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The Law and Patient Beneficence: Provider Competency on Involuntary Hospitalization, a Systematic Review

Jennifer L. Robertson*, **Candice C. Beasley**

School of Social Work, Tulane University, New Orleans, LA, United States

ABSTRACT

The aim of this systematic review is to evaluate competencies of healthcare providers in addressing psychiatric emergencies that may result in involuntary hospitalization. Specifically, this review explores if healthcare providers are competently prepared for involuntary hospitalization. Federal and state laws must be followed if a provider is to be competent in addressing a psychiatric emergency. According to federal law HR 4302, District of Columbia Mental Health Civil Commitment Modernization Act of 2004, the involuntary care of a person is defined as one "who is an imminent risk to themselves or others or is gravely disabled due to mental illness." In accordance with federal law, all states have the ability to write and maintain their own statutes specific to involuntary hospitalization. It is notably difficult to address and evaluate competency across the nation with 50 different sets of statutes. However, if competency is not achieved by providers related to involuntary hospitalization, vulnerable people are at risk for harm and the loss of civil liberties. A systematic review of literature, since the October 2004 enactment of HR 4302, across the disciplines of social work, psychology, psychiatry, medicine, and law has yielded 461 articles. Using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA), 12 articles meet the requirements for inclusion for competency in knowledge on involuntary hospitalization by health care providers. People with mental health diagnoses have been marginalized and stigmatized throughout history due to antiquated education and the misuse of policy. Through innovative education, continued research, introspective growth, and systematic change, healthcare providers in the United States can be the competent practitioners that communities depended upon.

Keywords: Law; Patient; Hospitalization; Psychiatry; Diagnoses

INTRODUCTION

The Mental Health Civil Commitment Act of 2002, revised to the District of Columbia Mental Health Civil Commitment Modernization Act of 2004 (HR 4302), has outlined an updated national policy on involuntary hospitalization. The act set forth the Commission on Mental Health, laws for emergency observation detention, and providing counsel for patients. In addition, this law provided checks and balances for involuntary hospitalization, protections for professionals acting in good faith, and protections for vulnerable patients [1].

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Corresponding author: Jennifer L. Robertson, School of Social Work, Tulane University, New Orleans, LA, United States; E-mail: jrobertson@tulane.edu

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The Civil Rights of Institutionalized Persons Act of 1980 and the Americans with Disabilities Act (ADA) were instrumental in developing and implementing HR 4302. These two Acts required agencies to utilize the 'least restrictive' care to meet the needs of patients, like outpatient, community-based services as feasibility permits [2]. 'Least restrictive' is a common clinical term referring to using treatment and care to maximum autonomy while meeting the behavioral and healthcare treatment needs recommended by the attending providers [3]. Along with utilization of least restrictive care, HR 4302, the Civil Rights Act, and ADA, emphasizes the protection of individual rights and protects against discrimination. However, the lack of understanding by healthcare providers on national and state statute related to involuntary hospitalization continues to put patients at risk of improper and illegal care, increasing the likelihood of iatrogenic illness [4,5,3].

Literature Review

The policies and statutes on involuntary hospitalization stem from the social construct of 'parens patriae' or a society's governmental responsibility to protect the people within the society [6-8]. During involuntary hospitalization, a person is linked to crisis and emergency mental health services that are inaccessible to many people [9]. However, the limitation on a person's liberties often mirrors the limitation in the criminal justice system, (*i.e.* unable to leave at will, clothing and skin checking, limited access to friends/family, etc.). A major difference is involuntary hospitalization is often initiated by medical and mental health professionals that have little to no training in state statue [10,11] and frequently without a court hearing [9,2]. Additionally, unlike the medical health system, patients can be mandated to access mental health treatment [12].

Accessing mental health care through outpatient treatment continues to be challenging, often increasing the perceived need for inpatient treatment. Even with the Affordable Care Act implementation, the increasing insurance coverage for patients hoped to rectify the lack of accessibility to services, but the number of providers has not risen to meet the service demand [13]. In rural areas, there are few, if any, specialized mental health practitioners (psychiatrists, psychologists, social workers, counselors, etc.) [14]. Olfson, found that rural states, like Idaho, have only 5.2 psychiatrists per 100,000 people, and urban states, like Massachusetts, have 24.7 psychiatrists per 100,000. These numbers would equate to caseloads ranging from 4,000 to 20,000 people if every resident needed services. Lueck and Poe found college campuses, on average, only had one counselor per 1,737 students [15]. The shortage of access to mental health professionals affects over 100 million Americans [16]. Due to the shortage of providers and the increase in the use of the emergency room, healthcare professionals face mental health emergencies at a significantly higher rate. Changes to healthcare usage are forcing healthcare professionals to respond to the community's needs with limited access to specialized care.

The most recent report to Congress, from the U.S. Department of Health and Human Services, found that from 2004-2016 there was a 44% increase in emergency room usage with a primary need for mental health or substance use disorder [17].

The Federal Emergency Medical Treatment And Active Labor Act, commonly known as EMTALA, requires hospitals to triage all patients, providing evaluation and stabilization, before transferring for specialized care where possible [18]. Systemic constraints of the United States healthcare system means the only place a person can be guaranteed an acute mental health evaluation is the emergency room. Unfortunately, emergency rooms are counterproductive to mental health healing as they are notoriously loud, busy, lack privacy, and are over stimulating [19]. Brennanman also explains that due to a lack of specialized care, patients with mental health diagnoses are in the emergency room longer than patients with medical diagnoses, exacerbating the crowding. Dolan, also reports the overcrowding in emergency rooms makes it challenging for those who need emergent care to get that care quickly, and provides additional complication to serving families of a patient in a mental health crisis. The lack of appropriate beds in appropriate places is a nationwide crisis yet to be solved by policymakers; therefore, continuously leaving healthcare professionals without resource allocations so that they may best meet their professional abilities and ethical requirements mandated by their profession.

The ethics of involuntary hospitalization has been an ongoing conversation as the mental health field has progressed [10]. In both mental health and medical treatment, there is a constant cost-benefit analysis of autonomy versus beneficence [10,20]. Arena Ventura et al. found mental health professionals, in the admissions department of a mental health hospital, lack knowledge about involuntary hospitalization laws and regulations [21]. Kaufman and Way, found resident psychiatrists identified knowledge of involuntary hospitalization criteria is important, however in the study scenario, 74% of the residents improperly involuntarily hospitalized a patient with mental health concerns. Hotzy et al., found non-psychiatric residents showed low levels of confidence in their ability to decide if involuntary hospitalization was needed, suggesting the need for specialized teams to support decision making. When providers are unable to appropriately assess risk and inappropriately assign an involuntary status, patients and their civil liberties reap the consequences.

A significant amount of stigma comes with a mental health diagnosis in the United States. For example, Yanos et al., found those people diagnosed with mental illness are perceived as more dangerous than people who do not have a mental health diagnosis. This perception of "dangerousness" increases the likelihood that a healthcare provider will involuntarily hospitalize the patient [10]. Involuntary hospitalization increases stress-related stigma, suicidality [22], and increases distrust of the healthcare system [23]. The stigma and distrust of the system decreases the likelihood of ongoing care while, increasing the need for emergency care. Discrimination is common among people who have been diagnosed with a mental health illness. A person's ability to make decisions for themselves is overridden by the simple diagnosis of a mental illness; as a result, people with mental illness are seen as incompetent in making "sound" decisions [24].

There is also the potential for involuntary commitments to be seen as a "transfer of responsibility." For example, a hospital or provider can be viewed as needing to rescue or save a person from themselves; therefore, this person may not have to take (or may take less) responsibility for their care [25].

Research has shown people are more likely to respond to treatment when they take responsibility for their care, make decisions about care, and are offered hope [2]; in contrast to those who are negatively impacted due to the involuntary hospitalization process. Zervakis et al., report patients who have been involuntarily hospitalized felt discouraged from seeking future treatment, had a decrease in rapport with healthcare providers, and had an overall increase in feelings of coercion, even during voluntary hospitalizations. Understanding and utilizing positive pressure in statements such as: "This must be scary for you," "the doctor is recommending this medication to help you feel more calm and less scared so we can figure this out together;" or, "can I tell you more about this medication?" versus lack of transparency in the negative pressure process "if you do not calm down and take your pill I will just give you a shot." creates a feeling of coercion [26,27]. Nurses, like other medical and mental health professionals, have a code of ethics that does not condone the use of coercion and encourages professionals to obtain consent to the extent possible [20]. Nurses have found themselves justifying coercion, despite not wanting to participate in forced care, and would benefit from training in decision-making during potentially coercive situations.

Healthcare professionals and legal professionals see involuntary hospitalization from different perspectives. While both seek the best interest and care for the patient, healthcare professionals will look at symptomatology, and legal professionals will look for proof of predicted dangerousness [28]. The balance between what is legal, ethical and in the best care for the patients is delicate. While an involuntary hospitalization's intended purpose is the safety and well-being of people, the iatrogenic harm may be greater than the benefit sought [29]. Kaufman and Way and Hotzy et al., both explain the amount of knowledge on involuntary hospitalization among psychiatric and non-psychiatric residents is lacking. The knowledge, education, and competency of providers charged with the welfare of patients can be one of the most important protections patients have. If the information is not received in school or residency, where is it acquired?

Under HR 4302, individual states can develop and implement statutes related to involuntary hospitalization for mental health. Over the 50 United States, there are eight different possible reasons for involuntary hospitalization and 22 different types of professionals/citizens who can initiate involuntary hospitalization [9]. Additionally, the length of the hospitalization and rights available to patients vary greatly, state to state; therefore, it is difficult to summarize. Law ambiguity serves a purpose for broad application to various people in different situations.

However, it often creates difficulties for providers and patients to understand their rights and responsibilities [30]. When healthcare providers are not knowledgeable about legal rights and responsibilities, there is a greater risk of iatrogenic harm to patients [4]. Risks include but are not limited to stigma-related stress, post-traumatic stress, an increase in suicidal thoughts, the feeling of coercion, distrust of the healthcare system, delirium, and loss of family, jobs, money, and housing [4,25,31-33,20,22,23,27]. Further, providers risk being viewed as "fraudulent" if they do not accurately represent important information about hospitalization [8].

Methods

A preliminary literature search shows a theme of healthcare providers lacking education and knowledge on involuntary hospitalization. The authors seek to understand if healthcare providers have the competency, through education and knowledge, to address the increasing need for mental health emergencies through the application of involuntary hospitalization in the United States. Through a systematic review of the literature published since the enactment of HR 4302 in 2004, the authors attempt to understand the scope of competency of healthcare professionals related to involuntary hospitalization.

The PRISMA flow diagram was used to perform a systematic review [34]. The purpose of this comprehensive assessment of the literature, which spanned seventeen years, was to determine if the body of literature supporting healthcare professionals' competency adequately equipped them to handle involuntary hospitalization. Seventeen years began in October of 2004, the first month after the enactment of HR 4302 to the beginning of systematic review in October 2021. Gray literature was excluded from this systematic search since only peer-reviewed, published literature was sought. There is not yet a mandate that researchers use gray material while conducting systematic reviews. According to Paez [35], while gray literature is referred to as an "important resource", it is not required for a reliable systematic review and is viewed as one tool to address publication bias. Due to the sensitive nature of involuntary hospitalization, the authors decided the use of peer-reviewed literature was best suited for this endeavor. A two-reviewer process was used to critically appraise articles, with each author appraising independently for inclusionary and exclusionary criteria. All reasonable attempts were made to retrieve articles, however due to copyright laws; three articles were unable to be obtained by either author, therefore excluding them from this study. Each author read all retrieved articles, rating each as included or excluded with reason. Any discrepancies were discussed, and a consensus was achieved.

PRISMA Flow Diagram

The authors completed the following steps to gather generalized, operational, and current literature regarding guidance in critically identifying ways by which health professionals gain competency regarding involuntary hospitalization.

To locate this body of literature, a systematic search was performed utilizing the following EBSCO Research databases: SocINDEX with Full Text, Academic Search Complete, Alt HealthWatch, APA PsycArticles, APA PsycInfo, Criminal Justice Abstracts With Full Text, ERIC, Family Studies Abstracts, Health Source: Nursing/Academic Edition, Legal Source, LGBTQ+ Source, MEDLINE, Military And Government Collection, Professional Development Collection, Psychology and Behavioral Sciences Collection, Race Relations Abstracts, Social Work Abstracts, Urban Studies Abstracts, Violence and Abuse Abstracts, Women's Studies International, and CINAHL Complete. Through a seventeen-year review, these databases were searched from October 2004 through October 2021 screening for peer-reviewed publications. The keywords utilized were: health professional, nurses, physicians, counselor, psychologist, social work, mental health law, mental health professional, education, knowledge, practice, competency, involuntary hospitalization, and emergency mental health, (Appendix 1). Inclusionary criteria entailed that articles were to be published within the last seventeen years; the articles must be peer-reviewed, in the English language with full text available. The articles also were to be specific to involuntary hospitalization conducted within the United States of America and identify involuntary hospitalization efforts that reflect healthcare professional competence. Exclusionary criteria included: Articles and journals that were not peer-reviewed, articles published prior to October 1, 2004, articles where research was not conducted within the United States of America, were not peer-reviewed, were not in the English language, and articles that did not include mention of healthcare professional, involuntary hospitalization, competency, and knowledge.

RESULTS

Through the use of the 2020 PRISMA flow diagram [34], records identified, through the keyword search, yielded 461 possible articles; 136 duplicate articles were removed. Therefore, 325 full-text articles were assessed for eligibility. Authors were unable to retrieve three articles through university libraries and digital resources. Out of the 322 articles, 310 articles failed to meet the inclusionary standards; 201 articles possessed research that was conducted or published outside of the USA; 40 articles were not peer reviewed research (*i.e.* first person narratives, instructional guides, and book reviews), and 69 articles did not meet the Boolean search terms for the aforementioned inclusionary criteria. Therefore, twelve articles (n=12), met all aspects of the inclusionary criteria (**Figure 1 and Table 1**).

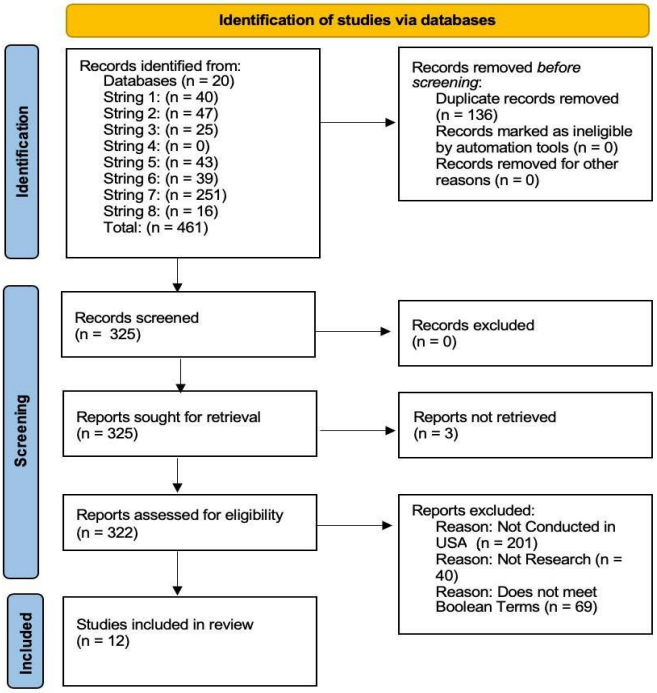

Figure 1: PRISMA flow diagram.

Inclusionary articles	Peer reviewed	Published 10/2004-10/2021	Conducted in USA	Healthcare professional knowledge/ education	Involuntary hospitalization
Allen	X	X	X	X	X
Brodwin	X	X	X	X	X
Brooks	X	X	X	X	X
Hashmi et al.	X	X	X	X	X
Holder et al.	X	X	X	X	X
Hom et al.	X	X	X	X	X
Jain et al.	X	X	X	X	X
Lincoln	X	X	X	X	X
Reder and Quan	X	X	X	X	X

Sattar et al.	X	X	X	X	X
Shdaimah and O'Reilly	X	X	X	X	X
Westmoreland	X	X	X	X	X

Table 1: Systematic review results.

DISCUSSION

This systematic review focuses on the importance of competence regarding involuntary hospitalization among healthcare professionals as there must be a collective understanding regarding the importance and shared responsibility of balancing the safety of the community with protecting the civil liberties of those with psychiatric emergencies. Although such a responsibility is seemingly apparent; the policies, procedures, and legal mandates in actualizing this responsibility may be quite difficult as laws governing involuntary hospitalization, from its definition and verbiage to its procedures, are governed by the states; therefore, there are no federal standards allowing for cohesive application and practice on a national level [36].

The literature regarding the connection between involuntary hospitalization laws and professional healthcare practice reveals a myriad of reasons why authentic, meaningful, and non-performative training and application of involuntary hospitalization laws are imperative for mental healthcare professionals. Differing themes may emerge when both novice and veteran professionals are either partially or not well versed on the involuntary hospitalization laws and policies that govern their state as well as the ethical tenets assumed within this decision-making process.

Brodwin, offers the theme of ambivalence; defined as the “The spontaneous expressions about right and wrong, the obligatory and the forbidden and the legitimacy of medical power made by clinicians immersed in ordinary work routines” (p. 528). [37]. In short, when themes of ambivalence enter into the practice of involuntary hospitalization, it allows mental health care professionals to authentically presume their clinical actions support patient/client beneficence while consciously disregarding state involuntary hospitalization laws.

In a study by Jain et al., which surveyed one hundred sixty-five physicians that specializes in substance use disorder, the theme of ambivalence is expressed through the mental health provider’s personal values and beliefs [38]. The findings of the study showed that approximately twenty-one percent of the physicians were not in favor of involuntary hospitalization laws in their state and approximately eighteen percent were uncertain of their thoughts regarding this issue. Further, thirty-nine percent of participants reported that they were “somewhat familiar” with involuntary committal laws within their state and thirty-eight percent of participants reported being “not familiar” with involuntary hospitalization laws.

Lincoln, infers agreement with the theme of ambivalence by finding how social factors, such as: the positive correlation between the professional’s personal risk taking behaviors and being agreeable to engaging in the involuntary hospitalization process [39], direct decision making in who will be involuntarily hospitalized; thus, allowing for the perception that it is the mental health professionals explicit intent to place their own values and beliefs regarding involuntary hosptialization-even above that of state law.

Westmoreland et al., reveals the theme of bias within the involuntary hospitalization process [36]. In this analysis of the application of involuntary hospitalization with those diagnosed with anorexia nervosa, the study found that although this diagnosis is amongst the more lethal of the psychiatric diagnoses, there is often reluctance to subject patients with anorexia nervosa to involuntary hospitalization due to the patients with this diagnosis being viewed as "intelligent" and "self-disciplined" in comparison to patients with subsequent mental health diagnoses.

In contrast, Hom et al., describes bias through the removal of client/patient autonomy. This study identified bias, among mental health care professionals, by analyzing the perspectives of service received by ninety-six suicide attempt survivors. Of these survivors, eighty-two percent reported at least one negative experience while in contact with a mental health care professional with common experiences being: “stigma from the provider, involving being belittled for having attempted suicide; poor therapeutic alliance; and inadequate training to work with individuals at elevated suicide risk, often evidenced by discomfort with participant disclosure" [29]. This study also found that participants who ascribed to be female were more likely to have reported negative experiences than participants that ascribed to be male, inferring bias in the mental healthcare experience based upon sex/gender. The Jain et al., study also shares the sentiment in that there is a concept of privilege within the involuntary hospitalization process. As it relates to substance use disorders, this study reports that physicians were more likely to support involuntary hospitalization for opioid and alcohol addiction but not for subsequent substances such as over-the-counter medications and inhalants.

Themes of professional competency must also be explored as there is a lack of uniformity in the understanding and application of involuntary hospitalization policy, procedures, and laws [40].

Hom et al., further found that study participants that reported negative mental health care experiences associated these experiences with involuntary hospitalization, including "being confined to the same space with individuals with more severe psychopathology and being physically restrained" [29]. In a study of approximately seven hundred mental health care professionals across the United States, Brooks, found that respondents exemplified competency in conceptualizing the legal components of involuntary hospitalization which focuses upon danger to self-and/or others. However, when examined on subsequent legal grounds of this concept, such as: grave disability, substance addiction, and in some states "sexual predator status," competency seemingly declined. Further, this study identified that mental health care professionals, within the study, were not well versed on legal grounds of involuntary hospitalization, beyond those that were commonly experienced within their practice setting as well as having limited knowledge of outpatient involuntary hospitalization procedures within their state [7]. Even more concerning, a study by Hashmi et al., found that out of 81 patients within their study that were involuntarily hospitalized, "more than one third of the patients lacked sufficient clinical justification for involuntary hospitalization" (p. 621) [41].

Holder et al., study within an emergency department, found that procedural competency, regarding involuntary hospitalization, lacks consistency across health care disciplines with social workers performing better than medical doctors and nurse practitioners [36]; results that are concerning as it is not uncommon for social workers to take orders and directives from these professionals within the emergency department. A study by Reder and Quan, found that mental health professionals and administrators within their study, believed that it was not the emergency department's responsibility to "pry" into the lives of their clients; hence, the emergency department is to only concern itself with acute life-threatening mental health behaviors and not "unclear" mental health issues [42].

Continuing the theme of competency, Allen, discusses an intersectional theme of violence, finding that when compared to licensed nurses, unlicensed mental health care workers were three times more likely to be assaulted within in-patient setting causing difficulty in sustaining safe environments for all involved within the in-patient setting [43].

Finally, Westmoreland et al., discusses physician countertransference and how the physician "bears the brunt" of anger from clients' families when the idea of involuntary hospitalization stems from the mental healthcare team and is not a request from the family [44]. When this occurs, especially for a mental health diagnosis that may also be viewed as a physical medical diagnosis, the physician may concede and allow the patient more autonomy regarding their mental health care plan. This type of countertransference is yet another barrier in adhering to state involuntary hospitalization laws by unintentionally disregarding professional competency.

Future Implication

Consistently throughout the literature, researchers call for training and education to support providers in making ethical, statute driven, and safe decisions related to involuntary hospitalization [43,19,41,36,29,10,11,45,39,40].

Offering acontinuing education course is a cost-effective way to engage healthcare and mental health professionals. Allen, notes education does not create 'one and done' change, continuous conversation about ethics and decision making provide for a culture of commitment to meaningful patient care. Whether implemented by state regulatory boards, the Centers for Medicare and Medicaid Services, universities or individual agencies, the benefit of continued education and training on involuntary hospitalization will resonate within the communities served.

Additionally, these authors seek more structural changes along with education. Several mental illnesses fall under the protection of disability rights, however, the accommodations made for people with mental illnesses are not comparable to those made for people with mobility disabilities [24]. For example, ramps and elevators are commonplace in western society; however, Szmukler, brings up the concept of supportive decision making for people with severe mental illness as an accommodation in a society with few accommodations for people with mental illness. An invisible disability deserves equal accommodation to 'visible' disabilities. As part of their Mental Health Act (MHA), Alberta, Canada has implemented the use of mental health patient advocates. Under the MHA, which has similar wording to American state statutes, access to mental health patient advocates is a right of any person involuntarily hospitalized that is deemed unsafe to self or other due to mental health reasons [46]. The primary purpose of advocates is to provide information, help patients advocate for themselves, and investigate concerns or questions of patients. Advocates can assist patients in obtaining legal counsel, apply for an appeal of treatment decisions, review patient records, and ask reasonable questions of providers involved in care [47]. Additionally, advocates and the advocacy office provide presentations and training, free of charge, to professionals, community organizations, people who use mental health services, family and caregivers of those with mental illness, students, and any interested community members [48]. The transparency and support given to patients can increase use of services, positively impact people and communities, and increase ethical care of all patients.

Hom et al., study participants provided recommendations of different support systems being offered during hospitalization to improve outcomes. An option for hospitals is to have a specialty team for supportive decision making and patient advocacy. Potentially housed within the emergency department, this team would be able to help patients who are at risk for involuntary hospitalization or have medical and/or mental health struggles that may require additional explanation to ensure informed consent is achieved. This team would also be able to support hospital staff in understanding involuntary hospitalization statutes and patient rights. Led by a mental health nurse practitioner (or the state's equivalent) and made up of different levels of medical and mental health staff, including licensed practical nurses, registered nurses, and bachelor's and master's level social workers.

Bachelor's level social workers and LPNs are able to serve on this team as they are not performing assessments of the patient but supporting the patient's ability to make informed decisions. Like a mental health patient advocates, their primary job would be the rights of patients with a secondary job of providing knowledge and training to the hospital staff. With a patient's right specialty team, patients will have additional protections on their autonomy, and providers will have additional resources to support their ability to provide high quality care to more patients.

Decreasing unnecessary involuntary hospitalization can decrease the crowding in the emergency room allowing for a more efficient flow of services [49,50].

CONCLUSION

Without increasing advocacy for patients and education for providers, our society both decreases the positive impact of treatment and places vulnerable people at risk. An article written for the New York Times in November of 2022 reports on the mayor of a major city announcing concerns over the 'crisis' of homelessness in the city, insinuating it is a mental health crisis. The article reports the mayor pushing for law enforcement to force people struggling with housing instability to be evaluated for mental health, equating housing instability with grave disability due to mental health. Currently, New York state statute Chapter 27, Title B, Article 9 does not allow for involuntary hospitalization due to 'grave disability', only for suicidality and homicidality.

In cases like the aforementioned, whose responsibility is it to know the state statutes and ethics of caring for the community? If local authorities and providers are not knowledgeable on the state statutes and advocacy groups are unable to keep up with the high demand for services, what is the risk to the vulnerable populations? Involuntary hospitalization is not just an emergency room or psychiatric hospital issue. The effects of involuntary hospitalization are pervasive and worth the time of all providers to attain the knowledge to provide the best quality services to their communities.

LIMITATIONS

The most notable limitation of this systematic review is the small sample size. The size is limited due the absence of peer-reviewed studies on health provider competency conducted in the United States. This limitation highlights a significant gap in the literature and research on health care provider competency, indicating that in the United States, perhaps a greater focus should be placed on the evaluation of our practices and processes related to involuntary hospitalization. Other countries have shown, through the literature, an importance placed on the evaluation and competency of providers. Additional systematic reviews would be indicated once the United States have bridged the current gaps by researching and evaluating the process by which they allow providers to remove civil liberties of vulnerable people.

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