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Assisted Outpatient Treatment: A State-by-State Comparative Review

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ABSTRACT

Assisted outpatient treatment, otherwise known as preventive outpatient commitment, is rapidly expanding across the United States, aiming to address mental health needs and reduce homelessness, hospital costs, and community violence. Since 2019, fifteen preventive outpatient commitment statutes have been passed or expanded. These statutes, which authorize courts to mandate community treatment for nondangerous individuals with mental illnesses, have evaded close scrutiny, rest on misconceptions, and raise significant constitutional concerns. An analysis of legislative debates, court opinions, and scholarship reveals a fundamental misunderstanding about the prevalence of these laws, which contributes to their speedy passage. Additionally, no analysis exists of these statutes' varying compositions. Consequently, commentators underestimate their potential scope and enforceability. Furthermore, a lack of clarity regarding the elements responsive to states' parens patriae and police power interests hinders accurate legal and policy analyses.

This Article explicates current preventive outpatient commitment statutes to enhance understanding of states' authority to compel community treatment. It seeks to dispel common misconceptions about these statutes, including their prevalence, minimal invasiveness, applicability to only those lacking insight into their condition, and unenforceability through courts' contempt power. It also offers a detailed analysis of the aspects of these statutes most crucial to their justifiability, i.e., criteria related to dangerousness and treatment decision-making incapacity. Such examination is necessary to understand the evolving relationship between states and individuals with mental disorders, discern the goals of compelled treatment statutes, and assess their

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legality. It is also essential for evaluating the success of these statutes and determining when a state's objectives have been fulfilled such that courts may not renew commitment orders.

This analysis aims to enrich future debates about the authority underpinning these statutes, their ideal composition, and their impact. It also lays the foundation for future projects to examine the constitutionality of these statutes, their efficacy, and their broader justifications.

CONTENTS

I. INTRODUCTION

On July 12, 2024, law enforcement officers in Fontana, California, conducted "Operation Shelter Me" with the aim of assisting the area's houseless individuals.[1] Officers searched for individuals exhibiting symptoms of mental illness from 6 a.m. to 4 p.m.[2] In 2023, the county had opted into California's assisted outpatient treatment law, which permits courts to order community treatment for individuals with serious mental illnesses to prevent deterioration likely to result in grave disability or harm.[3] Unlike most states with similar laws, California requires that authorities invite targeted individuals to voluntarily accept services before processing a court petition for compelled treatment.[4] On July 12, all targeted individuals voluntarily accepted treatment, rendering court petitions for mandatory treatment unnecessary.[5]

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[1] *See Authorities Help Dozens of Homeless People During Special Operation in Fontana Area*, FONTANA HERALD NEWS (July 15, 2024), https://www.fontanaheraldnews.com/news/authorities-help-dozens-of-homeless-people-during-special-operation-in-fontana-area/article_5e974cc8-42da-11ef-9e21-a3d647254c9b.html.

[2] *Id.*

[3] *See id.*; CAL. WELF. & INST. CODE § 5346(a) (Deering 2024).

[4] CAL. WELF. & INST. CODE § 5348(b) (Deering 2024).

[5] *See* FONTANA HERALD NEWS, *supra* note 1.

Other states are also looking to assisted outpatient treatment—more accurately termed preventive outpatient commitment ("POC")[6]—as a possible solution to societal ills ranging from homelessness to soaring hospitalization costs and community violence.[7] Twenty-three states currently authorize POC,[8] with fifteen having enacted or expanded their statutes since 2019.[9] At least five states are currently

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6 Outpatient commitment is a "statutory and/or court-derived mandate for treatment in the community" with goals of "increasing outpatient treatment compliance, decreasing use of inpatient resources, and improving quality of life for persons with serious mental illness." Jeffrey L. Geller, *The Evolution of Outpatient Commitment in the USA: From Conundrum to Quagmire*, 29 INT'L J.L. & PSYCHIATRY 234, 234 (2006).

7 *See, e.g.*, Jan Ransom et al., *New York Claims Progress in Moving Mentally Ill People Off Streets,* N.Y. TIMES (Nov. 29, 2023), https://www.nytimes.com/2023/11/29/nyregion/nyc-adams-homeless-mentally-ill.html; Alisa Chang, *The Politics of Involuntary Commitment*, NAT'L PUB. RADIO (March 29, 2023, 5:00 PM), https://www.npr.org/2023/03/29/1166782560/the-politics-of-involuntary-commitment (reporting that Portland Mayor Ted Wheeler called for expanding the scope of outpatient commitment to address homelessness and quoting New York City Mayor Eric Adams's announcement: "[i]f severe mental illness is causing someone to be unsheltered and a danger to themselves, we have a moral obligation to help them get the treatment and care they need"); Assisted Outpatient Treatment Demonstration Project Act of 2002, ch. 1017, 2002 Cal. Legis. Serv. (A. B. 1421) (West) (codified at CAL. WELF. & INST. CODE §§ 5345–5349.5 (Deering 2024)) (ordering counties to report on "the effectiveness of the strategies employed . . . in reducing homelessness and hospitalization of persons in the program and in reducing involvement with local law enforcement by persons in the program").

8 *See infra* Table A; *see also* ALA. CODE § 22-52-10.2(a) (2024) (expiring Dec. 31, 2024, effective Jan. 1, 2025); CAL. WELF. & INST. CODE § 5346(a) (Deering 2024); DEL. CODE ANN. tit. 16, § 5013(a) (West 2024); FLA. STAT. ANN. § 394.467 (West 2024); GA. CODE ANN. § 37-3-1(12) (West 2024); GA. CODE ANN. § 37-3-1(12.1) (West 2024); HAW. REV. STAT. ANN. § 334-121 (LexisNexis 2024); 405 ILL. COMP. STAT. ANN. 5/119.1 (LexisNexis 2024); KY. REV. STAT. ANN. § 202A.081(5) (LexisNexis 2024); LA. STAT. ANN. § 28:66(A) (West 2024); ME. REV. STAT. ANN. tit. 34B, § 3873-A (2023); MD. CODE ANN., HEALTH-GEN. § 10-6A-05 (West 2025); MONT. CODE ANN. § 53-21-127(7) (West 2023) (expiring June 30, 2025, effective July 1, 2025); MONT. CODE ANN. § 53-21-126(1)(d) (West 2023); NEV. REV. STAT. ANN. § 433A.335(3) (LexisNexis 2023); N.M. STAT. ANN. § 43-1B-3 (LexisNexis 2024); N.Y. MENTAL HYG. LAW § 9.60(c) (LexisNexis 2025) ("Kendra's Law") (expiring June 30, 2027); N.C. GEN. STAT. § 122C-271(a)(1) (2024); OHIO REV. CODE ANN. § 5122.01(B)(5)(a) (West 2024); OKLA. STAT. tit. 43A, § 1-103(20) (West 2024) (expiring Oct. 31, 2024, effective Nov. 1, 2024); OR. REV. STAT. ANN. § 426.133(2)-(3) (West 2024); 50 PA. STAT. AND CONS. STAT. § 7301(c) (West 2024); TEX. HEALTH & SAFETY CODE § 574.0345(a) (West 2024); UTAH CODE ANN. § 26B-5-351(14) (LexisNexis 2024); WASH. REV. CODE ANN. § 71.05.148(1) (LexisNexis 2024).

In March 2024, Kansas passed a new law that may qualify as a POC statute. *See* KAN. STAT. ANN. § 59-2967 (West 2024). Because the statute authorizes a court to order outpatient treatment "in lieu of any type of order that would have required inpatient care and treatment," outpatient treatment may only substitute for an inpatient commitment order. *See id.* However, this interpretation renders superfluous the new statutory standard added in section 59-2967(a)(2), which seems to permit outpatient commitment before the person meets the inpatient standard. *See id.* Given the effective date of the statute (July 2024), it is too early to tell which interpretation is correct.

9 *See infra* Table A.

considering broadening or enacting new POC statutes.[10] Advocates for POC extol its ability to increase treatment effectiveness at systemic and individual levels by broadening treatment delivery, offering a proactive intervention, inducing active participation in treatment, and increasing "the appreciation of community life by allowing for a sustained period of psychosis-free living in communities."[11]

POC is controversial because it compels mental health treatment before affected individuals qualify for involuntary hospitalization.[12] POC statutes often (though not always)[13] target individuals with a history of multiple hospitalizations and prior (though not necessarily current) unwillingness to participate in treatment.[14] These statutes focus on "revolving door" patients—individuals with serious mental illnesses who require hospitalization, return to the community once stabilized, fail to access community treatment, relapse, and ultimately deteriorate to the point of needing hospitalization again.[15]

By expanding the scope of states' power to compel treatment, POC enlarges states' nets of social control. This largely differentiates POC from two other common, less

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[10] *See, e.g.*, S. 980, 193rd Gen. Assemb. § 8 ½(a) (Mass. 2023) (filed in January 2023, sent to a study order by the Joint Committee on the Judiciary on July 1, 2024); H.B. 508, 113th Gen. Assemb. (Tenn. 2023) (pending consideration in the House Health Subcommittee). Sofia DeMartino, *Nowhere to Turn: Mental Health Care in Crisis*, THE GAZETTE (Feb. 2, 2025), https://www.thegazette.com/staff-columnists/nowhere-to-turn-mental-health-care-in-crisis/ [https://perma.cc/Q7UD-R73Q] (Iowa); OFFICIAL WEBSITE OF GOVERNOR KATHY HOCHUL, GOVERNOR HOCHUL PROPOSES STRENGTHENING INVOLUNTARY COMMITMENT LAWS AND KENDRA'S LAW TO PROVIDE SUPPORT AND RESOURCES FOR NEW YORKERS EXPERIENCING SERIOUS MENTAL ILLNESS, https://www.governor.ny.gov/news/governor-hochul-proposes-strengthening-involuntary-commitment-laws-and-kendras-law-provide (Jan. 14, 2025) [https://perma.cc/836Y-XN74]. New Mexico is slated to address an expansion to the state's Assisted Outpatient Treatment Act during a sixty-day session in January 2025. *See* Daniel J. Chacón, *Governor Withdraws Highly Contentious Bill from Special Session Agenda*, SANTA FE NEW MEXICAN, https://www.santafenewmexican.com/news/local_news/governor-withdraws-highly-contentious-bill-from-special-session-agenda/article_da056f72-33d8-11ef-ae55-0b8030ae15d1.html (last updated July 15, 2024).

[11] Geller, *supra* note 6, at 236.

[12] Candice T. Player, *Involuntary Outpatient Commitment: The Limits of Prevention*, 26 STAN. L. & POL'Y REV. 159, 164, 176 (2015).

[13] *See infra* Part V.A.

[14] *See, e.g.*, CAL. WELF. & INST. CODE § 5346(a)(4)(A) (Deering 2024); KY. REV. STAT. ANN. § 202A.0815(2)(a) (LexisNexis 2024); NEV. REV. STAT. ANN. § 433A.335(3)(c)(1) (LexisNexis 2023).

[15] David Sharrett et al., *Report of Task Force on Involuntary Outpatient Commitment*, AM. PSYCHIATRIC ASS'N (1987) ("Many of these patients responded well to treatment when hospitalized, but rapidly relapsed after discharge, leading to the 'revolving door' syndrome of repeated brief hospitalizations followed by relapse after discharge."); *see* Ashley Primeau et al., *Deinstitutionalization of the Mentally Ill: Evidence for Transinstitutionalization from Psychiatric Hospitals to Penal Institutions*, 2 COMPREHENSIVE PSYCH. 1, 2 (2013).

controversial forms of outpatient commitment.[16] One form offers compelled community treatment as a less restrictive alternative to involuntary hospitalization.[17] Another uses it as a means of conditional release from hospitalization,[18] where release requires individuals' compliance with community treatment.[19] Importantly, the criteria of less-restrictive and conditional-release outpatient commitment statutes often (although not always)[20] mirror states' inpatient commitment criteria.[21] As a result, both forms of commitment can serve to reduce a deprivation of liberty by allowing individuals who might otherwise be involuntarily hospitalized to receive treatment in a less restrictive community setting. Additionally, by linking outpatient commitment to the current or recent fulfillment of inpatient commitment criteria, these forms of compelled community treatment are limited to individuals at the highest risk of requiring hospitalization if they do not adhere to medication directives.

POC statutes have evaded close scrutiny,[22] rest on misconceptions, and are of dubious constitutionality.[23] Commentators and policy advocates often fail to distinguish between important variations of outpatient commitment statutes that target different populations and serve different purposes.[24] Without detailing the varying compositions of these statutes, commentators underappreciate their scope and enforceability.[25] Furthermore, a lack of clarity regarding the elements responsive to

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16 *See* Bruce J. Winick, *Outpatient Commitment: A Therapeutic Jurisprudence Analysis*, 9 PSYCH. PUB. POL'Y & L. 107, 111–13 (2003).

17 *See id.* at 111.

18 *See, e.g.*, ALASKA STAT. § 47.30.795 (West 2024); ARIZ. REV. STAT. ANN. § 36-540.01(A) (West 2024).

19 *See* Christopher Slobogin, *Involuntary Community Treatment of People Who Are Violent and Mentally Ill: A Legal Analysis*, 45 HOSP. & CMTY. PSYCHIATRY 685, 686 (1994).

20 *See* Richard C. Boldt, *Conditional Release and Consent to Treatment*, 48 L. & PSYCH. REV. 39, 42 (2023) ("In some jurisdictions, the step-down conditional release arrangement is based on an assessment that the patient no longer meets the state law requirements for inpatient commitment, particularly that she is no longer dangerous to herself or to others.").

21 Winick, *supra* note 16, at 111.

22 Earlier versions of preventive commitment statutes were the subject of considerable scholarly commentary but rarely granular analysis. *See generally, e.g.*, Steven J. Schwartz & Cathy E. Costanzo, *Compelling Treatment in the Community: Distorted Doctrines and Violated Values*, 29 LOY. L.A. L. REV. 1329 (1987); Slobogin, *supra* note 19; Elyn R. Saks, *Involuntary Outpatient Commitment*, 9 PSYCH. PUB. POL'Y & L. 94, 106 (2003); Winick, *supra* note 16, at 109; Richard C. Boldt, *Perspectives on Outpatient Commitment*, 49 NEW ENG. L. REV. 39, 39–40 (2014); Player, *supra* note 12, at 161.

23 *See* E. Lea Johnston, *The Constitutionality of Assisted Outpatient Treatment*, 86 OHIO ST. L. J. (forthcoming 2025) (on file with author) (deriving a framework for assessing the constitutionality of POC laws and applying it to existing state statutes).

24 *See infra* Part II.

25 *See infra* Part III.

the two sources of states' commitment powers—their parens patriae and police power interests—hinders accurate legal and policy analyses.[26]

This Article explicates current POC statutes to offer a more comprehensive and accurate understanding of the scope of states' power to compel treatment. It aims to dispel common misconceptions about these statutes—including their incidence,[27] minimal invasiveness,[28] application only to individuals lacking insight into their condition,[29] and unenforceability due to exemptions from courts' contempt power.[30] It also provides a detailed analysis of the portions of these statutes most crucial to their justifiability. Such close examination is necessary to understand the evolving relationship between states and individuals with mental disorders, discern the goals of compelled treatment statutes, and assess their legality. This analysis is also crucial for measuring the success of POC and determining when a state's goals have been met so that commitment orders should end.[31] Finally, the authors hope this Article will foster a more honest debate about the authority underpinning these statutes, their ideal composition, and their impact.

Part II of this Article provides data from a fifty-state survey on preventive and less-restrictive outpatient commitment statutes. These data aim to dispel misunderstandings about the prevalence of each type of statute—confusion that is often leveraged in contemporary legislative battles. Part III provides information on the scope of existing POC statutes. Although research on the actual content of court-ordered treatment plans is lacking, data on authorized components reveal the quality and quantity of intrusions into the lives of individuals who—before passage of these statutes—were beyond the reach of state control. Part III also addresses enforcement mechanisms available in each state and how clearly statutes provide notice of the existence (or absence) of these methods.

The remainder of the Article examines the statutory elements most relevant to states' commitment power. Part IV examines the element of treatment decision-making incapacity, which is crucial for a valid exertion of parens patriae authority. Part V analyzes the harms that POC statutes aim to address. POC statutes target individuals who cycle between the community and mental hospitals and carceral facilities due to treatment nonadherence. To gauge how well these statutes target their intended population, Part V.A examines the historical requirements of POC statutes.

Part V then assesses elements related to dangerousness, which are relevant to the state's police power. This discussion emphasizes three aspects of dangerousness: the nature of the anticipated harm, its imminence, and its likelihood. Specifically, Part V.B discusses POC statutes seeking to prevent deterioration to the satisfaction of

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26 *See infra* Parts IV & V.

27 *See infra* Part II.

28 *See infra* notes 71–73.

29 *See infra* notes 223, 225–27 and associated text.

30 *See infra* notes 122, 136–37.

31 *See* Slobogin, *supra* note 19, at 687 ("The predicted deterioration standard could easily create a class of patient who never escape the state's control because their dangerousness is always just around the corner."); *infra* note 120 (discussing the "lobster pot" effect).

inpatient criteria, while Part V.C addresses statutes aimed at preventing conditions less severe than those covered by inpatient standards. Statutes in the latter category—especially those without treatment incapacity elements—constitute more questionable expansions of states' authority over individual autonomy.

II. INCIDENCE OF PREVENTIVE OUTPATIENT COMMITMENT STATUTES

Widespread confusion exists about the prevalence of POC statutes.[32] Most uncertainty stems from the dual usage of the term "assisted outpatient treatment" ("AOT").[33] AOT originated as a statutory term of art used solely to denote a form of POC.[34] Eleven states have AOT statutes.[35] All employ criteria broader than those necessary for inpatient civil commitment.[36] Most aim to prevent deterioration that could lead to grave disability or harm, although not all do.[37] Most, but not all, require that the prospective committee have a demonstrated noncompliance with treatment resulting in hospitalizations, receipt of forensic services, or acts of violence.[38]

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[32] *See infra* notes 35, 39–44.

[33] John Kip Cornwell, *Exposing the Myths Surrounding Preventive Outpatient Commitment for Individuals with Chronic Mental Illness*, 9 PSYCH., PUB. POL'Y, & L 209, 209 n.3 (2003).

[34] *See* Erik Roskes et al., *"Assisted Outpatient Treatment": An Example of Newspeak?*, 64 PSYCH. SERVS. 1179 (2013) ("[T]he term ['assisted outpatient treatment'] was devised by proponents of Kendra's Law in New York . . . . It is clear to me . . . that use of the term 'assist' in this regard was a deliberate attempt to make the intervention seem less coercive and therefore more palatable.").

[35] *See* CAL. WELF. & INST. CODE § 5346 (Deering 2024); GA. CODE ANN. § 37-1-120(2) (West 2024); KY. REV. STAT. ANN. § 202A.0815 (LexisNexis 2024); NEV. REV. STAT. ANN. § 433A.335 (LexisNexis 2023); N.M. STAT. ANN. § 43-1B-3 (LexisNexis 2024); N.Y. MENTAL HYG. LAW § 9.60(c) (LexisNexis 2025); OKLA. STAT. ANN. tit. 43A, § 1-103(20) (West 2024); OR. REV. STAT. ANN. § 426.133 (West 2024); 50 PA. STAT. AND CONS. STAT. ANN. § 7301(c) (West 2024); UTAH CODE ANN. § 26B-5-351 (LexisNexis 2024); WASH. REV. CODE ANN. § 71.05.148 (LexisNexis 2024). Hawaii refers to POC as "assisted community treatment," and Louisiana refers to it as "assistive outpatient treatment." *See* HAW. REV. STAT. ANN. § 334-121 (LexisNexis 2024); LA. STAT. ANN. § 28:66 (West 2024).

[36] *Compare* POC statutes, *supra* note 35, *with* these corresponding inpatient commitment or treatment statutes: CAL. WELF. & INST. CODE ANN. § 5250; GA. CODE ANN. § 37-3-1(9.1); KY. REV. STAT. ANN. § 202A.026; NEV. REV. STAT. ANN. §§ 433A.0175(1), 433A.0195; N.M. STAT. ANN. §§ 43-1-11(E), 43-1-3(N), (O); N.Y. MENTAL HYG. L. § 9.37(a); OKLA. STAT. ANN. tit. 43A, § 1-103(13)(a); OR. REV. STAT. ANN. § 426.005(1)(f); 50 PA. STAT. AND CONS. STAT. § 7301(a), (b); UTAH CODE ANN. §§ 26B-5-332(16)(a), 26B-5-301(24) (defining "substantial danger"); WASH. REV. CODE ANN. §§ 71.05.240(4)(a), 71.05.020(37) (defining "likelihood of serious harm"), 71.05.020(25) (defining "gravely disabled").

[37] *See infra* Part V.B–C.

[38] *See infra* Part V.A.

Despite this shared statutory context, it is now common to proclaim—in scholarly publications,[39] news articles,[40] legislative testimony,[41] and state and federal court cases[42]—that AOT exists in forty-seven states. Essentially, "AOT" is now commonly used as a catch-all for all forms of involuntary outpatient commitment—that used as a less restrictive disposition to hospitalization and that serving a preventive function.[43] This fused terminology generates misinformation about the prevalence and type of involuntary outpatient treatment programs.[44]

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[39] *See, e.g.*, Robin E. Gearing et al., *Evolution of the Assisted Outpatient Treatment (AOT) Program Through the Application of a Social Work Lens*, 34 RSCH. ON SOC. WORK PRAC. 256, 257 (2024) ("47 states have implemented some form of an AOT program."); Marcia L. Meldrum et al., *Implementation Status of Assisted Outpatient Treatment Programs: A National Survey*, 67 PSYCHIATRIC SERVS. 630, 630 (2016) ("45 states have statutes authorizing assisted outpatient treatment."). Meldrum et al. characterize these statutes as serving a preventive function. *See id.*

[40] *See* Christina Hager, *Massachusetts is One of Only Three States Without this Mental Health Law*, WBZ NEWS, https://www.cbsnews.com/boston/news/i-team-massachusetts-assisted-outpatient-treatment-mental-health-legislation/ (last updated Feb. 7, 2024, 9:29 AM); Jhilam Biswas, *Opinion: A Missing Link in Massachusetts Mental Health Law*, BOSTON GLOBE, https://www.bostonglobe.com/2022/12/19/opinion/missing-link-massachusetts-mental-health-law/ (last updated Dec. 19, 2022, 3:00 AM) ("Forty-seven states have passed an Assisted Outpatient Treatment law.").

[41] *See The Mental Health – Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment: Hearing on S. 453 Before the S. Fin. Comm.*, 2024 Leg., 446th Sess. (Md. 2024) (statement of Evelyn Burton, Md. Advocacy Chair, Schizophrenia & Psychosis Action Alliance) ("It is time for Maryland to join the 47 other states and the District of Columbia and enable AOT."); *The Mental Health – Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment: Hearing on S. 453 Before the S. Fin. Comm.*, 2024 Leg., 446th Sess. (Md. 2024) (statement of David Trone, Rep., Md. 6th District) ("Maryland is one of only three states without the ability to connect our constituents with . . . care through assisted outpatient treatment services.").

[42] *See In re* K.L., 806 N.E.2d 480, 480 (N.Y. 2004) (asserting that, in 1999, New York "join[ed] nearly 40 other states in adopting a system of assisted outpatient treatment"); Coleman v. State Sup. Ct., 697 F. Supp. 2d 493, 506 n.8 (S.D.N.Y. 2010) ("New York is one of over 40 states with some type of AOT program.").

[43] *See, e.g.*, Doris A. Fuller & Debra A. Pinals, *Assisted Outpatient Treatment (AOT): Community-Based Civil Commitment*, NCSC, https://www.ncsc.org/__data/assets/pdf_file/0026/16964/mhf2-assisted-outpatient-treatment-jan-2020.pdf (last visited Feb. 28, 2024) (defining AOT as "a form of civil commitment that authorizes the judicial system to commit eligible individuals with severe psychiatric disorders to mental health intervention in the community" and equating it more broadly with "mandatory outpatient treatment" and "outpatient civil commitment;" later noting that "[c]riteria for AOT vary among the states" with about half having statutory criteria identical to those for inpatient commitment and the other half having distinct criteria).

[44] *See* Rachel A. Scherer, Note, *Toward A Twenty-First Century Civil Commitment Statute: A Legal, Medical, and Policy Analysis of Preventive Outpatient Treatment*, 4 IND. HEALTH L. REV. 361, 369–70 (2007) (observing that "different terms and abbreviations [referencing AOT] are being used interchangeably and possibly incorrectly in academic and medical discourse" and urging that, "[f]or clarification purposes, . . . the existing set of terms should be consolidated

To clarify the crucial differences in purpose and design among outpatient commitment statutes, this Article offers data from a fifty-state survey on state statutes authorizing less-restrictive outpatient commitment, POC, or both.[45] These data, presented in Table A, reveal that twenty-two states currently permit POC. In May 2024, an additional state (Maryland) passed a POC statute that will go into effect in July 2025.[46] Conversely, thirty-four states authorize outpatient commitment as a less restrictive alternative to hospitalization. In total, forty-seven states have statutes providing for less-restrictive-alternative outpatient commitment, POC, or both.

Table A also indicates when states' POC laws were passed and their most recent dates of expansion. Fifteen of twenty-three POC statutes were passed or have been expanded in the last five years. Although originating forty years ago,[47] POC is a relatively new and undoubtedly growing phenomenon.

TABLE A. CATEGORIES OF OUTPATIENT COMMITMENT AUTHORIZED BY STATE[48]

State	Less restrictive option	Preventive function	Year preventive aspect added / most recently expanded
Alabama		X	1991 / 2022
Alaska	X		
Arizona	X		
Arkansas	X		
California	X[49]	X	2002 / 2023

or a new set should be devised in order to begin effectively distinguishing among the three types of AOT").

45 This paper's focus is civil commitment that does not require hospitalization immediately preceding the order. Conditional release is not at issue in this paper.

46 MD. CODE ANN., HEALTH-GEN. § 10-6A-05 (West 2025).

47 *See* Susan Stefan, *Preventive Commitment: The Concept and Its Pitfalls*, 11 MENTAL & PHYSICAL DISABILITY L. REP. 288, 288 (1987) (noting that North Carolina first established POC in 1983).

48 Not included are statutes permitting outpatient commitment as a form of conditional release from hospitalization.

49 An individual in California deemed "gravely disabled" may be detained for involuntary treatment or subject to a conservatorship. CAL. WELF. & INST. CODE § 5256.6 (Deering 2024); *id.* § 5350 (West 2024). A conservator may place their conservatee in the "least restrictive alternative placement," which may consist of inpatient or outpatient treatment. *Id.* § 5358.6 (West 2024).

TABLE A. CATEGORIES OF OUTPATIENT COMMITMENT AUTHORIZED BY STATE[48]			
Colorado	X		
Connecticut			
Delaware	X[50]	X	2014
District of Columbia	X		
Florida		X	2005 / 2024
Georgia		X	1986 / 2022
Hawaii		X	1984 / 2019
Idaho	X		
Illinois		X	2010
Indiana	X		
Iowa	X		
Kansas	X	*[51]	
Kentucky		X	2017 / 2022
Louisiana		X	2008 / 2021
Maine		X	2010 / 2020
Maryland		X[52]	2024
Massachusetts			

50 *See* Michele Joy et. al., *A Guide to Involuntary Commitment in Delaware*, 2 DEL. J. PUB. HEALTH 36 (2016) (identifying outpatient treatment as a "less restrictive alternative" to hospitalization).

51 *See supra* note 8 and accompanying text (discussing a recently passed law that may, or may not, be preventive).

52 This statute goes into effect on July 1, 2025. *See supra* note 46.

TABLE A. CATEGORIES OF OUTPATIENT COMMITMENT AUTHORIZED BY STATE[48]			
Michigan	X		
Minnesota	X		
Mississippi	X		
Missouri	X		
Montana	X	X	1997 / 2001
Nebraska	X		
Nevada		X	2021 / 2023
New Hampshire	X		
New Jersey	X		
New Mexico		X	2016
New York		X	1999 / 2022
North Carolina		X	1983
North Dakota	X		
Ohio	X	X	2014
Oklahoma	X	X	2016 / 2019
Oregon	X	X	2013 / 2015
Pennsylvania	X	X	2019
Rhode Island	X		
South Carolina	X		
South Dakota	X		
Tennessee	X		
Texas		X	2019

TABLE A. CATEGORIES OF OUTPATIENT COMMITMENT AUTHORIZED BY STATE[48]			
Utah	X[53]	X	2019 / 2024
Vermont	X		
Virginia	X		
Washington	X	X	2018 / 2022
West Virginia			
Wisconsin	X		
Wyoming	X		

Interestingly, fourteen states authorizing POC do not provide for outpatient commitment as a less restrictive alternative.[54] Judges in these states may be in a difficult position. Some individuals who qualify for involuntary hospitalization may be effectively treated in the community under the court's supervision.[55] But the court might lack this option if individuals are ineligible for POC due to bureaucratic hurdles or unmet historical criteria (e.g., prior hospitalizations).[56]

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[53] The court orders a committed individual to the custody of a local mental health authority, which is responsible for the "supervision and treatment" of those committed to its custody. UTAH CODE ANN. § 26B-5-332(16)(a) (West 2024); *id.* § 26B-5-324(1) (West 2024). The individual may be ordered to receive outpatient or inpatient treatment. *Civil Commitment,* UTAH DEP'T OF HEALTH AND HUM. SERV., https://sumh.utah.gov/providers/civil-commitment/ (last visited Feb. 1, 2025).

[54] Alabama, Florida, Georgia, Hawaii, Illinois, Kentucky, Maine, Maryland, Louisiana, Nevada, New Mexico, New York, North Carolina, and Texas all allow commitment on an outpatient basis only upon the satisfaction of broader criteria than their inpatient standards. *Compare* POC statutes, *supra* note 8, *with* these corresponding inpatient commitment statutes: ALA. CODE § 22-52-10.4(a) (2024); FLA. STAT. ANN. § 394.467(2)(b) (West 2024); GA. CODE ANN. § 37-3-1(9.1) (West 2024); HAW. REV. STAT. ANN. § 334-60.2 (West 2024); ILL. COMP. STAT. ANN. § 5/1-119 (West 2024); KY. REV. STAT. ANN. § 202A.026 (LexisNexis 2024); ME. REV. STAT. ANN. TIT. 34-B, § 3864(6)(A) (2024); MD. CODE ANN., HEALTH-GEN. § 10-632(e)(2) (West 2024); LA. STAT ANN §§ 28:55(E)(1), 28:2(6) (defining "dangerous to others"), 28:2(7) (defining "dangerous to self"), 28:2(13) (defining "gravely disabled") (2024); NEV. REV. STAT. ANN §§ 433A.0175(1), 433A.0195 (LexisNexis 2023); N.M. STAT. §§ 43-1-11(E), 43-1-3(N), (O) (LexisNexis 2024); N.Y. MENTAL HYG. LAW § 9.37(a) (LexisNexis 2025); N.C. GEN. STAT. §§ 122C-268(j), 122C-3(11) (West 2024) (defining "dangerous to self or others"); TEX. HEALTH & SAFETY. Code § 574.034(a) (West 2024).

[55] *See* Winick, *supra* note 16, at 114; Saks, *supra* note 22, at 96.

[56] *See* John Petrila & Annette Christy, *Law & Psychiatry: Florida's Outpatient Commitment Law: A Lesson in Failed Reform?*, 59 PSYCHIATRIC SERVS. 21 (2008) (detailing the timing and paperwork requirements that hinder use of Florida's prior POC law).

These data are important because preventive and less-restrictive outpatient commitment statutes serve different purposes, have varying impacts, and pose distinct moral and constitutional quandaries.[57] As Professor Hiday details, these two types of outpatient commitment address different societal challenges, target different populations, and rely on different empirical assumptions.[58] Although not without its controversies,[59] for those whose mental illnesses and dangerousness can be effectively managed in the community, outpatient commitment as a less restrictive alternative to hospitalization can increase individuals' freedom, reduce coercion, and facilitate post-release adjustment,[60] while saving states money and freeing scarce hospital beds.[61]

POC is more controversial. Not serving as an alternative to involuntary hospitalization, POC may replace autonomous living and strip individuals of their ability to choose their own treatment.[62] POC is considered a "medical intervention" with purported health benefits,[63] such as preventing deterioration, relapse, hospital readmission, homelessness, or incarceration.[64] As Professor Churchill reflects, "[l]ike any medical intervention, in order to be adopted as a form of best practice, [POC] should demonstrate effectiveness in terms of improved health outcomes compared with the available alternatives,"[65] such as voluntary treatment[66] paired with

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57 *See infra* notes 58–70.

58 *See* Virginia Aldigé Hiday, *Outpatient Commitment: The State of Empirical Research on its Outcomes*, 9 PSYCH. PUB. POL'Y & L. 8, 8–12 (2003).

59 As Professor Richard Boldt has pointed out, outpatient commitment used as a step-down from inpatient hospitalization or as a less restrictive alternative can be longer in duration and more reliant on medication than inpatient commitment. Moreover, these forms of coerced community treatment may produce overall net-widening by coercively treating people who would otherwise not be involuntarily hospitalized and who might accept voluntary community treatment if the resources were available and offered through modalities such as assertive community treatment. I am grateful to Professor Boldt for sharing these important observations.

60 *See* Edward P. Mulvey et al., *The Promise and Peril of Involuntary Outpatient Commitment*, 42 AM. PSYCH. 571, 578 (1987).

61 *See* Barbara Dickey et al., *The Cost and Outcomes of Community-based Care for the Seriously Mentally Ill*, 32 HEALTH SERV. RSCH. 599, 600 (1997).

62 *See* Player, *supra* note 12, at 208.

63 RACHEL CHURCHILL ET AL., INTERNATIONAL EXPERIENCES OF USING COMMUNITY TREATMENT ORDERS 18 (2007).

64 Marvin S. Swartz & Jeffrey W. Swanson, *Involuntary Outpatient Commitment, Community Treatment Orders, and Assisted Outpatient Treatment: What's in the Data?*, 49 CANADIAN J. PSYCHIATRY 585, 585 (2004).

65 CHURCHILL ET AL., *supra* note 63, at 18.

66 In particular, randomized controlled trials ("RCTs") are needed that compare the effectiveness of outpatient commitment to that of Assertive Community Treatment ("ACT"), which is an aggressive, comprehensive, and intensive method of treatment delivery designed for resistant individuals with severe mental illnesses. *See, e.g.*, Lisa Brophy et al., *Community*

supportive services,[67] and advance directives, which convey the treatment preferences of a person when competent.[68] These empirical questions of absolute and comparative efficacy remain unanswered.[69] Moreover, while objections to outpatient commitment as a less restrictive alternative have been largely practical in nature (e.g., will coerced care reduce willingness to seek voluntary care?), objections to POC are both pragmatic and normative, including opposition due to its potential to unnecessarily expand the net of social control.[70] Conflating these categories as "AOT" allows supporters to dodge the difficult questions that arise around preventive, but not less-restrictive, outpatient commitment.

III. ONEROUSNESS OF PREVENTIVE OUTPATIENT COMMITMENT

Another commonly under-evaluated assertion is that this form of outpatient commitment involves a trivial deprivation of liberty.[71] This argument has two

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Treatment Orders: Towards a New Research Agenda, 26 AUSTRALIAN PSYCHIATRY 299, 301 (2018); Boldt, *supra* note 22, at 81; M. SUSAN RIDGLEY ET AL., THE EFFECTIVENESS OF INVOLUNTARY OUTPATIENT TREATMENT: EMPIRICAL EVIDENCE AND THE EXPERIENCE OF EIGHT STATES 99 (2001). RCTs are also needed to compare the effectiveness of outpatient commitment to that of more economical intensive case management options. *See* Lucinda Smith & Richard Newton, *Systematic Review of Case Management*, 41 AUSTL. & N.Z. J. PSYCHIATRY 2 (2007). One option is "community mental health teams" (CMHT), a cheaper—yet as effective—alternative to ACT that typically includes sectorized multidisciplinary teams, small caseloads, regular contact, a high percentage of contacts at home, a close focus on ensuring maintenance medication, and provision of health and social care. *See* Tom Burns, *The Rise and Fall of Assertive Community Treatment?*, 22 INT'L REV. PSYCHIATRY 130, 130 (2010) (reviewing evidence comparing effectiveness of ACT and CMHTs). CMHTs differ from ACT in having slightly larger caseloads and deviating from ACT's specific staffing configuration. *See id.*

67 Hiday, *supra* note 58, at 12.

68 *See infra* notes 277–78.

69 As one of this article's authors details at length elsewhere, evidence of efficacy—of any kind—is murky at best. *See* E. Lea Johnston, *Coercive Compassion: Theorizing Assisted Outpatient Treatment* 4–5 (June 30, 2023) (unpublished manuscript) (on file with the author). No strong evidence suggests that compelled community treatment reduces hospital readmissions or length of hospital stay, or increases contact with mental health services or compliance with medication. *See* CHURCHILL ET AL., *supra* note 63, at 134–35 (reporting five health-service outcomes from U.S. RCT and Cochrane review); Tom Burns et al., *Community Treatment Orders for Patients with Psychosis (OCTET): A Randomised Controlled Trial*, 381 LANCET 1627, 1632 (2013). Additionally, the studies with the strongest research designs are unanimous in finding no significant effect in patient outcomes including general mental state, psychopathology, social functioning, quality of life, offenses resulting in arrest, homelessness, or carer satisfaction. *See* CHURCHILL ET AL., *supra* note 63, at 136–39 (reporting fourteen patient-level outcomes from U.S. RCT and Cochrane review).

70 Hiday, *supra* note 58, at 11.

71 *See* Geller, *supra* note 6, at 236 (representing POC supporters' argument that, "because most refusal of or noncompliance with treatment is rooted in mental illness, and because the symptoms of mental illness abridge an individual's autonomy, small intrusions into self-determination–'a tincture of coercion'–actually increases freedom"); *Our Interview with Cornelius Kuteesa on the Assisted Outpatient Treatment Bill*, HELP IN THE HOME (April 18,

components. First, any restriction of the affected individual's liberty interest "is far less onerous than the complete deprivation of freedom" that could result absent treatment.[72] Second, deprivations exist only to the extent the state can enforce them;[73] and, in the context of court-ordered treatment plans, states essentially lack enforcement through courts' contempt powers.[74] These positions ignore the broad scope of outpatient commitment orders, oversimplify states' enforcement mechanisms, and trivialize the experiences of those coerced into treatment. This minimization also affects the quantum of state interests necessary to justify the infringement of liberty.[75]

An informed examination of POC statutes' effects on individuals' liberty interests requires a detailed understanding of their content, scope, and enforcement mechanisms. This Part provides data essential for that analysis. Part A details various components authorized for inclusion in outpatient treatment orders. Part B examines the enforcement mechanisms that are, and are not, available in each state to enforce these orders.

A. Authorized Components of Outpatient Treatment Orders

Minimal research has been conducted on the content of court-ordered POC plans.[76] This section and Table B assess various statutorily authorized services.[77] The presence of these components in court orders likely varies by state, reflecting differences in available resources and the individual practices of judges and treatment team members.[78] However, understanding treatment plans' possible scope is essential for grasping the sanctioned reach of state control and evaluating affected individuals' interests.

2022), https://helpinthehomellc.com/2022/04/18/our-interview-with-cornelius-kuteesa-on-the-assisted-outpatient-treatment-bill/ (characterizing arguments that POC would violate "one's right to choose their own course of treatment" as a "misunderstanding," and clarifying that AOT "is a collaborative outpatient program that does not allow for forced treatment or change of hospital commitment criteria"); *infra* notes 72–73.

[72] *In re* K.L., 806 N.E.2d 480, 485 (2004) ("[A]ny restriction on an assisted outpatient's liberty interest felt as a result of the legal obligation to comply with an AOT order is far less onerous than the complete deprivation of freedom . . . if the patient were to be or remain involuntarily committed in lieu of being released on condition of compliance with treatment.").

[73] *Id.* ("The restriction on a patient's freedom effected by a court order authorizing [AOT] is minimal, inasmuch as the coercive force of the order lies solely in the compulsion generally felt by law-abiding citizens to comply with court directives.").

[74] *See infra* notes 135–36

[75] *See* Johnston, *supra* note 23.

[76] The authors were unable to locate any existing studies on the content of individuals' outpatient treatment plans.

[77] *See infra* Table B.

[78] *See* Meldrum et al., *supra* note 39, at 633 (reporting that, of twenty active AOT programs, informants from ten states reported inadequate resources).

Medication is the most commonly authorized statutory component, and anecdotal evidence underscores its prevalence in treatment plans.[79] As Table B reflects, court-ordered medication is explicitly authorized in seventeen POC statutes.[80] Several states' statutes specify that courts may order individuals to self-administer specific medications at particular intervals or accept medication administered by another person.[81] Four states authorize periodic blood testing for medication compliance.[82] Some statutes grant treatment providers wide discretion to change the ordered dosage or specific drug included in individuals' treatment plans without court approval.[83] Patient surveys from other countries indicate that many individuals perceive mandated medication as the most coercive condition typically imposed under community treatment orders.[84]

States often authorize other components for inclusion in court orders. As Table B depicts, nineteen of twenty-three states with POC laws list certain services that judges

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79 *See* AM. PSYCHIATRIC ASS'N, POSITION STATEMENT ON INVOLUNTARY OUTPATIENT COMMITMENT AND RELATED PROGRAMS OF ASSISTED OUTPATIENT TREATMENT 3 (2020), https://www.psychiatry.org/getattachment/d50db97b-59aa-4dd4-a0ec-d09b4e19112e/Position-Involuntary-Outpatient-Commitment.pdf ("Psychotropic medication is an essential part of treatment for most patients under involuntary outpatient commitment."); TEXAS AOT PRACTITIONER'S GUIDE 27 (2022), https://www.texasjcmh.gov/media/svlj51l4/texas-aot-practitioners-guide.pdf (noting "it would certainly be unusual for medication to be omitted" from an outpatient treatment plan).

80 *See infra* notes 157–68 (listing these seventeen states' statutes); Table B.

81 *See infra* note 173 and accompanying text.

82 *See* LA. STAT. ANN. § 28:70(D)(2)(c) (2024); NEV. REV. STAT. ANN. § 433A.337(2)(b)(2) (LexisNexis 2023); N.M. STAT. ANN. § 43-1B-2(D)(2) (LexisNexis 2024); N.Y. MENTAL HYG. LAW § 9.60(a)(1) (LexisNexis 2025).

83 *See* LA. STAT. ANN. § 28:71(E) (2024) (providing a treatment provider need not apply for court approval prior to "a change in the dosage or the specific psychotropic drug within the type ordered by the court"); 50 PA. STAT. AND CONS. STAT. ANN. § 7304(f)(4) (West 2024) (authorizing "the treatment team, in accordance with their professional judgment and under supervision of the prescribing physician, to perform routine medication management, including adjustment of specific medications and doses"); HAW. REV. STAT. ANN. § 334-127(b) (West 2024) (permitting courts to authorize classes of medications which health care providers may use in treatment at their discretion).

84 *See* Hanne K. Stuen et al., *Increased Influence and Collaboration: A Qualitative Study of Patients' Experiences of Community Treatment Orders Within an Assertive Community Treatment Setting*, BMC HEALTH SERVS. RSCH., 4, 4 (2015) ("[M]ost participants described the coercive elements of the CTO to be that they had to take medications, and that the psychiatrist had the authority to impose restrictions."); Teresa L. Scheid-Cook, *Controllers and Controlled: An Analysis of Participant Constructions of Outpatient Commitment*, 15 SOCIO. HEALTH & ILLNESS 179, 188 (1993) ("Many clients did not like being 'forced to take their medication.'"); Richard L. O'Reilly et al., *A Qualitative Analysis of the Use of Community Treatment Orders in Saskatchewan*, 29 INT'L J. L. & PSYCHIATRY 516, 521 (2006) ("Many subjects talked about coercion . . . in the context of having to take medication.").

should consider. Eleven states encourage individual or group therapy,[85] or psychiatric and psychological services.[86] Six authorize full-day or partial-day programming activities.[87] Seven states encourage vocational activities,[88] while six encourage educational activities.[89] Ten states authorize substance use disorder treatment and counseling[90] and four permit periodic blood or urine testing for the presence of alcohol or narcotics.[91]

TABLE B. STATUTORILY AUTHORIZED COMPONENTS OF POC PLANS BY STATE	
Authorized components	**States**
Medication	Florida, Georgia, Hawaii, Illinois, Kentucky, Louisiana, Maryland, Montana, Nevada, New Mexico, New

85 *See* GA. CODE ANN. § 37-3-1 (12.2) (West 2024); HAW. REV. STAT. ANN. § 334-122 (West 2024); KY. REV. STAT. ANN. § 202A.0817 (LexisNexis 2024) (allowing "recovery-oriented therapies" in the treatment plan); LA. STAT. ANN. § 28:70(D)(2)(d) (2024); NEV. REV. STAT. ANN. § 433A.337(2)(b)(3) (West 2023); N.M. STAT. ANN. § 43-1B-2(D)(3) (LexisNexis 2024); N.Y. MENTAL HYG. LAW § 9.60(a)(1) (LexisNexis 2025); OHIO REV. CODE ANN. § 5122.01(V)(2)(d) (West 2024); PA. STAT. AND CONS. STAT. ANN. tit. 50, § 7103.1(4) (West 2024).

86 *See* CAL. WELF. & INST. CODE § 5348(a)(2)(B) (West 2024).

87 *See* GA. CODE ANN. § 37-3-1 (12.2) (West 2024); HAW. REV. STAT. ANN. § 334-122 (West 2024); LA. REV. STAT. ANN. § 28:70(D)(2)(e) (2024); NEV. REV. STAT. ANN. § 433A.337(b)(4) (West 2023); N.M. STAT. ANN. § 43-1B-2(D)(4) (LexisNexis 2024); N.Y. MENTAL HYG. LAW § 9.60(a)(1) (LexisNexis 2025).

88 *See* CAL. WELF. & INST. CODE § 5348(a)(2)(B) (West 2024); HAW. REV. STAT. ANN. § 334-122 (West 2024); KY. REV. STAT. ANN. § 202A.0817(3)(b) (LexisNexis 2024) (allowing "supported employment" in the treatment plan); LA. STAT. ANN. § 28:70(D)(2)(f) (2024); NEV. REV. STAT. ANN. § 433A.337(b)(6) (West 2023); N.M. STAT. ANN. § 43-1B-2(D)(5) (LexisNexis 2024); N.Y. MENTAL HYG. LAW § 9.60(a)(1) (LexisNexis 2025).

89 *See* CAL. WELF. & INST. CODE § 5348(a)(4)(D) (West 2024); HAW. REV. STAT. ANN. § 334-122 (West 2024); LA. STAT. ANN. § 28:70(D)(2)(f) (2024); NEV. REV. STAT. ANN. § 433A.337(b)(5) (West 2023); N.M. STAT. ANN. § 43-1B-2(D)(5) (LexisNexis 2024); N.Y. MENTAL HYG. LAW § 9.60(a)(1) (LexisNexis 2025).

90 *See* CAL. WELF. & INST. CODE § 5348(a)(2)(B) (West 2024); FLA. STAT. ANN. § 394.467(4)(d)(3) (West 2024); LA. STAT. ANN. § 28:70(D)(2)(g) (2024); MONT. CODE ANN. § 53-21-149(1) (West 2023); NEV. REV. STAT. ANN. § 433A.337(b)(7) (West 2023); N.M. STAT. ANN. § 43-1B-2(D)(6) (LexisNexis 2024); N.Y. MENTAL HYG. LAW § 9.60(a)(1) (LexisNexis 2025); OHIO REV. CODE ANN. § 5122.01(V)(2)(h) (West 2024); OKLA. STAT. ANN. tit. 43A, § 5-416(P) (West 2024); PA. STAT. AND CONS. STAT. ANN. tit. 50, § 7103.1(8) (West 2024).

91 *See* LA. STAT. ANN. § 28:70(B) (2024); NEV. REV. STAT. ANN. § 433A.337(b)(8) (West 2023); N.M. STAT. ANN. §§ 43-1B-7(D), 43-1B-2(D)(7) (LexisNexis 2024); N.Y. MENTAL HYG. LAW § 9.60(a)(1) (LexisNexis 2025).

TABLE B. STATUTORILY AUTHORIZED COMPONENTS OF POC PLANS BY STATE	
	York, North Carolina, Ohio, Oklahoma, Pennsylvania, Texas, Utah
Periodic medication testing	Louisiana, Nevada, New Mexico, New York
Therapy	California, Georgia, Hawaii, Kentucky, Louisiana, Nevada, New Mexico, New York, Ohio, Oklahoma, Pennsylvania, Utah
Programming activities	Georgia, Hawaii, Louisiana, Nevada, New Mexico, New York
Educational activities	California, Hawaii, Louisiana, Nevada, New Mexico, New York
Vocational training	California, Hawaii, Kentucky, Louisiana, Nevada, New Mexico, New York
Substance use disorder treatment	California, Florida, Louisiana, Montana, Nevada, New Mexico, New York, Ohio, Oklahoma, Pennsylvania
Periodic alcohol/drug testing	Louisiana, Nevada, New Mexico, New York, Oklahoma
Housing or supervised living services	California, Hawaii, Illinois, Kentucky, Louisiana, Montana, Nevada, New Mexico, New York, Ohio, Pennsylvania, Texas

Twelve states explicitly provide housing or supervised living services of varying natures. Five states encourage the provision of supportive housing (independent housing in the community with the provision of mental health support services) or other housing assistance or services.[92] California appears particularly committed to

[92] *See* KY. REV. STAT. ANN. § 202A.0817(3)(b) (LexisNexis 2024) (allowing "supported housing" in the treatment plan); OHIO REV. CODE ANN. § 5122.01(V)(2)(g) (West 2023) (allowing "[h]ousing or supervised living services" in the treatment plan); PA. STAT. AND CONS. STAT. ANN. tit. 50, § 7103.1(7) (West 2025) (allowing "housing or supervised living services" in the treatment plan); TEX. HEALTH & SAFETY CODE § 574.037(b)(2) (West 2024) (allowing "supported housing" in the treatment plan); *infra* note 93.

appropriate housing that maximizes independence and family unification.[93] Conversely, seven states authorize court-ordered, supervised living arrangements,[94] which may include residential care programs, group homes, foster homes, and supervised apartments.[95] Two additional states permit a court to order an individual's placement in the care and custody of a relative or other willing person.[96] Patient surveys from other countries indicate that supervised living arrangements can be among the most onerous and intrusive components of court-ordered treatment plans,[97] as shared housing can decrease privacy and independence.[98] While empirical research finds that service users of housing settings prefer to live independently,[99] some qualitative data suggest that supervised housing can provide welcome structure and support for those at an early stage in recovery.[100]

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93 *See* CAL. WELF. & INST. CODE § 5348(a)(2)(B) (West 2024); *id.* § 5348(a)(2)(J) (offering services including a "[p]rovision for housing for clients that is immediate, transitional, permanent, or all of these"); *id.* § 5348(a)(4)(A) (mandating the provision of "appropriate services, to the extent feasible, that are designed to enable [AOT] recipients to [l]ive in the most independent, least restrictive housing feasible in the local community, and, for clients with children, to live in a supportive housing environment that strives for reunification with their children or assists clients in maintaining custody of their children, as is appropriate").

94 *See* HAW. REV. STAT. ANN. § 334-122 (West 2024); LA. STAT. ANN. § 28:70(D)(2)(h) (2024); NEV. REV. STAT. ANN. § 433A.337(b)(9) (West 2023); N.M. STAT. ANN. § 43-1B-2(D)(8) (LexisNexis 2024); N.Y. MENTAL HYG. LAW § 9.60(a)(1) (LexisNexis 2025); OHIO REV. CODE ANN. § 5122.01(V)(2)(g) (West 2024); PA. STAT. AND CONS. STAT. ANN. tit. 50, § 7103.1(7) (West 2025).

95 *See* Myra Piat et al., *Housing for Persons with Serious Mental Illness: Consumer and Service Provider Preferences*, 59 PSYCHIATRIC SERVS. 1011, 1011 (2008).

96 *See* MONT. CODE ANN. § 53-21-149(2) (West 2023) (permitting a court to order "specific residential or housing requirements that may include being under the care or custody of a relative or guardian"); 405 ILL. COMP. STAT. ANN. § 5/3-812(a)(i) (West 2024) ("The court may issue an order placing the respondent in the care and custody of a relative or other person willing and able to properly care for him or her . . . .").

97 *See* Stuen et al., *supra* note 84, at 4 (quoting one participant in a supervised residency as saying, "I didn't realize that it would be like this. I feel stigmatized. My whole life has been taken over, controlled by others").

98 *See* Jack Tsai et al., *Housing Preferences and Choices Among Adults with Mental Illness and Substance Use Disorders: A Qualitative Study*, 46 CMTY. MENTAL HEALTH J. 381, 383–85 (2010).

99 *See* Dirk Richter & Holger Hoffmann, *Preference for Independent Housing of Persons with Mental Disorders: Systematic Review and Meta-analysis*, 44 ADMIN. & POL'Y IN MENTAL HEALTH & MENTAL HEALTH SERVS. RSCH. 817, 821 (2017) (finding that that 84% of interviewed participants preferred to live in their own apartment with individuals of their choice).

100 *See* Jack Tsai et al., *supra* note 98. *But see* Dirk Richter & Holger Hoffmann, *Independent Housing and Support for People with Severe Mental Illness: Systematic Review*, 136 ACTA PSYCHIATRICA SCANDINAVICA 269 (2017) (finding, in a systematic review of randomized and non-randomized controlled trials, that independent housing achieves similar or better outcomes than residential care); JENNIFER MATHIS & ROBERT BERNSTEIN, A PLACE OF MY OWN: HOW THE

States sometimes authorize other services for inclusion in treatment plans. For example, Louisiana offers transportation.[101] Pennsylvania and Ohio authorize financial services.[102] California, Kentucky, Maryland, and Ohio authorize peer support services.[103] Ohio offers community psychiatric supportive treatment,[104] and Kentucky authorizes psychosocial rehabilitation.[105] California offers outreach to families living with severely mentally ill adults, along with family support and consultation services.[106] Many states authorize case management services[107] or assertive community treatment ("ACT").[108]

States encouraging specific services typically note their list is not exhaustive and other services may be provided.[109] Only Maryland limits components to those "essential" for maintaining the individual's health or safety.[110] Several states provide broad latitude to order "any other services prescribed to treat the patient's mental disorder and to assist the patient in living and functioning in the community, or to attempt to prevent a deterioration of the patient's mental or physical condition."[111]

ADA IS CREATING INTEGRATED HOUSING OPPORTUNITIES FOR PEOPLE WITH MENTAL ILLNESSES 3–4 (2014) (critiquing over-reliance on congregate housing for people with disabilities and embracing the principle, adopted by twenty-eight national disability organizations, that "[h]ousing should not be conditioned on compliance with treatment or with a service plan").

101 LA. STAT. ANN. § 28:70(D)(2)(i) (2024).

102 PA. STAT. AND CONS. STAT. ANN. tit. 50, § 7103.1(6) (West 2025); OHIO REV. CODE ANN. § 5122.01(V)(2)(f) (West 2024).

103 CAL. WELF. & INST. CODE ANN. § 5348(a)(2)(E) (West 2024); KY. REV. STAT. ANN. § 202A.0817(3)(b) (West 2024); OHIO REV. CODE ANN. § 5122.01(V)(2)(e) (West 2024); MD. CODE ANN., HEALTH-GEN. § 10-6A-01(i)(2)(iii) (West 2025).

104 OHIO REV. CODE ANN. § 5122.01(V)(2)(a) (West 2024).

105 KY. REV. STAT. ANN. § 202A.0817(3)(b) (LexisNexis 2024).

106 CAL. WELF. & INST. CODE ANN. § 5348(a)(2)(E)–(G) (West 2024).

107 *See, e.g.*, GA. CODE ANN. § 37-3-1 (12.2) (West 2024); LA. STAT. ANN. § 28:70(D)(1) (2024); MONT. CODE ANN. § 53-21-149(1) (West 2023).

108 *See, e.g.*, KY. REV. STAT. ANN. § 202A.0817(3)(b) (LexisNexis 2024); LA. REV. STAT. ANN. § 28:70(D)(2)(a) (2024); MONT. CODE ANN. § 53-21-149(1) (West 2023); N.M. STAT. ANN. § 43-1B-7(C) (LexisNexis 2024); N.Y. MENTAL HYG. LAW § 9.60(a)(1) (LexisNexis 2025); OHIO REV. CODE ANN. § 5122.01(V)(2)(b) (West 2024); 50 PA. STAT. AND CONS. STAT. ANN. § 7103.1(2) (West 2025); CAL. WELF. & INST. CODE ANN. § 5348(a)(1) (West 2024).

109 *See, e.g.*, CAL. WELF. & INST. CODE ANN. § 5348(a) (West 2024); KY. REV. STAT. ANN. § 202A.0817(3)(b) (LexisNexis 2024); LA. STAT. ANN. § 28:70(D)(2) (2024).

110 *See* MD. CODE ANN., HEALTH-GEN. § 10-6A-08(b)(2)(ii) (West 2025).

111 N.M. STAT. ANN. § 43-1B-2 (D)(9) (LexisNexis 2024); *see also* GA. CODE ANN. § 37-3-1 (12.2) (West 2024); HAW. REV. STAT. ANN. § 334-122 (West 2024); NEV. REV. STAT. ANN. § 433A.337 (b)(10) (West 2023); N.Y. MENTAL HYG. LAW § 9.60(a)(1) (LexisNexis 2025); OHIO REV. CODE ANN. § 5122.01(V)(2)(i) (West 2024); PA. STAT. AND CONS. STAT. ANN. tit. 50, § 7103.1(9) (West 2025); UTAH CODE ANN. § 26B-5-301(25) (West 2024).

Such flexibility grants commitment courts vast discretion. For instance, one committing court in Ohio pressured a respondent to take long-acting contraception.[112] A recent legislative debate over whether to prohibit POC judges from ordering a person to submit to electroconvulsive shock therapy or birth control reveals these highly intrusive services are at least theoretically available.[113]

The potentially lengthy duration of court-ordered treatment plans is relevant to their onerousness. Hawaii authorizes community treatment orders for two years.[114] Washington permits orders effective for eighteen months.[115] Multiple states permit one-year, renewable terms of compelled community treatment.[116] Oklahoma does not limit the duration of outpatient treatment, only requiring annual reevaluation of the individual's treatment needs.[117]

Courts and service providers often expect that POC-qualifying individuals will require repeated renewal of court-ordered care,[118] with some researchers asserting that long duration is essential to effective compelled community treatment.[119] This can

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112 *See* Jillian Weinberger, *Courts Are Using the Powerful "Black Robe Effect" to Treat Severe Mental Illness. Should They?*, VOX (Nov. 27, 2017, 6:00 AM), https://www.vox.com/policy-and-politics/2017/11/27/16689142/courts-mental-illness-assisted-outpatient-treatment.

113 After charges that his amendment went "overboard," Senator Clarence Lam—one of two physicians in the Maryland legislature—withdrew his proposed amendment to prohibit electroconvulsive shock therapy and birth control in POC orders. *See* Leah Harris, *Maryland Enacts a "Draconian" Assisted Outpatient Treatment Program*, MAD IN AM. (May 4, 2024), https://www.madinamerica.com/2024/05/maryland-enacts-a-draconian-assisted-outpatient-treatment-program/; Danielle J. Brown, *Should People with Severe Mental Health Needs Get Court-Ordered Treatment? State Senate to Decide*, MD. MATTERS (Apr. 5, 2024, 8:40 AM), https://marylandmatters.org/2024/04/05/should-people-with-severe-mental-health-needs-get-court-ordered-treatment-state-senate-to-decide/.

114 HAW. REV. STAT. ANN. § 334-127(b) (West 2024).

115 WASH. REV. CODE ANN. § 71.05.148(3) (LexisNexis 2024).

116 *See* LA. STAT. ANN. § 28:71(B) (2024); *id.* § 28:72(A) ("If a respondent has been ordered to receive outpatient treatment for four consecutive six-month to one-year periods, the period of any subsequent order may exceed one year but shall not exceed two years."); N.Y. MENTAL HYG. LAW § 9.60(j)(2), (k)(2) (LexisNexis 2025); OKLA. STAT. ANN. tit. 43A, § 5-416(M), (B)(1)(b) (West 2024); UTAH CODE ANN. § 26B-5-351(17)(a)–(b) (West 2024); MD. CODE ANN., HEALTH-GEN. § 10-6A-08(b)(1) (West 2025).

117 *See* OKLA. STAT. ANN. tit. 43A, § 5-416(B)(1) (West 2024).

118 *See, e.g.*, TEXAS AOT PRACTITIONER'S GUIDE, *supra* note 79, at 31 ("[I]n the case of a 'temporary' AOT order, one term of 90 days should almost never be considered time enough, unless it has been determined that the participant was not appropriate for AOT in the first place.").

119 *See* G.B. MELTON ET AL., PSYCHOLOGICAL EVALUATIONS FOR THE COURTS: A HANDBOOK FOR MENTAL HEALTH PROFESSIONALS AND LAWYERS 333 (2017); Marvin S. Swartz et al., *Assessing Outcomes for Consumers in New York's Assisted Outpatient Treatment Program*, 61 PSYCHIATRIC SERVS. 976, 976 (2010) (finding that court orders exceeding six months yielded

create a "lobster pot" effect, "in that [community treatment orders] can be easy to apply whilst also difficult to justify removing."[120]

B. Enforcement Mechanisms

Commentators have noted the widespread, "mistaken" view that courts respond to noncompliance with forcible medication or sanctions,[121] criticized commitment statutes' reliance on this belief,[122] and called for patient education to dispel widespread ignorance.[123] However, no scholar has analyzed courts' actual authority to compel compliance with court-ordered treatment plans to better understand individuals' "mistaken" views. This section examines the potential enforcement

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improved medication possession rates and reduced hospitalization outcomes even when intensive case coordination services were discontinued).

120 Hannah Jobling, *The Legal Oversight of Community Treatment Orders: A Qualitative Analysis of Tribunal Decision-Making*, 62 INT'L J.L. & PSYCHIATRY 95, 96 (2019); *see id.* at 100 (finding that tribunals in England often renewed community treatment orders ("CTOs") on grounds of "maintaining the status quo" if they were effective, yet also on grounds of lack of insight, risk, or lack of social support if the tribunal saw, or feared, difficulty in treatment compliance). Jobling identified this "double bind": "If a service user is perceived as doing well, the justification for CTO renewal is to maintain progress, but if a service user demonstrates a lack of progress, the justification for renewal is to maintain treatment adherence. This analysis of practitioner reasoning suggests that the renewal of CTOs can be justified whether service user responses to its imposition are positive or negative, as discharging a CTO would be taking a risk in both cases." *Id.* at 101.

121 *See, e.g.*, Michael A. Hoge & Elizabeth Grottole, *The Case Against Outpatient Commitment*, 28 J. AM. ACAD. PSYCHIATRY & L. 165, 167 (2000) (identifying as "troubling" the suggestion by the American Psychiatric Association "that most patients are likely to comply with prescribed medications because they mistakenly believe that the medications might otherwise be forced."); Stefan, *supra* note 47, at 295 ("Preventive commitment . . . operates as a kind of judicial intimidation, which can only work if the respondent mistakenly assumes that the judge's order must be obeyed."); Frank Holloway et al., *Involuntary Outpatient Treatment*, 13 CURRENT OP. PSYCHIATRY 689, 690 (2000) ("[D]ata confirm clinical experience that adherence to [involuntary outpatient treatment] often rests on erroneous beliefs of patients regarding the sanctions that could be enforced in the face of noncompliance."); THOMAS SZASZ, LIBERATION BY OPPRESSION: A COMPARATIVE STUDY OF SLAVERY AND PSYCHIATRY 123–24 (1st ed. 2002) (asserting that outpatient commitment laws "are generally believed to authorize the forcible treatment of certain mental patients" and that "[m]ental health professionals encourage that false belief").

122 *See* Hoge & Grottole, *supra* note 122, at 167 ("A strategy that relies on patient misinformation to foster its success violates ethics principles, the integrity of the physician-patient relationship, and the notion of informed consent."); Holloway, *supra* note 122, at 690 ("Conscious use of patient ignorance is, of course, highly ethically unsatisfactory in any form of health care.").

123 Hoge & Grottole, *supra* note 122, at 167 ("The profession has an obligation to education patients subject to mandated outpatient treatment about the scope and limits of the mandate. To do otherwise is to employ deception of individuals under the guise of attempting to promote their health and welfare."); BRUCE J. WINICK, CIVIL COMMITMENT, A THERAPEUTIC JURISPRUDENCE MODEL 254 (2005) (characterizing the failure to educate patients on the consequences of noncompliance as violating basic principles of informed consent).

mechanisms of contempt of court, forcible medication, and involuntary evaluations for inpatient treatment. Two states—Delaware and Maryland—provide no guidance on how courts may deal with noncompliance.[124] Consistent with scholars' understanding, the vast majority of POC statutes respond to noncompliance with the forcible return of an individual to an inpatient facility for a multi-day evaluation for involuntary hospitalization.[125] No state expressly provides that commitment courts can enforce their outpatient treatment orders by threatening fines or incarceration for noncompliance. This is not surprising since a court's contempt power is integral to its functioning and need not be statutorily granted.[126]

Examination suggests that most states' courts do have the power to hold disobedient individuals in contempt because most POC statutes do not expressly remove courts' contempt power.[127] Examination also provides statutory grounds for understanding individuals' widespread belief—correct or incorrect—that they must comply with treatment orders or face sanctions or possibly forcible medication, even when court orders explicitly prohibit physically forced medication.[128] Only a minority of states' statutes expressly prohibit courts' enforcing an ordered treatment plan through contempt proceedings or clarify that forcible medication is impermissible.[129] Moreover, statutory language often strongly suggests that compliance is required and that, if medication is not voluntarily taken, it may be forcibly given.[130] This language is so suggestive that at least two courts have equated court-ordered medication with its forcible administration.[131]

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[124] Maryland does, however, provide that noncompliance cannot be grounds for a finding of contempt or involuntary admission. *See* MD. CODE ANN., HEALTH-GEN. § 10-6A-10(d).

[125] *See* Boldt, *supra* note 22, at 68–69.

[126] *See infra* notes 132, 134.

[127] *See infra* note 137 and associated text.

[128] *See* Randy Borum et al., *Consumer Perceptions of Involuntary Outpatient Commitment,* 50 PSYCHIATRIC SERVS. 1489, 1489–90 (1999) (in a study of 306 outpatients in North Carolina, 82.7% of respondents believed they were required to take court-ordered medication, even though the court order "explicitly prohibits the use of physically forced medication," and 6.2% did not know whether they were required or not, and explaining that "respondents may have believed that they can be forced to comply" because of their past experiences with coercive care and because it would "seem[] counterintuitive that a person could be required to do something without any provision to force adherence if the person failed to comply").

[129] *See infra* notes 137, 157.

[130] Statutory ambiguity regarding the availability of contempt and forcible medication may strengthen a "narrative truth reflecting a considerable sense of coercion and loss of personal dignity" even if strong enforcement mechanisms are unavailable within a given state. Henry A. Dlugacz, *Involuntary Outpatient Commitment: Some Thoughts on Promoting a Meaningful Dialogue Between Mental Health Advocates and Lawmakers*, 53 N.Y.L. SCH. L. REV. 79, 88–89 (2009).

[131] *See* Protec. & Advoc. Sys. v. City of Albuquerque, 195 P.3d 1, 20 (N.M. Ct. App. 2008); Coleman v. State Sup. Ct., 697 F. Supp. 2d 493, 506 (S.D.N.Y. 2010) (framing the federal substantive due process claim presented by New York's POC statute as whether authorizing the

1. Contempt

All courts inherently possess the power to find insubordinates in contempt of court.[132] Contempt is typically punished with a fine, incarceration, or both.[133] Indeed, the court's contempt power is considered integral to its authority and essential for its functioning.[134] In the context of POC, however, commentators assert that, although "[i]n theory, . . . noncompliance could be subject to a proceeding for contempt, . . . it is unlikely that such an approach is often pursued."[135]

Despite commentators' (and the government's)[136] belief that noncomplying committed individuals will not face contempt charges, few statutes establish the unavailability of contempt in the context of POC. Only ten of twenty-three statutes specify that noncompliance with treatment orders cannot be grounds for a contempt finding.[137] Two additional states remove incarceration as a sanction for treatment noncompliance.[138] The authors were unable to find similar prohibitions, imposed statutorily or through case law, in the remaining eleven states. Individuals in these

forcible administration of antipsychotic drugs was justified by an essential government interest); *cf.* State v. Kotis, 984 P.2d 78, 104 n.14 (Haw. 1999) (construing a POC statute's language of "medication specifically authorized by court order" as equivalent to authorizing "involuntary medication of a patient on an outpatient basis").

132 *See Ex parte* Robinson, 86 U.S. 505, 510 (1874) ("The moment the courts of the United States were called into existence and invested with jurisdiction over any subject, they became possessed of [the power to hold in contempt].").

133 Margit Livingston, *Disobedience and Contempt*, 75 WASH. L. REV. 345, 345 (2000).

134 *Ex parte* Robinson, 86 U.S. at 510 (noting that the existence of a court's contempt power is "essential to the preservation of order in judicial proceedings, and to the enforcement of the judgments, orders, and writs of the courts, and consequently to the due administration of justice"); State v. Thomas, 550 So. 2d 1067, 1070 (Ala. 1989) ("Without contempt powers, courts could neither maintain their dignity, transact their business, nor accomplish the purpose of their existence.").

135 Boldt, *supra* note 22, at 69; *see also* Dlugacz, *supra* note 131, at 88 (asserting that "most" outpatient commitment statutes do "not have contempt provisions, so while a person is ordered to follow a certain course of treatment, there are few consequences attached to noncompliance").

136 *See, e.g.*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., CIVIL COMMITMENT AND THE MENTAL HEALTH CARE CONTINUUM: HISTORICAL TRENDS AND PRINCIPLES FOR LAW AND PRACTICE 14 n.15 (2009) ("In other legal contexts, failure to comply with a court order can result in a criminal contempt citation. In contrast, and by design, there is no 'criminalizing' consequence of not following through with a civil court order for outpatient mental health treatment.").

137 *See* CAL. WELF. & INST. CODE § 5346(f) (West 2024); KY. REV. STAT. ANN. § 202A.0823 (LexisNexis 2024); LA. STAT. ANN. § 28:71(F) (2024); N.M. STAT. ANN. § 43-1B-13(B) (LexisNexis 2024); N.Y. MENTAL HYG. LAW § 9.60(n) (LexisNexis 2025); OKLA. STAT. ANN. tit. 43A, § 5-416(Q) (West 2024); 50 PA. STAT. AND CONS. STAT. ANN. § 7304(f)(6) (West 2025); TEX. HEALTH & SAFETY CODE ANN. § 574.037(c-4) (West 2024); UTAH CODE ANN. § 26B-5-351(19) (West 2024); MD. CODE ANN., HEALTH-GEN. § 10-6A-10(d).

138 OHIO REV. CODE § 5122.15(N) (West 2024); FLA. STAT. ANN. § 394.467(10)(b) (West 2024).

states may risk contempt sanctions, including incarceration, if they fail to comply with court-ordered treatment plans.[139]

In fact, courts have suggested that noncompliance with POC plans can be punished. A New Mexico appellate court indicated that failure to follow an outpatient treatment order can be punished as contempt of court absent an express statutory statement to the contrary.[140] The court stressed that "[t]he orderly process of law demands that respect and compliance be given to orders issued by courts . . . and one who defies the order of a court having jurisdiction does so at his peril."[141]

Other courts, even in states with specific statutory prohibitions, have signaled a person may be guilty of contempt for conduct related to POC. A Louisiana appellate court indicated a person may be found guilty of constructive contempt based on both a failure to comply with treatment orders and a failure to appear in response to that noncompliance.[142] In that case, the defendant, T.S., failed to attend both scheduled outpatient appointments and his subsequent court hearing.[143] The judge issued a bench warrant, and T.S. was placed in a correctional center, where he remained for nearly two months.[144] At the contempt hearing, the judge found T.S. in contempt, sentenced him to ninety days in jail, suspended the jail sentence, and conditioned his probation on receipt of outpatient treatment.[145] The appellate court reversed the trial court, but only because the judge treated T.S.'s noncompliance and nonappearance as direct contempt (which would be appropriate for acts committed in the immediate view of the judge) instead of as constructive contempt.[146] Anticipating that T.S. would be found guilty of constructive contempt on remand, the appellate court approved the punishment imposed as appropriate.[147]

Holding individuals with mental illnesses in contempt for failing to comply with treatment directives is inappropriate for several reasons. First, denial of one's condition and need for treatment is a common symptom of serious mental illness, so noncompliance may not be "willful".[148] The U.S. Supreme Court has recognized that a trial judge must conduct a hearing on mental capacity and permit a defense based

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139 Additionally, the constitutionality of states' contempt-removal provisions is uncertain. *See* Johnston, *supra* note 23, at Part II.B.2.

140 *See* Protec. & Advoc. Sys. v. City of Albuquerque, 195 P.3d 1, 20–21 (N.M. Ct. App. 2008).

141 *Id.* at 20–21 (quoting Apodaca v. Our Chapel of Memories of N.M., Inc., 392 P.2d 347, 349 (N.M. 1964)).

142 *See In re* T.S., 32 So. 3d 1026, 1028–29 (La. Ct. App. 2d Cir. 2010).

143 *Id.* at 1026.

144 *Id.* at 1028.

145 *Id.*

146 *Id.* at 1029.

147 *Id.*

148 *See* Erika F. King, *Outpatient Civil Commitment in North Carolina: Constitutional and Policy Concerns*, 58 L. & CONTEMP. PROBS. 251, 273–74 (1995).

upon mental illness before punishing an individual of uncertain mental capacity for contumacious conduct.[149] Second, incarceration is uniquely burdensome and nontherapeutic for individuals with serious mental illnesses, and may result in deterioration and victimization.[150] Therefore, a carceral sanction may be disproportionate to any willful violation. Finally, in the civil commitment context, presumably competent individuals who fail to comply with treatment directives are merely exercising cherished and protected aspects of liberty: the right to bodily integrity, to control one's person, and to refuse unwanted treatment.[151] Sanctioning a person for exercising a constitutional right may be an abuse of state power.

2. Forcible Medication

Commentators frequently remark that POC does not authorize forcible medication.[152] Some have concluded, therefore, that court-ordered medication should not weigh in the coercion calculus.[153] However, statutory prohibitions against forcible medication are rarely so clear. Furthermore, language often strongly suggests that medication can be non-consensually administered.[154]

Several factors contribute to beliefs that individuals must comply with courts' medication orders or risk forcible medication.[155] First, as established earlier, most states (17/23) expressly provide that court-ordered treatment plans can include medication.[156] Less than half of those states (5/17) clearly specify that a POC order

149 *See* McNeil v. Dir., Patuxent Inst., 407 U.S. 245, 251 (1972).

150 E. Lea Johnston, *Vulnerability and Just Desert: A Theory of Sentencing and Mental Illness*, 103 J. CRIM. L. & CRIMINOLOGY 147, 158–83 (2013) (discussing the likelihood of physical and sexual assaults, housing in solitary confinement, and psychological deterioration during incarceration).

151 *See* Cruzan v. Dir., Mo. Dep't Health, 497 U.S. 261, 270 (1990) ("The logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is, to refuse treatment."); Union Pac. Ry. v. Botsford, 141 U.S. 250, 251 (1891) ("No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law."); Riggins v. Nevada, 504 U.S. 127, 137 (1992) (acknowledging "the defendant's liberty interest in freedom from unwanted antipsychotic drugs").

152 *See* Player, *supra* note 12, at 177; SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN., *supra* note 136, at 14 n.15; John Kip Cornwell & Raymond Deeney, *Exposing the Myths Surrounding Preventive Outpatient Commitment for Individuals with Chronic Mental Illness*, 9 PSYCH. PUB. POL'Y & L. 209, 222 (2003).

153 *See In re* K.L., 806 N.E.2d at 484 (emphasizing that the POC law "neither authorizes forcible medical treatment in the first instance nor permits it as a consequence of noncompliance").

154 *See infra* notes 157–69, 172–94.

155 *See* Borum et al., *supra* note 128.

156 *See infra* notes 157–68.

does not create new authority to forcibly medicate a patient.[157] The remaining eleven states' POC statutes do not clarify whether the court's treatment order can be forcibly implemented. In particular, the statutory provisions pertaining to POC in Florida,[158] Georgia,[159] Illinois,[160] Kentucky,[161] Louisiana,[162] Maryland,[163] Montana,[164] New York,[165] Ohio,[166] Oklahoma,[167] and Pennsylvania,[168] expressly authorize court-

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157 *See* HAW. REV. STAT. § 334-129(b) (West 2024) ("No subject of the order shall be physically forced to take medication under a family court order for [POC] unless the subject is within an emergency department or admitted to a hospital . . . ."); NEV. REV. STAT. ANN. § 433A.343(4) (West 2024) ("The court shall not order the use of physical force or restraints to administer medication."); N.M. STAT. ANN. § 43-1B-13(B) (LexisNexis 2024) ("A respondent's failure to comply with an order of [POC] is not grounds for . . . a finding of contempt of court, or for the use of physical force or restraints to administer medication to the respondent."); N.C. GEN. STAT. ANN. § 122C-273(a)(3) (2024) ("In no case may the respondent be physically forced to take medication or forcibly detained for treatment unless he poses an immediate danger to himself or others. In such cases inpatient commitment proceedings shall be initiated."); TEX. HEALTH & SAFETY CODE § 574.037(c-3) (West 2024) ("The court shall order the patient to participate in the program but may not compel performance."); *see also id.* § 576.002(1) ("The provision of court-ordered . . . mental health services to a person [is] not a determination or adjudication of mental incompetency and does not limit the person's rights as a citizen, or . . . legal capacity."); *id.* § 576.002(b) ("There is a rebuttable presumption that a person is mentally competent unless a judicial finding to the contrary is made under the Estates Code.").

158 FLA. STAT. ANN. § 394.467(3) (West 2024).

159 GA. CODE ANN. § 37-3-1(12.2), (17) (West 2024).

160 405 ILL. COMP. STAT. ANN. 5/3-209 (West 2024). Notably, Illinois law directs that all recipients of mental health services "be informed of [their] right to refuse medication . . . [and] given the opportunity to refuse generally accepted mental health . . . services, including but not limited to medication." 405 ILL. COMP. STAT. ANN. 5/2-107(a) (West 2024). It is unclear the extent to which this occurs in practice.

161 KY. REV. STAT. ANN. § 202A.0817 (LexisNexis 2024).

162 LA. STAT. ANN. § 28:70(A), (D)(2) (2024); *id.* § 28:71(D).

163 MD. CODE ANN., HEALTH-GEN. § 10-6A-05 (West 2025).

164 MONT. CODE ANN. § 53-21-149 (West 2023); *see id.* § 53-21-127 (permitting forcible medication if "necessary to . . . facilitate effective treatment").

165 N.Y. MENTAL HYG. LAW § 9.60(a)(1), (i), (j)(4) (LexisNexis 2025).

166 OHIO REV. CODE ANN. § 5122.01(V) (West 2024).

167 OKLA. STAT. ANN. tit. 43A, § 5-416(K) (West 2024).

168 *See* 50 PA. STAT. AND CONS. STAT. ANN. § 7304(e)(8)(iii) (West 2025) (prohibiting a *proposed* treatment plan from *recommending* "the use of physical force or restraints to administer medication to the person").

ordered medication but do not expressly disallow its forcible administration.[169] However, three of the seven states whose POC statutes do not directly permit court-ordered medication[170] nonetheless clarify that POC does not authorize forcible medication.[171] In summary, fewer than one-third of POC statutes (8/23) clearly relay that POC does not authorize the forcible administration of medication, even though a court may order the administration of a particular medication at a particular dosage by a particular individual.[172]

Second, the language of POC statutes often strongly suggests that forcible administration is permissible. Multiple states' statutes authorize a court to "order the patient to self-administer psychotropic drugs or accept the administration of such drugs by authorized personnel as part of [a POC] program."[173] Some states include multiple provisions with this or similar language.[174] Nearly half (3/7) of statutes with this kind of language do not specify that forcible medication is unauthorized.[175] Two of these states—New York and Louisiana—expressly authorize periodic blood tests or urinalysis to confirm compliance with prescribed medication, deepening the

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169 The codes of at least three of these states—Georgia, Florida, and Illinois—have later, more broadly applicable statutory provisions concerning mental health patients' rights to give informed consent for treatment or refuse medication. *See* GA. CODE ANN. §37-3-163 (West 2024); FLA. STAT. ANN. § 394.459(3)(a)(1) (West 2024); 405 ILL. COMP. STAT. ANN. 5/2-107(a) (West 2024); 405 ILL. COMP. STAT. ANN. 5/2-107(a) (West 2024); *supra* note 160.

170 These states include Alabama, California, Delaware, Maine, Oregon, Utah, and Washington. California provides that a service planning and delivery process will include "coordination and access to medications." CAL. WELF. & INST. CODE § 5348(a)(2)(B) (West 2024). However, "medication is not a component of the court order in California." Sarah L. Starks et al., *Client Outreach in Los Angeles County's Assisted Outpatient Treatment Program: Strategies and Barriers to Engagement*, 32 RSCH. SOC. WORK PRAC. 839, 841 (2022).

171 *See* OR. REV. STAT. ANN. § 426.133(1) (West 2024) ("[POC] . . . does not include taking a person into custody or the forced medication of a person."); CALIF. WELF. & INST. CODE § 5348(c) (West 2024) ("Involuntary medication shall not be allowed absent a separate order by the court pursuant to Sections 5332 to 5336, inclusive."); UTAH CODE ANN. § 26B-5-351(15) (West 2024) ("A court order for [POC] does not create an independent authority to forcibly medicate a patient"). In addition, at least two states—Maine and Washington—have separate statutes governing involuntary treatment. *See* ME. REV. STAT. ANN. tit. 34B, § 3861 (West 2023); WASH. REV. CODE ANN. § 71.05.215 (LexisNexis 2024).

172 *See supra* notes 157, 171.

173 OKLA. STAT. ANN. tit. 43A, § 5-416(K) (West 2024); *see* NEV. REV. STAT. ANN. § 433A.343(4) (West 2024); N.M. STAT. ANN. § 43-1B-7(C) (LexisNexis 2024); LA. STAT. ANN. § 28:71(D) (2024); *id.* § 28:70(A); N.Y. MENTAL HYG. LAW § 9.60(j)(4) (LexisNexis 2025); N.C. GEN. STAT. ANN. § 122C-273(a) (2024); 50 PA. STAT. AND CONS. STAT. ANN. § 7304(e)(8)(iii) (West 2025).

174 *See* LA. STAT. ANN. §§ 28:70(A), 28:71(D) (2024); N.Y. MENTAL HYG. LAW § 9.60(i), (j)(4) (West 2025).

175 *See* OKLA. STAT. ANN. tit. 43A, § 5-416(K) (West 2024); LA. STAT. ANN. §§ 28:71(D), 28:70(A) (2024); N.Y. MENTAL HYG. LAW § 9.60(i), (j)(4) (LexisNexis 2025).

impression that medication may be compelled.[176] New York also defines its POC program in part as a system "to ensure compliance with court orders."[177]

At least one court has equated the compulsive force of a court order to "self-administer psychotropic drugs or accept the administration of such drugs by an authorized professional" with an order to forcibly administer medication.[178] A New Mexico appellate court rejected an argument differentiating the two.[179] The court stressed that "the [POC] [o]rdinance allows a court to order a subject with capacity to comply with a treatment plan, which can include taking medication, to which he or she does not consent," while, in contrast, "the [civil] [c]ode prohibits the administration of medication absent consent except where the individual lacks capacity."[180] Therefore, the ordinance and the code are "in conflict and cannot be harmonized."[181] Crucially, the court recognized that the coercive nature of the court order itself compels the acceptance of unwanted medication without consent, regardless of the availability of sanctions for noncompliance.[182] Additionally, in dicta, the Hawaii Supreme Court construed the Hawaii POC statute's language of "medication specifically authorized by court order" as equivalent to authorizing "involuntary medication of a patient on an outpatient basis."[183]

Third, some statutes authorize forcible medication under conditions likely to be present for individuals subjected to POC. For instance, Illinois permits the forcible administration of medication for 90 days when a person with a serious mental illness exhibits suffering or deterioration of the ability to function, this suffering or deterioration has existed continuously for some (unspecified) period or has appeared episodically over the course of the illness, the benefits of treatment outweigh its harm,

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176 *See* LA. STAT. ANN. § 28:70(D)(2)(c) (2024); N.Y. MENTAL HYG. LAW § 9.60(a)(1) (LexisNexis 2025).

177 N.Y. MENTAL HYG. LAW § 9.60(a)(4) (LexisNexis 2025).

178 Protec. & Advoc. Sys. v. Albuquerque, 195 P.3d 1, 19 (N.M. Ct. App. 2008) (quoting Albuquerque, N.M., Ordinance O–06–21, § 8(B)).

179 *Id.* at 20.

180 *Id.* The Code in that case provided: "No psychotropic medication . . . shall be administered to any client without proper consent. If the client is capable of understanding the proposed nature of treatment and its consequences and is capable of informed consent, his consent shall be obtained before the treatment is performed." *Id.*

181 *Id.* (stressing POC "permits the court-ordered treatment of an individual with the capacity to make an informed consent," while the prohibition on forcibly medicating a competent person "prohibits such an act").

182 *Id.* at 21 ("Further, regardless of whether there are sanctions in the Ordinance for failure to comply with court-ordered treatment, the coercive nature of a court order requiring treatment would clearly allow an act contrary to the . . . mandate that an individual's consent be obtained as long as the individual has capacity.").

183 *See* State v. Kotis, 984 P.2d 78, 89 n.14 (Haw. 1999).

the recipient lacks treatment capacity, and less restrictive services are not available.[184] These elements resemble those of several POC statutes.[185]

Finally, at least two states appear to actually authorize the forcible medication of POC recipients. Montana authorizes preventive commitment to a community facility, program, or course of treatment,[186] when the individual's "mental disorder, as demonstrated by [their] recent acts or omissions, will, if untreated, predictably result in deterioration of [their] mental condition to the point at which [they] will become a danger to self or to others or will be unable to provide for [their] own basic needs of food, clothing, shelter, health, or safety."[187] The commitment may last three or possibly six months.[188] For these individuals, "[t]he court may authorize . . . a physician . . . to administer appropriate medication involuntarily if the court finds that involuntary medication is necessary . . . to facilitate effective treatment."[189] No other criteria are required.[190] Additionally, Montana authorizes the court, in response to "substantial noncompliance that is likely to result in [satisfaction of involuntary commitment criteria]," to "take reasonable steps to ensure compliance" including "presenting the respondent to the mental health facility or program for treatment, including the administration of medication."[191] Similarly, in Pennsylvania, a person may face emergency involuntary treatment within a treatment facility for up to 120

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184 405 ILL. COMP. STAT. ANN. 5/2-107.1(4), (5) (West 2024).

185 *See, e.g.*, TEX. HEALTH & SAFETY CODE § 574.0345(a)-(c) (West 2024) (requiring for a POC order a finding that, without treatment, the individual will "experience deterioration of the ability to function independently to the extent that the proposed patient will be unable to live safely in the community," which must be demonstrated by evidence of a recent overt act or continuing pattern of behavior); FLA. STAT. ANN. § 394.467(2)(a) (West 2024) (permitting a POC order upon a finding that the person is "unlikely to survive safely in the community without supervision[,]" "has a history of lack of compliance with treatment for mental illness[,]" has a history of hospitalization or violent acts or threats, "is unable to determine for himself or herself whether services are necessary" or has refused (or is likely to refuse) to comply with treatment, is likely to benefit from treatment, and less restrictive services are not appropriate or available, among other requirements).

186 MONT. CODE ANN. § 53-21-127(7) (West 2023).

187 *Id.* § 53-21-126(1)(d); *see also id.* § 53-21-126(4)(d) (additional criteria).

188 *See id.* § 53-21-127(3)(b)(i)–(ii).

189 *Id.* § 53-21-127(6). The physician designated by the court and, if possible, a medication review committee must approve the involuntary administration prior to its administration. *Id.*; *see also id.* § 53-21-145 (including other guidelines for administration of medication).

190 *See In re* Mental Health of S.C., 15 P.3d 861, 863 (Mont. 2000) (discussing the applicable procedure and stressing that courts must explain why involuntary medication was chosen from among other alternatives).

191 MONT. CODE ANN. § 53-21-151(2)(b) (West 2023). Where statutory criteria are satisfied, individuals lack a common law right to refuse medication. *See In re* Mental Health of S.C., 15 P.3d at 862.

hours[192] simply upon a determination that they meet the criteria for POC.[193] This period may be extended for up to twenty days.[194] Outside of emergency treatment, Pennsylvania does not permit forcible medication during a POC term.[195]

3. Hearing or Involuntary Examination Regarding Inpatient Treatment

Most states respond to noncompliance with attempts to elicit compliance, modification of the treatment plan, or an involuntary examination for inpatient civil commitment if criteria may plausibly be satisfied. This section details these statutory responses.

Most state statutes suggest measures to gain compliance before considering revocation of an outpatient treatment order. Most, but certainly not all,[196] states require efforts to attain cooperation before evaluating the person for inpatient treatment.[197] For example, North Carolina dictates that a treatment provider shall make, document, and report to the court, with a request for a supplemental hearing, "all reasonable effort to solicit the respondent's compliance."[198]

In addition, several states encourage courts or treatment providers to modify a treatment plan to foster adherence.[199] Montana suggests courts respond to noncompliance by directing a friend of the respondent to attempt to persuade them to comply with the plan, or by directing the treatment provider "to work with the respondent to bring about compliance."[200] Maine's statute uniquely suggests that the court's treatment order contain conditional remedies to ensure compliance.[201] These remedies may include committing the individual to the supervision of an ACT team,

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192 50 PA. STAT. AND CONS. STAT. ANN. § 7302(b), (d) (West 2025).

193 *Id.* § 7301(a).

194 *Id.* § 7303(a), (f).

195 *Id.* § 7304(e)(8)(iii).

196 *See* ALA. CODE § 22-52-10.3(e), (f) (2024); GA. CODE ANN. § 37-3-82(b) (West 2024); 405 ILL. COMP. STAT. ANN. 5/3-812(b), (c) (West 2024); ME. REV. STAT. ANN. tit. 34B, § 3873-A(8) (West 2023); N.M. STAT. ANN. § 43-1B-13(A) (LexisNexis 2024); OHIO REV. CODE ANN. § 5122.15(N) (West 2024); 50 PA. STAT. AND CONS. STAT. ANN. § 7304(f)(5) (West 2025); TEX. HEALTH & SAFETY CODE § 574.037(c-3) (West 2024); UTAH CODE ANN. § 26B-5-333(2) (West 2024).

197 *See, e.g.*, CAL. WELF. & INST. CODE § 5346(d)(6), (f) (West 2024); FLA. STAT. ANN. § 394.467(10) (West 2024); HAW. REV. STAT. ANN. § 334-129(d) (West 2024); LA. STAT. ANN. § 28:75(A) (2024); NEV. REV. STAT. ANN. § 433A.344(1)(b) (West 2024); N.C. GEN. STAT. ANN. § 122C-273(1), (2) (2024); OKLA. STAT. ANN. tit. 43A, § 5-416(P) (West 2024).

198 N.C. GEN. STAT. ANN. § 122C-273(1) (2024).

199 *See* FLA. STAT. ANN. § 394.467(10)(a) (West 2024); 405 ILL. COMP. STAT. ANN. 5/3-812(c) (West 2024); 50 PA. STAT. AND CONS. STAT. ANN. § 7304(f)(5) (West 2025); TEX. HEALTH & SAFETY CODE § 574.037(c-3) (West 2024); WASH. REV. CODE ANN. § 71.05.590(1) (LexisNexis 2024).

200 MONT. CODE ANN. § 53-21-151(2) (West 2023).

201 ME. REV. STAT. ANN. tit. 34B, § 3873-A(7) (West 2023).

"[e]ndors[ing] an application for admission to a psychiatric hospital . . . conditioned on receiving a certificate from a medical practitioner that the patient has failed to comply with an essential requirement of the treatment plan," and ordering that current liberty restrictions will end upon achieving designated goals under the treatment plan.[202]

Sixteen states permit noncompliance with an ordered treatment plan to serve as grounds for an involuntary hold and examination to determine the appropriateness of inpatient commitment.[203] Some of these states empower treatment providers with discretionary holds,[204] but others require court approval.[205] Illinois grants persons given care and custody of the patient "the authority to admit a respondent to a hospital [for a 24-hour examination] if the respondent fails to comply with the conditions of the order"—apparently without any input from a service provider.[206] An additional six states provide a failure to comply can be grounds for an immediate hearing to consider inpatient treatment.[207] In these states, upon a report of material noncompliance, the court sets a hearing to determine if the treatment order should be revoked or modified, or if the individual meets inpatient criteria.[208]

States typically, but not always, apply the same inpatient commitment standard to noncomplying individuals under POC as they do to those outside this context. However, at least one state, Utah, permits the hospitalization of an outpatient

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202 *Id.*

203 *See* CAL. WELF. & INST. Code § 5346(f) (West 2024) (so long as "in the clinical judgment of the licensed mental health treatment provider, the person may be in need of involuntary admission to a hospital for evaluation"); FLA. STAT. ANN. § 394.467(10)(a) (West 2024); HAW. REV. STAT. ANN. § 334-129(d) (West 2024); 405 ILL. COMP. STAT. ANN. 5/3-812(b) (West 2024); KY. REV. STAT. ANN. § 202A.0823 (LexisNexis 2024) ("A person's substantial failure to comply with a court order for assisted outpatient treatment may constitute presumptive grounds for an authorized staff physician to order a seventy-two (72) hour emergency admission . . . ."); LA. STAT. ANN. § 28:75(C), (D) (2024); NEV. REV. STAT. ANN. § 433A.344 (West 2024) (so long as a mental health professional believes the failure to comply may cause the person to harm themselves or others); N.M. STAT. ANN. § 43-1B-13(A) (LexisNexis 2024); N.Y. MENTAL HYG. LAW § 9.60(n) (LexisNexis 2025); N.C. GEN. STAT. ANN. § 122C-273(2) (2024); *infra* note 205.

204 *See supra* note 203.

205 *See* GA. CODE ANN. § 37-3-82(b) (West 2024); OKLA. STAT. ANN. tit. 43A, § 5-416(P) (West 2024); ME. REV. STAT. ANN. tit. 34B, § 3873-A(7)-(8) (West 2023); 50 PA. STAT. AND CONS. STAT. ANN. § 7304(f)(5) (West 2025); TEX. HEALTH & SAFETY CODE § 574.037(c-3) (West 2024); WASH. REV. CODE ANN. § 71.05.590(1)-(2) (LexisNexis 2024).

206 *See* 405 ILL. COMP. STAT. ANN. 5/3-812(b) (West 2024).

207 *See* ALA. CODE § 22-52-10.3(e), (f) (2024); ME. REV. STAT. ANN. tit. 34B, §3873-A(8) (West 2023); MONT. CODE ANN. § 53-21-151(1) (West 2023); OHIO REV. CODE ANN. § 5122.15(N) (West 2024); OKLA. STAT. ANN. tit. 43A, § 5-416(B)(2), (P) (West 2024); UTAH CODE ANN. § 26B-5-333(2) (West 2024).

208 *See supra* note 207.

committee who has failed to comply with treatment directives upon a lesser showing than that required for individuals without a history of noncompliance.[209]

States afford different evidentiary weight to treatment refusal when determining the need for inpatient commitment. Two states specify that refusal to take medications can factor into this calculus.[210] One state, Kentucky, provides that a "substantial failure" to comply with court-ordered treatment may constitute "presumptive grounds" for emergency hospitalization.[211] Six states make clear that refusal of treatment alone cannot be grounds for involuntary hospitalization.[212]

North Carolina differentiates between "situational" and "contumacious" noncompliance.[213] Situational noncompliance stems from "social and illness factors,"[214] such as a lack of transportation or insufficient funds for treatment upkeep.[215] Contumacious noncompliance is characterized by an unwillingness to comply.[216] In response to situational noncompliance—when "the respondent fails to comply, but does not clearly refuse to comply, . . . after reasonable effort to solicit the

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209 *See* UTAH CODE ANN. § 26B-5-333(2) (West 2024) (permitting an individual ordered to outpatient treatment to be involuntarily committed if the court finds the person is "is still mentally ill," no less restrictive alternative to inpatient commitment exists," and "based upon the patient's conduct and statements during the preceding six months, or the patient's failure to comply with treatment recommendations during the preceding six months, the court finds that absent an order of involuntary commitment, the patient is likely to pose a substantial danger to self or others"); *id.* § 26B-5-332(16)(a) (authorizing the inpatient commitment of an adult if the court finds by clear and convincing evidence that the patient has a mental illness, because of that mental illness poses a substantial danger to self or others, and "lacks the ability to engage in a rational decision-making process regarding the acceptance of mental treatment as demonstrated by evidence of inability to weigh the possible risks of accepting or rejecting treatment").

210 *See* LA. STAT. ANN. § 28:75(D) (2024); N.Y. MENTAL HYG. LAW § 9.60(n) (LexisNexis 2025).

211 KY. REV. STAT. ANN. § 202A.0823 (LexisNexis 2024).

212 *See* HAW. REV. STAT. ANN. § 334-129(d) (West 2024); LA. STAT. ANN. § 28:71(F) (2024); N.M. STAT. ANN. § 43-1B-13(B) (LexisNexis 2024); N.Y. MENTAL HYG. LAW § 9.60(n) (LexisNexis 2025); OKLA. STAT. ANN. tit. 43A, § 5-416(Q) (West 2024); MD. CODE ANN., HEALTH-GEN. § 10-6A-10(d) (West 2025).

213 *See* King, *supra* note 148, at 272–73.

214 *Id.* at 272.

215 *See* Virginia Adigé Hiday & Teresa L. Scheid-Cook, *The North Carolina Experience with Outpatient Commitment: A Critical Appraisal*, 10 INT'L J.L. & PSYCHIATRY 215, 218 (1987) (listing examples of social and illness factors leading to noncompliance).

216 *See* King, *supra* note 148, at 274; Hiday & Scheid-Cook, *supra* note 215, at 218 ("The Study Commission thought that these social and illness factors, as opposed to recalcitrance, could be overcome and compliance obtained by the authority of a court order, the strength of a sheriff's pick up and custody, and the extra effort and attention required of mental health personnel.").

respondent's compliance"[217]— upon the treatment provider's request, the clerk of the court (without the court's involvement) "shall issue an order to a law-enforcement officer to take the respondent into custody and to take him immediately to the designated outpatient treatment physician or center for examination."[218] Presumably, the physician then tries to persuade the individual to accept treatment.[219] However, in response to contumacious noncompliance—if the individual "clearly refuses to comply"—they will not be subjected to this custody order or involuntary examination on the basis of noncompliance alone.[220] In exempting the refusing individual from the involuntary transportation, examination, and physician persuasion, North Carolina demonstrates respect for the clearly expressed treatment preference of the committed individual.[221]

IV. TREATMENT INCAPACITY

Perhaps the largest source of misinformation around POC is the extent to which it applies only to those without treatment decision-making capacity. Supporters of POC typically justify the practice (at least in substantial part) by pointing to the inability of many individuals with serious mental illnesses to make rational treatment decisions.[222] For example, psychiatrist E. Fuller Torrey and lawyer Jonathan Stanley—both of the Treatment Advocacy Center, a major driver of POC expansion[223]—have argued that POC applies only to those who "do[] not have a normally functioning brain and [whom we] suspect . . . cannot make informed choices. Forcing [them] to take medication is assisting [them] to make the choice we think

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217 N.C. GEN. STAT. ANN. § 122C-273(2) (West 2024).

218 *Id.*

219 King, *supra* note 148, at 273.

220 *Id.*

221 In response to noncompliance for any reason, the court may hold a hearing where the court will determine its causes. N.C. GEN. STAT. ANN. § 122C-274(c) (2024). The court may order an examination to determine the necessity for any form of commitment, reissuing or changing the outpatient commitment order, or releasing the individual from the commitment order and dismissing the case. *Id.*

222 *See* Boldt, *supra* note 22, at 47 ("[S]ome even argue that because of the phenomenon of anosognosia, the practice of subjecting severely mentally ill individuals to judicially ordered outpatient treatment does not constitute 'involuntary' outpatient commitment at all, but rather 'assisted' outpatient treatment. This is the case, they explain, because the imposed treatment is likely what the patient would have chosen had he or she not been afflicted by this neurological disorder that impairs one's ability to recognize the need for treatment."); Player, *supra* note 12, at 164 ("Most authors on bioethics and mental health law rest the moral justification for outpatient commitment on . . . impaired insight, decisional-incapacity, or incompetence to refuse treatment."); *infra* note 224.

223 *See, e.g.*, *Wrapping Up 2022 and Looking Ahead to 2023*, SMI ADVOC. (Winter 2022), https://www.votervoice.net/mobile/Treatment/newsletters/47171 (discussing legislative accomplishments of 2022).

[they] would make if [they] had a normally functioning brain."[224] The articulated aims of state statutes and governmental bodies also convey an intent to provide treatment to those whose mental disorders impair their decision-making.[225] Media accounts of POC also reflect this understanding of its limited use.[226]

A. State's Parens Patriae Commitment Power

Courts have long recognized that caring for those who cannot care for themselves justifies state action.[227] A key justification for a state's ability to order an individual with mental disability to involuntary community treatment has been the parens patriae doctrine,[228] which allows the government to make decisions in the best interest of individuals whose disability renders them unable to make such decisions for themselves.[229] Historically, legislatures and courts have treated serious mental illness

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224 E. Fuller Torrey & Jonathan Stanley, *"Assisted Outpatient Treatment": An Example of Newspeak?: In Reply*, 64 PSYCHIATRIC SERVS. 1179, 1179 (Nov. 1, 2013).

225 *See, e.g.*, S. 5762-A, 222d Sess. (N.Y. 1999) ("The legislature . . . finds that some mentally ill persons, because of their illness, have great difficulty taking responsibility for their own care, and often reject the outpatient treatment offered to them on a voluntary basis."); 2024 Md. Legis. Serv. Ch. 704 (West 2024) (finding, in the preamble to the POC bill, that "[a] small but persistent subset of individuals with severe mental illness struggle to engage voluntarily in treatment necessary to live safely in the community, in many cases due to an inability . . . to maintain awareness or understanding of their mental illness"); Utah Dept. of Health & Hum. Serv., Integrated Health, *Assisted Outpatient Treatment (AOT) in Utah*, https://dsamh.utah.gov/pdf/Adult%20MH/Utah%20AOT%20Defined.pdf [https://web.archive.org/web/20231102023359/https://dsamh.utah.gov/pdf/Adult%20MH/Utah%20AOT%20Defined.pdf] ("The purpose of the AOT program is to provide evidence-based mental health care in the least restrictive environment for adult individuals with serious mental illness who are experiencing psychosis and have difficulty complying with treatment.").

226 *See, e.g.*, Courtney Bergan, *Commentary: Marylanders Need Access to a Diverse Array of Dignified Mental Health Supports, Not Assisted Outpatient Treatment*, MD. MATTERS (Apr. 10, 2023, 6:30 AM), https://marylandmatters.org/2023/04/10/commentary-marylanders-need-access-to-a-diverse-array-of-dignified-mental-health-supports-not-assisted-outpatient-treatment/ ("Physician proponents of AOT suggest it is needed to serve 'a small, but specific subset of the population' that fails to recognize their need for treatment.").

227 *See infra* note 229.

228 *See* Schwartz & Costanzo, *supra* note 22, at 1361 ("These broader commitment criteria usually represent a significant extension of the *parens patriae* authority."); John Kip Cornwell, *Understanding the Role of the Police and Parens Patriae Powers in Involuntary Civil Commitment Before and After Hendricks*, 4 PSYCH. PUB. POL'Y & L. 377, 385 (1998) ("[A] number of states have endeavored to assume *parens patriae* commitment authority over persons who, although not yet gravely disabled or a danger to themselves, are likely to become so in the near future.").

229 *See* State *ex rel.* Hawks v. Lazaro, 202 S.E.2d 109, 117–22 (W. Va. 1974) (discussing the origins, evolution, and modern application of the *parens patriae* authority); Matter of D.C., 679 A.2d 634, 643 (N.J. 1996) ("Under the *parens patriae* theory, the state draws on 'the inherent equitable authority of the sovereign to protect those persons within the state who cannot protect

as synonymous with mental incapacity, including in the context of mental health care.[230] Still today, the presumed incompetence of individuals with serious mental illnesses remains widespread,[231] even among treating physicians.[232] One manifestation of this widespread belief is the omission of any element requiring decision-making incapacity from many civil commitment statutes seemingly issued under the state's parens patriae authority.[233]

The common equation of serious mental illness with decision-making incapacity reflects a frequent hallmark of serious mental illness: anosognosia.[234] Anosognosia is the lack of insight into one's illness, the pathological source of one's symptoms, or one's need for treatment.[235] Researchers estimate that 40% of individuals with bipolar disorder and 57–98% of individuals with schizophrenia have partial or no insight into

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themselves because of an innate legal disability,' such as minority, mental illness or incompetency." (quoting *In re* Grady, 426 A.2d 467 (N.J. 1981)). For a detailed examination of the history of the *parens patriae* doctrine and its evolution over time, see Schwartz & Costanzo, *supra* note 22, at 1336–46.

230 *See* Jackson v. Ind., 406 U.S. 715, 736 (1972) ("The States have traditionally exercised broad power to commit persons found to be mentally ill."); Cornwell, *supra* note 228, at 382 (criticizing civil commitment statutes that "relied entirely on standards that conflated mental illness, either explicitly or implicitly, with the predicate need-for-treatment requirement" and noting others' objection of "vagueness and circularity, charges that may be fairly leveled as well against modern statutes whose definitions likewise suffer from inherent ambiguity"); *infra* note 231.

231 *See* George Szmukler & Brendan D. Kelly, *We Should Replace Conventional Mental Health Law with Capacity-Based Law*, 209 BRITISH J. PSYCHIATRY 449, 449 (2016) (statement of George Szmukler) ("There is an underlying assumption in mental health legislation that 'mental disorder' necessarily entails mental incapacity, and that the wishes and preferences of a person with a 'disordered mind' are not a reliable guide to where their best interests lie.").

232 *See* Dilip V. Jeste et al., *Magnitude of Impairment in Decisional Capacity in People with Schizophrenia Compared to Normal Subjects: An Overview*, 32 SCHIZOPHRENIA BULL. 121, 122 (2006) ("Based on the [National Bioethics Advisory Commission] report and surveys of clinicians, there appears to be an existing bias that assumes almost everyone with schizophrenia has impaired decisional capacity, whereas nonpsychiatric comparison subjects (NPCs) are not impaired.").

233 *See* Boldt, *supra* note 22, at 62–63; Player, *supra* note 12, at 212. However, the vast majority of states now recognize inpatients' right to refuse intrusive treatment (including antipsychotic medication) absent an emergency, a finding of incompetency, or some other statutory grounds for overriding a treatment refusal. *See* Boldt, *supra* note 20, at 79 ("In most jurisdictions, psychiatric patients, including those who are civilly committed, retain significant legal discretion to refuse antipsychotic medications.").

234 *See* Douglas S. Lehrer & Jennifer Lorenz, *Anosognosia in Schizophrenia: Hidden in Plain Sight*, 11 INNOVATIONS CLINICAL NEUROSCIENCE 10, 11 (2014); Shmuel Fennig et al., *Insight in First-Admission Psychotic Patients*, 22 SCHIZOPHRENIA RSCH. 257, 259–60 (1996); *Agnosia*, CLEVELAND CLINIC (last updated Apr. 21, 2022) https://my.clevelandclinic.org/health/diseases/22832-anosognosia [https://perma.cc/8K36-4GJ9].

235 *See* Anthony S. David, *Insight and Psychosis*, 156 BRITISH J. PSYCHIATRY 798, 805 (1990) (proposing three distinct, overlapping dimensions of insight).

those matters.[236] Mounting neuroscientific evidence suggests anosognosia is the product of anatomical and functional brain abnormality, especially in the frontal areas, that affects a range of cognitive and self-evaluative processes.[237] Damage to these areas can impair a person's ability to accurately update their self-image. Importantly, anosognosia (a pathological inability to grasp reality due to brain defects) differs from denial (a psychological means of coping in healthy individuals).[238] This lack of insight predisposes certain people, perhaps particularly individuals with a psychotic disorder, to treatment noncompliance,[239] deterioration, and rehospitalization.[240]

However, accumulated empirical evidence demonstrates that presuming incompetence to make rational treatment decisions from the common feature of anosognosia is unfounded and reinforces damaging stereotypes about the "master status" of mental disorder.[241] A 2020 meta-review of literature reviews evaluating the treatment decision-making ability of individuals with mental disorders found a consensus: most individuals with severe mental disabilities retain the capacity to make rational, informed treatment decisions.[242] Severe mental illness does not necessarily—or even usually—negate one's ability to make intricate risk-reward[243] or

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236 *See supra* note 234.

237 *See* G.H.M. Pijnenborg et al., *Brain Areas Associated with Clinical and Cognitive Insight in Psychotic Disorders: A Systematic Review and Meta-Analysis*, 116 NEUROSCIENCE & BIOBEHAVORIAL REV., 301, 322–26 (2020).

238 *See* Tiffany L. Baula, Awareness of the Unaware: Anosognosia as a Comorbidity in Mental Health Conditions 7 (2020) (B.S.N. thesis, University of Central Florida) https://stars.library.ucf.edu/cgi/viewcontent.cgi?article=1820&context=honorstheses [https://perma.cc/656P-V3S3].

239 Zachary D. Torry & Kenneth J. Weiss, *Medication Noncompliance and Criminal Responsibility: Is the Insanity Defense Legitimate?*, 40 J. PSYCHIATRY & L. 219, 230–31 (2012). *But cf.* Tania M. Lincoln et al., *Correlates and Long-Term Consequences of Poor Insight in Patients with Schizophrenia. A Systematic Review*, 33 SCHIZOPHRENIA BULL. 1324, 1328 (2007) (critically examining studies on the subject).

240 Gunnar Morken et al., *Non-Adherence to Antipsychotic Medication, Relapse and Rehospitalisation in Recent-Onset Schizophrenia*, 8 BMC PSYCHIATRY, 1 (2008).

241 *See* William H. Fisher et al., *Beyond Criminalization: Toward a Criminologically Informed Framework for Mental Health Policy and Services Research*, 33 ADMIN. & POL'Y MENTAL HEALTH & MENTAL HEALTH SERVS. RSCH. 544, 549 (2006).

242 A. Calcedo-Barba et al., *A Meta-Review of Literature Reviews Assessing the Capacity of Patients with Severe Mental Disorders to Make Decisions about their Healthcare*, 20 BMC PSYCHIATRY 1, 12 (2020) ("Authors across studies are coincident in emphasising [sic] that most patients with a severe mental disorder are able to make rational decisions about their medical care and to participate in decision-making regarding treatments despite temporal impairments.").

243 *Id.* ("The findings also reveal that patients with psychotic disorders or other severe mental illnesses can make complex risk-reward decisions in usual clinical practice.").

treatment decisions.[244] Likewise, a decision to abstain from treatment need not be—nor is likely—uninformed or irrational.[245] Rather, treatment refusal often stems from sound reasons, including a preference to avoid the well-known, serious side effects associated with certain medications.[246] Outpatient treatment may also be incompatible with an individual's life commitments.[247]

Crucially, the logic of the parens patriae doctrine dictates that the state can only legitimately exercise its authority over individuals incapable of identifying their best interests.[248] This limitation may also be a requirement of substantive due process.[249] In the context of compelled community treatment, the parens patriae power only justifies state action over individuals unable to make rational treatment decisions.[250] Given the scientific consensus that most individuals with serious mental disorders retain the ability to make rational treatment decisions, compulsory treatment under the state's parens patriae power requires a finding that the individual lacks that particular capacity in a given case.[251]

B. Treatment Decision-making Incapacity

Despite the crucial import of a treatment decision-making incapacity element, only two of the twenty-three states that allow courts to mandate POC require findings of impaired decision-making ability. In Kentucky, an individual must be "unlikely to adequately adhere to outpatient treatment on a voluntary basis based on a qualified mental health professional's: (a) [c]linical observation; and (b) [i]dentification of

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244 *Id.* (finding "that people with schizophrenia have the capacity to make other difficult decisions related, for instance, to . . . the type of treatment they prefer to receive").

245 Elyn R. Saks, *Competency to Refuse Treatment*, 69 N.C. L. REV. 945, 990–91 (1990).

246 *Id.* at 984.

247 Player, *supra* note 12, at 210.

248 *See Developments in the Law: Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1213 (1974) ("Since the state interest in acting as *parens patriae* is premised on the need for the state to act to protect the well-being of its citizens when they cannot care for themselves, the imposition of involuntary commitment would seem necessary to vindicate that interest only when an individual is incapable of making his own evaluation of his need for psychiatric treatment."); Bruce J. Winick, *On Autonomy: Legal and Psychological Perspectives*, 37 VILL. L. REV. 1705, 1772 (1992); *In re* Torski C., 918 N.E.2d 1218, 1228 (Ill. App. Ct. 2009).

249 *See* In re *Torski C.*, 918 N.E.2d at 1228 ("To satisfy due process, it is understood that the State's powers cannot be extended to those individuals capable of making their own treatment decisions.").

250 *See* MELTON ET AL., *supra* note 119, at 326; Winick, *supra* note 248, at 1771–75; *Developments*, *supra* note 249, at 1213. Commentators are divided on the degree of incapacity to require within the context of POC. Some advocate for a standard of full legal incompetence to make rational treatment decisions, while others contend that impaired clinical capacity is sufficient to justify overriding an individual's right to refuse treatment. *See* Boldt, *supra* note 20, at 51–53, 86–88 (identifying various positions and charting the evolution of the views of the American Psychiatric Association on this topic).

251 *See supra* note 250.

specific characteristics of the person's clinical condition that significantly impair the person's ability to make and maintain a rational and informed decision as to whether to engage in outpatient treatment voluntarily."[252] Oregon also requires decision-making impairment—the person must be "unable to make an informed decision to seek or to comply with voluntary treatment"—but this incapacity need not stem from a mental disorder.[253] Notably, empirical studies establish that many conditions besides mental disability can hamper decision-making capabilities. Stress,[254] fatigue,[255] and anger[256] can each impact individuals' abilities to reach rational decisions.

Three additional states may require either decisional or volitional impairment. For purposes of this Article, a person may be volitionally impaired if, although competent to make rational treatment decisions, they have an impaired ability to translate their decisions into action due to a mental disorder.[257] An example of volitional impairment may be seen in a person able to rationally decide to participate in treatment but unable follow through because their attention is too scattered due to their mental disorder. Along these lines, Georgia requires a finding that the individual's "[c]urrent mental status or the nature of their illness limits or negates their ability to make an informed decision to seek voluntarily or to comply with recommended treatment."[258] Hawaii and North Carolina include similar elements in their POC statutes.[259] Alternatively, due to ambiguous statutory drafting, these three statutes may require decisional, not volitional, impairment.[260]

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252 KY. REV. STAT. ANN. § 202A.0815(3) (LexisNexis 2024).

253 OR. REV. STAT. ANN. § 426.133(2)(a)(D) (West 2024).

254 *See, e.g.*, Johannes Leder et al., *Exploring the Underpinnings of Impaired Strategic Decision-making Under Stress*, 49 J. ECON. PSYCH. 133, 138 (2015).

255 *See, e.g.*, William D. S. Killgore, *Impaired Decision Making Following 49 H of Sleep Deprivation*, 15 J. SLEEP RSCH. 7, 11 (2006).

256 *See, e.g.*, Sarah N. Garfinkel et al., *Anger in Brain and Body: The Neural and Physiological Perturbation of Decision-making by Emotion*, 11 SOC. COGNITIVE & AFFECTIVE NEUROSCIENCE 150, 155–56 (2016).

257 In the context of the insanity defense, "volitional impairment" refers to an inability to conform one's conduct to the requirements of law. *See* E. Lea Johnston, *Delusions, Moral Incapacity, and the Case for Moral Wrongfulness*, 97 IND. L.J. 297, 309–10, 310 n.81, 357 (2022) (identifying sixteen states that include volitional incapacity elements in their insanity defense).

258 GA. CODE ANN. § 37-3-1(12.1)(C) (West 2024) (emphasis added).

259 *See* HAW. REV. STAT. ANN. § 334-121(2) (LexisNexis 2024); N.C. GEN. STAT. ANN. § 122C-263(d)(1)(d) (West 2024).

260 These statutory provisions could require decisional incapacity—not volitional incapacity—if the statutes were interpreted to require that the individual's "[c]urrent mental status or the nature of their illness limits or negates their ability to make an informed decision . . . to comply with recommended treatment," as opposed to "limits or negates their ability . . . to comply with recommended treatment." GA. CODE ANN. § 37-3-1(12.1)(C) (West 2024); *see also* HAW. REV. STAT. ANN. § 334-121(2) (LexisNexis 2024); N.C. GEN. STAT. ANN. § 122C-263(d)(1)(d) (West 2024).

Crucially, the remaining eighteen states do not require decisional or volitional impairment. These states—the overwhelming majority (78%) of contemporary POC statutes—permit courts to override the treatment decisions of individuals whose mental disorders currently neither impair the rationality of their treatment decisions, their willingness to be treated, nor their ability to comply with treatment directives.[261] Five states include optional treatment incapacity elements.[262] Five additional states include no language resembling a treatment incapacity requirement at all.[263]

Seven states require only that individuals be "unlikely to voluntarily participate" in treatment due to their mental illness.[264] One additional state merely requires—for any reason other than one related to financial, transportation, or language issues—that the individual be "unlikely to adequately adhere to outpatient treatment on a voluntary basis."[265] At first blush, these elements seem to require volitional impairment. However, a person may be unlikely to voluntarily participate in a treatment plan—even as a result of their mental illness—for a host of reasons external to the individual. For example, for many individuals, the benefits of a prescribed medication or dosage may not outweigh its negative side-effects.[266] Access barriers,[267] including the limited availability of mental health services, can inhibit adherence to treatment

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261 Some mental health professionals assert that some states' definitions of mental disorder include treatment decision-making incapacity. MELTON ET AL., *supra* note 119, at 443. However, in reviewing states' definitions of "mental illness," "mental disorder," and other mental elements required in POC statutes, the authors were unable to locate any requiring the individual to have an impaired ability to make treatment decisions.

262 *See* ALA. CODE § 22-52-10.2(a)(3) (2024); TEX. HEALTH & SAFETY CODE § 574.0345(a)(2)(D) (West 2024); DEL. CODE ANN. tit. 16, § 5013(a)(4) (West 2024); FLA. STAT. ANN. § 394.467(2)(a)(1)(a) (West 2024); UTAH CODE ANN. § 26B-5-351(14)(c)(i-ii) (West 2024).

263 *See* CAL. WELF. & INST. CODE § 5346(a) (West 2024); 405 ILL. COMP. STAT. ANN. 5/1-119.1(2) (West 2024); ME. REV. STAT. ANN. tit. 34B, §§ 3873-A(1)(B), 3801(4-A)(D) (West 2023); MONT. CODE ANN. §§ 53-21-126(1)(d), 53-21-126(4)(d)(i)(C) (West 2023); WASH. REV. CODE ANN. § 71.05.148(1) (LexisNexis 2024).

264 *See* LA. STAT. ANN. § 28:66(A)(5) (West 2024); NEV. REV. STAT. ANN. § 433A.335(3)(d) (West 2024) (using the language "unwilling or unlikely); N.M. STAT. ANN. § 43-1B-3(D) (LexisNexis 2024) (same); N.Y. MENTAL HYG. LAW § 9.60(c)(5) (LexisNexis 2025); OHIO REV. CODE ANN. § 5122.01(B)(5)(a)(iii) (West 2024); OKLA. STAT. ANN. tit. 43A, § 1-103(20)(e) (West 2024); 50 PA. STAT. AND CONS. STAT. ANN. § 7301(c)(1)(iii) (West 2025); FLA. STAT. ANN. § 394.467(2)(a)(1)(a) (West 2024).

265 *See* MD. CODE ANN., HEALTH-GEN. § 10-6A-05(a)(5) (West 2025).

266 *See* Boldt, *supra* note 20, at 82 ("When evaluated alongside the significant negative side effects that are common to both classes of antipsychotic medications, it is apparent that the choice to undergo maintenance treatment with these drugs involves a complex judgment of relative benefits and risks, rather than the simple narrative of therapeutic benefit offered by advocates for the use of legal coercion, including medication compliance requirements for conditional discharge from involuntary hospitalization.").

267 In states other than Maryland, cognizable access barriers could also include those stemming from financial and transportation difficulties.

directives.[268] Voluntary participation could be improbable due to the social stigma associated with mental disorder or mental health treatment.[269] Past experiences of trauma, including negative interactions with the mental health system, can create barriers to seeking treatment.[270] Additional factors that decrease a person's likelihood of treatment participation include lack of social support, cultural or religious beliefs concerning mental health, systemic barriers (e.g., long waiting lists, bureaucratic hurdles, and shortages of mental health professionals), and legal concerns (e.g., fears of civil commitment or law enforcement).[271]

C. Consent and Participation of Individual

Paradoxically, POC overrides individuals' treatment decisions while premising the creation of treatment plans on their participation.[272] Indeed, empirical research suggests—and treatment providers recognize—that individuals' cooperation is vital to the success of this treatment modality.[273]

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[268] Angela Carbonell et al., *Challenges and Barriers in Mental Healthcare Systems and Their Impact on the Family: A Systematic Integrative Review*, 28 HEALTH SOC. CARE CMTY. 1366, 1367 (2020).

[269] Ahmed A. Ahad et al., *Understanding and Addressing Mental Health Stigma Across Cultures for Improving Psychiatric Care: A Narrative Review*, 15 CUREUS e39549 (May 26, 2023), https://www.cureus.com/articles/159889-understanding-and-addressing-mental-health-stigma-across-cultures-for-improving-psychiatric-care-a-narrative-review#!/.

[270] Viktoria Kantor et al., *Perceived Barriers and Facilitators of Mental Health Service Utilization in Adult Trauma Survivors: A Systematic Review*, 52 CLINICAL PSYCH. REV. 52 (2017).

[271] Importantly, most of these obstacles to voluntary treatment are capable of remediation by the state.

[272] Richard Boldt recently explored this paradox in the context of conditional release. Boldt, *supra* note 20, at 83–84 ("On the one hand, the legal coercion associated with outpatient commitment . . . is justified by the premise that these patients are unlikely to comply with prescribed treatment absent the legal obligations imposed by the state. On the other hand, virtually all agree that these legal interventions cannot succeed absent the cooperation of these very same individuals.").

[273] *See* Winick, *supra* note 16, at 100–11 (discussing the psychological literature on the value of choice for treatment success); Boldt, *supra* note 20, at 83 ("[T]he success of outpatient commitment in all its various forms necessarily depends on the willingness of patients to cooperate with the treatment orders attached to their release or issued by judges."); Annette Christy et al., *Involuntary Outpatient Commitment in Florida: Case Information and Provider Experience and Opinions*, 8 INT'L J. FORENSIC MENTAL HEALTH 122, 127 (2009) (reporting that some treatment providers "wrote about clients needing to 'have some level of insight in order for involuntary outpatient to work'. . . [and] that the success of [outpatient commitment] 'is completely dependent on the client and their internal motivation at the time of admission'"); Schwartz & Costanzo, *supra* note 22, at 1382 ("Only those individuals who are at least somewhat willing to accept mental health care and comply with judicially-approved treatment regimens are deemed eligible for outpatient commitment. This precondition of cooperation appears remarkably similar to a test of voluntariness.").

Some POC statutes presuppose that individuals retain the capacity to make treatment decisions.[274] A New York court observed that the state's POC statute "envisions a process where a patient with capacity actively participates in the planning of his or her treatment plan."[275] Most states give individuals a statutory right to participate in treatment planning.[276] However—consistent with civil commitment's transfer of decision-making authority from the individual to the state—the right of a committed person, even if competent, to participate in a treatment plan's creation does not signify that the plan will cohere with their preferences.

States' treatment of individuals' advance mental health directives reflects the merely advisory status of competent individuals' treatment preferences. Advance directives permit a competent individual to memorialize their treatment preferences in case they become unable to make rational treatment decisions.[277] Numerous commentators have identified advance directives as a means to facilitate mental health treatment while respecting individuals' autonomy.[278] Ten states with POC laws provide that treatment providers must consider any advance directives when

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274 *See In re* K.L., 806 N.E.2d, 480, 484 (N.Y. Ct. App. 2004) (finding that New York's POC law targets those "patients capable of participating in their own treatment plans" and remarking that "a large number of patients potentially subject to court-ordered [AOT] would be ineligible for the program if a finding of [treatment] incapacity were required"); *infra* note 275 and accompanying text.

275 *In re* Urcuyo, 714 N.Y.S.2d 862, 868 (N.Y. Sup. Ct. 2000).

276 *See* ALA. CODE § 22-56-4(b)(2) (2024); CAL. WELF. & INST. CODE § 5348(a)(3) (West 2024); FLA. STAT. ANN. § 394.467(4)(d)(3) (West 2024); 405 ILL. COMP. STAT. ANN. 5/2-102(a) (West 2024); KY. REV. STAT. ANN. § 202A.0817(1) (LexisNexis 2024); LA. STAT. ANN. § 28:70(A) (2024); MD. CODE ANN., HEALTH-GEN. § 10-6A-06(b)(1) (West 2025); MONT. CODE ANN. §§ 53-21-150(3), 53-21-150(4) (West 2023); NEV. REV. STAT. ANN. § 433A.337(3)(b) (West 2023); N.M. STAT. ANN. § 43-1B-7(B) (LexisNexis 2024); N.Y. MENTAL HYG LAW § 9.60(i)(2) (LexisNexis 2025); OHIO REV. CODE ANN. § 5122.01(V)(2) (West 2024); OKLA. STAT. ANN. tit. 43A, § 5-416(G) (West 2024); 50 PA. STAT. AND CONS. STAT. ANN. § 7304(e)(8)(ii) (West 2025). *Cf.* UTAH CODE ANN. § 26B-5-350(1)(b) (West 2024) ("The local mental health authority . . . shall include . . . an individualized treatment plan, created with input from the proposed patient when possible."). In addition, some—embracing a supported decision-making model—mandate consultation with family members and other significant persons as appropriate. *See, e.g.*, CAL. WELF. & INST. CODE § 5348(a)(3) (West 2024); OKLA. STAT. ANN. tit. 43A, § 5-416(H) (West 2024).

277 *See* Jeffrey W. Swanson et al., *Psychiatric Advance Directives and Reduction of Coercive Crisis Interventions*, 17 J. MENTAL HEALTH 255, 255 (2008).

278 *See, e.g.*, Saks, *supra* note 22, at 103 n.14; Eric B. Elbogen et al., *Effectively Implementing Psychiatric Advance Directives to Promote Self-Determination of Treatment Among People with Mental Illness*, 13 PSYCH. PUB. POL'Y & L. 273, 274 (2007); Mark H. de Jong et al., *Interventions to Reduce Compulsory Psychiatric Admissions: A Systematic Review and Meta-analysis*, 73 JAMA PSYCHIATRY 657, 657 (2016) (finding "a statistically significant and clinically relevant 23% reduction in compulsory admissions in adult psychiatric patients" due to the use of advance directives).

formulating a treatment plan.[279] However, only Kentucky and Maryland mandate that treatment plans honor the directions in advance directives.[280] Two other states—New Mexico and Louisiana—specify that a treatment plan cannot conflict with an individual's advance directive absent good cause.[281] Other states are more dismissive of a competent individual's treatment wishes. Florida requires advance directives be provided to courts but does not dictate their consideration.[282] Maine specifies that courts may consider an advance directive but are "not bound by" it.[283]

V. THREATENED HARM

A common—although not universal—feature of POC statutes is a required finding that, without treatment, the individual's mental disorder will deteriorate to the point of threatening harm.[284] Such elements may be crucial. The state's police power authority, its second source of commitment power, allows it to protect the community from danger.[285] Thus, a state's police power interest may, to the extent the statute's dangerousness element meets necessary constitutional thresholds, buttress weaknesses in the state's parens patriae interest in justifying deprivations effected by POC.[286] Most current POC statutes include a hybrid justification.[287]

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279 *See* CAL. WELF. & INST. CODE § 5346 (West 2024); NEV. REV. STAT. ANN. §§ 433A.337(3)(a), 433A.337(6) (West 2023); N.M. STAT. ANN. §§ 43-1B-7(B), (E) (LexisNexis 2024); N.Y. MENTAL HYG. LAW § 9.60(i)(2) (LexisNexis 2025); OHIO REV. CODE ANN. § 5122.01(V)(3) (West 2024); OKLA. STAT. ANN. tit. 43A, § 5-416(H), (I) (West 2024); 50 PA. STAT. AND CONS. STAT. ANN. § 7304(e)(8)(ii) (West 2025); *infra* notes 280–81.

280 *See* KY. REV. STAT. ANN. § 202A.0817(2) (LexisNexis 2024); MD. CODE ANN., HEALTH-GEN. § 10-6A-06(b)(2) (West 2025).

281 N.M. STAT. ANN. § 43-1B-8(F) (LexisNexis 2024); *see* LA. STAT. ANN. § 28:70(A) (2024) ("The treatment plan shall reflect the expressed preferences of the respondent to the extent the preferences are reasonable and consistent with the respondent's best interests.").

282 FLA. STAT. ANN. § 394.467(4)(d)(3) (LexisNexis 2024).

283 ME. REV. STAT. ANN. tit. 34B, § 3873-A(5)(F) (West 2023).

284 *See infra* Part V.B–C.

285 *See* Addington v. Texas, 441 U.S. 418, 426 (1979). The scope of states' involuntary commitment authority has changed over time, as have the sources of the state's authority used to justify such power. *See* Cornwell, *supra* note 228, at 379–90. The extent to which the police power permits the state to intervene to protect an individual from danger to self is a source of contention among commentators but is widely approved by courts. *See* Robert F. Schopp, *Civil Commitment and Sexual Predators: Competence and Condemnation*, 4 PSYCH. PUB. POL'Y & L. 323, 331 (1998).

286 *See* Johnston, *supra* note 23.

287 Boldt, *supra* note 22, at 57 ("[D]ecision makers in . . . jurisdictions [that have adopted "potential-for-deterioration" grounds] have concluded that *parens patriae*-based interventions may improve the functioning and quality of life of individuals with chronic mental illness . . . and may also yield longer-term police power benefits in preventing dangerousness . . . .").

The bounds of the state's power to protect public health and safety are ill-defined.[288] Most commentators agree that legitimate exercise of police power depends on a favorable balance between the nature and extent of the deprivation of liberty and the nature, probability, and imminence of harm to be avoided.[289] In addition, liberty deprivations must effectively advance the state's objectives.[290]

No scholar has yet conducted a detailed analysis of POC statutes' harm components. Although often passed in the wake of violence,[291] POC statutes neither narrowly target—nor are likely to significantly reduce—acts of community violence.[292] Instead, commentators frequently assume these statutes target individuals whose deterioration would predictably lead to hospitalization, either by posing a danger to others or themselves.[293] Indeed, lawmakers often identify reducing hospitalization expenditures as a primary aim of POC statutes.[294] Reduced hospitalization is also a key measure of efficacy studies.[295]

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[288] Courts tend not to analyze these interests individually to determine their sufficiency. *See* Schopp, *supra* note 285, at 331.

[289] *See* Slobogin, *supra* note 19, at 686–87. Brooks has identified four aspects of dangerousness: the nature of the harm (its magnitude), its likelihood, its imminence, and the frequency with which it may occur. ALEXANDER D. BROOKS, PSYCHIATRY AND MENTAL HEALTH SYSTEMS 67–82 (1974). Because no civil commitment statute acknowledges this last aspect, this Article focuses on the first three factors.

[290] Slobogin, *supra* note 19, at 687.

[291] *See* Boldt, *supra* note 22, at 53.

[292] *See id.* at 53–56 (noting that laws like New York's "Kendra's Law" are "likely to be over-inclusive, sweeping up persons in the community who are mentally ill and not engaged actively in effective treatment, but who do not present an immediate threat," and detailing why the mere treatment of mental disorder is unlikely to reduce criminal involvement); *id.* at 50–51 (discussing the ability of mental health professionals to make reasonably accurate predictions regarding individuals' likelihood of violence and the probability of false positives). Although studies with weaker research methodologies have reached contrary conclusions, studies with strong research designs have found that outpatient commitment has a minimal effect on violence. *See* Steve R. Kisely & Leslie A. Campbell, *Compulsory Community and Involuntary Outpatient Treatment for People with Severe Mental Disorders*, 41 SCHIZOPHRENIA BULL. 542, 543 (2015). In their Cochrane Review, Professors Kisely and Campbell concluded it would take 238 outpatient commitment orders to prevent one arrest. *Id.*

[293] *See, e.g.*, Player, *supra* note 12, at 159 ("[POC] laws require people with mental illnesses to participate in mental health treatment before they meet the criteria for inpatient civil commitment.").

[294] *See, e.g.*, 2024 Md. Legis. Serv. Ch. 704 (West 2024) (identifying AOT as a means "to reduce . . . needless hospitalizations"); Assisted Outpatient Treatment Demonstration Project Act of 2002, ch. 1017, 2002 Cal. Legis. Serv. (A. B. 1421) (West) (codified at CAL. WELF. & INST. CODE §§ 5345–5349.5 (Deering 2024) (requiring each county operating an AOT program to report yearly on its effectiveness in reducing hospitalization).

[295] *See, e.g.*, Steve Kisely et al., *The Benefits and Harms of Community Treatment Orders for People Diagnosed with Psychiatric Illnesses: A Rapid Umbrella Review of Systematic Reviews and Meta-Analyses*, AUSTL. & N.Z. J. PSYCHIATRY 555, 559 (2024).

This Part assesses the extent to which POC statutes require findings of current or future deterioration that will predictably result in harm. POC statutes are aimed at revolving-door patients who cycle in and out of public institutions and the community due to treatment nonadherence. Therefore, this Part starts by evaluating the extent to which POC statutes demand relatively recent evidence of treatment nonadherence that resulted in hospitalization, forensic services, or acts of violence (or threatened violence). A minority do, with a handful of others requiring a history of treatment nonadherence without a specific time frame. One-third of POC statutes do not require any documented history of failure to adhere to recommended treatment. This omission raises questions about these statutes' fidelity to their stated rationale and decreases the likelihood that targeted individuals will both refuse recommended treatment in the future and that feared deterioration would lead to hospitalization or incarceration.

Next, this Part scrutinizes POC statutes' criteria relating to deterioration to harm. A majority of states require findings of current or future deterioration that will predictably result in satisfaction of states' involuntary hospitalization criteria. Many, but not most, of these statutes necessitate recent evidence of treatment nonadherence.[296] Furthermore, a growing minority aim to prevent deterioration that, even if it occurred, would not be severe enough to warrant involuntary hospitalization. A few, mostly recent, statutes do not require a likely danger of harm at all. These statutes' constitutionality may be dubious.[297]

A. Historical Evidence of Treatment Nonadherence

POC statutes require compliance with community treatment plans to prevent the predictable deterioration of certain mentally ill individuals and to interrupt their cycle through mental hospitals and carceral facilities.[298] To ensure these statutes target their intended populations and to increase the likelihood that a person, if untreated, would continue to deteriorate to the point of requiring hospitalization, some statutes require relatively recent evidence of treatment nonadherence resulting in hospitalization, receipt of forensic services, or acts (or threats) of violence.[299] Commentators often regard the requirement of such evidence as a hallmark of POC statutes, which serves to mitigate net-widening concerns.[300]

An examination of POC statutes reveals that only ten of twenty-three require specific evidence of past treatment failures.[301] Moreover, required instances of violence, hospitalization, or forensic care do not need to be particularly recent; most

296 *See infra* note 302.

297 *See* Johnston, *supra* note 23, Part IV.

298 *See supra* note 15; Joan B. Gerbasi et al., *Resource Document on Mandatory Outpatient Treatment*, 28 J. AM. ACAD. PSYCHIATRY & L. 127, 128 (2000).

299 *See infra* Table C.

300 *See supra* note 15; Gerbasi et al., *supra* note 298, at 128.

301 Alternatively, some statutes allow recent discharge from hospitalization to satisfy this requirement. *See, e.g.*, N.M. STAT. ANN. § 43-1B-3(C)(3) (LexisNexis 2024).

statutes consider incidents within the preceding 48 months.[302] Statutes demanding evidence of recent incidents typically (but not always)[303] require at least two prior hospitalizations but only one prior act of serious or threatened violence.[304] Additionally, most of these states do not mandate that hospitalization have been involuntary.[305] Table C categorizes states based on their requirements for treatment noncompliance.

TABLE C. REQUIRED HISTORY OF TREATMENT NONADHERENCE[306]	
Required History of Treatment Nonadherence	**States**
Prior hospitalizations, forensic services, or act of violence within last 36 months	Maryland, Oklahoma[307]
Prior hospitalizations, forensic services, or act of violence within last 48 months	California, Kentucky, Nevada, New Mexico, New York, Ohio, Pennsylvania, Washington[308]

302 *See* CAL. WELF. & INST. CODE § 5346(a)(4) (West 2024); KY. REV. STAT. ANN. § 202A.0815(2) (LexisNexis 2024); NEV. REV. STAT. ANN. § 433A.335(3)(c) (West 2023); N.M. STAT. ANN. § 43-1B-3(C) (LexisNexis 2024); N.Y. MENTAL HYG. LAW § 9.60(c)(4) (LexisNexis 2025); OHIO REV. CODE ANN. § 5122.01(B)(5)(a)(ii) (West 2024); 50 PA. STAT. AND CONS. STAT. § 7301(c)(ii) (West 2025); WASH. REV. CODE ANN. § 71.05.148(1)(c) (LexisNexis 2024).

303 *See* 50 PA. CONS. STAT. AND CONS. STAT. § 7301(c)(ii)(A) (West 2025) (requiring that, within the preceding 12 months, the person's failure to adhere to treatment contributed to "involuntary inpatient hospitalization or receipt of services in a forensic or other mental health unit of a correctional facility").

304 *See, e.g.*, MD. CODE ANN., HEALTH-GEN. § 10-6A-05(a)(3) (West 2025); CAL. WELF. & INST. CODE § 5346(a)(4) (West 2024); KY. REV. STAT. ANN. § 202A.0815(2) (LexisNexis 2024); NEV. REV. STAT. ANN. § 433A.335(3)(c) (West 2023).

305 *See, e.g.*, WASH. REV. CODE ANN. § 71.05.148(1)(c) (LexisNexis 2024). *But see* 50 PA. STAT. AND CONS. STAT. ANN. § 7304(e)(8)(ii) (West 2025).

306 This table omits reference to alternative means of satisfying this requirement through an extremely recent hospitalization. *See, e.g.*, NEV. REV. STAT. ANN. § 433A.335(3)(c)(3) (West 2023).

307 *See* MD. CODE ANN., HEALTH-GEN. § 10-6A-05(a)(3) (West 2025); OKL. STAT. tit. 43A, § 1-103(20)(d) (West 2024).

308 *See supra* note 302.

TABLE C. REQUIRED HISTORY OF TREATMENT NONADHERENCE[306]	
Documented history of treatment nonadherence within an unspecified time period	Florida, Delaware, Hawaii, Illinois, Louisiana[309]
None	Alabama, Georgia, Maine, Montana, North Carolina, Oregon, Texas, Utah[310]

Five states require a history of treatment nonadherence without specifying a time frame. Of these, only one state's statute dictates that the "history" must include more than one instance of noncompliance.[311] Meanwhile, eight POC statutes do not require any documented history of treatment failures. Among these, three require evidence of prior treatment noncompliance or decisional impairment.[312] The remaining five do not reference historical treatment nonadherence at all.

B. Deteriorating to Satisfy Involuntary Hospitalization Standards

Fourteen of twenty-three POC statutes aim to prevent deterioration that would predictably result in the satisfaction of states' involuntary hospitalization standards.[313]

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309 *See* FLA. STAT. ANN. § 394.467(1)(3) (LexisNexis 2024) (requiring the person have "a history of lack of compliance with treatment"); DEL. CODE ANN. tit. 16, § 5013(a)(5) (West 2024) (requiring the person either have "a documented history of lack of adherence with recommended treatment" or "pose an extreme threat of danger . . . based upon recent actions"); HAW. REV. STAT. ANN. § 334-121(3) (LexisNexis 2024) (requiring the person *either* have a "[m]ental illness that has caused that person to refuse needed and appropriate mental health services in the community" *or* "[a h]istory of lack of adherence to treatment for mental illness"); 405 ILL. COMP. STAT. ANN. 5/1 119.1(2) (West 2024) (requiring the person "whose mental illness has, on more than one occasion in the past, caused the person to refuse needed and appropriate mental health services"); LA. REV. STAT. ANN. § 28:66(A)(4) (West 2024) (requiring the person have "a history of lack of compliance with treatment for mental illness").

310 *See* ALA. CODE § 22-52-10.2(a) (2024) (requiring evidence of inability to maintain consistent engagement with outpatient treatment as demonstrated by *either* actions within the preceding 24 months *or* aspects of the individual's clinical condition that impair treatment decision-making); GA. CODE ANN. § 37-3-1(12.1) (West 2024); ME. REV. STAT. ANN. tit. 34B, § 3873-A (West 2023); MONT. CODE ANN. § 53-21-126(4)(d) (2023) (requiring evidence that the individual's mental disorder "has resulted in the respondent's refusing or being unable to consent to voluntary admission for treatment"); *id.* § 53-21-127(7); N.C. GEN. STAT. ANN. § 122C-271(a)(1) (West 2024); OR. REV. STAT. ANN. § 426.133(2) (West 2024); TEX. HEALTH & SAFETY CODE ANN. § 574.0345(a)(2)(D) (West 2024); UTAH CODE ANN. § 26B-5-351(14) (West 2024).

311 405 ILL. COMP. STAT. ANN. 5/1 119.1(2) (West 2024) (requiring the person "whose mental illness has, on more than one occasion in the past, caused that person to refuse needed and appropriate mental health services").

312 *See* ALA. CODE § 22-52-10.2(a) (2024); TEX. HEALTH & SAFETY CODE ANN. § 574.0345(a)(2)(D) (West 2024); MONT. CODE ANN. § 53-21-126(4)(d) (2023).

313 *See infra* Table D.

All but five of these states require evidence of historical treatment noncompliance.[314] Crucially, these fourteen statutes' harm components often extend beyond future violence and may be quite speculative. Table D includes these statutes' harm components. As Table D depicts, the statutes vary in whether they require current or mere predicted, future deterioration; the likelihood of that deterioration occurring; the nature of the feared, ultimate harm; the probability that harm will occur; and the span of time within which the harm should manifest.

TABLE D. STATE POC STATUTES WITH DETERIORATION PREDICTED TO SATISFY INPATIENT CRITERIA

State	**Harm Component of POC Statute**
Florida	"In view of the person's treatment history and current behavior, the person is in need of involuntary outpatient services in order to prevent a relapse or deterioration that would be **likely** to result **in serious bodily harm to himself or herself or others**, or a **substantial harm to his or her well-being** as set forth in [involuntary examination criteria]."[315] Involuntary examination criteria: "(1) Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and it is not apparent that such harm may be avoided through the help of willing, able, and responsible family members or friends or the provision of other services; or (2) There is a substantial likelihood that without care or treatment the person will cause serious bodily harm to himself or herself or others in the near future, as evidenced by recent behavior.")[316]
Hawaii	"[I]s **unlikely** to live safely in the community without available supervision, [and] is now in need of treatment in order to prevent a

[314] Maine, Montana, North Carolina, Oregon, and Texas do not. *See supra* Table C.

[315] FLA. STAT. ANN. § 394.467(4)(d)(3) (LexisNexis 2024). In the inpatient context, a "real and present threat of substantial harm to . . . well-being must entail some risk to personal safety." Hedrick v. Fla. Hosp. Med. Ctr., 633 So. 2d 1153, 1154 (Fla. Dist. Ct. App. 1994).

[316] FLA. STAT. ANN. § 394.463(1)(b) (LexisNexis 2024).

TABLE D. STATE POC STATUTES WITH DETERIORATION PREDICTED TO SATISFY INPATIENT CRITERIA	
	relapse or deterioration that would **predictably result in the person becoming imminently dangerous** to self or others. [317],[318]
Illinois	"[I]f left untreated, is **reasonably expected** to result **in an increase in the symptoms** caused by the illness to the point that **the person would meet the criteria for [inpatient] commitment**"[319] Criteria for inpatient commitment: "[B]ecause of his or her illness [either] is reasonably expected, unless treated on an inpatient basis, to engage in conduct placing **such person or another in physical harm** or in **reasonable expectation of being physically harmed**; . . . is **unable to provide for his or her basic physical needs so as to guard himself or herself from serious harm** without the assistance of family or others, unless treated on an inpatient basis; or . . . is unable to understand his or her need for treatment, **and** if not treated on an inpatient basis, **is reasonably expected . . . to suffer mental or emotional deterioration and is reasonably expected, after such deterioration, to [engage in conduct placing such person or another in physical harm or in reasonable expectation of being physically harmed] or [be unable to provide for his or her basic physical needs so as to guard himself or herself from serious harm without the assistance of family or others, unless treated on an inpatient basis]."[320]**

317 HAW. REV. STAT. ANN. § 334-1 (LexisNexis 2024) (defining "imminently dangerous to self or others" to mean "that, without intervention, the person will likely become dangerous to self or dangerous to others within the next forty-five days"); *id.* (defining "dangerous to self" to mean "the person recently has: (1) [t]hreatened or attempted suicide or serious bodily harm; or (2) [b]ehaved in such a manner as to indicate that the person is unable, without supervision and the assistance of others, to satisfy the need for nourishment, essential medical care, including treatment for a mental illness, shelter or self-protection, so that it is probable that death, substantial bodily injury, or serious physical debilitation or disease will result unless adequate treatment is afforded"); *id.* (defining "dangerous to others" to mean "likely to do substantial physical or emotional injury on another, as evidenced by a recent act, attempt or threat"). "Recently" is defined to mean "within the not-so-distant past." State of Haw., Dep't of the Att'y Gen., Opinion Letter on Standards for Mental Health Intervention and the Assisted Community Treatment Law (Apr. 20, 2023), https://ag.hawaii.gov/wp-content/uploads/2023/04/AG-Opinion-23-01.pdf at No. 23-01 [hereinafter Opinion No. 23-01]. "Likely" means a high probability. *Id.*

318 HAW. REV. STAT. ANN. § 334-121(2) (LexisNexis 2024).

319 405 ILL. COMP. STAT. ANN. 5/1-119.1(2) (West 2024).

320 *Id.* at 5/1-119.

TABLE D. STATE POC STATUTES WITH DETERIORATION PREDICTED TO SATISFY INPATIENT CRITERIA	
Louisiana	"[I]s **unlikely** to survive safely in the community without supervision[; and . . . in] view of the treatment history and current behavior of the respondent, the respondent is in need of involuntary outpatient treatment to prevent a relapse or deterioration which would be **likely** to result in the respondent's becoming **dangerous to self**[321] **or others**[322] or **gravely disabled.**"[323]
Maine	"[P]oses a likelihood of serious harm," meaning "in view of the person's treatment history, current behavior and inability to make an informed decision, a **reasonable likelihood**[324] that the person's mental health will deteriorate and that the person will in the **foreseeable future pose a likelihood of serious harm**.[325]"[326]
Maryland	"In view of the respondent's treatment history and behavior at the time the petition is filed, the respondent is in need of assisted outpatient treatment in order to prevent a relapse or deterioration that would

321 LA. STAT. ANN. § 28:2(7) (2024) (defining dangerous to self to mean "the condition of a person whose behavior, significant threats or inaction supports a reasonable expectation that there is a substantial risk that he will inflict physical or severe emotional harm upon his own person").

322 *Id.* § 28:2(6) (defining dangerous to others to mean "the condition of a person whose behavior or significant threats support a reasonable expectation that there is a substantial risk that he will inflict physical harm upon another person in the near future").

323 *Id.* § 28:2(13) (defining "gravely disabled" to mean "the condition of a person who is unable to provide for his own basic physical needs, such as essential food, clothing, medical care, or shelter, as a result of serious mental illness or a substance-related or addictive disorder and is unable to survive safely in freedom or protect himself from serious physical harm or significant psychiatric deterioration").

324 *See* Bangor Hist. Track, Inc. v. Dep't of Agric., Food & Rural Res., 837 A.2d 129, 132 (Me. 2003) (defining "likelihood" to mean "at most, a probability; at least, a substantial possibility").

325 ME. REV. STAT. ANN. tit. 34B, § 3801(4-A) (West 2023) (defining "likelihood of serious harm" to mean either "a substantial risk of physical harm to the person as manifested by recent threats of, or attempts at, suicide or serious self-inflicted harm; a substantial risk of physical harm to other persons as manifested by recent homicidal or violent behavior or by recent conduct placing others in reasonable fear of serious physical harm; [or] a reasonable certainty that the person will suffer severe physical or mental harm as manifested by recent behavior demonstrating an inability to avoid risk or to protect the person adequately from impairment or injury").

326 *Id.* § 3801(4-A)(D); *id.* § 3801(4-A)(A–C) (defining "likelihood of serious harm").

TABLE D. STATE POC STATUTES WITH DETERIORATION PREDICTED TO SATISFY INPATIENT CRITERIA	
	create a **substantial risk** of **serious harm** to the individual or harm to others."[327]
Montana	"[T]he respondent's mental disorder, as demonstrated by the respondent's recent acts or omissions, will, if untreated, **predictably result** in deterioration of the respondent's mental condition to the point at which the respondent **will** become a **danger to self or to others** or will be **unable to provide** for the respondent's own **basic needs** of food, clothing, shelter, health, or safety."[328]
Nevada	"Prevent **further disability or deterioration** that **would** result in the person becoming a person in a mental health crisis," defined as one "[w]hose capacity to exercise self-control, judgment and discretion in the conduct of the person's affairs and social relations or to care for his or her personal needs is diminished, as a result of the mental illness, to the extent that the person **presents a substantial likelihood of serious harm**[329] to himself or herself or others."[330]
New Mexico	"[I]s in need of assisted outpatient treatment as the least restrictive appropriate alternative to prevent a relapse or deterioration **likely** to

327 MD. CODE ANN., HEALTH-GEN. § 10-6A-05(a)(4) (West 2025); *id.* § 10-6A-01(d) (defining "harm to others" as "an act or attempt at or credible threat of serious violent behavior toward others"); *id.* § 10-6A-01(e) (defining "harm to the individual" as "self-harming behavior or an attempt at suicide").

328 MONT. CODE ANN. § 53-21-126(1)(d) (2023); *id.* § 53-21-127(7).

329 NEV. REV. STAT. ANN. § 433A.0195 (West 2023) ("[A] person shall be deemed to present a substantial likelihood of serious harm to himself or herself or others if, without care or treatment, the person is at serious risk of: 1. Attempting suicide or homicide; 2. Causing bodily injury to himself or herself or others, including, without limitation, death, unconsciousness, extreme physical pain, protracted and obvious disfigurement or a protracted loss or impairment of a body part, organ or mental functioning; or 3. Incurring a serious injury, illness or death resulting from complete neglect of basic needs for food, clothing, shelter or personal safety.").

330 *Id.* § 433A.0175(1).

TABLE D. STATE POC STATUTES WITH DETERIORATION PREDICTED TO SATISFY INPATIENT CRITERIA	
	result in **serious harm to self**[331] or **likely** to result in **serious harm to others**.[332]"[333]
New York	"[I]s unlikely to survive safely in the community without supervision, based on a clinical determination;[334] . . . [and] in view of his or her treatment history and current behavior, is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be **likely** to result in **serious harm[335] to the person or others**."[336]
North Carolina	By clear and convincing evidence, "is capable of surviving safely in the community with available supervision from family, friends, or others . . . [and] [b]ased on the respondent's psychiatric history, the respondent is in need of treatment in order to prevent **further disability or deterioration** that would **predictably** result in **dangerousness.**"[337]

331 N.M. STAT. ANN. § 43-1-3(N) (LexisNexis 2024) (defining "likelihood of serious harm to oneself" as being "more likely than not that in the near future the person will attempt to commit suicide or will cause serious bodily harm to the person's self by violent or other self-destructive means, including grave passive neglect").

332 *Id.* § 43-1-3(O) (defining "likelihood of serious harm to others" as being "more likely than not that in the near future a person will inflict serious, unjustified bodily harm on another person or commit a criminal sexual offense, as evidenced by behavior causing, attempting or threatening such harm, which behavior gives rise to a reasonable fear of such harm from the person").

333 *Id.* § 43-1B-3(E).

334 N.Y. MENTAL HYG LAW § 9.60(c)(3) (LexisNexis 2025).

335 *Id.* § 9.01 (defining "likely to result in serious harm" to mean either "a substantial risk of physical harm to the person as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that the person is dangerous to himself or herself," or "a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm").

336 *Id.* § 9.60(c)(6).

337 N.C. GEN. STAT. ANN. § 122C-271(a)(1) (West 2024); *see id.* § 122C-3(11)(a) (defining "dangerous to self" to mean either: (1)"the individual would be unable, without care, supervision, and the continued assistance of others not otherwise available, to exercise self-control, judgment, and discretion in the conduct of the individual's daily responsibilities and social relations, or to satisfy the individual's need for nourishment, personal or medical care, shelter, or self-protection and safety" [and] "[t]here is a reasonable probability of the individual's suffering serious physical debilitation within the near future unless adequate treatment is given;" (2) "[t]he individual has attempted [or threatened] suicide . . . [and] there is a reasonable probability of suicide unless adequate treatment is given;" or (3) "[t]he individual

TABLE D. STATE POC STATUTES WITH DETERIORATION PREDICTED TO SATISFY INPATIENT CRITERIA	
Oklahoma	"[I]s unlikely to survive safely in the community without supervision, based on a clinical determination,[338] . . . [and] in view of his or her treatment history and current behavior, is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be **likely** to result in **serious harm to the person or persons.**"[339]
Oregon	"Is incapable of surviving safely in the community without treatment; and [r]equires treatment to prevent a deterioration in the person's condition that will **predictably** result in the person becoming a **person with mental illness**."[340] A "person with mental illness"[341] is defined to mean "(A) **dangerous to self[342] or others[343]**, (B**) [u]nable to provide for basic personal needs[344]** that are **necessary to avoid serious physical harm in the near future**, and is not receiving such care as is necessary to avoid such harm, [or (C) has] . . . a chronic mental illness, . . . who, within

has mutilated himself or herself or has attempted to mutilate himself or herself and . . . there is a reasonable probability of serious self-mutilation unless adequate treatment is given"); *id.* § 122C-3(11)(b) (defining "dangerous to others" to mean "[w]ithin the relevant past, the individual has inflicted or attempted to inflict or threatened to inflict serious bodily harm on another, or has acted in such a way as to create a substantial risk of serious bodily harm to another, or has engaged in extreme destruction of property; and . . . there is a reasonable probability that this conduct will be repeated"). The statute also includes evidentiary guidance. *Id.* § 122C-3(11)(a)–(b).

338 OKLA. STAT. ANN. tit. 43A, § 1-103(20)(c) (West 2024).

339 *Id.* § 1-103(20)(f).

340 OR. REV. STAT. ANN. § 426.133 (2)(b)(A–B) (West 2024). The statute includes factors the court must consider when deciding whether to issue an order requiring AOT. *Id.*

341 *Id.* § 426.130(1)(a).

342 *See In re* Jacobson, 922 P.2d 670, 673 (Or. Ct. App. 1996) ("[T]he danger to self standard does not require a threat of immediate harm. Instead, consistent with the basic needs standard, the threat must exist in the near future.").

343 *In re* D.L., 505 P.3d 1101, 1103 (Or. Ct. App. 2022) ("A person is 'dangerous to others' . . . if his mental disorder makes him highly likely to engage in future violence towards others, absent commitment."). The determination of whether an individual is "dangerous to others" involves considering "the conduct itself and the circumstances under which it occurred, all as viewed in light of . . . [the individual's] personal history and other contextual clues." *Id.*

344 *In re* Johnson, 886 P.2d 42, 45 (Or. Ct. App. 1994) ("In order to meet the basic needs standard, the state must prove by clear and convincing evidence that appellant is unable to obtain some commodity or service without which he cannot sustain life . . . . [B]asic needs may be met through his own resources or with the help of family or friends."). The threat must exist in the "near future." *In re* Jacobson, 922 P.2d at 672.

TABLE D. STATE POC STATUTES WITH DETERIORATION PREDICTED TO SATISFY INPATIENT CRITERIA	
	the previous three years, has twice been placed in a hospital or approved inpatient facility . . ., is exhibiting symptoms or behavior substantially similar to those that preceded and led to one or more of the hospitalizations or inpatient placements . . ., and [w]ho, unless treated, **will continue, to a reasonable medical probability, to physically or mentally deteriorate so that the person will become [dangerous to self or others or unable to provide for basic personal needs necessary to avoid serious physical harm in the near future]**."[345]
Texas	By clear and convincing evidence that, "as a result of the mental illness, the proposed patient **will**, if not treated, **experience deterioration** of the ability to function independently to the extent that the proposed patient will be **unable to live safely in the community** without court-ordered outpatient mental health services; [and] outpatient mental health services are needed to prevent a relapse that would **likely result in serious harm** to the proposed patient or others."[346]

The subsections below analyze the varying degrees of harm that statutes seek to prevent. Despite POC proponents' focus on needing to protect the individual and the community, only a minority of states (6/23) require a physical danger. The remaining statutes allow for commitment to prevent other types of harm, ranging from psychiatric harm to property destruction. Most of these statutes impose minimal likelihood requirements and do not require that any risk of harm or deterioration be imminent.

1. Future Risk of Physical Harm

Historically, state intervention has been deemed particularly appropriate in responding to danger of bodily harm due to mental disorder.[347] Only six states—Maryland, Montana, New Mexico, New York, Oklahoma, and Oregon—require a determination that the individual would deteriorate such that they would put themselves or another at risk of physical harm.[348] Table E depicts the variation in criteria among these states' POC statutes, including the statutes' varying imminence and likelihood requirements.

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345 OR. REV. STAT. ANN. § 426.005(f) (West 2024).

346 TEX. HEALTH & SAFETY CODE ANN. § 574.0345(a)(2)(B) (West 2024).

347 Hoge & Grottole, *supra* note 122, at 166.

348 Illinois's statute could also be read as requiring risk of physical harm. *See infra* notes 370–71.

TABLE E. CRITERIA FOR POC STATUTES REQUIRING FUTURE RISK OF PHYSICAL HARM						
State	**Current deterioration**	**Currently unlikely to safely survive**	**Risk of serious physical harm**	**Historical criteria**	**Imminence requirement**	**Likelihood requirement**
MD			X	X		X (substantial risk)
MT						
NM			X	X	X	X (preponderance)
NY		X	X	X		X (substantial risk)
OK		X	X[349]	X		X (likely)
OR		X	X[350]			X (predictably/ reasonable medical probability)

[349] The individual must need treatment to deterioration "which would be likely to result in *serious harm to the person or persons*." OKLA. STAT. ANN. tit 43A, § 1-103(20)(f) (West 2024) (emphasis added). "Serious harm" is not defined in Oklahoma's code, but it is likely intended to refer to "physical harm." Assisted outpatient treatment is defined to include services ordered to prevent "deterioration that may reasonably be predicted to result in suicide or the need for *hospitalization*." *Id.* § 1-103(21) (emphasis added). Inpatient criteria, defined in the same section of Oklahoma's code, permits hospitalization if an individual presents a substantial risk of grave disability that poses a risk of death or immediate serious *physical* injury, poses a risk of immediate *physical* harm to self or others, or creates fear in another that the individual will engage in violent behavior or impose serious physical harm. *Id.* § 1-103(13). An order for inpatient hospitalization can alternatively be based on a sufficiently severe state of deterioration that creates a substantial risk of "severe impairment or injury to the person." *Id.* § 1-103(13)(a)(4). However, the absent "serious harm" definition, coupled with the proximity of the inpatient criteria and the heavy reliance on requiring risk of physical harm, likely means a risk of physical harm is required for a POC order in Oklahoma.

[350] To justify a POC order based on dangerousness to self, the state must show that the individual's mental illness has resulted in, or led to a situation likely to result in, physical "harm to []self." State v. D.A.H., 250 P.3d 423, 425 (Or. Ct. App. 2011) (holding appellant was not a danger to self because there was no evidence the appellant was in "danger of substantial physical harm" or that appellant "had any desire to harm herself"); *see also* State v. F.C., 243 P.3d 144, 146 (Or. Ct. App. 2010). Similarly, POC based on posing a danger to others requires "a clear risk of future violence." *D.A.H.*, 250 P.3d at 426 (holding appellant was not a danger to others because the alleged acts did not constitute a "clear risk of future violence" and there was no evidence appellant intended to harm, or was likely to harm, anybody).

None of these states requires current deterioration,[351] but New York, Oklahoma, and Oregon require that the person currently be unlikely to survive safely in the community without treatment.[352] Maryland, New Mexico, New York, and Oklahoma require that the anticipated deterioration place the individual at direct risk of causing or suffering serious physical harm.[353] However, the likelihood of the individual's deterioration resulting in serious bodily harm need not be high. New Mexico utilizes a preponderance standard.[354] New York and Maryland require a substantial risk of such harm ultimately occurring.[355] Additionally, only New Mexico includes an imminence element, requiring that serious bodily harm from anticipated deterioration be likely to result in the near future.[356]

Oregon's POC statute includes a more attenuated risk of serious physical harm but requires treatment incapacity.[357] Commitment is appropriate for an individual, "unable to make an informed decision to seek or comply with voluntary treatment," who is "incapable of surviving safely in the community without treatment" and deteriorating such that the person will predictably qualify as an inpatient.[358] One way that an individual may satisfy inpatient criteria is if they possess certain historical and behavioral characteristics[359] and, without treatment, will continue, to a reasonable medical probability, to physically or mentally deteriorate such that they will become dangerous or incapable of providing their basic physical needs necessary to prevent "serious physical harm in the near future."[360] Therefore—combining the two—Oregon's POC statute allows the state to compel treatment to prevent deterioration that predictably "will continue, to a reasonable medical probability" to the degree that

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351 *But see* N.Y. MENTAL HYG. LAW § 9.60(c)(6) (LexisNexis 2025) (requiring consideration of their "treatment history and current behavior" in determining if the individual needs AOT to prevent a relapse or deterioration); OKLA. STAT. ANN. tit. 43A, § 1-103(20)(f) (West 2024) (same).

352 *See supra* notes 334, 338, 340; *cf.* N.M. STAT. ANN. § 43-1B-3(D) (LexisNexis 2024) (requiring the person who "is unwilling or unlikely, as a result of a mental disorder, to participate voluntarily in outpatient treatment that would enable the person to live safely in the community without court supervision"). Case law does not require any particular factual predicate to satisfy this criterion.

353 *See supra* note 327 (Maryland); *supra* notes 331–33 (New Mexico); *supra* notes 335–36 (New York); *supra* note 339 (Oklahoma).

354 *See supra* notes 332–33.

355 *See supra* notes 335–36 (New York); *supra* note 327 (Maryland).

356 N.M. STAT. ANN. § 43-1-3(N), (O) (LexisNexis 2024).

357 OR. REV. STAT. ANN. § 426.133(2)(b)(B) (West 2024); *id.* § 426.005(f)(A)–(C).

358 *Id.* § 425.133(2)(a), (b).

359 The individual must have a chronic mental illness, have been placed in a hospital or inpatient facility twice within the preceding three years, and be acting similarly or showing signs of symptoms similar to those preceding the previous placements in a hospital or inpatient facility. *Id.* § 425.005(f) (A)–(C).

360 *Id.*

the person will become dangerous or gravely disabled.[361] Oregon caselaw does not detail what facts are required to satisfy the criterion of being "incapable of surviving safely in the community without treatment."[362] Thus, it appears that treatment may be compelled at the court's discretion, primarily upon a finding of treatment incapacity with largely only the historical portions of the statute to guide it.[363]

Montana requires the individual be at risk of deteriorating such that they will pose a danger to themselves or others or they will be "unable to provide for their own basic needs of food, clothing, shelter, health, or safety."[364] In differentiating typical conditions of grave disability from "danger to themselves," Montana appears to embrace a more capacious understanding of grave disability that would not necessarily involve danger of physical harm. However, its evidentiary requirements include recent behavior "that creates difficulty in protecting the respondent's life or health,"[365] so physical harm may be at risk.[366] This risk may be aggravated by the statute's requirement that the individual's mental disorder cause their refusal or inability to consent to voluntary treatment.[367] As for likelihood and imminence, Montana's statute merely requires that the individual's untreated mental disorder predictably result in deterioration that will pose the anticipated danger at some unconstrained time in the future.[368] "Predictably" is undefined.[369]

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361 "Grave disability" is commonly defined as being unable to provide for one's own basic needs, such as food, clothing, and shelter, due to mental disability. *See e.g.*, IND. CODE ANN. § 12-7-2-96 (West 2024); CAL. WELF. & INST. CODE § 5008(h)(1)(A) (West 2024).

362 *See generally* State v. J.W.B., 492 P.3e 142 (Or. App. 2021).

363 *See supra* notes 357, 359.

364 *See supra* note 328.

365 *Id.*

366 This interpretation is also consistent with courts' construal of grave disability as a form of harm to self. *See In re* LaBelle, 728 P.2d 138, 146 (Wash. 1986) (explaining that "under the gravely disabled standard, the danger of harm usually arises from passive behavior—i.e., the failure or inability to provide for one's essential needs" and construing this term to require "a showing of a substantial risk of danger of serious physical harm resulting from failure to provide for essential health and safety needs" to justify the "massive curtailment of liberty" of civil commitment).

367 *See* MONT. CODE ANN. § 53-21-126(4)(d)(i)(C) (2023).

368 *Id.* at § 53-21-126(1)(d).

369 *But see In re* Mental Health of A.S.B., 180 P.3d 625, 630 (Mont. 2008) (conflating "predictably" with "statistically likely" and "likely" when discussing the deterioration standard).

2. Future Risk of Other Types of Harm

Eight states allow for POC absent risk of physical injury. Two of these states—Illinois[370] and Texas—seek to prevent serious harm (not necessarily physical harm) to self or others.[371] Florida aims to prevent substantial harm to well-being.[372] Hawaii and Louisiana recognize risks of emotional harm.[373] Maine and Nevada seek to avoid mental harm.[374] North Carolina permits POC for an individual who has "engaged in extreme destruction of property" when "there is a reasonable probability that this conduct will be repeated."[375] Table F details the varying criteria among these nine states.

TABLE F. CRITERIA AMONG POC STATUTES ALLOWING FOR FUTURE RISK OF NON-PHYSICAL HARM

State	Current deterioration	Current inability to safely survive without treatment	Imminence requirement	Likelihood requirement
FL		X		X (*likely* to result in harm)
HI		X	X (dangerousness within 45 days)	X (deterioration *predictably* would result in the individual *likely* posing a

370 405 ILL. COMP. STAT. ANN. 5/1-119.1 (West 2024).

371 *See id.* 5/1-119.1(2) (permitting POC when, without treatment, the person's mental illness is reasonably expected to deteriorate such that they will be "unable to provide for his or her basic physical needs so as to guard himself or herself from serious harm" without inpatient treatment); *In re* Evans, 408 N.E.2d 33, 36 (Ill. App. Ct. 1980) (interpreting "serious harm" to include a "worsening [of] his already unstable mental condition"); *supra* note 346 (Texas).

372 *See* FLA. STAT. ANN. § 394.467(2)(a)(4) (LexisNexis 2024). It is unclear what "substantial harm to their well-being" entails beyond posing a personal safety risk. *See* Hedrick v. Fla. Hosp. Medical Ctr., 633 So. 2d 1153, 1154 (Fla. Dist. Ct. App. 1994).

373 *See* HAW. REV. STAT. ANN. § 334-1 (LexisNexis 2024); LA. STAT. ANN. § 28:2(7) (2024).

374 ME. REV. STAT. ANN. tit. 34B, § 3801(4-A)(C) (West 2023) (permitting POC to avoid severe *mental* harm, evidenced by "recent behavior demonstrating an inability to avoid risk or to protect the person adequately from impairment or injury"); NEV. REV. STAT. ANN. § 433A.0195(2) (LexisNexis 2023) (permitting POC to prevent a serious risk of causing bodily injury, defined to include "a *protracted loss or impairment of . . . mental functioning*").

375 N.C. GEN. STAT. ANN. § 122C-3(11)(b) (West 2024). This provision lacks an imminence requirement.

TABLE F. CRITERIA AMONG POC STATUTES ALLOWING FOR FUTURE RISK OF NON-PHYSICAL HARM				
				high probability of causing harm)
IL				X (deterioration *reasonably expected* such that individual *would* meet inpatient criteria)
LA		X	X (dangerous to others in the near future)[376]	X (deterioration *likely* to lead to a *reasonable expectation* of *substantial risk* of harm)
ME			X (harm in the foreseeable future)	X (*reasonable likelihood* of deterioration leading to *substantial risk / reasonable certainty* of harm)
NC	X		X (serious physical debilitation in the near future)[377]	X (*predictably* result in a *reasonable*

[376] Louisiana imposes an imminence requirement for individuals who pose a danger to others, but not for those who are gravely disabled or who pose a danger to themselves. *Compare* LA. STAT. ANN. § 28:2(6) (2024) (imposing a "near future" restraint in the "dangerous to others" definition) *with* LA. STAT. ANN. § 28:2(7), (13) (2024) (lacking an imminence requirement in the "dangerous to self" and "gravely disabled" definitions).

[377] POC may be ordered in North Carolina to prevent danger to self or others. North Carolina only imposes a "near future" imminence constraint within the "danger to self" definition. The defining provision ponders a range of elements that may establish one's dangerousness to self. N.C. GEN. STAT. ANN. § 122C-3(11)(a) (West 2024). An imminence requirement is imposed

TABLE F. CRITERIA AMONG POC STATUTES ALLOWING FOR FUTURE RISK OF NON-PHYSICAL HARM				
				probability harm will occur)
NV	X			X (deterioration *would* result in *substantial likelihood* of harm)
TX				X (*will* deteriorate such that the individual *will* be unable to live safely; relapse would *likely* result in harm)

Only Nevada and North Carolina require evidence of current deterioration or disability,[378] and about half of these states require a current inability to survive safely in the community without treatment.[379] As previously noted, Hawaii's and North Carolina's POC statutes include elements of decisional or volitional impairment.[380] These findings of impairment may justify POC under a state's parens patriae authority upon a lesser showing of potential harm than would be necessary under a police power rationale.[381]

only when dangerousness is established due to risk of physical debilitation. *Id.* § 122C-3(11)(a)(1)(II).

[378] *See supra* note 329 (Nevada); *supra* note 337 (North Carolina).

[379] *See* OHIO REV. CODE ANN. § 5122.01(B)(5)(a)(i) (West 2024); HAW. REV. STAT. ANN. § 334-121(2) (LexisNexis 2024); LA. STAT. ANN. § 28:66(A) (2024); FLA. STAT. ANN. § 394.467(2)(a)(2) (LexisNexis 2024); *cf.* ME. REV. STAT. ANN. tit. 34B, § 3873-A(G) (West 2023) ("Compliance will enable the patient to survive more safely in a community setting without posing a likelihood of serious harm."); NEV. REV. STAT. ANN. § 433A.335(3)(e) (LexisNexis 2023) ("Assisted outpatient treatment is the least restrictive appropriate means to prevent further disability or deterioration that would result in the person [presenting a substantial likelihood of serious harm to himself or herself or others]."). Another requires a finding of a *future* inability to survive safely in the community. *See* TEX. HEALTH & SAFETY CODE § 574.0345(a)(2)(B) (West 2024).

[380] *See* HAW. REV. STAT. ANN. § 334-121(2) (LexisNexis 2024); N.C. GEN. STAT. ANN. § 122C-263(d)(1)(d) (LexisNexis 2024).

[381] *See* Johnston, *supra* note 23, at Part III.B (differentiating between the dangerousness criteria necessary to establish police power and *parens patriae* commitment authority).

In these eight states, the required probability that anticipated deterioration will lead to the expected harm is often low. For example, in Louisiana, an individual may be committed to prevent deterioration that would "likely"[382] lead to a reasonable expectation that there is a substantial risk that they will suffer severe emotional harm or inflict physical harm on themselves or others.[383] Maine and Hawaii require a slightly higher probability that the anticipated deterioration will ultimately lead to harm. In Maine, there must be a reasonable likelihood that the individual's mental health will deteriorate such that they pose a substantial risk of physical harm to themselves or others or such that there is reasonable certainty that the individual will suffer severe mental or physical harm.[384] In Hawaii, treatment must be necessary to prevent "deterioration that would predictably result in the person becoming imminently dangerous,"[385] which is defined to mean the individual will likely become dangerous within forty-five days.[386] An individual will be considered "dangerous" when there is a high probability[387] they will cause substantial injury or experience serious physical debilitation, as evidenced by recent behavior.[388] Conversely, Nevada requires commitment to prevent deterioration that would result in a substantial likelihood of serious harm.[389]

Very few of these eight states include imminence requirements. For example, Illinois and Nevada lack timing requirements altogether.[390] Maine requires that the individual's mental illness be likely to deteriorate such that they will pose a likelihood of serious harm in the foreseeable future.[391] Hawaii's statute requires that the person reach a dangerousness threshold within a particular timeframe but does not impose a limitation on when the anticipated injury experienced.[392]

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382 LA. STAT. ANN. § 28:66 (2024).

383 *Id.* § 28:2(6)–(7). Louisiana also permits outpatient commitment to prevent deterioration likely to result in grave disability. *Id.* §§ 28:66(A)(6), 28:55((E)(1).

384 ME. REV. STAT. ANN. tit. 34B, § 3801(4-A) (West 2023).

385 *See supra* notes 317–18.

386 HAW. REV. STAT. ANN. § 334-1 (LexisNexis 2024).

387 Opinion No. 23-01, *supra* note 321.

388 HAW. REV. STAT. ANN. § 334-1 (LexisNexis 2024).

389 NEV. REV. STAT. ANN. § 433A.335(3)(e) (LexisNexis 2023) ("Assisted outpatient treatment is the least restrictive appropriate means to prevent further disability or deterioration that would result in the person becoming a person in a mental health crisis."); *id.* § 433A.0175(1) (defining "person in a mental health crisis" to mean one who "presents a substantial likelihood of serious harm").

390 Louisiana and North Carolina include timing requirements for certain types of anticipated harm. *See* LA. STAT. ANN. § 28:2(7) (2024); *id.* § 28:2(6); *id.* § 28:2(13); N.C. GEN. STAT. ANN. § 122C-271(a)(1) (West 2024).

391 ME. REV. STAT. ANN. tit. 34B, § 3801(4-A)(D) (West 2023).

392 *See supra* note 385–88 and accompanying text.

C. Deteriorating to Satisfy a Lower Standard than Inpatient Criteria

Nine states' statutes—nearly 90% of which were passed or amended since 2019[393]—permit mandated outpatient treatment to prevent deterioration that, if it occurred, would result in conditions less acute than those required for involuntary hospitalization.[394] One-third of these states do not require historical evidence of treatment noncompliance.[395] These statutes significantly expand the reach of states' social control over individuals with mental disorders. Moreover, most of these statutes seek to avoid nebulous harms of uncertain meaning, such as becoming "unlikely to survive safely in the community without supervision."[396] Two statutes, when applied to individuals with treatment incapacity, lack a dangerousness requirement altogether.[397] Ambiguous harms or a simple need for treatment invite courts to exercise wide discretion in depriving individuals of their liberty. Because these statutes seek to override autonomy to prevent lesser harms, they deserve heightened scrutiny.

Table G provides the language of statutes aimed to prevent deterioration to conditions less pressing than those necessary for involuntary hospitalization. This table also includes the incapacity requirements of each statute. The latter is important because treatment incapacity could justify state intervention upon a lesser showing of harm than that necessary to sustain states' police power authority.[398] Table H details specific criteria among these eight statutes, such as their likelihood requirements, historical criteria, and whether the individual must be currently deteriorating.

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393 *See supra* Table A (Alabama, California, Georgia, Kentucky, Washington, Pennsylvania, Utah).

394 These states' inpatient commitment criteria can be found here: ALA. CODE § 22-52-10.4(a) (2024); CAL. WELF. & INST. CODE § 5250(a) (West 2024); DEL. CODE ANN. tit. 16, § 5011(2) (West 2024); GA. CODE ANN. § 37-3-1(9.1) (West 2024); KY. REV. STAT. ANN. § 202A.026 (LexisNexis 2024); 50 PA. STAT. AND CONS. STAT. ANN. § 7301(a) (West 2025); 50 PA. STAT. AND CONS. STAT. ANN. § 7301(b)(1)–(2) (West 2025) (defining "clear and present danger"); UTAH CODE ANN. § 26B-5-332(16)(a)(ii) (West 2024); WASH. REV. CODE ANN. § 71.05.240(4)(a) (LexisNexis 2024).

395 These states include Alabama, Georgia, and Utah. *See supra* Table C.

396 *See* CAL. WELF. & INST. CODE § 5346(a)(3)(A) (West 2024); DEL. CODE ANN. tit. 16, § 5013(a)(3) (West 2024); WASH. REV. CODE ANN. § 71.05.148(1)(b)(ii) (LexisNexis 2024); *see also* ALA. CODE § 22-52-10.2(a)(2) (2024) ("[W]ill suffer mental distress and experience deterioration of the ability to function independently."); KY. REV. STAT. ANN. § 202A.0815(4) (LexisNexis 2024) ("[I]s in need of court-ordered [AOT] as the least restrictive alternative mode of treatment presently available and appropriate.").

397 *See infra* notes 443–44 (Utah and Kentucky).

398 *See* Johnston, *supra* note 23, at Part III.B (differentiating between the dangerousness criteria necessary to establish police power and *parens patriae* commitment authority).

TABLE G. STATE POC STATUTES THAT REQUIRE DETERIORATION TO SATISFY A LESSER STANDARD THAN INPATIENT COMMITMENT		
State	**POC Criteria**	**Incapacity Element**
Alabama	"As a result of the mental illness, the respondent, if not treated, **will suffer mental distress** and **experience deterioration of the ability to function independently**."[399]	Optional[400]
California	"[I]n view of the person's treatment history and current behavior," *either:* (A) "The person is **unlikely to survive safely** in the community without supervision and the person's **condition is substantially deteriorating**."[401] *or* (B) "The person is in need of . . . treatment in order to prevent a relapse or deterioration that would be **likely** to result in **grave disability**[402] or **serious harm** to the person or to others[.]"[403]	None
Delaware	**"[R]easonably expected** to become **dangerous to self**[404] or **dangerous to others**[405] *or* **otherwise unlikely to survive safely** in the community without treatment for the person's mental condition."[406]	Optional[407]

399 ALA. CODE § 22-52-10.2(a)(2) (2024).

400 *Id.* § 22-52-10.2(a)(3).

401 CAL. WELF. & INST. CODE § 5346(a)(3)(A) (West 2024).

402 *Id.* § 5008(h) (defining "gravely disabled" as "[a] condition in which a person, as a result of a mental health disorder, is unable to provide for his or her basic personal needs for food, clothing, or shelter").

403 *Id.* § 5346(a)(3)(B).

404 DEL. CODE ANN. tit. 16, § 5001(4) (West 2024) ([d]efining "dangerous to self" to mean "by reason of mental condition there is a substantial likelihood that the person will imminently sustain serious bodily harm to oneself").

405 *Id.* § 5001(3) (defining "dangerous to others" to mean "by reason of mental condition there is a substantial likelihood that the person will inflict serious bodily harm upon another person within the immediate future").

406 *Id.* § 5013(a)(3).

407 *Id.* § 5013(a)(4).

TABLE G. STATE POC STATUTES THAT REQUIRE DETERIORATION TO SATISFY A LESSER STANDARD THAN INPATIENT COMMITMENT		
Georgia	"[B]ased on their psychiatric condition or history, is in need of treatment in order to prevent further disability or deterioration that would **predictably** result in **dangerousness to self or others**."[408]	Decisional or volitional impairment[409]
Kentucky	"Is in need of court-ordered assisted outpatient treatment **as the least restrictive alternative mode of treatment** presently available and appropriate."[410]	Decisional impairment[411]
Ohio	"[I]s unlikely to survive safely in the community without supervision, based on a clinical determination . . . [and] [i]n view of the person's treatment history and current behavior, . . . is in need of treatment in order to prevent a relapse or deterioration that would be **likely** to result in **substantial risk of serious harm** to the person or others."[412]	None[413]

408 GA. CODE ANN. § 37-3-1(12.1)(B) (West 2024). Although the feared state of deterioration in Georgia may permit inpatient commitment in other states, it would not in Georgia because of the greater likelihood and imminence requirements for inpatient commitment. *See infra* note 439.

409 *Id.* § 37-3-1(12.1)(C); *supra* note 258 and accompanying text.

410 KY. REV. STAT. ANN. § 202A.0815(4) (LexisNexis 2024).

411 *Id.* § 202A.0815(3).

412 OHIO REV. CODE ANN. § 5122.01(B)(5)(a) (West 2024).

413 *Id.* § 5122.01(B)(5)(a)(iii) ("The person, as a result of the person's mental illness, is unlikely to voluntarily participate in necessary treatment."); *see supra* notes 264, 266–71 and accompanying text (discussing this and similar elements and their implications).

Pennsylvania	"[I]s unlikely to survive safely in the community without supervision, based on a clinical determination[;]"[414] and, "[b]ased on the person's treatment history and current behavior, . . . is in need of treatment in order to prevent a relapse or deterioration that would be **likely** to result in **substantial risk** of **serious harm to the others or himself**."[415]	None[416]
Utah	Either the individual: "needs assisted outpatient treatment in order to prevent relapse or deterioration that is **likely** to result in the proposed patient posing a **substantial danger**[417] to self or others"[418] or "lacks the ability to engage in rational decision-making process regarding the acceptance of mental health treatment, as demonstrated by evidence of inability to weigh the possible risks of accepting or rejecting treatment."[419]	Optional[420]
Washington	"Based on a clinical determination and in view of the person's treatment history and current behavior," either: "the person is **unlikely to survive safely in the community** without supervision and the person's condition **is substantially deteriorating**; or [t]he person is in need of [AOT] in order to prevent a relapse or deterioration that would be **likely** to result in	None

414 50 PA. STAT. AND CONS. STAT. ANN. § 7301(c)(1)(i) (West 2025).

415 *Id.* § 7301(c)(1)(iv).

416 *Id.* § 7301(c)(1)(iii) ("The person, as a result of the person's mental illness, is unlikely to voluntarily participate in necessary treatment."); *see supra* notes 264, 266–71 and accompanying text.

417 UTAH CODE ANN. § 26B-5-301(24) (West 2024) (defining "substantial danger" to mean "due to mental illness, an individual is at serious risk of: (a) suicide; (b) serious bodily self-injury; (c) serious bodily injury because the individual is incapable of providing the basic necessities of life, including food, clothing, or shelter; (d) causing or attempting to cause serious bodily injury to another individual; (e) engaging in harmful sexual conduct; or (f) if not treated, suffering severe and abnormal mental, emotional, or physical distress that: (i) is associated with significant impairment of judgment, reason, or behavior; and (ii) causes a substantial deterioration of the individual's previous ability to function independently").

418 *Id.* § 26B-5-351(14)(c)(i)–(ii).

419 *Id.* § 26B-5-351(14)(c)(ii).

420 *Id.* § 26B-5-351(14)(c)(i).

	grave disability[421] or a **likelihood of serious harm**[422] to the person or to others."[423]	

Without a treatment incapacity requirement, several of these POC statutes are difficult to justify. Alabama's POC statute has the least demanding harm requirement and is the most susceptible to challenge.[424] Alabama permits compelled treatment when a competent person with mental illness has a treatment history suggesting that they are unable to maintain consistent, voluntary engagement with outpatient treatment and that, without treatment, they will experience mental distress and deterioration of their ability to function independently.[425] This statute neither requires treatment incapacity, current deterioration, nor an unlikelihood of surviving safely in the community without treatment or supervision.[426] Thus, the court may order an individual capable of assessing their own best interests, who is not considered a future risk to others, to accept a treatment plan merely to prevent deterioration of their condition.[427]

Washington, California, and Delaware, while less sweeping than Alabama, each permit outpatient commitment upon a finding of improbability of surviving safely in the community without supervision or treatment.[428] California and Washington pair

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421 WASH. REV. CODE ANN. § 71.05.020(25) (LexisNexis 2024) (defining "gravely disabled" as "a condition in which a person, as a result of a behavioral health disorder: (a) [i]s in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety; or (b) manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety").

422 *Id.* (defining "likelihood of serious harm" as (a) [a] substantial risk that: (i) [p]hysical harm will be inflicted by a person upon his or her own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on oneself; (ii) physical harm will be inflicted by a person upon another, as evidenced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm; or (iii) physical harm will be inflicted by a person upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others; or (b) [t]he person has threatened the physical safety of another and has a history of one or more violent acts").

423 *Id.* § 71.05.148(1)(b)(ii).

424 *See* Johnston, *supra* note 23, at Part IV.A.3.

425 ALA. CODE § 22-52-10.2(a)(2) (2024).

426 *See generally id.* § 22-52-10.2(a).

427 Current case law suggests that Alabama's broad-sweeping POC criteria may be unconstitutional. *See* Johnston, *supra* note 23, Part IV.A.3.

428 WASH. REV. CODE ANN. § 71.05.148(1)(b)(ii) (West 2023); CAL. WELF. & INST. CODE § 5346(a)(3)(A) (West 2024); DEL. CODE ANN. tit. 16 § 5013(a)(3) (West 2024). These statutes mimic the language of *O'Connor v. Donaldson*, which held that "a State cannot constitutionally confine, without more, a nondangerous individual who is capable of surviving in freedom by himself or with the help of willing and responsible family members or friends." 422 U.S. 563, 576 (1975); *see also id.* at 575 ("[W]hile the State may arguably confine a person to save him from harm, incarceration is rarely if ever a necessary condition for raising the living standards

that predictive element with a requirement that "the person's condition is substantially deteriorating."[429] Delaware's standard does not. In addition, Delaware requires only that the individual be "reasonably expected to become unlikely to safely survive without treatment,"[430] while Washington and California require the individual be presently unlikely to safely survive in the community.[431] Conditions necessary for independent, safe, community survival are undefined.[432] In reflecting on the implications of a similar criterion in Ohio, Steven Strang argued:

> This [element] gives an individual [mental health] professional significant discretion and power. The "unlikely to survive safely in the community" test predicts future behavior, and there is no requirement that the professional cite the past behavior that led him to this conclusion. This type of general diagnosis is inherently less specific, more subjective, and potentially less accurate than diagnoses based on specified past behavior.[433]

Additionally, this standard "requires trying to distinguish between individuals who live an impoverished existence and individuals whose existence is impoverished because of treatable mental disorder."[434] While Washington, California, and Delaware require findings that address each of the required criteria,[435] none requires the

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of those capable of surviving safely in freedom, on their own or with the help of family or friends.").

429 CAL. WELF. & INST. CODE § 5346(a)(3)(A) (West 2024); WASH. REV. CODE ANN. § 71.05.148(1)(b)(ii) (West 2023).

430 DEL. CODE ANN. tit. 16, § 5013(a)(3)(A) (West 2024).

431 WASH. REV. CODE ANN. § 71.05.148(1)(b)(ii) (West 2023); CAL. WELF. & INST. CODE § 5346(a)(3)(A) (WEST 2024).

432 *See generally* WASH. REV. CODE ANN. § 71.05.148 (West 2023); CAL. WELF. & INST. CODE § 5346 (WEST 2024); DEL. CODE ANN. tit. 16, § 5013 (West 2024).

433 Steven Strang, Note, *Assisted Outpatient Treatment in Ohio: Is Jason's Law Life-saving Legislation or a Rash Response?*, 19 HEALTH MATRIX 247, 255–56 (2009).

434 MELTON ET AL., *supra* note 119, at 328 (raising this critique of the "predicted deterioration" standard).

435 *See* WASH. REV. CODE ANN. § 71.05.148(1)(b)(i), (4), (5)(a) (West 2023) (the court must find "by clear, cogent, and convincing evidence pursuant to a petition . . . based on a clinical determination and in view of the person's treatment history and current behavior . . . [that] [t]he person is unlikely to survive safely in the community without supervision and the person's condition is substantially deteriorating;" petition "must allege specific facts based on personal observation, evaluation, or investigation"); CAL. WELF. & INST. CODE § 5346(a)(3)(A) (West 2024) (the court must find by clear and convincing evidence that the facts stated in the petition are true, including that "[t]here has been a clinical determination that, in view of the person's treatment history and current behavior, . . . the person is unlikely to survive safely in the community without supervision and the person's condition is substantially deteriorating"); DEL. CODE ANN. tit. 16, § 5013(a), (b) (West 2024) ("[t]he court shall set out specific findings of facts and conclusions of law which address each of the required criteria for involuntary outpatient treatment," which must be satisfied by clear and convincing evidence).

identification of past behavior or episodes that support the court's conclusion that a person, without treatment, is unable to survive safely in the community.[436] Other states decrease the subjectivity and increase the accuracy of such predictions by requiring specification of past behavior.[437] Additionally, neither Washington, California, nor Delaware requires that individuals be incapable of making rational treatment decisions.[438]

Georgia also includes a vague harm requirement. Georgia requires the individual need treatment to avoid deterioration that would "predictably result in dangerousness to self or others."[439] "Dangerousness" is not defined, so its breadth is unclear.[440] Notably, Georgia requires treatment be necessary to prevent "further" deterioration,[441] which seems to require that the individual be deteriorating at the time commitment is initiated.

Neither Utah nor Kentucky has a dangerousness requirement for individuals incapable of making rational treatment decisions.[442] In Kentucky, the individual must be "in need of court-ordered [AOT] as the least restrictive alternative mode of treatment presently available and appropriate," have a history of repeated treatment nonadherence, and be unlikely to adhere adequately to voluntary treatment.[443] In Utah, for individuals with treatment incapacity, there merely needs to be "no appropriate less-restrictive alternative" to a court order for compelled treatment,[444] suggesting that the need for treatment must meet some—undefined—threshold.

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436 *See generally* WASH. REV. CODE ANN. § 71.05.148(1)(b)(i), (4), (5)(a) (West 2023); CAL. WELF. & INST. CODE § 5346(a)(3)(A) (West 2024); DEL. CODE ANN. tit. 16, § 5013(a), (b) (West 2024).

437 Strang, *supra* note 433, at 256; *see* TEX. HEALTH & SAFETY CODE § 574.0345(b) (West 2024) (requiring "expert testimony and evidence of a recent overt act or a continuing pattern of behavior that tends to confirm" this element).

438 DEL. CODE ANN. tit. 16, § 5013(a)(4) (West 2024); *supra* note 263 (California and Washington).

439 GA. CODE ANN. § 37-3-1(12.1)(B) (West 2024). "Dangerousness" is not defined. In contrast, Georgia's inpatient statute authorizes the hospitalization of "a person who is mentally ill and who presents a substantial risk of imminent harm to that person or others, as manifested by either recent overt acts or recent expressed threats of violence which present a probability of physical injury to that person or other persons; or who is so unable to care for that person's own physical health and safety as to create an imminently life-endangering crisis . . . ." *Id.* § 37-3-1(9.1).

440 Additionally, this term is not used in the inpatient context.

441 GA. CODE ANN. § 37-3-1(12.1).

442 In Utah, treatment incapacity is an optional requirement. *See* UTAH CODE ANN. §§ 26B-5-351(14)(c)(i)–(ii) (West 2024). To commit a competent individual, Utah requires that treatment be necessary to prevent the individual from deteriorating such that they are likely to pose a substantial danger. *Id.* § 26B-5-351(14)(c)(ii); *id.* § 26B-5-301(24) (defining "substantial danger").

443 KY. REV. STAT. ANN. § 202A.0815 (LexisNexis 2024).

444 UTAH CODE ANN. § 26B-5-351(14)(b) (West 2024).

Pennsylvania's and Ohio's statutes are the least susceptible to challenge among this group.[445] Both states' statutes require the individual currently be "unlikely to survive safely in the community without supervision, based on a clinical determination" and in need of treatment to prevent deterioration "likely to result in substantial risk of serious harm" to self or others.[446] Although this standard does not justify inpatient commitment in either Pennsylvania or Ohio,[447] it does in many other states.[448]

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445 *See* Addington v. Texas, 441 U.S. 418, 426 (1979) ("The state . . . has authority under its police power to protect the community from the dangerous tendencies of some who are mentally ill.").

446 50 PA. STAT. AND CONS. STAT. ANN. § 7301(c)(i), (iv) (West 2025); OHIO REV. CODE ANN. § 5122.01(B)(5)(a)(i), (iv) (West 2024).

447 *See* 50 PA. STAT. AND CONS. STAT. ANN. § 7301(a) (West 2025) (requiring "a clear and present danger of harm to others or to himself").

448 *See e.g.*, 405 ILL. COMP. STAT. ANN. 5/1-119 (West 2024) (authorizing inpatient commitment upon a finding that an individual is, "if not treated on an inpatient basis, [] reasonably expected, based on his or her behavioral history, to suffer mental or emotional deterioration and is reasonably expected, after such deterioration" to "engage in conduct placing such person or another in physical harm or in reasonable expectation of being physically harmed" or be "unable to provide for his or her basic physical needs so as to guard himself or herself from serious harm without the assistance of family or others"); GA. CODE ANN. § 37-3-1(9.1) (West 2024) (defining an "inpatient" as one "[w]ho is so unable to care for that person's own physical health and safety as to create an imminently life-endangering crisis" or "[w]ho presents a substantial risk of imminent harm to [themselves] or others"); HAW. REV. STAT. ANN. §§ 334-60.2, 334-1 (LexisNexis 2024) (allowing inpatient commitment if an individual is "gravely disabled" or if, without intervention, "the person will likely become dangerous to self or dangerous to others within the next forty-five days"). A court may order inpatient commitment in Pennsylvania when, "as a result of mental illness, [the individual's] capacity to exercise self-control, judgment and discretion in the conduct of his affairs and social relations or to care for his own personal needs is so lessened that he poses a clear and present danger of harm to others or to himself." 50 PA. STAT. AND CONS. STAT. ANN. § 7301(a) (West 2025); *id.* § 7301(b) (defining "clear and present danger of harm").

TABLE H. CRITERIA AMONG POC STATUTES THAT REQUIRE DETERIORATION TO SATISFY A LESSER STANDARD THAN INPATIENT COMMITMENT					
State	**Current deterioration**	**Minimum harm**	**Historical criteria**	**Imminence requirement**	**Likelihood requirement**
AL		Mental distress; deterioration of ability to independently function	*[449]		X (without treatment, *will* suffer harm)
CA	X[450]	Unlikely to safely survive in community	X	X (presently unlikely to safely survive) [451]	X (presently *unlikely* to safely survive)
DE		Unlikely to safely survive in community	X		X (*reasonably expected* to *become* unlikely to safely survive)
GA	X	Dangerousness (undefined)			X (deterioration would *predictably* result in dangerousness)
KY		"Is in need of court-ordered assisted	X		

[449] Historical evidence of treatment nonadherance is only required if there is no evidence of decisional impairment.

[450] Instead of showing current deterioration, the court may find that POC is necessary to "prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to the person or to others." CAL. WELF. & INST. CODE § 5346(a)(3)(B) (West 2024).

[451] Alternatively, the court may find that POC is necessary to "prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to the person or to others." *Id.*

TABLE H. CRITERIA AMONG POC STATUTES THAT REQUIRE DETERIORATION TO SATISFY A LESSER STANDARD THAN INPATIENT COMMITMENT					
		outpatient treatment"			
OH		Serious harm	X		X (deterioration *likely* to result in *substantial risk* of harm)
PA		Serious harm	X		X (deterioration *likely* to result in *substantial risk* of harm)
UT		None (if treatment incapacity)			
WA	X[452]	Unlikely to safely survive in community[453]	X	X (presently unlikely to safely survive)	X (presently unlikely to safely survive)

VI. CONCLUSION

Preventive outpatient commitment—compelled community treatment for nondangerous individuals whose symptoms do not yet permit involuntary hospitalization—is rapidly spreading throughout the United States.[454] Policymakers and commentators champion POC as a means to protect committed individuals and shield communities from future threats, while imposing minimal burdens on

452 In Washington, the "current deterioration" element is only one way to establish the need for POC in Washington. Alternatively, it is sufficient for the court to find POC is needed to "prevent a relapse or deterioration that would be likely to result in grave disability or a likelihood of serious harm to the person or others." WASH. REV. CODE ANN. § 71.05.148(1)(b)(ii) (West 2023).

453 "Alternatively, to establish POC is necessary in Washington, the court may find that POC is necessary to "prevent a relapse or deterioration that would be likely to result in grave disability or a likelihood of serious harm to the person or others." *Id.*

454 *See supra* Table A.

individual liberty.[455] However, discussions around POC laws have not been honest or fully informed. Proponents misconstrue, or misrepresent, aspects of POC crucial to its defensibility. Without accurate information, honest evaluation of the scope of states' commitment power cannot occur.

This Article addresses the most prevalent misconceptions about POC, specifically its incidence, invasiveness, applicability, and enforceability. Data demonstrate that POC is less common among states, potentially more onerous, more applicable to individuals competent to make rational treatment decisions, and more enforceable than typically represented.[456]

The information herein allows for more accurate debates concerning the adoption or expansion of POC and for greater accountability. Clearing the ruse that all but three states authorize POC should enable legislatures to more thoroughly discuss the merits of POC and consider alternatives. Comprehending statutory elements permits assessment of the extent that statutes faithfully reflect their articulated purposes. Awareness of elements is also necessary to determine when these purposes have been satisfied in a given case such that commitment must end.

This descriptive project should spark a range of future work. Understanding the elemental differences among statutes allows for an informed normative analysis and possible identification of states for emulation. To this end, scholars should detail additional differences among statutes, including the mental health predicate for POC, requirement that POC be the least restrictive placement necessary to avert the contemplated harm, required finding of likely personal benefit from POC, and required collection of data relating to POC over time.

The data in this Article can inform empirical projects to evaluate the effects of different substantive standards. For instance, different standards may[457]—but may not[458]—carry different net-widening implications. Grasping the range of services provided with POC also permits more useful efficacy analyses, which hold important policy and constitution implications.

Analyzing the constitutionality of POC laws requires accurate information on treatment decision-making incapacity and dangerousness.[459] This information is also crucial to assess the broader policy justifications for POC, including the prevalent "thank you" theory.[460] This theory posits that, after undergoing compelled treatment,

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455 Geller, *supra* note 6, at 236.

456 *See supra* Parts II, III, IV.B.

457 *See* Ruth E. Ross et al., *A Framework for Classifying State Involuntary Commitment Statutes*, 23 ADMIN. & POL'Y MENTAL HEALTH 341, 352 (1996) ("[S]tates with less stringent involuntary commitment statutes . . . had higher admissions to state and county psychiatric hospitals . . . .").

458 *See* R. Michael Bagby & Leslie Atkinson, *The Effects of Legislative Reform on Civil Commitment Admission Rates: A Critical Analysis*, 6 BEHAV. SCI. & LAW 45, 57 (1988) ("[T]here is little evidence to support the assumption that mental health professionals adhere to the legislative guidelines, rendering specific admission criteria a somewhat meaningless independent variable in commitment outcome studies") (citation omitted).

459 *See* Johnston, *supra* note 23.

460 *See* Johnston, *supra* note 69.

individuals—now capable of making informed decisions—will likely be grateful they were subjected to treatment, despite their objections at the time.[461] This theory seems incapable of justifying POC in states authorizing the commitment of individuals capable of making informed treatment decisions.

Finally, a solid understanding of the composition of POC laws permits locating POC statutes among compelled outpatient treatment statutes of other countries and those responding to current human rights trends. For nearly two decades, countries have struggled to respond to the provisions of the United Nations Convention on the Rights of Persons with Disabilities (UN-CRPD),[462] which rejects tests of mental incapacity to deny legal capacity[463] and prohibits involuntary treatment on the basis of disability.[464] Compliance with the UN-CRPD requires ratifying U.N. Member States to "take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity."[465] Widespread use of advance directives and supported decision-making further this objective.[466] Armed with accurate information, myriad other projects concerning the wisdom of POC are no doubt possible.

In sum, close examination of POC statutes should inspire more complete, candid examinations of POC, its justifications, impacts, and alternatives. Given the United States' history of disregarding the personhood, autonomy, and lived experience of individuals with mental illnesses,[467] careful inquiry is long overdue.

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461 *See* ALAN A. STONE & CLIFFORD D. STROMBERG, MENTAL HEALTH AND LAW: A SYSTEM IN TRANSITION 69–70 (1975).

462 *See* U.N. CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES art. 14(1)(b), Dec. 13, 2006, 2515 U.N.T.S. 3 [hereinafter CRPD].

463 *See* U.N. CRPD, General Comment No. 1, U.N. Doc. CRPD/C/GC/1, ¶ 3 (May 19, 2014).

464 *See* U.N. CRPD art. 14(1)(b); Rep. of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, at 16, U.N. Doc. A/HRC/22/53 (Feb. 1, 2013); U.N. CRPD, General Comment No. 1, 11 (May 19, 2014) (asserting that forced treatment "denies the legal capacity of a person to choose medical treatment and is therefore a violation of article 12 of the Convention").

465 U.N. CRPD art. 12(3).

466 *See* Gavin Davidson et al., *Supported Decision-making: A Review of the International Literature*, 38 INT'L J.L. & PSYCHIATRY 61, 61–62 (2015).

467 *See generally, e.g.*, Schwartz & Costanzo, *supra* note 22.