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Mental Health Commitment Laws A Survey of the States

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Brian Stettin, Esq.

Policy Director, Treatment Advocacy Center

Jeffrey Geller, M.D.

Professor of Psychiatry

Member of the Board, Treatment Advocacy Center

Kristina Ragosta, Esq.

Director of Advocacy, Treatment Advocacy Center

Kathryn Cohen, Esq.

Legislative and Policy Counsel, Treatment Advocacy Center

Jennay Ghowrwal, MHS

Research and Communications Associate, Treatment Advocacy Center



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The Treatment Advocacy Center is a national nonprofit organization dedicated exclusively to eliminating barriers to the timely and effective treatment of severe mental illness. The organization promotes laws, policies and practices for the delivery of psychiatric care and supports the development of innovative treatments for and research into the causes of severe and persistent psychiatric illnesses, such as schizophrenia and bipolar disorder.

EXECUTIVE SUMMARY

The tragic consequences of ignoring the needs of individuals with the most severe mental illness who are unable or unwilling to seek treatment are on vivid display nationwide: on our city streets, where an estimated quarter million people with untreated psychiatric illness roam homeless; in our jails and prisons, which now house 10 times as many people with severe mental illness than do our psychiatric hospitals; in our suicide and victimization statistics, where individuals with psychotic disorders are grossly overrepresented; and in our local news, which reports daily on violent acts committed by individuals whose families struggled vainly to get them into treatment.

In the U.S., primary responsibility for treatment of this vulnerable and at-risk population falls to state and local governments. The performance of this vital public health function is guided by an array of laws, regulations, policies and budgeting choices, all of which vary markedly from one jurisdiction to the next. As a result, any individual's likelihood of receiving timely and effective treatment for an acute psychiatric crisis or chronic psychiatric disease depends largely on the state and county where he or she happens to be located when such need arises.

For "Mental Health Commitment Laws: A Survey of the States," the Treatment Advocacy Center comprehensively examined the laws each state uses to determine who within its population might qualify to receive involuntary treatment and for what duration and graded each state on two measures of their response to the treatment needs of this small but high-impact population:

- **Quality of involuntary treatment (civil commitment) laws:** the adequacy of its statutory provisions to facilitate emergency hospitalization for evaluation in a psychiatric emergency; commitment to a psychiatric facility for treatment; and/or – in the 45 states where applicable – commitment to the less-restrictive option of a court order to remain in treatment as a condition of living in the community.
- **Use of involuntary treatment laws:** the extent to which the state applies its laws to intervene and provide treatment for psychiatric crisis and/or chronic severe mental illness in the population that meets its civil commitment standard, according to mental health officials within the state

The analysis found the following:

- No state earned a grade of "A" on the use of its civil commitment laws.
- Only 14 states earned a cumulative grade of "B" or better for the quality of their civil commitment laws.
- 17 states earned a cumulative grade of "D" or "F" for the quality of their laws.

- Only 18 states were found to recognize the need for treatment as a basis for civil commitment to a hospital, and several of those were found to have less than ideal standards.
- While 45 states have laws authorizing the use of court-ordered treatment in the community, only 20 of those were found to have optimal eligibility criteria.
- 27 states provide court-ordered hospital treatment only to people at risk of violence or suicide even though most of these states have laws allowing treatment under additional circumstances.
- 12 states rarely or never make use of court-ordered outpatient treatment (often called “assisted outpatient treatment” or “AOT”), including eight states with laws on their books authorizing such treatment.
- 20 states received penalty points for the prevalence of bed waits. In two of the most populous states – Florida and Texas – bed waits were reported to typically exceed two weeks.
- Significant delays in delivering medication over objection were found in only five states, four of them in New England. In Vermont and New Hampshire, the typical delay in providing medication over objection to individuals in psychiatric crisis who were unable to recognize their need for treatment was found to be more than two months.

The deplorable conditions under which more than one million men and women with the most severe mental illness live in America will not end until states universally recognize and implement involuntary commitment as an indispensable tool in promoting recovery among individuals too ill to seek treatment. To that end, the Treatment Advocacy Center recommends:

- Universal adoption of need-for-treatment standards to provide a legally viable means of intervening in psychiatric deterioration prior to the onset of dangerousness or grave disability.
- Enactment of AOT laws by the five states that have not yet passed them – Connecticut, Maryland, Massachusetts, New Mexico and Tennessee.
- Universal adoption of emergency hospitalization standards that create no additional barriers to treatment.
- Provision of sufficient inpatient psychiatric treatment beds for individuals in need of treatment to meet the standard of 50 beds per 100,000 in population.

THE QUALITY OF INVOLUNTARY TREATMENT LAWS

Watching a loved one fall into the grip of severe mental illness can be painful and terrifying in equal measure, as the person's behavior becomes increasingly more bizarre and self-destructive. Long-treasured bonds to family and friends may fall by the wayside. Personal hygiene is often neglected, along with the person's concern for his own basic welfare. Life savings can be rapidly depleted in manic spending sprees. And yet sometimes, to the chagrin and astonishment of those who want to help the ill person find a way back to the life he once had, pleas to seek treatment are met with emphatic insistence that everything is fine. Pressing the matter often only leads to further alienation and hostility. At some point, when things become unbearable for the concerned observer, a call will be made to police or a local mental health facility: "Something is very wrong.... He's not himself.... Can you help?"

It is at this moment the situation becomes not merely a health emergency, but also a legal matter. The caller is asking authorities to override the mentally ill person's constitutional liberty interests, by detaining him against his will for evaluation and/or treatment. Of course, no constitutional right is absolute. As in all things, we rely here on law to strike the right balance between individual rights and societal imperatives.

Which leads to a critical question: what exactly *are* the societal imperatives activated by a psychiatric crisis? One obvious answer is the need to eliminate a substantial risk of imminent death or physical injury. But what if the person is neither threatening violence against anyone nor at any apparent imminent risk of injuring himself? What if the concern spurring the family member to seek help is simply that the person is suffering, tormented by terrifying delusions, yet somehow unaware that he is ill? Do we as a society have reason to intervene?

To answer "yes," we must believe there is a compelling societal imperative *beyond* preventing imminent injury or death – an imperative to liberate a person from a hellish existence he would *never* – in his "right mind" – choose.

This is a major question that states have had to grapple with in crafting their laws on involuntary treatment. And the answer each state reaches has implications far beyond the initial need to detain a person for an emergency evaluation. Laws must also address the circumstances that typically follow a diagnosis of severe mental illness: how long and under what criteria the person should be held under court order for continued inpatient treatment against his wishes ("civil commitment"); whether the state, upon releasing the person from hospital care, should require him to adhere to a prescribed treatment plan ("assisted outpatient treatment"); and how far down the spiral of relapse a person must fall before he is involuntarily re-hospitalized.

Over the last 50 years, this has been a highly turbulent area of the law. Prior to the 1960s, obtaining involuntary treatment was straightforward. Typically, state laws hinged on a simple determination that the person required care and allowed commitments to be continued indefinitely without ongoing judicial oversight.ⁱ The deinstitutionalization movement of the 1960's brought a national trend to reform these laws, shifting the focus to the person's "dangerousness to self or others" as the basis for civil commitment.ⁱⁱ The trend accelerated in

(over)reaction to the 1975 U.S. Supreme Court ruling in *O'Connor v. Donaldson*, which held that “a State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.”ⁱⁱⁱ

Kenneth Donaldson, the individual seeking release in the *O'Connor* case, had been confined for 15 years in a Florida state hospital with no meaningful attempt to offer him treatment for his mental illness symptoms. This absence of treatment was critical to the court’s analysis of the case, and the ruling was carefully limited to address the constitutionality of confinement “without more” – meaning without *treatment*. Justice Stewart, writing for the unanimous court, even went out of his way to point out that “there is no reason now to decide ... whether the State may compulsorily confine a nondangerous, mentally ill individual for the purpose of treatment.”^{iv} The clarification went largely unnoticed as *O'Connor* came to be widely understood as a wholesale repudiation of *all* commitments of non-dangerous individuals.

Compounding this tragedy in the wake of *O'Connor*, there began to take hold within American mental health systems an exceedingly narrow understanding of what it means to be “dangerous to self.” Despite a clear statement to the contrary in the *O'Connor* opinion,^v “dangerous to self” came to be understood to mean that a person was at risk of imminent suicide or intentional self-injury – and nothing else.

In the late 1970s, many psychiatrists, policymakers and academics began looking at the results of deinstitutionalization and wondering if perhaps the pendulum had swung too far. Though community placement had undoubtedly improved the lives of some, a large number of desperately ill people had been abandoned to the streets, “trans-institutionalized” to the penal system^{vi} or consigned to an early grave.

And so began a counter-movement to re-think state laws again, which continues to this day. The goals of this re-examination have been twofold:

- To affirm that there are circumstances other than the imminent risk of violence or suicide that warrant hospital commitment; and
- To minimize the need for such involuntary hospitalizations through the lesser liberty intrusion of court-ordered *outpatient* treatment, where appropriate.

INPATIENT COMMITMENT

At the core of a state’s legal scheme for involuntary treatment are its laws authorizing involuntary hospital admission. These are the laws that empower a court to order a mentally ill person held over his objection for a period of care and treatment in a hospital. At a minimum, these laws must address both the *criteria* for commitment (the legal standard under which the judge decides whether commitment is necessary) and the *process* of commitment (the nuts and bolts of getting the matter before a judge for consideration). Each is essential in ensuring access to care.

Inpatient Criteria

The widespread misunderstanding of the role of “dangerousness” in the civil commitment equation is rooted in two intertwined misconceptions.

The first is the notion that a person must at the time of clinical evaluation or court appearance be a danger to self or others to be committable. As noted in the discussion of *O’Connor* above, the U.S. Supreme Court has never addressed this question in the context of commitment for purposes of treatment. But several state high courts have upheld standards based on a finding that a person will foreseeably *become* dangerous in the near future if allowed to remain untreated in the community.

The second misconception is that “dangerousness” means only one thing: a likelihood to intentionally cause serious physical harm to oneself (i.e., suicide or self-mutilation) or another (i.e., violence). Common sense should tell us that there are ways to be dangerous to self or others without intent to harm anyone. (Justice Stewart tells us, too, in a footnote to his *O’Connor* opinion: “Of course, even if there is no foreseeable risk of self-injury or suicide, a person is literally ‘dangerous to himself’ if for physical or other reasons he is helpless to avoid the hazards of freedom[.]”)

To varying degrees, most states have moved beyond these fallacies in their statutory civil commitment criteria. The more progressive commitment standards come in two basic varieties – known generally as the “grave disability” standard and the “need-for-treatment” standard.

The “grave disability” standard is rooted in the premise that a person may pose a physical threat to himself through inability (other than for reasons of indigence) to provide for the basic necessities of human survival, just as surely as if he were actively trying to harm himself. A grave disability standard opens the door to the hospital commitment of a person whose untreated mental illness has led him to living under a bridge and foraging in dumpsters for food. A good representative is the law of Alaska, which states:

“‘gravely disabled’ means a condition in which a person as a result of mental illness ... is in danger of physical harm arising from such complete neglect of basic needs for food, clothing, shelter, or personal safety as to render serious accident, illness, or death highly probable if care by another is not taken[.]”

The “need-for-treatment” standard opens the hospital gates wider still. The underlying notion here is that deterioration of general health, psychiatric damage and loss of ability to function independently – all of which typically follow when severe mental illness goes untreated – are unacceptable harms per se. Typically, a need-for-treatment standard requires a finding that the person’s mental illness prevents him from seeking help on a voluntary basis and, if not treated, will cause him severe suffering and harm his health. Need-for-treatment laws make commitment available to the person who suffers greatly in the grip of severe mental illness, even if he manages to meet his basic survival needs and exhibits no violent or suicidal tendencies. Arizona offers a prime example of such a standard. Commitment there is available to a person found “persistently and acutely disabled,” defined as follows:

"Persistently or acutely disabled" means a severe mental disorder that meets all the following criteria:

(a) If not treated has a substantial probability of causing the person to suffer or continue to suffer severe and abnormal mental, emotional or physical harm that significantly impairs judgment, reason, behavior or capacity to recognize reality.

(b) Substantially impairs the person's capacity to make an informed decision regarding treatment and this impairment causes the person to be incapable of understanding and expressing an understanding of the advantages and disadvantages of accepting treatment and understanding and expressing an understanding of the alternatives to the particular treatment offered after the advantages, disadvantages and alternatives are explained to that person.

(c) Has a reasonable prospect of being treatable[.]

It must be emphasized that there are great differences in usefulness among states' grave disability and need-for-treatment standards. Under the best of them, like those highlighted above, it is enough that a certain consequence of non-treatment is likely to occur at some point if no action is taken. Under the least useful, people in crisis are not eligible for rescue until impending doom appears to lurk just around the corner.

An example of the less useful variety is Georgia's grave disability standard, which is only available if the person is "so unable to care for [his] own physical health and safety as to create an imminently life-endangering crisis." Standards like these force would-be petitioners for commitment to bide their time until things get worse. Needless to say, it is not always so easy to precisely time a petition for commitment to reach a judge just before the "imminent" loss of life occurs.

It is also important to note that, even in the few states that do not expressly articulate standards beyond a general notion of "danger," a mental health evaluator or judge could reasonably interpret "danger" to encompass grave disability or need for treatment. However, experience has shown that, where state law does not spell out a grave disability and/or a need for treatment standard, law enforcement and crisis workers responding to emergency calls and the prosecutors and judges handling civil commitment cases too often default to the highest possible bar: likelihood of violence or intentional self-harm. Families are routinely told to call again when the individual either hurts someone or tries or threatens to.

Knowing as we do that evidence of imminent risk of violence or suicide is demanded even in some jurisdictions that *have* explicitly broader laws, we harbor no illusions that mental health system dysfunction may be cured legislatively. Nonetheless, there can be little doubt that explicitly broad criteria are a necessary (if not sufficient) condition for sound commitment policies and have important ripple effects. As one example, a 2011 study published in *Social Psychiatry and Psychiatric Epidemiology* found a significant association between broader state commitment standards and lower rates of homicide.^{vii}

Inpatient Process

Flexible criteria for inpatient commitment are of little consequence if the process of petitioning for commitment is unduly burdensome or if being committed does not lead to a sufficient period of treatment to offer the person a reasonable chance to stabilize psychiatrically. While there are many important procedural aspects to a state's hospital commitment law, we focus here on two that are critical.

- **The right of private persons to petition the court for commitment.**
The more broadly this right is extended, the better. We are not advocating here for allowing anyone to be committed on the basis of lay opinion. In all cases, expert testimony of a professional who has recently examined the person is appropriately required for hospital commitment. This is why local mental health authorities or providers are usually the natural parties to petition the court. The problem is that in some cases, a brief mental health evaluation conducted by a designated examiner (e.g., psychiatrist, social worker, other professional) lacking any history with the person does not yield sufficient relevant information to substantiate the need to commit. Private individuals – including but not limited to family members and other caregivers, neighbors, teachers, employers – are typically in a better position to know the individual's baseline of behavior and functioning, psychiatric history, triggers and signs and symptoms of deterioration or crisis. A disinterested professional evaluation is essential, but it is often private individuals outside the mental health system who can place the evaluation in a more meaningful context for the judge.
- **Maximum duration of the commitment order.**
Court-ordered hospitalization is not meant to be punitive but rather a means to restore health. Accordingly, the time period attached to a commitment order is not a “sentence.” It is in fact unconstitutional to detain a person in a hospital under a civil commitment if his treating physician has determined he no longer meets the state's inpatient commitment standard. Thus, if a person committed for six months is deemed stabilized after three days, the authority to maintain the commitment evaporates.

In practice, it takes longer than three days for a person in psychiatric crisis to achieve stability; most medications used to foster stability do not achieve therapeutic efficacy in less than two weeks. The length of time mental health providers are afforded to deliver treatment is thus critically important to the likelihood of arriving at the desired outcome of involuntary inpatient treatment – restoring sufficient stability for the individual to return safely and successfully to the community.

In most (if not all) public psychiatric hospitals in our era of chronic public bed shortages, there is inherent tension between the need to treat and the need to clear beds to meet incoming demand. The length of commitment orders plays directly into this tension. While it is always possible to renew an expiring commitment if the patient is thought to continue to need hospital care, in practice, the expiration of an order has the effect of pushing the person out the door, fully stabilized or not. A state law that limits an initial court order of hospital commitment after emergency detention to less than 30 days is inadequate, and a limitation of such order to 14 days (as in West Virginia and

Washington) substantially undermines the effectiveness and intent of the hospitalization order. In fact, short hospital stays have been found to correlate positively with a higher likelihood of re-hospitalization, an outcome that is desirable neither for the individual nor the mental health system.^{viii}

OUTPATIENT COMMITMENT (ASSISTED OUTPATIENT TREATMENT/AOT)

The notion of civil commitment is generally associated with a hospital setting. But there is another, longstanding and well-established form of court-ordered commitment that is nearly as essential to the optimal functioning of a mental health system. It is *outpatient* commitment – or alternatively, “assisted outpatient treatment” (AOT) – the practice of court-ordering a person with mental illness who meets certain legal criteria to adhere to a specific program of outpatient treatment as a condition of remaining in the community.

To grasp the importance of AOT, it must be understood that non-adherence to prescribed treatment is the single largest reason that people get caught in the mental health system’s “revolving door,” shuttling endlessly between hospitals, correctional facilities and the streets. Improved treatment adherence is the key to avoiding this, but not easily accomplished – particularly for those with anosognosia, a brain condition that prevents the sufferer from recognizing his own illness.

The importance of court-ordered outpatient treatment is also related to the dire shortage of inpatient beds and the rise of the ultra-short psychiatric stay. Until and unless sufficient public psychiatric beds are available, individuals who once would have received intensive hospital care instead will be left to make do with no acute care at all or discharged from hospitals after insufficient hospitalization to make do while they are still psychiatrically unstable. Either of these circumstances bodes ill for their recovery and for their communities. Although outpatient commitment in the community is no substitute for inpatient care, it does represent an evidence-based mechanism for supporting recovery, fostering stability and avoiding the consequences of receiving no treatment at all.

AOT is not a panacea to these complex conundrums, but it is a proven best practice to mitigate the damage. Multiple studies have conclusively established its potential to significantly reduce a number of negative outcomes – including hospitalization, incarceration, suicide, violence and crime – among the hardest-to-treat people with severe mental illness,^{ix} and save money in the process.^x In 2011 the U.S. Department of Justice, Office of Justice Programs certified AOT as an effective, “evidence-based” approach to reducing crime and violence.^{xi}

Looking only at the research, one might expect AOT to be practiced universally by local mental health systems overwhelmed by the disproportionate needs of patients who lack insight. But AOT remains controversial in the mental health field because it mandates treatment an individual otherwise would reject. Just as there is resistance in some corners to the involuntary hospitalization of anyone not posing an imminent risk of violence or suicide, some are offended by the notion of “coercing” an individual to follow a treatment plan, however compelling the need or positive the outcomes, both for the individual and for society at large.

To some extent, the controversy around AOT is rooted in misunderstanding of its aims. In just about any other legal context, the point of a court order is to discourage undesirable acts or omissions through the court's power to *punish* – with jail, fines or both – those who show it “contempt.” This association is understandably troubling when considered in the context of a person whose errant behavior is driven by illness.

In fact, the threat of punishment plays *no* role in AOT. Violation of an AOT court order typically leads to nothing more than a re-evaluation of the person's need to be committed to hospital care. And such commitment can only occur if the person is found to meet the ordinary criteria for hospitalization, just as it would in the absence of an AOT order.

This might reasonably cause some to wonder: What, then, is the point of AOT? Experience suggests that when practiced correctly, AOT works for three fundamental reasons.

- AOT motivates patients by impressing upon them, through the symbolic power of the judge as an authority figure, the seriousness of their need to comply with treatment. (This is sometimes called “the black robe effect.”)
- AOT lights a fire under treatment providers by alerting them that the court identifies a patient as high risk and expects a commensurate level of care.
- AOT typically provides close monitoring of patients so non-adherence is detected early and addressed before deterioration makes it harder to intervene effectively.

Because AOT is not merely an approach to outpatient treatment but also a type of court procedure, it requires state law to specifically authorize it. By 2013, all but five states – Connecticut, Maryland, Massachusetts, New Mexico, and Tennessee – had enacted such laws.

However, it must be acknowledged that the 45 existing state AOT laws on the books vary greatly in quality. Some are carefully conceived and used to great effect, in pockets if not throughout their states. Others give scant indication of how AOT might function in practice, or include insurmountable barriers to practical use.

AOT Criteria

States' approaches to defining the eligibility criteria for AOT take two basic forms.

- **To treat AOT and inpatient commitment as entirely separate, with distinct criteria.** The underlying rationale here is that inpatient criteria tend to focus on the person's current “dangerousness” and are thus ill-suited for the *outpatient* commitment of a person who is at the time is under treatment and *not* dangerous but has a documentable history of treatment non-adherence with bad outcomes (e.g., re-hospitalization, suicide attempts, violence). In states with rigid inpatient standards, having separate criteria for AOT facilitates the use of AOT as a discharge planning tool. This is a point at which the person is entitled to release because he no longer meets

inpatient criteria yet may not be fully stable and in any case remains at great risk of recidivating.

- **To treat “commitment” as a unitary process with a single set of criteria and to allow the court to choose the type of commitment** – inpatient or outpatient – that is the “least restrictive alternative” meeting the person’s particular needs at the time. A more common approach than separate criteria, this makes it easy for a court to change the nature of the person’s commitment as circumstances evolve.

Either of these approaches to AOT criteria can work well. However, for the unitary (single-standard) approach to be usable in hospital discharge planning, a need-for-treatment standard must be part of it. Otherwise, AOT is essentially unavailable to the dischargée who needs continued treatment but – thanks to his hospitalization – is stable enough to leave the hospital. A good example of a flexible standard is Idaho’s, which applies to any mentally ill person who:

lacks insight into his need for treatment and is unable or unwilling to comply with treatment and, based on his psychiatric history, clinical observation or other clinical evidence, if he does not receive and comply with treatment, there is a substantial risk he will continue to physically, emotionally or mentally deteriorate to the point that the person will, in the reasonably near future, inflict physical harm on himself or another person.

Conversely, the more narrow a state’s unitary commitment standard, the more likely it becomes that AOT won’t be usable at all. Consider, for example, the standard of Pennsylvania, which applies only to a person who:

within the past 30 days ... has inflicted or attempted to inflict serious bodily harm on another and ... there is a reasonable probability that such conduct will be repeated; [or] has acted in such manner as to evidence that he would be unable, without care, supervision and the continued assistance of others, to satisfy his need for nourishment, personal or medical care, shelter, or self-protection and safety, and that there is a reasonable probability that death, serious bodily injury or serious physical debilitation would ensue within 30 days unless adequate treatment were afforded under this act[; or] has attempted suicide and that there is the reasonable probability of suicide unless adequate treatment is afforded under this act[; or] has substantially mutilated himself or attempted to mutilate himself substantially and that there is the reasonable probability of mutilation unless adequate treatment is afforded under this act.

It is hard to imagine how a person could be safely placed in the community while meeting that standard. It should surprise no one that, while authorized in the civil commitment code, AOT is non-existent in Pennsylvania.

Even among states that opt for distinct criteria for inpatient and outpatient commitment, there are sometimes barriers to the effective use of AOT. An example is Virginia, which has an AOT law requiring among its criteria that the person “has agreed to abide by his treatment plan.” AOT was designed primarily for individuals who are unable to recognize they are in psychiatric

distress and need care. This Virginia requirement essentially renders AOT unavailable to the very individuals who most need support to live safely and successfully in the community.

AOT Process

Aside from the eligibility criteria, various features define an effective AOT law. A more detailed statute – provided, of course, that the details are good – offers mental health officials a useful blueprint for using AOT and thus is preferable to a fill-in-the-blanks statute that provides little implementation direction.

Four qualities characterize the AOT laws that are most easily implemented:

- **A provision for response to non-adherence.**

The consequences of non-adherence should in no way resemble punishment. Rather, they should be oriented towards triggering a re-evaluation of whether outpatient placement is still appropriate to meet the person's needs. For example, Utah provides:

If at any time during the specified period it comes to the attention of the court, either that the patient is not complying with the order, or that the alternative treatment has not been adequate to meet the patient's treatment needs, the court may, after proper hearing:

(1) Consider other alternatives, modify its original order and direct the patient to undergo another program of alternative treatment for the remainder of the 90-day period; or

(2) Enter a new order directing that the patient be hospitalized for the remainder of the 90-day period.

- **A provision that not only compels the patient to comply with mandated treatment but compels the mental health system to actually provide the treatment.** In other words, a provision that binds the system and patient to one another in a compact. The state that goes furthest in this direction is New York, where judges actually order mental health officials to provide essential services. But a large part of the reason this works is that New York's AOT law requires every county to establish an AOT program. In other states, it is a trickier proposition because local mental health officials are free to forgo AOT altogether, which they are more likely to do if they perceive that opening the process imposes new obligations upon them. A more subtle approach to ensuring quality treatment that works well in many states is to require the local mental health system to develop a detailed treatment plan and line up all providers prior to the AOT hearing. The plan is then explained at the hearing and incorporated into the court's order.
- **A provision that allows families and others in a position to observe the individual personally to petition the court rather than reserving the right to petition to**

mental health officials. The same logic applies here as to allowing private individuals to petition for inpatient treatment.

- **Provisions that empower courts to order AOT of longer duration.** Independent outcome studies indicate that AOT sustained for at least six months is more effective than AOT of shorter duration in improving patient outcomes and reducing consequences of non-treatment (e.g., homelessness, arrest, incarceration, victimization, suicide, violence)^{xii} The maximum length of AOT orders varies by state, ranging from two months to one year. Although orders typically are renewable if the need persists, there is a discouraging effect in forcing mental health officials to return frequently to court. Thus, the length of the order plays a role in determining the period of time that a person will actually receive AOT and in turn the likelihood it will produce the desired outcome of promoting safe and successful recovery in the community. A state law that limits the maximum duration of an AOT order to six months is inadequate; a limitation to three months is significantly worse.

EMERGENCY HOSPITALIZATION FOR EVALUATION

In contrast to the inpatient commitment and AOT processes detailed above, the process to have a person in psychiatric crisis detained for a short period to evaluate his or her need for commitment is relatively consistent across the U.S. In every state, a law enforcement officer is empowered to detain an individual and remove him to an evaluation facility if the officer finds probable cause to believe the person may be in need of commitment or if an empowered mental health professional has directed the officer to do so. All states allow this to take place without a court order if there appears to be an imminent need to prevent physical harm to the person or others. Some require a court order first, if the suspected danger does not appear to be imminent. Maximum lengths of evaluation periods range only slightly – most states allow 72 hours, while a few limit the period to 48 hours. Virginia uniquely requires the individual under emergency detention be evaluated within four hours – with one two-hour extension possible – creating an inordinately high barrier to treatment in rural locations or anywhere that designated examiners are not available immediately.

Two major features are relevant to the quality of a state's emergency hospitalization provisions.

- **Concurrence with the state's inpatient commitment standard.** Any person reasonably suspected of meeting inpatient civil commitment criteria should be eligible to be detained for an evaluation. There is, after all, little value in a state having a progressive commitment standard if an overly stringent emergency evaluation standard prevents the person from ever receiving the psychiatric exam necessary to substantiate the need for commitment.
- **Provision for private individuals, including family members, to petition the court for emergency evaluation.** Police and empowered treatment professionals are not always in the best position to note signs and symptoms that an individual with severe

mental illness is decompensating and warrants an emergency evaluation. Empowering private individuals to petition for evaluation gives voice to the observers most likely to recognize these signs and frees families from being forced to wait for the individual to exhibit the sort of violent behavior that tends to draw police attention. (Some desperate families have even resorted to falsely reporting threats of violence after finding no other way to activate intervention in a psychiatric crisis.)

THE USE OF INVOLUNTARY TREATMENT LAWS

In 2013, there were an estimated 7.7 million people in the United States living with bipolar disorder or schizophrenia. Approximately 3.3 million were untreated at any given time. Civil commitment laws exist in every U.S. state and throughout the world as a mechanism both to improve the well-being of those whose untreated symptoms are a demonstrable threat to their own well-being and to promote the safety of the public.

The civil commitment laws described in the preceding section of this report might best be thought of as representations of each state's best hopes. The laws tell us what the basic involuntary interventions (emergency hospitalization, court-ordered hospitalization, court-ordered outpatient treatment) *should* look like in that state and under what conditions people in psychiatric crisis *should* be eligible to receive them. This, of course, is half the story at most. For timely and adequate treatment to be the norm, state mental health systems must stand ready to make full use of their legal authority and provide the facilities and services with which to implement that authority.

For one thing, this requires state legislators and governors to put their money where their laws are, by adequately funding their mental health systems to meet needs for hospital beds, appropriate medications, community-based services, and intensive case management. For another, it requires state mental health systems to be led and staffed by people who recognize the role that strategic and judicious use of involuntary treatment can play in the recovery of individuals who are too ill to direct their own treatment in a self-interested manner. On both fronts – fiscal and ideological – the state systems have long been under siege.

The fiscal challenges are by now familiar. For decades, state lawmakers have reached into mental health budgets whenever a need arises to find some money somewhere. In the early period of deinstitutionalization, this was demonstrated when funds saved from state hospital closings did not go towards community services as initially promised, but rather into states' general funds. But the temptation to slash mental health seems to have grown exponentially in the recent period of recession and diminishing tax revenues. (A cynic might wonder whether it has anything to do with the relative voicelessness of those who bear the brunt of such cuts.) A 2011 study by the National Alliance on Mental Illness (NAMI) documented the devastation: \$1.6 billion cut from state funds for mental health services from FY2009 to FY2011 alone. The Treatment Advocacy Center's 2012 report *No Room At the Inn* focused on the impact on the availability of state hospital beds, finding a 14% decline in bed populations nationally from 2005 to 2010.

Less understood is how ideological antipathy to involuntary treatment – a continuing legacy of the deinstitutionalization movement – feeds into and provides political cover for the demolition of critical services. We do not mean to paint here with too broad a brush. To be sure, there are many mental health professionals whose daily interactions keep them clear-eyed about what it takes to reach a person who lacks insight into his condition. But these professionals are often the first to acknowledge the systems they work in are suffused with bias against “coercive” methods. The anti-coercion flame is further fanned by a national network of federally funded “Protection & Advocacy” (P&A) attorneys and by a small but highly vocal “anti-psychiatry”

movement led by high-functioning individuals with psychiatric diagnoses who would not themselves be candidates for civil commitment. While these groups typically decry cuts to the all-voluntary “peer-based recovery support services” they favor, they cheer on the shuttering of state hospitals and campaign against AOT on grounds (among others) that it’s too expensive.

The mental health mainstream’s embrace of the anti-coercion perspective is reflected all too well in the “National Consensus Statement on Mental Health Recovery” released in 2006 by the Substance Abuse and Mental Health Services Administration (SAMHSA), a federal agency charged with improving the quality and availability of state mental health services. The Consensus Statement was released with much fanfare by a SAMHSA-appointed panel of prominent mental health officials and advocates. It conveys the “Ten Fundamental Components of Recovery” upon which reasonable minds could scarcely disagree. The first stated component is “Self Direction,” with the explanation that “[b]y definition [emphasis added], the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.”

The statement is reasonable when applied to individuals with the capacity to “self-direct” and make informed decisions about their “own life goals.” But what about those with severe mental illness who lack such capacity? Under-resourced state systems seem reluctant to serve them, and yet people who simply cannot “self-direct” aren’t going away. We wonder to what degree official enthusiasm for self-directed care is based on the short-sighted observation that self-directed *refusal* of care saves the system money by rendering some eligible individuals unable to access the services they need. Of course, when left untreated long enough, these individuals often engage in behaviors that cannot be ignored and ultimately become more expensive for state and local governments.

OBSTACLES TO THE USE OF INVOLUNTARY TREATMENT

Civil commitment laws may be universal, but their use is not, as the findings of this survey report. Several barriers obstruct uniform and universal utilization of commitment standards.

Misconceptions of dangerousness

The most pervasive myth in American mental health may be the notion that imminent risk of violence or suicide is the sole permissible basis for hospital commitment. The myth persists even in states with the most progressive commitment standards and among the gatekeepers to mandatory treatment, such as law enforcement officers responding to psychiatric crisis calls who determine whether to transport an individual to a hospital for evaluation. And most tragically, it is the sort of myth that becomes true in the retelling.

For a vivid example of how state mental health systems contribute to the perpetuation of this myth, consider West Virginia. The hospital commitment statute there includes a classic “grave disability” standard, making commitment available to an individual who “is behaving in a manner as to indicate that he or she is unable, without supervision and the assistance of others, to satisfy his or her need for nourishment, medical care, shelter or self-protection and safety. . . .” But like many states, West Virginia does not call this standard “grave disability.”

Instead, the standard is offered as one of several alternative definitions of “likely to cause serious harm.” Of course, the typical West Virginian seeking commitment of a loved one is unlikely to peruse a law book to learn all of the definitions of “likely to cause serious harm.” Rather, he will fill out the standard commitment application form, promulgated by the state, which is handed to him at the courthouse. And on this form, the applicant is simply instructed to “list any and all recent acts which support your belief that the respondent is likely to cause serious harm to him/herself and/or others. Include approximate date(s) when each act occurred.” There is nothing whatsoever in this language to indicate that a failure to attend to basic survival needs might render a person “likely to cause serious harm.” On the contrary, the form’s demand for recent “acts” with “dates” seems to rule out an explanation of the person’s general neglect of health and safety. And, that easily, the breadth of the statute is effectively nullified.

The stark reality is that the lack of hospital beds to accommodate all who qualify under state criteria forces the system to triage: those deemed likely to imminently commit violence against self or others are perceived as *more* in need of the beds than those who might qualify on other grounds, and so the system pushes the others out. This problem is compounded by the misconception among some mental health professionals and attorneys – with no basis in statute or legal precedent – that the right to refuse treatment may give way *only* to a credible threat or attempt to hurt oneself or another.

Underuse of assisted outpatient treatment (AOT) laws

While all but five states have laws authorizing assisted outpatient treatment (AOT), most of these laws do not see widespread use.

A notable exception to this is the AOT law of New York, known informally as Kendra’s Law. A single sentence in the New York statute distinguishes it from other state laws by mandating that each county in the state “operate, direct and supervise an assisted outpatient treatment program.” While it would be a great exaggeration to claim this mandate has led to universal uniform implementation of court-ordered outpatient treatment across New York, it has at least assured AOT a place in the treatment landscape in all of the state’s populous counties.

In other states, AOT exists only as an option for local mental health officials (and, under some state laws, individual treatment providers and/or family members) who wish to tap its power; those who do not wish to use the option are free to ignore it. In California, the nation’s most populous state, the option faces a uniquely high barrier: each county board of supervisors must vote to opt in, creating the need for an additional legislative authorization.

Because counties outside of New York are not mandated to include court-ordered outpatient treatment in their toolboxes of options for treating those with the most severe mental illnesses, AOT implementation tends to be patchy. In some counties – Seminole in Florida, Bexar in Texas, Summit in Ohio – full-fledged AOT programs may operate to great effect. In the next county over, use of the law may be occasional, half-hearted or non-existent.

Underuse of conditional release

The practice of “conditional release” is often confused with AOT. Both involve the integration of a person with mental illness into the community on the condition that he adheres to a specific program of treatment, essentially leveraging the motivational power of the person’s natural preference to stay out of the hospital into a healthy decision.

There are two key differences between the strategies. First, AOT can be utilized either for a person leaving a hospital or as a hospital diversion tactic for a person currently in the community but symptomatic or decompensating. Conditional release is strictly a mechanism for hospital discharge.

The second key difference is that conditional release draws upon the authority of a hospital administrator, mental health department or other agency, not the court, i.e., there is no court order directing the patient to adhere nor ongoing court supervision of the patient’s progress. If and when it appears that the release is not serving the patient’s needs, the hospital or supervising agency simply revokes the release and returns the patient to the hospital.

It should be clear that conditional release is no substitute for AOT. Without a court order, there is no potent “black robe effect” to provide motivation to adhere to treatment. And, in states where the standard for inpatient commitment is based on a narrow conception of dangerousness, conditional release serves a much more limited population than the typically more stable AOT candidates.

But conditional release has a place alongside AOT in a functional mental health system. Generally, patients who qualify for AOT upon hospital release should receive it. But those constitute a small portion of people discharged from hospital commitments. AOT is most commonly used for patients with histories of relapse caused by treatment non-adherence. But virtually any patient nearing the end of an involuntary hospital stay, even if he doesn’t meet his state’s AOT standard, would benefit from the “soft landing” of a supervised transition back to community life.

Bed shortages

Given the decimation of the public hospital bed supply over the last half-century at the same time the country nearly doubled its population, it should come as no surprise that there are not enough public inpatient beds for all the individuals in acute psychiatric crisis. This produces a number of unfortunate effects, among them:

- Gatekeepers to civil commitment – including law enforcement, mental health professionals and family members – are discouraged from attempting to access involuntary options.
- Individuals who reach a hospital emergency department in psychiatric crisis spend days or weeks in the ER because there is no bed available for their treatment.

- Civil commitment laws are interpreted more stringently than written in order to reduce the number of people who qualify for a hospital bed.
- Those who do eventually qualify for hospitalization through the civil commitment process do not receive immediate hospital care as intended by the laws. Some committed patients are forced to spend periods of days or even weeks receiving little if any meaningful treatment while waiting for psychiatric beds to become available.
- Once in the hospital, committed patients typically receive “ultra-short” care of less than a week and are discharged before stabilizing to make room for the next patient, a circumstance that undermines the likelihood they will achieve psychiatric stability and increases the likelihood they will require re-hospitalization.

While the reality of bed waiting is bad enough in any case, the disgrace is sometimes exacerbated by the location in which a patient must bide his time. It is the fortunate patients who are housed in hospital emergency rooms or crisis stabilization units, where they at least receive monitoring by medical staff. In some jurisdictions, acutely ill patients are forced to wait in correctional settings (jails or holding cells). Waits in the range of one to two months are not unheard of.

Obstacles to medication over objection

Misunderstanding of what “involuntary” (or, among detractors, “forced”) treatment entails are widespread, even in the mental health community. “Involuntary treatment” is an umbrella term for any form of enforced intervention – from a 72-hour hold for an emergency psychiatric evaluation to inpatient commitment for months. What is not implicit in “involuntary treatment” is authorization for psychiatric providers to medicate an individual without his permission. Almost without exception “medication over objection” must take place in a hospital and, in many states, only in a public hospital. In other words, it is not applicable to individuals under court-ordered treatment in the community (AOT).

Predictable as it might be that acutely ill individuals who are unable to recognize they need treatment and/or unwilling to be hospitalized voluntarily will reject pharmaceutical treatment once in the hospital, very few states consider the authority to medicate an implicit component of the commitment order. The overwhelming majority provide under statute, regulation or court precedent (or some combination) that medication over objection of a committed patient requires a separate finding that the patient lacks the capacity to make his own informed treatment decisions. In some states, this finding must be made by courts, while others call for administrative proceedings presided over by non-treating physicians.

What is most critical to the recovery of acutely ill patients is not *how* a state authorizes a treating physician to medicate over objection but that it takes place in an efficient and timely fashion. Procedures that cause undue delay in the administration of medicine too often lead to “warehousing” of patients, i.e., hospitalization without treatment likely to produce stabilization. This accomplishes nothing for the individual other than to prolong his suffering and confinement to the more-restrictive hospital setting. For other patients and staff in those facilities, it heightens the risk of serious assault. Most troublingly, a delay in treatment doesn’t

merely postpone potential recovery but makes it much less likely to ever occur. Research has linked delays in mental health treatment to substantially poorer prospects that such treatment will achieve its aims of restoring the individual's mental health.^{xiii}

METHODS AND SCORING

QUALITY OF LAWS

An 80-point grading scale was developed to evaluate the involuntary treatment laws of each state in accordance with the values and policy preferences expressed in the preceding section of this report, as follows:

- 34 points – roughly 42% of the total – were awarded based on the state’s inpatient commitment laws.
- 34 points were awarded based on the state’s assisted outpatient treatment (AOT) laws.
- 12 points – 15% of the total – was awarded based on the state’s emergency hospitalization laws.

The scoring was computed as follows:

Inpatient commitment: 34 points.

Commitment criteria: 25 points

0-10 points for presence and adequacy of a “grave disability” standard, explicitly making commitment available to persons whose mental illness renders them unable to satisfy basic needs of human survival and/or protect self from harm

0-25 points for presence and adequacy of a “need for treatment” standard that makes commitment available on basis of person’s inability to seek voluntary care to prevent psychiatric deterioration

Access to court: 5 points

3 points if a family or household member may petition the court for commitment

2 points if another concerned adult civilian may petition the court for commitment

Maximum duration of initial commitment order (after first contested hearing): 4 points

1 point for initial commitment order that may exceed 14 days

3 additional points for initial order that may exceed 30 days

Assisted outpatient commitment (AOT): 34 points

4 points for authorization by statute

0-20 points for criteria sufficiently broad to provide actual access

0-5 points for procedures sufficiently detailed to guide practitioners

Duration of commitment order:

2 points for an initial order of 90 days or more

2 additional points for an initial order of 180 days or more

1 point for renewal periods of 180 days or more

Emergency hospitalization for evaluation: 12 points

8 points for criteria that is not more restrictive than the state's inpatient commitment standard

4 points for procedure authorizing private individuals to petition the court for an evaluation

The raw scores were converted into letter grades for each of the three areas of analysis and totaled for conversion to cumulative letter grades.

Grades were assigned by combining the points scored in the categories described above and applying the following scale:

- A = 88% or more of available points
- B = 75-87% of available points
- C = 63-74% of available points
- D = 50-62% of available points
- F = less than 50% of available points

USE OF INVOLUNTARY TREATMENT LAWS

To assess and validate whether and how well each of the nation's 3,000-plus counties is making use of its involuntary treatment laws is beyond the resources available and scope of this study. In its place, the Treatment Advocacy Center surveyed public psychiatrists and other officials in position to observe and report with accuracy the extent to which civil commitment laws are used in their own states.

To accomplish this, a wide-ranging questionnaire about the use of state treatment laws was developed and sent in 2011 to each state department of mental health's medical director. Responses to the questionnaire were secured from 30 of the 51 state medical directors.

For the 20 states whose medical directors did not respond, the questionnaire was submitted in 2011-2012 to prominent public-system psychiatrists, most of whom practice at state psychiatric hospitals, or to state mental health officials other than the director. Ultimately, responses were obtained from all states. For many states, multiple officials returned questionnaires; good faith efforts were made to reconcile any divergences in responses by re-contacting officials in affected states.

When responses were known to be inaccurate, they were amended to reflect verifiable information.

The following information was sought from each state:

- How widespread, if it occurs at all, is the practice of pursuing hospital commitments of people with severe mental illness who do NOT appear to present an imminent risk of violence to self or others?
- How widespread, if it occurs at all, is the practice of AOT? In the jurisdictions of the state that practice AOT, is it practiced routinely, rarely, or does frequency vary by jurisdiction?
- Does your state practice conditional release? If so, is it used for civilly committed patients, forensic patients, or both?
- Is it common in the state for civilly committed patients to be forced to wait for beds to become available? If so, are patients forced to wait for beds in clinical or non-clinical settings? What is the typical duration of bed waits?
- How long does it typically take in the state from the day that a hospital-committed patient refuses medication to the day that treating physicians are authorized to medicate over the patient's objection?

A 14-point grading scale was developed to weight the answers according to their significance in the overall quality of a state mental health system. In addition to 14 credit points, 11 penalty points were possible for specific forms of under-use.

The scoring was computed as follows:

5 points (maximum) credit for inpatient commitments in the absence of a risk of violence:

- 0 points if such commitments are rare
- 3 points credit if such commitments common in parts of state
- 5 points credit if such commitments are common across state

5 points (maximum) credit for use of assisted outpatient treatment (AOT)

- 0 points if AOT practiced nowhere in the state
- 1 point credit if AOT practiced in some of state
- 2 points credit if AOT practiced in most of state
- 3 points credit if AOT practiced statewide

AOT rarely used where practiced: 0
AOT use varies where practiced: +1
AOT routinely used where practiced: +2

2 points (maximum) credit for use of conditional release

1 point credit for conditional release being practiced
1 additional point credit for conditional release practiced for both civilly committed and forensic patients

7 points (maximum) penalty for bed waits (no credit available)

-2 points penalty if bed waits are common
-2 points penalty if bed waits commonly occur in non-clinical settings (e.g., jail)

-1 points penalty if bed waits typically last 2 to 7 days
-2 points penalty if bed waits typically last 1 to 2 weeks
-3 points penalty if bed waits typically last more than 2 weeks

2 points (maximum) credit to 4 points (maximum) penalty for use of medication over objection

+2 points credit if typical delay is less than 1 week
0 points credit or penalty if typical delay is 1 week to 1 month
-2 points penalty if typical delay is 1 to 2 months
-4 points penalty if typical delay is more than 2 months

Each state's raw score was converted to a letter grade. Grades were assigned in absolute terms, according to what we believe state mental health systems *ought* to achieve, rather than on a curve. A raw score of zero or below was converted to a grade of "F." To earn a grade of "A," a state needed a raw score of 12 or higher.

DISCUSSION

Since the recognition in the late 1970s that the pendulum of deinstitutionalization had swung too far away from making treatment possible for those in acute or chronic psychiatric crisis, the quality of many state civil commitment laws has improved significantly. Eight states and a Canadian province have expanded their mental illness treatment options to include assisted outpatient treatment since the Treatment Advocacy Center was founded in 1998, including Nevada, which passed an AOT law in 2013 and left only five states without such a law. Numerous states also have improved their emergency hospitalization and/or inpatient commitment statutes, either independently or in concert with the Treatment Advocacy Center.

Nonetheless, the quality of the civil commitment laws in the vast majority of states remains far below what is necessary to provide a readily accessible path to treatment and recovery for individuals with the most severe mental illnesses who are unable to seek care for themselves.

FINDINGS

Among the findings of this study:

- No state earned a grade of “A” on the use of its civil commitment laws.
- Only 14 states earned a cumulative grade of “B” or better for the quality of their civil commitment laws.
- 17 states earned a cumulative grade of “D” or “F” for the quality of their laws.
- Only 18 states were found to recognize the need for treatment as a criterion for civil commitment, and several of those were found to have less than ideal standards.
- While 45 states have laws authorizing the use of court-ordered treatment in the community, only 20 of those have optimal eligibility criteria.
- While most states allow a person to be taken to a hospital for emergency evaluation upon reasonable belief that the person meets commitment criteria, 11 states apply a more stringent test for emergency evaluation than they do for commitment. In effect, this raises the bar for commitment itself, since it is impossible in many cases to build a legal case for commitment without first detaining the person for psychiatric examination.
- 27 states provide court-ordered hospital treatment only to people at risk of violence or suicide even though 23 of these states have laws allowing treatment under additional circumstances.
- 12 states make no use whatsoever of court-ordered outpatient treatment, including eight states with AOT laws on their books.
- 20 states received penalty points for the prevalence of bed waits. In two of the most populous states – Florida and Texas – bed waits were reported to typically exceed two weeks.
- On the positive side, significant delays in delivering medication over objection were found in only five states, four of them in New England. In Vermont and New Hampshire, the typical delay in providing medication over objection to individuals in psychiatric crisis who were unable to recognize their need for treatment was found to be more than two months.

RECOMMENDATIONS

Because the deficiencies in the quality and use of states' civil commitment laws vary significantly among the states, the measures necessary to address them vary significantly as well. However, regardless of where any state stands in relation to others, there is not one state whose citizenry would not benefit from improvements to either the quality of its laws, the use of its laws or both.

To promote those benefits, the Treatment Advocacy Center makes the following recommendations to the nation's governors, lawmakers and mental health departments.

- Universal adoption of need-for-treatment standards to provide a legal mechanism for intervening in psychiatric deterioration prior to the onset of dangerousness or grave disability. This reform would also be achieved by passage of the relevant provisions in Sen. Tim Murphy's "Helping Families in Mental Health Crisis Act."
- Enactment of AOT laws by the five states that have not yet passed them – Connecticut, Maryland, Massachusetts, New Mexico and Tennessee.
- Universal adoption of emergency hospitalization standards that make psychiatric evaluation possible before individuals have so thoroughly decompensated they meet the inpatient standard for commitment.
- Development of sufficient psychiatric beds for individuals in need of treatment to meet the standard of 50 beds per 100,000 in population.

INVOLUNTARY TREATMENT LAWS: QUALITY AND USE

State	QUALITY OF LAWS				Use of Laws Grade
	Inpatient Commitment Grade (42.5%)	Outpatient Commitment Grade (42.5%)	Emergency Evaluation Grade (15%)	Cumulative QOL Grade	
Alabama	F	B	F	F	F
Alaska	B	F	A+	D	F
Arizona	A-	A+	D	A-	D
Arkansas	A-	A-	A+	A	F
California	F	F	C	F	F
Colorado	B-	F	A+	C	D
Connecticut	C-	F	A+	F	C+
Delaware	F	F	F	F	C
District of Columbia	F	B	C	D	C
Florida	F	A	A+	C+	F
Georgia	F	A+	A+	C+	C-
Hawaii	C-	A	C	B-	D
Idaho	A+	A+	C	A	B-
Illinois	A+	A	A+	A+	D
Indiana	A+	B+	A+	A	C+
Iowa	C-	C+	D	C-	B
Kansas	C-	C-	A+	C	B-
Kentucky	C-	F	C	F	D
Louisiana	C-	A+	A+	B+	C
Maine	F	A	A+	B-	C-
Maryland	F	F	A+	F	F
Massachusetts	F	F	A+	F	C+
Michigan	A	C+	A+	B+	D
Minnesota	C-	C	F	D	B-
Mississippi	A+	B	A+	A	D
Missouri	B	B+	A+	A-	C-
Montana	F	A	C	C	B-
Nebraska	F	C+	C	C-	C-
Nevada	F	A	C	C+	C+
New Hampshire	A	B	C	A-	F
New Jersey	F	C+	C	D	D
New Mexico	F	F	C	F	F
New York	F	A+	A+	C	C
North Carolina	A-	A-	A+	A	C-
North Dakota	A+	B	A+	A	C+
Ohio	C-	D	A+	C-	C+
Oklahoma	C-	C-	C	C-	D

Oregon	A-	B-	F	C+	C-
Pennsylvania	F	F	C	F	C-
Rhode Island	F	F	F	F	D
South Carolina	A+	A	D	A-	B-
South Dakota	C-	D	A+	C-	D
Tennessee	F	F	C	F	D
Texas	C-	A	D	C+	F
Utah	C-	C-	D	D	B+
Vermont	D	D	D	D	D
Virginia	D	D	A+	C-	C
Washington	B-	C+	C	B-	C-
West Virginia	D	C+	A+	C	C-
Wisconsin	A	A	A+	A	C+
Wyoming	F	C+	A+	C-	F

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