State Civil Commitment Laws: A White Paper

American Health Lawyers Association

**ABSTRACT:** On April 24, 2019, the Substance Abuse and Mental Health Services Administration (SAMHSA) and the American Health Lawyers Association hosted a convener session on state civil commitment law issues. Experts from around the country gathered for a day-long meeting to identify the most pressing issues and discuss possible solutions. The participants in attendance represented a diversity of backgrounds, expertise, and viewpoints on the issue. Convener participants were all individuals who handle matters related to state mental health laws, and they presented their individual viewpoints on the subject.

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INTRODUCTION

The American Health Lawyers Association (AHLA) hosts nonpartisan expert panel convener sessions in order to provide a neutral forum for the frank and candid exchange of views and analyses among invited experts on select health care policy issues that have a clear legal nexus. White papers and supplemental resources often result from these convener sessions. These sessions underscore AHLA’s commitment to promote a better understanding of health care issues and to encourage constructive dialogue among all affected industry stakeholders, government, academia, and the lay community.

On April 24, 2019, the Substance Abuse and Mental Health Services Administration (SAMHSA) and AHLA hosted a convener session on state civil commitment law issues. Experts from around the country gathered for a day-long meeting to identify the most pressing issues and discuss possible solutions. The participants in attendance represented a diversity of backgrounds, expertise, and viewpoints on the issue. Convener participants were all individuals who handle matters related to state mental health laws, and they presented their individual viewpoints on the subject.

This white paper captures the major themes and recurring issues that convener participants—with their diverse experience, expertise, and perspectives—discussed and debated during the day-long session. It offers a range of feasible and practical options and solutions that were suggested as a result of the healthy dialogue that took place—options and potential solutions that political leaders, community activists, and patient advocates may want to consider and tailor to the current needs of their communities. Given the nature of convener discussions, this white paper includes statements that reflect everything from a broad consensus of all participants to the view of an individual participant.

Civil commitment is the legal process by which a judge can order an individual with a serious mental illness to be confined against his/her will or compelled to receive outpatient treatment. State civil commitment laws play an important role in mental health care systems. The civil commitment process is often viewed as a last resort to helping an individual access necessary treatment.

This article will discuss suggestions for how states can (1) reduce the number of civil confinements and (2) improve the civil commitment process. Ultimately, states should strive to decrease its number of civil commitment incidents and increase its focus on developing comprehensive systems of community supports to address mental health services. What can policymakers do to create a robust, community-based
system that helps individuals avoid involuntary detention? What does a system with less fragmentation and increased access to services look like? How can policymakers be convinced to spend scarce public resources to implement reforms?

Comprehensive mental health systems are currently the exception in the U.S., making civil (i.e., involuntary) commitment necessary to ensure that individuals with serious mental illness receive prompt and much needed care. The laws and procedures that govern the process of civil commitment must ensure that individuals with mental illnesses are treated with dignity. Currently, there is no consensus on how state laws can strike the right balance between protecting the civil rights of individuals while also providing timely access to care. States are struggling to do the following while also addressing the issues that may arise in pursuing these goals within their existing legal frameworks: (i) effective implementation of court-supervised treatment programs; (ii) safe transportation of individuals suffering a mental health crisis; (iii) use of the civil commitment process for individuals with substance use disorders; and (iv) data collection on patient outcomes.

While this article does not provide a panacea that will make mental health care systems or the civil commitment process work better, it does provide suggestions that may be helpful for policymakers to consider.

**PRE-CIVIL COMMITMENT ISSUES**

*Improving Access and Treatment:* The need for improved access to various treatment modalities and services is clear. States should evaluate what services this patient population needs and where services may be lacking. The issue is not necessarily about keeping individuals out of certain types of facilities but rather, ensuring that a continuum of care can provide individuals with clinically appropriate, evidence-based services. When an appropriate treatment or service is unavailable, other levels of care become disrupted due to a bottleneck effect, *i.e.*, an increasing number of patients awaiting treatment that is unavailable or in short supply. A range of community-based treatment options already exist beyond involuntary commitment. In addition, an individual’s needs and preferences change over time; it is important to keep in mind the fluidity of the human condition, especially when dealing with one’s mental health.

Disparate options are available to those living with serious mental illness depending on where they live in the country. Some states have more robust treatment options than others. The availability of options is widely determined by a state’s Medicaid funding (*i.e.*, whether the state is a Medicaid expansion state or not), as well as the
criminal justice system’s role in diverting people to mental health care facilities rather than incarcerating them. A large percentage of this patient population is on Medicaid, Medicare, or otherwise uninsured. Expanding coverage for mental health treatment and services through federal health care programs must be part of any long term solution that aims to increase access to mental health care.

Discussion about the barriers that exist for patients receiving institutional care is ongoing. Under the Institutions for Mental Diseases (IMD) exclusion, states are forbidden from using federal Medicaid funds to reimburse inpatient mental health and substance use disorder facilities with more than 16 beds that provide treatment for non-geriatric adults. Medicare beneficiaries are also capped to 190 days of inpatient psychiatric care in their lifetime.

Several newer options are available for states to obtain a waiver of the IMD exclusion that may assist in expanding capacity for residential care. Yet, only a few states have applied for these waivers as of the date of this article’s publication.

A lack of funding is a major obstacle to increasing the availability of treatment options. Many states face bed shortages that disrupt the health care system. As the number of public psychiatric hospitals continue to shrink, more individuals with serious mental illness are left untreated or must seek inadequate treatment from hospital emergency room departments. Funding issues also disrupt the continuity of care. A lack of resources has been cited as a reason for high employee turnover at facilities, resulting in patients having to frequently start new relationships with different social workers, psychiatrists, and therapists. Finally, uncertainty over whether Medicare or Medicaid will reimburse providers can result in patients not receiving services when transitioning out of inpatient facilities.

States should consider providing more community-based programs, coupled with social services, to individuals with mental illnesses. Resources related to housing, transportation, and employment-related assistance are needed just as much as health care services and should be made available to this patient population. Making these services accessible is one of the most effective ways to keep people with mental illnesses out of hospitals and jails. A common suggestion is to make it clear that these social services are reimbursable. Other suggestions for reducing civil commitments include:

- Using early intervention programs in schools and primary care programs (i.e., screening, brief intervention, and referral to treatment) to help persons receive care before a mental health crisis occurs.
• Increasing the use of alternative payment models to help improve patient outcomes.

• Using mental health courts and other court-supervised treatments as a way to divert patients from jail or sporadic crisis-based inpatient treatment, and into options with more longevity and resources for stability.

Preserving Autonomy and Psychiatric Advance Directives: Psychiatric advance directives are a potential way to preserve patient autonomy and make their wishes known. An advance directive or mental health power of attorney enables a person who anticipates a potential mental health crisis to draft a document setting out how the individual would prefer to receive treatment in a crisis.

Although the Centers for Medicare & Medicaid Services (CMS) has recognized the importance of psychiatric advance directives since 2006, their use is uncommon. There have been instances where hospitals have delayed providing someone with inpatient treatment because staff did not understand how an advance directive works.¹ Health care providers and state policymakers can take action to facilitate their use, and states should consider providing more education and training about advance directives.

For example, one recommendation is that states adopt legislation that explicitly permits the use of advance directives, as opposed to validating them through other applicable laws.² Specific laws can assist with education efforts for clinicians, particularly if the advance directive was made a component of community-based treatment programs for those with a chronic mental health condition.

Facilities must also be aware of when an individual has an advance directive. This issue in particular surfaces when a patient is transferred between facilities. An advance directive must be in a patient’s electronic medical record and each health care provider must have access to the same document for it to be effective. It is important therefore that advance directives are included in health information exchanges.

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¹ Regardless of whether an advance directive is explicitly permitted by state law, facilities receiving Medicare and Medicaid reimbursements are required to recognize advance directives for behavioral health. See SAMHSA, ADVANCE DIRECTIVES FOR BEHAVIORAL HEALTH, https://www.samhsa.gov/section-223/governance-oversight/directives-behavioral-health (last updated May 17, 2019).

² “Currently, 25 states have laws that permit psychiatric advance directives. For states that do not, an individual can still draft a PAD under the more general statutes connected to health care directives, or Living Wills” according to the National Alliance on Mental Illness. See Psychiatric Advance Directives (PAD), NAMI, https://www.nami.org/Learn-More/Mental-Health-Public-Policy/Psychiatric-Advance-Directives-(PAD) (last visited Sept. 15, 2019).
THE CIVIL COMMITMENT STANDARD

While most mental health services and treatments are provided voluntarily, civil commitment is widely viewed as necessary under certain circumstances. These laws can prevent the negative consequences that may occur when an individual who is a danger to him/herself or others goes without treatment. Every state has adopted laws that stipulate when someone can be involuntarily committed; however, there are considerable differences between these laws. For example, nearly every state has a law that says individuals who are “dangerous to self or others” can be subjected to involuntary inpatient treatment. But several states have expanded their commitment laws to allow “serious deterioration” as a separate standard. Regardless of the language used, every state permits involuntary commitment for individuals who are unable to take care of their basic needs because of mental illness.

States should consider whether using the word “dangerousness” in their standards for civil commitment creates a stigma for mental illness. Most people still believe that an individual must be dangerous in order to be committed into a mental hospital, even though many states have moved away from this being the only criterion for commitment. States could potentially remove the word “dangerousness” from their statutes without effectively changing how their civil commitment standards are applied.

There is also some dispute over whether lowering the threshold for inpatient commitments improves access to care. It has been suggested that when the commitment standard is set below “medical necessity,” it has very little impact on who gets committed. State law almost always requires a medical professional’s opinion to support commitment. Psychiatrists and psychologists are unlikely to recommend involuntary commitment when it is not considered medically necessary because it would contravene their professional obligations and likely violate insurance and Medicaid policies that will not pay hospitals for admitting patients at a lower standard.

Yet, the standard could still influence who comes into the commitment pipeline. Commitment cases are initiated for a variety of reasons. Family members and others often consider this standard before starting the process. Thus, the standard can become a way to get an individual access to care even in cases where ultimately there is not a commitment hearing.

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MODEL CIVIL COMMITMENT LAW

Given the wide variations between state laws, a model law could be a useful reference for legislators. States have different rules and procedures related to several parts of the civil commitment process, including the length of time an individual may be held in custody before a psychiatric evaluation occurs and when hearings must happen, but it is difficult to generate consensus on what a model law should look like. In addition, civil commitment laws are not uniformly applied within states. Therefore, even if a great law existed, there would still be significant variations on how it is interpreted and implemented. Drafting a model law also may be premature because there is not enough data to support what types of standards and procedures work best.

IMPROVING THE CIVIL COMMITMENT PROCESS

Training and Education: Overcoming the stigma associated with civil commitment is challenging but critical to helping communities understand that the concept of civil commitment adds to the dignity and increases the rights of individuals with serious mental illness. Civil commitment, which may often be portrayed as denying someone their civil liberty, can be the tool that provides an individual the right to receive needed care and treatment, as well as the means to protect the individual from harming him/herself or others.

A common suggestion for improving the civil commitment process is to provide more cross-training about the legal system between the different disciplines of health care providers, such as physicians, therapists, nurses, and other clinicians; and likewise providing attorneys and judges with more training about the health care system.

Increased cross-training can help everyone recognize when the involuntary commitment process needs to take effect, including the additional opportunities the system has for a patient so that future crisis interactions can be avoided. Such increased cross-training can also reduce conflicts between clinical staff and legal professionals. One consideration to take into account in efforts to increase cross-training amongst and between the various clinicians and legal professionals is having states approve more online and on-demand classes for professional continuing education credits.

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5 One participant noted there has not been a significant push towards drafting a uniform law since the American Psychiatric Association published its model civil commitment law in 1982.
**Forced Medication:** Another issue that states must consider is the use of medication. One idea to consider is that courts resolve medication-related issues during civil commitment hearings to avoid delaying treatment to patients. Many of these patients need medication to help them get through a mental health crisis, and the longer they wait for treatment, the more harm they suffer.

Typically, a patient does not get better simply by being in a psychiatric unit without medication. Deciding medication-related issues during a separate hearing may open the door for judges and attorneys to second guess decisions that are best left to the doctors. However, a patient's treatment preference should not be disregarded out of hand. It is important to recognize that civil commitment and forced medication are two distinct legal issues. Health care providers must understand that patients can refuse treatment under certain circumstances. Sometimes the best way to resolve medication-related issues is for health care providers to work with patients and their counsel to find a solution.

**Transportation:** For many patients, the civil commitment process begins in an emergency department and yet, there are numerous reasons to move patients out of this setting as quickly as possible. Emergency departments are not ideal therapeutic environments (bright lights, high noise level, lots of activity) for individuals experiencing a mental health crisis. In addition, the patient experiencing such a crisis often does not receive immediate, necessary, and active treatment and care. However, transporting patients between facilities during the civil commitment process can be a burdensome and challenging issue for states and private hospitals for several reasons:

- Lack of available beds at inpatient facilities
- Disputes over who is responsible for moving the patient
- The proximity between facilities in large rural states
- Issues related to transferring a patient with dignity

States vary on who is authorized to transport individuals during a mental health crisis. For example, some states exclusively rely on law enforcement to transport patients. Conversely, other states permit transportation by non-law enforcement, such as emergency responders and dedicated crisis response units.
Law enforcement agencies spend an extraordinary amount of time and resources transporting individuals with mental illnesses. Some of these individuals are not actively dangerous, thus eliminating the need for law enforcement to perform this task; however, ambulances and stretcher vans are either too costly or considered inadequate alternatives given the patient’s legal status of emergency detention and inability to refuse transfer to the psychiatric facility.

Relatedly, concerns have been raised over the use of handcuffs and marked police cars to transport patients. State law should ensure that patients are transferred with dignity, particularly in situations involving minors and elderly adults. One suggestion is for states to adopt frameworks that permit transportation in unmarked vehicles with plain clothes officers and mental health techs trained in crisis intervention. States can also tackle transportation-related issues by requiring local municipalities to develop transportation plans with input from law enforcement agencies, hospitals, and other stakeholders. Other considerations for improving the commitment process:

- A person’s dignity must be considered during civil commitment hearings, regardless of what guardians and legal representatives have planned for meeting the person’s needs. Counsel participating in involuntary hearings should be mindful to avoid paternalistic thinking that they know what is best for the patient in the absence of the patient’s ability to self-promote his or her own wishes.

- A treating physician’s testimony during a hearing can have an adverse impact on the patient-physician relationship. Allowing a non-treating physician to perform a psychiatric evaluation and subsequently testify about the results is a potential way to preserve this relationship; however, this option may not always be available because it requires additional staffing and resources. Obtaining a psychiatric evaluation by a non-treating physician can also make it more difficult to present evidence in support of committing an individual. As a best practice, physicians should inform their patients about the reasons for an evaluation and the possibility that they might have to testify about the results of such an exam.

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6 Law enforcement spends almost a billion dollars every year transporting individuals, a participant said.
CIVIL COMMITMENT AND SUBSTANCE USE DISORDERS

There are divergent views over whether civil commitment proceedings should be used for individuals with substance use disorders. The opioid epidemic has raised awareness of drug addiction issues. As a result, more state resources are being used for patients with substance use disorders; however, the opioid epidemic has not necessarily led to more involuntary commitments.

Addiction and the involuntary commitment process are not easily squared. While some states’ laws allow for the process to be utilized in severe cases of addiction, practitioners (physicians and lawyers alike) rarely encounter the process used to place someone in treatment against their will. There is a lack of appropriate placement facilities for substance use disorders. In addition, and most controversial, clinicians find it difficult to confidently determine whether addiction has overridden a person’s free choice.

Substance use disorders can be life threatening. Individuals who have addiction issues may fall under already existing civil commitment standards. Someone who has overdosed multiple times may not be able to take care of his/her basic needs, and thus be subject to involuntary commitment; however, concerns have been raised over whether explicitly including substance use disorders disincentivizes a person from voluntarily seeking treatment.

When the civil commitment process is used in instances involving substance use disorders, there must be clear and firm standards that protect the individual’s civil rights, but some have questioned whether commitment proceedings for these types of situations should have different standards and procedures.

Substance use disorders and other types of mental illness often co-occur. It can be unclear whether the underlying disability is drug addiction or another mental illness. Creating separate civil commitment rules and procedures for substance use disorders may cause hearings to become too focused on deciding an individual’s diagnosis, whereas commitment hearings should be focused on whether an individual needs treatment for a mental illness. Moreover, creating a separate process could also add stigma to addiction issues without expanding access to meaningful treatments. Further, many believe the use of the drug court model is an important tool in the case of substance use disorders, particularly given the volume of interaction with the criminal justice system and substance use disorder cases.
ASSISTED OUTPATIENT TREATMENT, MENTAL HEALTH COURTS, AND OTHER DIVERSION PROGRAMS

Nearly every state now has laws that permit assisted outpatient treatment (AOT) for persons who meet certain criteria. AOT allows courts to order individuals with severe and impairing mental illness into community-based treatment programs. Typically, outpatient commitment laws are aimed at individuals who have a history of not complying with treatment and who have a history of serious impairment as a result of untreated mental illness that endangers them or others.

AOT has been demonstrated to reduce hospitalizations and arrests, and it provides another option to help patients get access to care. However, some states still have not provided the structure or resources to make AOT effective. Moreover, questions exist about whether courts can hold patients accountable for failing to follow through with their treatment plans. In many states, AOT relies on a “black robe effect” to encourage individuals to comply with recommended treatment. Some will refuse treatment just because that treatment is required by a court order, but a court order can be of assistance in helping individuals make a decision about participating in recommended treatment. Some suggestions related to AOT implementation include the following:

- Provide judges with quick reference guides about inpatient and outpatient laws. Provide treatment teams with a companion manual.
- Obtain more data about how AOT, mental health courts, and diversion programs can be more effective.
- Free up beds by connecting forensic patients to services in their community, rather than having them wait in hospitals for competency examinations.
- Require law enforcement agencies to provide to mental health courts a list of those participating in AOT and who have been arrested. Doing so can help ensure that individuals with mental illness receive treatment, and it can also help the courts track individuals in their programs.

THE NEED FOR MORE DATA

The theme for which there was universal agreement was the need for more data and information about what can be done to engage this patient population with meaningful treatment and services. It is difficult to advocate for this patient population because
of a lack of data points that describe the current situation for the most seriously mentally ill who are not able to access the treatment system effectively.

More data can help measure whether states are improving patient outcomes or whether resources are being used effectively. State collection of data on recidivism rates—how frequently individuals are incarcerated or placed in inpatient facilities and hospitals—may be a useful data collection point.

Data can also play an important role in convincing policymakers that certain health care reforms are needed. One consideration is making the “business case” to legislators that it is fiscally responsible to take a course of action. This patient population takes a significant amount of resources away from the system. By engaging this patient population, states can generate cost savings.

Hospitals have developed programs to address the 5% of the population that takes 50% of the emergency department resources, and a similar concept could be applied to a community-wide mental health program. Having a data sharing construct that enables a case manager to follow a targeted group of persons with frequent interactions with law enforcement, hospital emergency departments, and psychiatric units—ensuring that they are connected to all available community resources—could help avoid the costly, cyclical, and often traumatic crisis interventions.

However, policymakers should not simply consider cost neutrality. For example, there has been some pushback related to whether mental health courts are a less expensive solution than incarcerating an individual; however, the role of government is to assist its citizens.

Incarceration is associated with a substantial risk of not receiving treatment for a mental illness which contributes to adverse outcomes for those individuals including a worsening of illness and development of a mental illness that may be more difficult to treat with currently available medications and therapies. Therefore, not every decision should be based on cost alone.
CONCLUSION

Civil commitment is a powerful tool that may be used by states to provide those living with serious mental illness care and safety. Civil commitment laws vary greatly and come with many considerations for states and local organizations. Ideally, the goal is to have a comprehensive and robust system of mental health care to intervene early and avoid civil commitment. In the absence of such a system, we must rely on civil commitment as a necessary tool and do all we can to ensure it is implemented as effectively as possible.