



Frontline Perspectives

Spotting Risk, Saving Lives: Insights on Involuntary Commitment

Submitted by Lynn Nanos, LICSW, Author, *Breakdown: A Clinician's Experience in a Broken System of Emergency Psychiatry*, February 28, 2026

Recognizing when someone with severe mental illness needs involuntary care can be the difference between life and death. As a full-time mobile psychiatric emergency clinician in Massachusetts for over seventeen years, I respond to crises wherever they occur — from shelters and group homes to apartments and public spaces. My experience shows how critical it is to accurately identify when someone requires involuntary commitment and to effectively advocate for their safety and treatment. These lessons have national relevance, informing policies and practices that protect individuals, support families, and ensure access to life-saving care.

As a licensed independent clinical social worker, I'm able to authorize the involuntary transportation of people to the hospital to avoid the likelihood of serious harm due to mental illness, referred to as *Section 12* in Massachusetts. According to the Section 12 application, mental illness means a "substantial disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life." It's my job to determine whether there is danger or risk of danger based on interviewing the person with a mental illness.

Whether someone wants to be hospitalized does not determine whether Section 12 criteria are met. However, it is a good idea to issue a Section 12 even when the person is agreeable to being hospitalized. This ensures that if they change their mind while being transported, the ambulance crew and police officers are legally authorized to keep them in care.

A Section 12 may be authorized when there is a substantial risk of serious harm to oneself. This typically applies to active suicidal ideation involving a plan, means, and intent to act. These types of Section 12s are very common. For example, a Section 12 would be appropriate if someone is expressing that they plan to hang themselves from a tree branch using tools they intend to buy at Home Depot. Passive suicidal thoughts, particularly if they are baseline for the individual, do not usually qualify.

A Section 12 can be implemented when there is a substantial risk of serious harm to others. While less common than suicidal ideation, these situations are just as dangerous. Hospital emergency department doctors are often more likely to release someone who is making threats

to harm others if the behavior stems from a personality disorder (for example, antisocial personality disorder). However, a Section 12 is more likely to be upheld if the homicidal ideation is associated with psychosis. For example, the person might believe that killing a specific individual will prevent widespread harm, such as protecting a large group of children from sexual abuse. In these cases, the risk perceived by the clinician warrants issuing a Section 12.

A Section 12 can be issued when a person is at substantial risk of sustaining physical harm or injury, or when their judgment is so impaired that they cannot protect themselves from basic harm in the community, and reasonable alternatives to keep them safe are not available outside of a secured setting. This typically applies to individuals experiencing psychosis or being out of touch with reality. In rare cases, a Section 12 may be warranted for severe depression that leaves a person unable to meet basic biological needs.

Psychosis and agitation can interfere with the ability to participate in a thorough interview. An individual in crisis may be highly agitated, verbally aggressive, yelling or screaming uncontrollably, or banging objects roughly. They might be uncooperative and unresponsive to attempts to engage. Some may be self-dialoguing and responding to internal stimuli, involving whispering or talking aloud in isolation. They may be disoriented to the situation and unaware of why the intervention is occurring. Paranoia is common, with the person falsely believing that others intend to harm them. Evidence from family members, friends, or outpatient treatment providers can support the need for a Section 12. Information about baseline functioning and whether the current behavior represents a significant deviation is often used to guide the decision. A Section 12 can be issued even if the individual in crisis has not been personally examined.

A Section 12 cannot be issued for symptoms caused solely by use of alcohol or illicit drugs, as substances can mask or mimic mental illness. Similarly, a Section 12 cannot be authorized for symptoms caused solely by neurological disorders, including dementia. However, severe mental illness is biological and can impair perception, judgement, and the ability to distinguish reality from delusion. Disorientation may therefore indicate unmanaged serious mental illness. For example, an individual might be disoriented to self, believing they are a queen or CIA agent. Conversely, delusions about others' identities or intentions can pose significant risk, which typically warrants a Section 12. Although nonadherence to treatment often contributes to psychiatric deterioration, refusal to engage in recommended treatment does not meet the criteria for a Section 12.

Although a Section 12 authorization allows the receiving hospital to prevent the patient from leaving for up to three business days, the patient may be discharged earlier, depending on available resources and clinical decisions.

Thorough and detailed documentation is essential when issuing a Section 12. Clear records of the individual's presentation, observed behaviors, collateral information, and risk factors

provide a legal and clinical foundation for the order. This documentation ensures that all decision-making is transparent, defensible, and centered on the individual's safety and well-being. Detailed notes also guide hospital staff in providing appropriate care and continuity of treatment.

Accurate documentation can make a critical difference in outcomes. It helps prevent unnecessary delays in care, reduces liability for clinicians and first responders, and supports families and caregivers in understanding the rationale for intervention. In the absence of careful documentation, critical details can be overlooked, increasing the risk that someone in crisis may be discharged prematurely or without adequate support. Ultimately, detailed documentation upholds both the safety of the individual and the integrity of the mental health system.

Involuntary commitment is never a decision made lightly. It requires clinical judgment, ethical clarity, and the courage to act when the risk of serious harm outweighs the discomfort of overriding a person's immediate wishes. My years on the front lines have shown that when applied thoughtfully, Section 12 is not about control — it is about protection, stabilization, and preserving life. Clear standards, careful assessment, and thorough documentation ensure that this intervention remains both compassionate and legally sound. When used appropriately, it serves as a vital safeguard for individuals in their most vulnerable moments.

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