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The utilization of involuntary civil commitment to a psychiatric facility is a rigid and regulated process in which an individual's rights and autonomy are questioned and temporarily suspended, due to the presence of a dangerous mental illness. This process requires an individual to display behaviors constituting danger to self or others as the result of mental illness, and refusal to accept help (voluntarily consent to treatment). This is a patient's rights issue that intersects medicine in the form of psychiatry, with screening (a state regulated division) and legal via a review by a judge (Fourteenth Amendment to the Constitution- prohibits depriving individuals of liberty without due process of law (Richards & Schub, 2017)). The decision is between the individual's liberty, protected by legal, and unwanted intervention, as determined by medicine (Henwood, 2008). In addition, it poses a provider conflict concerning the ethical obligations of "beneficence and respect for autonomy" (Testa & West, 2010, pg 30).

Management must oversee this process, assist with resolution of disposition disagreements and violation of the law or regulation governing this, and participate in the review process. When any one of these systems fail, it is the accountability and responsibility of management to rectify and resolve discrepancies. In addition, it is management's task to ensure involuntary civil commitment is beneficial and results in improved patient outcomes. Finally, it is obligatory of providers to ensure patient rights and least restrictive care are honored and maintained with integrity. During routinely scheduled chart reviews, agencies such as the state of New Jersey, public advocate, screening directors, psychiatrists, social workers, and patient advocates are able to review screening documents for accuracy and appropriateness.

Management may determine that the process is acceptable without need for independent review, or may decide to critique, through quality improvement or risk management, that one

facet of the above process has deviated. This might include assessing the medical clearance process, the screening process, the psychiatrist associated with screening, the inpatient unit's treatment of the patient, the attending psychiatrist's documentation, and the judge's review of all of this documentation during the biweekly court proceedings. In addition, this process is ensured through the court appointed patient advocate. As one can see, there are multiple moving parts, with concurrent opportunities for system failure, requiring close oversight and knowledge of all aspects of involuntary civil commitment. There currently exist mechanisms accessible by management, to ensure integrity of involuntary civil commitment, including a dedicated manager of involuntarily committed patients, a bimonthly Systems Review Committee, Physician Performance Review, and the court's process.

Alternatives to involuntary civil commitment include utilization of a Psychiatric Advance Directive (PAD), which is created during periods of capacity, and executed when the individual is deemed incapable. This process supports the development of individual wishes regarding medication preferences, proxy, hospital choices, and generally guides the treatment team of individual wishes, utilizing a recovery oriented focus toward self-directed treatment, selection, and empowerment as fundamental values (Henwood, 2008). A theoretical framework noted three aspects PAD: a) enhancing individual autonomy; b) improving of the therapeutic alliance; c) integrating care through system efforts (Zelle, Kemp, & Bonnie, 2015).

An additional option is community-based treatment, which would support greater individual access to case management, medication, and specialized treatment services, which can include education in self-care, housing, and legal issues. Additionally, the variable of coercion would appear to be reduced, increasing self-determination and productivity as community citizens (Goldman, 2015). Effective implementation of outpatient commitment, when shared

with intensive community services for an adequate duration, can increase treatment adherence and outcomes, but violence reduction outcomes are unknown (Swartz, Bhattacharya, Robertson, & Swanson, 2016).

A review of the history contributing to the current state of involuntary civil commitment may demonstrate its impact and effect. Late in the 20th century, individuals were justifiably committed for having a serious mental illness affecting insight and rational decision-making, as well as self-care. With deinstitutionalization, rising health care costs, and improved medication and resultant outcomes, fiscal decisions lent public policy toward adding dangerous behavior and a medico-legal review of commitment. Ensuring liberty of the individual, as well as the least restrictive setting, guided efforts toward improving community treatment resources and services. Some individuals decompensated in the community setting, contributing to mentally ill individuals seeking housing in shelters as well as the judicial settings (Zanni & Stavis, 2007). Involuntary outpatient commitment stemmed from this process, which seemed to address a substantial number of previously raised issues. The remaining ethical questions include the state's ability to exercise this type of structure, and benefits of this program by measuring individual outcomes to unwilling and those lacking rational thought decision-making, particularly when having exhibited dangerous actions in the community. Separating out the types of data and outcomes needed, as well as quantifying quality of life and value-measured results, is part of the inherent challenge to validate this intervention (Zanni & Stavis, 2007).

There are multiple stakeholders who are affected by involuntary civil commitment, such as the Division of Mental Health and Addiction Services (DMHAS), who funds these beds and oversees the county level Designated Screening Centers (DSC) and their regulations, the individuals who are being screened for involuntary civil commitment, the individual's families

who are frequently adversely affected by the individual's mental health and associated actions, the community/society, also affected by individual's actions, the judicial system, comprising police, court, and judges, hospitals and their employees, payers in the form of the state or private managed care companies, and the services required and recommended to support individuals through their recovery. This last is critical to maintain positive patient outcomes and reduce recidivism/readmission.

The first and most affected stakeholder is the individual, sometimes described as the patient. The individual's values should be discussed when controversial decisions are presented. These values include freedom of choice, feelings of safety, with non-paternalistic and respectful interactions. These efforts will demonstrate consideration of moral deliberation toward patient values (Valenti, Giacco, Katasakou, & Priebe, 2014).

Family members and those who care for individuals with mental illness are also affected by involuntary civil commitment, and as such, should be involved in decisions. At times, families are driven to seek treatment for an individual when they fear they cannot support the individual's dangerous actions or need for resources; though their tolerance is a moving target, contributing to role conflict, moral stress, and fear of misinterpretation and perceived abandonment. The individual values independence, while the family wants to ensure the safety and health of the individual as well as others. Families can be vital toward the development and implementation of an effective and therapeutic treatment plan, as well as to provide collateral information regarding the individual's progressive illness over time. The family's ability, willingness, and ready resources are often guiding determinants of care. Families may experience relief that their member is receiving necessary care, as well as sharing the responsibility for the individual along with the mental health treatment team. These feelings are crucial to share, as

developing rapport, forming trust, and engaging and empowering individuals to facilitate recovery toward their autonomous self are paramount (Arya, 2014).

Expanding upon the priority stakeholders, the function of the psychiatrist is to strongly consider beneficence due to predominant impact of irrationality on the functioning of the mentally ill individual. With the goal of restoring rational decision-making via treatment planning and implementation, the moral basis for interfering with the individual's liberty and hence welfare appears justified (medical paternalism) (MacLachlan & Mulder, 1999). Psychiatrists' balance of administering treatment without consent can be challenging (Valenti, Giacco, Katasakou, & Priebe, 2014). Considering procedural justice to augment individual decision-making participation and autonomy would reduce the perception of coercion (McKenna, Simpson, & Coverdale, 2000). The psychiatrist must consider taking responsibility for managing involuntary individuals, disempowering them and making treatment decisions, (Arya, 2014). Offering alternatives such as Involuntary Outpatient Commitment (related to dangerousness), Psychiatric Advance Directives (treatment planning), and Long Acting Injectable (LAI) medications, additional autonomy can be supported.

Payers may also be impacted by involuntary civil commitment of individuals, resulting in disagreements between providers and payers as well as affecting long term care decisions by providers. Strategies to reduce conflicts include ensuring contractual language that encompasses this consideration, supporting interventions to reduce the need for commitment, standardization of risk assessment processes, determining the impact of perceived coercion, managing possible cost shifting, and discussing financial considerations with providers during treatment planning (Petrila, 1995). Consistent reviews of insurance contract, denial of prior authorization or payment, data points including volumes of involuntarily committed individuals, length of stay,

long term care, recidivism, and quality improvement efforts may yield outcomes and areas of opportunity for renegotiation efforts,

Payers can also be impacted regarding psychotropic medications and formularies, both on an inpatient basis and as it relates to involuntary outpatient commitment regulations. Hospital formularies maintain certain medication for inpatient use, which may or may not be the same medication available from the individual's insurance plan. Non-adherence is a significant variable that requires acknowledgement and significant individual and family psychoeducation, in order to reduce recidivism. Additionally, deductibles and copays impact the individual's fiscal ability to afford the prescribed medication. The development of Long Acting Injectable antipsychotic medications has affected the impact of stigma by expanding the duration of effect, allowing between two weeks and three months between injections. This reduces relapse, as well as confusion and uncertainty between poor/partial response and poor/partial adherence, allowing easier and more evidence-based treatment decisions (Kane, 2014).

The massive majority (50 to 80 percent) of severely mentally ill individuals lack insight, which is a predictor of decline, involuntary hospitalization, recidivism, and negative outcomes. Insight, in this context, includes awareness of one's illness and social impact, recognition and attribution of current and historic symptomatology, and understanding the need for treatment (van Baars, Wierdsma, Hengeveld, & Mulder, 2013). It has been suggested that involuntarily committed individuals with psychotic illness predicted by improved insight have better functioning. Interventions associated with improving social relationships, housing, and fiscal domains through social support, case management, and assertive community resources could positively impact illness insight, reduce chronicity, and improve long term outcomes (van Baars,

Wierdsma, Hengeveld, & Mulder, 2013). Involuntary admissions were seen as lower in regions with a broader range of social and psychiatric resources (Richards & Schub, 2017).

Additionally, improved satisfaction with treatment yields higher desired treatment outcomes, which includes quality of life, level of functioning, and fewer hospitalizations, whereas reduces satisfaction denotes more likely disengagement with aftercare. Decrease in satisfaction with treatment has been linked to involuntary admission, co-morbid substance use, less procedural justice and greater perceived coercion, whereas greater satisfaction has associated with higher insight and therapeutic relationship with the individual's provider. This last supports a patient-centered approach, supporting autonomy, patient rights, and respect (Richards & Schub, 2017; Smith et al., 2014). Desired outcomes include safety of the patient and others, preservation of patient health via meeting basic needs, and providing effective patient care- all short term goals.

Chronic and well recognized barriers to effective and seamless mental health care include access to care, the burdensome legal process, financial support, and limited qualified providers. Solutions in play to increase access include federal and state grants supporting additional development of treatment centers, both on an inpatient and outpatient basis. When a community has limited resources for mental health care, individuals delay care, waiting until symptoms are unmanageable and require emergent (and costly) intervention. Additionally, limited community resource prohibits effective continuity of care for individuals discharged from inpatient units, resulting in recidivism. The legal process has undergone some efficiencies, but making changes to policy and regulation takes dedicated lobbyists and political buy-in. In 2008, Financial support and access has also been partially addressed by parity, in which a federal law that prevents group health plans and health insurance issuers that provide mental health or substance use disorder

benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits. A final in-process intervention is for Advance Practice Nurses to be trained to screen and commit mental health patients, which would improve efficiency and the number of providers qualified to initiate involuntary civil commitments. P.L.1987, c.116 (C.30:4-27) would authorize psychiatric advanced practice nurses to complete certain certificates required for involuntary commitment to treatment and was enacted February 26, 2018. This effort will enable individuals in need of involuntary civil commitment receive appropriate, specialized assessment in an efficient time frame (https://www.njleg.state.nj.us/2018/Bills/S2500/2049_11.HTM, accessed 1.5.19).

Reviewing the above information from a Utilitarian, or naturalistic, moral perspective, one would support the current process of involuntary civil commitment, as the general number of those affected by commitment (family members, society in general, individuals whose compromised mental state/affected ability to perform sufficient self-care without psychiatric intervention) is significantly greater than those committed (those with affected capacity affecting autonomy, dangerous, refusing treatment). The happiness level and common good impacting society likely outweighs those committed. It would be difficult to calculate the intensity of common good, when comparing those affected by individuals with dangerous mental illness, and those with dangerous mental illness. Economically, psychiatric treatment is expensive with considerable recidivism and the related limited return on investment. Where it becomes less level is the broad social policy government is attempting to support; patient rights for the mentally ill are reinforced by state ombudsmen and court oversight.

Review of the above information from a Rights-Based perspective, rights of one group, say, those with dangerous mental illness, can affect those without- herein lies a level of conflict.

If it protects from the harmful acts of others, involuntary civil commitment serves a valuable purpose. If all individuals are treated with dignity and respect, then those with dangerous mental illness would not impose onto society in general. However, if rights are governed by autonomy, and autonomy is affected, rights are therefore affected, resulting in a disjointed presentation. To respect the human aspect of the patient rights angle, “freedom from threats of severe bodily harm by others” (McCall, pg.11) could be the essence of the dangerous criteria required for involuntary civil commitment. When the rights of dignity, autonomy, and respect are interference with, morality is thus affected.

The decision to support Utilitarian over Patient Rights is one not to be considered lightly. Interventions, such as Psychiatric Advance Directives (PAD) and Involuntary Outpatient Commitment (IOC), have been implemented, albeit in a limited manner, to provide alternatives to involuntary civil commitment, which was initiated across the country following deinstitutionalization. There remains a place for use of inpatient involuntary commitment, but when one reviews minimal positive outcomes, patient rights, and recidivism, it may encourage education and political support to exercise the less restrictive and more self-determination directions to guide toward greater maintenance of health and wellness over the need for imposition of respect for autonomy. So in summary, I continue to support involuntary civil commitment, but with the contingency of increased use of the alternatives listed above, toward decrease reliance on restrictive measures and greater on best practices and outcomes-driven options. Practitioners must have strong understandings of law and moral issues that complicate treatment of these individuals (Wilk, 1994). Maintaining compassion and objectivity are integral to optimal treatment and care of these individuals.

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