Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice

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Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice

Part I. Origins and Current Status of Civil Commitment

Part II. Principles to Guide Civil Commitment

Part III. Practical Tools to Assist Policy Makers in Evaluating, Reforming, and Implementing Involuntary Civil Commitment

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Involuntary civil commitment in the United States is a legal intervention by which a judge, or someone acting in a judicial capacity, may order that a person with symptoms of a serious mental disorder, and meeting other specified criteria, be confined in a psychiatric hospital or receive supervised outpatient treatment for some period of time. Standards and procedures for commitment are provided by state law, in every state.[1] Contemporary commitment proceedings must comport with due process protections under state and federal law, in accord with constitutional rights as recognized by the U.S. Supreme Court; these include a qualified right to refuse treatment and the general right of law-abiding persons not to be confined unless they pose some risk of harm. A record of involuntary commitment can affect other rights, too, notably the right of private citizens to possess firearms; federal and state laws limit this right specifically for persons with a history of commitment or other mental disability-related adjudications.[2]

As commitment laws and policies have evolved, public behavioral health care systems face new challenges in delivering mental health services under fiscally constrained circumstances. The locus of continuing care and treatment of adults with serious mental illnesses has shifted almost entirely away from state mental hospitals. Behavioral health financing trends—notably privatization and managed care—have transformed public mental health systems, leading to the devolution of long-standing organizational structures and authorities in many jurisdictions, and redefining the notion of accountability for the care of persons with disabling mental illnesses.

An apparent shortage of psychiatric beds in many areas has created a situation in which involuntary commitment may be seen as a virtual entitlement—a way to prioritize intensive mental health services for individuals who would have difficulty accessing these services otherwise. Constraints on access greatly influence involuntary commitment practice and policy. Outpatient commitment, commonly termed "Assisted Outpatient Treatment" (AOT), may serve as a portal to services in some communities, using the legal leverage of commitment law.

To meet these challenges in a shifting policy landscape, some guidance is needed to assist state policymakers and practitioners in reforming, implementing, and appropriately targeting commitment law and practice—both inpatient and outpatient—to the small proportion of adults who require and may benefit from its use. Part I of this report reviews the history and current status of involuntary commitment in the United States.[3] Part II sets forth expert consensus

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[1] Federal laws can also authorize involuntary commitment in some circumstances, for example, when a person suffering from a serious mental illness is accused of a crime or adjudicated under the federal criminal justice system, or found not guilty by reason of insanity. Persons deemed to be sexually dangerous may also be committed under federal law. This report largely excludes discussion of commitment under federal laws.

[2] The U.S. Supreme Court's landmark *Heller* decision in 2008 affirmed that the Second Amendment to the Constitution confers the right for private individuals to bear arms for personal protection, but left in place longstanding firearm prohibitions applying to certain categories of people, including those with a record of involuntary civil commitment (*Heller v District of Columbia*, 554 U.S. 570 (2008); Felthous & Swanson (2017)).

[3] The report's focus is on ordinary civil commitment of adults with mental illnesses. Different laws and procedures apply to the commitment of persons with intellectual disabilities (see *Heller v Doe*, 509 U.S. 312 (1993)), children (see *Parham v J.R.,* 442 U.S. 584 (1979)), criminal defendants found not guilty by reason of insanity (see *Foucha v Louisiana*, 504 U.S. 71 (1992)), and sex offenders leaving confinement in criminal or juvenile justice institutions (see *Kansas v Hendricks*, 521 U.S. 346 (1997)).

principles to guide the optimal, ethical use of commitment. Part III provides practical tools—briefly stated guidelines and a checklist of requirements—to assist policy makers and others responsible for reforming or implementing civil commitment laws or systems.

Part I. Origins and Current Status of Civil Commitment

Before the mid to late twentieth century, public mental health services in the United States were provided almost exclusively in large state hospitals. Today, all but about two percent of care is provided in other settings, including other inpatient settings. Indeed, less than 37 percent of inpatient psychiatric beds are located in public (state or county) hospitals. If one includes in the inpatient count beds in residential treatment centers and nursing home beds serving patients with serious mental illnesses, the percentage of beds located in public psychiatric hospitals drops to 11 percent. And this calculation takes no account of emergency room beds, crisis beds, group living beds, or supported housing beds. In all, 7.5 million individuals receive publically funded mental health services annually in the United States, nearly all in the community. Only one in 57 is served in a state or county hospital (Lutterman, et al., 2017).[4]

Civil Commitment: Historical Roots

The vast majority of mental health services today are provided on a voluntary basis. Every state, however, provides for the civil commitment of those who meet the requisite legal standard. These standards and the procedures that are followed to impose commitment vary from state to state. Nearly all were crafted in the last 50 years. Before the late 1960's, commitment decision-making was less legalistic.

Brakel traces the early developments of civil commitment, beginning in Greece in the fourth century B.C. (Brakel, et al., 1985). Recognizing mental illness as a natural phenomenon, Hippocretes and his followers suggested persons with mental disabilities "be confined in the wholesome atmosphere of a comfortable, sanitary, well-lighted place." Early Roman law recognized the authority of a guardian to oversee the affairs of individuals with mental disabilities, with suspension of the guardianship during periods of the individual's lucidity. English law, beginning in the 13th century, distinguished between "idiots" (who "hath no understanding from [their] nativity") and "lunatics" (who "had understanding, but…hath lost the use of [their] reason"). The former—persons described today as having intellectual disabilities—were provided for by the King, who assumed custody of the person's lands and retained any profits therefrom in excess of the cost of the person's care. Upon the person's death, the lands were returned to the person's heirs. Individuals known as "lunatics"—persons with mental illness in today's parlance—also were provided for by the King, who held the person's lands during periods of the person's lunacy and used all of the land's profits for the maintenance of the person and the person's household. Any excess was returned to the person "when they c[a]me to right mind."

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[4] E. Fuller Torrey and colleagues from the Treatment Advocacy Center have observed that the number of people with symptoms of a serious mental illness who are incarcerated in the nation's jails and prisons is "ten times more than [the number] remaining in state psychiatric hospitals" (Torrey, et al., 2014). But are state hospitalization numbers an apt point of comparison? No one suggests every jail or prison inmate with mental illness symptoms should instead be in an inpatient-level of care, much less a state hospital. Considering how mental health care has evolved in the last half century, perhaps it would be more meaningful to say that nearly 20 times more people with a serious mental illness today receive care in the nation's public mental health systems than are housed in its jails and prisons.

Brakel notes that the system developed in England for the maintenance of persons with mental disabilities did not transfer well to the American colonies, given their lack of any established infrastructure for administering support. Families assumed responsibility for their mentally disabled members. Individuals without family support were on their own, sometimes joining others in "transient bands, drifting from town to town." There are reports of communities voting to help impoverished families with the cost of maintaining a disabled member, but the care provided was generally without force of law or legal administration.

The first American hospitals for the care of persons with mental disabilities appeared in the late 1700's and early 1800's. Until the mid-1800's, however, their numbers were so few that it was commonplace for persons with mental disabilities to land in jail, as vagrants, or to be taken into almshouses, "tossed together with the indigent physically ill and disabled, alcoholics, the retarded, the senile, and the slothful" (Appelbaum, 1994). Reformers of the day, led by Dorothea Dix, shone a light on the poor conditions under which so many people with mental illness lived and advocated for the development of residential facilities for their care. States took notice, and a "great surge of construction of state-run asylums moved across the country, beginning with the Worcester State Hospital in Massachusetts in 1833" (Appelbaum, 1994). Admission criteria, to the extent they were articulated, were simply that the person needed or would benefit from treatment. Typically, a family member would propose admission, and a physician would certify the admission for an indefinite period. The common law right to challenge an unwanted confinement in court, by writ of habeas corpus, was recognized in cases as early as 1845 (*Matter of Josiah Oaks*, 8 Law Rep.123 (Mass. 1845)). But it was not often used.

Following a series of celebrated cases in the late 1800's alleging wrongful commitment, procedures for commitment (but not legal criteria) were tightened. Judicial certification was required in many states, including the right to a jury trial in some. This legalization of the process slowed commitment in some cases, delaying treatment. In 1951, the National Institute of Mental Health (NIMH) released a "Draft Act Governing Hospitalization of the Mentally Ill," calling for commitment decision-making to be returned to medical professionals (US Public Health Service, 1952). Many states followed suit, establishing procedures for medical certification, with the right to a hearing only after admission. Detention and emergency admission might be initiated by the police. Wisconsin was among the states that took this approach.

Late Century Reform: Dangerousness as a Standard for Commitment

In 1971, Alberta Lessard was admitted to a facility in Wisconsin on the application of two police officers. The officers presented their allegations to a judge three days later. On the basis of their testimony, the judge continued Ms. Lessard's stay in the facility for an additional 10 days. Subsequently, a psychiatrist from the facility reported to the court that Ms. Lessard suffered from schizophrenia and should be committed "permanently." Without Ms. Lessard present, the judge continued her commitment and ordered two additional evaluations. The court assigned Ms. Lessard a guardian *ad litem* but did not appoint counsel to represent her. Ms. Lessard retained counsel privately, and the court scheduled a hearing five days later. Finding Ms. Lessard to be "mentally ill," the court continued her commitment for 30 additional days. Subsequently, the facility released Ms. Lessard on outpatient "parole," but her commitment was extended monthly, every month thereafter.

Before her release, Ms. Lessard filed a federal class action lawsuit (on behalf of herself and others similarly situated) challenging the constitutionality of Wisconsin's commitment law. A year later, the court issued an opinion in Ms. Lessard's favor, finding the procedures used to

commit her defective on a variety of grounds and ruling that, absent a finding of "dangerousness to self or others," commitment was unconstitutional (*Lessard v Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972)). Quoting from the U.S. Supreme Court's opinion in *Humphrey v Cady* (405 U.S. 504, 509 (1972)), the court declared that the degree of dangerousness necessary for commitment must be "great enough to justify such a massive curtailment of liberty." Moreover, the court ruled, dangerousness must be "immediate;" must be evidenced by a "recent overt act, attempt or threat to do substantial harm to oneself or another;" and must be proved beyond a reasonable doubt.

Lessard was not the first court opinion requiring dangerousness for commitment. In the 1845 habeas corpus case referenced above, *Matter of Josiah Oaks*, a Massachusetts court ruled that "[t]he question must then arise in each particular case, whether a patient's own safety, or that of others, requires that he should be restrained for a certain time, and whether restraint is necessary for his restoration or will be conducive thereto."

Dangerousness first found statutory recognition in 1964, with Congress' enactment of the Ervin Act, which controlled commitments in the District of Columbia (D.C. Code Secs. 21-501 to 21-591 (Supp. V. 1966)). The Act was noteworthy not only for establishing a dangerousness standard for commitment but, perhaps more significantly, for recognizing less restrictive alternatives to hospitalization as a dispositional option. In 1966, the DC Court of Appeals interpreted the Act to require consideration of less restrictive alternatives: "Deprivations of liberty solely because of dangers to the ill persons themselves should not go beyond what is necessary for their protection" (*Lake v Cameron*, 364 F.2d 657 (1966)). Recognition that a commitment order might extend to services outside a hospital opened the door to notions of outpatient civil commitment, discussed later in this report.

In 1969, California enacted the Lanterman-Petris-Short Act, or LPS Act (California Welfare and Institutions Code, Sec. 5150ff)), requiring for commitment either imminent dangerousness or "grave disability" (a condition rendering a person unable to meet his or her basic needs for survival). The LPS Act served as a model for other states considering reform of their commitment laws. By the end of the 1970's, practically every state had revised its commitment law to require dangerousness (or some condition akin to dangerousness) as grounds for commitment.

Most commentators suggest the dangerousness criterion is rooted in the state's "police power" to protect public safety. In contrast, commitment to benefit the person (e.g., on grounds of need for treatment) reflects its *parens patriae* power: to act in the person's interest. But there is no evidence that dangerousness as a criterion for commitment was intended to widen the scope of commitment, to include persons who were not mentally ill or did not need treatment or placement for their benefit. These laws' purpose has never been preventive detention, per se. Every state's statute requires that persons subject to commitment have a mental illness, and most require need for treatment as well (if only in their definition of mental illness). Certainly all states recognize a right to treatment for persons who have been committed. Thus, one might argue that even the dangerousness standard for commitment reflects the state's *parens patriae* power—to benefit those persons whose need for treatment is so great as to place them at risk for harm. The standard may be restrictive, but the commitment it supports is indisputably beneficent in intent.

The U.S. Supreme Court has said very little about the boundaries of ordinary civil commitment. Probably the most directly the Court has addressed commitment standards is in *O'Conner v Donaldson*, in 1975 (422 U.S. 563 (1975). Kenneth Donaldson was a patient in a Florida state

hospital for almost 15 years, committed there on grounds of having a mental illness (schizophrenia) and needing "care, maintenance, and treatment." He contested his commitment from the beginning, without success, and finally sued in federal court, claiming that the state had "intentionally and maliciously deprived him of his constitutional right to liberty." The evidence at his trial showed that he was dangerous neither to himself nor to others, that the hospital had provided him no meaningful treatment during his stay, and that responsible persons had undertaken to care for him outside the hospital, if necessary upon his release. He won his suit, and the hospital appealed. The U.S. Supreme Court upheld the verdict in Donaldson's favor, ruling "a State cannot constitutionally confine, without more, a non-dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends." A debate persists whether the language "without more" can be read to permit commitment of a non-dangerous person if treatment is provided. Note, however, that earlier in the opinion, the Court stated: "Assuming that that term ['mental illness'] can be given a reasonably precise content and that the 'mentally ill' can be identified with reasonable accuracy, there is still no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom." Many observers suggest this case stands for the proposition that dangerousness must be established for commitment to be constitutional.

The U.S. Supreme Court weighed in again three years later, this time on the standard of proof applicable in civil commitment proceedings (*Addington v Texas*, 441 U.S. 418 (1978)). The question before the Court was whether committability—whether a person meets commitment standards—must be established beyond a reasonable doubt[5], as the *Lessard* court had ruled seven years earlier, or whether a less restrictive standard would suffice. Mr. Addington had been committed upon a finding by "clear, unequivocal and convincing evidence"[6] that he was mentally ill, required hospitalization for his own welfare and protection or the protection of others, and was mentally incompetent. He appealed his commitment, arguing that the proper standard of proof should be the same as is required for conviction of a crime, i.e., beyond a reasonable doubt. The Texas Court of Appeals agreed with Addington and overturned his commitment. On further appeal, the Texas Supreme Court reversed, ruling that not only was the state's clear and convincing standard sufficient, Addington's commitment would have been proper even if established only by a "preponderance of the evidence."[7] Ultimately the case reached the U.S. Supreme Court. The Court recognized the significant liberty interests at stake for the person facing commitment (including the stigma that accompanies commitment) and rejected out of hand the preponderance standard: "The individual should not be asked to share equally with society the risk of error when the possible injury to the individual is significantly greater than any possible harm to the state." But it refused to adopt the reasonable doubt standard, noting the "lack of certainty and the fallibility of psychiatric diagnosis" and reasoning that "there is a serious question as to whether a state could ever prove beyond a reasonable doubt that an individual is both mentally ill and likely to be dangerous." The "middle level" of clear

[5] Proof beyond a reasonable doubt is the highest standard of proof required by law. Although the law does not quantify standards of proof, many scholars suggest proof beyond a reasonable doubt anticipates a degree of certainty approaching 90%.

[6] Proof by clear and convincing evidence requires that the matter in question be substantially more likely to be true than untrue, a degree of certainty that some scholars would peg at 75%.

[7] Preponderance of the evidence is the standard of proof applicable in most civil law suits and is sometimes expressed as the "greater weight of the evidence" produced by the two competing sides. It may be quantified as greater than a 50% likelihood.

and convincing evidence is followed in 25 states, the Court noted, and "strikes a fair balance between the rights of the individual and the legitimate concerns of the state."

Reactions to a Decade of Change

By the end of the 1970's, commitment jurisprudence was well established. Nearly every state had revised its commitment law in accordance with *Lessard, O'Conner, and Addington*. Not everyone was satisfied, however. Among the early and most vocal critics of the decade's developments was a Wisconsin psychiatrist named Darryl Treffert. Treffert's letter, "Dying with their Rights On," published in 1973 by the *American Journal of Psychiatry* (Treffert, 1973), detailed a series of cases in which prospective patients found not to be committable met sad ends. As Paul Appelbaum, however, points out his wonderful book, *Almost a Revolution* (Appelbaum, 1994), Treffert's criticism may have proved too strong for some. In particular, he points to an article by University of Virginia psychiatrist and law professor Browning Hoffman, who wrote: "Patients should not die with their rights on; but they should not live with their rights off, either" (Hoffman, 1977).

Whether the tightening of commitment criteria that occurred in the 1970's in fact has made a difference in commitment decision-making is an open question. Critics assumed it would, and many, like Treffert, were quick with anecdotal evidence to prove it. But, as Appelbaum discusses in his *Almost a Revolution*, the empirical evidence is not so clear. Considering studies of individual cases, studies of persons not committed, and examinations of aggregate data, Appelbaum concludes: "To the extent that consistent findings are available, they tend to show that the statutes have had less impact than expected (and in some cases minimal effect) on overall rates of commitment and on the nature of committed populations." By way of explanation, he points to the work of sociologist Carol Warren, who observed hearings in California and found that the participants, despite their differing roles—psychiatrist, attorney or judge—tend to "cooperatively reach an outcome that they all agree is desirable: hospitalization of a person they believe is clearly in need of care."[8] It should be noted, however, that this approach to civil commitment has received harsh legal criticism, the hearing process even being labelled a "charade"[9] for failing to provide meaningful opportunity for vulnerable individuals to contest the substantial liberty curtailment they face .

Despite the many studies suggesting that changes in commitment law had made little difference in practice, there remained the view that many who needed treatment were being left out. To address this concern, psychiatrist and Harvard Law Professor Alan Stone offered his "Thank-You Theory of Civil Commitment" (Stone, 1975). Intended to provide a treatment-oriented alternative to a

[8] Outpatient commitment hearings, too, sometimes resemble collaborative proceedings in which the different lawyers representing the state and the patient, respectively, work together toward a common goal—that the patient receive a court-ordered treatment plan that is likely to be beneficial. However, this is not always the case. Some lawyers who represent clients in outpatient commitment proceedings vigorously defend their clients' wishes, emphasizing the inherent coercion and deprivation of liberty that is at stake and discounting the potential that services the court might impose will be beneficial. Thus, based on a lawyer's libertarian or paternalistic perspective on mental illness and mandatory outpatient treatment, he or she might adopt a vigorously adversarial stance, defending the client against court-imposed treatment, or, alternatively, embrace a common goal of getting the client the services he or she "needs." (Swanson, 2009).

[9] Michael Perlin (2018) argues that mental health courts, being situated in the criminal justice system (with its emphasis on the rights of the accused), afford far greater due process protection than civil commitment courts. Commitment courts, he suggests, function as extensions of the public mental health system, which he believes is dominated by a tradition of medical paternalism, with almost complete judicial deference to psychiatrists' discretionary recommendations.

purely dangerousness approach, the model keyed on the competency of the proposed patient to decide about treatment and consisted of "five steps," or criteria:

1. Reliable diagnosis of a severe mental illness;
2. Without treatment, a short-term prognosis of major distress, including "profound anxiety, depression or other painful affects, deterioration of the personality, and the proliferation or intensification of symptoms;"
3. The availability of treatment that is likely to be effective;
4. Incompetency to consent to or refuse treatment; and
5. That a reasonable person would accept the treatment being offered.

Stone's Thank You Theory formed the basis for a Model Civil Commitment Law endorsed by the American Psychiatric Association in 1982 and published by Stone and attorney Clifford D. Stromberg a year later (Stromberg and Stone, 1983). Although not yet adopted in any state, several of its elements are popular among proponents of reform today.

Deinstitutionalization

At the same time that states were tightening their commitment laws, a movement was afoot to deinstitutionalize mental health care. Although some would point to the new restrictive laws as the cause of deinstitutionalization, in fact the movement began at least a decade earlier. In 1955, there were more than 550,000 state and county psychiatric beds. By 1975, when the new commitment laws were just beginning to take effect, the number already had dropped below 200,000 (President's Commission on Mental Health, 1978). In 2017, there were 37,209 beds in state and county facilities. But there were another 64,142 beds in other inpatient facilities, including private hospitals, general hospitals with separate psychiatric units, and VA Medical Centers. If one were to add in beds in 24-hour residential treatment centers, the number would climb another 41,079, to a total of 170,200 (Lutterman, et al., 2017). Considering population growth since the 1950's, of course, this number represents just a fraction of the inpatient *rate* when deinstitutionalization began.

The forces shaping deinstitutionalization are myriad. Although stricter commitment laws may play some role, far more important factors include:

- The advent of effective medications, beginning in the 1950's (and continuing today), enabling many consumers of services to live outside institutions for the first time and speeding recovery for those who are admitted;
- The Community Mental Health Act of 1963, which endorsed community-based care as an alternative to hospitalization and promised (though never fully delivered) funding for community mental health centers nation-wide;
- Changes in Medicaid laws, denying financial coverage for inpatient services for persons between the ages of 21 and 65 (the Institutions for Mental Disease, or IMD, Rule), which incentivized states to use community-based services whenever possible;[10]

[10] Similarly, mental health block grant funds may not be used for inpatient services in any setting. Note that the IMD Rule recently was amended to permit coverage for "short-term" inpatient stays, under certain circumstances (Letter from Mary C. Mayhew, Deputy Administrator and Director, CMS, to State Medicaid Directors, dated November 13, 2018).

- Advances in the treatment of epilepsy, neurosyphilis, developmental and intellectual disabilities, and geriatric dementia, conditions that accounted for large swaths of the psychiatric inpatient population in years past;
- Managed care, establishing strict medical necessity criteria for insurance reimbursement of the costs of hospitalization; and
- Federal disability laws such as the Civil Rights of Institutionalized Persons Act of 1980 (CRIPA) and regulations implementing the U.S. Supreme Court's decision in *Olmstead v L.C.* (527 U.S. 581 (1999)), which was based on the American with Disabilities Act and implores states to use community alternatives to inpatient care.

Psychiatric care is not the only medical care in the U.S. that has experienced deinstitutionalization. "From 2005 to 2014, the total number of hospital stays for all causes fell by 6.6 percent; for mental health/substance use conditions, hospital admissions rose by 12.2 percent in the United States—the only category of hospitalization that increased in the time period" (Pinals and Fuller, 2017). Clearly, inpatient services still have a vital place in the continuum of mental health care, ideally integrated with community-based services to assure smooth transitions between levels of care as a consumer's clinical needs change (NASMHPD, 2014). But, for many reasons, inpatient settings no longer are a primary locus of care. And inpatient commitment no longer serves as an essential gateway to services.

Inpatient commitments continue in every state but now affect a small proportion of mental health service recipients. In 2015, on average across states, only an estimated 9 out of every 1,000 persons with a serious mental illness were involuntarily committed. States varied widely in their estimated annual rate of commitment, however, ranging from 0.23 to 43.8 per 1,000 persons with serious mental illness, in Hawaii and Wisconsin, respectively.[11] Recent studies of inpatient commitment among adults with serious mental illnesses and served in public mental health systems have found a lifetime commitment prevalence of 12.8 percent in two large counties in Florida (Swanson et al., 2014) and 4.7 percent in Connecticut (Swanson et al., 2013). Commitment rates in these states, of course, are far lower in any given year.

Evolving Standards of Commitment

Standards and procedures for civil commitment have softened considerably since the 1970's. *Lessard v Schmidt*, with its requirement of imminent dangerousness, evidenced by a recent overt act and proved beyond a reasonable doubt, represents the high water mark for the legalization movement. Although dangerousness continues to serve as a commitment criterion in nearly every state, what must be shown to establish dangerousness has changed. In many states, the risks presented no longer need be imminent or immediate. The requirement of a recent overt act has been removed in some states. In others, the law now speaks of recent "acts or omissions." Finally, dangerousness need not always mean risk of violent behavior. In Iowa, a person may be committed who "is likely to inflict serious emotional injury on members of the person's family or others who lack reasonable opportunity to avoid contact with the person…if the person…is allowed to remain at liberty without treatment." "Serious emotional injury" is defined as "an injury which does not necessarily exhibit any physical characteristics, but which can be

[11] The 2015 average across 37 states was 9.4 (with a standard deviation of 10.4) commitments per 1,000 persons with serious mental illness in the population. These estimates are based on data from states that reported information on involuntary commitments to the NRI state profiles survey, available at: http://www.nri-inc.org/. Estimates of the number of persons with serious mental illness in state populations were derived from the National Survey on Drug Use and Health conducted by RTI International, available at: https://nsduhweb.rti.org/respweb/homepage.cfm

recognized and diagnosed by a licensed physician or other mental health professional and which can be causally connected with the act or omission of a person who is, or is alleged to be, mentally ill."

However it may be defined in statutes today, "dangerousness" commonly has been understood to refer to a person's risk for behaving violently—for causing injury to self or others. Scientific studies of the correlates of interpersonal violence and intentional self-injury have shown that these are complex, multi-determined human behaviors; many different factors in an individual's life history and circumstances, including certain symptoms of mental illness, may elevate risk of harmful acts within a particular timeframe (Swanson, 2016; Swanson & Van Dorn, 2010; Li et al., 2011). However, for the narrow legal purpose of authorizing involuntary commitment to psychiatric treatment— and for preventing unwarranted commitment—a person's putative dangerousness must be due to a mental illness that is amenable to treatment. Other factors might also contribute to heightened risk, perhaps by interacting with certain symptoms of mental illness, yet it must be the case—in order for a person to be committable—that *but for* the presence of a treatable mental illness, the person's risk of harmful acts (or omissions) would not rise above a threshold of concern. This is different from saying that a person's potential harmful behavior must be "caused by mental illness" or that mental illness itself provides a sufficient scientific explanation for the behavior. Indeed, the most advanced multivariable causal models that have been produced from empirical research describing violent or suicidal behavior leave much of the variability in these phenomena unexplained (despite specifying numerous statistically significant effects.)

This difference between scientifically sufficient *explanation* and legally sufficient *attribution* (for the purpose of commitment to treatment) may be one without a distinction in the law. And it must be acknowledged, this "eye of the needle" definition of significant risk linked to mental illness does not address, and was never intended to address, the larger public health problems of violence and suicide in the population. Indeed, violence risk *as an associated symptom of mental illness* excludes from commitment many individuals in need of intervention from public safety or social welfare agencies—even in some cases where psychopathology contributes to the accumulation of risk. To reiterate the key point: the purpose of commitment is to assure treatment—treatment to ameliorate those symptoms of mental illness that contribute significantly to an individual's elevated risk of harm to self or others.

As ubiquitous as dangerousness may seem in the world of commitment, active dangerousness no longer is the sole commitment criterion in most states. Nearly every state now provides alternative grounds for commitment. Dangerousness may still appear in a state's statute, but "grave disability" or "serious deterioration" is likely to be there as well.

Grave disability is typically defined as an inability to provide for basic personal needs for food, clothing, or shelter. In some states, the disability must be so grave as to cause substantial risk that the individual will experience harm. In Alaska, for example, "'gravely disabled' means a condition in which a person, as a result of mental illness, (A) is in danger of physical harm arising from such complete neglect of basic needs for food, clothing, shelter, or personal safety as to render serious accident, illness, or death highly probable if care by another is not taken; or (B) will, if not treated, suffer or continue to suffer severe and abnormal mental, emotional, or physical distress, and this distress is associated with significant impairment of judgment, reason, or behavior causing a substantial deterioration of the person's previous ability to function independently" (Alaska Stat., § 47.30.915(9)).

In a few states, the language defining "grave disability" appears, without use of the term, "grave disability," in the definition of "danger to self." For example, in North Carolina, "[d]angerous to himself" means that "within the relevant past, the individual has acted in such a way as to show: I. that he would be unable, without care, supervision, and the continued assistance of others not otherwise available, to exercise self-control, judgment, and discretion in the conduct of his daily responsibilities and social relations, or to satisfy his need for nourishment, personal or medical care, shelter, or self-protection and safety; and II. that there is a reasonable probability of his suffering serious physical debilitation within the near future unless adequate treatment is given pursuant to this Chapter…" (N.C. Gen. Stat., § 122C-3(11)(a).

The latest development in commitment law is the use of "serious deterioration" as a freestanding commitment criterion, or as a condition of grave disability (as in the Alaska and North Carolina statutes presented above). First recognized by the American Psychiatric Association in its 1982 Model Civil Commitment Law, serious deterioration found early statutory expression in some states' outpatient commitment laws—language permitting outpatient commitment if an individual were not currently dangerous (and, thus, not subject to inpatient commitment) but experiencing serious mental or physical deterioration such that, without treatment, the individual predictably would become dangerous. Now, some states permit *inpatient* commitment on grounds of deterioration. For example, in Oregon, a person may be committed who is dangerous (paragraph A of the statute), who is gravely disabled (paragraph B), or "who, unless treated, will continue, to a reasonable medical probability, to physically or mentally deteriorate so that the person will become a person described under subparagraph (A) or (B) of this paragraph or both" [i.e., dangerous and/or gravely disabled] (OR. Rev. Stat., § 426.005(1)(f)).

In Wisconsin, a person may be committed upon a showing of "substantial probability, as demonstrated by both the individual's treatment history and his or her recent acts or omissions, that the individual needs care or treatment to prevent further disability or deterioration and a substantial probability that he or she will, if left untreated, lack services necessary for his or her health or safety and suffer severe mental, emotional or physical harm that will result in the loss of the individual's ability to function independently in the community or the loss of cognitive or volitional control over his or her thoughts or actions" (Wis. Stat. Ann., § 51.20(1)(a)).

As is evident in the statutes profiled above, serious deterioration, where it appears, always is coupled with the risk that a person, without treatment, will become dangerous in some sense. To the extent that dangerousness remains an essential criterion for commitment (as many read the U.S. Supreme Court's opinion in *O'Conner v Donaldson*), the question arises, may the risk that a person will become dangerous if not treated qualify as current dangerousness for commitment purposes? Dangerousness may be defined as some level of risk that a person, at some point in the future, will act in a way that causes a harm of some sort, to a sufficient degree that a particular intervention (here, commitment) is justified. Dangerousness does not require prediction that an individual will act in a way that results in harm, only that there is some risk he or she will. The degree of risk that is necessary is not settled, nor, in most states, is the immediacy of the risk or even the type of harm the individual is at risk for. There are no bright lines delineating dangerousness. Certainly an argument can be made that a person who is experiencing a deterioration in his or her functioning due to a mental illness, making it likely that, without treatment, the person's risk of harm will become significant, is dangerous. The legislature in Arkansas would seem to agree. Among the conditions in that state that qualify as a "clear and present danger" to self, for purposes of commitment, is the following: "(i) The person's understanding of the need for treatment is impaired to the point that he or she is unlikely to

participate in treatment voluntarily; (ii) The person needs mental health treatment on a continuing basis to prevent a relapse or harmful deterioration of his or her condition; and (iii) The person's noncompliance with treatment has been a factor in the individual's placement in a psychiatric hospital, prison, or jail at least two times within the last forty-eight months or has been a factor in the individual's committing one or more acts, attempts, or threats of serious violent behavior within the last forty-eight months" (Ark. Code Ann., § 20-47-207(c)(2)(D)).

The same thinking may apply to grave disability. Even in states whose statutes separate out dangerousness to self and grave disability, the conditions that constitute grave disability might be seen as showing dangerousness. The question ultimately is one for the commitment decision-maker: does the risk the person presents, whatever it may be, justify the intervention.

A final commitment criterion found in some states' laws is incompetency. When laws for the commitment of persons with mental illnesses first appeared, need for treatment in a psychiatric hospital was presumed to include incompetency. By the late 1960's, however, a new emphasis on respect for patient autonomy in medical decision-making, generally, called into question whether acutely ill psychiatric patients necessarily were incapable of providing adequate consent. In a context where respecting patient rights increasingly came to mean documenting one's reliable consent to or refusal of recommended treatment, the adjudication of mental incompetence—with assignment of a guardian or conservator as a substitute decision-maker—became the high standard for overriding a patient's treatment refusal. A few states went further and required incompetency as a perquisite for commitment. In these states, no person who was capable of making an informed choice about treatment could be committed. Incompetency still survives as a commitment criterion in a few states. In Alabama, a person may not be committed unless he or she is "unable to make a rational and informed decision as to whether or not treatment for mental illness would be desirable" (Ala. Code, § 22-52-10.4(a)(4)). In New York, "'in need of involuntary care and treatment' [one of the requirements for inpatient commitment] means that a person has a mental illness for which care and treatment as a patient in a hospital is essential to such person's welfare and whose judgment is so impaired that he is unable to understand the need for such care and treatment" (N.Y. Mental Hygiene Law, § 9.01).

Impaired understanding of one's need for treatment (although not necessarily full incompetency) is required in Arkansas, as a condition of commitment on grounds of serious deterioration (discussed above). The law is similar in Idaho, where impaired understanding is termed "lack of insight." In Idaho, a person may be committed on grounds of grave disability if he or she is either "(a) in danger of serious physical harm due to an inability to provide for his basic personal needs… or (b) lacking insight into his need for treatment and is unable or unwilling to comply with treatment and…there is a substantial risk he will continue to physically, emotionally or mentally deteriorate to the point that the person will, in the reasonably near future, be in danger of serious physical harm due to the person's inability to provide for any of his own basic needs…" (Idaho Code, § 66-317(13)).

Review: Component Parts of an Inpatient Commitment Standard

Inpatient commitment law today consists of several component parts:

- Mental illness—required in every state; generally defined in terms suggesting serious mental illness (e.g., substantial disorder of thought or mood that grossly impairs judgment, behavior, or ability to negotiate demands of life), usually excluding substance use disorders, intellectual disabilities, and dementia;

- Dangerousness to self or others—appearing in the law in nearly every state, although no longer as an exclusive criterion in most; defined in various ways, as discussed above;
- Grave disability—part of the law in most states; generally defined as inability to provide for basic personal needs, as discussed above;
- Need for treatment—required in nearly every state, either as an explicit criterion or as part of the definition of mental illness, and certainly contemplated in every state by commitment's essential purpose, which is treatment; no longer an exclusive criterion for commitment in any state, except where defined to encompass risk of harm or some other commitment criterion;
- Deterioration—beginning to appear as a distinct criterion in some states' laws, or as part of the definition of grave disability, as discussed above; never an exclusive criterion; and
- Incompetence—part of the law in a few states; never an exclusive criterion.

In addition to these criteria, most states require that commitment comport with the principle of the least restrictive means, providing either (i) that a person may not be committed if his or her needs can be met in a less restrictive setting, or (ii) that a person whose needs can be met in a less restrictive setting may be committed to services in that setting but may not be committed as an inpatient. The latter view contemplates outpatient commitment, discussed below.

Procedural Considerations and an Opportunity for Diversion

At least since the reforms of the 1970's, every state's inpatient commitment law has provided procedural protections for persons facing commitment. Proceedings typically may be initiated by a family member, a mental health provider, a law enforcement officer, or a court official. In 38 states, any adult may petition (or apply) for commitment. In some states, before an individual may be taken into custody, a court or other judicial official (e.g., magistrate) must approve the commitment petition, upon a finding of probable cause to believe the individual meets criteria. In other states, a law enforcement officer, serving as petitioner, or an officer who has received a petition from certain other authorities, may take the individual into custody directly, without further authorization, and deliver him or her to a facility for evaluation. In some states, the individual must be taken first to an emergency facility, where the individual may be medically "certified" for admission and then transported to a treatment facility for stabilization and additional evaluation pending further proceedings.

A hearing to adjudicate the individual's committability typically must be held within some number of hours or days after commencement of custody. Not every state requires a hearing, however. In New York, hearings are held only upon request. Individuals who are medically certified for admission may be held for up to 60 days without any court order, although they are assigned legal counsel and may request a hearing at any time. Retention beyond 60 days must be authorized by a court, but no hearing need be held unless requested (NY Mental Hygiene Law, §9.33).

Individuals facing commitment have the right to notice of hearings; the right to the assistance of counsel; the right to appear, to testify, and to present witnesses and other evidence contesting commitment; and the right to confront witnesses appearing "against" them (i.e., in support of commitment). A judge or other judicial or quasi-judicial official presides and, in most cases, hears the evidence and decides committability. In some states, individuals may request a jury. In every state, in accord with the U.S. Supreme Court's decision in *Addington v Texas*, the

individual may be committed only if found to meet commitment criteria by, at a minimum, clear and convincing evidence.

The period of time in which a candidate for commitment may be held in custody for evaluation, before further review, ranges from 23 hours (in North Dakota) to 10 days (in New Hampshire and Rhode Island) and 60 days in New York. The most common period of pre-review hold is 72 hours (in at least 17 states). In three states (Kansas, Nebraska, and West Virginia), no time period is specified (Hedman, et al, 2016). During this time, the individual may be offered treatment and, typically, the opportunity to accept a voluntary admission (if appropriate) or other, community-based services. If it appears that the individual does not require commitment, he or she may be released, ideally with an "aftercare" plan for services in the community. Mental health systems may wish to prioritize these individuals for services, if only to avoid the more costly alternative of commitment.

It is not known how many people placed in a facility for pre-commitment evaluation are diverted to services voluntarily (or otherwise released), obviating the need for commitment. But anecdotal reports suggest the numbers may be significant. Indeed, these "emergency holds" may represent an important gateway to services for many consumers.

Outpatient Commitment

By the latter decades of the twentieth century, deinstitutionalization had swept tens of thousands of long-term psychiatric patients out of state mental hospitals and into community settings. Mental health policymakers and stakeholders of the day were optimistic about a new generation of more effective medications and therapies, and animated by a belief in the salubrious, normalizing quality of community participation and support; long-term institutionalization had been part of what kept people from recovering, they thought. But the medicines alone were never quite as effective as promised—at least not for everyone—and the comprehensive community-based care system that was envisioned to meet the complex needs of persons with severe, disabling disorders such as schizophrenia never fully materialized.

Facing formidable barriers to accessing community care, and some being unable or unwilling to adhere voluntarily to treatment that was available, a substantial number of adults with serious mental illnesses fell into a cycle of clinical deterioration,[12] marked by rounds of exigent short-term psychiatric admission and, often, further desistance and alienation from services upon discharge. A common clinical pattern involves an individual receiving treatment, doing well for a period of weeks or months, and then dropping out of treatment. Some become involved with the criminal justice system, often as a result of low-level offending related indirectly to untreated psychiatric symptoms.[13]

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[12] The cycle of deterioration was frequently made worse by co-occurring substance abuse, which can exacerbate psychiatric symptoms while inhibiting the person's ability or willingness to adhere to prescribed psychotropic medications, and also exposing them to unhealthy (even criminogenic) social networks and environments (Volavka and Swanson, 2010).

[13] Research on people with mental illnesses who become involved with the criminal justice system has shown that only a small proportion of these individuals were arrested either for violent offenses or for behaviors directly attributable to their mental illness symptoms. A large study of arrests involving people with serious mental illnesses in Connecticut's public behavioral health system found that only 10% of these arrests were for violent offenses, while nearly half were for miscellaneous minor offenses such as trespassing or breach of the peace (Swanson et al., 2013). Another study of jail inmates with serious mental illnesses found that about 9 out of 10 were in jail for the same reasons as others facing minor charges—reasons associated with homelessness, joblessness, poorly structured

Thus, a number of factors combined to create circumstances in which many state and county-based mental health systems found themselves ill-equipped to provide appropriate community-based services to persons with the most serious mental illnesses. In tandem with changes in the locus as well as the organization and financing of mental health care, and in response to increasing concerns regarding the plight of so-called "revolving door" patients, court-mandated community treatment laws and programs emerged beginning in the 1980s (Miller, 1988). These included, notably, North Carolina's pioneering "preventive outpatient commitment" law (King, 1994) and, later, New York's "Assisted Outpatient Treatment" (AOT) program, also known as "Kendra's Law"[14] (Swartz et al., 2009; 2010).

From a legal perspective, outpatient commitment represented an extension of states' civil commitment authority into the community. Conceptually, a community treatment order "committed the patient" to a treatment plan,[15] but perhaps more importantly it "committed the mental health authority" to serving the high-need patient as a priority, creating an extra layer of system accountability. As a practical matter, outpatient commitment laws have sometimes been used to leverage or prioritize outreach and intensive community-based services to individuals who are difficult to engage in treatment, just as inpatient commitment laws have been used to prioritize access to beds for acutely ill psychiatric patients.

What services do people receive on AOT, and is this targeted allocation of scarce public mental health resources fair to people who do not qualify for court-ordered treatment? The types of services often included in AOT treatment plans include Assertive Community Treatment (ACT), intensive case management, supported housing, prescribed medication and frequent individual therapy visits. Some advocates argue that giving outpatient-committed individuals priority access to these services is unfair, insofar as it displaces others in need who could benefit from the same array of services—and would voluntarily receive them—but do not qualify for outpatient commitment. While this is a reasonable concern, research on New York's AOT program found

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leisure time, and substance abuse. However, all of these conditions disproportionately affect people with serious mental illnesses; thus, symptoms may be said to contribute indirectly to criminal offending in this group (Skeem et al., 2011; Peterson et al., 2010).

[14] Some critics of outpatient commitment regard the term, "Assisted Outpatient Treatment," as a euphemism designed to soften or distract from the involuntary nature of a mandatory treatment regime (Roskes, 2013).

[15] Persons subject to outpatient commitment are mandated by a judge to follow a treatment plan, which typically includes visits to a mental health provider and taking prescribed medication; but it should be noted that legal sanctions for non-adherence are weak. In other legal contexts, failure to comply with a court order can result in a criminal contempt citation. In contrast, and by design, there is no "criminalizing" consequence of not following through with a civil court order for outpatient mental health treatment. Under most outpatient commitment statutes, the non-adherent individual may only be picked up by the police and transported to a health care facility for evaluation. At that point, if the person continues to refuse or resist treatment and does not meet criteria for involuntary hospitalization, he or she must be released. Note in particular that, with only rare exceptions, no legal mechanisms exist for forced medication in an outpatient setting. The effect of these weak sanctions, however, is somewhat ambiguous. Whereas some clinicians suggest that outpatient commitment is "toothless," evidence shows that the majority of persons under outpatient commitment believe that they are legally obligated to comply, given the court order, and that they act accordingly (Borum, et al., 1999). Some observers have termed this the "black robe effect." Whether the ends here justify the means, however, is controversial. Hoge and Grottole argue that "a strategy that relies on patient misinformation to foster its success devalues the individuals being served, and undermines the physician-patient relationship.... The profession has an obligation to educate patients subject to mandated outpatient treatment about the scope and limits of the mandate. To do otherwise is to employ deception of individuals under the guise of attempting to promote their health and welfare" (Hoge & Grottole, 2000).

that any adverse "crowd-out" effect of AOT was short-lived, confined to the first two to three years following enactment of the law. Over time, the appropriation of new funding for services that accompanied the enactment of AOT potentially benefitted anyone who needed intensive mental health services; enhanced service capacity meant that many more people were assigned to ACT teams or intensive case managers, whether or not they legally qualified for AOT (Swanson et al., 2010).

When outpatient commitment laws first appeared, they were used most often as a step down for inpatients upon their discharge, or for individuals with extensive histories of admission and release, to bring an end to what was perceived as a "revolving door" cycle of hospitalization. In more recent decades, as the locus of care has shifted more and more into community care settings, and fewer patients are hospitalized in the first instance, outpatient commitment may be initiated in the community for persons without a history of multiple hospitalizations.

A body of empirical research has shown that these laws, as implemented in some jurisdictions, can make a difference—that outpatient commitment orders, if kept in place for at least 6 months and paired with intensive services,[16] are associated with reduced incidence of hospitalization and improved quality of life for many persons with a serious mental illness. Still, this interpretation of the extant studies of effectiveness remains contested in some quarters, and the policy remains controversial (Swanson, Swartz & Moseley, 2017a; 2017b). And, importantly, there remains considerable variability in outpatient commitment laws and policies, implementation models, and practices. Some may not work as effectively as others. If badly designed, poorly implemented, or under-resourced, they pose the risk of subjecting individuals they commit to services that are non-existent or of poor quality, further alienating these individuals from the services system.

Is there an ideal or best outpatient commitment or "AOT" law? There probably is no single "ideal" AOT law, but research evidence and clinical experience support certain features of AOT statutes and programs as important ingredients for success. Key aspects include the "what, who, and how" of AOT: what AOT consists of (the services and treatment plan that it offers and, importantly, the resources available for implementing it); who qualifies for AOT (its eligibility requirements); and how AOT is implemented and enforced (its administrative infrastructure, due process protections, sanctions for noncompliance, limitations and duration.)

It is clear that an AOT order can only be as effective as the treatment plan that it authorizes and the capacity of the local mental health care system to provide the services described in the plan. New York's AOT statute is exemplary in its requirement for a written treatment plan that "shall include case management services or assertive community treatment team services to provide care coordination…" and "any other services … to treat the person's mental illness and to assist the person in living and functioning in the community, or to attempt to prevent a relapse or deterioration that may reasonably be predicted to result in suicide or the need for hospitalization." Importantly, the enabling legislation in New York included an allocation of substantial new funding—$32 million for direct support of AOT programs and $125 million yearly for enhanced community services, specifically including increased capacity for Assertive Community Treatment (ACT) and Intensive Case Management (ICM); arguably the success of

[16] The Duke Mental Health Study reported a significant positive effect of extended outpatient commitment in reducing hospitalizations, but the effect was essentially conditioned on receipt of a certain level of intensive services—specifically, at least 3 billed outpatient service events per month (Swartz et al., 1999). Similarly, the evaluation of New York's AOT program found that AOT significantly reduced hospitalization in combination with Assertive Community Treatment (ACT), but provided no evidence of an AOT benefit in the absence of available intensive services. (Swartz et al., 2009; 2010).

the program depended on these resources being made available in tandem with the new law (Swartz et al., 2009).

North Carolina's 1983 law provided flexibility to use outpatient commitment in a way that applied more broadly to people who were not imminently dangerous or mentally incompetent, but whose history of illness clearly showed a pattern of clinical deterioration resulting from treatment non-adherence. It was among the first of the outpatient commitment laws to permit mandatory community-based treatment of individuals who did not meet inpatient commitment standards (King, 1995). Historically, "outpatient commitment" only applied to people who already met criteria for involuntary hospitalization—essentially people with a mental illness who were deemed to be "dangerous to self or others." This high threshold essentially allowed two types of outpatient commitment. First, a person might be committed to services in the community as a less restrictive alternative to hospitalization. Second, a "conditional release" might be granted at the end of an involuntary hospital stay—a release to court-ordered, community-based treatment as a step-down disposition, pending return to the hospital should the patient's condition deteriorate.

These earlier types of outpatient commitment were mostly non-controversial, but, from a clinical standpoint, they were not very practical. In cases where a patient had already been determined to meet a "dangerousness" criterion for involuntary commitment, risk-averse psychiatrists were reluctant to recommend release into the community.[17] And in cases where a patient could be safely discharged, the criteria for commitment seemed not to apply.[18] Without a change in the law, then, outpatient commitment remained a promising idea but was not widely implemented. Against this backdrop, North Carolina enacted a "preventive" form of outpatient commitment that became the prototype for the AOT laws later adopted in other states such as New York and California.

More specifically, under a preventive outpatient commitment law, a person with mental illness who was not currently dangerous, and therefore not legally committable to a hospital, could be ordered to community treatment on the basis of a complex clinical assessment and prediction about the future. The North Carolina statute set forth the following criteria: "a. The respondent is mentally ill; b. The respondent is capable of surviving safely in the community with available supervision from family, friends, or others; c. Based on the respondent's psychiatric history, the respondent is in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness…; and d. The respondent's current mental status or the nature of the respondent's illness limits or negates the respondent's ability to make an informed decision[19] to seek voluntarily or comply with recommended treatment" (N.C. General Statutes, § 122C-261).

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[17] For fear that the harms for which the person was at risk would materialize, despite treatment provided in the community.

[18] Because anyone deemed safe for release could not be seen as "dangerous."

[19] The meaning and practical implication of this criterion regarding impaired decision-making is somewhat ambiguous. It is notable that the criterion seems to require a clinical determination of at least some degree of illness-related diminished capacity to make an "informed decision" (that is, a decision to seek or comply with recommended treatment). At the same time, the criterion clearly does not meet the legal standard for mental incompetence (that is, an inability to understand risks and benefits of treatment, to reason, and communicate a reliable decision about treatment.) This ambiguity serves both the paternalistic and libertarian sides of the outpatient commitment debate, as the criterion can be interpreted in two ways—on the one hand justifying the intervention of

Some states' AOT statutes, exemplified by Kendra's Law in New York, included additional criteria that made it more difficult for an individual to qualify for AOT, but also provided safeguards to prevent its overuse and to protect the civil rights of mental health consumers. Specifically, Kendra's Law requires that a candidate for AOT have been hospitalized at least twice within the prior three years as a result of non-compliance with treatment, or have committed, attempted, or threatened an act of violence or self-harm within the prior two years. The law also requires a determination that the candidate is "likely to benefit" from AOT. Whether these criteria are necessary to prevent the unwarranted application of a mandatory treatment regime, or stand as a needless hindrance to the provision of services, is a matter of some disagreement. Clearly, the interests at stake require a careful balancing.[20]

It should be noted that the ostensible public safety function of AOT—essentially the idea that AOT might prevent random acts of serious violence by persons with untreated mental illness—became an important theme in vigorous efforts to build public support for enacting preventive outpatient commitment laws beginning in late 1990s.[21] To a degree, the strategy was successful; it was not an accident that at least three states' outpatient commitment laws were named for victims of sensational homicides perpetrated by erstwhile psychiatric patients who had stopped taking their prescribed antipsychotic medications. "Kendra's Law" in New York was named in memory of Kendra Webdale, a young woman pushed into the path of an oncoming subway train by Michael Goldstein in 1999[22]; "Laura's Law" in California was named for Laura Wilcox, a college student who was fatally shot inside a public behavioral health clinic in Nevada County by Scott Harlan Thorpe in 2001; and "Kevin's Law" in Michigan was named for Kevin

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outpatient commitment in the best interests of a person whose capacity to make a fully informed decision is diminished, while on the other hand seeming to undermine the state's authority to override a clear treatment refusal by a person who may lack sound judgment but is not mentally incompetent (and whose wishes, thus, should still be honored).

[20] In the *Matter of K.L.*, a 2004 case addressing the constitutionality New York's AOT law, the New York Court of Appeals ruled that Kendra's Law met federal and state constitutional requirements. The Court's decision read, in part: "[T]he assisted outpatient's right to refuse treatment is outweighed by the state's compelling interests in both its police and *parens patriae* powers. Inasmuch as an AOT order requires a specific finding by clear and convincing evidence that the patient is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to self or others, the state's police power justifies the minimal restriction on the right to refuse treatment inherent in an order that the patient comply as directed. Moreover, the state's interest in the exercise of its police power is greater here than in *Rivers*, where the inpatient's confinement in a hospital under close supervision reduced the risk of danger he posed to the community." Notably, the court's conclusion that AOT passed constitutional muster was bolstered by the fact that mandatory treatment under AOT has limited enforceability: "The restriction on a patient's freedom effected by a court order authorizing assisted outpatient treatment is minimal, inasmuch as the coercive force of the order lies solely in the compulsion generally felt by law-abiding citizens to comply with court directives. For although the Legislature has determined that the existence of such an order and its attendant supervision increases the likelihood of voluntary compliance with necessary treatment, a violation of the order, standing alone, ultimately carries no sanction." (Matter of K.L., February 17, 2004, NY Court of Appeals). Had the law authorized involuntary administration of medications, for example, it is not likely the Court would have ruled as it did.

[21] These efforts were spearheaded in particular by the Treatment Advocacy Center and its founder, Dr. E. Fuller Torrey (Torrey, 2008).

[22] Goldstein had attempted, unsuccessfully, to access treatment shortly before he pushed Ms. Webdale off of the subway platform; thus his case may better illustrate the inadequacy of care and outreach in public mental health services than the problem of treatment avoidance (Winerip, 1999)

Heisinger, another student who was beaten to death in the Kalamazoo bus station by Brian Williams in 2000.

All three of the offenders in these cases were well known both to the public mental health systems, where they had been long-term clients, and to the police and criminal justice systems with which they also had been intermittently involved. All had some history of violence and aggression, and, at least in Goldstein's and Thorpe's cases, extreme anger directed against the mental health system for, in their view, failing to adequately serve them. All three were institutionalized following their crimes—Goldstein sentenced to prison upon conviction of 2nd degree murder, Thorpe committed as incompetent to stand trial, and Williams committed after being found not guilty by reason of insanity—and thus were incapacitated from harming others in the future. Whether Kendra, Laura, and Kevin could have been saved by their eponymous outpatient commitment laws is uncertain, but there is little question that the publicity surrounding these cases, and what the advocates for outpatient commitment strategically made of it at the time, played a crucial role in these laws being enacted (Swanson, Swartz & Moseley, 2017a).

Research evidence has shown only a weak link between mental illness and any violent behavior; while an estimated 18.3 percent of Americans suffer from some form of mental illness (Substance Abuse and Mental Health Services Administration, 2016), only about 4 percent of community violence is attributable to psychopathology per se (Swanson, 1994).Thus, there is little convergence between the goal of preventing violence, as a complex and multi-determined public health problem in its own right, and a policy such as AOT, which is designed essentially to provide treatment access to people with mental illness, the overwhelming majority of whom are not violent toward others. The promotion of AOT as a way to prevent violence—especially with regard to rare and extreme acts such as multi-casualty mass public shootings—is largely misplaced, and can have the unintended adverse effect of reinforcing and increasing the social stigma associated with mental illness (McGinty et al., 2018; Swartz et al., 2017).

If outpatient commitment is going to be used, what is its recommended duration? Researchers in North Carolina studied this question in the 1990's, concluding that six months was the evidence-based minimum duration for an involuntary outpatient commitment order that could be expected to significantly reduce hospital admissions or lengths of stay (of course, presuming the availability of effective services).[23] There is no research suggesting an optimal maximum

[23] It should be noted that some scholars have criticized the Duke Mental Health Study's finding as the result of a post hoc analysis, noting that the duration of outpatient commitment was not subject to random assignment in the study's original design. According to this criticism, clinicians might have disproportionately extended the length of outpatient commitment for the most agreeable patients (who would have had the best outcomes anyway), and failed to renew the orders for those who were less agreeable and, thus, less rewarding to serve (and who, therefore, may have been more likely to be re-hospitalized). While acknowledging this limitation in their methodology, the study authors have argued from their data that patients whose outpatient commitment orders were renewed had significantly lower baseline scores on insight into illness and medication adherence prior to their index hospitalization—factors that otherwise correlate positively with readmission. Moreover, the study protocol required that the treatment team conduct an explicit review of the statutory criteria prior to requesting a renewal hearing, and that they request renewal for all patients who continued to meet the criteria for outpatient commitment. Thus, according to this counterargument, if the renewal process was biased, it was most likely to have been in a conservative direction that would have favored not finding an effect for extended outpatient commitment (Swanson & Swartz, 2014). Importantly, the methodological critique of the Duke Mental Health Study's "dose effect" analysis does not concern the study's primary finding of a significant positive main effect for outpatient commitment from the randomized trial analysis. Incorporating observations of hospital admissions for all months of follow-up in a

duration. The question of whether court-ordered treatment should be continued in any given case or be allowed to expire without renewal is typically addressed as an individualized matter, informed by a psychiatrist's or treatment team's recommendation and determined by the court. The clinical recommendation is contingent on a consumer's progress under outpatient commitment. Individuals vary in their responses and reactions to outpatient commitment, as do clinicians in their attribution of particular results to the policy's intended benefits or potential drawbacks. As always, the continuing availability of services is critical.

The Duke Mental Health Study found that persons with serious mental illnesses who received outpatient commitment orders lasting 6 to 12 months had 57 percent fewer readmissions and an average of 20 fewer hospital days during the study year than a control group that received no outpatient commitment. Study participants who received less than 6 months of outpatient commitment had no better outcomes than those who received none (Swartz et al., 1999). The study also showed that participants who had longer periods of court-ordered treatment had a significantly better quality of life at one-year follow-up, by their own report (Swanson et al., 2003). Levels of perceived coercion, however, were somewhat higher in association with longer periods on outpatient commitment, an adverse effect that moderated its positive impact on quality of life. However, for most, the benefits can be said to outweigh the downside of longer doses of outpatient commitment. Research showed that the strength of consumers' preferences for remaining in the community and avoiding hospitalization were substantially greater than the strength of preferences for avoiding court-ordered outpatient treatment.

New York's 1999 outpatient commitment (AOT) statute (Kendra's Law, §9.60 of the Mental Hygiene Law) initially specified 6 months as the maximum duration of a court order. An evaluation of the New York AOT program showed that most participants in the period from 1999-2007 received an initial order of 6-months duration. As a group, they experienced significant improvements in their patterns of services utilization and outcomes: medication adherence and intensive outpatient services participation significantly increased, while inpatient admissions and number of days hospitalized (for those who were) significantly decreased. The New York AOT evaluation also showed that participants who remained under court-ordered treatment for longer periods—7 to 12 months—experienced even better outcomes. Moreover, those who "graduated" from AOT after having spent a longer period in the program were less likely to relapse and be rehospitalized than those who had spent a shorter period on AOT. Based partly on these research findings, New York amended Kendra's Law in 2013 to extend the allowable duration of an initial AOT order from 6 months to 1 year.

Current status of outpatient commitment in law and practice. Although still controversial in many circles, outpatient commitment, if properly designed and implemented, with comprehensive services and supports readily available, is now generally considered to be a valuable tool in mental health services delivery. But there is considerable variation across states in the statutory criteria for eligibility, models of implementation and financing, and in the proportion of the population with serious mental illness that is targeted and affected by outpatient commitment regimes.

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repeated-measures analysis, the investigators found that "[a]ssignment to the outpatient commitment group was associated with significantly lower odds of any readmission (odds ratio=0.64, 95 percent CI=0.46–0.88, $p \leq 0.01$)" (Swartz et al., 1999).

A useful description of what is perhaps the prevailing professional view of outpatient commitment appears in a 2015 position statement and resource document of the American Psychiatric Association (APA, 2015):

> "1. Involuntary outpatient commitment, if systematically implemented and resourced, can be a useful tool to promote recovery through a program of intensive outpatient services designed to improve treatment adherence, reduce relapse and re-hospitalization and decrease the likelihood of dangerous behavior or severe deterioration among a subpopulation of patients with severe mental illness.
>
> 2. The goal of involuntary outpatient commitment is to mobilize appropriate treatment resources, enhance their effectiveness and improve an individual's adherence to the treatment plan. It should not be considered as a primary tool to prevent acts of violence.
>
> 3. Some of the research studies have shown that involuntary outpatient commitment is most effective when it includes a range of medication management and psychosocial services, equivalent in intensity to those provided in Assertive Community Treatment or intensive case management.
>
> 4. States adopting involuntary outpatient commitment statutes should assure that adequate resources are available to provide such intensive treatment to those under commitment."

In 2016, the Policy Surveillance Program (Law Atlas, 2016) conducted a systematic 50-state legal survey of the features of outpatient commitment statutes. The survey identified 47 states with laws that permit some form of outpatient commitment, with 32 states having a "preventive" type of outpatient commitment law, where the eligibility criteria include a determination that outpatient commitment is needed to prevent future dangerousness to self or others, or to prevent clinical deterioration that would predictably lead to future dangerousness. The same year, Meldrum and associates (Meldrum et al., 2016) conducted a national survey of the implementation of outpatient commitment, identifying 20 states with "active" outpatient commitment/AOT programs. A 2005 MacArthur study in 5 states estimated that between 12 and 20 percent of consumers with serious mental illnesses who were being served in the public-sector mental health system had received some form of outpatient commitment in the past (Monahan et al., 2005).

A cross tabulation of classification schemes from these studies reveals a correlation between states having a "preventive" type of outpatient commitment statute and those having "active" AOT programs. As shown in Table 1, the majority of active AOT programs (75 percent) were in states with "preventive" statutes. Only 5 states with more traditional statutes (that is, where inpatient commitment criteria must first be met) had active AOT programs. Of the 32 states with preventive AOT statutes, 20 (63 percent) had active AOT programs; of the 18 states without a preventive statute, 5 (33 percent) had active AOT programs.

The Meldrum study also found that AOT programs varied considerably in (i) their style of implementation, (ii) the agency responsible for administering the program, (iii) whether an approved treatment plan was incorporated into the court order, (iv) the monitoring procedures that were in place, and (v) the numbers of participants involved. There were three distinct (but not mutually exclusive) implementation models found to be in use in different states. The first was a model that views AOT as a "community gateway" into treatment—that is, targeting people with untreated mental illness who are living in the community and are not in touch with the mental health system. The second model was a "hospital transition" model, where AOT is used as a step-down program for people who have been involuntarily hospitalized and are re-entering

the community. The third model was a “surveillance” or “safety net” model to monitor people with serious mental illness who are considered to be at risk of desisting from treatment.

Stakeholders tend to perceive a common set of problems and implementation challenges across all three of these AOT models, including: (i) inadequate resources in many communities, (ii) lack of enforcement power, (iii) inconsistent monitoring of whether the AOT conditions and treatment plan are being adhered to, and (iv) weaknesses in the networks of inter-agency collaboration which may be required for AOT to succeed. As a result, AOT programs continue to be unevenly implemented, if implemented at all, in many states. Stakeholders, including judicial officers, mental health clinicians, and legal professionals, continue to express ambivalence about their roles and about the priority and scope of AOT programs, especially in view of these difficulties of implementation under existing funding constraints.

Table 1. States with preventive AOT statues and Active AOT programs

State	Preventive AOT Statute*	Active AOT Program**	
Arizona	Yes	Yes	
California	Yes	Yes	
Idaho	Yes	Yes	
Illinois	Yes	Yes	
Indiana	Yes	Yes`	
Maine	Yes	Yes	
Montana	Yes	Yes	
Nevada	Yes	Yes	
New York	Yes	Yes	
North Dakota	Yes	Yes	
Oklahoma	Yes	Yes	
Rhode Island	Yes	Yes	
Vermont	Yes	Yes	
Washington	Yes	Yes	
Wisconsin	Yes	Yes	**Total Yes/Yes: N=15**
Alabama	Yes	No	
Arkansas	Yes	No	
Florida	Yes	No	
Georgia	Yes	No	
Hawaii	Yes	No	
Kansas	Yes	No	
Louisiana	Yes	No	
Michigan	Yes	No	
Minnesota	Yes	No	
Mississippi	Yes	No	
New Jersey	Yes	No	
North Carolina	Yes	No	
Ohio	Yes	No	
Tennessee	Yes	No	
Virginia	Yes	No	
West Virginia	Yes	No	
Wyoming	Yes	No	**Total Yes/No: N=17**
Delaware	No	Yes	
Iowa	No	Yes	
Nebraska	No	Yes	
New Hampshire	No	Yes	
South Carolina	No	Yes	**Total No/Yes: N=5**
Alaska	No	No	
Colorado	No	No	
Connecticut	No	No	
Kentucky	No	No	
Maryland	No	No	
Massachusetts	No	No	
Missouri	No	No	
New Mexico	No	No	
Oregon	No	No	
Pennsylvania	No	No	
South Dakota	No	No	
Texas	No	No	
Utah	No	No	**Total No/No: N=13**
Total	**Yes: N=32**	**Yes: N=20**	

* Meldrum et al., (2016); ** Policy Surveillance Program (2016)

Part II. Ethical Principles to Guide Civil Commitment

In the United States, as we have seen, confinement of a person to a mental health facility against the person's will is authorized, typically, under a state law intended to protect the person from harm—to secure for the person the treatment he or she needs to avoid bringing harm to self or others. Outpatient commitment may be authorized as a less-restrictive alternative for individuals who need ongoing treatment and support to prevent relapse or a deterioration of their mental illness symptoms, increasing their risk for harm; such persons must be able to live safely in the community with available supports but be unlikely to adhere voluntarily to prescribed treatment without the legal leverage and additional supervision that a court order provides.

Involuntary commitment, whether associated with hospitalization or a community treatment program, involves a significant limitation of liberty—the kind of limitation that is rare outside of the criminal justice system. For this reason, among others, commitment remains controversial, especially among recovery-oriented mental health stakeholders who place a high value on personal autonomy and self-determination. Ethical critiques of commitment invoke the dubious moral legacy of psychiatric paternalism from a previous century, when long-term institutionalization of persons with mental disabilities was commonplace, and, in some cases, used as a form of social control.

How do commitment laws comport with broad ethical principles that guide contemporary practice in community mental health settings ? Well-intended clinicians and other parties aim to deliver services that are beneficial, not harmful, person-centered, and fair. Consideration of civil commitment, to inpatient or outpatient settings, necessarily introduces an element of adversity and poses challenges to these ethical principles of services delivery. The bioethicists Thomas Beauchamp and James Childress developed a framework adaptable to this analysis, using four principles to highlight potential ethical concerns in a health-related policy, practice, or decision (Beauchamp and Childress 2012; Beauchamp 2009). Applying these principles to involuntary commitment provides a useful way to evaluate the ethical issues at stake, and to articulate normative injunctions and general rules for using commitment in beneficial and just ways, and for avoiding its use in ways that may be harmful or unfair.

Beauchamp and Childress' four main ethical principles are: (1) respect for autonomy (respecting the decision-making capacities of autonomous persons); (2) non-maleficence (avoiding the causation of harm); (3) beneficence (providing benefits and balancing benefits against risks); and (4) justice (fairness in the distribution of benefits, burdens and risks).[24] In the discussion that follows, we briefly examine each principle as it may apply to inpatient and outpatient commitment.

Respect for autonomy

Do civil commitment regimes protect personal autonomy, or do they mainly undermine the right of autonomous persons to make their own decisions about health care, including the right to refuse psychiatric treatment? The concern, of course, is that mandating treatment is inherently coercive, and that coercion on its face is antithetical to self-determination. Thus, court-ordered treatment requires a strong justification, such as helping persons whose mental illness symptoms (and consequential poor judgment) might otherwise lead them to behave in ways injurious to their health or safety, or that of others. For many persons facing inpatient commitment, that is the

[24] Other widely recognized ethical principles, such as truthfulness, are implied or assumed by one or more of the four principles discussed by Beauchamp and Childress.

justification. Most people who face outpatient commitment, however, do not pose a danger to themselves or others—at least not an imminent danger. Could it reasonably be argued that there are insufficient grounds to violate these individuals' autonomy by insisting they undergo unwanted mental health treatment?

One counterargument to the autonomy-based critique of outpatient commitment is that the affective, cognitive, and behavioral symptoms of serious mental illness already have limited the autonomy of people who would be eligible for outpatient commitment—that their ability to make reliable decisions in their own best interests already is impaired, preventing them from pursuing important life goals. This counterargument suggests that outpatient commitment, rather than undermining autonomy, may actually restore and promote autonomy in the long run—that is, if commitment results in access to treatment that effectively addresses the symptoms that impair reliable decision making. Court-ordered treatment can be the means to an end where the committed individual "gets help," experiences symptom relief, and thereby eventually regains a measure of autonomy that was otherwise limited by untreated mental illness. This idea is consistent with the ideals of "therapeutic jurisprudence" (Winick, 2003).

Whether an individual's impairment in decision-making ability must rise to the level of current legal incompetence (inability to weigh the risks and benefits of treatment and express a voluntary, informed choice) is an interesting question. Some states require incompetence for inpatient commitment; but inpatient commitment entails greater liberty restriction than outpatient commitment. A finding of incompetence generally is required for medication over objection—even for individuals who have been committed. But medications entail risks not associated with most other outpatient services. Certainly an argument can be made that incompetency is not necessary for outpatient commitment, generally, particularly given its relative unenforceability.

A second counterargument to the objection that outpatient commitment limits autonomy is that, so often, the only alternative to outpatient commitment is involuntary hospitalization—if not immediately, predictably in the near future. Insofar as receiving treatment in the community is less restrictive than being confined to a hospital, and may enable the individual to avoid the traumatic experience of repeated involuntary hospitalizations, outpatient commitment is arguably the "less coercive" alternative over time.

Both of these counterarguments assume that the individual who is a candidate for outpatient commitment has acute symptoms of mental illness at a point in time—symptoms that impair functioning and decision-making capacity, though the person is not necessarily "imminently dangerous" or legally incompetent. Yet psychiatrists understand that the symptoms of mental illness tend to wax and wane over periods of months, and that many patients respond to treatment (such as medication and psychosocial recovery support services) in a way that restores their "baseline" judgment and functioning. This means that a patient may become able to participate in rational decision making in the short term—for example, following a hospital stay or crisis intervention—and then, within a period of weeks or months, fall out of treatment and experience a return of symptoms that compromise his or her decision-making ability. Thus, the goal of mandated outpatient treatment might be seen as use of a time-limited override of an

individual's inauthentic treatment refusal in order to provide those services, of sufficient duration to restore the individual's ability to govern his or her own life with purpose and authority.[25]

Both sides in this debate rely on competing empirical claims about the effectiveness (or non-effectiveness) of outpatient commitment. The assertion that outpatient commitment promotes long-term autonomy is undermined if the mandated treatment is experienced as so coercive that it alienates the patient or prevents the formation of trust within the provider-patient relationship that is considered essential for recovery.

Under some states' statutory criteria, individuals with mental illnesses who do not have impaired decision-making capacity may still qualify for outpatient commitment because they are deemed to pose a safety threat to themselves—for example, if they have a history of dangerous behavior associated with treatment noncompliance. In such cases, outpatient commitment might be justified on the basis that the treatment it brings prevents harm (as in the example of inpatient commitment). Autonomous persons may decide to harm themselves or others, but, for people with active symptoms of a serious mental illness, the argument is that such decisions very often are the product of their symptoms; in many cases, the harms experienced are entirely unintentional, a result not of acts but of omissions. Interventions that restrict the liberty of people with mental illnesses in order to prevent harm must carefully balance risks and rights.[26]

Non-maleficence Could involuntary commitment cause harm? Most inpatient psychiatric settings today are clean, safe, and therapeutic, a far cry from the kinds of institutions that existed in many states in the 1960's and early 1970's, when the first restrictive commitment laws were enacted. That said, seclusion and restraint continue to be used in inpatient commitment settings, and the experience can be highly traumatic for some patients, especially those who have been victims of sexual assault or other violence in the past (Zervakis et al., 2007). And, of course, persons committed to inpatient facilities today experience the same "massive curtailment of liberty" that the courts decried in the 1970's, different from and far greater than the liberty restrictions occasioned by mandated treatment in the community. Thus, the more restrictive standards for inpatient commitment. So, the question becomes: whether the harms inevitably suffered by the committed inpatient are outweighed by the harms staved off. Predictable risks to the safety or well-being of the individual or others must be at stake, lest the harms facing the individual render commitment unjustifiable. Once commitment is ordered, moreover, every effort must be taken to minimize harm to the patient, including not only providing safe and effective care but promoting the patient's autonomy to the greatest extent possible and assuring services in the least restrictive setting, with an eye toward release at the earliest opportunity.

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[25] In other words, outpatient commitment may facilitate access to and engagement in treatment and recovery support services, enabling the individual to attain stability and more fully lead a self-directed life in the community, unimpeded by the interruptions of the most serious mental illness symptoms.

[26] A psychiatric advance directive (PAD) can help to preserve patient autonomy and promote self-determination through periods of impaired decisional capacity. A thorough discussion of PADs is well beyond the scope of this report. However, it is important to note briefly that the PAD is designed as a patient-centered legal instrument to reduce the need for civil commitment—ideally, to prevent involuntary mental health interventions altogether—by enabling people with serious mental illnesses to plan ahead for their own treatment during a future incapacitating crisis: to record their preferences in a legal document while they are competent, and to authorize a trusted family member or friend to make decisions on their behalf should they lose capacity to make or communicate their own treatment choices. Some research has shown that psychiatric patients with fluctuating decisional capacity, who are at risk of coercive crisis intervention, can benefit from PADs. Completing these documents can promote personal empowerment in the course of recovery and foster a better working alliance with providers. Unfortunately, however, PADs have not been widely implemented (Swanson et al., 2007).

Anything less, again, raises question about the proper balance of harms and the propriety of commitment.

Ethical critiques of outpatient commitment based on non-maleficence—also applicable to inpatient commitment—focus on the inherent coerciveness of "forced treatment" and the theoretical notion that removing choice makes recovery difficult or impossible. An early example of this argument is seen in a statement from the Coalition to Stop Outpatient Commitment in New York: "People recover when they have a choice among alternative treatments and services, when they are empowered to make their own decisions and take responsibility for their lives, and when they are offered hope. These conditions are impossible under outpatient commitment" (Kramer 1999). Along the same lines, and more recently, a 2015 position statement of Mental Health America expressed concern that "outpatient commitment risks transforming the mental health system into a vehicle of social control over many people living in the community." (MHA 2015)

To the contrary, proponents of outpatient civil commitment have argued that the intervention is not about social control but, rather, is about the alleviation of suffering by people who, as a result of their illness, are unwilling or unable to accept treatment on their own. A strict "rights" argument against involuntary treatment in such cases may fall short, they contend, insofar as the assumption of "voluntariness" is undermined by the fact that no rational person would choose the suffering and risks that untreated mental illness entails. Allowing people to "rot with their rights on," as Paul Appelbaum and Thomas Gutheil once put it (echoing Darryl Treffert, in his 1973 letter), is inhumane—assuming, of course, that the treatments occasioned by commitment, even if provided over objection, are effective and can prevent or mitigate such suffering (Appelbaum and Gutheil 1979). E. Fuller Torrey makes the case in terms that are even more dire: "What kind of civilization allows seriously mentally ill persons to be victimized—to live on the streets and beneath bridges...? A civilization that allows such things cannot claim to be humane" (Torrey 2008).

Still, whether outpatient commitment is, in fact, "non-maleficent" is essentially an empirical question, the answer to which requires an evaluation of the exercise in terms that are meaningful to the people who are subjected to it. Several studies have examined the comparative preferences of individuals enrolled in outpatient commitment programs. These have included a study of the relative importance assigned to avoiding involuntary hospitalization versus avoiding outpatient commitment, assuming these to be trade-offs (Swartz et al., 2003a); individuals' perceptions of the coerciveness and benefit of outpatient commitment, after having experienced it (Swartz et al., 2003b); perceptions of the fairness and effectiveness of outpatient commitment (Swartz et al., 2004); and measured improvements in subjective quality-of-life following outpatient commitment (Swanson et al., 2003).

The overall result of these person-centered studies is that most individuals who were subjected to outpatient commitment for at least six months reported that avoiding inpatient commitment was more important than being free from the (comparatively mild) strictures of mandated community treatment (Swartz et al., 2003a). The perception that outpatient commitment is "fair" (or not) was significantly dependent on whether individuals believed that the programs they participated in were generally effective—that is, that the services they received helped them get better and stay better (Swartz et al., 2004). Only about 1 in 4 people who experienced outpatient commitment retrospectively endorsed their program as being personally beneficial; but the rate of endorsement rose to approximately 50 percent in the subgroup who had good outcomes on outpatient commitment—those who remained out of the hospital, were not arrested, and had a

relatively high final score at 12-months follow-up on the Global Assessment of Functioning scale (Swartz et al., 2003b). Still, a significant percentage (indeed, the majority) regarded the experience as unhelpful. Given that the services were unwanted, one might conclude that, from the perspective of the individuals under commitment, the harms they suffered (having to engage in unwanted services) outweighed the benefits they enjoyed.

The third study mentioned above (Swanson et al., 2003) showed that duration of outpatient commitment (number of days under court-ordered treatment) was significantly correlated with higher subjective qualify of life, when measured at 12-months follow-up. At the same time, however, such duration was significantly associated with higher perceived coercion, which (paradoxically) had a negative impact on quality of life. Importantly, though, in this study the positive effect of outpatient commitment on increased quality of life was larger overall—of greater statistical significance—than the downside of its attendant coerciveness. This double effect is analogous to a prescribed drug that produces some benefits through symptom relief, but also has some predictable adverse side effects; the former must outweigh the latter in order for the treatment to be considered worthwhile. This also illustrates how non-maleficence and beneficence may be two sides of the same coin, and thus must be considered together.

Beneficence

Does civil commitment help people with disabling mental health disorders? Does commitment promote what is "good" for others, and prevent harm? Determining the answers involves an evaluation of whether commitment adequately advances the long term best interests of persons with mental illness—improving their clinical condition and overall well-being and protecting their safety (and the safety of others)—while also respecting their rights. Related to the principle of respect for and right to autonomy, beneficence in civil commitment means balancing the value of self-determination and choice with the social responsibility to care for persons who, at times, have a diminished capacity to act in their own best interest.

So-called "benign medical paternalism" implicitly privileges beneficence over respect for autonomy when these principles appear to conflict, based on the assumption that an expert clinician "knows best" in decisions about mental health treatment. This view provides some ethical justification for the use of legal leverage to effectuate the clinician's recommendation for treatment—to override a patient's refusal of, or non-adherence with treatment—when the patient's conflicting judgment is considered to be clouded or compromised by symptoms of an illness.

Still, difficult tradeoffs present themselves in this arena. Overriding a person's right to refuse treatment and to be left alone—invading their privacy with a mandated treatment order—should never be taken lightly, even (and perhaps especially) when the person in question is vulnerable to the loss of autonomy in the ways that a serious mental illness such as schizophrenia often entails. At the same time, it is important to bear in mind that commitment, whether inpatient or outpatient, can produce substantial benefits. As already mentioned, given the realities of fiscally constrained public mental health systems in an era of managed care and a shrinking safety net, commitment is being used to leverage scarce resources for treatment and other services, including not only inpatient care but comprehensive outpatient care as well.

Appropriating civil commitment as a tool to leverage intensive services could be seen as a misuse of the law, in a way that curtails a person's liberty. This may not be the fairest way to distribute limited resources, or to the impose the burdens of a legal mandate (from either the patients' or the provider's point of view). However, the fact that commitment *is* being used as

leverage in this way—that such leverage is, in fact, being applied both to individuals under a commitment order and to the providers of the services that are mandated—is a reality spawned by an imperfect system of care. Unfortunate as it may be, it is a compromise that is acceptable to many well-meaning actors—for now, while they aspire to a more ideal care system in which the need for coercion might "wither away."

Individuals under outpatient commitment frequently are assigned to intensive case management or assertive community treatment (an ACT team), and many receive priority for subsidized housing—all services in short supply in most communities. If these services, in turn, lead to improved recovery outcomes for consumers, as they have been shown to—reducing their involvement in the criminal justice system, limiting their need for repeated and traumatic involuntary hospitalizations, improving their ability to live productively in the community, and ultimately promoting their exercise of autonomous decision-making in their own best interests—the values of beneficence would be well served, lending support to the case for commitment. Still, if the problem is merely one of addressing removable barriers to treatment—that is, providing access to services that the person would be willing and able to accept voluntarily, if available—there may be no ethical case for using an involuntary commitment order simply to accomplish that goal.

Justice

Are inpatient and outpatient commitment programs just? Do they fairly distribute benefits, burdens, and risks—to the individuals who need treatment (but may lose their autonomy), to the stretched-thin providers who are accountable for the treatment they deliver (and the treatment they withhold), and to the society that pays for these services in public systems of care (and that bears the economic, social, and moral costs of untreated mental illness)?

As discussed above, most states' inpatient commitment laws were written at a time when commitment entailed lengthy stays in substandard facilities, with little meaningful care. Balancing the risks and other burdens patients faced in those days, the laws established strict standards and procedures for commitment. Today, in virtually every state, lengths of stay for committed patients are (usually) brief, typically a week to 10 days, and the facilities that are used are, by and large, clean, safe, and therapeutic. Inpatient commitment standards have softened in recent years, but all still require a showing of substantial disability—serious mental illness resulting in a significant risk of harm (whether or not couched in terms of "imminent dangerousness"). And the procedures in place, guaranteeing representation by counsel and requiring the state to prove committability by clear and convincing evidence, are designed to assure justice for participants. Given the improved quality of care today, the legal safeguards in place in most states, and the very low risk of lengthy confinement, one would be hard pressed to argue that the balance struck by these laws is unfair to consumers.

With respect to outpatient commitment and the question of justice, from a societal perspective, when a small group of individuals who would refuse treatment are placed in commitment and thus given priority for services—using scarce public resources, arguably to the detriment of other people who actually want treatment and cannot get it—fairness and equity in the distribution of these resources may be questioned (Swanson et al., 2010). On the other hand, it may not be considered fair (or even humane) to allow a small group of very ill people to choose to forego treatment, assuming their choice reflects a compromised understanding of risks and benefits and could result not only in their own continued suffering but, potentially, in the suffering of others as well. Moreover, underserved consumers in the community may present higher financial costs

for communities, insofar as these individuals tend to use more expensive publicly funded services, cycling between homelessness, hospitalization, and, too often, the criminal justice system.

Another factor that may raise fairness concerns is the large disparity between jurisdictions in the likelihood that any given person with a serious mental illness will be committed. In Florida, for example, public behavioral health clients with serious mental illnesses are about three times more likely to have a lifetime record of (inpatient) commitment than their counterparts in Connecticut (Swanson et al., 2013; 2016). Given that involuntary commitment involves an unwanted deprivation of liberty—and that research shows patients can be traumatized by forced treatment, in a way that negatively impacts their future experience even with voluntary mental health care (Zervakis et al., 2007)—it appears to be clearly unjust that one's chances of experiencing or avoiding commitment could depend largely on what state one happens to live in.

There are also difficult questions about the equity of treatment in cases of apparent racial disparity, such as the overrepresentation of African Americans among persons under outpatient commitment in New York (Swanson et al 2009). For those who see involuntary treatment as an unjustifiable form of coercion, reducing and minimizing involuntary treatment in a minority population will be seen as an equitable improvement. For those who see involuntary treatment as beneficial to its recipients—an avenue to accessing scarce resources—more involuntary treatment provided to members of a historically deprived minority population might be considered a proportional remedy, and thus equitable. Preferred alternative value frameworks, such as liberalism and libertarianism versus egalitarianism or communitarianism, may guide policymakers toward different conclusions, necessitating checks and balances in these laws and policies and cultural sensitivity in their implementation.

This part of the report concludes with a set of specific goals for involuntary civil commitment policy and practice. Table 2 lists these goals as they are aligned with, and could be derived from, the ethical principles that we have discussed.

Table 2. Goals for commitment practice derived from general ethical principles

	Respect for autonomy	Non-maleficence	Beneficence	Justice
Personal autonomy and self-agency are respected by listening carefully to individuals who are subjected to commitment, and honoring their treatment preferences to the extent possible, especially when their wishes are documented in competently prepared legal advance directives.	x		x	x
Involuntary commitment is never used solely to leverage access or transport to treatment when a patient is otherwise able and willing to participate voluntarily in services, and other means to overcome barriers to care are available.	x	x		x
Dignity of the person is respected and protected in every step of the process.	x			
The individual in crisis is assisted to be in the least restrictive setting to resolve the crisis, whether or not they are committed.	x			x
Person-centered approaches are individualized to a meet a person's needs and include shared decision-making that honors hope, trustworthiness, engagement, and collaborative treatment.	x		x	
Relevant information is clearly communicated to the patient about commitment status, purpose, process, reevaluation, criteria for ending commitment, risks and benefits of treatment, and legal issues, including right to appeal or refuse treatment; information about commitment is shared with supportive family members and significant others, consistent with the patient's rights and wishes.	x		x	
Clinicians recognize and seek to carefully balance potential conflict between beneficence and personal autonomy.	x		x	

Table 2. (continued)

	Respect for autonomy	Non-maleficence	Beneficence	Justice
Duration of commitment is as short as reasonably possible to restore the individual to the capacity to participate meaningfully in beneficial treatment.	x	x	x	
Due process protections are understood and employed at every level for the person.		x	x	x
Restrictive interventions such as seclusion and restraint are used as a last resort to ensure safety, and explicit procedures are developed to minimize their use.		x		
The assessment and commitment process allows for care transitions into less restrictive levels of care and supports transitions into and out of settings.	x	x		x
Trauma history is taken into consideration as part of a thorough assessment while minimizing the risk of re-triggering trauma.		x	x	
Throughout and following the commitment process, the person's individual strengths are determined, recognized, and incorporated into treatment and recovery support services.			x	
Collateral information from family and others who have knowledge of the person is collected and informs the outcome.			x	
Clarity and purpose of commitment is carefully reviewed and considered including what services are provided and the criteria for the commitment to be ended.				x
Persons involved in the commitment process are free of material conflict of interest.				x

III. Practical Tools to Assist Policy Makers in Evaluating, Reforming, and Implementing Involuntary Civil Commitment

Taking account of the competing interests at stake in civil commitment, and considering the inherent ethical concerns, this final part of the report offers two practical tools to assist policy makers and others responsible for reforming or implementing civil commitment laws or systems: first, a list of ten general guidelines with which to align commitment policy and practice; and second, a checklist of specific model requirements for inpatient and outpatient commitment statutes.

III.A. Policy Guidelines for Involuntary Commitment

1. Civil commitment, whether inpatient or outpatient, should be reserved for those reliably diagnosed with a serious mental illness for which there is available treatment that is likely to be effective. Commitment's purpose must be treatment, and need for treatment is an essential requirement for commitment.
2. If the person is willing and able to engage with services voluntarily, he or she should not be committed. In deciding whether to order commitment, courts should consider the preferences of the person and the degree to which the person understands the nature of his or her mental illness and the likely effect of treatment.
3. A person should not be subject to inpatient commitment unless, without a hospital-level of care, the person will be at significant risk, in the foreseeable future, of behaving in a way, actively or passively, that brings harm to the person or others. Unless the serious mental illness for which treatment is needed places the person at risk for harm, inpatient commitment should not be used. Risk for harm, however, should not require risk of violent behavior. If an individual is at risk for injury, illness, death, or other major loss solely due to mental illness symptoms such as an inability to exercise self-control, judgment, and discretion in the conduct of his or her daily activities, or to satisfy his or her need for nourishment, personal or medical care, shelter, or self-protection and safety, he or she should be committable.
4. If a less restrictive alternative to inpatient commitment is available, including outpatient commitment, inpatient commitment should not be ordered. If, with the help of family, friends, or others who are available and willing to help, a person is capable of remaining in the community without presenting risks associated with need for treatment, he or she should not be subject to inpatient commitment.
5. A person should not be subject to outpatient commitment unless (i) he or she meets the standard for inpatient commitment, but may be served in a less restrictive setting, or (ii) without the treatment proposed, and other supports the court might order, it is reasonably predictable that the person will experience further disability or deterioration to a degree that, in the foreseeable future, the person will meet the inpatient commitment standard. Because commitment under this second prong (i.e., on grounds of further disability or deterioration) addresses risks of harm that are less immediate, respect for personal autonomy may require an additional finding of impairment in the person's understanding of the nature of his or her mental illness and the treatment proposed, including the potential risks and benefits of such treatment and the expectable consequences if commitment is or is not ordered. Full legal incompetency, however, should not be required.

6. Legal proceedings should accord due process protection, including prompt notice of rights, assignment of counsel, and an opportunity to challenge commitment before a judge or other judicial authority without unreasonable delay.
7. Commitment practices should respect the privacy and dignity of the individual. Every effort should be made to minimize trauma. If law enforcement agencies are responsible for transporting individuals proposed for or under order of commitment, they should assign plainclothes officers in unmarked cars, whenever possible. Shackles and other restraints should be used only if necessary, never as a matter of routine.
8. Unless already incarcerated for a criminal offense, or facing criminal charges, no candidate for commitment should be detained in a jail or other correctional facility pending commitment, and no person who has been committed should be placed in a correctional facility for treatment services.
9. Jail and prison authorities, when planning for the release (re-entry) of an inmate with a serious mental illness, should consider whether to initiate commitment proceedings (inpatient or outpatient), depending on the inmate's needs and the likelihood that the inmate will cooperate with treatment once released. Such authorities likewise should be attentive to the needs of inmates while incarcerated and, when faced with an inmate whose needs cannot be met in the institution, should take whatever steps are provided by law for the inmate's transfer or commitment to a more therapeutic setting.
10. Civil commitment should never be used solely for preventive detention or community control. Treatment staff should have the authority to terminate commitment without the court's authorization and should terminate commitment as soon as the individual progresses to the point where he or she no longer meets commitment criteria. No court should insist that a hospital or other treatment provider retain an individual in services at a level of care that the hospital or provider believes is unnecessary. Before terminating an individual's commitment, treatment staff should arrange appropriate services and supports for the individual in the community.

III.B. Requirements for Civil Commitment: A Checklist for Policy Makers and Practitioners

All Civil Commitments (Inpatient or Outpatient)

- ☐ The individual is reliably diagnosed with a serious mental illness.
- ☐ Treatment for the individual's mental illness is available.
- ☐ The treatment that is available is likely to be effective.
- ☐ A reasonable effort has been made to help the individual understand the nature of his or her mental illness and the treatment proposed, including the potential risks and benefits of such treatment and the expectable consequences if he or she is or is not committed.
- ☐ The individual refuses the treatment or is unable to provide valid consent.
- ☐ If the individual is committed, treatment staff have the authority to terminate the commitment without the court's authorization and understand their responsibility to terminate commitment when the individual no longer meets commitment criteria.

Inpatient Commitments

- ☐ Without commitment, and as a result of the serious mental illness diagnosed, the individual will be at significant risk, in the foreseeable future, of behaving in a way, actively or passively (i.e., by acts or omissions), that brings harm to the person or others; harm to the person may include injury, illness, death, or other major loss due to an inability to exercise self-control, judgment, and discretion in the conduct of his or her daily activities, or to satisfy his or her need for nourishment, personal or medical care, shelter, or self-protection and safety.
- ☐ There are no suitable less restrictive alternatives to inpatient commitment, including outpatient commitment.

Outpatient Commitments

- ☐ Without the treatment and other supports that would be available as a consequence of an outpatient commitment order, it is reasonably predictable, given the individual's psychiatric history, that the individual, as a result of the serious mental illness diagnosed, will experience further disability or deterioration to a degree that, in the foreseeable future, the individual will meet the requirements for inpatient commitment described above.
- ☐ The respondent is capable of surviving safely in the community with available supervision from family, friends, or others.
- ☐ The individual's understanding of the nature of his or her mental illness and the treatment proposed, including the potential risks and benefits of such treatment and the expectable consequences if he or she is or is not committed, is impeded to a significant degree by the symptoms of a serious mental illness or other mental disability, limiting or negating the individual's ability to make an informed decision whether to accept or comply with recommended treatment.

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