

MENTAL HEALTH RELATED INVOLUNTARY CIVIL DETENTION OF ADULTS

By Thomas G. Glick and Misty A. Watson

As lawyers, we spend a great deal of our efforts focusing on time. We respond to deadlines measured in days, weeks, months, even years. However, people who are mentally ill and a threat to themselves or others need legal attention in hours and minutes. For this reason, the State has crafted a system for involuntary detention and treatment of certain persons with express procedures when appropriate.¹ In Missouri, the Probate Division is the traditional court for handling the affairs of those who cannot manage their affairs themselves, either because of death, disability or minority.² As a result, involuntary detention of mentally ill people who are also experiencing substantial

problems and potentially acting contrary to their own interests, are also assigned to the Probate Divisions in Missouri.³ Unfortunately, the procedures as expressly laid out in Chapters 631 and 632 for Involuntary Commitment rely heavily upon the actions of a local mental health coordinator.⁴ Local mental health coordinators are mentioned repeatedly throughout the statute and play an important role in the involuntary commitment process.⁵ Unfortunately, since 2004, mental health coordinators have not existed in Missouri and have not been funded.⁶ As a result, the statute written to revolve around mental health coordinators must continue to function on its own without these individuals. For this reason and because of the urgent nature mental health cases present, a general legal practitioner might well benefit from a primer on involuntary detention and treatment. This article addresses how the involuntary detention statutes currently functions in the absence of funding for mental health coordinators. Specifically excluded from this discussion are the statutory provisions in the mental health statute addressing sexually violent predators⁷ and mentally ill minors.⁸

Involuntary detention procedures are clearly civil matters under Missouri statute.⁹ Frequently this procedure is referred to as involuntary civil commitment. However, because they involve such a substantial denial of personal liberty in a locked-door facility many aspects of the rights of criminal defendants are also present in the involuntary commitment statute.¹⁰ For example, there is an absolute right to an attorney¹¹ and the statute specifically provides for an attorney assigned to the respondent by the Probate Division.¹² Similarly, respondents to a Petition for Involuntary Detention have an absolute right to remain silent and from self-incrimination

similar to the rights afforded to criminal defendants.¹³ Correlations between this civil procedure and criminal procedure are further highlighted by the fact these petitions are prosecuted by the prosecuting attorney or county counselor for that circuit court, even though petitions are created for and by mental health institutions.¹⁴

Any person who, as a result of a mental disorder, presents a likelihood of serious harm to himself or others may be subject to involuntary detention of varying durations.¹⁵ Although, modern psychiatry clearly indicates that drug and alcohol abuse and dependence are mental illnesses,¹⁶ these are specifically excluded by the Missouri State Legislature from the involuntary detention procedures found in Chapter 632.¹⁷ However, a separate provision is made for involuntary detention of persons who present a likelihood of serious harm to themselves or others as a result of drug or alcohol abuse.¹⁸ In both cases, the petitioner must meet a burden of proof with clear and convincing evidence of both the respondent's mental illness and the likelihood of serious harm by the respondent to himself or others in order to prevail and have a petition granted for detention or additional detention.¹⁹

Involuntary Detention Procedures

The venue of an initial petition is any place where the respondent is either domiciled or can be found.²⁰ Subsequent hearings are properly held in the venue of the mental health facility where the respondent can be found.²¹ However, respondents have the right to transfer venue from the location of their detention to their county of domicile by mere request of the same.²²

As the time of possible detention for the respondent increases, the statutes correlatively provide for the due process rights of the respondent to increase. Initially,

Respondents may be detained for up to 96 hours by the presentation of an affidavit and/or testimony to any judge.²³ These petitions can be presented *ex parte* and can call for the detention for up to 96 hours.²⁴ Although the statutory scheme indicates that the primary means of achieving such involuntary detention is through a mental health coordinator,²⁵ the absence of the mental health coordinators means that alternatives must be pursued for practical implementation of the statute.²⁶ Normally, the statute is implemented either by the presentation of an affidavit by a family member, or any adult person²⁷ or by the presentation of an affidavit from a mental health professional where the mentally ill individual has through various possible means come for treatment.²⁸ The involuntary detention procedure may also result from voluntary detention when patients who voluntarily admit themselves into an inpatient mental health facility and subsequently rescind their consent to treatment and demand release.²⁹ Under these conditions, if in the discretion of the treating physician or other healthcare workers, release is inappropriate because the respondent represents the likelihood of serious harm to himself or others, then the 96-hour hold may be initiated.³⁰

The 96-hour treatment is defined not to include any holidays recognized by the facility or court.³¹ In addition to the 96 hours, if a facility has applied for up to 21 days additional detention and treatment, the respondent may be held for up to two judicial days to permit the court the opportunity to convene a hearing. The 96-hour provisions can be readily calculated by use of the following chart f.³² (For weeks without any holidays)

Involuntary Admission on	96-hour hold concludes at
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	the same time on:
Monday	Friday
Tuesday	Monday
Wednesday	Tuesday
Thursday	Wednesday
Friday	Thursday
Saturday	Friday
Sunday	Friday

Because as discussed earlier, the location of the healthcare facility is determinative of venue for additional detention and treatment, courts in counties which include publicly financed healthcare institutions often adjudicate a substantially greater amount of petitions for additional detention and treatment based on the location of that facility within their jurisdiction.³³

Detentions for Additional Detention and Treatment

Following the initial 96 hour hold period health care professionals can petition for an additional 21-day involuntary commitment for a person who is mentally ill with an illness other than drug and alcohol dependence.³⁴ Because petitions for additional detention and treatment always involve a person who has previously been involuntarily detained for a 96-hour hold in an inpatient treatment facility, these petitions are normally pursued by the inpatient treatment facility where the petitioner resides.³⁵ In these instances, such facilities are also represented by the local county prosecuting attorney or county counselor.³⁶ As a result, confusion created by the absence of the mental

health coordinators is alleviated to the extent that there is an existing, experienced health care institution which can initiate the petition for additional detention and treatment. The grant of a Petition for 21 Days of Additional Treatment is predicated upon proof that there is a facility willing to accept the respondent for those 21 days.³⁷ However, the facility in which a respondent has been held for 96 hours does not necessarily have to be the facility where he or she is petitioned for treatment for an additional 21 days. Often because of matters relating to health care expenses and/or provision of certain specialized services, a respondent is directed from one facility for a 96-hour detention to another for a 21-day commitment.

The filing of a petition for an additional detention for up to a 21 day duration must be set within two judicial days of the filing of the petition.³⁸ Unlike the 96-hour detention, a petition for 21 days requires an adversarial courtroom hearing in which the respondent is represented by an attorney appointed by the probate division.³⁹ The court appointed attorney must have met with the respondent prior to the hearing.⁴⁰ An open legal question is whether or not a respondent with the ability to hire private counsel can replace their court appointed counsel. Presumably the right to select one's own counsel in combination with similar questions raised about court appointed counsel in guardianship and conservatorship proceedings would dictate that a moderately competent respondent could substitute private counsel.⁴¹

Respondent has a right to a jury trial on both the issue of mental illness and on the likelihood of serious harm to himself or others.⁴² The Missouri Supreme Court has

provided pattern instructions and verdicts for this purpose.⁴³ The petitioner also enjoys a right to refrain from testifying.⁴⁴ As in criminal matters, testimony can subject the respondent to cross examination by the attorney for the respondent. Unlike criminal defendants, the respondent in involuntary detention matters has a more difficult decision with regard to his determination to testify or not because of the short time frame in which the hearings must occur and the extremely limited budget for a 21 day involuntary commitment court appointed attorney. Frequently, the only testimony presented by the petitioner is that of the treating physician. There is limited opportunity as a practical matter to obtain testimony from additional expert witnesses within the two days allotted for preparation of the case. As a result, many respondents face the difficult decision of presenting no evidence, or in the alternative, waiving their right to refrain from testifying.

At the conclusion of the hearing or shortly thereafter, the judge will issue a ruling granting or denying the petition for additional detention and treatment.⁴⁵ Because the petition presented is for *up to* 21-days of additional detention and treatment, the discretion for a shorter term would appear to be vested in the physician and facility and not in the judge issuing the order for additional detention and treatment.

The current state of psychiatric treatment permits a large number of mentally ill persons to achieve a certain level of mental stability with 21 days of detention and administration of modern medication.⁴⁶ However, on rare occasions, it is necessary for the facility to repeat the process and petition the court for additional treatment beyond the original 21 days. In these cases, the health care professional once again, through

the prosecutor or county counselor, petitions to the probate division, this time for up to an additional 90-days of treatment.⁴⁷ The procedures for an additional 90-day treatment are essentially the same as for a 21-day petition except for the inherent additional burden of proof raised by the due process requirements for the substantial additional length of time.⁴⁸ The additional length of time is often counterbalanced by the additional latitude and budget afforded to court appointed attorneys and the additional time necessary to obtain additional medical opinions in advance of trial.⁴⁹

The petition for 90 days of additional treatment must be presented within 17 days of the grant of the petition for 21 days of additional detention and treatment.⁵⁰ This provision effectively prohibits the extension of time beyond 21 days in the same way that the 96 hours can be extended an additional two days to allow the court the ability to convene a hearing.⁵¹

If a respondent is in need of additional inpatient treatment following the 90-day petition, the institution may seek additional detention for up to one year under similar conditions.⁵² Petitions after the first one-year petition are filed annually or for subsequent single additional years with the same standard applied.⁵³

Although the involuntary commitment procedures can be used to indefinitely detain an individual, they are rarely used for that purpose as long term detentions appear to be within the purview of the guardian and conservatorship code with an entirely different standard applied to the respondent's mental condition.⁵⁴

Facilities are specifically charged with considering the possibility of guardianship for an involuntary detained respondent.⁵⁵ However, there appears to be no statutory mechanism for enforcement of this provision. Mentally ill persons who cannot provide for their own care and treatment may theoretically be independently declared incapacitated, but there is no provision for prosecution of this action by the prosecutor or county counselor.⁵⁶ As a result, guardianship must be pursued either by the health care institution, family, or friends of the respondent.

The use of the involuntary detention is specifically excluded for certain classes of patients whose needs are frequently met by the guardianship code.⁵⁷ This includes specific exclusion from involuntary detention for anybody who is mentally retarded, developmentally disabled or suffering from senile dementia.⁵⁸

Drug and Alcohol Related Detentions

Also excluded from Chapter 632 involuntary detention procedures are for patients impaired by drugs or alcohol without evidence of additional mental illnesses.⁵⁹ Many people who suffer from drug and alcohol addiction have a “dual diagnosis” whereby they also suffer from a mental illness.⁶⁰ The involuntary detention procedures for people who are mentally ill may be used for somebody who is both mentally ill and suffering from alcohol or drug addiction.⁶¹ However, Chapter 632 specifically excludes people who suffer only from drug and alcohol addiction.⁶² The legislature has provided for involuntary detention and treatment of addicted patients in a separate but similar statute.⁶³

Persons who are addicted to drugs and/or alcohol and present a likelihood of serious harm to themselves or others because of this addiction are also subject to 96-

hour involuntary detention.⁶⁴ This Chapter incorporates by reference many of the provisions of Chapter 632 discussed previously.⁶⁵ The primary distinction between the 96 hour hold provisions for drug and alcohol addiction treatment and other mental health issues revolves around the role played in such treatment by the mental health coordinator.⁶⁶ Since the mental health coordinator no longer plays a role in the mental health provisions, the 96-hour hold provisions for both drug and alcohol and mental health provisions are even more similar in practice than the legislature intended. Subsequent to a 96-hour drug and alcohol detention, the institution in which a drug and/or alcohol abuser is held for 96 hours may similarly present a petition for additional treatment and detention.⁶⁷ The most obvious distinction between drug and/or alcohol abusers and persons who are otherwise mentally ill is that the first petition for additional treatment is for 30 days in the case of drug and/or alcohol abusers as opposed to 21 days for people who are otherwise mentally ill.⁶⁸ Most other procedures are identical for drug abusers and people who are otherwise mentally ill including many specific references in the drug and alcohol chapter to the mental health chapter.⁶⁹ The most significant distinction between Chapter 631 and 632 is the lack of inclusion by reference of the provision granting jury trials for persons who are mentally ill.⁷⁰ As a result persons being committed for drug and alcohol abuse do not enjoy a statutory right to trial by jury.

Ramifications of Involuntary Detention and Treatment

Persons who are involuntarily detained for up to 96 hours may be involuntarily prescribed medicines only under limited conditions.⁷¹ If a Respondent who has not been evaluated by a doctor represents an imminent likelihood of serious physical harm

to himself or others, he may be involuntarily medicated.⁷² For 24 hours, prior to the hearing for a 21-day detention the Respondent has a right to refuse any medication except for life saving treatment.⁷³ However, once a petition for additional detention and treatment has been granted, the treating physician and/or health care facility acquires the right to involuntarily administer medications and treatments except for electroconvulsive therapy.⁷⁴ If the treating physician believes that a patient meets the criteria for treatments by electroconvulsive therapy, explicit court permission must be sought and granted.⁷⁵ Frequently, when electroconvulsive therapy is sought, it is combined in a Petition for a 21-day detention and is tried at the same time as a petition for additional detention and treatment.

Conclusion

The civil detention procedures appear to rely heavily on the inclusions of the mental health coordinator as a check on the power of the health care system, however, the inclusion of judicial officials in the process appears to allow to assure adequate due process rights such that the civil detention procedure can continue to fairly and effectively function even in the absence of the anticipated mental health coordinators.

Biographies

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- ¹ MO. REV. STAT. § 632.105 to MO. REV. STAT. § 632.475 (2000).
- ² MO. REV. STAT. § 472.020 (2000).
- ³ MO. REV. STAT. § 632.300(1) (2000).
- ⁴ See e.g. MO. REV. STAT. § 632.300(1) (2000).
- ⁵ See e.g. MO. REV. STAT. § 632.005(10) (2000).
- ⁶ Department of Mental Health –FY04 Budget (2004)
- ⁷ For more on the Sexually Violent Predator Statute see MO. REV. STAT. § 632.480 (2000) *et. seq.*
- ⁸ For more on mentally ill minors see MO. REV. STAT. § 632.110 (2000), § 632.115 (2000) & § 632.500 *et. seq.* (2000)..
- ⁹ MO. REV. STAT. § 632.325 (2000).
- ¹⁰ MO. REV. STAT. § 632.324 (2000)
- ¹¹ MO. REV. STAT. § 632.324(4) (2000).
- ¹² MO. REV. STAT. § 632.415 (2000).
- ¹³ MO. REV. STAT. § 632.325 (2000).
- ¹⁴ MO. REV. STAT. § 632.405 (2000).
- ¹⁵ MO. REV. STAT. § 632.005(9) (2000).
- ¹⁶ American Psychiatric Ass'n, *Diagnostic & Statistical Manual of Mental Disorders: DSM-IV-TR* (Alan Frances, Harold A. Pincus, and Michael B. First eds., 4th ed. 2000).
- ¹⁷ MO. REV. STAT. § 632.380 (2000).
- ¹⁸ MO. REV. STAT. § 631.005-175 (2000).
- ¹⁹ MO. REV. STAT. § 632.145(4) (2000); MO. REV. STAT. § 632.335(4) (2000).
- ²⁰ MO. REV. STAT. § 632.410 (2000).
- ²¹ *Id.*
- ²² *Id.*
- ²³ MO. REV. STAT. § 632.305 (2000)
- ²⁴ MO. REV. STAT. § 632.305(2) (2000).
- ²⁵ MO. REV. STAT. § 632.300 (2000).
- ²⁶ MO. REV. STAT. § 632.305(1) (2000).
- ²⁷ MO. REV. STAT. § 632.305(4) (2000).
- ²⁸ MO. REV. STAT. § 632.150 (2000).
- ²⁹ *Id.*
- ³⁰ *Id.*
- ³¹ MO. REV. STAT. § 632.005(14) (2000).
- ³² MO. REV. STAT. § 632.330(1) (2000).
- ³³ MO. REV. STAT. § 632.410 (2000).
- ³⁴ MO. REV. STAT. § 632.330 (2000).
- ³⁵ *Id.*
- ³⁶ MO. REV. STAT. § 632.405 (2000).
- ³⁷ MO. REV. STAT. § 632.330.2(6) (2000).
- ³⁸ MO. REV. STAT. § 632.005(7) (2000).
- ³⁹ MO. REV. STAT. § 632.335 (2000).
- ⁴⁰ MO. REV. STAT. § 632.450 (2000).
- ⁴¹ See In re: Mildred Agatha Link, 713 S.W. 2d 487 (Mo. banc 1986).
- ⁴² MO. REV. STAT. § 632.350 (2000).
- ⁴³ Mo. Approved Jury Instr. (Civil) 31.14 (6th ed.)
- ⁴⁴ MO. REV. STAT. § 632.335.2(4) (2000).
- ⁴⁵ MO. REV. STAT. § 632.350(5) (2000).

⁴⁶ HARRIS B. STRATYNER, *FORWARD TO THE PDR DRUG GUIDE FOR MENTAL HEALTH PROFESSIONALS* (Thompson 2nd ed. 2004).

⁴⁷ Mo. REV. STAT. § 632.340 (2000).

⁴⁸ *Id.*

⁴⁹ Mo. REV. STAT. § 632.345 (2000).

⁵⁰ Mo. REV. STAT. § 632.340.2 (2000).

⁵¹ *Compare* Mo. REV. STAT. § 632.330(1) (2000).

⁵² Mo. REV. STAT. § 632.355 (2000).

⁵³ Mo. REV. STAT. § 632.360 (2000).

⁵⁴ Mo. REV. STAT. § 475.010 (2000) defines an incapacitated person as “one who is unable by reason of any physical or mental condition to receive and evaluate information or to communicate decisions to such an extent that he lacks capacity to meet essential requirements for food, clothing, shelter, safety or other care such that serious physical injury, illness, or disease is likely to occur.”

⁵⁵ Mo. REV. STAT. § 632.330.4 (2000).

⁵⁶ Mo. REV. STAT. § 475.805 (2000).

⁵⁷ Mo. REV. STAT. § 632.380 (2000).

⁵⁸ *Id.*

⁵⁹ *Id.*

⁶⁰ The mental health field has recently exploded with information regarding dual diagnosis including publication by the Medical College of Georgia of the *Journal of Dual Diagnosis*. The journal was first published November 1, 2006 and is published quarterly. The journal publishes “all research of relevance to the comorbidity of drug and alcohol substance abuse disorders with psychiatric disorders.” <http://www.mcg.edu/som/psychiatry/JDD.htm>

⁶¹ Mo. REV. STAT. § 632.380 (2000).

⁶² *Id.*

⁶³ Mo. REV. STAT. § 631.005-175 (2000).

⁶⁴ Mo. REV. STAT. § 631.120 (2000).

⁶⁵ Mo. REV. STAT. § 631.175 (2000); Mo. REV. STAT. § 632.305 (2000).

⁶⁶ *Compare* Mo. REV. STAT. § 631.115 (2000) to Mo. REV. STAT. § 632.300 (2000).

⁶⁷ Mo. REV. STAT. § 631.140 (2000).

⁶⁸ *Compare* Mo. REV. STAT. § 631.140 (2000) to Mo. REV. STAT. § 632.330 (2000).

⁶⁹ Mo. REV. STAT. § 631.175 (2000) *incorporating Chapter 632 by reference*.

⁷⁰ Mo. REV. STAT. § 632.350(2000).

⁷¹ Mo. REV. STAT. § 632.305 (2000).

⁷² Mo. REV. STAT. § 632.325(8) (2000).

⁷³ Mo. REV. STAT. § 632.329(8) (2000).

⁷⁴ Mo. REV. STAT. § 630.130 (2000).

⁷⁵ Mo. REV. STAT. § 630.130 (2000).