CE

Involuntary Civil Commitment of Minors

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ABSTRACT

Although NPs and other licensed providers generally retain a comprehensive grasp of the best health care practices for their respective professions, these competencies are often stretched when treating minors with underlying mental illnesses. NPs and all nurses practicing in settings where they are likely to encounter pediatric patients need to be concretely prepared to respond to youth in psychiatric crisis necessitating involuntary commitment. This article reviews the history of involuntary psychiatric commitment of minors and suggests practical approaches to the management of such situations.

Keywords: civil commitment, involuntary commitment, minor, nurse practitioner

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The role of the nurse practitioner (NP), school nurse, psychiatric nurse, and other providers is to promote patient health and wellness through accepted standards of practice and care. Although these licensed providers generally possess a comprehensive grasp of the best health care practices for their respective professions, these competencies are often stretched when treating minors with underlying mental illnesses. All nurses practicing in settings where they are likely to encounter pediatric patients need to be concretely prepared to respond to youth in psychiatric crisis that necessitates involuntary commitment.

While various practitioners share common competencies of health care, they clearly have differentiated roles in responding to psychiatric emergencies.

This CE learning activity is designed to augment the knowledge, skills, and attitudes of nurse practitioners and assist in their understanding of involuntary civil commitment of minors.

At the conclusion of this activity, the participant will be able to:

A. Differentiate between standards for adult civil commitment and those of minors
B. Explain the process of instituting a civil commitment proceeding
C. Apply legal principles to the nurse practitioner role in the civil commitment of a minor

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For instance, the NP has the requisite practice knowledge and skills to act autonomously in the presenting psychiatric emergency, including ordering diagnostic assessment, making direct referrals, and prescribing stabilizing medications.[1] The school nurse, on the other hand, is likely to have limited ability to respond to a psychiatric emergency beyond recognition of the need for and requesting law enforcement and emergency medical support.[1]

On the other hand, a psychiatric nurse is often primarily responsible for the initial assessment, diagnosis, and plan of care in psychiatric emergencies.[1] Other nurses from a wide variety of practice settings may likely encounter youth in psychiatric crisis and need but not possess the knowledge and skills for appropriate responses.

Rather than just treating the patient for general health conditions, when a clinician suspects the patient is a danger to self or others, the clinician must critically assess the likelihood of this risk and need for intervention. While nurses in emergency departments (EDs) and psychiatric units are likely to conduct emergency psychiatric assessment (EPA), NPs and nurses in nonemergency or nonpsychiatric settings are not generally trained for such assessment. However, given the likelihood of childhood psychiatric crisis, all nurses working with youth must be prepared to respond appropriately. This includes, importantly, a working knowledge of the legal system through which the youth will pass in the involuntary commitment process. Thus, this article seeks to fill the knowledge gap by providing an overview of involuntary commitment statutes and practical management suggestions when assessing and treating minors who may pose a threat to themselves or to others.

INVOLUNTARY CIVIL COMMITMENT

The practice of involuntary emergency hospitalization, also known as civil commitment, has changed a great deal over the past 100 years. Formerly, asylums, such as Bedlam Hospital in London, were charged with housing the mentally "insane" for the protection of society as a whole.[2] Patients deemed dangerous to themselves or others were kept in institutions indefinitely, unable to appeal their involuntary commitment or many of the "treatment measures" that came with such institutionalization.[3] Children in Victorian England were not treated differentially from adults and thus were not spared from indefinite institutionalization. Often, such children were labeled "imbecilic from birth" or other damning "diagnoses" that rendered them confined for their entire youth and well into adulthood.[4]

In the United States, children diagnosed as mentally ill were likewise confined to institutions (usually called "almshouses" or "orphanages," despite such children not normally being orphans) for lengthy durations of confinement and "treatment."[5] Toward the end of the 19th century, children identified as "mentally retarded" were sent to "idiot schools," institutions for rehabilitation, rather than confinement in almshouses or orphanages.[6]

It was not until 1899 in Cook County, Illinois, that youth judged to be dangerous—many of whom were likely psychiatrically diagnosable—were sent before a judge in what was then the first "juvenile court." Such courts became common, with the intent to "rehabilitate" youth rather than confine them indefinitely. The effort was a direct result of social reformers who were responding to the inhumane orphanages in which youth had previously been interred.[7]

As legal and psychiatric interests clashed throughout the 20th century, the role of *parens patriae,* or the states' legal duty to civilly confine "persons against their will when they are unable to care for themselves," developed into the multitude of state and federal statutes currently classified as civil commitment laws.[8] Subsequent developments in involuntary civil commitment (ICC) law extended previous provisions on "dangerousness." Under these provisions, the need for treatment and concern about dangerousness in the presence of mental illness, excluding substance abuse/drug-induced dangerousness to self or others, were recognized as necessary for enactment of ICC.[9] Until the 1970s, children in mental health crises were generally treated the same as adults for purposes of state-ordered confinement. It was not until the mental health deinstitutionalization movement, started in California by then Governor Ronald Reagan, that children in mental health crises were separated by the courts from adults.[5]

Today, as it applies to minors, ICC may differ by state, but generally states recognize the rights of