rights Act and Kennedy. We started emptying out historical state hospitals across the country. Many people point out that this experiment in de-institutionalization started with the best intentions, as old state hospitals were [known for] awful conditions. These institutions were nothing the country could be proud of, but we had them for a logical reason. As long as we’ve had people, society has tried to help folks with serious mental illnesses and also sometimes protect the public when those same individuals are a risk to others.

With the advent of new medication options in the 1950s and early 1960s, and with a focus on civil rights, and with the understanding of negative aspects of state hospitals, the country optimistically set out to help people stay in their communities with access to these medications. But the money that was promised to community mental health systems never fully materialized, and our mental health system coped with that reality in a disadvantageous way, [with mental health centers often only able to accept] patients who could pay and were less “trouble.” So many people who were homeless or very severely mentally ill, sometimes with legal complications or problems with aggression or traumatic brain injuries, couldn’t get access to care. This has persisted for a number of decades.

The result has been a huge rise in people with serious behavioral health conditions on the streets or in jails and prisons. That speaks to a whole other process that our field refers to as “criminalization of mental illness” or “trans-institutionalization.” People who were previously in state hospitals but are now in jails and prisons, so what have we accomplished?”

- Dr. Dave Iverson

In fact, the largest provider of “mental health care” in the United States is prisons. Laws exist throughout the country that criminalize mental illness and homelessness—and particularly their co-occurrence—resulting in a need for crisis responses that protect people in crisis but also do not result

## II. Mental Illness and Homelessness *(cont.)*

in the incarceration of individuals experiencing mental health emergencies. Because people are being arrested, detained, sentenced, and imprisoned as a result of behavior that occurs during mental health crises, providers of health care are always seeking alternatives, and confronting the core dilemma of supporting safety and access to care in a crisis while not contributing to discourses and structures of criminalization.

## III. The Involuntary Commitment Process

Broadly speaking, the generally-accepted legal standard for involuntary commitment throughout the country relies upon a) a person having an identified/diagnosed mental illness, and b) the person posing “imminent harm,” or an immediate danger, to themselves or others. However, one of the most complicated facets of understanding involuntary commitment is the fact that each state in the US (and many municipalities) has different legal standards and judicial processes for involuntary commitment. As the Treatment Advocacy Center (TAC) puts it in Grading the States, their 2020 report on state laws related to IC, “The United States is effectively running 50 different experiments, with no two states taking the same approach. As a result, whether or not an individual receives timely, appropriate treatment for an acute psychiatric crisis or chronic psychiatric disease is almost entirely dependent on what state he or she is in when the crisis arises.”<sup>9</sup>

It is crucial for any clinician involved in involuntary commitment processes to understand the legal context for their own state and municipality (see the TAC’s state-by-state guide, compiled and available on [MentalIllnessPolicy.Org](http://MentalIllnessPolicy.Org), for details).<sup>10</sup> A few examples of differences across jurisdictions include:

- **Who is allowed to initiate the intervention**
- **The legal meaning of "imminent" harm**
- **Definitions of "harm to self"**
- **Conditions for which a person may or may not be involuntarily committed (e.g. severe mental illness, severe physical illness, dementia, or cognitive impairment such as traumatic brain injury)**
- **The relevance/admissibility of substance use to the intervention**
- **The amount of time for which a person may be involuntarily committed, and the settings in which the commitment occurs**

The basic process of involuntary commitment is: 1) Intervention, 2) Transportation, 3) Evaluation. However, there are risks of interruption at each step of this process. The involvement of multiple entities in this process means that it can be difficult to maintain an accepted standard of care across



### III. The Involuntary Commitment Process *(cont.)*

“  
*...if those things don't happen, then people don't come out believing that the system can help.*”

- Dr. David Iverson

entities in this process means that it can be difficult to maintain an accepted standard of care across all phases. This can lead to traumatic experiences for patients, and inconsistency in outcomes—compounded by the lack of resources in many communities to support in-patient care or community-based health care beyond the initial hold.

“When we debate the ethics of involuntary care,” says Dr. Iverson, “I think it breaks one way or another for people with lived experience based upon what happened to them. Some people, including colleagues and friends, tell me it saved their life—they didn't like it, but they're glad someone stepped in. And other people say it was traumatic and the worst thing that ever happened to them, and that they'll never trust the mental health system again.” The intrinsic difficulties and shortcomings of the broader system make involuntary commitment an incredibly difficult issue for clinicians—both with respect to individual cases, and as a field more broadly. However, Dr. Iverson notes that there are some critical factors for clinicians that impact the likelihood of patients receiving effective and motivational care: “Quality of care, professionalism, ethics, how closely guidelines under the law are adhered to, respectfulness, trauma-informed care, considerate behavior, and empowerment of the individual to guide their own care even in an involuntary setting—if those things don't happen, then people don't come out believing that the system can help.”



## IV. Interpersonal Best Practices for Providers

(cont.)

**Corinne Lovett** is the former Health Policy Manager for the National Health Care for the Homeless Council. Mx. Lovett has the unique experience of working in the field and also having experienced involuntary commitment themselves; in their words:

“ I have a severe psychotic disorder and bipolar disorder, and have experienced several psychotic episodes. I experienced involuntary commitment many times over the course of my life... My last psychotic episode was in 2011, and at the end of that I finally was willing to take medication. While I’ve had periods of depression since then, I haven’t had a psychotic episode or a manic episode since I’ve been taking medication. Since then, I got a college degree and started working, and now I’m in graduate school and own a house, and have a successful life. Prior to that, during my periods of prolonged active illness, I was homeless for many years. I was trafficked for several years, and it was a lot of suffering before I was able to get effective treatment for myself. Having been through it and having now come out on the other side as a person who is involved in my own care, I consider myself always working on [my mental health] and in recovery, but I am stable.”

- Mx. Corinne Lovett

“A lot of people who have been committed involuntarily don’t want to share their experiences,” says Mx. Lovett, which is reasonable since involuntary commitment is often a traumatic experience—“the worst day of that person’s life,” they call it. But Mx. Lovett also believes that sharing their experiences with the system can help other people struggling with mental health, and can also provide some insight for clinicians and others who are involved in placing patients into situations of involuntary commitment. One of the main things that made their last experience with involuntary commitment “stick,” Mx. Lovett explains, was their relationship with that particular care provider:

“ I had already had horrific experiences with involuntary commitment, but had I not been involuntarily committed that last time, I believe I would have died on the street... The last time my therapist committed me, it was the middle of February, 0 degrees, and I was wearing summer clothes and I’d been awake for 7 days and hadn’t eaten—I couldn’t remember the last time I had food. I definitely would have died if he hadn’t done it. It was a life-or-death decision, and he saved my life. I can’t emphasize that enough. I know it was a hard choice for everybody but I’m happy I’m alive. I’m happy I stuck it through and have the life I have now.”

Before that, being involuntarily committed pushed me further away from accepting treatment because I felt like I didn’t get to make my own choices and I started



## IV. Interpersonal Best Practices for Providers

(cont.)



*"Fire Cross Walk" by Alexa, PhotoVoice Digital Exhibit, Health Right 360, San Francisco, CA*

viewing mental health professionals as the “enemy.” But when I got a really good therapist, having that trusting relationship with him made me willing to see a psychiatrist and take medication. One thing I value about that relationship with that therapist was at the beginning he set out clear expectations, and described other times he'd had to commit someone and told me what their experience was like.

So really what I want providers to know is that when they establish a relationship with a patient, before the person gets to the point of crisis, the patient needs to know that [involuntary commitment] is an option in the future. The provider needs to be completely upfront and let them know that they might have to take that step.

I thought my providers wanted to control me and put me in the hospital so they wouldn't have to deal with me anymore. It should be communicated to a patient that it's an incredibly difficult decision, because it makes a big difference for re-establishing a trusting relationship. It's really important that the patient knows that it could happen, and that the provider feels for them and wants to make it as easy as possible.

I'm still with that therapist now. I've been with him for 11 years. He's still my therapist because of these steps he took to show me he cares. Him letting me know that putting me in the hospital against my will was a difficult choice and he agonized about it and it worried him that something bad might happen to me, either there or during the process or if he didn't do it. He felt he couldn't really win either way and was trying to do what I would want if I was in a better state of mind. He wasn't doing what he wanted; he was doing what I would want for myself. This was much more powerful than the line, “I was doing what's best for you.”

- Mx. Corinne Lovett

Mx. Lovett's specific memories of their various experiences with involuntary commitment are riven with the experience of “people talking over me, not talking to me, making decisions without me, and injecting medication into me without telling me what was happening.” They remember saying over

## IV. Interpersonal Best Practices for Providers (cont.)

and over that they hadn't done anything wrong: "I didn't understand what was happening, but you remember the fear, and you remember when someone doesn't treat you with respect." They recall specifically feeling terrified of police officers and handcuffs, which can be particularly triggering for people who have experienced trauma and/or have PTSD.

Reflecting on their experiences with involuntary commitment, Mx. Lovett can identify some factors that decreased the amount of trauma involved in their last experience, the one that finally positioned them to accept treatment. Based off this range of experiences, here are some suggestions for care providers:

- **Let the patient know in advance that involuntary commitment is a possibility; give them information on what is involved in involuntary commitment, and what conditions would necessitate taking that step for you, as a care provider.**
- **If a person is actively in crisis, take them into a comfortable space, if possible.**
- **Make sure at least two people are with them, for safety, but minimize their exposure to crowds and spectators.**
- **Stay with the patient through the entire process, if possible.**
- **Protect the patient's health privacy as much as possible.**
- **Don't touch the person if it can be avoided. Always ask permission.**
- **Ask for consent as much as possible.**
- **Communicate with the patient directly rather than talking over them or about them to others.**
- **Talk to the patient calmly and gently during the crisis, particularly about police presence; it may be helpful to say things like:**
  - ◆ **"The police are not here to hurt you."**
  - ◆ **"You haven't done anything wrong."**
  - ◆ **"This is for safety. We want to make sure you are safe."**
  - ◆ **"You are not going to jail. You haven't committed a crime."**
  - ◆ **"You are not being punished."**

**“ ...but you remember the fear, and you remember when someone doesn't treat you with respect”**

*- Mx. Corinne Lovett*

## IV. Interpersonal Best Practices for Providers

(cont.)

- Follow up with the patient while they are in the hospital. Call to check up on them and see how they are doing; “even one brief conversation can be crucial to making sure there is good care coordination, and to maintaining a relationship of trust.”
- “Try to think about how scary this is for the other person.” Extend care, empathy, and an offering of presence to the person.

Involuntary commitment is an ethically-complicated last-resort effort to save a life, but there are some ways that care providers can work to decrease the traumatic impact on a patient while preserving the therapeutic relationship. “Being trauma-informed is essential if you must pursue involuntary commitment,” says Mx. Lovett. “This is already the worst day of that person’s life. You can actually do so much to make it better... People might not understand everything in the moment, but when they look back they’ll remember whether you talked to them like a person.”

### Communicating with a Patient Experiencing a Mental Health Crisis

- ✓ Keep your voice calm
- ✓ Listen to the person
- ✓ Express support and concern
- ✓ Avoid continuous eye contact
- ✓ Ask how you can help
- ✓ Keep stimulation level as low as possible
- ✓ Move slowly
- ✓ Offer options whenever possible
- ✓ Ask permission before touching the person
- ✓ Be patient
- ✓ Gently announce actions before initiating them
- ✓ Don’t make judgement comments
- ✓ Don’t argue or try to reason with the person

These tips have been adapted from NAMI’s helpful guide, *Navigating a Mental Health Crisis* (2018).<sup>11</sup>

Learn more at: <https://nami.org/Support-Education/Publications-Reports/Guides/Navigating-a-Mental-Health-Crisis/Navigating-A-Mental-Health-Crisis>

## V. Promoting Social and Structural Change

The big-picture, structural issues associated with involuntary care systems are daunting, but many jurisdictions have been working toward improving processes and communications at a higher level, and many clinicians—having witnessed systemic shortcomings—are involved in pushing for improvements to the system, and pushing back against the stigma that blocks many people from accessing and receiving the care they need. As ever, education, awareness-raising, and trauma-informed care are cornerstones of mental health promotion.

## V. Promoting Social and Structural Change *(cont.)*

### Improving Care Coordination Systems

Dr. Crosland offers Washington, DC's Interagency Council on Homelessness as an example of a municipal body that is seeking to improve care coordination across the systems involved in IC/CC, by bringing together as many stakeholders as possible for multi-week conversations, culminating in a practical document that states:



*"Tired" by Steve, PhotoVoice Digital Exhibit, Daily Planet, Richmond, VA*

“ While involuntary hospitalization should never be thought of as a strategy to address homelessness in and of itself, the process can be utilized to help severely ill people get the treatment they need to eventually heal and thrive. However, taking someone’s freedom, even if the intention is to help them, must never be taken lightly. The bar for involuntary commitment should be high. Additionally, involuntary hospitalization must be seen not as the endpoint, but a component of a larger system of care. For example, it’s important to ensure the quality of the care received and to know that there is a plan for the person once they are psychiatrically and medically stabilized. When helping people in this category, stakeholders will need to continually ask: What kind of outpatient care will they receive? What kind of housing and other supports will be provided once hospitalization is no longer necessary? What are other, less restrictive settings where someone can receive residential treatment than a psychiatric hospital?”<sup>12</sup>

- Dr. Catherine Crosland

“I really appreciate what the Interagency Council in DC did,” says Dr. Crosland, “by bringing together all of the players at the table...” She mentions a few key points of dialogue that were important for the Interagency Council and can serve as a model for other similar bodies:

- **Assessing points where breakdowns and interruptions in the system are more likely to occur**
- **Understanding roles and responsibilities of various stakeholders and participants in the process.**

## V. Promoting Social and Structural Change (cont.)

- Identifying places where communication could be more effective, as well as strategies for improving communication and care coordination.
- Discussing systems for making sure everyone is in the loop about what is happening so that there is continuity of care.
- Addressing the local capacity for inpatient beds and developing community-based crisis bed programs.
- Expanding access to community-based programs and resources for people who don't have documents and insurance lined up.
- Discussing local initiatives to de-institutionalize the experiences of people dealing with severe mental illness.
- Conducting resource mapping activities to figure out where the resources are in this jurisdiction and where stakeholders need to advocate for more resources at various levels.

Community conversations like these, says Dr. Crosland, can lead to improvements in the system—which is necessary, since often clinicians “are so demoralized from past experiences with the process that they don't even make the call in the first place.” For systems to work as intended, they must be intentionally improved by people who understand the nuances and complexities of the issue.

“ [clinicians] are so demoralized... they don't even make the call in the first place ”

- Dr. Catherine Crosland

### Improving Larger Systems

Clinicians who have been involved in IC proceedings have a sense of how many structures intersect at this particular nexus—legal constructs, judicial systems, hospitals, law enforcement, community mental health and substance use organizations, and a whole spectrum of homeless services providers. There are opportunities for clinicians to share their experience and expertise at all of these levels. At Colorado Coalition for the Homeless, says Dr. Iverson,

“ We encounter our clients in a variety of settings—in outreach, in shelters, at their residences or in other programming. So when someone is in a mental health crisis or suicidal or homicidal, has physically hurt somebody, or is psychotic or manic... we place mental health holds when we feel like we have no other options... as a potentially life-saving endeavor. We work with the cops who mostly understand our situation and send officers who are inclined to do this sort of work. In Denver we're also rolling out a much better co-responder model [the STAR Program]

## V. Promoting Social and Structural Change (cont.)

“where social workers accompany the cops, or may go on 911 calls themselves.

Any of us can tell you horror stories about holds we placed on people who were so very impaired. [I remember] a man who had sawed his own ear off because of voices. And people may threaten suicide because they want to be hospitalized. Sometimes a mental health hold is the best ticket to getting that done, because our colleagues at the emergency department will take the person more seriously. But we also struggle on a daily or weekly basis in medical emergencies in which we won't place a hold-- because the person has recently been on a hold and was already put back on the streets. Very often there just aren't good options.

As a psychiatric director, I coach my team to basically call it as I they see it. I invite my colleagues to consider the stories about people who lost someone or were otherwise failed by the system to help keep their perspective... We have a state task force [that operates] in an advisory capacity to a legislative oversight committee on criminalization ... [And] we continue to build partnerships. I'm also part of a nationwide network of doctors pushing for universal health care [PNHP]. Sometimes my colleagues [ask in] despair, “how can I keep doing this?” when the ‘revolving door’ creates such futility. We're signing off on four or five death certificates a week, which is tough on young clinicians. We have no choice but to keep trying to get people good care, reverse stigma, advocate and educate.”

- Dr. Dave Iverson

### Reducing Stigma

As always, one of the most important tools to decrease the need for involuntary commitment is to strike at its roots, by pushing back against the stigma that prevents so many people from seeking and accepting mental health care. Community education and awareness-raising are key components



of preventative mental health care. Mx. Lovett notes that “if our society had less stigma around mental illness, there would be less need for IC because people would be more willing to get treatment before reaching a crisis point. I hope that when I'm old I can see our society become more accepting.”

*“Shopping Cart” by Ady, PhotoVoice Digital Exhibit, Healthcare Without Walls, Wellesley, MA*



## VI. Conclusion

Involuntary commitment is one of the most difficult ethical issues facing providers of health care for homeless populations, as they seek to find the balance between saving lives, promoting safety, and respecting autonomy and civil rights. Clinicians seeking to improve their practice can deepen their understanding of historical, theoretical, and municipal contexts around mental health, homelessness, and the law. They can work to improve care coordination and larger systems, while also practicing individualized, compassionate, trauma-informed care with people who are in crisis.

Speaking to the demoralization that many people feel when confronted with systems that often fail to improve consumers' lives, Mx. Lovett says: "I don't want people to be afraid to talk about their health. I want to normalize [the existence of] severe mental illness, and I also want people to know they can get better. It's hard for clinicians who have many experiences with people who don't get better—but I want them to know that what they do makes a difference and people can go on to live wonderful fulfilling lives because of the hard work that they do."

“

**I want to normalize [the existence of] severe mental illness, and I also want people to know they can get better.”**

*- Mx. Corinne Lovett*

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<sup>12</sup> District of Columbia Interagency Council on Homelessness. (February 2021). Creating a stronger safety net for people experiencing homelessness with severe mental illness

## Disclaimer

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