# Detention Without Data: Public Tracking of Civil Commitment

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Civil commitment ranks among the most contentious and coercive elements of mental health care. Although civil commitment is practiced across the United States, basic statistics about these policies, such as the numbers of involuntary psychiatric hospitalizations each year, remain unknown or inaccessible to much of the public. Public tracking of civil commitment is complicated by numerous factors, including patient privacy concerns, decentralized systems of mental health care, and variable commitment criteria across jurisdictions. This column explores reasons to improve public tracking of civil commitment and offers recommendations for U.S. states to achieve this aim.

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Civil commitment, including involuntary hospitalization and mandated outpatient treatment, is a controversial pillar of mental health care in the United States. By providing legal authorization for involuntary psychiatric treatment, often on grounds of a patient's danger to self or others, civil commitment represents a contentious interface among medicine, law, and ethics. Forcing patients to receive psychiatric treatment against their wishes shapes not only the lives of individual patients but also the lives of patients' families and friends, first responders, clinicians, judicial authorities, and others in the community. Given that civil commitment is used in every U.S. state, does the public have enough information about these interventions?

Many empirical studies have evaluated civil commitment in the United States, including who initiates commitment proceedings, the characteristics of commitment hearings, and the effects of statutory changes on commitment practices (1, 2). Still, U.S. data on civil commitment are often sporadic, limited in scope, or inaccessible to the public. A 1976 article (3) pointed out that "vigorous legal scrutiny of systems for involuntary treatment of mental illness has created an increased need for information from the behavioral sciences. Unfortunately, little such information is available." Nearly 50 years later, basic statistics about civil commitment remain unavailable in many parts of the United States. At a 2019 conference, researchers highlighted that "the number of people detained nationally has never been reliably estimated" and identified yearly psychiatric detention data in just eight states (4). Extrapolating these data to the rest of the country, these researchers estimated there were more than one million emergency psychiatric detentions each year between 2013 and 2015. A 2016 book (5) noted that "there is no federal database that tracks the number of patients who are committed against their will to psychiatric units each year….Given the loss of liberty, the personal distress, and the stigma involved, this lack of data is astounding."

This column examines factors that complicate public tracking of U.S. civil commitments, explores reasons to improve public tracking of civil commitment, and offers recommendations for U.S. states to achieve this aim.

## Challenges to Public Tracking of Civil Commitment

Civil commitment data can be difficult to collect and to make publicly available on an ongoing basis. First, patient privacy concerns may limit access to civil commitment records. Patients have the right to privacy when receiving psychiatric care, and civil commitment does not automatically override

### HIGHLIGHTS

- Civil commitment is practiced across the United States, but basic statistics about these policies, such as the number of involuntary psychiatric hospitalizations each year, remain unknown to much of the public.
- Multiple factors, such as patient privacy concerns, decentralized systems of mental health care, and variable commitment criteria, complicate public tracking of civil commitment.
- Public tracking of civil commitment is necessary to monitor and to optimize use of these policies.

this right. Hospitals, courts, and other civil commitment gatekeepers often restrict access to records to protect patients' privacy, particularly because information about involuntary psychiatric treatment can be highly sensitive and stigmatizing. A 2016 article (6) described the effects of these obstacles in Oregon: "Commitment hearings are open to the public. But once the hearing is over, the records are sealed. That makes reporting on the subject difficult. It's impossible to search through a database of civil commitment cases to track trends."

Second, even if privacy concerns were addressed (e.g., all data were de-identified), collecting data across fragmented, decentralized systems of U.S. mental health care is challenging. California offers just one example of these challenges, given that its "58 counties have 58 different public mental health programs, each with their own set of covered services" (7). In addition to variation among county mental health programs, California's counties have diverse numbers of emergency departments, hospitals, clinics, jails, prisons, and courts, any of which may maintain records related to civil commitment and may not communicate readily with one another. When patients receive involuntary psychiatric care, the civil commitment process can include treatment in several facilities, adjudication by different courts, and transportation across multiple counties, which can make gathering coherent and accurate civil commitment data even more difficult.

Third, variability in commitment criteria complicates public tracking of civil commitment. Civil commitment generally falls under state, rather than federal laws; as a result, emergency, inpatient, and outpatient commitment criteria can vary among states, confounding geographic and temporal civil commitment comparisons. Simply understanding which civil commitment criteria are used across the United States remains the subject of active research. A 2016 study (8) of state laws governing emergency psychiatric holds concluded that "the difficulty of measuring these statutes in a scientifically valid manner has long presented a barrier to rigorous evaluation of emergency hold policy and, more broadly, of involuntary civil commitment."

In some cases, researchers can overcome these hurdles of patient privacy, fragmented mental health systems, and variable commitment criteria to produce empirical studies of civil commitment. However, for the general public, including those without research backgrounds, without resources to pursue data from hospitals and courts, or without access to scholarly journals, information about civil commitment is often out of reach.

## Reasons to Improve Public Tracking of Civil Commitment

Despite these challenges, better public tracking of civil commitment is necessary for several reasons. The U.S. public needs information to adequately understand the meaning and implications of civil commitment laws. Members of the public not only vote in elections and influence policy making on civil commitment, but they or their family members also may be subjected to involuntary psychiatric treatment under these statutes. Research suggests that much of the public misunderstands mental disorders and civil commitment, particularly in relation to violence. A 2018 survey (9) of 1,173 U.S. adults included a vignette about a person who met clinical criteria for schizophrenia. Approximately 65%−90% of respondents rated the person as potentially violent to self or others, and nearly 60% supported coerced hospitalization. The authors warned that these attitudes "could lead to policies that would be ineffective and misdirect the search for the underlying roots of violence while unnecessarily increasing stigma toward people with mental illness" (9). Limited available statistics about civil commitment distance the public from the realities of these laws and may foster these kinds of misperceptions.

Improved public tracking of civil commitment might help individuals navigate these laws. In many places, patients and their families might ask simple, important questions about civil commitment (e.g., "How long does involuntary hospitalization typically last?" or "How frequently are civil commitments overturned during hearings?"), to which first responders, clinicians, judges, and other authorities may not have accurate answers. For instance, research indicates that clinicians involved with civil commitment often lack knowledge about these laws. In a 2001 national survey (10) of more than 700 psychiatrists, approximately 30% of respondents gave incorrect answers about whether grave disability was grounds for civil commitment in their state. Public dissemination of civil commitment statistics might help educate stakeholders about these laws and enable them to better navigate these complex and high-stakes legal frameworks.

Public tracking is also needed for oversight and improvement of civil commitment laws. The 2016 study of emergency hold laws (8) noted, "The legitimacy and value of these interventions depend on several factors: the statutory criteria and their application, the accuracy of the process for triggering an emergency hold, the degree to which the intervention facilitates (or interferes with) access to care, and the relationship of holds and hold procedures to health and treatment outcomes. There is little research aimed at measuring these factors." Policy makers need up-to-date and longitudinal data when evaluating the usefulness of civil commitment laws. For example, a 2018 systematic review of 41 studies (2) concluded that compulsory community treatment "does not have a clear positive effect on readmission and use of inpatient beds." If a policy maker were considering supporting outpatient commitment to reduce inpatient bed utilization, these kinds of findings might give her pause. Greater public availability of civil commitment statistics, including frequency of use, who is affected, durations of commitments, treatment outcomes, and trends over time, is needed to develop evidence-based commitment policies.

Oversight and reform of criminal justice policies provide apt comparisons regarding this public need for civil commitment data (4). The U.S. criminal justice system is a vast enterprise with powers to detain and to supervise individuals, yet federal and state authorities collect and publish regular data about arrests and incarceration. For instance, the Bureau of Justice Statistics publishes annual reports stating the number of prisoners nationally as well as distributions of prisoner age, sex, race-ethnicity, location, citizenship, and offense characteristics (11). Civil commitment is not equivalent to criminal justice in structure or function, and criminal justice data reporting is not perfect; still, it is difficult to imagine a similar situation in which such basic information about the criminal justice system, such as the numbers of people incarcerated annually, remain a mystery.

## Paths Forward

The federal government could attempt to track national civil commitment data, but this may not be possible, or useful, without state participation. All U.S. states should establish secure systems for collecting and publishing statistics on civil commitment in their jurisdictions. Virginia offers one potential model. In 2006, the chief justice of the Supreme Court of Virginia appointed a Commission on Mental Health Law Reform. The commission conducted extensive research on Virginia's civil commitment proceedings and released a preliminary report (12) in 2007 with policy recommendations, which guided legislative reforms passed by the Virginia General Assembly in 2008. As part of this process, "the courts and mental health agencies collaborated to collect data needed for monitoring and informing policy" (13). The commission began publishing statistical reports on annual and monthly use of different emergency and inpatient commitments, dispositions after commitment hearings, and the number of individuals in mandatory outpatient treatment in Virginia. After the commission completed its work in 2011, the Institute of Law, Psychiatry, and Public Policy at the University of Virginia took over this reporting role. These reports are publicly available online and include statistics on Virginia's civil commitment proceedings dating back to 2009 (13). California (14), despite the challenges of collecting data from its 58 different counties, and Massachusetts (15) also provide useful models for publishing state-level civil commitment statistics on a regular basis.

States should publish annual statistics about civil commitment proceedings in their jurisdictions, including at least the number of involuntary psychiatric hospitalizations, specifying use of different stages related to inpatient commitment (e.g., emergency holds, extended commitments); number of inpatient commitment hearings and dispositional outcomes of these hearings; number of individuals in outpatient commitment; and number of outpatient commitment hearings and dispositional outcomes of these hearings. Ideally, these reports would include additional statistical outcomes, such as readmissions data after emergency, inpatient, or outpatient commitment. To protect patient privacy, agencies publishing these statistics should collect only de-identified information and restrict access to information beyond demographic characteristics and dispositional outcomes, unless an institutional review board approves additional access to data for research.

## Conclusions

After decades of debate over these laws, a striking amount of basic information about civil commitment, including annual numbers of involuntary psychiatric hospitalizations, remains unknown to the U.S. public. In recent years, some states have begun publishing annual statistical reports on civil commitment proceedings; however, this information remains unavailable or difficult to access in much of the country. Better public tracking of civil commitment is needed to enhance public understanding of these laws, to help individuals navigate these proceedings, and to facilitate oversight and reform of these interventions. States should establish systems for public tracking and reporting of civil commitment in their jurisdictions while protecting the privacy of patients.


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