

Winter 2023

Model Legal Processes for Court Ordered Mental Health Treatment - A Modern Approach

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Online ISSN: 2643-7759

Recommended Citation

Brian D. Shannon, *Model Legal Processes for Court Ordered Mental Health Treatment - A Modern Approach*, 18 FIU L. Rev. 113 (2023).

DOI: <https://dx.doi.org/10.25148/lawrev.18.1.8>

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MODEL LEGAL PROCESSES FOR COURT-ORDERED MENTAL HEALTH TREATMENT—A MODERN APPROACH

Brian D. Shannon*

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I. INTRODUCTION

In March 2020, the Conference of Chief Justices and the Conference of State Court Administrators established the National Judicial Task Force to Examine State Courts’ Response to Mental Illness (the “Task Force”).¹ The

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¹ Cheryl Wright, *Mental Health: What are the Tools for Change?*, NCSC (May 17, 2023), <https://www.ncsc.org/information-and-resources/trending-topics/trending-topics-landing-pg/mental->

primary purpose of the Task Force “was to help state courts better respond to the needs of court-involved individuals with serious mental illness.”² The Task Force’s work culminated in the issuance of a detailed report and recommendations in October 2022: “State Courts Leading Change.”³

Tangential to the broader efforts of the Task Force, “[a] blue ribbon workgroup, including several members of the Task Force, was formed in 2019 for the purpose of writing a model civil and criminal mental health law.”⁴ Specifically, “[t]he Task Force partnered with the Equitas Project and Mental Health Colorado on a three-year project to identify model statutory involuntary civil treatment language, and to recommend policy guidance in the areas of emergency intervention standards and medication over objection.”⁵ The project also focused on processes in “criminal cases involving individuals with mental health needs”⁶ This “workgroup of psychiatrists, law professors, judges and others” was “convened and work product [was] developed by The Equitas Project, a national initiative of Mental Health Colorado focused on disentangling mental health and criminal justice.”⁷

More specifically, Florida Judge Steven Leifman and Ron Honberg, the former Senior Policy Advisor for Advocacy and Public Policy at the National Alliance on Mental Illness (“NAMI”), joined with the Equitas Project and Mental Health Colorado in 2019 to create this Model Legal Processes Work Group.⁸ The overarching purpose of the Workgroup was to write “model civil

health-what-are-the-tools-for-change; NAT’L CTR. FOR STATE CTS., NATIONAL JUDICIAL TASK FORCE TO EXAMINE STATE COURTS’ RESPONSE TO MENTAL ILLNESS MEETS: REPORT ON DECRIMINALIZATION OF MENTAL ILLNESS RELEASED (2020), <https://cdm16501.contentdm.oclc.org/digital/collection/spcts/id/474>.

² Wright, *supra* note 1.

³ NAT’L JUD. TASK FORCE, STATE COURTS LEADING CHANGE: REPORT AND RECOMMENDATIONS (2023) [hereinafter NAT’L JUD. TASK FORCE REPORT], https://www.ncsc.org/__data/assets/pdf_file/0031/84469/MHTF_State_Courts_Leading_Change.pdf.

⁴ *Id.* at 31.

⁵ *Model Legal Processes to Support Clinical Intervention for Persons with Serious Mental Illnesses and Pathways to Care*, NCSC (Sept. 15, 2022), <https://www.ncsc.org/newsroom/behavioral-health-alerts/2022/model-legal-processes-to-support-clinical-intervention-for-persons-with-serious-mental-illnesses-and-pathways-to-care>.

⁶ *Id.*

⁷ NAT’L CTR. FOR STATE CTS., THE FUTURE IS NOW: DECRIMINALIZATION OF MENTAL ILLNESS 13 (2020), https://www.ncsc.org/__data/assets/pdf_file/0019/41653/Future_is_Now_Final_rev.pdf.

⁸ *See* THE EQUITAS PROJECT, MENTAL HEALTH COLO., MODEL LEGAL PROCESSES TO SUPPORT CLINICAL INTERVENTION FOR PERSONS WITH SERIOUS MENTAL ILLNESSES AND PATHWAYS TO CARE: A ROADMAP FOR COORDINATING CRIMINAL JUSTICE, MENTAL HEALTH CARE, AND CIVIL COURT SYSTEMS TO MEET THE NEEDS OF INDIVIDUALS AND SOCIETY 1 (2022) [hereinafter MODEL LEGAL PROCESSES], <https://www.mentalhealthcolorado.org/wp-content/uploads/2022/09/Model-Legal-Processes-to-Support-Clinical-Intervention-for-Persons-with-Serious-Mental-Illnesses-Final-9.2.2022.pdf> (describing the group’s formation). Judge Leifman, from Miami, is one of the nation’s foremost authorities on issues relating to criminal law and mental illness. Among his many activities, he served as a member of the National Judicial Task Force, co-chaired the American Bar Association’s Criminal Justice Mental Health

and criminal mental health law[s] that could be distributed and promoted for broad adoption across the country.”⁹ In particular, a primary goal of the Workgroup was “to produce legislative language that reflects cutting edge brain and behavior research, the civil liberties and patient’s rights advocacy of consumers and families, as well as health provider and public safety innovations and efficiencies.”¹⁰

The Model Legal Processes Workgroup completed its work and issued its final report and recommendations in August 2022.¹¹ Shortly thereafter, in October 2022, the Task Force endorsed the Workgroup’s model law proposals.¹² This Article will discuss the Workgroup’s recommendations and analyze aspects of the proposals that are intended as improvements to the laws in many states. In particular, the below Sections will address the Workgroup’s recommendations regarding criteria for court-ordered mental health treatment, emergency psychiatric interventions, medication over objection, and pathways to care for certain offenders with mental illness in the criminal justice process.

Committee, and is a past winner of the William H. Rehnquist Award for Judicial Excellence. *Judge Steven Leifman, JD*, KAISER PERMANENTE INST. FOR HEALTH POL’Y, <https://www.kpihp.org/bio/judge-steven-leifman-jd/> (last visited June 8, 2023). The Equitas Project, supported by the David and Laura Merage Foundation, is focused on promoting “mental health awareness and . . . laws, policies, and practices that prioritize improved population health outcomes, sensible use of resources, and the decriminalization of mental illness.” *The Equitas Project*, DAVID & LAURA MERAGE FOUND., <https://merage.org/initiatives/theequitasproject/> (last visited June 8, 2023).

⁹ See MODEL LEGAL PROCESSES, *supra* note 8, at 1 (describing the workgroup’s purpose).

¹⁰ *Id.* The Workgroup included “nationally recognized experts in mental health law, psychiatry, and advocacy . . .” *Id.* A full list of the members of the Workgroup is included in the group’s final report. The roster included multiple psychiatry professors from leading medical schools, other practicing psychiatrists, judges, law professors, and other attorneys. The author of this Article was one of three law professor members of the workgroup, along with Richard Bonnie of the University of Virginia and Christopher Slobogin of Vanderbilt University. See *id.* at 4–5 (listing members). Although the project began in 2019 and the group held two in-person meetings by March 2020, the global COVID-19 pandemic interrupted the Workgroup’s efforts and created delays in the completion of the undertaking. See NAT’L CTR. FOR STATE CTS., IMPROVED CIVIL COURT-ORDERED TREATMENT RESPONSES 1 (2022), https://www.ncsc.org/_data/assets/pdf_file/0021/79311/Improved-Civil-Court-Ordered-Treatment-Responses.pdf (describing the 2019 project start date and anticipated completion in late 2022). Of course, the COVID-19 pandemic adversely impacted the activities of most entities and individuals, and not just the Workgroup’s efforts. See ABA NEWS, *Pandemic Disrupts Justice System, Courts* (Mar. 16, 2020), <https://www.americanbar.org/news/abanews/aba-news-archives/2020/03/coronavirus-affecting-justice-system/> (last visited Nov. 8, 2023) (discussing disruptions across the justice system).

¹¹ MODEL LEGAL PROCESSES, *supra* note 8.

¹² See NAT’L JUD. TASK FORCE REPORT, *supra* note 3, at 31 (noting the Task Force’s endorsement). The Task Force observed further that one state, Arizona, had already directed that the Model Legal Processes Workgroup’s report “serve as a model” for the state’s review of its existing civil commitment laws. *Id.*

II. PROPOSED CRITERIA FOR COURT-ORDERED MENTAL HEALTH TREATMENT

The Model Legal Processes Workgroup collectively began its work with the view that “[m]odern mental health laws must be modified—and systems of health care, supports, and services enhanced—to improve access to timely, appropriate mental health care delivered in the least restrictive manner possible for those unwilling or unable to voluntarily accept that treatment.”¹³ As described in the introduction to the Model Legal Processes report:

Most states’ laws for the involuntary treatment of persons with mental illnesses in existence today were adopted in the 1970’s. As part of an effort to deinstitutionalize the treatment of mental illness, this generation of statutes favored “dangerousness” standards and individual rights-oriented court processes for involuntary treatment As a result, in some states today, individuals with mental illnesses who do not clearly present an imminent risk of harm may not be able to benefit from pathways to well-being that may only be available through involuntary treatment. . . . [T]hese persons can be more likely to experience homelessness, poverty, serious health consequences, and involvement in the criminal justice system.¹⁴

The Treatment Advocacy Center (TAC) has described “dangerousness” as a key “overarching concept necessary to understanding [today’s] involuntary treatment laws” and that “states have the authority to intervene

¹³ MODEL LEGAL PROCESSES, *supra* note 8, at 7.

¹⁴ *Id.* The dangerousness criterion stems, in part, from the Supreme Court’s decision in *O’Connor v. Donaldson*, determining that a person’s mental illness standing alone was insufficient to justify indefinite “custodial confinement” without treatment where a jury had found the patient to have been neither dangerous to himself or others. *See O’Connor v. Donaldson*, 422 U.S. 563, 575–76 (1975). Interestingly, the Court determined that it did not need to reach the question of whether a state “may compulsorily confine a non-dangerous, mentally ill individual for the purpose of treatment.” *Id.* at 573; *see also* *Lessard v. Schmidt*, 349 F. Supp. 1078, 1094–96 (E.D. Wis. 1972), *vacated*, 414 U.S. 473 (1974) (concluding that commitment criteria should include findings of dangerousness). As one recent analysis noted regarding *O’Connor v. Donaldson*, “the Court did not address the degree of dangerousness that must be proven to justify an involuntary commitment; as a result, the issue has been largely left up to states.” HANNAH-ALISE ROGERS, CONG. RSCH. SERV., R47571, INVOLUNTARY CIVIL COMMITMENT: FOURTEENTH AMENDMENT DUE PROCESS PROTECTIONS 19 (2023), <https://crsreports.congress.gov/product/pdf/R/R47571>; *see also* *Addington v. Texas*, 441 U.S. 418, 426, 430 (1979) (recognizing the state’s “legitimate interest under its *parens patriae* powers in providing care to its citizens who are unable because of emotional disorders to care for themselves” and rejecting application of a beyond a reasonable doubt standard given the “subtleties and nuances of psychiatric diagnosis”); *Parham v. J.R.*, 442 U.S. 584, 609–12 (1979) (upholding a juvenile statute that authorized a mental health commitment based on the child’s need for hospitalization and describing the questions at stake as “essentially medical in character”).

and provide involuntary care if an individual poses a danger to self or to other people.”¹⁵ But, the wide variations among “the states arises from the level of detail [each] legislature includes in defining dangerousness, particularly danger to self.”¹⁶ As to the latter, TAC has summarized that “states generally recognize that failing to meet basic needs for survival (food, clothing, shelter) due to mental illness qualifies as being dangerous to self.”¹⁷ Variations including criteria styled as “grave disability” or “psychiatric deterioration” remain closely connected to and stem from the concept of dangerousness to self.¹⁸

In addition, given decades of research, we know much more about serious mental illnesses, such as schizophrenia and bipolar disorder, today than in the 1970s.¹⁹ Although “[a]t this time, most mental illnesses cannot be cured, . . . they can usually be treated effectively to minimize the symptoms and allow the individual to function in work, school, or social environments.”²⁰ Yet, while voluntary psychiatric care is both desirable and preferable to court-ordered treatment, many persons with serious mental illness experience a symptom known as anosognosia, which limits their insight regarding their illness or need for treatment. As described by the Treatment Advocacy Center:

Anosognosia, also called “lack of insight,” is a symptom of severe mental illness experienced by some that impairs a person’s ability to understand and perceive his or her illness. It is the single largest reason why people with schizophrenia or bipolar disorder refuse medications or do not seek treatment. Without awareness of the illness, refusing treatment appears rational, no matter how clear the need for treatment might be to others. Approximately 50% of individuals with schizophrenia and 40% with bipolar disorder have symptoms of anosognosia. Long recognized in

¹⁵ LISA DAILEY ET AL., TREATMENT ADVOC. CTR., GRADING THE STATES: AN ANALYSIS OF U.S. PSYCHIATRIC TREATMENT LAWS 13 (2020) [hereinafter GRADING THE STATES], <https://www.treatmentadvocacycenter.org/storage/documents/grading-the-states.pdf>.

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ *See id.* (observing that for treatment criteria such as grave disability or deterioration, “at times the nexus to dangerousness gets lost”).

¹⁹ For general background information regarding schizophrenia and bipolar disorder, see for example, *Schizophrenia*, NAT’L INST. MENTAL HEALTH, <https://www.nimh.nih.gov/health/publications/schizophrenia> (last visited June 16, 2023); *Bipolar Disorder*, NAT’L INST. MENTAL HEALTH, <https://www.nimh.nih.gov/health/publications/bipolar-disorder#pub1> (last visited June 16, 2023).

²⁰ *Information About Mental Illness and the Brain*, NAT’L INST. HEALTH, <https://www.ncbi.nlm.nih.gov/books/NBK20369/> (last visited June 16, 2023); *see also* E. FULLER TORREY, SURVIVING SCHIZOPHRENIA: A FAMILY MANUAL 147 (7th ed. 2019) (observing that although not a curable disease, “[c]ontrary to popular stereotype, schizophrenia is an eminently treatable disease”).

stroke, Alzheimer's disease and other neurological conditions, studies of anosognosia in psychiatric disorders is producing a growing body of evidence of anatomical damage in the part of the brain involved with self-reflection. When taking medications, insight improves in some patients.²¹

In discussing anosognosia in persons with schizophrenia, Dr. E. Fuller Torrey has asserted that "lack of awareness of illness is the largest single cause of the need for involuntary hospitalization and medication"²² Correspondingly, however, with regard to the importance of insight in seeking or maintaining mental health care, NAMI has observed:

For a person with anosognosia, this inaccurate insight feels as real and convincing as other people's ability to perceive themselves. But these misperceptions cause conflicts with others and increased anxiety. Lack of insight also typically causes a person to avoid treatment. This makes it the most common reason for people to stop taking their medications.²³

When appropriate treatment is critical and necessary to alleviate the symptoms of a person's mental illness, anosognosia "is particularly challenging . . . as people experiencing anosognosia often refuse medication or inpatient care."²⁴

²¹ *Anosognosia*, TREATMENT ADVOC. CTR., <https://www.treatmentadvocacycenter.org/key-issues/anosognosia> (last visited June 16, 2023). As NAMI has explained:

When we talk about anosognosia in mental illness, we mean that someone is unaware of their own mental health condition or that they can't perceive their condition accurately. Anosognosia is a common symptom of certain mental illnesses, perhaps the most difficult to understand for those who have never experienced it.

Anosognosia, NAT'L ALL. ON MENTAL ILLNESS, <https://www.nami.org/About-Mental-Illness/Common-with-Mental-Illness/Anosognosia> (last visited June 16, 2023). For a summary of research on anosognosia, see *Serious Mental Illness and Anosognosia*, TREATMENT ADVOC. CTR., <https://www.treatmentadvocacycenter.org/storage/documents/backgrounders/smi-and-anosognosia.pdf> (last visited Nov. 3, 2023).

²² TORREY, *supra* note 20, at 49.

²³ NAT'L ALL. ON MENTAL ILLNESS, *supra* note 21.

²⁴ Esmey Jimenez, *Why It's Often Hard for People to Recognize Their Own Mental Illness*, SEATTLE TIMES (Feb. 10, 2022, 8:48 PM), <https://www.seattletimes.com/seattle-news/mental-health/why-its-often-hard-for-people-to-recognize-their-own-mental-illness/>. The author added, "Family members can be frustrated by their loved ones' response, and the person with mental illness likewise is frustrated—they can't recognize that they're sick and now feel alienated." *Id.* For more discussion of anosognosia and the impact of a lack of insight for persons with mental illness, see XAVIER AMADOR, I AM NOT SICK I DON'T NEED HELP!: HOW TO HELP SOMEONE ACCEPT TREATMENT (10th anniversary ed. 2012). Comparable to Ms. Jimenez's observations and Dr. Amador's findings, the author of this Article can attest to the realities of anosognosia. The author's younger brother was first diagnosed with schizophrenia when he was a twenty-two-year-old college senior. Over the first seven years of his illness,

With this backdrop, the Model Legal Processes Workgroup engaged in a thorough process over the course of three years to develop proposed statutory language to “create a more accessible legal pathway to involuntary care for the sake of an individual’s health and well-being than is presently available in most states.”²⁵ The members of the Workgroup, however, were also mindful of the following critical concepts about individual autonomy:

Court-ordered treatment is a significant event. By definition, it marks a diminution of the individual rights and freedoms of the person, so it is a legal step to be taken carefully. Taking account of current scientific understanding and legal precedent, the criteria for court-ordered treatment narrowly and objectively define the circumstances under which protecting a person’s long-term well-being justifies overriding a person’s freedom.²⁶

The Workgroup also recognized that simply retooling a state’s commitment criteria, without more, is inadequate to meet the needs of persons for whom the statute is intended. Indeed, “[p]assing laws and changing practices within the justice system may be easier than creating an equitable continuity of housing, supports, and services where there is little or none.”²⁷ That is, there must be adequate mental health treatment services. As the American Psychiatric Association has asserted, “[P]rograms of involuntary outpatient commitment must include . . . elements of well-planned and executed implementation, intensive, individualized services and sustained periods of outpatient commitment to be effective.”²⁸

he was hospitalized involuntarily four different times. Like many persons with mental illness, after a discharge from the hospital, he would eventually stop taking his medications and soon relapse. His symptoms would quickly recur and included auditory and visual hallucinations along with significant disordered thinking. When family members, including the author, would urge him to seek care voluntarily, he would respond that there was nothing wrong with him, even though that was clearly not the case. At times, he would recognize to some degree that something was wrong with him, but he would state nonsensical things such as, “I don’t need to see the doctor. My jeans are too tight. I’ll be better if I get some new jeans.” He also stated on more than one occasion while off his medications: “I have been smoking with my right hand, but the right hand is the hand of God. I’ll be fine if I remember to smoke with my left hand.” As a family, we were very appreciative that there was an accessible emergency detention and civil commitment process in our state. Happily, during his final court-ordered commitment, the state hospital prescribed a then-new medication for him that was very effective, Clozaril. He remained in recovery, stayed on that medication, and lived largely independently the rest of his life—with no further involuntary court interventions.

²⁵ MODEL LEGAL PROCESSES, *supra* note 8, at 2.

²⁶ *Id.* at 8.

²⁷ *Id.* at 2.

²⁸ AM. PSYCHIATRIC ASS’N, POSITION STATEMENT ON INVOLUNTARY OUTPATIENT COMMITMENT AND RELATED PROGRAMS OF ASSISTED OUTPATIENT TREATMENT 1 (2020) [hereinafter APA POSITION STATEMENT], <https://www.psychiatry.org/getattachment/d50db97b-59aa-4dd4-a0ecd09b4e19112e/Position-Involuntary-Outpatient-Commitment.pdf>.

A. Adding a Lack of Capacity Criterion

The Model Legal Processes Workgroup has proposed the following statutory language that defines three alternative bases for court-ordered treatment:

“Person requiring court-ordered treatment” means an individual who, as a result of mental illness and based on recent actions, omissions, or behaviors:

(a) presents a substantial risk of harm to self or others in the near future, which includes:

(i) suicidal behavior or inflicting significant self-injury; or

(ii) attempting, causing, or threatening to cause serious injury to others; or

(b) has demonstrated an inability to:

attend to basic physical needs such as medical care, food, clothing, or shelter; or protect the self from harm or victimization by others; or

exercise sufficient behavioral control to avoid serious criminal justice involvement; or

(c) lacks the capacity to recognize that they are experiencing symptoms of a serious mental illness and therefore are unable to:

make a decision regarding treatment; or

understand or retain information relevant to the treatment decision; or

use, weigh or appreciate that information as part of the process of making the treatment decision; or communicate the decision; or

appreciate the risks or benefits of treatment; and in the absence of treatment is likely to experience a relapse or deterioration of condition that would meet the criteria in (a) or (b).²⁹

The Model Legal Processes Workgroup acknowledged that “the criteria found in subsections (a) and (b) are relatively standard provisions in state

²⁹ MODEL LEGAL PROCESSES, *supra* note 8, at 7–8. Consistent with Supreme Court precedent, the Workgroup anticipated continued use of a clear and convincing evidentiary standard for proof of one or more of the three criteria. *See id.* at 9 (referencing *Addington v. Texas*, 441 U.S. 418, 432–33 (1979)).

statutes”³⁰ By way of contrast, however, the Workgroup described subsection (c) as follows:

[T]his alternative criterion for court-ordered treatment is advanced in response to the frequent complaint that under most existing laws a person must actually harm themselves or someone else in order to justify judicial intervention, no matter how clear, serious, or imminent the harm may be. The criterion is also intended to better comport with modern medical understanding of the symptoms of untreated serious mental illness.³¹

Specifically, subsection (c)’s alternative basis for allowing a court to order mental health treatment takes into account the impact of some untreated mental illnesses on a person’s capacity to recognize symptoms and make informed decisions about treatment. As the Workgroup explained in the official commentary:

Subsection (c) applies to individuals who do not meet the requirements of subsections (a) or (b), but who likely will meet one of those thresholds without treatment. Because of the nature of this standard, it requires an additional finding that the person lacks the capacity to recognize their symptoms of mental illness. This condition is a prerequisite for using this additional criterion. For example, a person might lack capacity to make a rational decision about the need for treatment if that person is regarded as unable to understand the information relevant to the decision due to mental illness. Alternatively, a person might be able to use information for some purposes but, due to their mental

³⁰ MODEL LEGAL PROCESSES, *supra* note 8, at 10. As to the traditional “dangerousness” alternative in subsection (a), the Workgroup added the following commentary:

Admittedly there is some element of prediction involved in these determinations, but established past conduct is relevant. The number of times harm has resulted in the past, the severity of that harm, how long-ago harmful conduct occurred, what treatment interventions, supports, and services may have intervened and could ameliorate repeat conduct—may all be relevant in establishing the nature and imminence of future conduct.

Id. at 9.

In addition, in commentary regarding the “inability to attend to basic needs” alternative in subsection (b), the drafters explained, “[t]he implication is that it requires a showing of more than poor life choices, or choices different than ones someone else might make, but rather substantial deficits in the ability to even make those choices.” *Id.*

³¹ *Id.* at 10.

illness, still not be able to appreciate the way the information pertains to their own situation.³²

Subsection (c), in effect, is an attempt to define incapacity in the mental health need for treatment context. In addition, notwithstanding the addition of this alternative criterion relating to an individual's lack of capacity to make treatment decisions because of the extant symptoms of a serious mental illness, there must still be a finding of a nexus to dangerousness to self or others or an inability to attend to basic needs. In particular, the last subpart of the alternative in subsection (c) requires the court to find that absent court-ordered treatment, the person "is likely to experience a relapse or deterioration of condition that would meet the criteria in (a) or (b)."³³ As the Workgroup explained:

[Subsection] (c)(vi) requires a finding that this condition contributes to a likelihood that the person will, in the future, meet the criteria described in (a) or (b). This finding would be based on evidence of past deterioration or relapse episodes. No specific timeline for that predicted deterioration is included because of the individualized nature of relapse.³⁴

State legislatures that contemplate adopting the Workgroup's recommended criteria for court-ordered treatment might encounter some degree of resistance as it is not uncommon or unusual for certain advocacy groups to oppose any perceived expansion of civil commitment laws.³⁵

³² *Id.* at 9. Consider also the discussion of anosognosia above. *See supra* notes 21–24 and accompanying text (describing the relatively common symptom of anosognosia, or lack of insight, associated with some serious mental illnesses).

³³ *See* MODEL LEGAL PROCESSES, *supra* note 8, at 8 (cross-referencing subsection (a) relating to dangerousness to self or others and subsection (b) pertaining to an inability to attend to basic needs).

³⁴ *Id.* at 10. Although subsection (c)'s focus on the person's lack of capacity to recognize their symptoms of mental illness would represent a change to the law in many states, its tie-in to whether "in the absence of treatment [the person] is likely to experience a relapse or deterioration of condition" resulting in dangerousness to self or others, is not unusual. *Id.* at 8. As the Treatment Advocacy Center has surveyed, "[c]lose to half (24) of all states include psychiatric deterioration in their criteria as a basis for inpatient civil commitment. Some states define this type of harm separately while others include it within their definition of danger to self or grave disability." GRADING THE STATES, *supra* note 15, at 20. For a further analysis of the workgroup's recommended criteria for court-ordered mental health treatment, see Symposium, *A Constitutional Analysis of the Pathways Project*, TEX. TECH L. REV. (2022) (videorecording of presentation by Christopher Slobogin) (available at 2022 *Mental Health Symposium Materials*, TEX. TECH L. REV., <http://texastechlawreview.org/mental-health-law-symposium-2022/>) (last visited July 27, 2023) (describing the proposals as constitutional but suggesting possible refinements). Professor Slobogin was a member of the Model Legal Processes Workgroup.

³⁵ *See, e.g., Position Statement 22: Involuntary Mental Health Treatment*, MENTAL HEALTH AM., <https://mhanational.org/issues/position-statement-22-involuntary-mental-health-treatment> (last visited June 27, 2023) (urging that involuntary treatment "be limited to instances where persons pose a serious risk of physical harm to themselves or others in the near future and to circumstances when no less

Consider, for example, California's enactment in 2022 of the Community Assistance, Recovery, and Empowerment (CARE) Act.³⁶ Once implemented, the state's CARE Court "program will connect a person in [a mental health] crisis with a court-ordered CARE plan to include comprehensive treatment, housing[,] and supportive services for up to 12 months."³⁷ Eligibility criteria focus on persons with untreated schizophrenia and other psychotic disorders whose "condition is substantially deteriorating" or the court-ordered services are needed "to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to the person or others."³⁸ Prior to its enactment in September 2022, numerous advocacy groups opposed the measure.³⁹ Thereafter, the California Supreme Court rejected a subsequent judicial challenge to the new law in April 2023.⁴⁰

restrictive alternative will respond adequately to the risk" and also generally opposing involuntary outpatient commitment); *Mental Health Systems*, BAZELON CTR. FOR MENTAL HEALTH L., <https://www.bazelon.org/our-work/mental-health-systems/> (last visited June 27, 2023) (expressing the view that "[f]orced mental health care is never appropriate, except when there are immediate and serious safety risks").

³⁶ S.B. No. 1338, 2022 Reg. Sess. (Cal. 2022).

³⁷ *Treatment Advocacy Center's Statement on the Passage of SB 1338, California's CARE Court Bill*, TREATMENT ADVOC. CTR., <https://www.treatmentadvocacycenter.org/about-us/features-and-news/4548-treatment-advocacy-centers-statement-on-the-passage-of-sb-1338-californias-care-court-bill> (last visited June 27, 2023).

³⁸ CAL. WELF. & INST. CODE § 5972(b)–(d) (West 2023). Eight counties in California are set to launch CARE Court programs in October 2023. See Eric Westervelt, *Parts of California to Have Care Court for Those with Untreated Severe Mental Illness*, NPR (Mar. 27, 2023, 5:32 PM), <https://www.npr.org/2023/03/27/1166340490/parts-of-california-to-have-care-court-for-those-with-untreated-severe-mental-il>.

³⁹ See *Disability Rights California & Over 50 Disability, Civil Rights, Racial Justice and Housing Advocacy Organizations Urge Newsom to Veto SB 1338*, DISABILITY RTS. CAL. (Sept. 1, 2022), <https://www.disabilityrightsca.org/latest-news/disability-rights-california-over-50-disability-civil-rights-racial-justice-and-housing> (asserting that the CARE Court statute "will lower the legal standard to order mental health treatment against the wishes of a person with a disability"). Governor Newsom signed the bill two weeks later. *Governor Newsom Signs CARE Court into Law, Providing a New Path Forward for Californians Struggling with Serious Mental Illness*, OFF. GOVERNOR GAVIN NEWSOM (Sept. 14, 2022), <https://www.gov.ca.gov/2022/09/14/governor-newsom-signs-care-court-into-law-providing-a-new-path-forward-for-californians-struggling-with-serious-mental-illness/#:~:text=%E2%80%9CThe%20CARE%20Act%20recognizes%20that,holding%20ourselves%20accountable%20to%20delivering>.

⁴⁰ *Disability Rts. Cal. v. Newson*, No. S278330, 2023 Cal. LEXIS 2153, at *1 (Cal. Apr. 19, 2023) (order denying petition for writ of mandate). See Gina Kim, *Calif. Justices Reject Challenge to CARE Courts*, LAW360 (Apr. 20, 2023, 4:00 PM), <https://www.law360.com/articles/1599272/calif-justices-reject-challenge-to-care-courts>. For another recent example of vocal opposition to steps taken to address the needs of persons with untreated serious mental illness, consider New York City Mayor Adams's late 2022 policy statement encouraging law enforcement, firefighters, physicians, and other licensed health care professionals who are part of authorized mobile crisis outreach teams to utilize their statutory authority for emergency interventions to facilitate mental health evaluations of persons with untreated serious mental illness in the city. See Off. of the Mayor of N.Y.C., *Mayor Adams Announces Plan to Provide Care for Individuals Suffering From Untreated Severe Mental Illness Across NYC*, Posting to Office of the Mayor, N.Y.C. (Nov. 29, 2022), <https://www.nyc.gov/office-of-the-mayor/news/870-22/mayor-adams-plan-provide-care-individuals-suffering-untreated-severe-mental-il> (announcing

implementation plan and legislative agenda); Andy Newman & Emma G. Fitzsimmons, *New York City to Involuntarily Remove Mentally Ill People From Streets*, N.Y. TIMES (June 20, 2023), <https://www.nytimes.com/2022/11/29/nyregion/nyc-mentally-ill-involuntary-custody.html> (summarizing Mayor Adams's announcement). Specifically, the policy encourages implementation of state statutes permitting law enforcement, clinicians, and other authorized persons to "remove or direct the removal of any person to a hospital for the purpose of evaluation for admission if such person appears to be mentally ill and is conducting themselves in a manner likely to result in serious harm to the person or others." Press Release, N.Y.C., *Mental Health Involuntary Removals*, N.Y.C. (Nov. 28, 2022), <https://www.nyc.gov/assets/home/downloads/pdf/press-releases/2022/Mental-Health-Involuntary-Removals.pdf>. The announcement of the policy generated criticism and "sparked controversy from stakeholder and advocacy groups over concerns that it could deprive unhoused persons of their liberty and further deter individuals with SMI from seeking mental health treatment." CONG. RSCH. SERV., *supra* note 14, at 2; see, e.g., *Testimony Regarding Oversight of Mental Health Involuntary Removals and Mayor Adams' Recently Announced Plan*, N.Y.C.L. UNION (Feb. 6, 2023), <https://www.nyclu.org/en/publications/testimony-regarding-oversight-mental-health-involuntary-removals-and-mayor-adams>; *Testimony Regarding Mental Health Involuntary Removals and Mayor Adams' Recently Announced Plan*, N.Y.C. BAR (Feb. 6, 2023), [https://www.nycbar.org/member-and-career-services/committees/reports-listing/reports/detail/mental-health-involuntary-removals-nyc-mayoradamsplan#:~:text=The%20NYC%20Removal%20Directive%20purports,extent%20that%20causes%20them%20harm](https://www.nycbar.org/member-and-career-services/committees/reports-listing/reports/detail/mental-health-involuntary-removals-nyc-mayoradamsplan#:~:text=The%20NYC%20Removal%20Directive%20purports,extent%20that%20causes%20them%20harm;); Lanya Snyder, *New York's Directive for Mental Health Involuntary Removals: The Intersectional Risk for Unhoused New Yorkers with a Serious Mental Illness*, 21 COLUM. SOC. WORK REV. 3, 4 (2023), <https://journals.library.columbia.edu/index.php/cswr/article/view/11201/5553>. A federal district court dismissed a legal challenge to the new policy for lack of standing in late January 2023. *Baerga v. City of N.Y.*, No. 21-CV-05762, 2023 WL 1107633, at *1 (S.D.N.Y. Jan. 30, 2023). It is important to note, however, that the New York City policy announcement did not involve any changes to New York's existing statutory criteria for emergency interventions. As one analysis observed:

The laws about involuntary hospitalization have not changed. Mental health workers, paramedics and the police have long been able to forcibly take people to the hospital if they appear mentally ill and are endangering themselves or others, and New York courts have held since the 1980s that being a danger to oneself includes not being able to take care of basic needs such as food, shelter and health care. What the mayor has mandated is a shift in practice, training and discretion.

Andy Newman & Joseph Goldstein, *Can New York's Plan for Mentally Ill Homeless People Make a Difference*, N.Y. TIMES (Dec. 15, 2022), <https://www.nytimes.com/article/nyc-homeless-mental-health-plan.html>.

In addition, for a further explanation of Mayor Adams's policy statement, see Brian Stettin & Norm Ornstein, *The Truth Behind the Adams Plan on Serious Mental Illness*, N.Y. DAILY NEWS (Dec. 20, 2022, 10:00 AM), <https://www.nydailynews.com/opinion/ny-oped-serious-mental-illness-20221220-irouakmrveqvcfig4v7tcnxa-story.html>. The authors observed that the directive was intended to clarify for the city's mobile crisis clinicians and first responders:

[T]he process for transporting an individual for hospital evaluation and amplifying longstanding New York case law which has recognized the legality of involuntary intervention when mental illness makes a person a danger to themselves by preventing them from meeting their basic needs of food, clothing, shelter, or medical care. The directive aims to conquer a pervasive myth, which too often thwarts care for people in obvious crisis, that the legal standard always requires an evident threat of violence, suicide or imminent harm.

Id. They also observed that the plan was:

[N]arrowly focused on meeting the urgent needs of a small subset of the unsheltered whose mental illness places them in danger. Many suffer from anosognosia . . . [and] [o]ften delusional, they resist voluntary treatment for diseases they don't know they have and their symptoms, left untreated, become ever more ruinous.

Id.

B. Default to Outpatient Treatment Orders

The Workgroup's report also includes a recommendation that a court's order directing mental health treatment default, ordinarily, to requiring outpatient treatment services.⁴¹ Subsection 2 of the proposed statutory language provides: "The court shall order treatment of a person requiring court-ordered treatment in an outpatient setting unless the court determines that outpatient treatment will not provide reasonable assurances for the safety of the individual or others or will not meet the person's treatment needs."⁴² Correspondingly, in the report's section on procedural recommendations, the drafters suggest the following discretion for courts: "If the court finds that the individual meets the statutory criteria, it should have authority to order placement of the individual in an inpatient or outpatient treatment setting, or a combination of both, depending on their assessed clinical need."⁴³

The Workgroup was intentional in recommending that the three alternative criteria for court-ordered mental health treatment apply to both inpatient and outpatient treatment orders.⁴⁴ First, doing so "obviate[d] the need for a separate provision for Assisted Outpatient Treatment (AOT)."⁴⁵ In

⁴¹ MODEL LEGAL PROCESSES, *supra* note 8, at 8.

⁴² *Id.*

⁴³ *Id.* at 11.

⁴⁴ See *id.* at 10 (reasoning that "[r]ather than having a distinct process for outpatient court-ordered treatment, the standard to invoke all non-emergency involuntary mental health treatment would be the same"). Most states authorize outpatient commitment orders, but only about half of those states have identical statutory criteria for both inpatient and outpatient treatment orders. See DORIS A. FULLER & DEBRA A. PINALS, NAT'L CTR. FOR STATE CTS., MENTAL HEALTH FACTS IN BRIEF—ASSISTED OUTPATIENT TREATMENT (AOT) COMMUNITY-BASED CIVIL COMMITMENT 1 (2020), https://www.ncsc.org/_data/assets/pdf_file/0026/16964/mhf2-assisted-outpatient-treatment-jan-2020.pdf (noting that "AOT in some form is authorized by statute in 47 states and the District of Columbia" and that "[i]n about half the states with AOT statutes, statutory criteria for inpatient and outpatient commitment are identical"). The authors acknowledged that AOT is "unevenly practiced and not available everywhere it is allowed" by statute. *Id.*

⁴⁵ MODEL LEGAL PROCESSES, *supra* note 8, at 10. With regard to AOT, the report recognized that "a number of jurisdictions have added a more direct role for judicial oversight [of outpatient treatment orders] and encouragement of the person and their treatment." *Id.* A detailed discussion of AOT is beyond the scope of this Article. In brief, as the Treatment Advocacy Center has described:

Assisted Outpatient Treatment (AOT) is the practice of providing outpatient treatment under civil court order to individuals with SMI who have demonstrated difficulty engaging with treatment on a voluntary basis. When systematically implemented and adequately resourced, AOT can dramatically reduce hospitalization, criminalization and other adverse outcomes for its target population. Although AOT is authorized by law in nearly every state, most states have a substantial unmet need for programmatic implementation on a local level.

Assisted Outpatient Treatment, TREATMENT ADVOC. CTR., <https://www.treatmentadvocacycenter.org/aot> (last visited June 13, 2023).

For more discussion and descriptions of AOT processes in two states, Ohio and Texas, see Treatment Adv. Ctr et al., *Ohio A.O.T. Implementation Manual: Developing an Effective Assisted Outpatient*

addition, because the proposal includes as a default position that a court should order treatment in an outpatient setting and only consider an inpatient order upon determining “that outpatient treatment will not provide reasonable assurances for the safety of the individual or others or will not meet the person’s treatment needs,” the members of the Workgroup were not persuaded that different standards would be appropriate.⁴⁶

The Model Legal Processes Workgroup’s recommendation that courts default to an outpatient treatment order unless the foregoing factors are present is laudable but, in some ways, remains aspirational. As the Workgroup commented, “Section 2 makes explicit the presumption for treatment in the least restrictive environment [(outpatient versus inpatient)].”⁴⁷ Almost all states have enacted statutory authorization for outpatient commitment orders.⁴⁸ As supported by clinical experience and research, “involuntary outpatient commitment can be effective when systematically and effectively implemented, linked to intensive outpatient services and prescribed for extended periods of time.”⁴⁹ The American Psychiatric Association has declared the following regarding AOT:

Involuntary outpatient commitment, if systematically implemented and resourced, can be a useful tool to promote recovery through a program of intensive outpatient services designed to improve treatment adherence, reduce relapse and re-hospitalization, and decrease the likelihood of dangerous

Treatment Program [hereinafter *Ohio A.O.T. Implementation Manual*], <https://www.treatmentadvocacycenter.org/storage/documents/aot-implementation-documents/ohio-aot-implementation-manual.pdf> (last visited Nov. 3, 2023); BRIAN STETTIN ET AL., TREATMENT ADVOC. CTR. ET AL., TEXAS AOT PRACTITIONER’S GUIDE (2022) [hereinafter TEXAS AOT PRACTITIONER’S GUIDE], https://www.treatmentadvocacycenter.org/storage/tac%20texas%20aot%20guide_final_6-2022.pdf (co-authored by the Author of this Article). As noted in a recent summary discussion of AOT, “[a]s research has emerged indicating AOT can improve outcomes for specific at-risk populations, the model has been endorsed by a variety of public agencies and national organizations and become more widely implemented.” FULLER & PINALS, *supra* note 44, at 1.

⁴⁶ MODEL LEGAL PROCESSES, *supra* note 8, at 8 (quoting from paragraph two of the proposed statutory language for court-ordered mental health treatment).

⁴⁷ *Id.* at 10.

⁴⁸ See GRADING THE STATES, *supra* note 15, at 22 (indicating that as of 2020 all states except for Connecticut, Maryland, and Massachusetts “authorize some form of outpatient civil commitment”).

⁴⁹ MARVIN S. SWARTZ ET. AL., AM. PSYCHIATRIC ASS’N, RESOURCE DOCUMENT ON INVOLUNTARY OUTPATIENT COMMITMENT AND RELATED PROGRAMS OF ASSISTED OUTPATIENT TREATMENT 15 (2015), <https://smiadviser.org/wp-content/uploads/2019/07/Resource-document-on-Involuntary-outpatient-commitment-2015-10-20.pdf>. The American Psychiatric Association has further observed, “Based on empirical findings and on accumulating clinical experience, involuntary outpatient commitment can be a useful tool in the effort to treat patients with severe mental illness with clinical histories of relapse and re-hospitalization.” See APA POSITION STATEMENT, *supra* note 28.

behavior or severe deterioration among a sub-population of patients with severe mental illness.⁵⁰

Notwithstanding the proven success of well-designed AOT programs, however, researchers have observed that “the practice has been inconsistently implemented” and that “[m]any states make little use of OPC [(outpatient commitment)] laws and do not specifically fund or evaluate OPC programs.”⁵¹ As examples, consider Texas and Pennsylvania. As described in the 2022 *Texas AOT Practitioner’s Guide*, “Texas is home to one of the nation’s pioneering AOT programs (established in Bexar County [San Antonio] in 2005), as well as a handful of newer programs established since 2016 in counties such as Harris, Travis, Tarrant, Smith, Johnson, and El Paso.”⁵² Although this recent advent of additional AOT programs in portions of Texas is a great start toward broadening the presence of AOT in the state, there are 254 counties state-wide and much more can be done.⁵³

Another example may be found in Pennsylvania. The state’s legislature enacted AOT legislation in 2018, but implementation has proceeded slowly.⁵⁴ Counties, for example, were able to opt out of implementing AOT programs and, initially, there was no targeted funding.⁵⁵ More recently, however,

⁵⁰ See *id.* (the first of fifteen principles advanced by the association). For a detailed discussion of the history and evolution of outpatient commitment, see SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., CIVIL COMMITMENT AND THE MENTAL HEALTH CARE CONTINUUM: HISTORICAL TRENDS AND PRINCIPLES FOR LAW AND PRACTICE 12–21 (2019) [hereinafter CARE CONTINUUM], <https://www.samhsa.gov/sites/default/files/civil-commitment-continuum-of-care.pdf>. Successful AOT programs depend on “collaborations between local mental health agencies and civil courts to systematically identify individuals who meet legal criteria for AOT, ensure due process of law, and provide each participant high-quality treatment and services with court oversight.” TEXAS AOT PRACTITIONER’S GUIDE, *supra* note 45, at 5. For a further discussion of the necessary key players in developing a successful AOT program, including “collaboration between the local court with jurisdiction over civil commitment cases and the local publicly-funded agency or organization responsible for community-based mental health services,” see *AOT Implementation FAQ*, TREATMENT ADVOC. CTR., <https://www.treatmentadvocacycenter.org/component/content/article/180-fixing-the%09system/3616-aot-implementation-faq> (last visited June 14, 2023) (describing the “essential players in an AOT program” and their roles).

⁵¹ Marvin S. Swartz et al., *Involuntary Outpatient Commitment and the Elusive Pursuit of Violence Prevention*, 62 CAN. J. PSYCHIATRY 102, 103 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5298526/pdf/10.1177_0706743716675857.pdf.

⁵² TEXAS AOT PRACTITIONER’S GUIDE, *supra* note 45, at 5.

⁵³ To that end, the co-authors of the 2022 TEXAS AOT PRACTITIONERS GUIDE developed the publication to “help more counties follow suit” and “to distill what Texans planning to implement and practice AOT in their own communities need to know about the relevant state law and the experience of other programs.” *Id.*

⁵⁴ See Mental Health Procedures Act—Omnibus Amendments, 2018 Pa. Laws 690, No. 106, <https://www.legis.state.pa.us/cfdocs/legis/li/uconsCheck.cfm?yr=2018&sessInd=0&act=106> (authorizing the use of AOT).

⁵⁵ See Juliette Rihl, *PA’s Controversial Mental Health Law on Involuntary Treatment Stands to Get a Test Run More Than 3 Years After Its Passing*, PUBLICSOURCE (July 5, 2022),

several counties within the state have developed AOT pilots after obtaining grant funding.⁵⁶ As with Texas, this is not intended to be critical of the pace of development of AOT programs in Pennsylvania, but to underscore the point that requiring a court to default to an outpatient commitment order might not yet be practical in many jurisdictions given the uneven presence of AOT programs. Nonetheless, as described by Judge Milt Mack, a member of both the Model Legal Processes Workgroup and the National Judicial Task Force, in referencing the Workgroup's recommended default to outpatient orders:

The existing legal framework for addressing mental illness is an inpatient model in an outpatient world, because its focus is on hospitalization. By promoting earlier intervention and making outpatient treatment the presumptive course of treatment, we are finally converting our system to an outpatient model in an outpatient world.⁵⁷

In recommending procedures for entering mandatory treatment orders, the Model Legal Processes Workgroup recognized that courts should be able to order placement either in an AOT program or an inpatient facility, or a combination of both. Specifically, the Workgroup recommended including the following language for placement options: "If the court finds that the individual meets the statutory criteria, it should have authority to order placement of the individual in an inpatient or outpatient treatment setting, or a combination of both, depending on their assessed clinical need."⁵⁸ As supporting commentary for this recommendation, the Workgroup explained "[h]aving placement options and a continuum of appropriate related services is a key part of achieving successful outcomes."⁵⁹

<https://www.publicsource.org/pa-aot-mental-health-involuntary-treatment-302/> (describing challenges in implementation including "a lack of funding and staff to unanswered logistical questions").

⁵⁶ Brett Sholtis, *Bucks Among Counties to Test Out Mental Health Pilot Program*, LEVITTOWNNOW.COM (Sept. 21, 2021), <https://levittownnow.com/2021/09/22/bucks-among-counties-to-test-out-mental-health-pilot-program/>.

⁵⁷ NAT'L JUD. TASK FORCE REPORT, *supra* note 3, at 31.

⁵⁸ MODEL LEGAL PROCESSES, *supra* note 8, at 11.

⁵⁹ *Id.* at 2. The report also emphasized the need for collaboration, coordination, and communications among the three branches of government and at both state and local levels. *See id.* at 11 (recommending collaboration and including "oversight structures"). The goal and concept of a robust continuum of care for persons with serious mental illness is not new. *See* DEBRA A. PINALS & DORIS A. FULLER, NAT'L ASS'N OF STATE MENTAL HEALTH PROGRAM DIRS. & TREATMENT ADVOC. CTR., BEYOND BEDS: THE VITAL ROLE OF A FULL CONTINUUM OF PSYCHIATRIC CARE 1-2 (2017), <https://www.treatmentadvocacycenter.org/storage/documents/beyond-beds.pdf> (recommending a robust continuum of both community mental health services and inpatient psychiatric beds, including criminal justice diversion).

C. Michigan

Although relatively novel, the inclusion of a capacity prong as an alternative basis for court-ordered mental health treatment is not unique to the recommendations of the Model Legal Processes Workgroup. Notably, Michigan revised its mental health code statutes in 2018 to add a “lack of understanding of the need for treatment [because of the person’s mental illness]” as a basis for court-ordered mental health treatment.⁶⁰ The revised Michigan statute defines a “person requiring treatment” as someone who meets any of the following three definitions:

- (a) An individual who has mental illness, and who as a result of that mental illness can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure himself, herself, or another individual, and who has engaged in an act or acts or made significant threats that are substantially supportive of the expectation.
- (b) An individual who has mental illness, and who as a result of that mental illness is unable to attend to those of his or her basic physical needs such as food, clothing, or shelter that must be attended to in order for the individual to avoid serious harm in the near future, and who has demonstrated that inability by failing to attend to those basic physical needs.
- (c) An individual who has mental illness, whose judgment is so impaired by that mental illness, and whose lack of understanding of the need for treatment has caused him or her to demonstrate an unwillingness to voluntarily participate in or adhere to treatment that is necessary, on the basis of competent clinical opinion, to prevent a relapse or harmful deterioration of his or her condition, and presents a substantial risk of significant physical or mental harm to the individual or others.⁶¹

Subsections (a) and (b) of the Michigan statute are largely in line with typical “danger to self or others” and grave disability bases for court intervention, and were not revised by the 2018 legislation.⁶² Subsection (c),

⁶⁰ See 2018 Mich. Pub. Acts 593 (revising, *inter alia*, MICH. COMP. LAWS § 330.1401(1)(c) (2023)). The 2018 legislation revised a previous effort in 2016 to amend the Michigan commitment standards to include a prong pertaining to a person’s inability to understand the need for treatment. See 2016 Mich. Pub. Acts 320.

⁶¹ MICH. COMP. LAWS § 330.1401(1)(a)–(c)(2023).

⁶² See GRADING THE STATES, *supra* note 15, at 4, 13 (describing a “grave disability” alternative basis for court-ordered treatment as a type of self-harm pertaining to a person’s “failure to meet basic

however, represents a change in focus to “recognize[] that untreated mental illness may itself create a risk of harm due to relapse or harmful deterioration of a person’s condition because of the individual’s lack of understanding of their need for treatment.”⁶³

Michigan’s three alternative criteria apply to both inpatient and outpatient proceedings.⁶⁴ Michigan also permits an order for “combined hospitalization and assisted outpatient treatment.”⁶⁵ Moreover, as Judge Milt Mack, the Michigan State Court Administrator Emeritus, has observed, “Michigan’s new standard [in subsection (c)] focuses on the risk of harm due to the individual’s lack of insight into their need for and refusal to accept treatment.”⁶⁶ He added, “This change in the law shifted the court’s focus from a person’s *conduct* to a person’s *capacity* to understand their need for treatment.”⁶⁷ Similarly, the recommendation by the Model Legal Processes Workgroup adds an alternative criterion for court-ordered mental health treatment relating to the person’s capacity. Specifically, the recommended criterion focuses on a person’s lack of “capacity to recognize that they are experiencing symptoms of a serious mental illness and therefore are unable to” weigh and make treatment decisions that could avoid “a relapse or deterioration” in their condition.⁶⁸ By way of further comparison, the Michigan statute “recognizes that untreated mental illness may itself create a risk of harm due to relapse or harmful deterioration of a person’s condition because of the individual’s lack of understanding of their need for

needs for survival (food, clothing, shelter) due to mental illness”). For the 2018 mark-up specifying the amendments to § 330.1401(1), see S. Substitute 5810, 2018 Leg., at 13 (Mich. 2018), <http://www.legislature.mi.gov/documents/2017-2018/billconcurrent/House/pdf/2018-HCB-5810.pdf>.

⁶³ Milton L. Mack, Jr., *Michigan’s Mental Health Code Reforms*, 55 TEX. TECH L. REV. 33, 41 (2022). Judge Mack was a member of the Model Legal Processes Workgroup and was a key leader in the Workgroup’s consideration of including a similar lack of capacity alternative as part of the workgroup’s recommendations.

⁶⁴ See MICH. COMP. LAWS § 330.1472a (2023) (setting forth provisions relating to court-ordered mental health treatment that are all applicable to “a finding that an individual is a person requiring treatment”). Note that Michigan’s three criteria set forth in § 330.1401(1)(a)–(c) are alternatives, but more than one of the criteria might be satisfied in a particular case. See *In re Tchakarova*, 936 N.W.2d 863, 868–70 (Mich. Ct. App. 2019) (affirming probate court order for involuntary mental health treatment based on findings under both criteria (a) and (c)). As to the capacity criterion, the *Tchakarova* court found persuasive certain medical testimony that the proposed patient “was so impaired that she was unable to understand the need for treatment” including “delusions related to stalking professors on college campuses” and leaving “the county or the country to avoid treatment.” *Id.* at 870.

⁶⁵ See MICH. COMP. LAWS § 330.1472a(1)(c) (1974).

⁶⁶ Mack, *supra* note 63, at 40.

⁶⁷ *Id.* at 41.

⁶⁸ MODEL LEGAL PROCESSES, *supra* note 8, at 8.

treatment.”⁶⁹ As Judge Mack summarized, the Michigan “Code is finally designed to permit intervention without waiting for a crisis.”⁷⁰

D. Other States

Several other states have incorporated a “lack of capacity” component as a part of their civil commitment statutes. For example, Arizona has specifically codified a lack of capacity element in its psychiatric deterioration alternative for court intervention.⁷¹ Described as “a good example of psychiatric deterioration criteria,”⁷² the Arizona law authorizing court-ordered mental health treatment includes the following definition:

“Persistent or acute disability” means a severe mental disorder that meets all the following criteria:

- (a) Significantly impairs judgment, reason, behavior or capacity to recognize reality.
- (b) If not treated, has a substantial probability of causing the person to suffer or continue to suffer severe and abnormal mental, emotional or physical harm.
- (c) Substantially impairs the person’s capacity to make an informed decision regarding treatment, and this impairment causes the person to be incapable of understanding and expressing an understanding of the advantages and disadvantages of accepting treatment and understanding and expressing an understanding of the alternatives to the particular treatment offered after the advantages, disadvantages and alternatives are explained to that person.

⁶⁹ Mack, *supra* note 63, at 41.

⁷⁰ *Id.* at 43. Similarly, consider the following analogy by the Treatment Advocacy Center regarding the need for timely treatment: “Just as it would be medically irresponsible to treat heart disease only after an individual suffers a heart attack, legislatures should not create needless statutory hurdles to early intervention, particularly for early episodes of psychosis.” GRADING THE STATES, *supra* note 15, at 22.

⁷¹ See ARIZ. REV. STAT. § 36-501(33) (2023) (defining “persistent or acute disability”); *id.* § 36-540(A) (authorizing court orders for either outpatient mental health treatment or a combination of inpatient and outpatient treatment upon proof “by clear and convincing evidence that the proposed patient, as a result of mental disorder, is a danger to self, is a danger to others or has a persistent or acute disability or a grave disability and is in need of treatment, and is either unwilling or unable to accept voluntary treatment”). In contrast, note that an alternative basis for court intervention pertaining to a person’s “grave disability” is focused on whether the “person, as a result of a mental disorder, is likely to come to serious physical harm or serious illness because the person is unable to provide for the person’s own basic physical needs.” *Id.* § 36-501(16).

⁷² GRADING THE STATES, *supra* note 15, at 20.

(d) Has a reasonable prospect of being treatable by outpatient, inpatient or combined inpatient and outpatient treatment.⁷³

Accordingly, comparable to both the Michigan statute and the Model Legal Processes proposal, Arizona's court-ordered treatment laws permit intervention if the symptoms of a person's mental illness substantially impair their capacity to appreciate the advantages or disadvantages of treatment.⁷⁴

Somewhat similarly, albeit more obscurely, Missouri includes language relating to a person's "impairment in his [or her] capacity to make decisions with respect to his [or her] hospitalization and need for treatment as evidenced by his [or her] current mental disorder or mental illness."⁷⁵ This capacity provision, is tied, in part, to whether the person is able to attend to "basic necessities of food, clothing, shelter, safety or medical care," but the lack of capacity language alternatively modifies whether the person is able "to provide for his [or her] own mental health care, which may result in a substantial risk of serious physical harm."⁷⁶ Although less clear than the Model Legal Processes Workgroup's recommendation of a separate, stand-alone criterion relating solely to a person's lack of capacity, Missouri appears to have enacted a comparable concept.⁷⁷

South Carolina also includes a commitment criterion that focuses on a person's lack of capacity due to mental illness, and the relevant South

⁷³ ARIZ. REV. STAT. § 36-501(33) (2023).

⁷⁴ See *supra* notes 60–70 and accompanying text (discussing Michigan provision); *supra* notes 29–34 and accompanying text (discussing Model Legal Processes' proposal relating to a person's lack of capacity because of untreated mental illness).

⁷⁵ MO. REV. STAT. § 632.005(10)(b) (2023).

⁷⁶ *Id.* In full, the relevant Missouri provision defines likelihood of serious harm to self as:

A substantial risk that serious physical harm to a person will result or is occurring because of an impairment in his capacity to make decisions with respect to his hospitalization and need for treatment as evidenced by his current mental disorder or mental illness which results in an inability to provide for his own basic necessities of food, clothing, shelter, safety or medical care or his inability to provide for his own mental health care which may result in a substantial risk of serious physical harm. Evidence of that substantial risk may also include information about patterns of behavior that historically have resulted in serious harm to the person previously taking place because of a mental disorder or mental illness which resulted in his inability to provide for his basic necessities of food, clothing, shelter, safety or medical or mental health care.

Id.

⁷⁷ See *supra* notes 29–34 and accompanying text (quoting and discussing the workgroup's proposal for a lack of capacity criterion). It should be noted, however, that the state's own mental health agency describes the criterion on its website more narrowly as the person's inability "to make decisions regarding hospitalization or treatment as evidenced by not providing for basic necessities of food, clothing, shelter, safety, or medical care." *Civil Involuntary Detention*, MO. DEP'T MENTAL HEALTH, <https://dmh.mo.gov/behavioral-health/help/civil#do> (last visited June 22, 2023).

Carolina statute is much simpler and cleaner.⁷⁸ Under South Carolina law, a court may order outpatient or inpatient mental health care upon finding that the person has a mental illness, “needs involuntary treatment[,] and because of his [or her] condition: (1) lacks sufficient insight or capacity to make responsible decisions with respect to his [or her] treatment; or (2) there is a likelihood of serious harm to himself [or herself] or others.”⁷⁹ South Carolina’s focus on a person’s lack of insight or capacity with regard to mental health treatment decisions is directly responsive to addressing the very common symptom of anosognosia, or a lack of insight.⁸⁰

In sum, the Model Legal Processes Workgroup’s recommendation to include as one alternative criterion for court-ordered mental health treatment an assessment of the person’s capacity to recognize their symptoms of a serious mental illness and corresponding impact on decision-making regarding treatment is neither novel nor unique. As described above, several states currently have statutory provisions along those lines.⁸¹ Given the Workgroup’s recommendation, however, it can be hoped that more states will follow suit.

III. EMERGENCY PSYCHIATRIC INTERVENTION

In addition to making recommendations relating to the standard for court-ordered mental health treatment, the Model Legal Processes Workgroup developed new guidance language for emergency psychiatric interventions.⁸² As with the Workgroup’s proposed criteria for court-ordered mental health treatment, the language recommended for initial emergency psychiatric assessments includes alternatives focused on danger to self or

⁷⁸ S.C. CODE ANN. § 44-17-580(A)(1) (2023).

⁷⁹ *Id.* §44-17-580(A).

⁸⁰ See *supra* notes 21–24 and accompanying text.

⁸¹ See *supra* notes 60–80 and accompanying text (describing similar provisions in Michigan, Arizona, Missouri, and South Carolina). For additional variations, see ARK. CODE ANN. § 20-47-207(c)(2) (D)(i)–(ii) (2023) (including, as part of a deterioration criterion for commitment, language requiring a determination that “[t]he person’s understanding of the need for treatment is impaired to the point that he or she is unlikely to participate in treatment voluntarily” and that mental health treatment is needed “on a continuing basis to prevent a relapse or harmful deterioration of his or her condition”); KAN. STAT. ANN. § 59-2946(f)(2) (2023) (providing a detailed definition of “[l]acks capacity to make an informed decision concerning treatment” that includes a person’s inability, due to mental illness, to understand the need for treatment or “to engage in a rational decision-making process regarding hospitalization or treatment”). On the other hand, this lack of capacity provision is not an independent basis for court ordered care in Kansas, but instead must be demonstrated in addition to proof of dangerousness to self or others. See *id.* § 59-2946(f)(1) (defining a “[m]entally ill person subject to involuntary commitment for care and treatment” as an individual with mental illness who also “[l]acks capacity to make an informed decision concerning treatment,” is “likely to cause harm to self or others,” and does not have one of several excluded disorders).

⁸² See MODEL LEGAL PROCESSES, *supra* note 8, at 11–18 (providing suggested statutory language and commentary).

others, the inability to provide for basic needs, or an inability “to recognize symptoms or appreciate the risks or benefits of treatment.”⁸³ Specifically, the recommended criteria for an initial emergency psychiatric assessment include the following:

a. A legally empowered person may initiate the process of obtaining an emergency assessment of an individual if there is good cause to believe that, as a result of mental illness and based on the individual’s recent actions, omission, or behaviors, the individual:

(1) poses a substantial risk of

- i. attempting suicide or inflicting serious self-injury;
- ii. causing or inflicting injury on others or engaging in threatening behavior or verbal threats that arouses fear of serious harm to self or others;
- iii. being unable to provide for immediate essential needs such as food, clothing, or shelter;
- iv. being unable to protect self from victimization by others; or
- v. being unable to exercise sufficient behavioral control to avoid criminal justice involvement, or

(2) is unable to recognize symptoms or appreciate the risks and benefits of treatment and, as a result, is unable or unwilling to adhere to treatment and attempts have been made to engage the person in receiving person-centered health care and a continuum of supports and services, placing them at substantial risk of a serious deterioration in their mental condition in the near future that would result in their meeting one or more of the criteria specified in (1).⁸⁴

For purposes of the foregoing recommended criteria, the Workgroup defined “mental illness” to include not only those mental illnesses identified in the Diagnostic and Statistical Manual, but also “people with substance-induced mental illness, co-occurring mental illness and substance use and/or substance use disorders, and/or cognitive disability, and/or other medical conditions or disabilities contributing to the [person’s] symptoms or behaviors.”⁸⁵ The drafters also commented that “‘good cause’ may be based on an examination of the individual, observation of the individual’s behavior,

⁸³ *Id.* § 3(a)(2), at 13.

⁸⁴ *Id.* § 3(a).

⁸⁵ *Id.* § 2(d), at 12.

and information provided by third parties, including family members, associates, or others who have observed the person's behavior."⁸⁶ That is, good cause can be determined based on first-hand observation or hearsay information provided by third parties.⁸⁷

This Section will address various aspects of the Workgroup's recommendations surrounding emergency psychiatric assessments, including those persons authorized to initiate the emergency intervention, expectations regarding transportation to appropriate emergency facilities, and the timing, duration, and ensuing proceedings.

A. Authorized Persons

The proposed statutory language authorizing an emergency psychiatric assessment provides that a "legally empowered person may initiate the process."⁸⁸ In turn, the Workgroup broadly defined "legally empowered person[s]" for purposes of the proposed statute to include:

- (1) physicians, nurse practitioners, advanced practice nurses, and physician assistants;
- (2) health care providers with expertise in diagnosing and treating mental illness, including but not limited to psychiatrists, advanced practice nurses with psychiatric expertise, psychiatric nurse practitioners, licensed clinical psychologists, licensed clinical social workers, and licensed professional counselors;
- (3) judges and other quasi-judicial officers such as a magistrate or magistrates;
- (4) law enforcement personnel and emergency medical personnel[;] and
- (5) legal guardians of the individual subject to treatment under this provision.⁸⁹

Although it is not altogether unusual for an emergency intervention statute to authorize a wide array of individuals to be able to petition a court to seek an emergency hold, "[t]here is significant variation across the states on who is authorized to initiate emergency evaluation."⁹⁰ Some limit

⁸⁶ *Id.* § 3(a), at 13.

⁸⁷ This approach is not dissimilar from, for example, the Texas emergency detention statutes that permit a peace officer to initiate an emergency detention of a person with mental illness who meets the state's criteria based on the officer's observations or based on "a representation of a credible person." TEX. HEALTH & SAFETY CODE ANN. § 573.001(c)(1) (West 2023).

⁸⁸ MODEL LEGAL PROCESSES, *supra* note 8, § 3(a), at 13.

⁸⁹ *Id.* § 2(c), at 12.

⁹⁰ GRADING THE STATES, *supra* note 15, at 16.

authorization to law enforcement, while others include categories such as family members or mental health care providers.⁹¹ “Others authorize any responsible adult with the necessary knowledge of a person’s circumstances”⁹²

Importantly, in listing the various categories of persons who are identified as “legally empowered persons,” the Model Legal Processes Workgroup was intentional in authorizing the initiation of an emergency psychiatric intervention without first requiring a court petition or limiting immediate intervention and transport to law enforcement. Specifically, the Workgroup recommended the following statutory approach: “To initiate the process of obtaining an emergency assessment, the legally empowered person may, if it is safe to do so, directly transport the person or may contact the authorized transport . . . , and, if the latter, should provide to the transporting authority, in writing or orally, the reason for the finding.”⁹³ This approach permits a wide array of mental health care providers and professionals such as physicians, nurses, psychologists, social workers, and counselors to be empowered to respond to a psychiatric emergency and, when safe to do so, take the person directly to an appropriate facility for an emergency psychiatric assessment.⁹⁴ In certain situations, however, when deemed unsafe, the proposed language authorizes initiation and transport by law enforcement.⁹⁵

The Workgroup’s proposal is not unique in this regard. Several states currently permit various medical and mental health professionals to initiate an emergency assessment. For example, in addition to law enforcement officers, Ohio authorizes psychiatrists, physicians, psychologists, and certain

⁹¹ See *id.* at 16–17 (discussing various categories of permissible initiating parties).

⁹² *Id.* at 17. For example, under Texas law any “adult may file a written application for the emergency detention of another person.” TEX. HEALTH & SAFETY CODE ANN. § 573.011(a) (2023). By way of contrast, however, under Texas law only a law enforcement officer or a person’s legal guardian may make a warrantless apprehension of a person for an emergency detention without filing a court application. See *id.* §§ 573.001, .003. Similarly, under Florida law an adult may petition a court to seek an order for an involuntary examination. FLA. STAT. § 394.463(2)(a)(1) (2023). Florida also permits law enforcement and certain mental health care providers to initiate an involuntary examination without first seeking court authority. *Id.* §§ 394.463(2)(a)(2)–(3). Other states, for example New Mexico and Tennessee, do not broadly authorize any adult to petition a court for an emergency intervention, but do allow peace officers and certain medical professionals to initiate an emergency evaluation without first going to a court. See TENN. CODE ANN. §§ 33-6-402, -404 (2023); N.M. STAT. ANN. § 43-1-10(A) (2023). For a chart summarizing the states’ various approaches to identifying those persons who may petition for an emergency evaluation, see GRADING THE STATES, *supra* note 15, at 38.

⁹³ MODEL LEGAL PROCESSES, *supra* note 8, at 13. The recommended statutory approach for appropriate transportation is discussed below in Section III.B. See *infra* notes 102–109 and accompanying text.

⁹⁴ See MODEL LEGAL PROCESSES, *supra* note 8, at 12 (listing a number of mental health and medical professionals as “legally empowered persons”).

⁹⁵ *Id.*

clinical nurse specialists and nurse practitioners to take a person who is in a mental health crisis to an appropriate hospital.⁹⁶ Similarly, Tennessee permits physicians, psychologists, and certain other designated mental health professionals to take persons in mental health crises “into custody without a civil order or warrant for immediate examination.”⁹⁷ Florida permits physicians, physician assistants, psychologists, psychiatric nurses, certain advanced practice nurses, mental health counselors, marriage and family therapists, and social workers to initiate the process for an involuntary examination.⁹⁸

Expanding upon the types of professionals who can initiate an emergency intervention and transport the person to an appropriate facility for an assessment is also consistent with efforts in recent years to deploy professionals other than, or in addition to, law enforcement in a mental health crisis. For example, communities are developing and utilizing mobile crisis outreach teams or co-responder teams to respond to mental health crisis calls.⁹⁹ Notable examples of the former include the CAHOOTS program in Oregon and the STAR program in Denver.¹⁰⁰ With regard to co-responder

⁹⁶ See OHIO REV. CODE ANN. § 5122.10(A)(1)(a)–(e) (LexisNexis 2023) (listing authorized professionals).

⁹⁷ TENN. CODE ANN. § 33-6-402 (2023).

⁹⁸ See FLA. STAT. § 394.463(2)(a)(3) (2023). The statute requires the professional to execute a certificate regarding the person’s condition and why “the person appears to meet the criteria for involuntary examination . . .” *Id.* Although the provision permits law enforcement to then transport the person to an appropriate facility, it also authorizes “other less restrictive means, such as voluntary appearance for outpatient evaluation . . .” *Id.*

⁹⁹ See Margaret E. Balfour et al., *Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies*, 73 PSYCHIATRIC SERVS. 658, 660 (2022), <https://ps.psychiatryonline.org/doi/epdf/10.1176/appi.ps.202000721> (describing mobile crisis teams as “typically one- or two-person teams composed of a combination of master’s-level clinicians, behavioral health technicians, or peers” who “meet patients where they are” in the community, and co-responder teams that pair police officers “with a clinician, peer, or other social services staff” for responding to mental health crisis calls).

¹⁰⁰ “CAHOOTS (Crisis Assistance Helping Out on the Streets) is a mobile crisis-intervention program” based in Eugene and Springfield, Oregon, which utilizes two-person crisis intervention teams that typically include “a crisis intervention worker who is skilled in counseling and de-escalation techniques, and a medic who is either an EMT or a nurse.” Ben Adam Climer & Brenton Gicker, *CAHOOTS: A Model for Prehospital Mental Health Crisis Intervention*, PSYCHIATRIC TIMES, Jan. 2021, at 15, 15, <https://www.psychiatristimes.com/view/cahoots-model-prehospital-mental-health-crisis-intervention>. In turn, Denver modeled its Support Team Assistance Response (STAR) program on the CAHOOTS program. Thomas S. Dee & Jaymes Pyne, *A Community Response Approach to Mental Health and Substance Abuse Crises Reduces Crime*, SCI. ADVANCES, June 10, 2022, at 1, 2, <https://www.science.org/doi/10.1126/sciadv.abm2106>. The STAR program:

[P]rovides a mobile crisis response for community members experiencing problems related to mental health, depression, poverty, homelessness, and/or substance abuse issues. The STAR response consists of two health care staff (i.e., a mental health clinician and a paramedic in a specially equipped van) who provide rapid, on-site

models involving the pairing of a peace officer with a clinician, recent interesting examples include those in Dallas and Galveston, Texas.¹⁰¹ Particularly, in the case of a mobile crisis outreach team in which law enforcement is not a part of the team responding to the mental health crisis, having statutory authority to initiate an emergency psychiatric intervention will be beneficial.

Correspondingly, by including judges and magistrates as “legally empowered persons,” the Workgroup has implicitly recognized that family members or other adults who are knowledgeable about the individual’s symptoms or circumstances can petition a court for an order for an emergency psychiatric assessment.

B. Transportation

Consistent with the proposed authorization for an array of legally empowered persons to initiate emergency psychiatric intervention, the Model Legal Processes Workgroup has urged that persons in need of being transported to an appropriate facility “should be transported to a location designated for an emergency psychiatric assessment by EMTs, paramedics,

support to individuals in crisis and direct them to further appropriate care including requesting police involvement, if necessary.

Id. A study of the STAR program revealed “robust evidence that the program reduced reports of targeted, less serious crimes (e.g., trespassing, public disorder, and resisting arrest) by 34%.” *Id.* at 1. For a further summary of the study, see Deon J. Hampton, *Denver’s Mental Health Approach to Low-Level 911 Calls Helped Reduce Minor Crimes, Researchers Find*, NBC NEWS (June 8, 2022, 8:41 PM), <https://www.nbcnews.com/news/us-news/denvers-mental-health-approach-low-level-911-calls-helped-reduce-minor-crimes-rcna32659>.

¹⁰¹ See Will Maddox, *How Meadows is Diversifying Crisis Response in Texas*, D MAG. (Mar. 21, 2023, 11:00 AM), <https://ps.psychiatryonline.org/doi/epdf/10.1176/appi.ps.202000721> (discussing the Dallas “Rapid Integrated Group Health Team, or RIGHT Care” co-responder program that provides mental health crisis response with a team that “includes a police officer, a licensed clinical social worker, a paramedic, and off-site clinicians”); Julie Wertheimer, *Galveston Expands Access to Crisis Care With New Response Teams*, PEW CHARITABLE TRS. (June 7, 2023), <https://www.pewtrusts.org/en/research-and-analysis/articles/2023/06/07/galveston-expands-access-to-crisis-care-with-new-response-teams> (describing the launch of a co-responder program in Galveston, Texas, “called Compassionate Open Access to Services and Treatment (COAST)” that utilizes a crisis response team which includes a paramedic, a trained police officer, and a licensed mental health clinician from the local mental health authority). For a detailed analysis of the Dallas RIGHT Care program, see MEADOWS MENTAL HEALTH POL’Y INST., MULTI-DISCIPLINARY RESPONSE TEAMS: TRANSFORMING EMERGENCY MENTAL HEALTH RESPONSE IN TEXAS (2021), <https://mmhpi.org/wp-content/uploads/2021/06/MDRT-Transforming-Crisis-Response-in-Texas.pdf>. In addition, for a description of the Harris County Sheriff’s Office’s long-time co-responder programs, see Wayne Parham, *10 Tips for Responding to Mental Health Crisis Calls*, POLICE MAG. (June 2, 2023), <https://www.policemag.com/patrol/blog/15539851/10-tips-for-responding-to-mental-health-crisis-calls> (noting that the department’s co-responder model began in 2011 and describing expanded efforts and program designs thereafter).

mobile crisis personnel, or other trained peers or crisis responders.”¹⁰² In addition, unless there are concerns about dangerousness or safety, the Workgroup recommended that law enforcement not be called for transporting the person.¹⁰³ Because an emergency psychiatric intervention is not a criminal matter, even when the situation requires law enforcement involvement, the Workgroup recommended the use of unmarked vehicles and discouraged the use of handcuffs or other physical restraints.¹⁰⁴

With regard to training expectations for individuals involved in transporting persons experiencing a mental health crisis, the drafters added the following commentary: “EMTs and paramedics responsible for routinely transporting individuals for emergency psychiatric assessments should complete Crisis Intervention Team (CIT) training or another certified training program in crisis de-escalation and the safe transportation of persons experiencing mental health crises.”¹⁰⁵ Similarly, although not referenced in the Workgroup’s legislative recommendations, if the emergency situation calls for law enforcement involvement because of safety concerns, it would be preferable for the responding officers to have received CIT training, or to deploy a co-responder team.¹⁰⁶

The legally empowered person who is initiating an emergency psychiatric intervention should, of course, transport, or arrange transportation for, the person to an appropriate facility for the initial emergency psychiatric assessment. In commentary, the Workgroup observed:

¹⁰² MODEL LEGAL PROCESSES, *supra* note 8, at 13. The model statutory language further defines Emergency Medical Technicians (EMTs) for purposes of crisis response as “state certified emergency responders trained to provide emergency medical care to people who are seriously ill or injured . . . [whose] responsibilities . . . include the transport of individuals to hospital emergency departments or other facilities responsible for providing emergency or crisis care.” *Id.* at 12.

¹⁰³ See *id.* at 13 (adding that “[l]aw enforcement officers should provide transport only when no other means are available to protect the safety of the individual or those providing the transport”).

¹⁰⁴ *Id.* Specifically, the recommended statutory language is the following: “Unmarked vehicles should be used whenever possible. Handcuffs or physical restraints should be used only as a last resort and limited to those persons who have been identified as risks to self or others without the use of restraints.” *Id.*

¹⁰⁵ *Id.* at 14.

¹⁰⁶ “The CIT training course requires an extensive 40-hour curriculum taught over five consecutive days. The course emphasizes understanding of mental illness and incorporates the development of communication skills, practical experience and role-playing.” *Training: Police-Mental Health Collaborative (PMHC) Toolkit*, BUREAU JUST. ASSISTANCE, <https://bja.ojp.gov/program/pmhc/training> (last visited June 22, 2023). NAMI has observed that “CIT reduces arrests of people with mental illness while simultaneously increasing the likelihood that individuals will receive mental health services” and can result in the “reduction of officer injuries during mental health crisis calls.” *Crisis Intervention Team (CIT) Programs*, NAMI, [https://www.nami.org/Advocacy/Crisis-Intervention/Crisis-Intervention-Team-\(CIT\)-Programs](https://www.nami.org/Advocacy/Crisis-Intervention/Crisis-Intervention-Team-(CIT)-Programs) (last visited June 22, 2023). For a summary of research on the effectiveness of CIT programs, see generally Michael S. Rogers et al., *Effectiveness of Police Crisis Intervention Training Programs*, J. AM. ACAD. PSYCHIATRY & L. (2019), <https://jaapl.org/content/early/2019/09/24/JAAPL.003863-19>.

One or more facilities or agencies within each region or mental health catchment area should be responsible for providing a safe, secure, welcoming space for conducting involuntary emergency psychiatric assessments. . . . These sites should be staffed by qualified mental health professionals [to conduct the emergency psychiatric assessments]. Additionally, they must have the capacity to provide basic medical screening and have relationships with emergency medical facilities for those individuals who require emergency medical interventions.¹⁰⁷

These facilities could include, for example, psychiatric hospitals, general hospital emergency departments, or other facilities established to provide emergency crisis care such as mental health crisis stabilization units.¹⁰⁸ Moreover, even when law enforcement is called to provide transportation, jails should never be used for these assessments.¹⁰⁹

C. Timing, Duration, and Subsequent Proceedings

The Model Legal Processes Workgroup recommended that “[e]mergency psychiatric assessments must be conducted by a qualified mental health professional” and “be initiated within 4 hours of arrival at an assessment site and shall be completed within 24 hours of arrival.”¹¹⁰ In turn, the “assessments may be provided either on site or through telehealth.”¹¹¹ The point is for a qualified mental health professional to conduct a psychiatric assessment promptly following the individual’s arrival at the facility.¹¹² The

¹⁰⁷ MODEL LEGAL PROCESSES, *supra* note 8, § 4, at 14.

¹⁰⁸ Crisis stabilization units are “also known as crisis and drop-off centers.” Rachel Lee, *4 Tips to Successfully Open a Crisis Stabilization Unit*, CSG JUST. CTR. (Sept. 8, 2020), <https://csgjusticecenter.org/2020/09/08/4-tips-to-successfully-open-a-crisis-stabilization-unit/>. For further discussion of facilities and services for mental health crisis response, see SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., NATIONAL GUIDELINES FOR BEHAVIORAL HEALTH CRISIS CARE: BEST PRACTICE TOOLKIT 22–24 (2020), <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>.

¹⁰⁹ See MODEL LEGAL PROCESSES, *supra* note 8, § 4, at 14 (commenting that “jails must not be used as an alternative to an appropriate assessment site, solely to detain persons who meet the criteria for emergency psychiatric assessment” and that “these provisions . . . [are intended] to prevent arrest as a mechanism to access care because there is no access to emergency psychiatric assessment”).

¹¹⁰ See MODEL LEGAL PROCESSES, *supra* note 8, §§ 5(a), (c), at 14–15. The workgroup recognized the possibility of the occasional exception to the time limits but limited them as follows: “Exceptions to these time requirements may be made only when medically necessary, and the facility must document that additional time is required in order to provide for safe transfer or discharge.” *Id.* § 5(c), at 15.

¹¹¹ *Id.* § 5(b), at 15.

¹¹² The proposed legislation broadly defines “qualified mental health professionals” to “include psychiatrists, psychiatric nurse practitioners, advance practice nurses with psychiatric training, physicians

purpose of the assessment is to assure that a qualified mental health professional may:

[D]etermine whether the person meets the criteria . . . for continued emergency assessment and intervention and, if so, whether the person needs continued treatment, the best type of facility or other setting in which to provide that treatment, consistent with the principle of using the least restrictive environment, and whether the individual will accept such treatment voluntarily.¹¹³

In addition, and not surprisingly, the Workgroup included language requiring that “[d]uring the period of the emergency psychiatric assessment, access to consultation with an appropriate psychiatric care provider must be available, in person or via telehealth, and appropriate treatment provided.”¹¹⁴ The designated facility “should provide or arrange for provision of treatment interventions to address the individual’s immediate health needs.”¹¹⁵

Upon a qualified mental health professional’s determination that a person meets the emergency treatment criteria, how long may the emergency mental health intervention continue? The Workgroup has recommended that “the individual may be held for up to an additional five calendar days in an appropriate facility or site.”¹¹⁶ Later in the proposed statutory language, the Workgroup stressed that the period for a “continuing emergency hold” could “continue up to, but no longer than 5 calendar days from the beginning of the assessment.”¹¹⁷

and physician assistants with psychiatric training, psychologists, and others defined in state laws as qualified to conduct emergency psychiatric assessments.” *Id.* § 2(e), at 12.

¹¹³ See *id.* § 5(a), at 14. (also referencing the criteria for continuing emergency assessment set forth in section 3(a) quoted above); *supra* note 8 and accompanying text. In further commentary, the workgroup expanded on the scope of these assessments, as follows:

This determination should consider not only the individual’s appearance and behavior in the evaluation facility but also the individual’s likely risks if discharged. The psychiatric assessment and determination of risk should also consider the contributions of cooccurring substance use, cognitive impairment, and medical issues that may exacerbate current or future risk. The evaluator should make every attempt to seek input from any care providers, family members, or others who have treated or observed the individual as part of the assessment, even absent the individual’s explicit consent.

Id. § 5(a), at 14.

¹¹⁴ *Id.* § 6, at 15.

¹¹⁵ *Id.*

¹¹⁶ *Id.* § 7(a), at 15. This assumes that “the individual continues to meet emergency treatment criteria of 3(a) and requires continued involuntary emergency mental health evaluation and intervention” *Id.*

¹¹⁷ *Id.* § 8(a), at 17.

The drafters recognized that the five-calendar-day (120 hour) hold period for emergency mental health interventions is longer than the period authorized in many states, but the timeframe is also not unique. In their 2020 survey of the nation's emergency detention and civil commitment laws, the Treatment Advocacy Center observed that "[s]tates vary widely in the duration for an emergency hold for evaluation" and recommended that the "limit for an emergency hold should not be less than 72 hours with 48 hours as an absolute minimum."¹¹⁸ The survey revealed that "[f]orty-three states allow for a hold of at least 48 hours, with 35 allowing a hold of 72 hours or longer."¹¹⁹ The report, however, added: "By contrast, Louisiana allows for holds of up to 15 days, Rhode Island for 10 days, and both Nebraska and New Mexico for seven days"¹²⁰ Several other states also authorize a five-day emergency hold.¹²¹ Accordingly, the Workgroup's recommendation of five calendar days is the same as or even shorter than is permitted in some states. The Workgroup noted the following rationale for recommending a five-day emergency hold period:

One value of a longer hold is that it may obviate further need for involuntary treatment because either the person signs in voluntarily or they improve to the point that they don't require court ordered treatment. Five days is a balance between individual due process rights and effective opportunities for treatment.¹²²

Similarly, in recommending a minimum emergency hold period of no less than seventy-two hours, the Treatment Advocacy Center urged that it

¹¹⁸ GRADING THE STATES, *supra* note 15, at 14.

¹¹⁹ *Id.* at 15. There can be variability in duration even within a state. For example, the default period in Texas is forty-eight hours, but that period is extended if the forty-eight-hour period ends on a weekend or holiday. TEX. HEALTH & SAFETY CODE § 573.021(b) (2023). For further analysis of the wide variation in state laws permitting emergency mental health holds, see Leslie C. Hedman et al., *State Laws on Emergency Holds for Mental Health Stabilization*, 67 PSYCHIATRIC SERVS. 529 (2016), <https://ps.psychiatryonline.org/doi/epdf/10.1176/appi.ps.201500205>.

¹²⁰ GRADING THE STATES, *supra* note 15, at 15. *See* LA. STAT. ANN. § 28:53(A)(1) (2023) (15 days); NEB. REV. STAT. § 71-923 (2023) (7 days); N.M. STAT. ANN. § 43-1-11 (2023) (7 days); 40 R.I. GEN. LAWS §§ 1-5-7(f)–(g) (2023) (10 days).

¹²¹ *See* ALA. CODE § 22-52-91(e) (2023) (up until the fifth business day); IDAHO CODE § 66-326 (2023) (24 hours for evaluation and up to five days, after court orders); OKLA. STAT. tit. 43A §§ 5-208(A)(3), (5) (2023) ("[A] period not to exceed one hundred twenty (120) hours or five (5) days, excluding weekends and holidays," but the period can be "tolled" if the person needs other medical treatment at a medical facility); OR. REV. STAT. § 426.232(2) (2023) (up to "five judicial days"); TENN. CODE ANN. § 33-6-413(a) (2023) (following a court certification based on probable cause, up to five days excluding weekends and holidays); WASH. REV. CODE §§ 71.05.153(1), 71.05.180 (2023) (up to 120 hours excluding weekends and holidays).

¹²² MODEL LEGAL PROCESSES, *supra* note 8, at 15–16.

“increases the chance that an individual will be stabilized before discharge or persuaded to accept voluntary admission or outpatient services.”¹²³

For an individual who remains at the emergency detention site at the conclusion of the permissible five-day period, the Workgroup has identified three alternatives as possible next steps: “[d]ischarge and referral for voluntary outpatient, home-based, or residential services in the community, . . . [c]ontinued hospitalization on a voluntary basis, . . . [or the filing of a] petition for involuntary treatment [with a court]”¹²⁴ Although “voluntary participation in treatment is always preferable[.]” the last of the three options recognizes that judicial intervention is often necessary for considering

¹²³ See GRADING THE STATES, *supra* note 15, at 14–15 (also reasoning that “[a] longer hold period helps to ensure there is ample time to decide whether a person qualifies for further treatment and that this decision is based on a medical evaluation rather than the patient simply “timing out” of the hold”).

¹²⁴ MODEL LEGAL PROCESSES, *supra* note 8, §§ 8(a)(i)–(iii), at 17. The full text of the three recommended alternatives is as follows:

b. Upon completion of the evaluation and intervention, one of the following dispositions must occur, as determined by a qualified mental health professional, in consultation with the individual and the individual’s caregivers and other mental health professionals who evaluated and treated the individual:

i. Discharge and referral for voluntary outpatient, home-based, or residential services in the community when the symptoms and behaviors that gave rise to the original emergency involuntary admission are no longer present and the individual’s underlying condition has stabilized or improved to the degree that the individual is able to voluntarily, safely, and effectively receive continuing treatment at a less intensive level of care, and appropriate services are available to provide that continuing treatment at the lower level of care[.]

ii. Continued hospitalization on a voluntary basis, as determined by the treatment team in consultation with the individual and the individual’s caregivers, as available, when it is determined that the person still needs an inpatient level of care and has agreed to participate voluntarily. If a voluntary patient chooses to leave against medical advice, the staff of the facility shall evaluate the individual to determine whether he or she meets criteria for continued involuntary mental health evaluation and intervention and should document that evaluation.

iii. A petition for involuntary treatment for either inpatient or outpatient treatment when it is determined that the person meets the criteria for involuntary treatment (such as those set out in Part I of this document). The decision whether to seek involuntary treatment on an inpatient or outpatient basis shall be based on an assessment of the level of care and supervision required by the individual as well as the availability of resources to provide such care. If a petition for involuntary inpatient or outpatient mental health treatment for an individual is filed, the individual is entitled to a hearing as soon as practicable, but in no circumstance longer than 7 days, in order to determine whether the individual meets the criteria for civil commitment for involuntary mental health treatment. During this period, treatment under the conditions described in section 7 should continue, and the individual should be regularly offered the opportunity to convert to voluntary status if clinically appropriate.

involuntary mental health care.¹²⁵ Given due process requirements and to protect the individual's rights, the drafters proposed that "the individual is entitled to a hearing as soon as practicable, but in no circumstance longer than 7 days . . . to determine whether the individual meets the criteria for civil commitment for involuntary mental health treatment."¹²⁶ At the ensuing court hearing, the court would need to determine whether the criteria for court-ordered mental health treatment are met and, if so, to order outpatient treatment "unless the court [separately] determines that outpatient treatment will not provide reasonable assurances for the safety of the individual or others or will not meet the person's treatment needs."¹²⁷

IV. MEDICATION OVER OBJECTION

Many states have processes in place for considering the administration of psychiatric medications over objection in civil matters.¹²⁸ The Model Legal Processes Workgroup proposed several principles applicable to involuntary medications in nonemergency situations for when "there are compelling reasons to provide psychiatric medications over objection in an ongoing manner in order to prevent future harm."¹²⁹ The proposed principles anticipate hearings before a judge or administrative tribunal that "should immediately follow the hearing on inpatient or outpatient court-ordered treatment."¹³⁰ The recommended criteria include required findings as to the effectiveness and medical appropriateness of the recommended medication and whether "[t]he person lacks capacity to make an informed treatment decision."¹³¹

¹²⁵ See *id.* at 19 (discussing the preference for voluntary participation in treatment in the context of the workgroup's recommendations for medication over objection procedures).

¹²⁶ *Id.* § 8(b)(iii), at 17.

¹²⁷ *Id.* § 2, at 8 (Guidance for Court Ordered Treatment). During the window of up to seven days following the petition and prior to the court hearing, the workgroup anticipates both that treatment "should continue, and the individual should be regularly offered the opportunity to convert to voluntary status if clinically appropriate." *Id.* § 8(b)(iii), at 17–18. Converting to voluntary care would, of course, obviate the need for a court hearing on the petition.

¹²⁸ See, e.g., MASS. GEN. LAWS ANN. ch. 123, § 8B (West 2023); TEX. HEALTH & SAFETY CODE ANN. §§ 574.101–.110 (2023).

¹²⁹ MODEL LEGAL PROCESSES, *supra* note 8, at 18.

¹³⁰ *Id.* § 2(b), at 20. The drafters added: "The person who is the subject of the hearing is entitled to be present, represented by counsel, and afforded the opportunity to present evidence." *Id.* § 2(a), at 20. In addition, any order permitting "non-emergency involuntary psychiatric medication should only occur if there is clear and convincing evidence, in most instances based on the individual's history of prior treatment experiences and both successful and unsuccessful treatment responses . . ." *Id.* § 1, at 13.

¹³¹ *Id.* §§ 1(b), (d), at 20. The four recommended criteria, in full, require proof by the clear and convincing evidence standard that:

a. Efforts to engage the person voluntarily in treatment have been tried but have not succeeded;

Moreover, the Workgroup’s recommended principles “assume that medication over objection will be considered only for persons who have been court-ordered to inpatient or outpatient treatment.”¹³² That is, there must be a nexus between judicially ordered mental health treatment and any court-ordered administration of medications.¹³³ Recognizing, of course, that individuals should generally have autonomy to make medication decisions, the Workgroup observed that “the administration of medication over one’s objection is only permissible if that person has already been determined to lack decisional capacity, after due process. Involuntarily medicating an individual requires a finding of decisional incapacity plus a determination about the appropriateness of the medication.”¹³⁴

The Workgroup’s recommendation to extend the authority for medication orders to persons subject to court-ordered outpatient treatment on its face appears relatively novel.¹³⁵ When read as a whole, however, the Workgroup’s principles for the nonemergency administration of psychiatric medications over objection do not contemplate the forcible administration of medication outside of an appropriate facility. Specifically, the proposed principles address a situation in which a person subject to a medication order while under a court-ordered outpatient treatment order “does not adhere to the court-order requiring medication over objection.”¹³⁶ In such a case, if

b. The medication is effective and medically appropriate (i.e., the benefits of the proposed treatment outweigh the risks, including the risks of the treatment and the risks of no treatment);

c. The medication is the least intrusive strategy for ameliorating the symptoms of mental illness that led to the person’s court ordered treatment; and

d. The person lacks capacity to make an informed treatment decision. If the person has executed a psychiatric advance directive (PAD) or another legally valid document in which the person expresses his or her preferences regarding treatment, it should be consulted in determining the most desirable course of treatment.

Id. §§ 1(a)–(d), at 20.

¹³² *Id.* at 19 (also observing that “even when a person meets criteria, voluntary participation in treatment is always preferable”). Correspondingly, one of the Workgroup’s principles in this regard states: “Administration of psychiatric medications under this provision may be authorized for the duration of the inpatient or outpatient treatment order.” *Id.* § 3, at 21. That is, the medication order will expire with the court’s order for treatment.

¹³³ *See id.* at 19 (including a paragraph heading entitled, “Nexus with involuntary inpatient or assisted outpatient treatment (AOT)”) (emphasis omitted).

¹³⁴ *Id.* at 18–19 (emphasis omitted). In framing the criterion to focus on the person’s lack of capacity regarding medication treatment decisions, the drafters were consistent with current law in many states. *See, e.g.,* CARE CONTINUUM, *supra* note 50, at 24 (“A finding of incompetence generally is required for medication over objection—even for individuals who have been committed.”); TEX. HEALTH & SAFETY CODE ANN. § 574.106(a-1)(1) (2023) (requiring a court to find by clear and convincing evidence “that the patient lacks the capacity to make a decision regarding the administration of the proposed medication and treatment with the proposed medication is in the best interest of the patient”).

¹³⁵ *See* CARE CONTINUUM, *supra* note 50, at 14 n.15 (noting “in particular that, with only rare exceptions, no legal mechanisms exist for forced medication in an outpatient setting”).

¹³⁶ MODEL LEGAL PROCESSES, *supra* note 8, § 4, at 21.

“the treatment team determines that continued medication remains necessary, and the person’s failure to adhere to medication has led to court-ordered treatment in the past[,]” then in a “nonemergency situation[], an ex-parte order may be obtained from the judge to have the person transported to a designated emergency facility to assess the need for involuntary medication(s) and to administer such medication(s).”¹³⁷ Accordingly, the proposal contemplates that any forcible administration of medication(s) pursuant to the court’s medication order will be in a clinical setting.¹³⁸

In this regard, the Workgroup’s proposed principles for court-ordered medications for a person under an order for outpatient treatment are largely comparable to existing law in some states.¹³⁹ For example, an outpatient commitment order under Texas law may include psychiatric “medication . . . considered clinically necessary by a treating physician,” but the AOT order

¹³⁷ *Id.* § 4(a), at 21. The proposed language provides that in an “emergency situation[] . . . the treatment team may initiate the order to have the person transported to a designated emergency facility for administration of involuntary medication(s)” rather than needing a court order. *Id.* § 4(b), at 21. Finally, the recommendations add: “States may facilitate this process further by granting the physician on the treatment team who is prescribing the medication the authority to initiate the order even on a non-emergency basis.” *Id.* § 4(c), at 21.

¹³⁸ Moreover, this approach is appropriate. The administration of medication over objection outside of a clinical setting, even under a court order, is problematic. As one commentator observed in connection with Texas legislation authorizing court orders for the administration of medication as a part of outpatient competency restoration programs in certain criminal matters:

Even if forced medication were legally permissible on an outpatient basis, there are few psychiatric physicians bold enough to pursue this option for at least two reasons: (1) The means of forcibly administering medications to persons receiving outpatient treatment are limited. It is unlikely that any facility or program would send a team of staff to a person’s residence and exert the force necessary to medicate a person who is otherwise refusing; and . . . (2) most providers would be very concerned as to the inability to monitor side effects of medications administered under such conditions—likely impossible in an outpatient setting.

Floyd L. Jennings, *Statutory Changes Regarding Mentally Ill Defendants*, 46 VOICE FOR DEF. 22, 25 (2017). The late Dr. Jennings was both a clinical psychologist and Chief of the Misdemeanor Mental Health Division of the Harris County, Texas, Public Defender’s Office. *Id.* For further analysis of medication non-adherence by persons subject to outpatient treatment orders, see MARVIN S. SWARTZ ET AL., AM. PSYCHIATRIC ASSOC., RESOURCE DOCUMENT ON INVOLUNTARY OUTPATIENT COMMITMENT AND RELATED PROGRAMS OF ASSISTED OUTPATIENT TREATMENT 14–15 (2015), https://www.psychiatry.org/File%20Library/Psychiatrists/Directories/Library-andArchive/resource_documents/resource-2015-involuntary-outpatient-commitment.pdf, (summarizing that “psychotropic medication is an essential part of treatment for most patients who are appropriate for involuntary outpatient commitment[.] . . . [but that] the involuntary administration of medication should not be authorized as a consequence of refusal to take medication as prescribed without subsequent review consistent with the state’s process for authorizing involuntary administration of medication”).

¹³⁹ See FULLER & PINALS, *supra* note 44, at 2 (“State statutes differ on the mechanics of enforcement, and a handful of states establish no procedures for responding to non-adherence to the court order. In most cases, however, the statute authorizes the court and/or the mental provider to initiate an involuntary psychiatric evaluation if an individual under an AOT order is not adherent . . .”).

may not allow for the outpatient treatment provider to compel medication.¹⁴⁰ Similarly, Ohio law relating to AOT contemplates, in the event a person under an AOT order is noncompliant with medications, the need for further judicial proceedings for inpatient hospitalization and the court's subsequent consideration of whether to order the administration of medication over objection.¹⁴¹ Michigan law similarly authorizes medication as part of an AOT order and permits the court to modify the order to inpatient or a combination of inpatient and AOT in the event of noncompliance.¹⁴²

In addition, one of the positive aspects of utilizing AOT is a greater likelihood of medication adherence. With active court involvement in an AOT program, the presence of a "black robe effect" can enhance treatment adherence.¹⁴³ With greater adherence, particularly with respect to psychiatric medications, there is less need for returning to the court for consideration of compelled medications, along with better patient outcomes.

V. CRIMINAL JUSTICE PATHWAYS

The final section of the Model Legal Processes report and recommendations is entitled "Pathways to Care: A Roadmap for

¹⁴⁰ See TEX. HEALTH & SAFETY CODE ANN. §§ 574.037(b)(2), (c-3) (2023) (permitting the court to "order the patient to participate in the program but . . . not compel performance"). One summary has analyzed the Texas provision as:

[D]raw[ing] a critical distinction between 'order[ing] the patient to participate in the program,' which the court *shall* do, and 'compell[ing] performance,' which the court *may not* do. This leaves no doubt that if an AOT order directing the participant to take medication is violated, physical restraint and forcible administration of the medication is not a permitted response.

TEXAS AOT PRACTITIONER'S GUIDE, *supra* note 45, at 29. In the event a person under a Texas AOT order is non-compliant, the outpatient provider may petition the court for a modification hearing, and the court is authorized to issue an order for temporary detention in an inpatient facility. TEX. HEALTH & SAFETY CODE ANN. §§ 574.037(c-3), 574.062–.064 (2023).

¹⁴¹ See *Ohio A.O.T. Implementation Manual*, *supra* note 45, at 15 (discussing medication over objection).

¹⁴² See MICH. COMP. LAWS §§ 330.1468(d)(i), 330.1475 (2023) (authorizing medication as part of the AOT order and permitting modifications in the event of noncompliance with the order). Michigan also now authorizes mediation between providers and persons needing mental health care. MICH. COMP. LAWS § 330.1206(a) (2023). See Mack, *supra* note 63, at 46 (describing the use of mediation as "an alternative to court hearings to promote treatment engagement and ownership of the treatment plan").

¹⁴³ See CARE CONTINUUM, *supra* note 50, at 14 n.15 (commenting on the "black robe effect" in the context of "evidence show[ing] that the majority of persons under outpatient commitment believe that they are legally obligated to comply, given the court order, and that they act accordingly"); TEXAS AOT PRACTITIONER'S GUIDE, *supra* note 45, at 27 (suggesting that incorporating the treatment plan into the court's order also serves "to impos[e] a 'black robe effect' upon the treatment team"); Mack, *supra* note 63, at 54 (describing anecdotal reports of Michigan "cases in which the treatment team determines that an order for outpatient treatment is no longer needed, [yet] the consumer insists upon continuing the order because they feel the order causes them to comply with treatment, including taking prescribed medication").

Coordinating Criminal Justice, Mental Health Care, and Civil Court Systems to Meet the Needs of Individuals and Society.”¹⁴⁴ Rather than recommending statutory language, the Pathways to Care portion of the Workgroup’s “guidance document describes opportunities for diverting people from the criminal justice system, and ways in which procedures in criminal justice can be retooled to produce better outcomes—both for public safety and for people needing mental health and substance use care.”¹⁴⁵ In effect, the Workgroup has recommended that policymakers from across “the criminal justice system, civil justice system, and mental health treatment system . . . work together as partners” to reimagine the overall processes to achieve better outcomes.¹⁴⁶

Critical of states’ overuse of the criminal competency restoration process in nonviolent cases involving persons with mental illness,¹⁴⁷ the report recommends that policymakers endeavor “to redesign their state and/or local criminal justice systems, step by step, to increasingly redirect justice-involved individuals with mental health and substance use care needs into the most appropriate pathway based on their criminogenic risks and needs and taking into account relevant responsivity and clinical considerations.”¹⁴⁸ In particular, the report urges that systems be established and tools employed to facilitate assessments not only of a person’s criminogenic risks, but also to examine the extent, if any, the person’s mental illness contributed to the charged crime.¹⁴⁹ As the drafters explained: “The

¹⁴⁴ MODEL LEGAL PROCESSES, *supra* note 8, at 22–44.

¹⁴⁵ See *id.* at 21 (also noting that “most contacts that people with unmet mental health and substance use care needs have with the justice system are in the criminal context, and far too many people who do contact the criminal justice system have poor outcomes”).

¹⁴⁶ See *id.* at 25 (describing the proposal’s aims and goals).

¹⁴⁷ See *id.* at 24 (“Most states expend enormous resources on ‘competency restoration’ processes, with little evidence of long-term effectiveness for either the individuals involved or for public safety.”).

¹⁴⁸ *Id.* at 28. For a discussion of the importance of considering criminogenic risks and mental health or substance use needs, see Douglas B. Marlowe, *The Most Carefully Studied, Yet Least Understood, Terms in the Criminal Justice Lexicon: Risk, Need, and Responsivity*, POL’Y RSCH. ASSOCS. (July 17, 2018), <https://www.praire.com/risk-need-responsivity/> (summarizing “that the best outcomes are achieved in the criminal justice system when (1) the intensity of criminal justice supervision is matched to participants’ risk for criminal recidivism or likelihood of failure in rehabilitation (criminogenic risk) and (2) interventions focus on the specific disorders or conditions that are responsible for participants’ crimes (criminogenic needs)”). For a further detailed discussion of the workgroup’s recommended criminal justice pathways, see Symposium, *Pathways to Care & Safety: A Roadmap for Redesigning the Criminal Justice System Processes to Produce Better Outcomes for CJ Involved Individuals with MH and SUD Conditions*, 54 TEX. TECH L. REV. 1 (2022) (presented by Steven Leifman & Kenneth Minkoff) (videorecording available at 2022 *Mental Health Symposium Materials*, TEX. TECH L. REV., <http://texastechlawreview.org/mental-health-law-symposium-2022/>) (last visited July 27, 2023). Dr. Minkoff and Judge Leifman were members of the Model Legal Processes Workgroup and headed up the subgroup that drafted the criminal justice pathways.

¹⁴⁹ See MODEL LEGAL PROCESSES, *supra* note 8, at 30 (discussing a need to assess “the question, ‘Would the crime likely have been committed in the absence of the individual’s mental illness(es)?’”).

crux of this metric is to determine whether the individual's criminal behavior is better addressed through mental health care rather than incarceration or other punitive restrictions. Research suggests that mental illness in general is not a risk factor for criminal conduct."¹⁵⁰

Although a detailed analysis of the recommended criminal justice pathways is beyond the scope of this Article, the recommendations overall urge that states be better positioned to divert individuals with mental illness who have been charged with low or moderate severity crimes into mental health treatment, AOT, or mental health court proceedings.¹⁵¹ The report also encourages much more limited use of competency restoration proceedings, yet greater emphasis on pre-arrest law enforcement diversion for nonviolent offenses.¹⁵² In sum, a key goal of the Workgroup's criminal justice recommendations is to encourage states to develop "a coordinated system of management promising long-term cost savings and improved public safety and health for the entire community."¹⁵³

¹⁵⁰ *Id.* Similarly, the report recommends an inquiry into whether the defendant's substance use contributed to the offense. *Id.* at 31. For further discussion of judicial use of risk assessment screening and tools with regard to alleged offenders with mental illness, see DEBRA A. PINALS, NAT'L CTR. FOR STATE CTS., MENTAL HEALTH FACTS IN BRIEF: VIOLENCE AND MENTAL ILLNESS MYTHS AND REALITY 4 (2022), https://www.ncsc.org/_data/assets/pdf_file/0030/85098/Violence-and-Mental-Illness-Myths-and-Reality.pdf (urging that "[b]ecause persons with mental illness are often before the court, it is critical that court personnel understand the risks of over-identifying mental illness with violence and that they understand the literature that points out that mental illness alone accounts for only a small percentage of violence in society").

¹⁵¹ See MODEL LEGAL PROCESSES, *supra* note 8, at 31–35 (describing in detail four different pathways that could trigger diversion options depending on the level of need, risks, and mental illness or substance use contribution to the crime). Two additional pathways track more traditional criminal court responses tied to more serious crimes or a lack of contribution of a defendant's mental illness to the conduct charged. See *id.* at 36–37 (describing pathways five and six).

¹⁵² See *id.* at 30 ("Competency restoration should not be used simply because there is no other pathway for the person to receive needed care[] . . . [and] should only be considered when the state's interest in prosecution is significant."); see also *id.* at 32 (noting that although the recommended alternative pathways focus on post-arrest processes, "the importance of deflection (law enforcement discretion exercised to not make an arrest, and to instead direct the person to crisis services or community care and support) and diversion (withholding or deferring the initiation of criminal charges) cannot be overstated"). For further recommendations focused on both the diversion of offenders with mental illness from the criminal justice system and limiting the use of competency restoration proceedings, see NAT'L JUD. TASK FORCE, LEADING REFORM: COMPETENCE TO STAND TRIAL SYSTEMS 1, 3–6 (2021), https://www.ncsc.org/_data/assets/pdf_file/0019/66304/Leading_Reform-Competence_to_Stand_Trial.pdf. For a summary of community diversion alternatives, see Jackson Beck et al., *Behavioral Health Crisis Alternatives: Shifting from Police to Community Responses*, VERA INST., <https://www.vera.org/behavioral-health-crisis-alternatives> (last visited Nov. 3, 2023).

¹⁵³ MODEL LEGAL PROCESSES, *supra* note 8, at 27.

VI. CONCLUSION

The Model Legal Processes Workgroup has proposed model legislative concepts relating to standards for court-ordered treatment, emergency psychiatric interventions, the administration of medication over objection for persons subject to court-ordered treatment, and a reimagining of criminal justice pathways for accused individuals with mental illness. Although states generally have current laws that address these various areas, the Workgroup members contend that the proposed statutory language “would create a more accessible legal pathway to involuntary care for the sake of an individual’s health and well-being than is presently available in most states.”¹⁵⁴ Having been crafted by experts from both the legal and medical fields, the proposed model legislation and principles were intended to “set the gold standard for least restrictive involuntary commitment (inpatient and outpatient), and for civil and criminal approaches to optimizing individual health outcomes, defending civil liberties, and preserving public safety.”¹⁵⁵ On the other hand, in balancing a person’s civil liberties with a need for treatment in a mental health crisis, policymakers should take into account the observation that “anyone who has experienced the horror of seeing a loved one deteriorate, and die, because their brain disease went untreated, knows we have no choice but to find ways to get people help that they do not themselves recognize they need.”¹⁵⁶

At least one state’s court system, Arizona, has already directed that the Workgroup’s report “serve as a model” as they examine their “civil court-ordered treatment statutes and rules.”¹⁵⁷ Rather than allowing the Workgroup’s report and proposals to simply lay dormant on a shelf, it is to be hoped that many more states will follow Arizona’s lead.¹⁵⁸ Legislatures should also recognize, however, that simply revising governing legislation, standing alone, is not the recipe for success without assuring that a robust, continuum of mental health services will also be available and accessible.

¹⁵⁴ *Id.* at 2.

¹⁵⁵ *Id.* at 1.

¹⁵⁶ See Stettin & Ornstein, *supra* note 40 (arguing in support of New York City Mayor Adams’s policies to encourage greater utilization of statutory intervention authority).

¹⁵⁷ NAT’L JUD. TASK FORCE REPORT, *supra* note 3, at 31 (quoting Arizona Chief Justice Robert M. Brutinel, who also served on the Task Force; also noting that the Task Force endorsed the Workgroup’s report).

¹⁵⁸ The Texas Judicial Commission on Mental Health invited the Author to speak about the workgroup’s recommended language for emergency psychiatric interventions at the October 2023 Texas Judicial Summit on Mental Health. See *Judicial Summit on Mental Health*, TEX. JUD. COMM’N ON MENTAL HEALTH, <https://iemvirtual.com/wp-content/uploads/2023-Summit-Agenda-at-a-Glance.pdf> (last visited Sept. 14, 2023) (agenda for Oct. 19, 2023).