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

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July 28, 2021

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Disclaimer

- This webinar was developed [in part] under contract number HHSS283201200021I/HHS28342003T from the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). The views, policies and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

Goals and Objectives

To help participants understand and appreciate:

- The history of civil commitment in the United States
- The role of “dangerousness” in determining an individual’s civil committability
- How commitment (inpatient and outpatient) may serve as a portal to services that are otherwise difficult to access
- How persons subject to commitment perceive their experience and how they fare
- Policy guidelines for implementing commitment effectively, respectfully, fairly, and sparingly

Introduction

- Inpatient civil commitment: state laws that allow people with mental disorders to be taken into custody and confined in locked facilities
- How is this different from criminal confinement?
  - Purpose different: to help, not to punish (*parens patriae* v police power)
  - Behaviors warranting commitment more broadly defined
  - Procedures relaxed
  - Duration of confinement indeterminate (though subject to review)

Commitment laws are relatively new

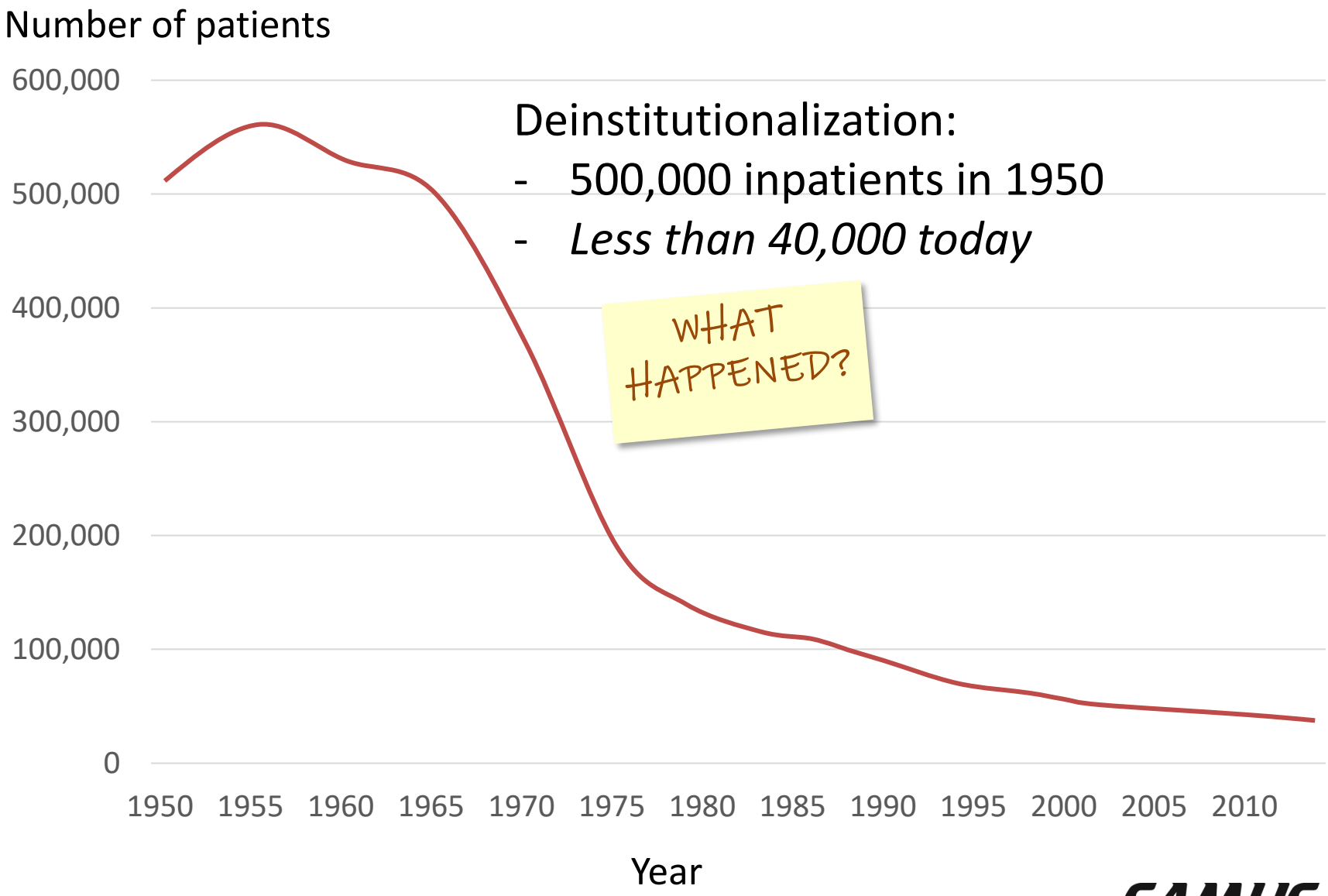
Historical approaches to mental health care in the Anglo-American world

- Old England
  - King could take individual's estate and provide supports or pay family to provide care (mostly used for people with intellectual disability)
- Colonial America
  - No formal system (no laws)
  - Family's responsibility—if no family, individual on own (roving bands of people with mental illness, sometimes removed by authorities to neighboring states)
  - Poor houses sometimes used (beginning early 1800's)
  - First MH hospital in Williamsburg (1773)—many more by mid- late 1800's

Early commitment process informal

- Family brings person to facility; person admitted if facility believes person, family, or society will benefit (substituted judgment)
- Some procedural reforms beginning in late 1800's (a few states requiring court approval or even jury trials), but no clear legal standard
- 1900- late 1960's: little due process most states; admission standard: "need for treatment"
- NIMH Draft Act Governing Hospitalization (1951): Need for treatment in a hospital and lacking in insight or capacity to seek admission (incompetence)

Trend in state and county psychiatric hospital patient population



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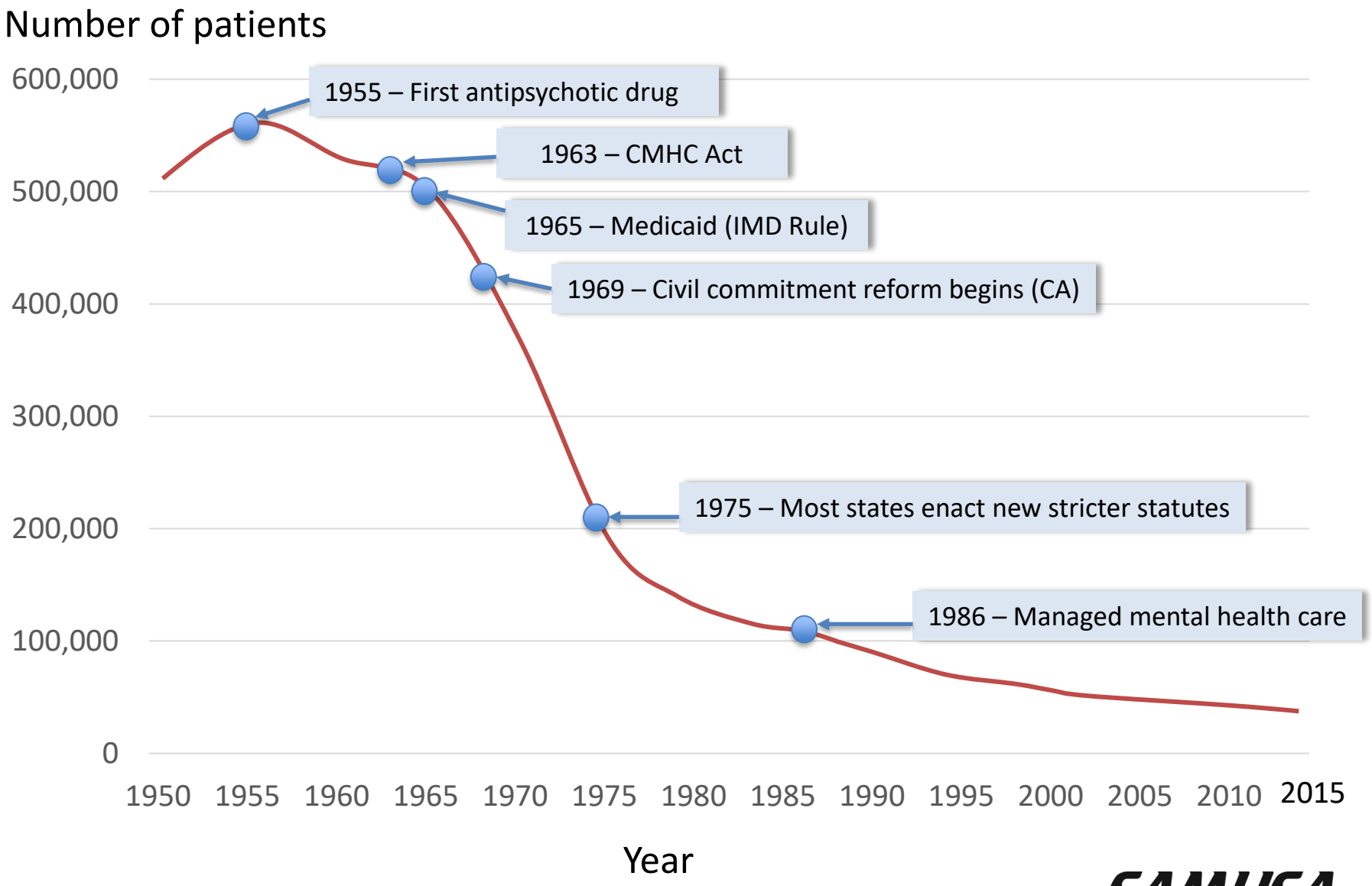

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Challenges to concept of mental disorder (and reliability of diagnoses)

- Some critics question existence of MI (Thomas Szasz, Nicholas Kittrie—"Right to be Different")
- Others claim diagnostic criteria too loose-- efforts to improve reliability (DSM I, II, II, etc.), but still much criticized: "ambiguous generalities," doctor may "shoehorn" anyone in (*Lessard v Schmidt*, 1972)

Challenges to consequences of commitment

- Poor facilities: unsanitary, dangerous, “snake pits” (*The Snake Pit*, 1948; *Cuckoo’s Nest,*1962/ 1975; *Titicut Follies*, 1967; *Frances*, 1982)
- Little meaningful treatment—*Wyatt v Stickney* (1974): right to treatment to promote opportunity for release
- Loss of civil rights
- Stigma
- Conclusion: commitment may be more deleterious than helpful

.

Changes, in the 1970's

- Medical model for commitment gives way to legal model (legal standards and procedures): commitment not just about treatment, also about liberty
- Goal: prevent abuses by narrowing circumstances justifying commitment and disciplining the commitment process (substantive and procedural due process)

1975: US Supreme Court (*O'Conner v Donaldson*):

- Can't commit, "without more," a non-dangerous person capable of living safely in freedom
- Read by many as requiring dangerousness
- But may suggest commitment of non-dangerous persons OK if treatment is provided (and that no treatment necessary if person is dangerous)
- Nonetheless, states re-writing their laws in the 1970's all required both dangerousness and need for treatment

Procedural reform

- Right to hearing before judge
- Right to counsel
- Right to confront witnesses
- Standard of proof: beyond a reasonable doubt in some states (height of legal model), but subsequent retrenchment: US Supreme Court has said clear and convincing evidence is OK (*Addington v Texas*, 1978)—diagnosis/ "dangerousness" prediction too imprecise to require proof beyond a reasonable doubt; also purpose is beneficent

Evolving standards for commitment

- Initially very strict-- e.g., “imminent risk of serious bodily harm, as evidenced by recent overt acts of violence”
- Some retrenchment, beginning in the 1980’s (and continuing today)

Elements of the legal standard in commitment laws today

- Mental illness
- Dangerousness to others
- Dangerousness to self/ grave disability
- Need for treatment
- Incompetence
- Serious deterioration
- Least restrictive alternative

Mental illness

Defined (in most states' statutes) by:
substantial disorder of thought or mood that grossly impairs judgment, behavior, or ability to negotiate demands of life—generally not including substance abuse, intellectual disability, or personality disorders

Dangerousness to others (due to MI, or to which MI contributes)

- Not defined (many states; may include, in law or practice, harm to property or “emotional harm” to family members or others, e.g., Iowa statute)
- Bodily harm (still in some states)
- Imminent or near future (still in many states)
- Recent overt act or threat (a few states)

Dangerousness to self (due to mental illness)

- Not defined (some states)
- Suicidal or likely to injure self; “active dangerousness” (some states)
- Grave disability/ inability to care for self (“passive dangerousness”): unable to provide for food, clothing, shelter, medical care, safety (many states)

Note on concept of dangerousness

- Risk of what?
- Degree of risk (how likely?)
- How soon?
- How frequent?
- Assessment of risk a clinical function; whether risk rises to the level of “dangerousness” (justifying commitment) a social value question for the judge to decide

Need for treatment (the essential commitment standard)

- Commitment laws generally include specific requirement that prospective patient need the treatment
- Ordinary civil commitment laws still based on *parens patriae*
- "Dangerousness" requirement intended to limit scope of commitment, not expand it to include dangerous people not in need of treatment: commitment OK only for those whose need for treatment so great that they pose a risk of harm without treatment (a need for treatment standard)

Incompetence

- Inability to understand and communicate rationally about the nature, purpose, and likely consequence of hospitalization, including the possible benefits, the risks, and the alternatives
- Required (along with other criteria) in a few states
- Stone-Roth "Thank-You" Theory (proposed in late '70's)
  - Reliable diagnosis of severe MI
  - Prognosis of major distress absent treatment
  - Incompetence
  - Appropriate treatment available and likely to help
  - Risk-benefit ratio such that a "reasonable person" would consent
  - "Brief" period treatment (Roth proposed 6 weeks—in 1979
  - After treatment, patient should say "Thank you, I needed that"

Serious deterioration: Wisconsin statute

". . . substantial probability, as demonstrated both by the individual's treatment history and by recent acts or omissions, that the individual needs care or treatment to prevent further disability or deterioration and a substantial probability that the individual 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."

Is civil commitment constitutional if individual not currently dangerous?

- Inpatient commitment: Maybe not (see *Zinermon v Burch,* 1990*; Foucha v Louisiana,* 1992). But what, after all, does "dangerousness" require? Would Wisconsin's deterioration language be enough?
- Outpatient commitment: Probably OK. Note, however, that the NY courts have said Kendra's Law OK only because it was not enforceable (*In the Matter of K.L.,* 2004*)*

“Least restrictive alternative”

- Services in the setting least restrictive of individual liberty (*Lake v Cameron*, 1976)
- Precursor to outpatient commitment

Commitment procedures (these days)

- Petition (interested persons)
- Emergency custody: police, mental health professional, judge may authorize custody for evaluation of committability
- Initial hospitalization decision may be medical, with subsequent legal review within period ranging from 23 hours to 60 days (most states 72 hours); many patients convert to voluntary or released with services
- Hearing before judicial officer, right to attorney, proof by clear and convincing evidence
- Review/ recommitment after period ranging from 15 days to 6 months

Effect of "legalization" of commitment

- Research shows commitment rates initially dropped when criteria were tightened but later returned to pre-reform levels (Appelbaum, *Almost a Revolution*, 1994)-- attorneys and others sensitive to clients' "best interests": Does the legal standard really matter?
- Lengths of stay, however, never returned (more effective treatments, managed care); but re-admission not uncommon
- Recent research shows much more than psychiatric treatment necessary for success in the community
  - Housing (ideally in successful neighborhoods)
  - Employment/ other meaningful daytime activity
  - Structured leisure time
  - Avoidance of substances
  - Attention to criminogenic risks

Special populations: juveniles (*Parham v JR*)

- Parents may commit kids who need treatment (with doctor OK'ing the admission)
- Like taking one's kids for other medical treatment
- Rationale: parents look out for their kids' interests; less risk of wrongful commitment

Special populations: correctional inmates (*Vitek v Jones*)

- Psychiatric commitment not an ordinary, expectable consequence of conviction; not all liberties extinguished by conviction
- Some due process required for transfer to psychiatric facility, but less required than for ordinary civil commitment
  - Administrative hearing (not necessarily judicial)
  - Assistance from "qualified and independent advocate" (not necessarily an attorney)
  - Need for treatment standard probably OK

NOTE: Many states provide full civil commitment protections for inmates (more than *Vitek* requires); others ignore *Vitek* requirements

Special populations: sexually dangerous offenders

- Laws in 20 states that allow for special civil commitment of sex offenders upon release from prison
  - Commitment standard: “mental abnormality or personality disorder” that makes individual sexually dangerous
  - Full procedural protection (hearing, attorney, clear and convincing evidence or beyond a reasonable doubt)
  - Treatability not required–ABA: The laws “distort the traditional meaning of civil commitment, misallocate psychiatric facilities and resources, and constitute an abuse of psychiatry”

Outpatient commitment: authority and context

- Extends state's civil commitment authority from the institutional setting to community-based mental health care
- Emerged in US after deinstitutionalization as a legal intervention to try to break the cycle of "revolving door" admissions.
- Began as a form of conditional release from hospital ("least restrictive alternative")

Key elements of outpatient commitment (AOT)

- Civil court order that requires certain people with a serious mental illness to comply with recommended outpatient treatment and receive services
  - Also (arguably) "commits the system" to the patient; creates accountability
- "Treatment plan wrapped in a legal order"
  - Services under AOT typically include intensive case management or assertive community treatment, medication, psychosocial treatment, and access to subsidized housing
- Sanction for non-adherence: police transport to a mental health facility for evaluation, hopeful persuasion, or involuntary hospitalization if needed
  - No forced medication in outpatient setting

Types of outpatient commitment statutes[1]

- Conditional release from hospital (40 states)
  - Also known as “trial visit” or “visit to discharge”
- Alternative to hospitalization for people meeting inpatient commitment criteria, i.e., dangerousness (16 states)
  - Least restrictive alternative
- Preventive outpatient commitment (35 states and DC)
  - Court-ordered treatment authorized at a lower threshold than inpatient commitment criteria with the purpose of preventing further deterioration
- No outpatient commitment (4 states: MA, CT, MD, NM)

[1]LawAtlas.org, 2016

Criteria for outpatient commitment in North Carolina

- Presence of a serious mental illness
- Capacity to survive in the community with available supports
- Clinical history indicating a need for treatment to prevent deterioration that would predictably result in dangerousness
- Mental status that limits or negates the individual's ability to make informed decisions to seek or comply voluntarily with recommended treatment

Opposing perspectives on outpatient commitment

Psychiatric paternalism, emphasis on individual compliance and treatment access: "Mandatory treatment for those too ill to recognize they need help is far more humane than our present mandatory non-treatment."

—E. Fuller Torrey, Founder of Treatment Advocacy Center

Civil rights, system reform advocacy: "Failure to engage people with serious mental illnesses is a service problem, not a legal problem. Outpatient commitment is not a quick-fix that can overcome the inadequacies of under-resourced and under-performing mental health systems. Coercion, even with judicial sanction, is not a substitute for quality services."

—Position statement, Bazelon Center for Mental Health Law

APA position statement: key points

- Involuntary outpatient commitment, if systematically implemented and resourced, can be a useful tool to promote recovery through a program of intensive outpatient services
  - designed to improve treatment adherence,
  - reduce relapse and re-hospitalization,
  - and decrease the likelihood of dangerous behavior or severe deterioration
  - among a sub-population of patients with severe mental illness

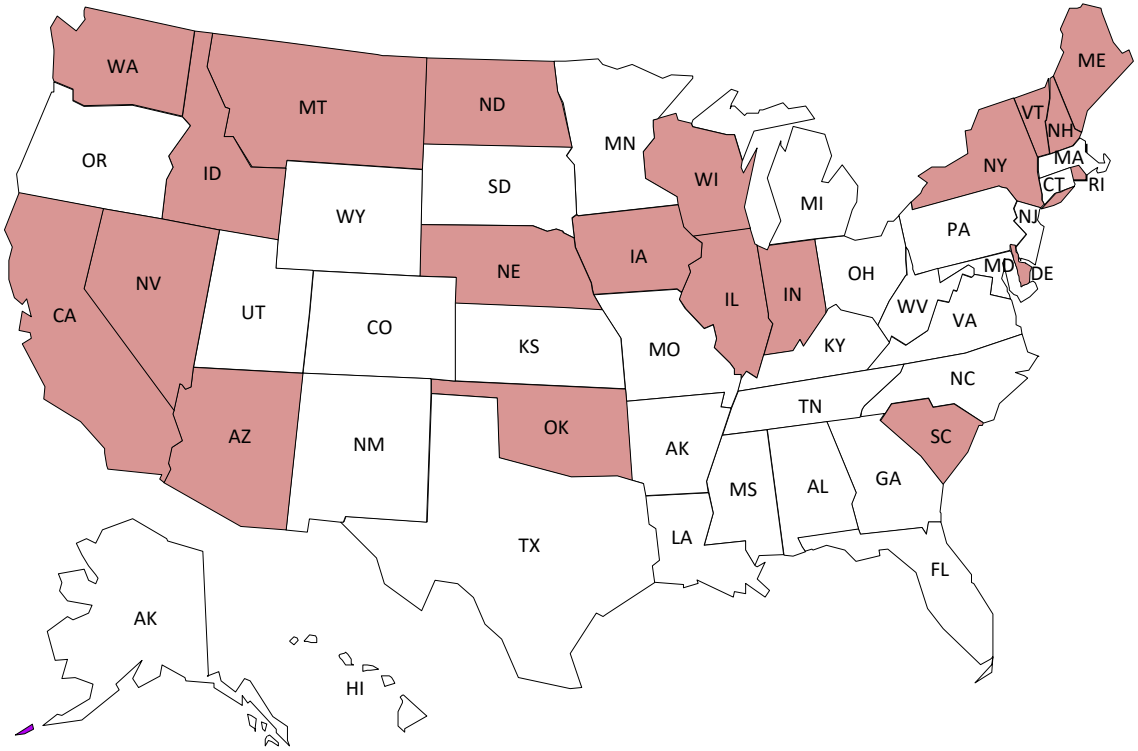
APA position statement: key points (cont.)

- The goal of involuntary outpatient commitment is to:
  - mobilize appropriate treatment resources,
  - enhance their effectiveness and improve an individual's adherence to the treatment plan.
- Involuntary outpatient commitment should not be considered as a primary tool to prevent acts of violence.

APA position statement: key points (cont.)

- Studies have shown that involuntary outpatient commitment is most effective:
  - when it includes a range of medication management and psychosocial services equivalent in intensity to those provided in assertive community treatment or intensive case management programs.
- States adopting involuntary outpatient commitment statutes should assure that adequate resources are available to provide such intensive treatment to those under commitment.

Implementation of OPC/AOT: “active programs” in 20 states



SOURCE: Meldrum ML, Kelly EL, Calderon R, Brekke JS, Braslow JT (2016). Implementation status of assisted outpatient treatment programs: a national survey. *Psychiatric Services* 67:630–635

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How common is outpatient commitment?

- About 12% - 20% of a large, 5-site sample of outpatients with serious mental illnesses in public systems of care reported experiencing outpatient commitment
- 44-59% report receiving some form of "leveraged" outpatient treatment, with civil legal, criminal justice, or social welfare (money or housing) contingencies linked to treatment participation

Source: Monahan et al., MacArthur Research Network on Mandated Community Treatment

Does outpatient commitment work?

Answer: It depends…

- What do we mean by “outpatient commitment”?
- What do we mean by “work”? (What is the goal?)
- Does it work . . . compared to what?
- Does it work . . . for whom?
- Does it work . . . where?
- Does it work . . . how? (And for how long?)
- Does it work . . . so what? (Should we do it?)

Evidence for effectiveness of outpatient commitment

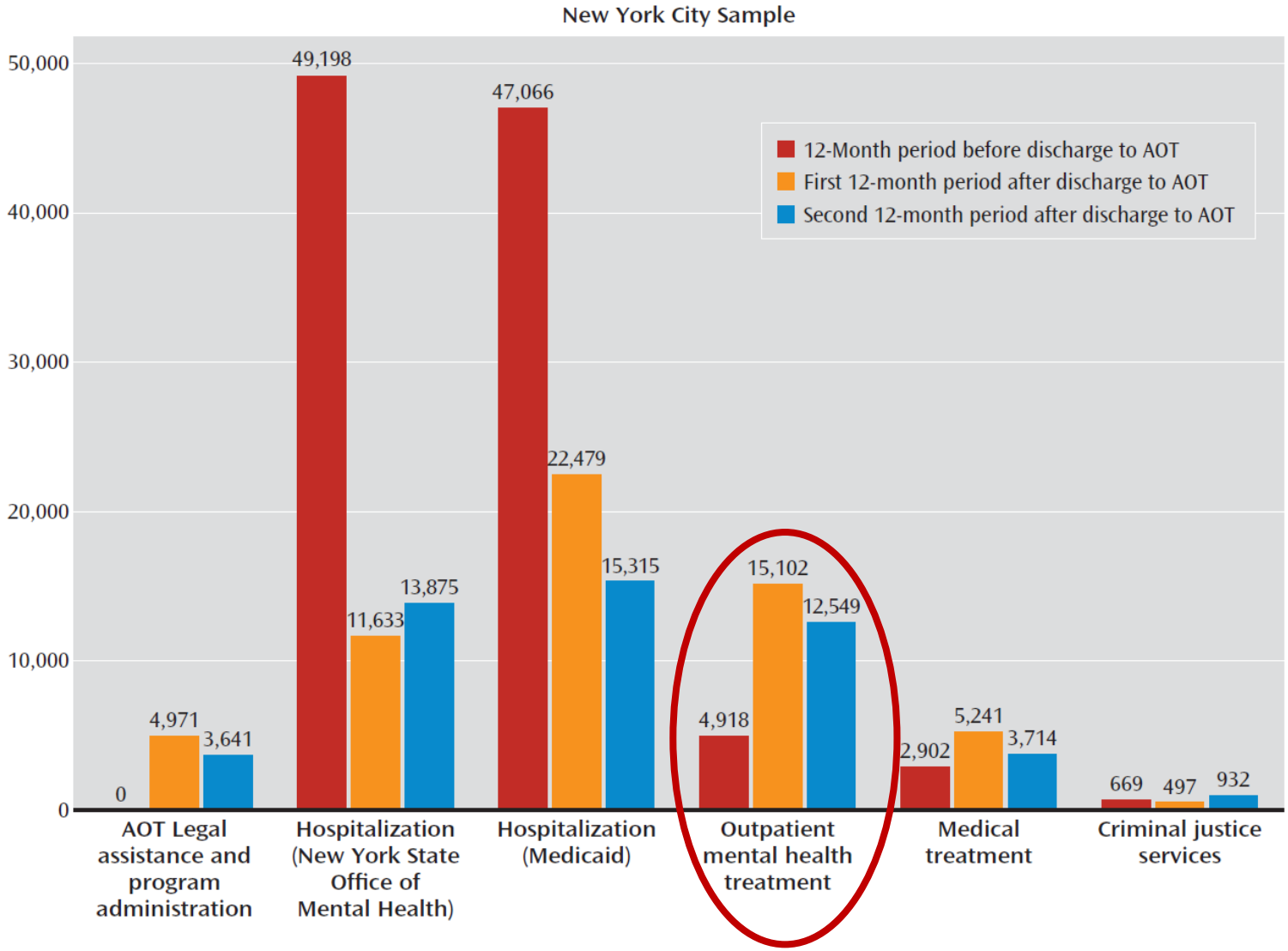
- Randomized trials
  - Duke Mental Health Study (Swartz et al., 1999)
  - Bellevue Study (Steadman et al., 2001)
  - UK OCTET study (Burns, 2014)
- Large, quasi-experimental evaluation
  - New York AOT studies (Swartz et al., 2010; Swanson et al., 2013)
- Evidence reviews
  - RAND study (Ridgely et al. 2000)
  - UK report (Churchill et al., 2007)
  - Cochrane Collaborative report (Kisely et al., 2011)

Evidence for effectiveness of outpatient commitment

Big picture summary: Evidence for the effectiveness of outpatient commitment is mixed, with success largely conditioned on:

- investment in effective implementation
- availability of intensive community-based services
- duration of the court order
- service-system utilization outcomes vs. individual perspectives and perceptions

Summary costs by category, AOT period, and sample



Swanson JW, Swartz MS, Van Dorn RA, Robbins PC, Steadman HJ, McGuire TG, Monahan J (2013). The cost of Assisted Outpatient Commitment: Can it save states money? *American Journal of Psychiatry*, 170:1423-1432.

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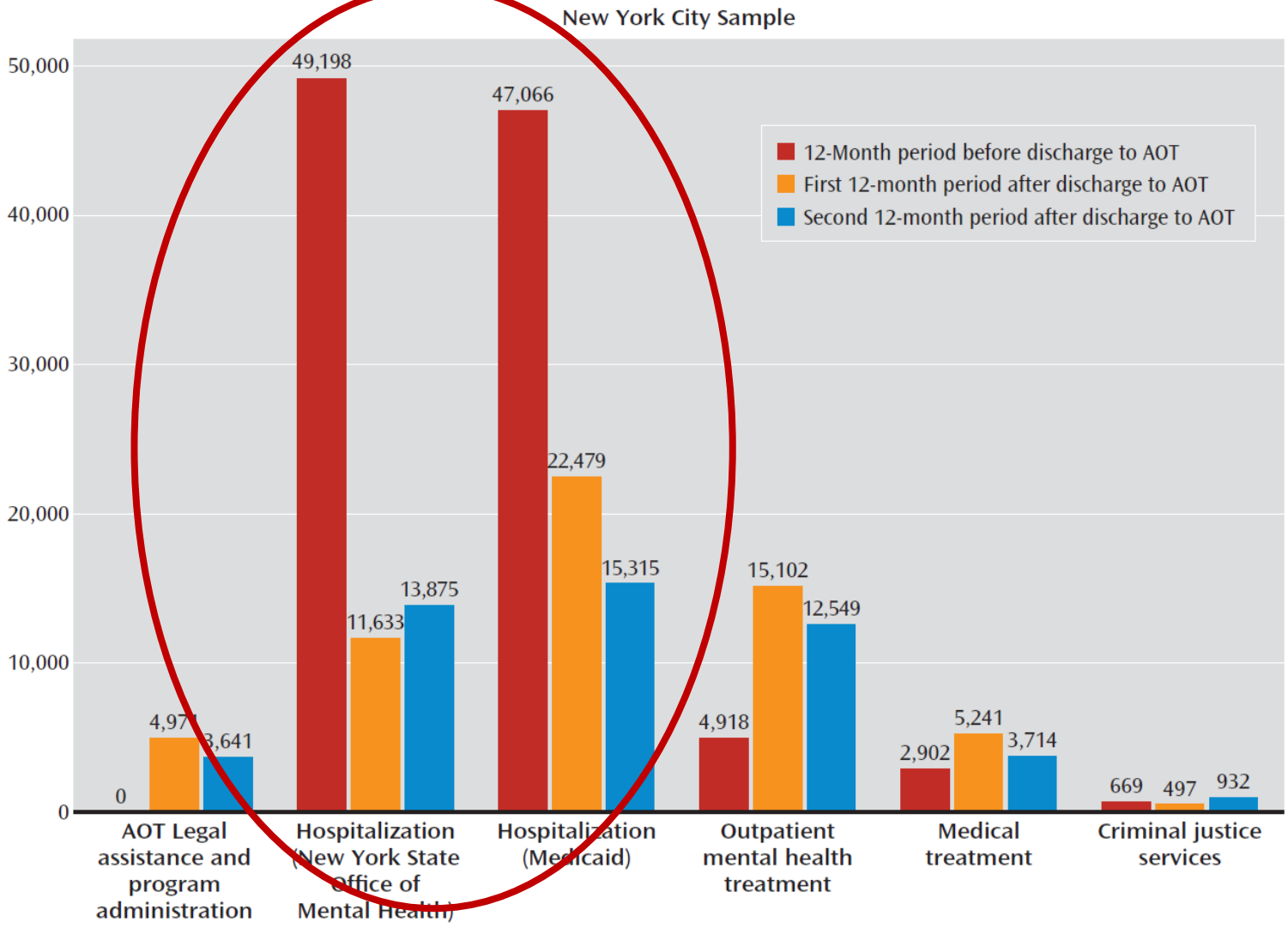

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Ethical principles to guide policy makers and practitioners

- **Non-maleficence.** Does involuntary commitment cause harm? Are the harms suffered by the committed patient outweighed by the harms staved off?
- **Beneficence.** Does civil commitment help people with disabling mental health disorders? Does commitment promote what is "good" (and for whom)?
- **Respect for autonomy.** Do civil commitment regimes protect personal autonomy, or do they mainly undermine the right of autonomous persons to make their own decisions about health care, including the right to refuse psychiatric treatment?
- **Justice.** Are inpatient and outpatient commitment programs just? Do they fairly distribute benefits, burdens, and risks?

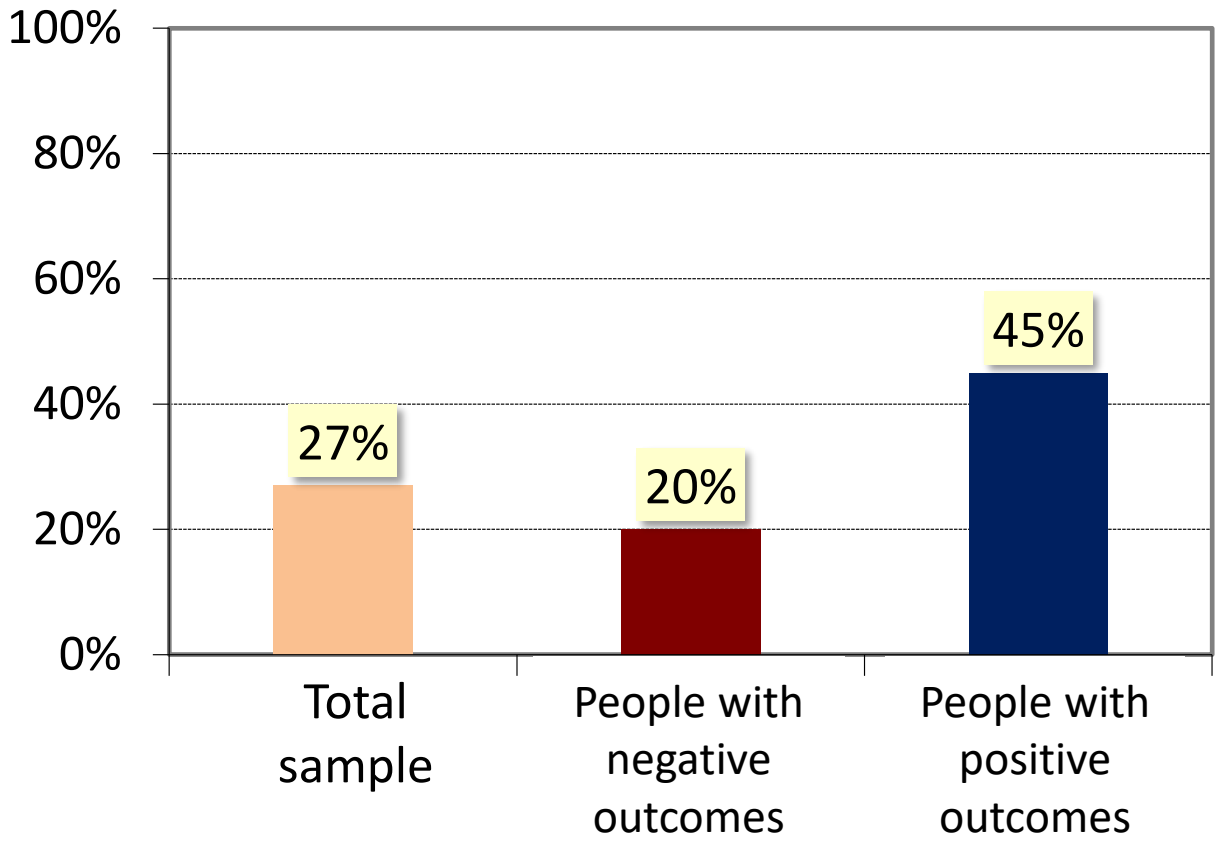
Beauchamp T and Childress J (2012). Principles of biomedical ethics. 7th ed. Oxford: Oxford University Press.

What do AOT recipients themselves think of AOT?

- Subjective quality of life
- Endorsement of personal benefit
- Formal preference assessments
- Perceived fairness
- Perceive coercion

Retrospective personal endorsement of benefit

Percent of participants endorsing personal benefit of AOT after 12 months



Swartz MS, Swanson JW, Monahan J (2003). Endorsement of personal benefit of outpatient commitment among persons with severe mental illness. *Psychology, Public Policy and Law*, 9:1, 70-93

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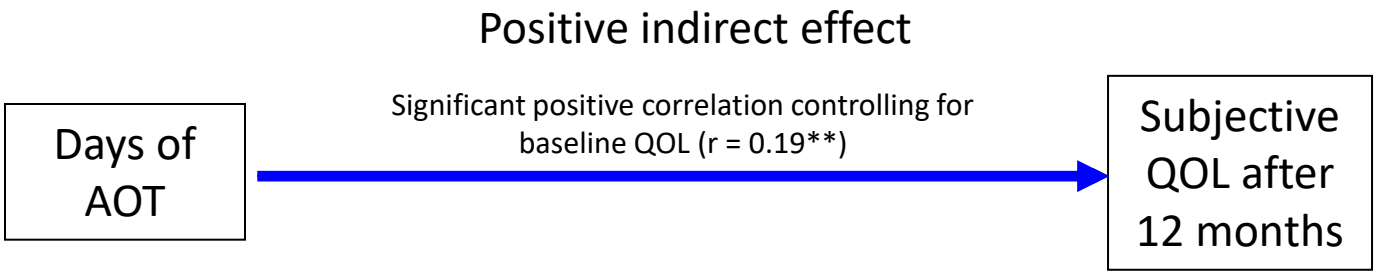
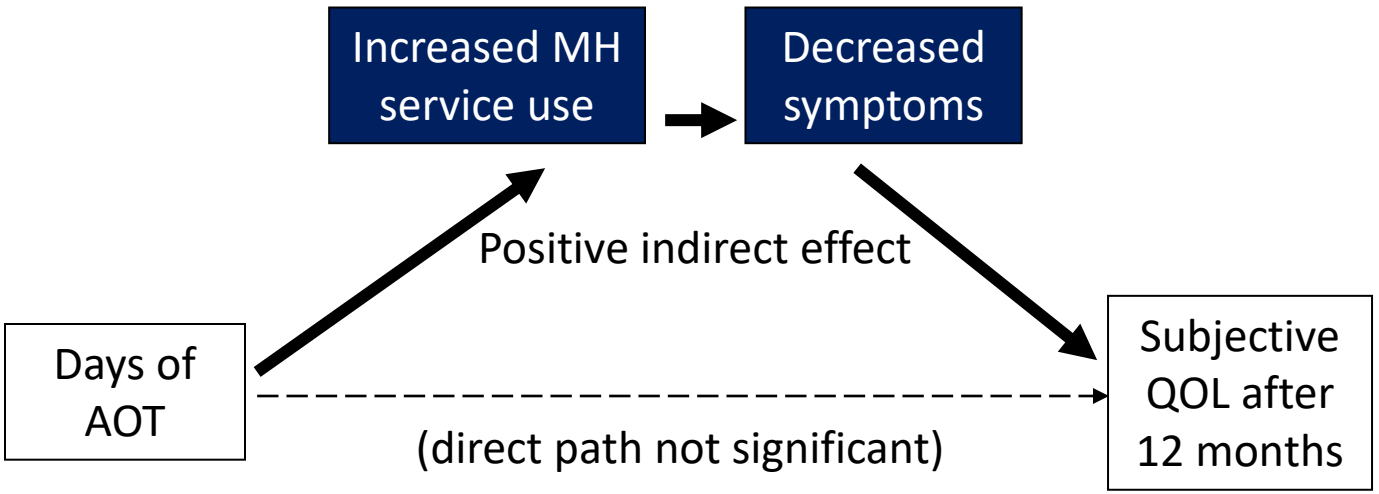
Direct and indirect effects of AOT on quality of life



** p<0.01

Adapted from Swanson JW, Swartz MS, Elbogen E, Wagner HR, Burns BJ (2003). Effects of involuntary outpatient commitment on subjective quality of life in persons with severe mental illness. *Behavioral Sciences and the Law,* 21, 473-491.

Direct and indirect effects of AOT on quality of life



LOOKS GOOD…

** p<0.01; *** p<0.001

Adapted from Swanson JW, Swartz MS, Elbogen E, Wagner HR, Burns BJ (2003). Effects of involuntary outpatient commitment on subjective quality of life in persons with severe mental illness. *Behavioral Sciences and the Law,* 21, 473-491.

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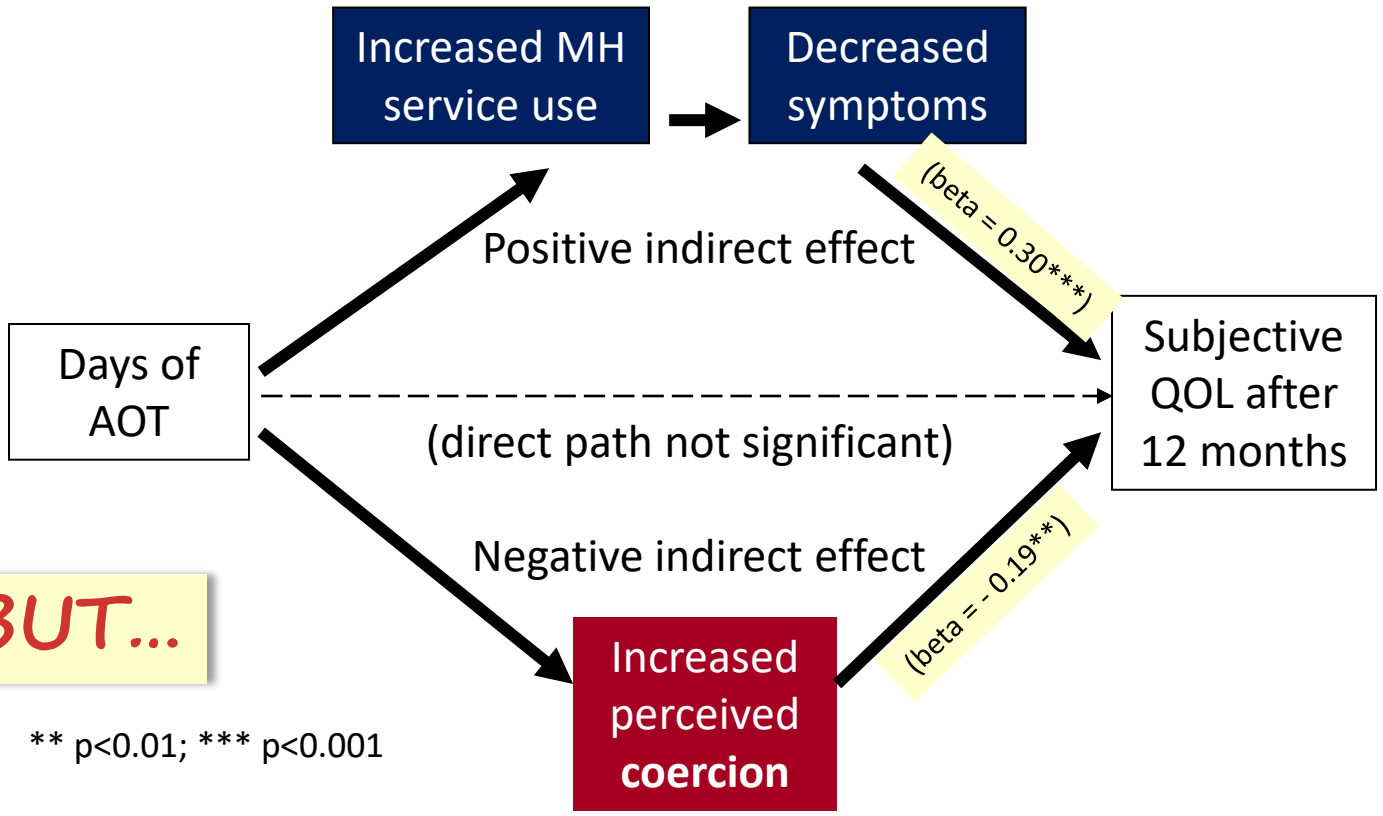
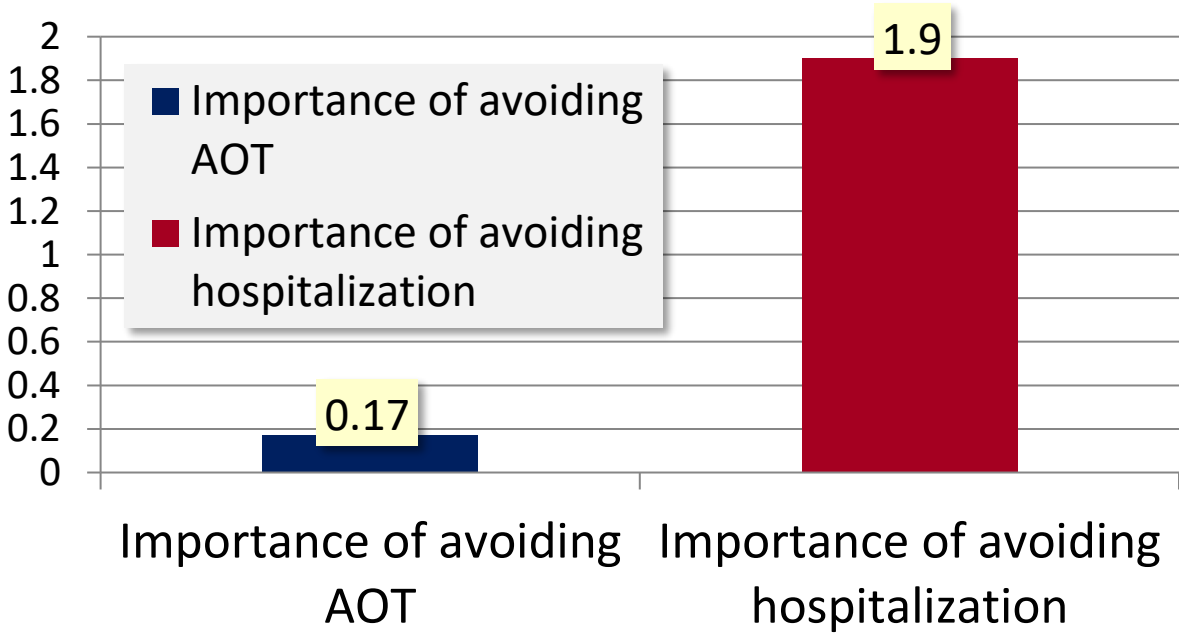


Adapted from Swanson JW, Swartz MS, Elbogen E, Wagner HR, Burns BJ (2003). Effects of involuntary outpatient commitment on subjective quality of life in persons with severe mental illness. *Behavioral Sciences and the Law,* 21, 473-491.

Preference weights for avoiding AOT v hospitalization

Regression utility weights* based on subjective preferences in for outcomes in vignettes about AOT



*Change in subjects' rating of the outcome vignette attributable to endorsement of a positive outcome. Positive coefficients denote a positive utility for the outcome.

Swartz MS, Swanson JW, Hannon MJ, Wagner HR, Burns BJ, Shumway M (2003.) Preference assessments of outpatient commitment for persons with schizophrenia: Views of four stakeholder groups. *American Journal of Psychiatry*, 160, 1139-1146

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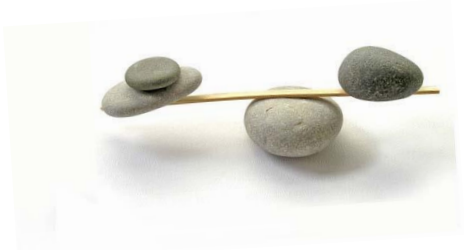
Is AOT fair?



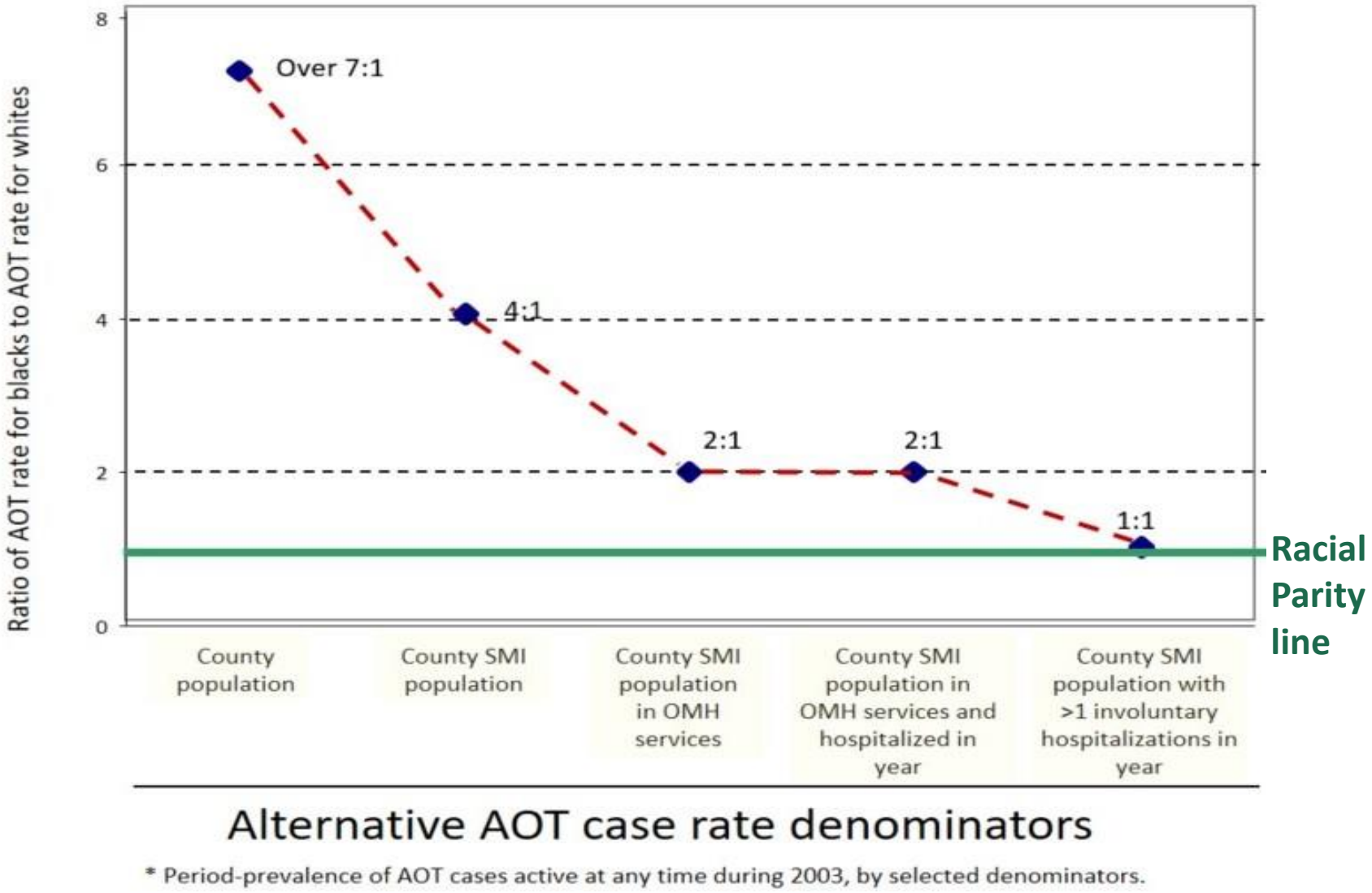
Racial disparities in AOT

- Swanson, J., Swartz, M., Van Dorn, R., Monahan, J., McGuire, T., Steadman, H., and Robbins, P. (2009). Racial disparities in involuntary outpatient commitment: Are they real? *Health Affairs*, 28, 816-826.

"Queue-jumping" in AOT

- Swanson JW, Van Dorn RA, Swartz MS, Cislo AM, Wilder CM, Moser LL, Gilbert AR, McGuire TG (2010). Robbing Peter to pay Paul: Did New York State's outpatient commitment program crowd out voluntary service recipients? *Psychiatric Services* 61, 988-95.

AOT racial disparity indices in New York County: Ratios of AOT rates* for Black compared to white patients, using alternative denominators



* Period-prevalence of AOT cases active at any time during 2003, by selected denominators.

Swanson, J., Swartz, M., Van Dorn, R., Monahan, J., McGuire, T., Steadman, H., and Robbins, P. (2009). Racial disparities in involuntary outpatient commitment: Are they real? *Health Affairs*, 28, 816-826.

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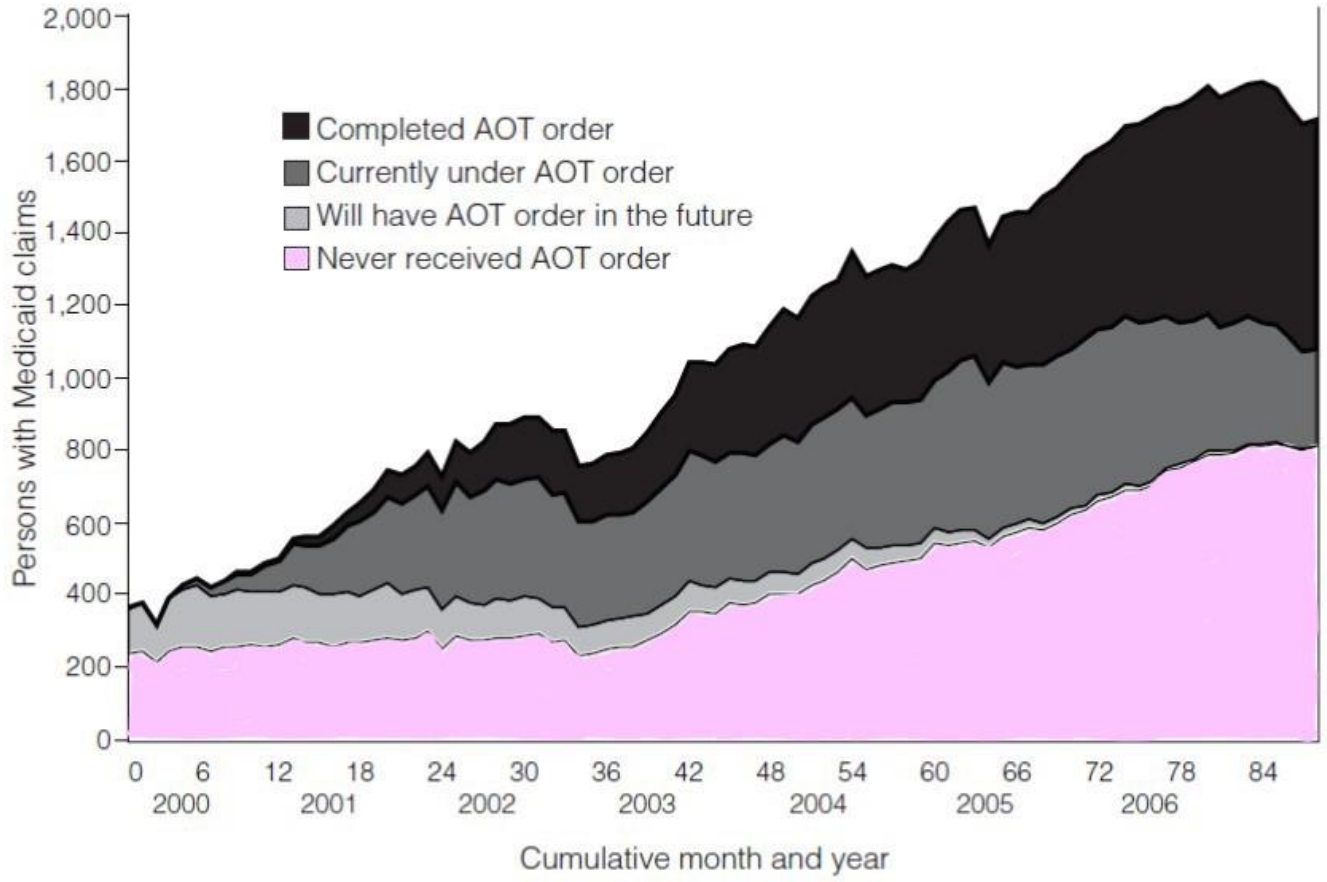
Does AOT "crowd out" voluntary treatment?

Distribution of Medicaid claims for assertive community treatment or intensive case management after implementation of assisted outpatient treatment (AOT), by month and AOT order status



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Policy guidelines: all commitments

- Purpose must be treatment
  - Need for treatment an essential element
  - No commitment, inpatient or out, without reliable diagnosis of a serious MI for which effective treatment is available
  - No commitment solely for preventive detention or community control
- No commitment if person willing and able to engage with services voluntarily
- Treatment staff should should have authority to (and should) terminate commitment when individual no longer meets commitment criteria

Policy guidelines, inpatient commitment

- No *inpatient* commitment unless, without hospital-level care, person at significant risk, in the foreseeable future, of behaving in a way, actively or passively, that brings harm to person or others
  - Risk for harm should not require risk of violent behavior
  - May include risk for injury, illness, death, or other major loss solely due to MI symptoms such as inability to exercise self-control, judgment, and discretion in conduct of daily activities, or to satisfy need for nourishment, personal/ medical care, shelter, or self-protection and safety

Policy guidelines: inpatient commitment (cont')

- No inpatient commitment if with help of family, friends, or others (who are available and willing to help), person capable of remaining in the community without presenting risk of harm
- No inpatient commitment if less restrictive alternative available, including outpatient commitment

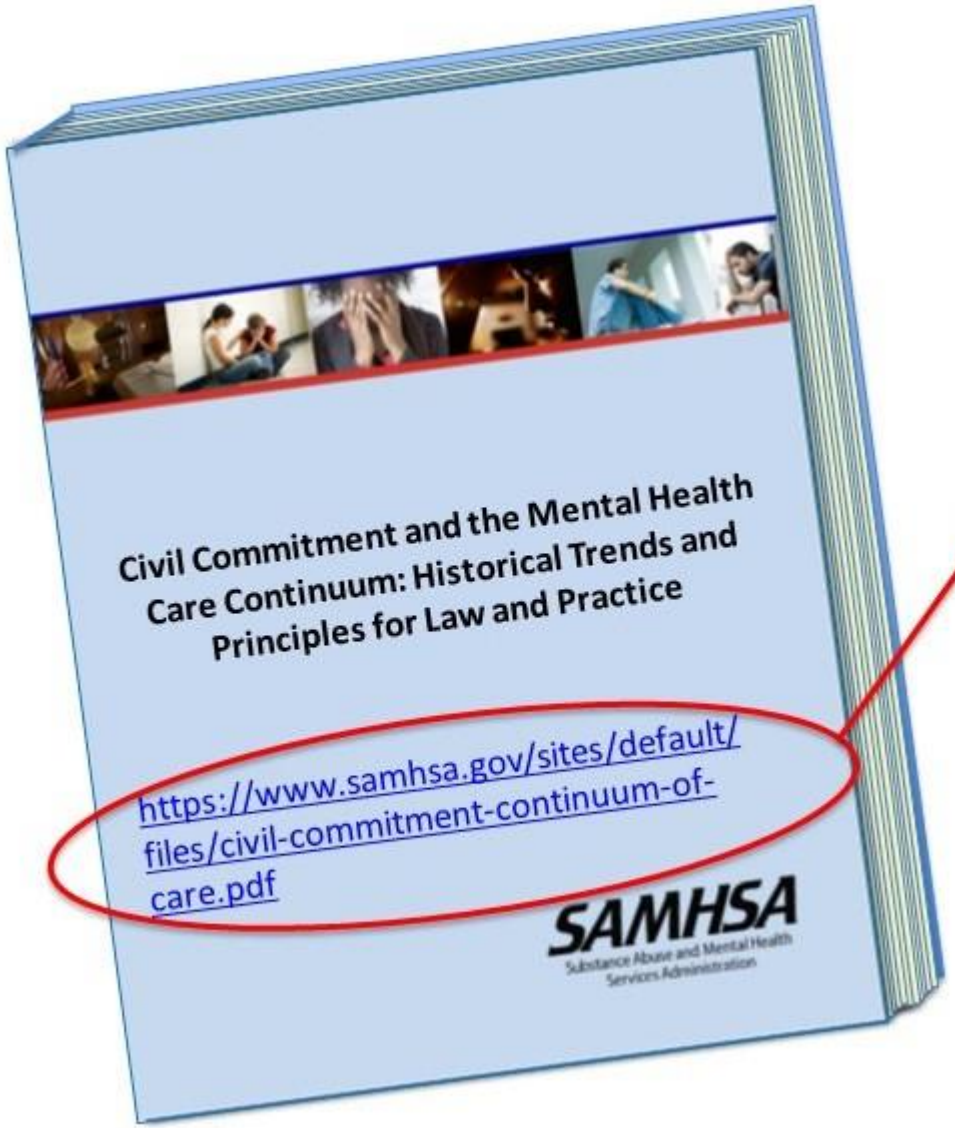
Policy guidelines: outpatient commitment

- No outpatient commitment unless:
  - (i) person meets inpatient commitment standard but may be served in less restrictive setting, or
  - (ii) without services proposed, it is reasonably predictable that person will experience further disability or deterioration to degree that, in the foreseeable future, person will meet inpatient commitment standard
- Outpatient commitment under (ii) may require additional finding of impairment in person's understanding of the nature of their MI and the treatment proposed, including potential risks and benefits of treatment and the expectable consequences if commitment is or is not ordered

Policy guidelines: procedural considerations

- Commitment practices should respect privacy and dignity and minimize trauma
  - If police provide transport, should use plainclothes officers in unmarked cars
  - Shackles and other restraints used only if necessary
- Unless person charged with crime (or serving sentence), no pre-commitment detention in jail
- Commitment proceeding should provide full due process (notice, counsel, right to court review)
- Before terminating any commitment, treatment staff should arrange appropriate services and supports in the community

Policy guidelines



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