

THE DANGEROUSNESS OF THE STATUS QUO: A CASE FOR MODERNIZING CIVIL COMMITMENT LAW

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I. INTRODUCTION

On January 8, 2011, Arizona Congresswoman Gabrielle Giffords was holding a meet-and-greet with her constituents at a local supermarket. The event was wrapping up when Jared Lee Loughner opened fire with a handgun, killing a federal judge before shooting Giffords in the head at close range.¹ When the shooting ceased, six people were dead, and twelve (including Giffords) were injured.² The incident ended with a bystander wrestling Loughner to the ground before he could reload.³ The shooting became fodder for gun control advocates nationwide, but a subset of observers realized that this tragedy could have been averted if Loughner had been civilly committed and provided treatment for his mental illness.

In the weeks leading up to the shooting, Loughner was suspended from college for erratic behavior. Police officers tasked with delivering news of the suspension described him as appearing to be in a “constant trance.”⁴ He had withdrawn from friends and feared that the government employed mind manipulation to control its citizens.⁵ Looking further into his past revealed other incidents that could have pointed to mental instability. However, Loughner never had any contact with the mental health system,⁶ and despite his strange behavior, his actions before the morning of the shooting did not suggest a person who was imminently dangerous to himself or others. In many jurisdictions, this is the statutory standard one must meet in order to receive treatment through involuntary civil commitment.⁷ Loughner was

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1. Marc Lacey & David M. Herszenhorn, *Congresswoman Is Shot in Rampage Near Tucson*, N.Y. TIMES, Jan. 9, 2011, at A1.

2. *Id.*

3. *Id.*

4. *Looking Behind the Mug-Shot Grin*, N.Y. TIMES, Jan. 16, 2011, at A1.

5. *Id.*

6. *Id.*

7. *See, e.g.*, ARIZ. REV. STAT. ANN. § 36-540(A) (West, Westlaw through legislation effective April 30, 2014 of the Second Reg. Sess. of the Fifty-First Legislature); GA. CODE ANN. § 37-3-1(9.1)(A)(i) (West, Westlaw through various Acts of the 2014 Reg. Sess.); HAW. REV. STAT. § 334-60.2(2) (West, Westlaw through Act 17 of the 2014 Reg. Sess.). *See also State-by-State Standards for Involuntary Commitment (Assisted Treatment)*, MENTAL ILLNESS POL’Y ORG., <http://mentalillnesspolicy.org/studies/state-standards-involuntary-treatment.html> (last visited May 26, 2014) (“When inpatient commitment is used, most states still rely on the

diagnosed with paranoid schizophrenia and declared incompetent to stand trial. He received extensive treatment in a government psychiatric hospital in the hope that he could stand trial.⁸ Loughner ultimately plead guilty to the shootings and received a sentence of seven life terms plus 140 years in prison.⁹

While such incidents are rare and not representative of the mentally ill community, they are becoming more frequent. In August 2012, James Holmes, a bipolar graduate student, opened fire on a screening of *The Dark Knight* in a crowded theater, killing twelve and wounding fifty-eight.¹⁰ Despite numerous warning signs and cries for help, no action was taken to commit him, and the court is evaluating him to see if he is competent to stand trial.¹¹ In December 2012, Adam Lanza, a man with Asperger's Syndrome, shot his mother in the head before proceeding to a nearby elementary school where he killed twenty first graders, six teachers, and finally himself.¹²

These mass shootings, while tragic, have fomented public outcry for new laws addressing the deficiencies in the mental health system, but most proposed legislation to date addresses background checks to preclude the mentally ill from obtaining firearms.¹³ Several experts have advocated for reforms to civil commitment laws combined with additional funding as a starting point to sweeping reform to the mental health system.¹⁴

Jared Loughner, James Holmes, and Adam Lanza are extreme examples of untreated mental illness. However, many in America are in need of treatment, but are unable or unwilling to obtain it. Currently, they will not receive it through involuntary civil commitment because they do not meet the standard of dangerousness set forth by the Supreme Court in 1975.¹⁵ The standard is difficult to meet, varies by state, and withholds involuntary treatment until it is too late to protect the public or help the mentally ill individual.

The ongoing economic recession required most states to cut funding for mental health services, which correlates to an increase in acute psychiatric episodes requiring involuntary civil commitment. Since 2009, twenty-nine

'dangerousness' standard, and rarely use the other standards they have available to them. Further 'dangerous' is often interpreted very narrowly to mean 'imminently' dangerous.'").

8. The court sealed the order declaring Loughner incompetent. This order extends his commitment for treatment and acknowledges the original order, which occurred on March 23, 2011. See *United States v. Loughner*, 807 F.Supp. 2d 828, 836 (D. Ariz. 2011).

9. Fernanda Santos, *Gunman Gets 7 Life Terms in Tucson Shooting of Congresswoman and Others*, N.Y. TIMES, Nov. 9, 2012, at A16.

10. Erica Goode et al., *Before Gunfire, Hints of 'Bad News'*, N.Y. TIMES, Aug. 27, 2012, at A1.

11. *Id.*

12. N.R. Kleinfeld et al., *Newtown Killer's Obsessions, in Chilling Detail*, N.Y. TIMES, Mar. 29, 2013, at A1.

13. See Peter Applebome & Johnathan Weisman, *Invoking Newtown Dead, Obama Presses Gun Laws*, N.Y. TIMES, Apr. 9, 2013, at A1.

14. Erica Goode & Jack Healy, *Focus on Mental Health Laws to Curb Violence is Unfair, Some Say*, N.Y. TIMES, Feb. 1, 2013, at A13.

15. See *Involuntary Commitment And Court-Ordered Treatment*, NAT'L ALLIANCE ON MENTAL ILLNESS, http://www.nami.org/Content/ContentGroups/Policy/Updates/Involuntary_Commitment_And_Court-Ordered_Treatment.htm (last visited May 26, 2014).

states have cut funding for mental healthcare due to the recession.¹⁶ At the same time, a survey by the United States Substance Abuse and Mental Health Services Administration demonstrates that serious mental illness is almost twice as prevalent in unemployed adults as it is in those with jobs.¹⁷ Unemployed individuals are twice as likely to suffer from a serious mental illness and are more likely to need the state funding that was cut because of the recession. Their inability to obtain state-funded care leads to a lack of medication and an increased chance of involuntary civil commitment.

The states, private healthcare organizations, and those with psychiatric disorders are poorly served by the vague “dangerousness” standard endorsed by the United States Supreme Court in *O’Connor v. Donaldson*,¹⁸ as well as the state statutes that adhere to the high bar set in its holding. This paper explores involuntary civil commitment from a variety of perspectives in order to highlight these issues and identify where improvements can be made. Part II will explain the history of the standard for involuntary commitment and how Supreme Court rulings have shaped it. Part III will examine the issues facing the states, the mentally ill, and private healthcare organizations in the current system. Part IV will propose solutions intended to improve the system for involuntary civil commitment. Specifically, this article proposes that the American Law Institute or the American Bar Association promulgate model rules intended to correct the system’s shortcomings and protect the various interested parties.

II. HISTORY OF INVOLUNTARY CIVIL COMMITMENT LAW

The United States Constitution guarantees that no person will be deprived of his or her liberty without due process of law by the federal government.¹⁹ This protection was extended to prevent the states from violating a person’s due process rights.²⁰ Mentally ill individuals present a unique challenge to the application of due process. While they are guaranteed these constitutional protections, the law also recognizes that it is sometimes in their best interest for the government to assert its *parens patriae* power to ensure their safety.²¹ Throughout the nation’s history, the Supreme Court has attempted to balance due process rights with states’ *parens patriae* powers through decisions addressing the rights of the mentally ill.

16. *State Mental Health Cuts: The Continuing Crisis*, NAT’L ALLIANCE ON MENTAL ILLNESS 1 (Nov. 2011), <http://www.nami.org/ContentManagement/ContentDisplay.cfm?ContentFileID=147763>.

17. *Results from the 2009 National Survey on Drug Use and Health: Mental Health Findings*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP’T HEALTH & HUMAN SERVS. 9 (Dec. 2010), <http://www.samhsa.gov/data/NSDUH/2k9NSDUH/MH/2K9MHResults.pdf> [hereinafter SAMHSA 2009].

18. 422 U.S. 563, 576 (1975).

19. U.S. CONST. amend. V.

20. U.S. CONST. amend. XIV § 1.

21. *Rone v. Fireman*, 473 F. Supp. 92, 118 (N.D. Ohio 1979).

During the colonial era, the United States struggled with balancing the danger that the mentally ill might inflict on society with the paternalistic responsibility to care for such individuals, often resulting in the jailing of such individuals.²² During the late eighteenth and early nineteenth century, physicians regularly institutionalized mentally ill persons absent judicial oversight.²³ Asylums and hospitals were satisfied with the arrangement so long as payment for treatment was promptly received when it came due.²⁴

By the mid-nineteenth century, states became concerned about the abuses that could occur absent judicial oversight, adopting various precursors to modern civil commitment laws.²⁵ The laws ran the gamut, with some invoking dangerousness as a requirement, while others went so far as to permit the commitment of non-dangerous insane persons provided they were paupers.²⁶ As the Great Depression ravaged the nation, the requirements for commitment were relaxed even further, with many states abolishing jury trials for commitment and adopting a need-for-treatment standard.²⁷ In the 1960s and 1970s, advocates such as the American Bar Association pushed back against the low standards for commitment, arguing that treatment and good intentions did not replace adequate constitutional safeguards.²⁸

The modern history of involuntary commitment began with the Supreme Court decision in *O'Connor v. Donaldson* in 1975. Donaldson, diagnosed with paranoid schizophrenia, was kept in a state-run mental hospital for nearly fifteen years following an involuntary commitment initiated by his father.²⁹ He repeatedly asked for his release, arguing that he was not being treated for his mental condition and did not pose a danger to himself or others.³⁰

The Supreme Court agreed, holding that in order to constitutionally commit and confine an individual, the state must show that the person is dangerous to himself or others and that they are not capable of living safely under the supervision of family or friends.³¹ Involuntary commitment must serve a "legitimate state interest," and both the interest and the reasons for committing an individual must be disclosed to an appropriate tribunal.³² In so holding, the Court reaffirmed the decision in *Jackson v. Indiana* that the nature and duration of a commitment must be reasonably related to its purpose.³³

22. JAMES A. HOLSTEIN, COURT ORDERED INSANITY: INTERPRETIVE PRACTICE AND INVOLUNTARY COMMITMENT 19-20 (1993) (analyzing a mandate for the confinement of mentally ill individuals from colonial Massachusetts); JUDITH LYNN FAILER, WHO QUALIFIES FOR RIGHTS? HOMELESSNESS, MENTAL ILLNESS, AND CIVIL COMMITMENT 73 (2002) (analyzing a similar New Hampshire statute).

23. HOLSTEIN, *supra* note 22, at 21.

24. *Id.*

25. *See id.* at 22.

26. *Id.* at 22-23.

27. *See FAILER supra* note 22, at 79.

28. *See HOLSTEIN, supra* note 22, at 24-25; FAILER *supra* note 22, at 81.

29. *O'Connor v. Donaldson*, 422 U.S. 563, 564-65 (1975).

30. *Id.* at 565.

31. *Id.* at 576.

32. *Id.* at 580 (Burger, C.J., concurring).

33. *Jackson v. Indiana*, 406 U.S. 715, 738 (1972).

The Court explicitly declined to discuss whether mentally ill individuals are entitled to treatment during the time they are being constitutionally held by the state under the dangerousness standard or if treatment alone is an adequate justification for involuntary commitment.³⁴ In its opinion, the appellate court indicated its belief that treatment was reason enough for confinement.³⁵ However, Justice Burger's concurrence was skeptical of the idea that treatment would be an adequate justification for commitment, arguing that treatment rendered does not provide "adequate 'compensation'" for the deprivation of due process and freedom.³⁶ The Court of Appeals for the First Circuit later held that a patient could refuse such treatment if competent, and a further hearing would be required to forcibly administer drugs when attempting to treat a patient who had met the standards for commitment described in *O'Connor*.³⁷

Chief Justice Burger's concurrence advocated systems for involuntary confinement that protect the due process rights of the mentally ill by providing periodic hearings at the patient's request or at statutory intervals to review the appropriateness of continued confinement.³⁸ State statutes limit the length of involuntary confinement to statutorily prescribed intervals to prevent a lengthy and unnecessary commitment like the one that occurred in *O'Connor*.³⁹ It also provides judicial oversight of state agencies whose responsibilities include involuntarily committing individuals when appropriate.

The Supreme Court has heard other cases concerning involuntary civil commitment, but none have changed the holding of *O'Connor*. Instead, they seek to clarify or make situation-specific addenda to the "dangerousness" doctrine. In *Addington v. Texas*, the Court clarified the burden of proof required for involuntary commitment.⁴⁰ The Court was concerned with the lack of clarity because involuntary commitment is a substantial deprivation of liberty that requires due process protection.⁴¹ The Court held that commitment requires proof by clear and convincing evidence that the person has a mental illness and that hospitalization is required because the person poses a danger to himself or others.⁴² The Court reasoned that a clear and convincing standard adequately balances the rights of the individual and the

34. *O'Connor*, 422 U.S. at 573.

35. *Donaldson v. O'Connor*, 493 F.2d 507, 527 (5th Cir. 1974).

36. *O'Connor*, 422 U.S. at 587-89 (Burger, C.J., concurring).

37. *Rogers v. Okin*, 634 F.2d 650, 653 (1st Cir. 1980), *vacated on other grounds sub nom. Mills v. Rogers*, 457 U.S. 291 (1982). The right to treatment argument will be explored more fully in this article. See *infra* Section III.

38. *O'Connor*, 422 U.S. at 580.

39. See, e.g., ARIZ. REV. STAT. ANN. § 36-540(D) (West, Westlaw through legislation effective April 30, 2014 of the Second Reg. Sess. of the Fifty-First Legislature) ("An order to receive treatment pursuant to subsection A, paragraph 1 or 2 of this section shall not exceed three hundred sixty-five days."). Every state has a provision similar to this one limiting the length of a commitment. One year is a standard ceiling, and judges usually have the option of assigning shorter commitments where appropriate.

40. 441 U.S. 418, 427 (1979).

41. *Id.* at 425.

42. See *id.* at 427.

public safety concerns of the state.⁴³ In so holding, the Court rejected the preponderance standard as violative of due process rights and the reasonable doubt standard as unnecessary.⁴⁴

In *Jones v. United States*, the Court held that a person found not guilty by reason of insanity may be committed after the finding until such a time as he can be reasonably considered sane and is no longer a danger to himself or others.⁴⁵ In *Foucha v. Louisiana*, the Court clarified that involuntary commitment cannot be an automatic consequence of an acquittal by reason of insanity.⁴⁶ In order to preserve the individual's due process rights, confinement cannot occur absent a showing by the state that the individual meets the statutory standards set forth in *Addington*—mental illness and dangerousness.⁴⁷ Since the state can no longer constitutionally hold an acquitted individual based on a criminal offense, it is necessary to meet these standards in front of a fact finder designated by state law in a civil proceeding.⁴⁸

In *Heller v. Doe*, the Court differentiated mental retardation from mental illness, holding that there is a lower burden of proof to be met for finding that an individual is mentally retarded.⁴⁹ Most of the time mental retardation manifests in childhood or after a serious occurrence such as an accident or injury, making it more of impairment than illness.⁵⁰ Mental illness can come on at any time and is harder to diagnose.⁵¹ The Court also recognized that mental illness is more likely to be treatable, making improvement more likely, and therefore requiring a higher burden of proof for continued confinement.⁵² This case makes the clinical diagnosis of an individual more important. A diagnosis of mental illness instead of mental retardation will trigger more expansive due process protections.

In 1999, a divided Supreme Court held that those institutionalized with mental illness or disabilities have the right under the Americans with Disabilities Act to be placed in a community setting provided that three conditions are met.⁵³ Physicians must determine such a placement is appropriate, the institutionalized individual must consent to the transfer, and finally, the placement must be reasonable taking into account the resources of the state and the needs of other mentally ill and disabled people for which the state is responsible.⁵⁴ The court emphasized that undue isolation is no more

43. See *Addington*, 441 U.S. at 431.

44. *Id.* at 432-33.

45. 463 U.S. 354, 370 (1983).

46. See *Foucha v. Louisiana*, 504 U.S. 71, 80 (1992).

47. *Id.* at 86 (plurality opinion).

48. See *id.* (plurality opinion).

49. 509 U.S. 312, 321 (1993).

50. See *id.*

51. *Id.* at 322.

52. *Id.* at 324-25.

53. *Olmstead v. L.C.*, 527 U.S. 581, 587 (1999).

54. *Id.*

appropriate for a person with a mental disability than it is for someone with a physical one.⁵⁵

This paper focuses primarily on involuntary civil commitment, but it is worthwhile to briefly acknowledge decisions involving criminal commitment of the mentally ill. In *United States v. Salerno*, the Court held that pretrial detention of accused persons is allowed in the event that it can be shown that they pose a danger to themselves or the community.⁵⁶ This detention does not qualify as punishment or violate due process rights of the accused.⁵⁷

Sex offenders are the subjects of the most recent jurisprudence in the area of involuntary commitment. The problem posed by sex offenders requires an overlapping statutory scheme composed of both state and federal law.⁵⁸ For the purposes of this paper, it is enough to note that the Necessary and Proper Clause allows federal district courts to civilly commit, following completion of his sentence, a federally convicted sexually violent offender without violating due process rights or being subject to a double jeopardy finding.⁵⁹ The Supreme Court had previously recognized the constitutionality of a state committing an offender who was classified a sexually violent predator due to a mental abnormality.⁶⁰

The dangerousness standard adopted in *O'Connor* has not been changed or updated since 1975. States have been hesitant to run afoul of the language and have adopted statutes that protect them from suits like the one in *O'Connor*, but do not always serve the mentally ill as well as they could or should.⁶¹ Private caregivers are often caught in the middle and forced to provide additional care to make up for state budget and statutory shortcomings.⁶² The interested parties in a civil commitment action accept a great deal of risk and see little of the relief that involuntary commitment can provide.

55. *Olmstead*, 527 U.S. at 601; Kevin M. Cremin, *Challenges to Institutionalization: The Definition of "Institution" and the Future of Olmstead Litigation*, 17 TEX. J. C.L. & C.R. 143, 155 (2012).

56. 481 U.S. 739, 747 (1987).

57. *Id.* at 748.

58. Corey Rayburn Yung, *Sex Offender Exceptionalism and Preventative Detention*, 101 J. CRIM. L. & CRIMINOLOGY 969, 974 (2011).

59. *United States v. Comstock*, 130 S. Ct. 1949, 1961 (2010).

60. *Kansas v. Hendricks*, 521 U.S. 346, 359-60 (1997).

61. Steven K. Erickson et al., *Beyond Overt Violence: Wisconsin's Progressive Civil Commitment Statute as a Marker of a New Era in Mental Health Law*, 89 MARQ. L. REV. 359, 369 (2005).

62. See *Emergency Department Challenges and Trends 2010 Survey of Hospital Emergency Department Administrators*, SCHUMACHER GRP. 3 (2010), http://filecache.drivetheweb.com/mr5mr_acep/177355/download/Survey+of+Hospital+Emergency+Department+Administrators+2010.pdf [hereinafter *Emergency Department Challenges and Trends*].

III. INTERESTED PARTIES IN THE CIVIL COMMITMENT PROCESS

A. *Who Are They?*

The ranks of the mentally ill are large and diverse. Almost five percent of the population of the United States suffered from a serious mental illness in 2009,⁶³ the definition of which closely mirrors the definition found in state statutes regarding mental illness.⁶⁴ The economic recession has placed an undue burden on the mentally ill. Many must pay for services such as therapy and medication in addition to necessities like food and shelter.

Mental illness is a strong predictor of struggles with unemployment and homelessness.⁶⁵ Serious mental illness afflicts seven percent of unemployed persons and thirty percent of homeless individuals.⁶⁶ At the peak of unemployment in October of 2009, ten percent of the United States population was unemployed.⁶⁷ Those individuals are unable to provide themselves with the mental healthcare that they require through employer-funded private insurance or their own discretionary funds as public funding for mental health services has not expanded at a rate equal to the funding for healthcare as a whole.⁶⁸ The federal government set up a website designed to provide helpful guidance to those experiencing mental health issues due to the economic downturn,⁶⁹ but it falls short of providing clear instructions for obtaining medical care or funding for medication.

Though the exact causes remain unclear, economic downturns are reliable predictors of increased psychiatric distress, including depression, suicide, and

63. SAMHSA 2009, *supra* note 17, at 1, 8.

64. *Id.* at 7 (“[The Substance Abuse and Mental Health Services Administration] defined SMI as persons aged 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) (American Psychiatric Association [APA], 1994) that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities.”).

65. David P. Folsom et al., *Prevalence and Risk Factors for Homelessness and Utilization of Mental Health Services Among 10,340 Patients with Serious Mental Illness in a Large Public Mental Health System*, 162 AM. J. PSYCHIATRY 370, 370 (2005).

66. SAMHSA 2009, *supra* note 17, at 9; *Current Statistics on the Prevalence and Characteristics of People Experiencing Homelessness in the United States*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. 4 (July 2011), http://homeless.samhsa.gov/ResourceFiles/hrc_factsheet.pdf.

67. *Labor Force Statistics from the Current Population Survey*, U.S. BUREAU LABOR & STATISTICS, <http://data.bls.gov/timeseries/LNS14000000> (last visited May 26, 2014).

68. RACHEL L. GARFIELD, KAISER COMM’N ON MEDICAID & THE UNINSURED, MENTAL HEALTH FINANCING IN THE UNITED STATES: A PRIMER 18 (2011), *available at* <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/818.pdf> (“[G]rowth in spending for behavioral health care in the United States has been slow relative to growth rates for other health services.”).

69. *Getting Through Tough Economic Times*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., <http://www.samhsa.gov/economy/#warningsigns> (last updated Dec. 2, 2011).

substance abuse.⁷⁰ In these situations, mentally ill individuals look to government programs, both federal and state, to help them obtain the care they need.

The National Governors Association believes that state budgets will not fully recover until late in this decade at the earliest.⁷¹ Because of the dire financial situation, states must make tough fiscal decisions.⁷²

Cuts have downsized or closed both inpatient treatment centers and community mental health clinics in several states.⁷³ Medicaid provides half of all public sector funding for mental healthcare, the rest of which is comprised mostly of general state funds.⁷⁴ In 2011, \$14 billion in Medicaid funding was cut due to the expiration of the federal stimulus packages.⁷⁵ These funds allowed states to cover budget shortfalls to some extent, but state revenues have not risen to the extent that the shortfall can be remedied. If anything, states now have even fewer funds to put toward preventative mental healthcare, which would indicate an increase in civil commitments is imminent due to an increase in acute episodes.⁷⁶

Even without factoring in the economic downturn, the mentally ill are at a disadvantage when it comes to paying for vital care. The Medicare program provides care for those over age sixty-five and some younger individuals with permanent disabilities.⁷⁷ Recipients are limited to 190 lifetime inpatient hospital days at a psychiatric hospital.⁷⁸ However, in a non-psychiatric setting, there is no lifetime limit on the number of inpatient hospital days Medicare will cover.⁷⁹ The result of this cost cutting measure is that the options of mentally ill Medicare patients are limited to a confusing patchwork of Medicare and privately covered services, which can lead to the mentally ill opting to forego treatment altogether and indicates a long standing bias against mental illness.⁸⁰

Medicare Part B, which pays for supplemental and physician services,⁸¹ requires individuals to pay a forty-five percent co-insurance rate on qualified outpatient psychiatric services, a requirement not imposed on non-psychiatric

70. Sidra J. Goldman-Mellor et al., *Economic Contraction and Mental Health*, INT'L J. MENTAL HEALTH, Summer 2010, at 24.

71. Raymond C. Scheppach, *The State Fiscal Situation: The Lost Decade*, NAT'L GOVERNORS ASS'N 1 (Sept. 2011), <http://www.nga.org/files/live/sites/NGA/files/pdf/0911FISCALLOSTDECADE.PDF>.

72. *See id.* at 2-3 (highlighting ways in which the recent economic downturn will affect state fiscal choices in the coming years).

73. *State Mental Health Cuts: The Continuing Crisis*, *supra* note 16, at 3.

74. *See id.* at 4.

75. *Id.*

76. *See* Ralph Catalano, *Health, Medical Care, and Economic Crisis*, 360 NEW ENG. J. MED. 749, 751 (2009).

77. 42 U.S.C. § 1395c (2006).

78. 42 C.F.R. § 409.62 (2012).

79. *See id.* at § 409.61(a); Stacey A. Tovino, *All Illnesses Are (Not) Created Equal: Reforming Federal Mental Health Insurance Law*, 49 HARV. J. ON LEGIS. 1, 4 (2012).

80. Tovino, *supra* note 79, at 4-5.

81. 42 U.S.C. § 1395k(a) (2006).

services.⁸² While this requirement will be phased out by 2014, this imposes a serious burden on the mentally ill population prior to that date and indicates long standing bias against the mentally ill.⁸³

Private insurers have traditionally been reluctant to provide benefits for mental healthcare.⁸⁴ Several legislative attempts to rectify this have fallen flat.⁸⁵ Finally, with the passage of the Patient Protection and Affordable Care Act,⁸⁶ private insurers are required to provide mental health and substance use disorder benefits in order to meet the statute's minimum requirements.⁸⁷ However, there are several classes of private plans that are either exempted or grandfathered in and not subject to the requirement, resulting in this change potentially not reaching millions of mentally ill in need of this coverage.⁸⁸

The economic barriers faced by the mentally ill are all but insurmountable. However, research shows that the seriously mentally ill face yet another issue in difficult economic times. During economic downturns, society's tolerance for behavior that deviates from the norm decreases, causing an increase in civil commitments not because of an increase in mental illness, but because of societal discrimination against the mentally ill.⁸⁹ In order to protect the vulnerable mentally ill population, it is incumbent upon state and private actors to ensure that they are cognizant of this phenomenon so as not to fall prey to it.

B. State Governments

While *O'Connor* sets forth the dangerousness standard that states follow when writing their civil commitment statutes, states have not applied the standard uniformly.⁹⁰ Some states define the dangerousness standard to include an inability to care for oneself, while other states define dangerousness

82. Tovino, *supra* note 79, at 5.

83. *See id.*

84. *See* Colleen L. Barry, *The Political Evolution of Mental Health Parity*, 14 HARV. REV. PSYCHIATRY 185, 186 (2006) (explaining why private insurers had little incentive to cover costs for psychiatric care that were already covered through public funding).

85. *See* Tovino, *supra* note 79, at 7 (“[N]either the federal Mental Health Parity Act of 1996 (“MHPA”) nor the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”) required private insurers to offer insurance benefits for mental illness.”) (footnotes omitted).

86. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified in scattered sections of 42 U.S.C.).

87. *Id.* at § 1302(b)(1)(E), 124 Stat. 119, 164 (codified at 42 U.S.C. § 18022(b)(1)(E) (2010)).

88. Patient Protection and Affordable Care Act § 1004 (codified at 42 U.S.C. § 300gg-11 (2010)).

89. Ralph Catalano et al., *Unemployment and Civil Commitment: A Test of the Intolerance Hypothesis*, 33 AGGRESSIVE BEHAVIOR 272, 272-73, 276 (2007) (explaining test results that showed how the incidence of civil commitment rose above or fell below expected values two months after the unemployment rate exhibited similar deviations).

90. *See* Elizabeth A. McGuan, *New Standards for the Involuntary Commitment of the Mentally Ill: “Danger” Redefined*, 11 MARQ. ELDER’S ADVISOR 181, 203-04, 205-06 (2009) (comparing application of dangerousness factors in different states).

based on the immediacy of the threat of physical violence to the individual or others in the community.⁹¹

For example, until 2001, Minnesota required a showing of immediate danger to the individual or others in order to civilly commit an individual.⁹² However, the legislature saw fit to change the requirements so that the danger posed does not have to be immediate with the result that intervention and treatment can begin earlier.⁹³ Ohio, on the other hand, requires that the danger to the individual or to the community be immediate as defined by statute.⁹⁴ Arizona, where Jared Loughner could have been committed, chooses a middle ground between the Ohio and Minnesota. Arizona requires that a reasonable practitioner be able to foresee harm coming to the individual or others.⁹⁵ In Part IV, this paper will argue in greater detail that Wisconsin's approach, which is even more progressive than Minnesota's, is the most beneficial to all parties involved in the process.⁹⁶

The vagueness of the dangerousness standard means that state legislatures must fill in the gaps, and in Arizona, Colorado, and Connecticut, erring on the side of a stricter standard arguably contributed to a tragedy. The feeling amongst some psychiatric professionals is that stricter standards, like

91. See Erickson *supra* note 61, at 368-69.

92. *Understanding the Minnesota Civil Commitment Process*, NAT'L ALLIANCE ON MENTAL ILLNESS: MINN. 6 (Sept. 2010), <http://www.namihelps.org/assets/PDFs/civilcommitmentSinglePg102108.pdf>.

93. *Id.*

94. OHIO REV. CODE ANN. § 5122.01(B) (West, Westlaw through Files 1 to 94 and Statewide Issue 1 of the 130th Gen. Assemb.). The statute provides:

(B) "Mentally ill person subject to hospitalization by court order" means a mentally ill person who, because of the person's illness:

- (1) Represents a substantial risk of physical harm to self as manifested by evidence of threats of, or attempts at, suicide or serious self-inflicted bodily harm;
- (2) Represents a substantial risk of physical harm to others as manifested by evidence of recent homicidal or other violent behavior, evidence of recent threats that place another in reasonable fear of violent behavior and serious physical harm, or other *evidence of present dangerousness*;
- (3) *Represents a substantial and immediate risk* of serious physical impairment or injury to self as manifested by evidence that the person is unable to provide for and is not providing for the person's basic physical needs because of the person's mental illness and that appropriate provision for those needs cannot be made immediately available in the community; or
- (4) Would benefit from treatment in a hospital for the person's mental illness and is in need of such treatment as *manifested by evidence of behavior that creates a grave and imminent risk to substantial rights of others or the person.*

Id. (emphasis added).

95. ARIZ. REV. STAT. ANN. § 36-501(5)-(6) (West, Westlaw legislation effective April 30, 2014 of the Second Reg. Sess. of the Fifty-First Legislature).

96. See *infra* Part IV.

Arizona's, move the focus away from helping those with mental illness and preventing decompensation toward a system that is more akin to the penal system.⁹⁷ While reluctance to inappropriately confine the mentally ill is a valid concern, it is also important to acknowledge that allowing their conditions to deteriorate into a state of dangerousness is worse. States need to adopt a progressive understanding that advocates for aggressive treatment as opposed to reactionism.⁹⁸

Wisconsin is perhaps the most progressive model in the United States, having adopted a standard that, in the eyes of the Wisconsin Supreme Court, both protects society from the dangerously mentally ill and exercises beneficence in caring for mentally ill persons who cannot care for themselves.⁹⁹

Unlike the application of the dangerousness standard, the second part of the *O'Connor* holding is applied with few variations between the states. Involuntary commitment must serve a "legitimate state interest," and both the interest and the reasons for committing an individual must be disclosed to an appropriate tribunal.¹⁰⁰ While states are able to tailor their processes to suit their needs, the Supreme Court has limited the unconstitutional deprivation of liberty in involuntary commitment to an extent that they more or less take the same form.¹⁰¹ For purposes of this article, Ohio's civil commitment procedure will provide a good example of the process used by most states, though Ohio chooses to apply the dangerousness standard strictly.

97. Joseph D. Bloom, *Thirty-Five Years of Working With Civil Commitment Statutes*, 32 J. AM. ACAD. PSYCHIATRY & L. 430, 438 (2004).

98. See Erickson, *supra* note 61, at 359-60.

99. Erickson explains Wisconsin's new standard as follows:

[T]he new standard focuses on whether the person's "acts or omissions" lead to a "substantial probability" that, if left untreated, the illness would result in the "loss of the individual's ability to function independently in the community or loss of cognitive or volitional control." Thus, this new Fifth Standard of Dangerousness explicitly places its emphasis on whether the alleged person is able to maintain living within the community instead of relying upon serious overt acts of violence or extreme neglect of personal self-care to provide for commitment.

Id. at 362 (footnotes omitted).

100. *O'Connor v. Donaldson*, 422 U.S. 563, 580 (1975) (Burger, C.J., concurring).

101. Austin Baumgarten, Comment, *Medical Treatment Demands Medical Assessment: Substantive Due Process Rights in Involuntary Commitments*, 45 U.C. DAVIS L. REV. 597, 605-06 (2011).

C. Involuntary Civil Commitment in Ohio

Commitment in Ohio can be effected one of two ways: the filing of an affidavit or through an emergency hospitalization.¹⁰² The affidavit is the more common method, while emergency hospitalization is used in only the most serious of situations.¹⁰³ It is important to note at the outset that the burden on the entity advocating commitment is to prove by clear and convincing evidence that the individual is mentally ill and that they pose a danger to themselves or others. Depending on the state, the definition of danger and the immediacy of the danger required may differ, as noted previously.

The process commences with the filing of an affidavit at the probate court level. It can be filed by anyone with actual knowledge that the individual has a mental illness, must be filed in the manner described by statute, must demonstrate that the statutory standard of dangerousness is met, and the allegations set forth must be supported by material facts.¹⁰⁴ The affiant may be required to submit a signed report by a psychiatrist indicating that the allegations are true or make a signed statement that the individual refused to be examined.¹⁰⁵

Next, a judge or magistrate who is an attorney must review the affidavit to see if there is probable cause to believe that the person is subject to involuntary commitment. If it exists, a hearing will be scheduled, and if the case is serious enough, the individual may be subject to a temporary order of detention and be held for treatment and observation until the hearing takes place.¹⁰⁶

In Ohio, the individual must be detained in a residential facility or some alternative that is similarly restrictive, and may only be detained in a penal setting if no less restrictive alternative is available. This detention may only last for forty-eight hours.¹⁰⁷

Emergency hospitalization is a legislative carve-out which allows an exception to the requirement that a person receive a form of judicial review before involuntary hospitalization.¹⁰⁸ Any “professional”¹⁰⁹ may transport a person directly to a general hospital, if the person has a mental illness and is substantially likely to cause harm to self or others if they remain at liberty.¹¹⁰ The individual can be taken to any general hospital, whether or not it is

102. OHIO REV. CODE ANN. § 5122.10-11 (West, Westlaw through Files 1 to 94 and Statewide Issue 1 of the 130th Gen. Assemb.); *Ohio's Involuntary Civil Commitment Process: Judicial Hospitalization*, OHIO LEGAL RIGHTS SERV. 2 (Mar. 2010), <http://www.disabilityrightsohio.org/sites/default/files/ux/ohio-involuntary-civil-commit-process.pdf> [hereinafter OLRs].

103. OLRs, *supra* note 102, at 2.

104. *Id.* at 3.

105. *Id.*

106. *Id.*

107. OHIO REV. CODE ANN. § 5122.17.

108. *See* OLRs, *supra* note 102, at 4.

109. OHIO REV. CODE ANN. § 5122.10 (enumerating those who may detain a person for the purpose of emergency hospitalization as a “psychiatrist, licensed clinical psychologist, licensed physician, health officer, parole officer, police officer, or sheriff . . .”).

110. *Id.*

licensed by the state department of mental health, forcing private facilities to temporarily house individuals until such time as they can be transferred to a licensed mental health facility.¹¹¹

In Ohio, as in most states, police have an important role in the emergency commitment of the mentally ill, as they are often the first point of contact in civil commitment proceedings. Though they receive some training in dealing with special populations like the mentally ill, their training leaves much to police discretion without providing the officers the proper tools to succeed.¹¹² As much as seventy-two percent of the time, their interactions with the mentally ill result in trying to defuse a situation or transport the individual to their homes.¹¹³ When less coercive interventions are unsuccessful, the police are forced to take more drastic action. Often the nature and difficulty of the hospitalization process can discourage law enforcement officers from taking that step.¹¹⁴ A psychiatric professional is both more qualified to make the decision as to the level of danger the individual presents and is more likely to disregard the inconvenience presented by the emergency hospitalization process because of experience, training, and professional duty.¹¹⁵

Once an individual is taken to the hospital, per Ohio law, the professional who took the individual into custody must give a written statement to the hospital, which can be made available to both the individual and the individual's attorney upon request.¹¹⁶ The individual must be transferred to a community mental health agency or state licensed mental hospital¹¹⁷ within twenty-four hours of admittance to the general hospital and be examined by the staff of the licensed hospital or community mental health agency within twenty-four hours of arrival there.¹¹⁸

If the chief clinical officer at the hospital or community mental health agency finds that the individual does not meet the statutory requirements for commitment, they must be released immediately.¹¹⁹ In the event that the individual does meet the requirements, the chief clinical officer has three court days to file an affidavit as described above to trigger a hearing or the individual must be released.¹²⁰ Emergency detention deprives an individual of their liberty prior to judicial review and is cause for more concerns regarding abuse or misuse by law enforcement especially. Ideally, it is employed less frequently than the affidavit process.

111. OHIO REV. CODE ANN. § 5122.10.

112. Linda A. Teplin, *Policing the Mentally Ill: Styles, Strategies, and Implications*, in JAIL DIVERSION FOR THE MENTALLY ILL: BREAKING THROUGH THE BARRIERS 11 (Henry J. Steadman, ed., 1990), available at <http://static.nicic.gov/Library/008754.pdf>.

113. Peter E. Finn & Monique Sullivan, *Police response to special populations: Handling the mentally ill, public inebriate, and the homeless*, NAT'L INST. JUST. 1 (1988).

114. See Teplin, *supra* note 112, at 12.

115. See *id.*

116. OHIO REV. CODE ANN. § 5122.10.

117. *Id.* at § 5122.01(F), (H).

118. *Id.* at § 5122.10.

119. *Id.*

120. *Id.*

Following receipt of the affidavit, the individual and the individual's spouse or parent (if applicable) must receive notice of the hearing.¹²¹ The mental health board in the individual's county of residence must also be notified at the time the affidavit is filed. The mental health board will make an assessment of the individual's case to judge whether commitment is appropriate, or if less restrictive services are available and could take the place of commitment.¹²² Often, less restrictive services take the form of outpatient treatment in the event that it is available in that jurisdiction.

The court will review the assessment of the mental health board and issue a report with a preliminary determination of whether or not the individual meets the statutory criteria for commitment. This report will be forwarded to the individual and the individual's lawyer.¹²³

An initial hearing must be held within five days of the initial detention to determine whether statutory requirements are met by clear and convincing evidence. If the court determines that they are, the court may order an interim order of detention.¹²⁴ If possible, the hearing will be held prior to the individual being taken into custody.¹²⁵ If the right to an initial hearing is waived, a full hearing must be held within thirty days of detention or the filing of the affidavit.¹²⁶ This hearing can also lead to interim detention.¹²⁷

The full hearing is comparable to a civil court trial. The individual has a right to be represented by counsel, call witnesses, and cross-examine witnesses called by the mental health board.¹²⁸ The attorney representing the mental health board will offer evidence of a diagnosed mental illness, prognosis of the condition, record of treatment, and any feasible less restrictive treatment plans.¹²⁹ After reviewing those items, the court may order up to a ninety-day hospitalization, during which the individual shall be examined not less than every thirty days in order to evaluate the appropriateness of continued hospitalization.¹³⁰

121. OHIO REV. CODE ANN. § 5122.12(A)-(B).

122. *Id.* at § 5122.05(A)(2).

123. *Id.* at § 5122.13.

124. *Id.* at § 5122.141(D).

125. *Id.* at § 5122.141(F).

126. *Id.* at § 5122.141(E).

127. OHIO REV. CODE ANN. § 5122.141(D).

128. *Id.* at § 5122.15(A)(2), (11).

129. *Id.* at § 5122.15(A)(10).

130. *Id.* at § 5122.15(C), (F).

D. The Costs of Commitment

Meeting the burden to commit an individual is a long process with many moving parts. It carries with it a great deal of expense for the state. Virginia established an involuntary mental commitment fund to pay for the administration of its system. In fiscal year 1994, that fund paid out \$12.2 million, which was not enough to cover the costs in their entirety.¹³¹ Other costs were borne by law enforcement and the state mental health system.¹³² The total costs of involuntary commitment in 1994 in Virginia were \$20 million.¹³³

The person being committed has the burden of paying for the commitment if he or she has private insurance or has reached the age of majority and is not yet old enough to qualify for Medicare.¹³⁴ After attempting to bill the individual, the state can attempt to collect from the individual through liens against Social Security and VA benefits, or any real estate the individual or a spouse owns.¹³⁵ This places a terrible burden on the individuals being committed, many of whom are unemployed or employed part-time, and will be reliant on Social Security disability benefits to live stable lives or obtain medication.¹³⁶ Forty-two percent of individuals in need of mental healthcare who did not receive it in 2009 did not obtain it because of the cost of obtaining it.¹³⁷ The inability of the mentally ill to obtain treatment after hospitalization raises the probability of another commitment and will foist those additional costs onto the already overburdened state mental health systems.

When states are forced to cover the costs of civil commitments, there is an incentive to commit fewer people. However, evidence shows that doing so may lead to an increase in homicide and other violent crime.¹³⁸ A study published in 2011 found that states with higher rates of involuntary commitment and lower statutory barriers to involuntary commitment experience fewer homicides perpetrated by the mentally ill.¹³⁹ The study also notes that the states offer more interventions through early treatment and efficient mental health systems.¹⁴⁰ However, realizing higher bed access and more proactive treatment requires money that is not currently available

131. See J. LEGIS. AUDIT & REVIEW COMM'N VA. GEN. ASSEMB., H. DOC. NO. 8, REVIEW OF THE INVOLUNTARY COMMITMENT PROCESS 23 (1994), available at <http://jlarc.virginia.gov/reports/Rpt164.pdf>.

132. *Id.*

133. *Id.* at 36.

134. *What to Do in a Psychiatric Crisis in Indiana*, NAT'L ALLIANCE ON MENTAL ILLNESS: IND. 11 (Jan. 2011), http://www.nami.org/Content/Microsites169/NAMI_Indiana/Home156/Crisis_Booklet1/Crisis%20BookletConvertedREv.pdf.

135. *Id.*

136. See SAMHSA 2009, *supra* note 17, at 9.

137. *Id.* at 23.

138. Steven P. Segal, *Civil Commitment Law, Mental Health Services, and U.S. Homicide Rates*, 47 SOC. PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY 1449 (2012).

139. See *id.* at 1454-55.

140. *Id.* at 1455.

through Medicaid or in the budget for state mental health systems. Nationwide, more than \$1.6 billion was cut from state mental health budgets between 2009 and 2012.¹⁴¹

It is important for states to realize that one way or the other, they will be funding the care of the mentally ill.¹⁴² Providing more affordable preventive care creates savings by lowering the number of commitments resulting from acute psychiatric episodes.¹⁴³ If preventative care is provided, the state will then have more resources to devote to quality care and treatment when an individual decompensates and requires commitment.

The state faces several burdens in its administration of the involuntary civil commitment process. The process is long and exacting, as it must be to protect the individual's due process rights. Additionally, the process is expensive, and those it commits often cannot pay for the services required, placing a large financial burden on the state, especially during an economic downturn.

E. The Mentally Ill

One of the greatest challenges to the mentally ill is the narrow definition of mental illness embraced by the law, which excludes individuals who could benefit from treatment and often resort to self-medication with drugs and alcohol and criminal behavior to fund their dependencies.¹⁴⁴ Psychiatric professionals treating the mentally ill go to great lengths to accurately define and diagnose the type of mental illness affecting an individual. The law, on the other hand, is concerned with the effects mental illness has on the individual's behavior.¹⁴⁵ Statutory definitions of mental illness are created to apply in the context of a commitment hearing but do not function to provide a specific or detailed diagnosis.¹⁴⁶ Ohio's statute is once again representative of the definition embraced by the majority of states. There is no concern for what mental illness the individual has or how that diagnosis may make the situation unique. The way that the mental illness affects the individual is what is important.¹⁴⁷

State statutes are written to embrace the state's role of protecting the public rather than the state's role of providing care to those who cannot care for

141. *State Mental Health Cuts: The Continuing Crisis*, *supra* note 16, at 1.

142. Olukunle Fadipe, Note, *Affordable Mental Health Care in the Post Healthcare Reform Era*, 57 WAYNE L. REV. 575, 594 (2011).

143. *See id.*

144. *See* Georgia Lee Sims, Note, *The Criminalization of Mental Illness: How Theoretical Failures Create Real Problems in the Criminal Justice System*, 62 VAND. L. REV. 1053, 1056-57, 1058 (2009).

145. *See* RALPH SLOVENKO, PSYCHIATRY IN LAW/LAW IN PSYCHIATRY 196 (2d ed. 2009).

146. Sims, *supra* note 144, at 1057.

147. OHIO REV. CODE ANN. § 5122.01(A) (West, Westlaw through Files 1 to 94 and Statewide Issue 1 of the 130th Gen. Assemb.) (“‘Mental illness’ means a substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life.”).

themselves.¹⁴⁸ The definition is cribbed from criminal proceedings, providing the standard that must be met in order for a person to be deemed not guilty by mental disease or defect, though the aims of the two systems are functionally different.¹⁴⁹ The civil process purports to advocate treatment, while the criminal process is properly punitive. The result is that mentally ill individuals are left alone until such a time that their mental illness causes behavior that satisfies the statutory definition promulgated by the state and they demonstrate that they are dangerous and can be dealt with through the commitment process.

Another issue for mentally ill individuals is the stigma associated with civil commitment proceedings. Due to the deprivation of liberty and other similarities to a criminal proceeding, the process carries with it stigma and embarrassment. Civil commitment calls for a long adjudicatory process that can involve the individual's friends and family being asked to testify as to their capacity to live independently, and the disposition at the end can feel criminal in nature, as the individual's liberty continues to be restricted.¹⁵⁰ Additionally, the adversarial nature of the proceedings can create distrust between the mentally ill person and the physicians and family members acting in the best interest of the mentally ill person.¹⁵¹ Ultimately, in order to be committed, the mentally ill person must be declared "dangerous," a stigma more serious and damaging than being diagnosed with mental illness.¹⁵² Often this stigma affects the ability of the mentally ill to obtain housing, perpetuating the connection between mental illness and homelessness.¹⁵³

Almost nine percent of adults with an unmet need for mental healthcare in 2009 cited a fear of being civilly committed as the reason for their choice not to seek care, and another nine percent were concerned by the stigma that would result just from obtaining treatment.¹⁵⁴ The civil commitment process carries with it a debilitating stigma from the standpoint of the mentally ill person. Mentally ill persons can see the transparency and thoroughness built into the process by the state to protect due process rights as attaching to their person a stigma worse than mental illness itself. The statute itself requires the state to demonstrate that the person is mentally ill, unable to care for themselves, and dangerous.¹⁵⁵

148. See SLOVENKO, *supra* note 145, at 433-34.

149. *Id.* at 434.

150. *See id.* at 439-40.

151. Henry Chen, Note, *The Mediation Approach: Representing Clients with Mental Illness in Civil Commitment Proceedings*, 19 GEO. J. LEGAL ETHICS 599, 609 (2006).

152. *Id.*

153. Amanda Clark, Comment, *The Patient Protection and Affordable Care Act and Efforts of the Mentally Ill to Achieve Equal and Adequate Health Coverage*, 88 U. DET. MERCY L. REV. 357, 361-62 (2010).

154. *See* SAMHSA 2009, *supra* note 17, at 24.

155. *See* FAILER, *supra* note 22, at 92-106. Failer posits that the state's narrative is two fold. First, the state paints a picture of the mentally ill person as one or several of four archetypes of mental illness—economically deficient, a bad family member, a non-survivor, or sufferer. Second, the state must characterize the individual as either an imminent danger or a danger waiting to happen.

For a time, this stigma was combated by asking mentally ill persons to sign into treatment voluntarily as an alternative to proceeding through the civil commitment affidavit process.¹⁵⁶ This allowed the individual to undergo treatment and avoid a court proceeding, but with the threat of civil commitment looming, voluntary commitment was often coercive.¹⁵⁷ This alternative fell out of favor when the Supreme Court recognized that voluntarily admitting a person who lacks the capacity to consent due to mental illness provides grounds for the individual to file a Section 1983 action.¹⁵⁸ Because the same end can be reached through involuntary commitment to an inpatient or outpatient setting, states use this voluntary alternative much more sparingly now to avoid the risk of such claims.¹⁵⁹ Interestingly, the United Kingdom heard a factually similar case and decided that concerns of capacity to consent to treatment are not present when a mentally ill person agrees to what it calls “informal admission.”¹⁶⁰ This deals with stigma by allowing the patient to avoid public court records, but does so at the expense of valuable and fundamental due process rights.¹⁶¹

States often provide themselves with legislative protection from suits like that in *O'Connor*. When an individual seeks recompense for a state action that deprives them of liberty, as in involuntary commitment, they file suit under 42 U.S.C. § 1983. State action is not achieved when a physician submits an affidavit to law enforcement or a magistrate in support of an involuntary commitment, because filing the affidavit does not make the doctor a state actor.¹⁶² County attorneys who initiate civil commitment proceedings on the county’s behalf are immune under Section 1983 because they are proceeding according to their statutory duty.¹⁶³ Finally, a psychiatrist acting on behalf of the state is immune to claims under Section 1983, so long as he acted in a way that is objectively reasonable when viewed in light of the practices of other psychiatric professionals.¹⁶⁴

The unavailability of monetary penalties for the behavior of these individuals can embolden these actors to push the boundaries of acceptability during hearings. It is common for county attorneys to fashion a rebuttal specifically intended to induce the mentally ill person to speak about past documented delusions or violent incidents not pertinent to the hearing at hand.¹⁶⁵ The questions asked by the district attorney often incite answers at

156. SLOVENKO, *supra* note 145, at 434.

157. *Id.*

158. *Zinermon v. Burch*, 494 U.S. 113, 137-38 (1990).

159. *See* SLOVENKO, *supra* note 145, at 434-35.

160. Lawrence O. Gostin & Lance Gable, *The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health*, 63 MD. L. REV. 20, 60 (2004).

161. *See id.* at 59-60.

162. *Scott v. Hern*, 216 F.3d 897, 907 (10th Cir. 2000).

163. *Scott*, 216 F.3d at 908-09.

164. *See id.* at 910.

165. HOLSTEIN, *supra* note 22, at 82-83 (summarizing representative commitment hearings to illustrate hallmarks of the process).

odds with the testimony offered by the psychologist in order to serve as evidence of obvious examples of a dangerous and incompetent individual.¹⁶⁶ While this behavior is not a violation of rights per se, it skirts the edge and can to some extent mislead the fact finder in a finding of incompetence and dangerousness.¹⁶⁷

Outpatient treatment is often the carrot used to convince a person to commit him or herself, sparing the state of thorny due process issues. The practice has both supporters and detractors. As a less restrictive alternative to traditional inpatient involuntary commitment, outpatient treatment is almost certainly constitutional under *O'Connor* and is an attractive alternative for states in treating people who do not fit the imminent dangerousness standard.¹⁶⁸ Outpatient commitment shares many features with inpatient commitment but explicitly eschews the requirement that individuals reside in the treatment facility, allowing them to continue to live in the community.¹⁶⁹ Proponents of outpatient commitment cite evidence that outpatient treatment, whether voluntary or involuntary, is positively correlated with a reduced rate of victimization following release,¹⁷⁰ a reduced rate of refusal to accept medicine,¹⁷¹ and a reduction of inpatient admissions following release.¹⁷² Detractors claim that individuals who are allowed to decline treatments and to participate in their own treatments assertively and actively will have more

166. HOLSTEIN, *supra* note 22, at 82-83.

167. *Id.* at 111 (“[I]n the course of eliciting this testimony, DAs ask relatively general questions . . . and respond minimally so as to invite continuation by the witnesses. Patients’ talk is seldom overlapped. New topics are repeatedly offered, crazy talk is marked off for special attention, and these noteworthy lines of talk are encouraged. Some of patients’ hearably incompetent or incoherent speech, then, is not merely of their own individual doing. Their testimony—their very talk—is produced *in concert* with their questioners. . . . [Furthermore], DAs’ cross-examination procedures deeply implicate [patients] in the production of perceivedly incompetent talk.”).

168. Jeffrey L. Geller & Jonathan A. Stanley, *Settling the Doubts About the Constitutionality of Outpatient Commitment*, 31 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 127, 131-38 (2005).

169. Michael Allen & Vicki Fox Smith, *Opening Pandora’s Box: The Practical and Legal Dangers of Involuntary Outpatient Commitment*, 52 PSYCHIATRIC SERVS. 342, 342 (2001).

Outpatient commitment is a mechanism used to compel a person with mental illness to comply with psychotropic drug and treatment orders as a condition of living in the community. If prescribed in a treatment plan, outpatient commitment may require that a person participate in full-day treatment programs, undergo urine and blood tests, frequently attend meetings of addiction self-help groups, enter psychotherapy with a particular therapist, or reside in a supervised living situation. In many states, orders may be extended for prolonged periods, without clear criteria for ending the order.

Id. (footnotes omitted).

170. Virginia Aldigé Hiday et al., *Impact of Outpatient Commitment on Victimization of People With Severe Mental Illness*, 159 AM. J. PSYCHIATRY 1403, 1409 (2002).

171. Virginia Aldigé Hiday & Teresa L. Scheid-Cook, *The North Carolina Experience with Outpatient Commitment: A Critical Appraisal*, 10 INT’L J.L. & PSYCHIATRY 215, 227, 229 (1987).

172. Guido Zanni & Leslie deVeau, *Inpatient Stays Before and After Outpatient Commitment*, 37 HOSP. & CMTY. PSYCHIATRY 941, 942 (1986).

success after a court order runs its course.¹⁷³ Outpatient programs are not uniformly available due to treatment strategies and funding availability but provide a good illustration of a less restrictive alternative to traditional commitment.

In *O'Connor*, Chief Justice Burger's concurrence was skeptical of the idea that treatment would be an adequate justification for commitment, arguing that treatment rendered does not provide "adequate 'compensation'" for the deprivation of due process and freedom.¹⁷⁴ According to the Supreme Court, the right to refuse treatment is a constitutionally protected liberty right enjoyed by all competent adults as stated in *Cruzan v. Missouri Department of Health*.¹⁷⁵ Additionally, every state has a statute recognizing the right to refuse medical treatment.¹⁷⁶ Therefore, the mentally ill also enjoy this right and states must take additional steps in order to forcibly medicate committed individuals.

Competence is an issue wholly separate from dangerousness in that a person requiring involuntary commitment may not be forced to take medication if commitment alone is enough to lessen the dangerousness to self or others.¹⁷⁷ In fact, courts have regarded forced medication as more restrictive than forced hospitalization.¹⁷⁸ With the exception of Utah, every state recognizes the right of an involuntarily committed individual to contest involuntary treatment separate from the decision to commit that person, through an additional judicial proceeding.¹⁷⁹ In order to refuse treatment involving psychotropic medication in many states, a patient need not demonstrate actual understanding, but rather the capacity to understand the advantages, disadvantages, and alternatives for treatment.¹⁸⁰

The law provides incompetent patients with protection from unwanted treatment in the form of the substituted judgment standard.¹⁸¹ In *In re Guardianship of Richard Roe, III*, the Supreme Judicial Court of Massachusetts ruled that when an incompetent patient refuses treatment, the parties responsible for the protection of that individual must seek a judicial determination of substituted judgment.¹⁸² It is important to note that this

173. Allen & Smith, *supra* note 169, at 344.

174. *O'Connor v. Donaldson*, 422 U.S. 563, 587 (1975) (Burger, C.J., concurring).

175. 497 U.S. 261, 278 (1990) ("The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions.").

176. Dora W. Klein, *Autonomy and Acute Psychosis: When Choices Collide*, 15 VA. J. SOC. POL'Y & L. 355, 377-78 (2008).

177. *See id.* at 377.

178. *Id.* at 376-77.

179. Jennifer Fischer, *A Comparative Look at the Right to Refuse Treatment for Involuntarily Hospitalized Persons with a Mental Illness*, 29 HASTINGS INT'L & COMP. L. REV. 153, 166-67 (2006). Utah requires the court first determine a mentally ill person's lack of capacity (to make treatment decisions) during the commitment hearing before the state can involuntarily hospitalize them. *Id.* at 167. This obviates the need for a separate hearing later. *Id.*

180. *See Klein, supra* note 176, at 378-79.

181. *Id.* at 379-80.

182. *In re Guardianship of Roe, III*, 421 N.E.2d 40, 51-52 (Mass. 1981).

standard applies to mentally ill and incompetent persons who are not involuntarily hospitalized.¹⁸³

In order to forcibly medicate a mentally ill person by substituted judgment, it must be shown by a preponderance of the evidence that, if competent, the individual most likely would have chosen that course of treatment.¹⁸⁴ A substituted judgment decision should be made by a court “(1) where a judicial substituted judgment determination indicates that the incompetent individual would, if competent, accept antipsychotic drugs, or (2) where there exists a State interest of sufficient magnitude to override the individual's right to refuse.”¹⁸⁵ In analyzing what the patient would want, the court applies the individual's values and preferences¹⁸⁶ to issues pertaining to the specific treatment.¹⁸⁷ In the case of the mentally ill, a considerable amount of attention is paid to side effects, as psychotropic drugs often have rather severe side effects that inform the decisions of the mentally ill regarding treatment.¹⁸⁸

Historically, horrible side effects have been a prominent feature of psychotropic and anti-psychotic medications that physicians prescribed to the involuntarily committed.¹⁸⁹ Prior to the advent of antipsychotic drugs in the 1950s, patients would often spend substantial portions of their lives in “large, often remote psychiatric hospitals. . . in horrifying, wretched conditions.”¹⁹⁰ When antipsychotic medications debuted in the 1950s, they brought with them great benefits and symbolized the greatest advancement in the treatment of psychotic conditions ever known.¹⁹¹ The drugs did not have the desired effect in all patients, often coming with side effects such as stiffness, diminished facial expression, tremors, restlessness, and delayed abnormal movement, which caused up to forty percent of patients to refuse to continue taking the drugs.¹⁹² Often, cases involving the right to refuse treatment and involuntary commitment would focus on the debilitating side effects that came along with psychotropic drugs.¹⁹³

183. *Roe*, 421 N.E.2d at 61. A committed person may be forcibly medicated only if the commitment does not function to diminish the danger to the person or others. Klein, *supra* note 176, at 377.

184. *See Roe*, 421 N.E.2d at 46, 51-52.

185. *Id.* at 61.

186. *Id.* at 52.

187. *Id.* at 57 (providing the following factors: “(1) the ward's expressed preferences regarding treatment; (2) his religious beliefs; (3) the impact upon the ward's family; (4) the probability of adverse side effects; (5) the consequences if treatment is refused; and (6) the prognosis with treatment[.]”).

188. *See id.* at 53-54.

189. Douglas Mossman, *Unbuckling the "Chemical Straitjacket": The Legal Significance of Recent Advances in the Pharmacological Treatment of Psychosis*, 39 SAN DIEGO L. REV. 1033, 1039-40 (2002).

190. *Id.* at 1064 (footnotes omitted).

191. *Id.* at 1065 n.159.

192. *Id.* at 1068-69.

193. Fischer, *supra* note 179, at 162; Mossman, *supra* note 189, at 1126-27 (footnotes omitted) (“[S]ome legal scholars and patient advocates, while acknowledging, sometimes only in passing, that antipsychotic medication is effective, have emphasized that antipsychotic drugs can

Since 1990, psychiatrists have had access to a new breed of antipsychotic drugs, which show increased capacity to combat the symptoms of psychiatric diseases while exhibiting a lower frequency of side effects than older drugs.¹⁹⁴ Courts have not yet re-evaluated the right to refuse treatment with antipsychotic drugs since the advent of these drugs.¹⁹⁵ Courts' previous reliance on side effects in decisions indicate that new drugs may potentially make them more supportive of involuntary treatment as side effects become less debilitating and serious.¹⁹⁶ In *Roe*, the Supreme Judicial Court of Massachusetts recognized that involuntary treatment jurisprudence could be reconsidered if advances were made that eliminated side effects.¹⁹⁷

It is not clear whether side effects have decreased enough to make treatment an adequate trade off with involuntary commitment in response to Justice Burger's concurrence in *O'Connor*.¹⁹⁸ State courts have noted with approval the reduced frequency of side effects exhibited by patients treated with newer drugs.¹⁹⁹ Recent advancements are encouraging and should encourage courts to re-evaluate the way in which they decide cases involving the refusal of treatment and recognize the value of antipsychotic drugs to patients, even when receiving them involuntarily.²⁰⁰

F. Private Healthcare Providers

Though involuntary civil commitment is a process administered by states using state funds, private healthcare providers can be licensed to provide mental health services on a state's behalf. As was noted in the discussion of the process for commitment, when emergency commitments occur, individuals are often first transported to private hospitals before their transfer

cause serious side effects and that unwanted administration of medications automatically raises a host of legal issues.”).

194. See Mossman, *supra* note 189, at 1070.

195. See Fischer, *supra* note 179, at 162.

196. *Id.*; Mossman, *supra* note 189, at 1128.

197. In re Guardianship of Roe, III, 421 N.E.2d 40, 54 n.12 (Mass. 1981) (“We admit the possibility and express the hope that future medical advances may produce antipsychotic drugs free from the severe adverse side effects we have described above. At the same time, it must be noted that the intended effect of the medication—to alter mental processes—by definition cannot be eliminated from those drugs we have described as ‘antipsychotic.’ Nevertheless, we do not foreclose reconsideration of these issues when and if it can be shown that the characteristics of antipsychotic drugs have changed.”).

198. In *Riggins v. Nevada*, 504 U.S. 127 (1992), Justice Kennedy addressed the side effects of antipsychotic medications in a criminal context in his concurring opinion. Justice Kennedy's concurrence opined that mentally ill criminal defendants could not be forced to take antipsychotic medications during trial to ensure continued competence absent an “extraordinary showing by the State . . .” *Id.* at 139 (Kennedy, J., concurring). Justice Kennedy further stated that “[t]he state of our knowledge of antipsychotic drugs and their side effects is evolving and may one day produce effective drugs that have only minimal side effects.” *Id.* at 145 (Kennedy, J., concurring).

199. Mossman, *supra* note 189, at 1141-48 (discussing District of Columbia, Minnesota, and New York appellate cases).

200. *Id.* at 1156.

to a state facility. Emergency rooms, as the first place many people go to receive healthcare, have been inundated with emergency commitments during the recession due to a lack of state funding and the shortcomings of the dangerousness standard.²⁰¹

A lack of inpatient mental health beds at qualified facilities forces emergency rooms to house mentally ill patients for an inordinate amount of time prior to transfer.²⁰² Eighty-six percent of hospital administrators surveyed answered that they are, at the least, sometimes unable to transfer these patients in a timely manner.²⁰³ The average time to transfer the patients to qualified facilities vacillated between twenty-four hours to over one week in some areas, which ER administrators feel compromises their ability to care for other patients in the ER.²⁰⁴

Administrators cited cuts in funding to state mental health programs and Medicaid cuts as causing an inability for patients to receive medicine and a corresponding increase in acute mental health conditions manifesting themselves in dangerous behavior.²⁰⁵ As a result, both private caregivers and other members of the community who utilize emergency room services are negatively affected. North Carolina has come up with a unique solution to the problem, forging a partnership between the state, local mental health management providers, and private providers to purchase bed space in local hospitals to board patients who are experiencing a mental health crisis.²⁰⁶

Private healthcare providers, state actors, and the mentally ill share some of the same problems—lack of funding and a lack of communication between constituents of the same system. Each could benefit from an overhaul of the system as it now exists which can save money and increase positive outcomes.

III. PROPOSED SOLUTIONS

The problems with the system as it exists currently are persistent and pervasive. They are national problems that are often being dealt with differently on a state-by-state basis. States have different interpretations of the dangerousness standard, different levels of funding earmarked for mental health, and differing views on when state intervention is appropriate. The flaws in this system are more apparent during an economic recession. The time has come to fix an ailing system.

The Supreme Court has demonstrated a reluctance to change the dangerousness standard since deciding *O'Connor* in 1975. Because involuntary

201. Lee Romney, *Task force seeks changes to 1967 mental illness law*, L.A. TIMES, Apr. 9, 2012, at AA.3.

202. *See Emergency Department Challenges and Trends*, *supra* note 62, at 5.

203. *Id.*

204. *See id.*

205. *See id.* at 15.

206. Press Release, N.C. Ctr. Pub. Policy Research, Center For Public Policy Research Assesses Three Key Components Of State's Mental Health Reform Strategy (Mar. 10, 2011), available at <http://www.nccppr.org/drupal/content/news/2011/03/10/4074/center-for-public-policy-research-assesses-three-key-components-of-stat>.

commitment implicates the *parens patriae* power of the states, the proper venue for change is in state legislatures. However, state legislatures have been grappling with the problem for years, achieving only middling results and at huge expense. State legislatures would accept guidance if it would lead to better care for the mentally ill and fiscal savings.

Groups like the American Law Institute and the American Bar Association are uniquely situated to provide states with the guidance needed to effect meaningful changes to the current system. The promulgation of the Model Penal Code and the Model Rules of Professional Conduct demonstrate that these groups have undertaken such a challenge before and had the results of their efforts adopted and ratified by the majority of states. They have the resources and ability to combine the experience and knowledge of experts in psychiatry, law enforcement, private and state healthcare providers, as well as lawyers and judges familiar with the process into a framework that is treatment focused, cost-effective, and allows state intervention at an earlier juncture. This bypasses the political fight that would likely ensue if the federal government attempted to create guidelines to replace or supersede state laws.

Willing participants could be found in mental health advocacy groups. The National Alliance for Mental Illness (“NAMI”) adopted a policy on involuntary treatment in 1995 that addresses many of the issues inherent in the current system.²⁰⁷ Their policy provides a plausible framework through which one can visualize how model rules of civil commitment may look.

According to NAMI, the expansion of community treatment options is extremely important.²⁰⁸ Community treatment options have been shown to lessen the need for involuntary treatment by providing reduced cost care to mentally ill populations, which in turn lessens the number of acute and emergency incidents that lead to involuntary commitments.²⁰⁹ These programs should exist in order to lower the burden on the state to preside over commitment proceedings and to help mentally ill individuals maximize their chances of leading productive lives.

The Patient Protection and Affordable Care Act directly addresses this need.²¹⁰ Section 4001 of the law establishes the National Prevention, Health Promotion and Public Health Council, a function of which is to promote and fund community based health programs throughout the country that are aimed at improving preventative care at the individual and community levels.²¹¹ The legislation also provides federal funding through grants for entities that seek to improve healthy living in a community, specifically mentioning mental health.²¹² The legislation additionally advocates increasing access to Medicaid for eligible adults and notes that this can be used to reduce the effect of

207. *See Involuntary Commitment And Court-Ordered Treatment*, *supra* note 15.

208. *See id.*

209. SLOVENKO, *supra* note 145, at 440.

210. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, (2010) (codified in scattered sections of 42 U.S.C.).

211. *See id.* at § 4001(d)(4).

212. *See id.* at § 4202(a)(3)(B)(ii).

mental disability and allow individuals to function at their highest possible level.²¹³ In addition to the improved community health options, Title I of the law designates mental health services as an essential health benefit, which must be covered by many private insurers.²¹⁴

Private health insurance and publicly funded programs like Medicare and Medicaid should cover the cost of involuntary commitment or court ordered treatment. PPACA makes it illegal for insurers to deny an individual coverage based on preexisting conditions, which is a good start.²¹⁵ This has the potential to allow more people with mental illness to receive the treatment they need without running up bills from which they can never escape. However, it is unacceptable to continue to treat mental illness differently than other diseases and reimburse for treatment at a lower rate or to put lifetime caps on the amount of treatment that will be covered. PPACA addresses this problem by establishing essential elements that must be a part of plans, but several classes of insurance are grandfathered in or exempted, meaning that 133 million Americans²¹⁶ still have inadequate coverage to allow them to receive mental health treatment.²¹⁷ Congress should pass legislation to make grandfathered healthcare plans meet the requirements imposed on other healthcare providers, including that of offering coverage for mental health and substance abuse treatment.²¹⁸ This will cause people to be able to continue preventative treatment, avoid the cost and trauma of being committed, or to continue treatment after the term of their commitment ends, reducing total healthcare costs.²¹⁹ "Increased access and utilization of mental health and substance use disorder benefits could result in a reduction of medical/surgical costs for individuals afflicted with mental health conditions and substance use disorders."²²⁰

One of the most potentially damaging trends to mental health, and also one of the most fixable, is the concept of states opting out of Medicaid as a political response to PPACA. PPACA allows states to expand Medicaid

213. Patient Protection and Affordable Care Act, § 4106(a)(13)(C).

214. *Id.* at § 1302(b)(1)(E).

215. *Id.* at § 1331(c)(2)(B).

216. *Fact Sheet: Keeping the Health Plan You Have: The Affordable Care Act and "Grandfathered" Health Plans*, HEALTHREFORM.GOV, https://web.archive.org/web/20130716130510/http://www.healthreform.gov/newsroom/keeping_the_health_plan_you_have.html (last visited May 26, 2014) (accessed by entering the search term "keeping the plan you have healthreform.gov" into the Google search engine).

217. *See* Tovino, *supra* note 79, at 9 (noting that some small group health plans continue to be exempt from the federal mental health parity law).

218. *Id.* at 50 ("A health insurance issuer that offers health insurance coverage in the individual, small group, or large group market shall ensure that such coverage includes the essential health benefits package.").

219. Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. 5410, 5424 (Feb. 2, 2010) (to be codified at 45 C.F.R. pt. 146).

220. *Id.*

coverage to individuals whose household income is 138%²²¹ of the federal poverty level—an expansion that will be covered entirely by federal government for the first three years and never drop below 90% of federal coverage.²²² However, as of March 2014, twenty-one states have declared they are not expanding Medicaid at this time,²²³ which could force a large population of Americans, including the mentally ill, to decide between paying out of pocket for treatment or going without.²²⁴ While these governors may see opting out as a means to reform Medicaid, the reality is that it serves to threaten the finances and health of those states' constituents.²²⁵ When it comes to the mentally ill who rely on Medicaid to pay for their treatment, opting out may result in more acute psychiatric episodes and more commitments of dangerous individuals who did not need to reach that point.²²⁶

As community treatment becomes more efficient and prevalent, the mentally ill population will receive better care and suffer fewer acute episodes. States will save money through funding fewer civil commitment proceedings. Private caregivers will be relieved of the burden of housing such a large number of mentally ill individuals awaiting transfer to other facilities. Research shows that untreated mental illness corresponds to higher total healthcare costs, while increased treatment of mental illness corresponds with lower total healthcare costs.²²⁷ Broader standards for involuntary commitment offer an avenue to provide that treatment earlier, thereby reducing costs to the system. They also take advantage of recent advances in the treatment of severe mental illness and the reductions of the corresponding side effects.²²⁸

NAMI advocates the adoption of broader standards for involuntary commitment.²²⁹ The standard NAMI envisions would allow earlier state

221. Austin B. Frakt & Aaron E. Carroll, *Sound Policy Trumps Politics: States Should Expand Medicaid*, 38 J. HEALTH POL. POL'Y & L. 165, 166 (2013).

222. See *Daily Briefing primer: ACA's Medicaid expansion*, ADVISORY BD. CO. (May 3, 2013), <http://www.advisory.com/Daily-Briefing/Resources/Primers/Medicaid-expansion>.

223. *Where the states stand on Medicaid expansion*, ADVISORY BD. CO. (Mar. 28, 2014), <http://www.advisory.com/daily-briefing/resources/primers/medicaidmap>.

224. See Frakt & Carroll, *supra* note 221, at 165-66.

225. *Id.* at 175.

226. See Tovino, *supra* note 79, at 13-14 (describing a scenario in which a mentally ill individual reaches a coverage ceiling or lacks coverage entirely and decompensates to require inpatient treatment).

227. *Id.* at 2.

228. See Mossman, *supra* note 189, at 1070.

229. *Involuntary Commitment And Court-Ordered Treatment*, *supra* note 15, at para. 5-7:

States should adopt broader, more flexible standards that would provide for involuntary commitment and/or court-ordered treatment when an individual:

- (A). Is gravely disabled, which means that the person is substantially unable, except for reasons of indigence, to provide for any of his or her basic needs, such as food, clothing, shelter, health or safety, or
- (B). Is likely to substantially deteriorate if not provided with timely treatment, or
- (C). Lacks capacity, which means that as a result of the brain disorder the person is unable to fully understand or lacks judgment to make an informed decision

intervention, which would prevent individuals from deteriorating to the point where they are likely to cause harm to themselves or others. States with strong community health programs as well as broader standards for involuntary commitment experienced markedly lower homicide rates than those with stricter standards.²³⁰ States should also be allowed to take past history into consideration when determining the appropriateness of commitment, as it is dependable, as well as a method embraced by medical professionals to make determinations and predictions about an individual's best future course of treatment.²³¹

The dangerousness standard must be broadened if it is to be used in the future. A state like Ohio interprets dangerousness to mean imminently dangerous.²³² Other states, like Iowa, observe a very broad standard in which dangerousness can include the mere potential to inflict emotional damage on the person's family or others.²³³ NAMI advocates a move toward a broader standard that does away with the idea of imminent dangerousness, as it allows individuals to deteriorate unnecessarily before the state can intervene.²³⁴ Combined with an increased emphasis on community treatment alternatives, a broader standard fulfills the dual function of improving treatment and making civil commitment look less punitive and more like an action taken by the state in the best interest of the individual. Some researchers have advocated doing away with the dangerousness standard altogether because it can make treatment of psychosis more difficult;²³⁵ this view goes too far, creating a risk that too many mentally ill are subjected to involuntary commitment and involuntary treatment. A broader dangerousness standard provides protection against unwarranted detention and unwanted treatment while allowing more individuals in need to get help through the state's *parens patriae* powers than do under the narrower standard.

Wisconsin's standard most closely mirrors NAMI's vision. It allows the state to take action in the event that a person can no longer meet their basic needs without assistance.²³⁶ Wisconsin believes this to be a more socially

regarding his or her need for treatment, care or supervision.

230. Segal, *supra* note 138, at 1449.

231. *Involuntary Commitment And Court-Ordered Treatment*, *supra* note 15, at para. 7.

232. OHIO REV. CODE ANN. § 5122.01(B)(4) (West, Westlaw through Files 1 to 94 and Statewide Issue 1 of the 130th Gen. Assemb.).

233. IOWA CODE § 229.1(17)(b) (West, Westlaw through immediately effective legislation signed as of April 25, 2014 from the 2014 Reg. Sess.).

234. *Involuntary Commitment And Court-Ordered Treatment*, *supra* note 15, para. 6.

235. Matthew M. Large et al., *Mental Health Laws that Require Dangerousness for Involuntary Admission May Delay the Initial Treatment of Schizophrenia*, 43 SOC. PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY 251, 252 (2008).

236. *See* WIS. STAT. § 51.20(2)(e) (2012):

For an individual, other than an individual who is alleged to be drug dependent or developmentally disabled, after the advantages and disadvantages of and alternatives to accepting a particular medication or treatment have been explained to him or her and because of mental illness, evidences either incapability of expressing an understanding of

conscious alternative to the traditional dangerous standard, better meeting the needs of both its mentally ill citizens and relieving the burden on the state apparatus.²³⁷ The focus of the state can shift to providing good psychiatric care instead of employing its police power to deal with dangerous mentally ill citizens.²³⁸ This standard aligns itself with NAMI's proposal, and other states seeking reform should closely monitor the outcomes from Wisconsin's efforts. The Supreme Court of Wisconsin upheld its standard in *In re the Commitment of Dennis H.*, noting that Wisconsin's standard does not dispense with the standard of dangerousness mandated by *O'Connor*, but rather reinterprets it in order to provide substantive care to the mentally ill as well as protecting the community.²³⁹ In doing so, the Wisconsin Supreme Court acknowledged the good that can be achieved by involuntary commitment in an era of more effective and insightful treatment, and gave credence to broader legislative determinations of the meaning of dangerousness.²⁴⁰

Updating the dangerousness standard will not change the fact that the first point of contact between a mentally ill person and the involuntary civil commitment process will be the police. Law enforcement officials need to undergo more extensive training in relation to interactions with the mentally ill population and the appropriateness of emergency commitments in different situations.²⁴¹ This is especially important in a recession, as law enforcement is often the first point of contact with an individual who may require emergency intervention. It is important that they be able to make informed decisions.

the advantages and disadvantages of accepting medication or treatment and the alternatives, or substantial incapability of applying an understanding of the advantages, disadvantages, and alternatives to his or her mental illness in order to make an informed choice as to whether to accept or refuse medication or treatment; and evidences a 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. The probability of suffering severe mental, emotional, or physical harm is not substantial under this subd. 2. e. if reasonable provision for the individual's care or treatment is available in the community and there is a reasonable probability that the individual will avail himself or herself of these services or if the individual may be provided protective placement or protective services under ch. 55. Food, shelter, or other care that is provided to an individual who is substantially incapable of obtaining food, shelter, or other care for himself or herself by any person other than a treatment facility does not constitute reasonable provision for the individual's care or treatment in the community under this subd. 2. e. The individual's status as a minor does not automatically establish a substantial probability of suffering severe mental, emotional, or physical harm under this subd. 2. e.

237. See Erickson, *supra* note 61, at 362.

238. *Id.* at 385.

239. See *In re Commitment of Dennis H.*, 647 N.W.2d 851, 864 (Wis. 2002); Erickson, *supra* note 61, at 363.

240. See Erickson, *supra* note 61, 375-76.

241. *Involuntary Commitment And Court-Ordered Treatment*, *supra* note 15, at para. 12.

These changes are not the only ones that can be made to fix involuntary commitment, but they demonstrate the way in which creative problem solving across disciplines can improve both the process and the results achieved. The resources and expertise available to ALI and ABA make it likely that even more insightful and effective ideas can be employed to improve the situation for the mentally ill, the states, and private healthcare providers.

IV. CONCLUSION

Involuntary civil commitment is employed nationwide as a method by which states attempt to both protect the public and to provide much needed treatment to people suffering from serious, and often untreated mental illnesses. However, states have been struggling to interpret and apply the dangerousness standard promulgated by the Supreme Court in *O'Connor v. Donaldson* almost forty years ago.

This standard has often been applied very narrowly and in a manner that allows mentally ill people to deteriorate needlessly. In the cases of Jared Lee Loughner and James Holmes, it seems that changing the standard could have prevented a tragedy, but the system would not allow the state to intervene to get them treatment in time to prevent it. The economic recession brought acute cases like this to the forefront, as spending cuts and the termination of community mental health services will result in more acute cases like Loughner's and Holmes's. Additionally, healthcare has become a tool for political brinksmanship, leading to compromises that negatively affect vulnerable populations like the mentally ill while failing to accomplish anything substantive. More tragedies could result if states are not allowed to intervene earlier.

It is imperative that the American Bar Association or the American Law Institute take it upon themselves to fix this growing problem. The resources exist to remedy the deficiencies inherent in the system. The resources and expertise these groups are able to combine can provide a permanent and lasting solution to a pervasive problem. Society owes it both to the general public and to the mentally ill unable to care for themselves to correct the course it has blindly followed since 1975. The economic recession is applying additional pressure and the stakes have never been higher.