

EMERGENCY DETENTION AND INVOLUNTARY HOSPITALIZATION: ASSESSING THE FRONT END OF THE CIVIL COMMITMENT PROCESS

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ABSTRACT

The allocation of treatment resources in the behavioral health system in the United States has shifted dramatically over the past fifty years. Most people who require mental health care, including patients who have severe mental illnesses, now receive treatment in outpatient settings. Inpatient care is often limited to brief stays of a week or less. Some jurisdictions have adjusted the statutes governing the initiation of involuntary hospitalization to reflect these clinical changes. These states may require some form of judicial oversight within the first hours or days of an individual's detention, and some also seek to connect patients in distress to community-based screening mechanisms to facilitate the diversion of eligible individuals to suitable alternatives to hospitalization and the civil commitment process. Other jurisdictions, however, have not made the sort of fundamental adjustments necessary to reflect the changed role of psychiatric hospitalization. In jurisdictions that have not adjusted their procedural timelines, it is possible for statutorily mandated adjudication to be pushed well beyond the seven- to ten-day average of most psychiatric hospitalizations, thereby rendering these formal legal protections ineffective. This potential mismatch between the timelines for regulating involuntary hospitalization and the relatively brief duration of most inpatient psychiatric episodes has received relatively little attention from commentators, courts, and state legislators. By contrast, a second problem endemic to the public mental health system has garnered considerably more attention: the difficulty of connecting patients with severe chronic mental illness who are resistant to treatment, but not yet

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imminently dangerous, to needed therapeutic services. Some of these individuals may be on the brink of exhibiting the degree of disability required for coercive state intervention but may not yet have reached the point of collapse most civil commitment statutes formally require. Paradoxically, then, the laws governing involuntary hospitalization in some jurisdictions may be understood as both too protective of liberty interests and not protective enough.

This Article considers the constitutional framework that governs the early stages of the civil commitment process and reviews a sampling of state statutory schemes that illustrate differing approaches to regulating emergency detentions and involuntary psychiatric hospitalizations. It then takes up the theory of transinstitutionalization, the question of whether the reduced reliance on and capacity of inpatient services has unduly shifted the management of persons with chronic mental illness to the criminal justice system and other public systems responsible for homelessness and like problems, and provides an overview of the responses to that theory by those who describe it as overly reductionist. The Article concludes that the substantive and procedural provisions governing the front end of the civil commitment system should be evaluated not simply in terms of whether they are sufficiently protective of individual liberty interests or sufficiently interventionist, but rather whether they are designed to ensure that patients receive an appropriate level of services, both in community settings and in hospitals, as their chronic disease progresses. This effective allocation of limited treatment and intervention resources, in turn, requires interdisciplinary redundancy and professional diversity within the group designated to make decisions about the detention of mentally ill persons.

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INTRODUCTION

The allocation of treatment resources within the behavioral health system in the United States has shifted dramatically over the past fifty years. Most people who require mental health care, including patients who have severe mental illnesses, now receive treatment in outpatient settings.¹ For those individuals

1. "Between 1955 and 1975, . . . the percentage of treatment episodes that took place in state psychiatric hospitals dropped from 77 to 28% and between 1955 and 2000, the number of state psychiatric hospital beds dropped from 339 per 100,000 to just 22 per 100,000." Seth J. Prins, *Does Transinstitutionalization Explain the Overrepresentation of People with Serious Mental Illnesses in the Criminal Justice System?*, 47 COMMUNITY MENTAL HEALTH J. 716, 717 (2011) (internal citations omitted). In 1955, the total daily patient population of all state psychiatric hospitals in the United States was nearly 559,000, but by 2003, the number had declined to 47,000 patients. Ronald W. Manderscheid et al., *Changing Trends in State Psychiatric Hospital Use from 2002 to 2005*, 60 PSYCHIATRIC SERVS. 29, 29 (2009). More generally, "[i]n 1970 there were 525,000 psychiatric beds in the United States, 80 percent of them provided by state and county mental hospitals. By 2002 the total number of psychiatric beds had declined to fewer than 212,000, with 27 percent of them provided by state and county mental hospitals." Steven S. Sharfstein & Faith B. Dickerson, *Hospital Psychiatry for the Twenty-First Century*, 28 HEALTH AFF. 685, 685-86 (2009).

with mental illness who are hospitalized, the inpatient care they receive in psychiatric hospitals, or in psychiatric beds in general hospitals, is often limited to brief stays of a week or less. Such care is designed to stabilize patients, fine-tune their diagnoses and treatment plans, and arrange for outpatient treatment.² At the same time, psychiatric hospitals operated by states and their political subdivisions now devote many of their limited resources to treating a separate population of patients whose stay is much longer – often measured in months or years.³ This long-term patient population is comprised, in significant part, of forensic patients and other difficult-to-manage persons with ongoing mental disabilities.⁴

Notwithstanding this shift in the allocation of treatment resources, many individuals with mental disabilities, including many with serious mental illnesses, do not receive adequate treatment either in the community or in inpatient settings.⁵ A

2. “[T]he average length of [hospitalization for serious mental illness] declined from 12.8 days in 1995 to 9.7 days in 2002.” Shinobu Watanabe-Galloway & Wanqing Zhang, *Analysis of U.S. Trends in Discharges from General Hospitals for Episodes of Serious Mental Illness, 1995–2002*, 58 PSYCHIATRIC SERVS. 496, 498 (2007); see also David Mechanic et al., *Changing Patterns of Psychiatric Inpatient Care in the United States, 1988–1994*, 55 ARCHIVES GEN. PSYCHIATRY 785, 790 (1998) (“Inpatient episodes are typically short and focused on managing crises and stabilizing symptoms.”); Sharfstein & Dickerson, *supra* note 1, at 686 (“The goals of care revolve around stabilizing the current crisis that led to the admission; defining a focal problem; developing a discrete set of objectives; making a correct diagnosis . . . ; determining which treatments to use; working with the patient’s family and other support systems to provide a bridge out of the hospital; and establishing an effective treatment plan.”).

3. William H. Fisher et al., *The Changing Role of the State Psychiatric Hospital*, 28 HEALTH AFF. 676, 679–81 (2009).

4. See *id.*; see also Manderscheid et al., *supra* note 1, at 33 (noting over half of the beds in some state psychiatric hospitals are occupied by forensically linked mental health consumers, and more recently, state hospitals have been built solely for sex offenders).

5. In recent decades, the prevalence of serious mental illness among adults in the United States has remained fairly constant at about 5.3% of people eighteen to fifty-four years old. See Watanabe-Galloway & Zhang, *supra* note 2, at 496. Overall, an estimated 10 to 17.5 million adults in the United States are thought to have a serious mental illness, defined as a mental disorder meeting the diagnostic criteria of the Diagnostic and Statistical Manual (DSM) and resulting in functional impairments that substantially limit one or more major life activities. *Id.* Other estimates vary considerably, depending on the criteria and methodology used. *Id.* Although the overall rate of treatment for adult patients with mental disorders increased between 2000 and 2010, most patients with mental illness, including many with serious mental illness, did not receive treatment. See Ronald C. Kessler et al., *Prevalence and Treatment of Mental Disorders, 1990 to 2003*, 352 NEW ENG. J. MED. 2515, 2518–20 (2005).

variety of factors have contributed to the mental health treatment system's failure to fully serve the population of persons in need. Stigma and denial drive some patients away from available treatment.⁶ In addition, the persistent problem of inadequate resources available for community mental health services also contributes to the under-treatment of persons with mental illness.⁷ More recently, a shortage of treatment beds in state and county psychiatric hospitals, and a shortage of capacity in many private psychiatric hospitals and specialized units of general hospitals, has exacerbated the problem.⁸

The legal rules developed in the 1960s and 1970s to ensure patients' liberty interests are protected in the civil commitment process may have contributed, to some degree, to the shift in emphasis from inpatient care to community-based treatment for most persons who are drawn into the behavioral health system.⁹ Changes in clinical practice, particularly the development of several generations of psychotropic medications, have also resulted in shorter hospital stays for most patients and a greater reliance on outpatient services.¹⁰ Finally, significant financial incentives created by the rules governing public funding of psychiatric treatment services and shifts in private insurance practices have also led to a dramatic decline in long-term hospitalization for most patients with mental illnesses,

6. See Patrick W. Corrigan et al., *The Impact of Mental Illness Stigma on Seeking and Participating in Mental Health Care*, 15 PSYCHOL. SCI. PUB. INT. 37, 37 (2014).

7. See Robert Bernstein & Tammy Seltzer, *Criminalization of People with Mental Illnesses: The Role of Mental Health Courts in System Reform*, 7 UDC/DCSL L. REV. 143, 147 (2003).

8. See Sharfstein & Dickerson, *supra* note 1, at 686; see also E. FULLER TORREY ET AL., TREATMENT ADVOCACY CTR., THE SHORTAGE OF PUBLIC HOSPITAL BEDS FOR MENTALLY ILL PERSONS 2-4, http://tac.nonprofitsoapbox.com/storage/documents/the_shortage_of_publichospital_beds.pdf.

9. The research on this question is inconclusive. Several studies suggest the procedural and substantive reforms of the late 1960s and 1970s produced little change in the outcome of commitment hearings. See, e.g., R. Michael Bagby & Leslie Atkinson, *The Effects of Legislative Reform on Civil Commitment Admission Rates: A Critical Analysis*, 6 BEHAV. SCI. & L. 45, 58-59 (1988).

10. See CHRISTOPHER SLOBOGIN ET AL., LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS 809 (6th ed. 2014).

including severe chronic mental illness.¹¹

Some jurisdictions have adjusted the procedural and/or substantive rules governing the initiation of involuntary hospitalization of individuals in emergency circumstances, or for observation or treatment, to reflect the clinical changes that have substantially reduced the length of inpatient care for most patients in the system.¹² These states may require some form of judicial oversight within the first hours or days of an individual's detention.¹³ Some also seek to connect patients in distress – along with their families and other responsible parties – to community-based screening mechanisms to facilitate the diversion of eligible individuals from hospitalization and civil commitment to suitable alternatives.¹⁴

Other jurisdictions, however, have not made the sort of fundamental adjustments – either to the procedural or substantive rules governing the involuntary admission of severely mentally ill persons through emergency departments or other means into psychiatric inpatient settings – necessary to reflect the changed role of psychiatric hospitalization in the behavioral health system.¹⁵ In these jurisdictions, a patient may be restrained on the basis of medical judgment alone, without a hearing before a

11. See Sharfstein & Dickerson, *supra* note 1, at 686–87. First, Medicaid rules and private managed care practices imposing strict standards of “medical necessity” and frequent reviews during inpatient treatment have “dramatically shortened lengths-of-stay.” *Id.* at 687. Second, a federal rule prohibiting most adult patients with Medicaid from receiving inpatient treatment in psychiatric hospitals has “contributed to the decline of state hospital beds.” *Id.* Third, a lifetime maximum of 190 days of inpatient care has “allowed Medicare to limit treatment in psychiatric hospitals.” *Id.*

12. See, e.g., *infra* notes 85–93 and accompanying text (discussing legislative changes in Massachusetts).

13. See, e.g., *infra* notes 165–69, 174–84 and accompanying text (discussing judicial involvement in the detention process in Virginia).

14. See, e.g., Nat'l Ctr. for State Courts, *Guidelines for Involuntary Civil Commitment*, 10 MENTAL & PHYSICAL DISABILITY L. REP. 409, 429–33 (1986); Becky Orr, *New Agreement Geared Toward Reducing Involuntary Hospitalizations*, WYO. TRIBUNE-EAGLE (Oct. 16, 2017), http://www.wyomingnews.com/news/local_news/new-agreement-geared-toward-reducing-involuntary-hospitalizations/article_a71985e4-b22f-11e7-af55-c70e9ff37cfa.html; *infra* notes 126–31 and accompanying text (discussing pre-petition screening provided for in California's detention process).

15. See SLOBOGIN ET AL., *supra* note 10, at 912–13.

judicial officer to contest that decision.¹⁶ To be sure, the decision of one or more physicians to certify a patient's retention for emergency care or observation and treatment remains subject to judicial review in every state—either at a full-blown civil commitment hearing or by way of a habeas corpus petition.¹⁷ Moreover, the statutory standards governing medical certification ordinarily require a finding that the patient is dangerous and in need of treatment.¹⁸ Nevertheless, it is possible, in jurisdictions that have not adjusted their procedural timelines, for the statutorily mandated adjudication to be pushed well beyond the seven- to ten-day average of most psychiatric hospitalizations, thereby rendering these formal legal protections less effective than they might be if they were made available earlier in the process.¹⁹ In addition, this timing problem may be present even with respect to the habeas remedy if the rules for adjudicating these petitions permit significant delay in setting return dates.²⁰

This mismatch between the timelines for regulating involuntary hospitalization set out in some state statutes and the relatively brief duration of most inpatient psychiatric episodes has received relatively little attention from commentators, courts, and state legislatures. By contrast, a second problem endemic to the public mental health system has garnered considerably more attention in recent years: the difficulty of connecting patients with severe chronic mental illness who are resistant to

16. See *id.*; see also *infra* notes 170–72 and accompanying text.

17. See generally SAMUEL BRAKEL ET AL., *THE MENTALLY DISABLED AND THE LAW* 50–56 (3rd ed. 1985) (explaining that, although police or administrative officials sometimes possess the power to detain a person with emergency psychiatric problems, judicial intervention is required at some point).

18. See Rael Jean Isaac & Samuel Jan Brakel, *Subverting Good Intentions: A Brief History of Mental Health Law "Reform"*, 2 CORNELL J.L. & PUB. POL'Y 89, 102–06 (1992); see also Richard C. Boldt, *Perspectives on Outpatient Commitment*, 49 NEW ENG. L. REV. 39, 44–46 (2015).

19. See Nat'l Ctr. for State Courts, *supra* note 14, at 478 (“[M]ost involuntary civil commitment cases are screened and diverted to the voluntary mental health care system before any substantial involvement by the courts. The majority of respondents in commitment cases never participate in formal court hearings.”).

20. See LOIS I. FISHER ET AL., *ATTORNEYS' HANDBOOK: MENTAL HEALTH ISSUES IN MARYLAND LAW* 27–30 (1996).

treatment, but not yet imminently dangerous, to needed therapeutic services.²¹ Some of these individuals may be on the brink of exhibiting the degree of disability and dangerousness required for coercive state intervention but may not yet have reached the point of collapse most civil commitment statutes formally require.²² Paradoxically, then, the laws governing involuntary hospitalization in some jurisdictions may be understood as both too protective of liberty interests and not protective enough. That is, in some cases, the demanding statutory standards for civil commitment may inhibit forced interventions at a point prior to psychiatric collapse when treatment could effectively forestall a looming emergency, while in other cases the rules may provide little or no protection against overly aggressive interventions undertaken on the basis of medical judgments not subject to timely judicial review.

The competing interests in individual autonomy, paternalism, and community safety that these issues raise can be explored from a variety of vantage points. One framing turns on the choice of decision makers and the respective institutional competencies of medical, legal, and other administrative actors to mediate the interests in tension.²³ A second framing explores the respective costs and benefits of psychiatric hospitalization versus care in a continuum of community settings,²⁴ and the

21. See Boldt, *supra* note 18, at 46–50. See generally E. FULLER TORREY, *THE INSANITY OFFENSE: HOW AMERICA'S FAILURE TO TREAT THE SERIOUSLY MENTALLY ILL ENDANGERS ITS CITIZENS* (2008) (outlining the implications, especially for the criminal justice system, of restrictive rules governing access to mental health services).

22. See Boldt, *supra* note 18, at 56–57.

23. See Nat'l Ctr. for State Courts, *supra* note 14, at 417 (providing a sustained analysis of the respective roles of actors within each of these groups, and arguing in favor of “[c]ooperation among the various disciplines, groups, agencies, and components of mental health-justice systems”).

24. See SLOBOGIN ET AL., *supra* note 10, at 868 (citations omitted) (“No data support any benefit from longer (as opposed to shorter) hospitalizations Other studies (mainly from outside the U.S.) suggest that provision of appropriate community care allows even individuals with severe mental illnesses to manage adequately outside hospitals.”). In light of this research on the limited benefits of long-term hospitalization for most patients, and considering the well-documented and significant harms associated with extended involuntary inpatient care, see Emily Dickinson, Note, *Developments in the Law: Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1193–201 (1974), the better course may be to adopt substantive and procedural rules

related question of how individual jurisdictions might implement a least-restrictive-alternatives methodology.²⁵ A third vantage point is provided by the debate over “transinstitutionalization,” questioning whether the reduced reliance on and capacity for inpatient services, including state mental hospitals, has unduly shifted the management of persons with chronic mental illness to the criminal justice system and other public systems responsible for homelessness and like problems, which are less suitable venues to treat this population effectively.²⁶ A fourth perspective focuses on the ways in which behavioral health care is financed and on the changing allocation of clinical resources produced, at least in part, by the pressures of these public policy choices.²⁷

Part I of this Article considers how the constitutional framework the U.S. Supreme Court, lower federal courts, and state courts have developed over the years governs the early stages of the civil commitment process. It then reviews a sampling of state statutory schemes that illustrate differing approaches to these issues. With the first and second frames of reference particularly in mind, this discussion notes how representative state laws allocate decision-making authority at the front end of the civil commitment system and how patients are sorted in or out of available inpatient treatment settings.

Part II takes up the transinstitutionalization theory and the question whether too many chronically ill patients are denied inpatient treatment due to the unavailability of these treatment resources or to inappropriately stringent screening criteria and procedures for involuntary admission. This Article then pro-

that divert eligible patients to community care or shorten the duration of hospitalization episodes. On the other hand, even if involuntary hospitalization can cause harm to some patients, advocates for more aggressive civil commitment standards and practices argue the harm is often less than that suffered by patients who go untreated. See E. FULLER TORREY, *OUT OF THE SHADOWS: CONFRONTING AMERICA'S MENTAL ILLNESS CRISIS* 152 (1997).

25. See SLOBOGIN ET AL., *supra* note 10, at 920 (explaining that state programs that mandate pre-petition or pre-hearing screening “function as the procedural facet of the least restrictive alternative doctrine”).

26. See Prins, *supra* note 1.

27. See Sharfstein & Dickerson, *supra* note 1, at 686–87.

vides an overview of the theory's critics, who describe it as overly reductionist. The Article concludes that the substantive and procedural provisions governing the front end of the civil commitment system should be evaluated not simply in terms of whether the provisions are sufficiently protective of individual liberty interests or sufficiently interventionist, but rather whether they are designed to ensure that patients receive appropriate services as their chronic diseases progress, both in community and hospital settings. This effective allocation of limited treatment and intervention resources, in turn, requires interdisciplinary redundancy and professional diversity within the group designated to make decisions about the detention of mentally ill persons.

I. A REVIEW OF STATE STATUTES GOVERNING INVOLUNTARY PSYCHIATRIC ADMISSIONS

Individuals with severe mental illness may experience state-sanctioned restraint or coercion at a number of points in the system.²⁸ They may be detained and transported to an emergency department for evaluation based on the petition of a health care professional or, in a number of states, based on the petition of a law enforcement officer, family member, neighbor, or friend.²⁹ Alternatively, persons with severe mental illness may suffer a loss of liberty as the consequence of a criminal arrest that brings them to the attention of the behavioral health system,³⁰ or they might begin treatment as a "voluntary" patient but have their status converted to an involuntary designation

28. William Brooks notes that involuntary hospitalization authorized by statute in some states may lack the requisite state action to trigger the Due Process Clause of the Fourteenth Amendment if the hospitalization is effectuated by the certification of one or more physicians and involves confinement in a private hospital facility. See William Brooks, *The Privatization of the Civil Commitment Process and the State Action Doctrine: Have the Mentally Ill Been Systematically Stripped of Their Fourteenth Amendment Rights?*, 40 DUQ. L. REV. 1, 2 (2001).

29. See BRAKEL ET AL., *supra* note 17, at 51.

30. See SLOBOGIN ET AL., *supra* note 10, at 920-21; see also Nat'l Ctr. for State Courts, *supra* note 14, at 441.

upon the expression of a desire to depart care.³¹

Given significant variation from state to state in the statutory provisions governing the initiation and management of the civil commitment process, it is difficult to provide generic labels for the procedural tools available to authorize involuntary restraint of persons with severe mental illnesses. One leading text suggests a brief taxonomy based on three characteristics: “(1) the purpose and length of the institutionalization, (2) the primary authority designated under the statute to decide whether the person shall be institutionalized, and (3) the degree of compulsion.”³² Following these criteria, the authors conclude states’ procedures generally fall into three somewhat overlapping categories: “emergency detention,” “observational institutionalization,” and “extended commitment.”³³

Many involuntarily hospitalized patients are discharged to outpatient treatment within a brief period of days and therefore never fall within the category of extended commitment.³⁴ For these persons, the substantive and procedural rules governing emergency and observational detention primarily define the legal parameters of the state coercion they experience. In some states these rules have undergone revisions over the past two decades with respect to the decision makers responsible for making the detention determination and the conditions under which that detention is authorized.³⁵ Some states have also adopted statutory revisions to make it easier for authorities to retain treatment-resistant patients on the basis of their past institutionalization and impending psychiatric collapse.³⁶ And

31. See BRAKEL ET AL., *supra* note 17, at 180; see also Richard C. Boldt, *The “Voluntary” Inpatient Treatment of Adults Under Guardianship*, 60 VILL. L. REV. 1, 9–11 (2015).

32. BRAKEL ET AL., *supra* note 17, at 50.

33. *Id.* at 51–55.

34. See SLOBOGIN ET AL., *supra* note 10, at 868.

35. See, e.g., *infra* notes 78–89 and accompanying text.

36. In the 1980s, the American Psychiatric Association promulgated *Guidelines for Legislation on the Psychiatric Hospitalization of Adults*, which provide for civil commitment when an individual “will if not treated suffer or continue to suffer severe and abnormal mental, emotional, or physical distress, and this distress is associated with significant impairment of judgment, reason, or behavior causing a substantial deterioration of his previous ability to function on his

some have addressed the respective responsibilities of distinct institutional actors within the behavioral health system, clarifying the obligations of local mental health officials, emergency departments, specialized psychiatric hospitals, general hospitals, and state facilities.³⁷ Before considering a representative sampling of state laws in this area, however, a brief review of the constitutional context in which they operate is in order.

A. *The Constitutional Context*

Over the years, litigants have sought to establish a constitutional basis for requiring a preliminary judicial hearing to review emergency psychiatric detentions early enough in the process to be a meaningful check on the exertion of state authority.³⁸ While some state courts and lower federal courts have found a right to a prompt hearing before a judicial officer under the Due Process Clause of the Fourteenth Amendment, no consistent position mandating such a review within a precise timeframe has been developed.³⁹ The analysis in most of these cases rested on a foundation of constitutional due process principles set out by the U.S. Supreme Court in other contexts.⁴⁰ In *Humphrey v. Cady*, the Court observed that commitment to a mental hospital produces “a massive curtailment of liberty.”⁴¹ In *Vitek v. Jones*, the Court built upon that observation to support its conclusion that basic due process protections attach to

own.” Am. Psychiatric Ass’n, *Guidelines for Legislation on the Psychiatric Hospitalization of Adults*, 140 AM. J. PSYCHIATRY 672, 675 (1983). This provision was intended to permit the commitment of “severely mentally ill individuals who are moving toward sudden collapse,” a group “commonly excluded from the mental health system by current legal standards.” *Id.* at 672–73; Boldt, *supra* note 18, at 57. A number of states have adopted this “potential-for-deterioration” ground. See, e.g., ALA. CODE § 22-52-10.2 (2017); N.C. GEN. STAT. § 122C-263(d) (2017); OR. REV. STAT. § 426.005(1)(f)(C) (2015); TEX. HEALTH & SAFETY CODE ANN. § 574.034 (West 2017).

37. See, e.g., VA. CODE ANN. § 37.2-808 (2017); see Nat’l Ctr. for State Courts, *supra* note 14.

38. See SLOBOGIN ET AL., *supra* note 10, at 917–19 (outlining attempts by the courts to determine an appropriate time period preceding judicial hearings).

39. See *id.* at 917–18.

40. See, e.g., *Vitek v. Jones*, 445 U.S. 480, 491 (1980); *Humphrey v. Cady*, 405 U.S. 504, 513 (1972).

41. *Humphrey*, 405 U.S. at 509.

the government's decision to transfer a prison inmate involuntarily to an inpatient psychiatric facility.⁴² The Court also applied a due process analysis to determine the requisite standard of proof for civil commitment hearings in its 1979 decision in *Addington v. Texas*⁴³ and to determine the basis for potential civil liability of state officials responsible for a patient's involuntary confinement in *O'Connor v. Donaldson*.⁴⁴ But the Court's ordinary preference for pre-deprivation procedural protections, recognized in other parts of its procedural due process jurisprudence,⁴⁵ has not found favor with respect to emergency civil commitments. Instead, the justices have recognized a post-deprivation hearing may meet constitutional standards, especially in the emergency detention context where immediate action may be necessary to prevent imminent harm to the restrained individual or to others, or in cases where an adversarial judicial proceeding might be counter-therapeutic.⁴⁶

Several lower federal courts reached a similar conclusion before the Supreme Court took up the question.⁴⁷ In 1972, the federal district court in *Logan v. Arafah* held a lack of prior

42. *Vitek*, 445 U.S. at 491-93.

43. See 441 U.S. 418, 425 (1979).

44. See 422 U.S. 563, 576 (1975).

45. In *Parratt v. Taylor*, the Supreme Court stated that "[t]he fundamental requirement of due process is the opportunity to be heard and it is an 'opportunity which must be granted at a meaningful time and in a meaningful manner.'" 451 U.S. 527, 540 (1981) (quoting *Armstrong v. Manzo*, 380 U.S. 545, 552 (1965)). The Court affirmed that due process ordinarily requires a hearing "at some time before a State finally deprives a person of his property interests," *id.*, but permitted a post-deprivation hearing in that case given "the necessity of quick action by the State or the impracticality of providing any meaningful predeprivation process . . . coupled with the availability of some meaningful means by which to assess the propriety of the State's action at some time after the initial taking." *Id.* at 539.

46. See *Parham v. J.R.*, 442 U.S. 584, 632-33 (1979) (Brennan, J., concurring in part and dissenting in part); see also *Logan v. Arafah*, 346 F. Supp. 1265, 1267-68 (D. Conn. 1972), *aff'd*, 411 U.S. 911 (1973); cf. *In re Commitment of M.G.*, 751 A.2d 1101, 1107 (N.J. App. Div. 2000) (alteration in original) (quoting *Logan*, 346 F. Supp. at 1268) (stating that an individual must have "an adequate means of testing the validity of [the] confinement within a reasonable period of time").

47. At least one lower federal court concluded that "a full hearing as to whether a person should be detained and treated for mental illness is not a necessary consequence of emergency detention." *Suzuki v. Quisenberry*, 411 F. Supp. 1113, 1126-27 (D. Haw. 1976) (requiring a prior hearing before a neutral judicial officer for a nonemergency, nonconsensual commitment).

process does not violate due process requirements provided that the individual has "an adequate means of testing the validity of [the] confinement within a reasonable period of time" after the detention commences.⁴⁸ And in *Lessard v. Schmidt*, a three-judge district court evaluating Wisconsin's statutes concluded "the state may sometimes have a compelling interest in emergency detention of persons who threaten violence to themselves or others" sufficient to permit custodial restraint without a prior judicial hearing, but "[s]uch an emergency measure can be justified only for the length of time necessary to arrange for a hearing before a neutral judge at which probable cause for the detention must be established."⁴⁹ The judges in these early cases did not, however, settle on a consistent view as to what length of time is permissible before a hearing is required once an emergency detention begins. In *Lessard*, the Court indicated that a maximum period of forty-eight hours without a preliminary hearing would be permitted,⁵⁰ and in *Lynch v. Baxley*, a three-judge panel evaluating Alabama's statute limited emergency detention to seven days without a probable cause hearing.⁵¹ Still other courts suggested that a maximum delay of between 96 and 120 hours would be acceptable,⁵² while one early opinion held that a fourteen-day period of detention without a judicial review of probable cause was beyond the permissible bounds of the Constitution.⁵³

More recently, state appellate courts have taken up this question of whether due process compels the prompt judicial review of emergency psychiatric detentions. In *New Mexico Department*

48. *Logan*, 346 F. Supp. at 1268 (alteration in original).

49. 349 F. Supp. 1078, 1091 (E.D. Wis. 1972).

50. *Id.*

51. 386 F. Supp. 378, 388 (M.D. Ala. 1974).

52. See *Wessell v. Pryor*, 461 F. Supp. 1144, 1145 (E.D. Ark. 1978) (upholding a provision requiring a probable cause hearing within 72 hours of an individual's court appearance, which may occur 24 to 48 hours after confinement, for a total time frame of 96 to 120 hours). By contrast, the Supreme Court of Minnesota, in *State ex rel. Doe v. Madonna*, held that "due process compels a preliminary probable cause hearing at least within 72 hours of initial confinement." 295 N.W. 2d 356, 365 (Minn. 1980).

53. See *In re Tedesco*, 421 N.E. 2d 726, 730 (Ind. Ct. App. 1981).

of Health v. Compton, the Supreme Court of New Mexico construed New Mexico's civil commitment provisions in light of federal due process requirements.⁵⁴ The state's Mental Health and Developmental Disabilities Code provides for three stages of involuntary civil commitment.⁵⁵ The first stage, involuntary commitment for "emergency mental health evaluation and care," permits a "peace officer" to transport an individual to a facility if the person is subject to arrest and there are reasonable grounds to believe he or she is dangerous to self or others because of mental illness or if a licensed doctor or psychologist has certified that the person is dangerous due to mental illness.⁵⁶ No judicial determination or court proceeding is required under the statute to authorize this custody and transportation for emergency evaluation and care,⁵⁷ although an admitting physician or psychologist must conduct a prompt evaluation upon the person's arrival to determine "whether reasonable grounds exist to detain the proposed client for evaluation and treatment."⁵⁸

A second stage of involuntary commitment under New Mexico law permits confinement for up to thirty days for evaluation and treatment.⁵⁹ Unlike the first stage, this thirty-day commitment does require a judicial hearing and court order, which must be scheduled within seven days of the patient's involuntary admission.⁶⁰ The third stage of the state's civil commitment system permits "extended commitment" for up to six months.⁶¹ Here again, a judicial hearing and court order are required, and the patient is entitled to elect a six-person jury to serve as the

54. See 34 P.3d 593, 600 (N.M. 2001) (holding the state's seven-day hearing requirement and procedures adequately protect a patient's constitutional right to due process).

55. See N.M. STAT. ANN. §§ 43-1-10 to -12 (2017).

56. *Id.* § 43-1-10(A).

57. *Id.* § 43-1-10(B).

58. *Id.* § 43-1-10(E).

59. *Id.* § 43-1-11(E).

60. *Id.* § 43-1-11(A).

61. *Id.* § 43-1-12.

decision maker.⁶²

Employing the balancing approach established by the U.S. Supreme Court in *Mathews v. Eldridge*,⁶³ the New Mexico Supreme Court assessed the constitutionality of the state's law permitting emergency detention and transportation without judicial review and the constitutionality of withholding any judicial involvement in the process for up to seven days.⁶⁴ With respect to emergency transportation and custody, the court noted a detained person holds a "significant liberty interest" in avoiding involuntary commitment,⁶⁵ thus placing considerable weight on the first *Mathews* factor.⁶⁶ It then observed procedural due process demands a claimant's right to be heard must take place "at a meaningful time and in a meaningful manner."⁶⁷ Taking up the remaining *Mathews* factors,⁶⁸ the court weighed the risk of error from the absence of a judicial hearing against the "compelling governmental interest of exercising its *parens patriae* power to protect individuals from themselves and its police power to protect society from dangerous individuals."⁶⁹ In assessing the risk of error, particularly the risk of false positives which occur when non-dangerous individuals are involuntarily retained, the New Mexico Supreme Court emphasized that the state's system reasonably relies on the judgment of two neutral actors—a peace officer and a "highly trained" mental health clinician—to determine whether reasonable grounds exist for the involuntary custody.⁷⁰ Moreover, the court noted

62. *Id.*

63. 424 U.S. 319, 334–35 (1976).

64. N.M. Dep't of Health v. Compton, 34 P.3d 593, 599 (N.M. 2001).

65. *Id.*

66. The first factor in the balancing test set out in *Mathews* is "the private interest that will be affected by the official action." *Mathews*, 424 U.S. at 335.

67. N.M. Dep't of Health, 34 P.3d at 599 (quoting *Mathews*, 424 U.S. at 333).

68. The remaining factors in the *Mathews* balancing test are: the risk of an erroneous deprivation of the individual interest by the government action's procedure and the probable value of any additional or substitute process, and the government's interest, including the burdens that additional or substitute process would entail. See *Mathews*, 424 U.S. at 335.

69. N.M. Dep't of Health, 34 P.3d at 599.

70. *Id.*

that persons committed involuntarily under the emergency provisions have a statutory right to counsel and to consult with an independent mental health professional.⁷¹ Under these circumstances, and given the State's compelling *parens patriae* and police power interests, the court held the absence of a preliminary judicial hearing for emergency detainees does not violate due process.⁷²

Turning to the seven-day hearing requirement for individuals subject to the thirty-day confinement alternative, the New Mexico court reviewed other, more parsimonious state court opinions that had determined that a preliminary judicial hearing is not constitutionally required, either because of the emergency nature of the involuntary civil commitment process or because, in the relevant jurisdictions, a full judicial commitment hearing was made available within a period of twenty days or more.⁷³ In light of these decisions upholding relatively lengthy involuntary hospitalizations on the basis of medical judgments alone, the New Mexico court concluded its seven-day hearing rule was constitutionally sufficient.⁷⁴

The idea that the state's interest in protecting the safety of severely mentally ill individuals and the general public is sufficiently weighty to displace any entitlement to a preliminary judicial review of the grounds for an emergency psychiatric admission has been recognized by other state courts as well; it has led one court to conclude that the basis for a seventy-two-hour "emergency hold" need not be based on either a judicial judgment or even a face-to-face evaluation by a medical or mental health professional.⁷⁵ Thus, in *Tracz ex rel. Tracz v. Charter Centennial Peaks Behavioral Health Systems, Inc.*, a Colorado appellate court upheld the constitutionality of a statute that

71. *See id.*

72. *See id.* at 599–600.

73. *See id.* at 600.

74. *See id.*

75. *See Tracz ex rel. Tracz v. Charter Centennial Peaks Behav. Health Sys., Inc.*, 9 P.3d 1168, 1171–72 (Colo. App. 2000).

permits an emergency involuntary admission for seventy-two hours on the basis of second-hand information that a statutorily authorized agent—a peace officer or “professional person”—obtained and “reasonably believes to be reliable.”⁷⁶ While nominally employing the *Mathews* balancing test, the *Tracz* court concluded that “sufficient safeguards against the risk of an erroneous decision are supplied by the requirement . . . that the professional’s evaluation be based on factual information from a person reasonably believed to be reliable,”⁷⁷ and by a separate statutory requirement that the involuntarily detained individual “receive an evaluation as soon after he is admitted as possible.”⁷⁸ Significantly, the opinion did not discuss judicial review in Colorado’s emergency detention system.⁷⁹

In short, despite several lower federal court and state supreme court decisions to the contrary,⁸⁰ there is no clear constitutional rule either requiring the preliminary judicial review of emergency psychiatric detentions or setting an absolute time limit on the period between the commencement of custody and a full adjudicatory hearing.⁸¹ The U.S. Supreme Court decisions dealing with the hospital admission of juveniles and the transfer of prisoners to a psychiatric facility provide some context for the due process analysis in this area;⁸² however, other than the Court’s summary affirmances of lower federal court decisions in the 1970s upholding lengthy delays between detention and judicial review,⁸³ there has been no unambiguous indication by the high court that a prompt preliminary judicial evaluation of

76. *Id.* (quoting COLO. REV. STAT. § 27-10-105(1)-(2) (1999)).

77. *Id.* at 1172.

78. *Id.* (quoting COLO. REV. STAT. § 27-10-105(4)).

79. *See id.* at 1168.

80. *See supra* notes 47-54 and accompanying text.

81. *See BRAKEL ET AL., supra* note 17, at 53.

82. *See generally* *Vitek v. Jones*, 445 U.S. 480 (1980) (dealing with the transfer of prisoners to psychiatric facilities); *Parham v. J.R.*, 442 U.S. 584 (1979) (dealing with the hospital admission of juveniles).

83. *See* *French v. Blackburn*, 428 F. Supp. 1351, 1362 (M.D.N.C. 1977), *aff’d*, 443 U.S. 901 (1979); *Logan v. Arafteh*, 346 F. Supp. 1265, 1272 (D. Conn. 1972), *aff’d sub nom.*, *Briggs v. Arafteh*, 411 U.S. 911 (1973).

an emergency detention is an essential component of due process.⁸⁴

As the average length of inpatient psychiatric treatment has declined and the initial detention decision has taken on greater importance, the case for requiring a systematic form of judicial review at the front end or relatively early in the detention process or both has strengthened. As the following discussion demonstrates, some jurisdictions have crafted statutory rules to reflect this need for prompt judicial oversight of the front end of the civil commitment system. Others have provided for an early form of judicial review but only on the condition that the restrained individual, or her representative, elect such a procedure. Still other jurisdictions maintain procedural timelines that delay judicial hearings until well after many detained patients' inpatient episodes have concluded. A representative sampling of these various approaches is set out below.

B. Massachusetts, New York, and California: Judicial Review by Request

In Massachusetts, an investigative report in the *Boston Globe*, published in 1997, which "described several cases of apparently improper emergency commitments" under the state's then existing law, triggered a round of statutory reforms.⁸⁵ The newspaper reporting and resulting public attention led to the creation of a court-appointed ad hoc committee to study the state's legal regulation of emergency commitments.⁸⁶ The committee's majority recommended promptly appointing counsel for all persons admitted pursuant to the emergency detention provisions, authorizing counsel to request judicial review within one business day of the detention decision, requiring hospitals to

84. See SLOBOGIN ET AL., *supra* note 10, at 917-18.

85. Marybeth Walsh, Note, *Due Process Requirements for Emergency Civil Commitments: Safeguarding Patients' Liberty Without Jeopardizing Health and Safety*, 40 B.C. L. REV. 673, 688 (1999) (discussing Don Aucoin & Mitchell Zuckoff, *Reform of Emergency Commitments Urged Lawmakers Push for Patient's Rights After Series Exposes Abuses of Law*, BOS. GLOBE, May 13, 1997, at B1).

86. See *id.* at 689.

file a formal petition for civil commitment within three days, and mandating a full judicial commitment hearing within the following five days.⁸⁷ In due course, the state's legislature adopted these recommendations with minor adjustments.⁸⁸

This amended legislation replaced Massachusetts's long-standing statute, which had permitted a "qualified physician"⁸⁹ to admit a person involuntarily for up to twenty-four days before a judicial hearing would be required, on a determination that serious harm was likely due to the patient's mental illness.⁹⁰ While the revised Massachusetts statute does contain a provision permitting other applicants to petition a court for an order directing that a mentally ill person be taken into custody for emergency evaluation,⁹¹ it also retains the earlier statute's alternative language permitting a qualified physician to authorize an individual's involuntary emergency admission, even without a prior court proceeding.⁹² The current statute's requirements with respect to the appointment of counsel and the patient's entitlement to a prompt review hearing,⁹³ however, ensure that this medical determination is not the only possible evaluation of the propriety of the detention within the first few days.

Current statutory standards in New York also call for the involvement of counsel and the availability of a review hearing before a judicial officer as part of the emergency commitment process. Under New York's Mental Hygiene Law, a person may be involuntarily admitted if a physician finds upon examination that the patient suffers from "a mental illness for which immediate observation, care, and treatment in a hospital is

87. *See id.* at 689-91.

88. 2010 Mass. Acts 1137 (codified at MASS. GEN. LAWS ch. 123, § 12(b) (2017)) (providing that a restrained individual may request an emergency hearing in the district court, which must be held within one business day after the request is filed with the court).

89. Walsh, *supra* note 85, at 673-74.

90. *See* MASS. GEN. LAWS ch. 123, §§ 7(c), 12(a), 12(d).

91. *See id.* § 12(e).

92. *See id.* § 12(b).

93. *See id.*

appropriate and which is likely to result in serious harm to himself or others.”⁹⁴ Once a patient is admitted, a second physician must confirm the statutory standard is met by examining the individual within the first forty-eight hours.⁹⁵ In addition, New York’s Mental Hygiene Legal Service, a group of specialized attorneys, must be notified promptly of the patient’s involuntary admission, and both the patient and her attorney are entitled to request a review hearing before a judge, which must be held within five days of receipt of the request.⁹⁶ If an involuntarily admitted patient either fails to request a hearing or the hearing officer determines detention is supported by “reasonable cause,” the hospital may hold the patient for up to fifteen days before being required to submit a petition for a long-term civil commitment order.⁹⁷ Once such a petition is filed, the court must hold a full civil commitment hearing within ten days.⁹⁸

Section 9.27 of New York’s Mental Hygiene Law provides an alternative process for initiating involuntary inpatient treatment. This section permits involuntary hospitalization on the basis of certification by two examining physicians together with an application by one of a number of designated persons, including family members, setting out facts supporting an allegation that the individual is mentally ill and in need of care and treatment.⁹⁹ After the application and two medical certifications are in place, either examining physician is authorized to request

94. N.Y. MENTAL HYG. LAW § 9.39(a) (McKinney 2017). The section defines “likelihood to result in serious harm” as:

1. [a] substantial risk of physical harm to himself as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that he is dangerous to himself, or
2. a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm.

Id.

95. *See id.*

96. *See id.*

97. *See id.*

98. *See id.* § 9.39(b).

99. *See id.* § 9.27(a)–(c).

law enforcement officers to take the individual into custody and transport the patient to an authorized hospital for observation and treatment.¹⁰⁰ The law then requires that a third staff physician also certify, after examination, that the patient is in need of involuntary care and treatment.¹⁰¹ As with emergency commitment under section 9.39, the process following an involuntary admission under section 9.27 requires notifying the Mental Hygiene Legal Service and permits the patient, an interested relative or friend, or the Mental Hygiene Legal Service to request a judicial review hearing, which must be held within five days of such a request.¹⁰² If no hearing is requested, or if the judicial review process confirms the propriety of the involuntary admission, New York law permits confinement for up to sixty days before a further court authorization must be obtained.¹⁰³

New York's Mental Hygiene Law also contains a provision specifically governing the emergency observation, care, and treatment of persons with mental illness by a "Comprehensive Psychiatric Emergency Program."¹⁰⁴ This provision, section 9.40

100. *See id.* § 9.27(i).

101. *See id.* § 9.27(e).

102. *See id.* § 9.31(c).

103. *See id.* § 9.33(a). Section 9.37(a) provides yet another variation. Under this provision, the director of community behavioral health services or her designee can initiate an involuntary admission process upon a finding that the individual "has a mental illness for which immediate inpatient care and treatment in a hospital is appropriate and which is likely to result in serious harm . . ." *Id.* § 9.37(a). In addition, section 9.41 permits emergency admissions by law enforcement officials, and section 9.43(a) authorizes New York courts to order the emergency admission of mentally ill individuals on the basis of a verified statement that the person poses a likely risk of harm to self or others. *Id.* §§ 9.41, 9.43(a).

104. In its 2012 annual report, the New York State Office of Mental Health stated:

Psychiatric emergency care in New York State was historically provided primarily in the emergency rooms of general hospitals and often resulted in overcrowded emergency rooms and over-utilized acute inpatient hospitalization services. An increase in the use of emergency rooms in the 1980s raised concern about the timeliness, quality, and continuity of care for people needing psychiatric emergency services. As the Office of Mental Health (OMH) continued to concentrate the locus of mental health treatment, rehabilitation, and support services in the community, there was a recognized need to support a more coordinated and comprehensive emergency service system.

Accordingly, Chapter 723 of the Laws of 1989 authorized OMH to develop a Comprehensive Psychiatric Emergency Program (CPEP)

of the Mental Hygiene Law, requires the director of a psychiatric emergency department to arrange an examination of the patient within six hours and permits the detention of the patient for up to twenty-four hours if the examining physician finds that the person has a “mental illness for which immediate observation, care and treatment in a comprehensive psychiatric emergency program is appropriate, and which is likely to result in serious harm to the person or others.”¹⁰⁵ If the determination reached in this initial examination is confirmed by a second staff physician, the patient may then be retained for up to seventy-two hours.¹⁰⁶ Section 9.40 of the Mental Hygiene Law contains the same notice and judicial review rights enumerated in section 9.39, which governs emergency commitments, although the seventy-two-hour limitation imposed on psychiatric emergency departments would seem to be inconsistent with these procedural protections which permit a delay of up to five days before a hearing must be held.¹⁰⁷ On the other hand, patients whose involuntary confinement is likely to extend beyond seventy-two hours can be involuntarily hospitalized under section 9.39, in which case the fifteen-day retention period is calculated from the patient’s first arrival in the emergency room.¹⁰⁸

In the early 1980s, New York’s statutory scheme was challenged in federal court on due process grounds because a per-

designed to provide a systematic response to psychiatric emergencies in urban areas

. . . Part K of Chapter 56 of the Laws of 2012 extended such authorization to July 2016.

. . . .

CPEPs are designed to directly provide or ensure the provision of a full range of psychiatric emergency services, seven days a week, for a defined geographic area.

N.Y. STATE OFFICE OF MENTAL HEALTH, 2012 ANNUAL REPORT TO THE GOVERNOR AND LEGISLATURE OF NEW YORK STATE ON COMPREHENSIVE PSYCHIATRIC EMERGENCY PROGRAMS 1-2 (2012), https://www.omh.ny.gov/omhweb/statistics/cpep_annual_report/2012.pdf.

105. MENTAL HYG. § 9.40(a)–(b).

106. *See id.* § 9.40(a)–(c).

107. *See id.* §§ 9.39, 9.40.

108. *See id.* § 9.39(a).

son involuntarily hospitalized under section 9.27 could be held in the hospital for up to sixty days without a judicial hearing unless a hearing was specifically requested, and a person admitted under section 9.39 could be held for fifteen days without a judicial hearing, unless such a hearing was requested.¹⁰⁹ In *Project Release v. Prevost*, a panel of the U.S. Court of Appeals for the Second Circuit, in a lengthy opinion that addressed a number of issues, held that the New York approach, which permits relatively prompt judicial review on request but does not automatically provide for it, passed constitutional muster given that the “numerous provisions in the statute for notice and hearing and reassessment of a patient’s status by . . . medical personnel and judicial officers . . . reflects a careful balance between the rights of the individual and the interests of society.”¹¹⁰ In challenging the New York approach, the plaintiffs relied on a line of cases from other states that had required probable cause hearings or other judicial review within the first few days of an emergency commitment. But the Second Circuit panel distinguished these cases by explaining that due process is flexible, requiring only those specific procedural protections “the particular situation demands” given the context of the state law taken as a whole.¹¹¹ Thus, unlike the approach challenged in the other states, explained the panel, New York’s Mental Hygiene Law provides “‘layers of professional [and judicial] review[,]’ . . . elaborate notice and hearing provisions[,] . . . the availability of a judicial hearing within five days of demand[,] . . . as well as habeas corpus relief” and is therefore consistent with the requirements of due process.¹¹²

In California, the involuntary detention of persons with mental health disorders is governed by a comprehensive civil commitment law passed in 1967 known as the Lanterman-Petris-

109. See *Project Release v. Prevost*, 722 F.2d 960, 967 (2d Cir. 1983).

110. *Id.* at 974.

111. *Id.* at 975 (quoting *Morrissey v. Brewer*, 408 U.S. 471, 481 (1972)).

112. *Id.* (alteration in original) (quoting *Addington v. Texas*, 441 U.S. 418, 428–29 (1979)).

Short Act.¹¹³ At the center of this statutory scheme are provisions that permit involuntary detention for up to two weeks without a judicial hearing when certified by two mental health professionals, one of whom must be a physician.¹¹⁴ Involuntary confinement without judicial review may be continued for an additional two weeks if two mental health professionals find the detention is based on a credible threat of suicide,¹¹⁵ or for an additional thirty days if the clinicians responsible for a patient's treatment certify he or she is "gravely disabled" and unwilling to voluntarily consent to treatment.¹¹⁶

Emergency admissions in California are authorized under section 5150 of the Lanterman-Petris-Short Act.¹¹⁷ It permits a peace officer or designated "professional person" to detain an individual with mental illness who poses a danger to self or others or who is gravely disabled.¹¹⁸ Upon presentment at an appropriate facility, a designated clinician must assess the detained person to determine whether he or she "can be properly served without being detained," and if "the person can be properly served without being detained, he or she shall be provided evaluation, crisis intervention, or other inpatient or outpatient services on a voluntary basis."¹¹⁹ If the designated professional determines the individual is dangerous or gravely disabled and cannot properly be served without being detained, the individual may be held involuntarily for up to seventy-two hours for evaluation and treatment.¹²⁰

113. See CAL. WELF. & INST. CODE § 5000 (West 2017).

114. See *id.* §§ 5250, 5251.

115. See *id.* §§ 5260, 5261.

116. The California statute defines "gravely disabled" to mean "a condition in which a person, as a result of a mental health disorder, is unable to provide for his or her basic personal needs for food, clothing, or shelter." *Id.* § 5008(h)(1)(A). The expressed legislative purpose of this provision is to prevent an overreliance on conservators who may be appointed under California law for persons who are gravely disabled.

117. See *id.* § 5150.

118. *Id.* § 5150(a).

119. *Id.* § 5150(c).

120. See *id.* § 5150(a). Article 1.5 of California's Lanterman-Petris-Short Act provides for a similar process for emergency detention and evaluation of persons with severe alcohol use

While this emergency detention does not involve any form of judicial authorization or review, California's statutory scheme also provides for an alternative procedure for initiating an emergency psychiatric admission that does require the involvement of a judge.¹²¹ Under section 5206 of the Lanterman-Petris-Short Act, a superior court judge can order that an individual undergo a mandatory evaluation if the judge finds the individual poses a danger to self or others as a result of a mental disorder or is gravely disabled and has refused or failed to accept evaluation voluntarily.¹²² The order must be served on the individual, who is "permitted to remain in his home or other place of his choosing" to be evaluated.¹²³ If the person subject to the order refuses to comply, however, the judge is authorized to order the individual be detained and transported to a facility for evaluation.¹²⁴ As with other emergency admissions for evaluation and treatment in California, the period of such detention is limited to seventy-two hours.¹²⁵

While this court-ordered evaluation provision is triggered by the submission of a petition, the Lanterman-Petris-Short Act contains a "pre-petition" requirement as part of the process leading to the court order.¹²⁶ Any individual may apply to a specified agency, designated by each county, for a petition alleging that an identified person is mentally ill and dangerous to self or others or is gravely disabled, and requesting that an evaluation of that person's condition be ordered.¹²⁷ The county agency is required to conduct a "reasonable investigation of the allegations and to make a reasonable effort to personally interview the subject of the petition."¹²⁸ The agency must also "deter-

disorders. *See id.* §§ 5170-76.

121. *See id.* § 5206.

122. *Id.*

123. *Id.*

124. *Id.*

125. *See id.*

126. *See id.* § 5202.

127. *Id.* § 5201.

128. *Id.* § 5202.

mine whether the person will agree voluntarily to receive crisis intervention services or an evaluation in his own home or in a facility designated by the county and approved by the State Department of Health Care Services.”¹²⁹ Following this pre-petition screening, the agency is authorized to file a petition if it is “satisfied that there is probable cause to believe that the person is, as a result of mental disorder, a danger to others, or to himself or herself, or gravely disabled, and that the person will not voluntarily receive evaluation or crisis intervention.”¹³⁰

The significance of this pre-petition process involves more than the nominal consideration of less restrictive alternatives that virtually all states require for civil commitment.¹³¹ Instead, California’s process—although limited to emergency detentions by petition—actively engages local officials in investigating the circumstances surrounding a requested involuntary admission, including the subject’s past treatment history, in order to determine whether an alternative arrangement in the community or under less coercive conditions could satisfy the state’s interest in the well-being of the individual and the safety of the community.¹³² For persons with chronic mental illness who are not imminently dangerous or gravely disabled, and thus not suitable for involuntary commitment, but whose past history of hospitalizations and/or criminal justice system involvement and current distress suggest the need for crisis intervention and other therapeutic measures, this pre-petition process offers the promise of linking the person to alternative resources in the community, potentially preventing complete decompensation and a subsequent psychiatric emergency.¹³³

129. *Id.*

130. *Id.* Article 3 of California’s Lanterman-Petris-Short Act provides for a similar process for the court-ordered detention and evaluation of persons with severe substance use disorders. *See id.* §§ 5225–5231.

131. *See SLOBOGIN ET AL., supra* note 10, at 888.

132. *See WELF. & INST.* § 5202.

133. *See SLOBOGIN ET AL., supra* note 10, at 919 (citation omitted) (arguing that the pre-screening process, by diverting individuals “to voluntary care, to halfway houses, and to other social agencies, ‘ensure[s] that persons are guided quickly and effectively toward the placement

As noted, if a person is detained for seventy-two hours under California's emergency evaluation provisions or the provisions governing the issuance of a court order for evaluation following petition and has received an evaluation, two physicians or one physician and one psychologist may certify the individual for up to fourteen days of intensive treatment related to a mental health disorder or chronic alcoholism.¹³⁴ In order for this certification to be made, clinicians at the facility providing the evaluation services must find that "the person is, as a result of a mental health disorder or impairment by chronic alcoholism, a danger to others, or to himself or herself, or gravely disabled."¹³⁵ In addition, the patient must be advised that treatment is necessary and must be unwilling or unable to accept treatment voluntarily.¹³⁶ With respect to the "gravely disabled" criterion, the statute draws from the U.S. Supreme Court's language in *O'Connor v. Donaldson*¹³⁷ by stating that an individual does not meet that requirement "if that person can survive safely without involuntary detention with the help of responsible family, friends, or others who are both willing and able to help provide for the person's basic personal needs for food, clothing, or shelter."¹³⁸

Importantly, a person certified under these provisions must be provided with written notice of the certification and must be informed that he or she is entitled to a "certification review hearing, to be held within four days of the [intensive treatment certification date] . . . unless judicial review is requested, to determine whether . . . probable cause exists to detain the person for intensive treatment related to the mental disorder or

and treatment indicated by their presenting problems").

134. WELF. & INST. § 5250.

135. *Id.* § 5250(a).

136. *Id.* § 5250(c).

137. 422 U.S. 563, 576 (1975) ("[A] State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.").

138. WELF. & INST. § 5250(d)(1).

impairment by chronic alcoholism.”¹³⁹ The person certified must also be informed of his or her rights with respect to the hearing, including the right to the “assistance of another person to prepare for the hearing or to answer other questions and concerns regarding his or her involuntary detention or both.”¹⁴⁰

The certification review hearing, which is the default procedure California uses, is not a judicial hearing or a preliminary hearing in court; rather, it is a decision-making process presided over by a commissioner, referee, or “certification review hearing officer.”¹⁴¹ That officer may be a “state qualified administrative law hearing officer, a physician . . . , a licensed psychologist, a registered nurse, a lawyer, a certified law student, a licensed clinical social worker, a licensed marriage and family therapist, or a licensed professional clinical counselor.”¹⁴² Certification review hearing officers are selected from a list of “eligible persons unanimously approved by a panel composed of the local mental health director, the county public defender, and the county counsel or district attorney designated by the county board of supervisors.”¹⁴³

At the certification review hearing, the person certified is entitled to the assistance of an attorney or a non-lawyer “advocate.”¹⁴⁴ The hearing is to be “conducted in an impartial and informal manner in order to encourage free and open discussion by participants . . . [and t]he person conducting the hearing shall not be bound by rules of procedure or evidence applicable in judicial proceedings.”¹⁴⁵ If the certification review hearing officer concludes there is probable cause to believe the person certified is, “as a result of a mental disorder or impairment by chronic alcoholism, a danger to others, or to himself or herself,

139. *Id.* § 5254.

140. *Id.*

141. *Id.* § 5256.1.

142. *Id.*

143. *Id.*

144. *Id.* § 5256.4(a)(1).

145. *Id.* § 5256.4(b).

or gravely disabled, then the person may be detained for involuntary care, protection, and treatment.”¹⁴⁶

As an alternative to the certification review hearing process, a person who has been certified for intensive treatment may elect to have judicial review of the certification decision by way of habeas corpus.¹⁴⁷ This judicial review must be in the superior court for the county in which the facility providing intensive treatment is located or in the county in which the seventy-two hour evaluation was conducted, and must take place within two “judicial days” of the patient’s request.¹⁴⁸ A person requesting judicial review is not limited to receiving assistance from a lay advocate, but is entitled to be represented by the public defender or other appointed counsel to help prepare the habeas corpus petition and represent her in the proceedings.¹⁴⁹ If the court finds that the criteria for certification have not been shown, it must order the certified individual’s immediate release.¹⁵⁰

While the system in California is similar to the systems in place in Massachusetts and New York in that it makes preliminary judicial review of the detention decision available within the first few days of custody upon the request of the detained individual or her agent, it is distinctive in its reliance on a default process that involves an informal review hearing frequently overseen by a mental health professional instead of a judge and supported by a lay advocate instead of appointed counsel. This choice to select a non-judicial actor as the default decision maker at the preliminary stage of the process is significant. Historically, states have deployed a number of different kinds of decision makers in the civil commitment process.¹⁵¹ Today, most jurisdictions authorize judges to make long-term

146. *Id.* § 5256.6.

147. *See id.* § 5275.

148. *Id.* § 5276.

149. *See id.*

150. *See id.*

151. *See BRAKEL ET AL., supra* note 17, at 51.

commitment decisions,¹⁵² while a few provide juries.¹⁵³ Several states rely on administrative boards to make detention review determinations, either early in the process or subsequently,¹⁵⁴ and some rely on medical or mental health professionals; however, no state currently permits medical or psychiatric decision makers to make the final long-term commitment decision.¹⁵⁵ Prior to 1970, however, psychiatric boards and other medical professionals were the dominant decision makers within the civil commitment system in the United States, precisely because the commitment decision was regarded as medical in nature rather than legal.¹⁵⁶

Notwithstanding the predominance of judicial decision makers later in the process, when long-term commitment determinations are made, California, and a number of other jurisdictions, rely heavily on non-judicial decision makers at the preliminary or emergency observational stage.¹⁵⁷ Given the relatively short length of most psychiatric inpatient treatment episodes, these non-judicial decision makers may, effectively, have the last word on the propriety of detaining most involuntarily treated psychiatric patients. Relevant to this practical predominance of non-judicial review in California and elsewhere is the U.S. Supreme Court's consideration, in *Parham v. J.R.*, of the respective qualifications of mental health professionals versus judicial officers in reviewing psychiatric admission decisions.¹⁵⁸ The Court in *Parham* stated:

Due process has never been thought to require that the neutral and detached trier of fact be law trained or a judicial or administrative officer. Surely, this is the case as to medical decisions, for

152. *See id.* at 50, 56.

153. *See id.* at 68.

154. *See id.* at 72–73.

155. *See id.* at 50.

156. *See id.*

157. *See id.* at 51.

158. *See* 442 U.S. 584, 607–09 (1979).

“neither judges nor administrative hearing officers are better qualified than psychiatrists to render psychiatric judgments.”

....

What process is constitutionally due cannot be divorced from the nature of the ultimate decision that is being made

Here, the questions are essentially medical in character

Although we acknowledge the fallibility of medical and psychiatric diagnosis, we do not accept the notion that the shortcomings of specialists can always be avoided by shifting the decision from a trained specialist using the traditional tools of medical science to an untrained judge or administrative hearing officer after a judicial-type hearing. Even after a hearing, the nonspecialist decisionmaker must make a medical-psychiatric decision.¹⁵⁹

A year after its decision in *Parham*, the Supreme Court in *Vitek v. Jones* once again held that an involuntary psychiatric admission, in this instance by way of transfer from a state prison to a psychiatric facility, did not require review by a judicial officer, although it did require an “independent [non-judicial] decisionmaker.”¹⁶⁰ Consistent with its earlier reasoning, the Court explained that the transfer decision at issue in the case “involve[d] a question that is essentially medical,” and on that basis approved the state’s use of non-lawyers in the process.¹⁶¹

This reasoning, that involuntary psychiatric-admission decisions are essentially medical questions that require specialized

159. *Id.* (citations omitted).

160. *Vitek v. Jones*, 445 U.S. 480, 495 (1980).

161. *Id.* Interestingly, while a plurality of the *Vitek* Court thought that appointed counsel was constitutionally required, Justice Powell’s concurring opinion concluded “a qualified and independent adviser” might be sufficient for due process purposes. *Id.* at 499-500 (Powell, J., concurring in part).

expertise, was called into question by Judge David Bazelon in a number of influential opinions in the Court of Appeals for the D.C. Circuit and in his scholarly writing. In one article, he relied on an analogy to the practice of judicial review of administrative agency decision making to mount the argument that psychiatric detention decisions involve *both* medical and legal components, and thus *both* mental health professionals and legal professionals have an appropriate and intersecting role to play in the involuntary commitment process.¹⁶² Judge Bazelon explained that medical decision makers properly should be relied upon to evaluate the clinical needs of individuals with severe mental disabilities, but that judicial decision makers have an equally important obligation to ensure that the process of balancing therapeutic and public safety interests with the liberty and autonomy interests of individual detainees has been undertaken rationally and with procedural regularity.¹⁶³ Bazelon thus observed:

There is a central but limited role for courts in [the system for involuntarily hospitalizing disturbed or disturbing individuals] – that role is to guide professional decisionmaking, and may be best described by the familiar model of judicial review of administrative decisionmaking. Courts must determine whether there has been a full exploration of all relevant facts, opposing views and possible alternatives, whether the results of the exploration relate rationally to the ultimate decision, and whether constitutional and statutory procedural safeguards have been faithfully observed. Our function is thus not to determine whether the decisions taken by those charged with handling disturbed or disturbing individ-

162. See David L. Bazelon, *Institutionalization, Deinstitutionalization, and the Adversary Process*, 75 COLUM. L. REV. 897, 910–11 (1975).

163. See *id.*

uals are correct or wise—but whether they are rational in the manner I have just described.

. . . [S]tate intervention involves a serious compromise of individual rights and hence a difficult balancing of power between the state and the individual . . . Courts have traditionally been the protector of individual rights against state power . . . We cannot delegate this responsibility to the medical professions. Those disciplines are, naturally enough, oriented toward helping people by treating them. Their value system assumes that disturbed or disturbing individuals need treatment, that medical disciplines can provide it, and that attempts to resist it are misguided or delusory. The medical disciplines can no more judge the legitimacy of state intervention into the lives of disturbed or disturbing individuals than a prosecutor can judge the guilt of a person he has accused.¹⁶⁴

C. *Virginia's Comprehensive Approach*

Perhaps in recognition of Judge Bazelon's observation about the important role that legal professionals can play alongside mental health professionals in the civil commitment system, Virginia's statutory provisions governing involuntary admissions for behavioral health care interpose a judicial officer as a required decision maker early in the process and often as a gatekeeper at the very front end of the process.¹⁶⁵ Unlike the approach used in California, New York, and Massachusetts—which makes a judicial hearing available within the first week

164. *Id.* at 910 (footnote omitted).

165. *See* VA. CODE ANN. § 37.2-814(B) (2017). The Virginia Code employs both magistrates and judges in this process. *See id.* §§ 37.2-808, -809, -814; *see also id.* § 19.2-37 (detailing the qualifications required to serve as a magistrate and explaining that a formal legal education is not needed).

or so of an emergency admission but only if the patient or her representative so requests – the Virginia approach provides for judicial review automatically.¹⁶⁶

Section 37.2-808 of the Virginia Code governs the emergency custody of persons with mental illness who are imminently dangerous to self or others and who require inpatient care.¹⁶⁷ This section empowers a magistrate to issue an emergency custody order based on the sworn petition of any “responsible person” or a treating physician, or on the magistrate’s own motion, if there is probable cause to believe that an individual is mentally ill, is likely to cause serious harm to self or others in the near future, is in need of treatment, and is unwilling or incapable of volunteering for hospitalization or treatment.¹⁶⁸ The section also contains detailed provisions directing the magistrate to specify the law enforcement officials responsible for transporting the patient and regulating the transfer of custody of the individual.¹⁶⁹ Alternatively, the section also permits a law enforcement officer to take an individual into custody and transport her for evaluation without prior authorization by a magistrate if the officer has probable cause to believe that the person meets the criteria for emergency custody based on personal observation or the reliable reports of others.¹⁷⁰

In either instance, whether founded on the prior authorization of a magistrate or on an officer’s determination of probable cause, the detained person may be held for up to eight hours under Virginia’s emergency custody provisions.¹⁷¹ During this

166. Compare CAL. WELF. & INST. CODE § 5275 (West 2017) (person certified for intensive treatment may elect to have judicial review of the certification decision by way of habeas corpus), and MASS. GEN. LAWS ch. 123, § 12(b) (2017) (providing that a restrained individual may request an emergency hearing in the district court, which must be held within one business day after the request is filed with the court), and N.Y. MENTAL HYG. LAW § 9.39 (McKinney 2017) (the patient and her attorney may request a review hearing before a judge, which must be held within five days of the request), with VA. CODE ANN. §§ 37.2-808, -809, -814 (2017).

167. VA. CODE ANN. § 37.2-808.

168. *Id.* § 37.2-808(A).

169. *Id.* § 37.2-808(C), (E).

170. *Id.* § 37.2-808(G).

171. *See id.* § 37.2-808(K).

period of confinement, Virginia's scheme contemplates that the individual will be evaluated by a specially trained and certified representative of the local community behavioral health services board to determine if she meets the criteria for temporary detention under section 37.2-809.¹⁷² The detained individual may be released at any point during the emergency custody or upon the expiration of the eight-hour emergency custody period, or may be detained beyond the eight-hour limit upon the issuance of a temporary detention order.¹⁷³

Temporary detention orders also require the participation of a magistrate, and permit the involuntary admission of an individual for up to seventy-two hours.¹⁷⁴ While temporary detention can result from the emergency custody process and evaluation, Virginia law also permits a magistrate to issue a temporary detention order without an emergency custody order proceeding.¹⁷⁵ In most such instances, the order is prompted when a "responsible party" or treating physician files a sworn petition.¹⁷⁶ Before a magistrate can issue an order, an authorized agent of the local community services board must evaluate the individual to determine if she has a mental illness that creates a substantial likelihood that the person is dangerous to self or others, is in need of hospitalization or treatment, and is unwilling or incapable of voluntarily consenting to care.¹⁷⁷

Under Virginia Code Annotated section 37.2-814, a full-blown "commitment hearing for involuntary admission" must be held at the conclusion of the seventy-two-hour temporary detention period if the individual is to remain involuntarily

172. *See id.* § 37.2-808(B).

173. *See id.* § 37.2-808(K).

174. *See id.* § 37.2-809(A), (D).

175. *See id.*

176. *See id.* § 37.2-809(B).

177. *See id.* In some instances, a magistrate may issue a temporary detention order without this prior evaluation, if the patient has been examined by an authorized agent of the local community services board within the previous seventy-two hours or presents a "significant physical, psychological, or medical risk" to those who would be involved in conducting an evaluation. *See id.* § 37.2-809(D).

hospitalized.¹⁷⁸ During the seventy-two-hour temporary detention window, those responsible for the patient's care are directed to "initiat[e] . . . mental health treatment to stabilize the person's psychiatric condition to avoid involuntary commitment where possible . . ." ¹⁷⁹ The commitment hearing, which is presided over by a district court judge or special justice, must include consideration of an independent examination conducted by a psychiatrist or psychologist¹⁸⁰ and a "preadmission screening report" prepared by the local community services board.¹⁸¹ The independent examination must contain: (1) a clinical assessment and substance abuse screening; (2) a risk assessment; (3) an assessment of the person's capacity to consent to treatment; (4) a review of the treatment records from the temporary detention facility; (5) a discussion of the individual's treatment preferences; (6) an assessment of whether the individual meets criteria for discharge to "mandatory outpatient treatment following a period of inpatient treatment"; (7) an assessment of the suitability of alternatives to inpatient treatment; and (8) a "recommendation[]" for the placement, care, and treatment of the person."¹⁸² The preadmission screening report, in turn, must evaluate the criteria for involuntary admission—including whether the individual suffers from mental illness and is imminently dangerous to self or others or incapable of providing for basic human needs—and must state whether a less restrictive alternative to inpatient treatment would be appropriate.¹⁸³

Broadly speaking, then, most involuntary hospitalizations in Virginia involve an initial determination by a magistrate that there is probable cause to believe the basic criteria for admission

178. *See id.* § 37.2-814(A).

179. *Id.* § 37.2-809(H).

180. *See id.* § 37.2-815(A).

181. *See id.* § 37.2-816.

182. *See id.* § 37.2-815(B).

183. *See id.* § 37.2-816.

are present,¹⁸⁴ and a further, carefully structured judicial hearing at the seventy-two-hour mark to ensure that the grounds for longer-term custody have been established by clear and convincing evidence.¹⁸⁵ The central role played in this scheme by judicial officers is supplemented by the carefully structured input of evaluators provided by the local community services board in the early stages and by a licensed physician or psychologist at a subsequent stage of the process.¹⁸⁶ The interdisciplinary redundancy of this system, together with its emphasis on identifying the least restrictive placement appropriate given the individual's circumstances, is designed to accomplish the same sort of balancing of interests that the Second Circuit Court of Appeals panel identified in the *Project Release* case.¹⁸⁷ The reliance on magistrates at the start of the process is a clear indication that even a short-term emergency or temporary detention for psychiatric evaluation, observation, and care is a significant intrusion on the liberty interests of the detained individual. Moreover, the fact that a full civil commitment hearing before a district court judge or special justice must be made available to those patients involuntarily held beyond the seventy-two-hour mark is directly responsive to the typically shortened period of hospitalization that most psychiatric patients now experience.¹⁸⁸ At the same time, the highly stylized approach set out in the Virginia statutes also suggests the influence of a changing system for financing behavioral health care, the importance of coordinating decision making between treatment facilities, and the critical need for an adequately supported continuum of treatment services in the community.

184. See *id.* § 37.2-808(A).

185. See *id.* § 37.2-814(A); see also *Addington v. Texas*, 441 U.S. 418, 418 (1979) ("A 'clear and convincing' standard of proof is required by the Fourteenth Amendment in a civil proceeding brought under state law to commit an individual involuntarily for an indefinite period to a state mental hospital.").

186. See VA. CODE ANN. § 37.2-809(B), (C).

187. See *supra* notes 108-10 and accompanying text.

188. See *supra* note 98 and accompanying text.

D. The Maryland Alternative

In contrast with the heavy reliance on judicial decision makers in the early stages of the process in Virginia, and the somewhat less insistent availability of judicial review in Massachusetts, New York, and California, the approach in Maryland permits emergency detention in a large number of instances without systematic judicial oversight.¹⁸⁹ In Maryland, a person suffering from severe mental illness may be detained and transported to an emergency room or local hospital for evaluation on the basis of an unendorsed petition submitted by a health professional or law enforcement official or on the basis of an endorsed petition submitted by any other “interested party,” including family, neighbors, or friends of the individual.¹⁹⁰ Before a person can be detained and transported pursuant to an endorsed petition, a trial court judge must find probable cause to believe the individual has a mental disorder and presents a danger to self or others.¹⁹¹ Persons taken into custody and transported pursuant to an unendorsed petition, however, do not receive this front-end judicial scrutiny.¹⁹²

An individual transported to an emergency facility pursuant to an endorsed or unendorsed petition must be evaluated by a physician within the first six hours.¹⁹³ The individual may be admitted if there is no less restrictive form of intervention available and the physician determines the patient has a mental disorder, is in need of inpatient care or treatment, presents a danger to self or others, and is unable or unwilling to be admitted voluntarily.¹⁹⁴ The individual may not be retained under these

189. *See generally* MD. CODE ANN., HEALTH-GEN. §§ 10-622 to -624 (LexisNexis 2017) (initial judicial review only required when a lay petitioner submits a petition with respect to a detained person).

190. *See id.*

191. *See id.* § 10-623(b).

192. *Compare id.* § 10-623(a) (requiring petitions to be presented to the court “for immediate review”), *with id.* § 10-624(a) (providing for patient transport without the need for judicial review of the petition).

193. *See id.* § 10-624(b)(2).

194. *See id.* § 10-632(e)(2).

provisions for more than thirty hours.¹⁹⁵ During this time, an application for involuntary admission, which may be submitted by any person who has “a legitimate interest in the welfare of the individual,” must be prepared.¹⁹⁶ The application must be accompanied by the certificates of two physicians – or one physician and either a psychologist or psychiatric nurse practitioner.¹⁹⁷ Each certificate must be based on a personal examination and must set out the basis for the physician’s opinion that inpatient treatment is necessary for the protection of the patient or others.¹⁹⁸

While persons subject to involuntary hospitalization under these Maryland provisions must, within twelve hours of being detained, be provided with notice regarding their confinement, their right to consult with a lawyer, and the standards for civil commitment,¹⁹⁹ a hearing before a judicial officer need not occur for ten days.²⁰⁰ The hearing may also be postponed for good cause for up to seven additional days.²⁰¹ Thus, an individual who has been taken into custody and transported to an emergency facility pursuant to an unendorsed petition submitted by a health care professional or law enforcement official could conceivably be held for seventeen days without any judicial review.²⁰² Of course, a patient seeking to contest his or her confinement in the intervening period could attempt review by way of a petition for habeas corpus.²⁰³ The hearing on the writ ordinarily should be heard within a week of being filed, but because of heavy court dockets, that is not necessarily the case.²⁰⁴

Accordingly, as in California and a number of other jurisdictions, the laws governing the front end of the involuntary

195. *See id.* § 10-624(b)(4).

196. *Id.* § 10-614(a).

197. *See id.* § 10-615(6).

198. *See id.* § 10-616(a).

199. *See id.* § 10-631(a)–(b).

200. *See id.* § 10-632(b).

201. *See id.* § 10-632(c).

202. *See id.* § 10-632(b)–(c).

203. *See FISHER ET AL.*, *supra* note 20, at 30.

204. *See id.*

admission process in Maryland do not systematically ensure that judicial decision makers supplement and review the judgments of medical and law enforcement officials, at least within a timeframe that is typical for most patients subject to inpatient psychiatric care. With respect to the initial decision to detain and/or transport a person for evaluation, a growing number of states do require the involvement of a judge or magistrate, either before the individual is taken into custody or shortly after the detention is initiated.²⁰⁵ Other jurisdictions, however, continue to permit law enforcement or medical personnel to make initial detention determinations without judicial endorsement or immediate review.²⁰⁶ Following the initial period of emergency detention, however authorized, some states provide an automatic judicial probable cause hearing while others make such a hearing available only by request.²⁰⁷ Among

205. Alabama law, for example, requires initial certification by a probate judge who must determine, "from an interview with the patient and other available persons what limitations, if any, shall be imposed upon the respondent's liberty and what temporary treatment, if any, shall be imposed upon the respondent . . . pending further hearings." ALA. CODE § 22-52-7(a) (2017). "If limitations on the respondent's liberty are ordered, the probate judge may order respondent detained . . . at a designated mental health facility or a hospital." *Id.* By contrast, an Idaho provision requires evidence of grave disability or imminent danger due to mental illness to be presented to a duly authorized court within twenty-four hours from the time an individual is placed in custody or detained. IDAHO CODE § 66-326(1) (2017). Similarly, in Maine, a written application for emergency detention, which must be accompanied by a certificate signed by a medical practitioner must be reviewed by a justice of the superior court, a judge of the district court, a judge of probate, or justice of peace. ME. STAT. tit. 34-B, § 3863(2)-(3) (2017). The person may be detained in hospital for a reasonable period of time, not to exceed twenty-four hours, pending endorsement by the judge/justice, if endorsement is sought immediately. *Id.* § 3863(3)(B).

206. In addition to Maryland, other states that take this approach include Kentucky and Louisiana. In Kentucky, any peace officer who has reasonable grounds to believe an individual needs emergency detention is authorized to take that individual into custody and transport her to a hospital or other psychiatric facility for evaluation. KY. REV. STAT. ANN. § 202A.041(1) (2017). If, after evaluation, a qualified mental health professional finds that the person meets statutory criteria for involuntary hospitalization, the person may be held pending certification and additional statutory procedures. *Id.* In Louisiana, a physician, psychiatric mental health nurse practitioner, or psychologist may execute an emergency certificate after examination of an individual. LA. STAT. ANN. § 28:53(B)(1) (2017).

207. And some states, such as Virginia, follow the recommendations of the National Task Force on Guidelines for Involuntary Civil Commitment by scheduling a full civil commitment hearing within the first three to five days of confinement, thereby obviating the need for a separate probable cause hearing. *See infra* Section II.B.

the states that provide for an automatic hearing, the time permitted between initial confinement and hearing can be as brief as a few days or as long as a few weeks.²⁰⁸ For those jurisdictions that require the patient, his or her attorney, or others to request a probable cause hearing, judicial review is typically made available within two to three days of receipt of the request.²⁰⁹ In the absence of such a request, however, these states usually permit confinement to continue for an extended period before a formal judicial proceeding is convened.²¹⁰

Each of these decisions – to require the involvement of a judicial officer in the initial detention determination or not; to require an automatic probable cause hearing, an optional hearing, or no probable cause hearing at all; and to mandate either a quick or a delayed timeline for whatever judicial oversight is statutorily provided – implicates the others, and all must be calibrated in a coordinated fashion with an understanding that together they constitute an integrated system. These interconnected decisions, in turn, rest on a set of fundamental questions about how the public mental health system, the criminal justice

208. In Arkansas, for example, a hearing must be held within seventy-two hours of a person's detention. ARK. CODE ANN. § 20-47-210(b)(3) (2016). In Indiana, an individual may be detained for up to seventy-two hours pursuant to an endorsed petition, but the superintendent of the facility or an attending physician must make a written report to the court before the end of the detention period. IND. CODE §§ 12-26-5-5, -5-1 (2016). The court must then consider the report within twenty-four hours of receiving it, *id.* § 12-26-5-8, and may order the individual released or permit the individual's continued detention pending a preliminary hearing or final hearing, either of which must be held no later than two days after issuance of the order, *id.* § 12-26-5-9. At the other end of the continuum, in Hawaii, the requisite judicial review must occur no later than ten days after the date a petition is filed, unless reasonable delay is sought for good cause shown by the subject of the petition, her attorney, or anyone entitled to receive notice under the law. HAW. REV. STAT. § 334-60.5(b) (2016).

209. *See, e.g.*, CONN. GEN. STAT. § 17a-502(d) (2017) (mandating that if a detained person or her representative requests a hearing in writing, the hearing "shall be held within seventy-two hours" of receipt of the request, excluding weekends and holidays). *But see* LA. STAT. ANN. § 28:53(D) ("Prior to or during confinement, . . . any person or his attorney shall have the right to demand a judicial hearing to determine if probable cause exists for his continued confinement under an emergency certificate. The hearing shall be held within five days of the filing of the petition.").

210. In Louisiana, for example, the timeline is fifteen days, LA. STAT. ANN. § 28:53(A)(1), and in Connecticut, emergency detention is permitted for up to fifteen days without court order, if no request for earlier review is made. CONN. GEN. STAT. § 17a-502(a).

system, and other relevant public and private institutions ought to be organized to most effectively shoulder the responsibility of caring for persons with severe mental illness and other significant mental disabilities. It is to that set of fundamental questions that we now turn.

II. TRANSINSTITUTIONALIZATION, INTERDISCIPLINARY REDUNDANCY, AND INTEGRATED SCREENING AND DECISION MAKING

The history of involuntary civil commitment in the United States is generally framed in terms of a sharp struggle between libertarian and paternalistic perspectives on the treatment of persons with severe mental disorders.²¹¹ Over the past fifty years, the relative balance reflected in state laws and practices, between the community's interest in helping individuals in need and safeguarding the public on the one hand, and protecting the liberty of those subject to coercive state interventions on the other, has shifted from one side to the other. In the 1950s, the emphasis was on providing "wide latitude" to professionals within the mental health treatment community to make commitment decisions based on discretionary clinical judgments about patients' treatment needs.²¹² During the late 1960s and 1970s, publicity about the deplorable conditions in large state institutions, growing skepticism about the accuracy of medical diagnoses and the efficacy of the treatment offered in state hospitals, and a sharpened focus on the civil rights of vulnerable citizens led advocates to press legislatures and courts for reforms adopting "legal safeguards in involuntary civil commitment laws resembling the due process guarantees of the criminal justice model."²¹³ By the mid-1980s, however, a chorus of voices—including some from the treatment community and the families of individuals with mental disabilities—began to

211. See Boldt, *supra* note 18, at 42–46.

212. Nat'l Ctr. for State Courts, *supra* note 14, at 415.

213. *Id.*

push back, advocating for broadened commitment standards, increased inpatient treatment capacity, and greater use of “assisted outpatient treatment” and other forms of outpatient commitment.²¹⁴

A. *Deinstitutionalization and Its Effects*

The struggle between these two perspectives, which has characterized the public debate with respect to involuntary civil commitment over most of the past half century, can be mapped onto a remarkable shift in the concrete features of the behavioral health treatment system in the United States over roughly the same period. The most dramatic element in this shifting practical landscape is the extreme decline in the system’s reliance on large state hospitals for the long-term care of persons with severe chronic mental illnesses and other significant mental disabilities. This is the well-documented phenomenon of deinstitutionalization. In 1955, the daily patient census in state and county psychiatric hospitals was roughly 560,000 individuals.²¹⁵ By 2003, that number declined to less than 50,000 individuals.²¹⁶ But the shifting landscape has other features worth noting as well. The location of inpatient treatment provided to psychiatric patients has moved significantly to “acute care settings in the private sector, which includes general and private psychiatric hospitals.”²¹⁷ The duration of inpatient episodes is now, on average, measured in days rather than weeks or months.²¹⁸ And, because of a decline in private psychiatric hospital beds as well as beds in state facilities, the system now relies on an increased use of emergency departments as sites for delivering acute psychiatric care.²¹⁹

214. See Boldt, *supra* note 18, at 46–47.

215. Samuel R. Bagenstos, *The Past and Future of Deinstitutionalization Litigation*, 34 CARDOZO L. REV. 1, 9 (2012).

216. *Id.*

217. Sharfstein & Dickerson, *supra* note 1, at 685.

218. See *id.* at 687 (discussing the increased use of “day hospitals and outpatient services”).

219. See generally Jennifer M. Park et al., *Factors Associated with Extended Length of Stay for*

While it is tempting to view the profound changes in substantive legal standards and the significant increase in procedural protections that came into the system in the 1960s and 1970s as the primary drivers of deinstitutionalization, thoughtful research suggests these changes in the civil commitment process played a relatively minor role in this shifting landscape.²²⁰ Likely more important was the introduction and proliferation in the use of neuroleptic medications in the mid-twentieth century and the further refinement of psychiatric pharmacotherapy, including the more recent development of second-generation antipsychotic drugs, which enabled a whole class of long-term patients to be discharged to community treatment.²²¹ And more important still were fundamental developments within the health care finance system, which created strong incentives for states to shift the locus of treatment from state hospitals to other settings.

In 1970, nearly 80% of the available inpatient psychiatric beds in the United States were in state and county hospitals.²²² By 2002, not only had the total number of beds declined significantly, but only about a quarter were located in public psychiatric hospitals.²²³ Indeed, by the first decade of the twenty-first century, 60% of the costs of inpatient psychiatric treatment were borne by Medicaid or Medicare.²²⁴ Essentially, the states have off-loaded a significant financial burden from their budgets onto federal health insurance programs by moving long-term psychiatric patients into nursing homes, group homes, and other community-based settings, and by encouraging the use of smaller psychiatric units in general hospitals and

Patients Presenting to an Urban Psychiatric Emergency Service: A Case-Control Study, 36 J. BEHAV. HEALTH SERV. & RES. 300 *passim* (2009) (discussing the acute care of psychiatric patients in emergency departments).

220. See Bagby & Atkinson, *supra* note 9 and accompanying text.

221. See SLOBOGIN ET AL., *supra* note 10.

222. *Id.* at 685.

223. See *id.*

224. See *id.* at 687.

private psychiatric hospitals to deliver short-term acute care.²²⁵

Regardless of whether deinstitutionalization was driven primarily by economics, civil libertarian legal reforms, the availability of new medical technologies, or a combination of these factors, many patients benefitted considerably by avoiding lengthy involuntary psychiatric hospitalizations.²²⁶ Research suggests brief hospitalizations focused on stabilizing acutely ill psychiatric patients with medication and arranging aftercare in the community can be as effective as long-term inpatient treatment in preventing self-harm.²²⁷ If patients are stabilized and released quickly, it is likely that the considerable human costs of long-term hospitalization—including loss of privacy and autonomy, increased risk of physical harm, functional deterioration, and isolation from family and community—can be minimized or avoided.²²⁸ Moreover, studies from the 1980s demonstrated that outpatient treatment and other forms of alternative care in nursing homes and halfway houses often can be “more effective and less costly than mental hospitalization,”²²⁹ and recent research has confirmed these conclusions.²³⁰

At the same time, the choice to limit the use of involuntary inpatient psychiatric treatment and to shorten the length of stay for those who are admitted may exact costs that approach or are even greater than those associated with the excess use of custodial care. One leading advocate for greater use of involuntary inpatient treatment has argued that “[a] tragic consequence of the efforts of mental health lawyers to make it difficult to hospitalize and treat the mentally ill is that the person’s symptoms

225. *See id.*; Prins, *supra* note 1, at 717–18.

226. *See generally* RICHARD G. FRANK & SHERRY A. GLIED, BETTER BUT NOT WELL: MENTAL HEALTH POLICY IN THE UNITED STATES SINCE 1950 (2008) (highlighting the benefits of recent advances in mental health care and the persistent systematic problems).

227. *See* SLOBOGIN ET AL., *supra* note 10, at 868.

228. *See* Dickinson, *supra* note 24.

229. SLOBOGIN ET AL., *supra* note 10, at 896 (quoting CHARLES A. KIESLER & AMY E. SIBULKIN, MENTAL HOSPITALIZATION: MYTHS AND FACTS ABOUT A NATIONAL CRISIS 179 (1987)).

230. *See id.* at 896–97. This research, however, did not include patients who were imminently dangerous to self or others, the primary group subject to civil commitment proceedings.

may irreversibly worsen.”²³¹ Others have made the case that moving the locus of treatment from the state hospital to the community has contributed to an epidemic of the “homeless mentally ill”²³² and has pushed many persons with chronic mental illness into the criminal justice system, where their interests in being treated with dignity and receiving effective care are likely to be even further undermined.²³³ Indeed, some writers have described as a “near-consensus” the view that deinstitutionalization has been a failure of well intended but poorly thought out public policy.²³⁴

The two narratives underlying the notion that deinstitutionalization has been a failure—that it contributed to an epidemic of homelessness and forced thousands of severely mentally ill individuals into jails and prisons—have become the subject of energetic critiques by others who have studied these phenomena. With respect to the first narrative, Samuel Bagenstos, Michael Perlin, and others have argued that in the early years of deinstitutionalization, the declining patient population of state and county mental hospitals was “more than offset” by a growing reliance on nursing homes and general hospitals.²³⁵ Further, they have argued that the increase of homelessness among those with chronic mental illness beginning in the 1980s was more a function of the deterioration of housing conditions, a failure of state and local governments to provide adequate supportive services, and a decline in support from the federal government and the states by way of Supplemental Security Income (SSI) and housing assistance.²³⁶

The second narrative at the heart of the claim that deinsti-

231. TORREY, *supra* note 24.

232. Bagenstos, *supra* note 215.

233. See RAELE JEAN ISAAC & VIRGINIA C. ARMAT, *MADNESS IN THE STREETS: HOW PSYCHIATRY AND THE LAW ABANDONED THE MENTALLY ILL* 11–13 (1990); Prins, *supra* note 1, at 716.

234. Bagenstos, *supra* note 215, at 4–7.

235. *Id.* at 10–11 (quoting BRENDAN O’FLAHERTY, *MAKING ROOM: THE ECONOMICS OF HOMELESSNESS* 235 (1996)).

236. See Michael L. Perlin, *Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization*, 28 HOUS. L. REV. 63, 75–79 (1991).

tutionalization has been a policy failure is based on a thesis that some have labeled “transinstitutionalization.”²³⁷ Proponents of this view start with the assumption that state and county psychiatric hospitals and criminal justice system institutions are “functionally interdependent.”²³⁸ The hypothesis that follows is that when states reduced the availability of psychiatric beds in state hospitals, the displaced former patients with severe mental illness found themselves in the community with inadequate treatment and other human services, and were drawn into jails and prisons, which became “de facto treatment facilities.”²³⁹ The narrative derived from these assumptions is causal in nature. The claim, in effect, is that deinstitutionalization, coupled with the failure of the community mental health system to provide adequate alternative care, caused a significant number of individuals with chronic mental disabilities to become enmeshed in a criminal justice system ill suited to their needs.²⁴⁰ Conversely, advocates for increased inpatient capacity and more paternalistic civil commitment standards and procedures argue, consistent with the causal account inherent in the transinstitutionalization hypothesis, that their policy positions would reduce the number of persons with severe mental illness in jails and prisons by drawing them back into inpatient hospital settings where they belong.²⁴¹

237. See generally Prins, *supra* note 1 (describing the phenomenon of “transinstitutionalization” as a direct link between deinstitutionalization and increased rates of persons with mental illness in jails and prisons).

238. See *id.* at 716.

239. *Id.*

240. Prins describes the thesis in two steps. The first step is the claim that deinstitutionalization “reduced the availability of intermediate and long-term” inpatient beds throughout the system. The second step is the claim that a subset of all patients with severe mental illness cannot be successfully managed through community-based strategies such as intensive case management and assertive community treatment, and therefore inevitably require inpatient care from time to time. *Id.* at 718. Given the limited supply of inpatient beds and the persistence of this subset of patients who are resistant to community-based treatment and require periodic hospitalization, the thesis concludes that these undertreated individuals end up in jails and prisons, which “in effect, serve the role of psychiatric inpatient services.” *Id.*

241. On the shortage of inpatient psychiatric beds and the consequences of this shortage on mentally ill individuals in jails and prisons, see TORREY ET AL., *supra* note 8.

Thoughtful critiques of this transinstitutionalization account have described it as a “reductionist narrative” that “mistakenly draw[s] a causal connection between two merely correlated trends: the decline in the availability of state psychiatric hospital beds and the rise in prevalence of [serious mental illness] in jails and prisons.”²⁴² The essential mistake cited is the assumption that the group of persons formerly served as inpatients in state and county psychiatric hospitals share relevant characteristics with the universe of offenders with mental illness who end up in the criminal justice system. The argument that reducing capacity in one linked institution (state hospitals) simply forces under-treated patients into alternative linked institutions (jails and prisons) fails, they explain, because many of those in the latter group (offenders with serious mental disabilities enmeshed in the criminal justice system) would not have been treated as inpatients in state and county hospitals even if deinstitutionalization had never happened.²⁴³ The data indicate that patients in state hospitals just before deinstitutionalization were more likely to be diagnosed with schizophrenia, more likely to be middle-aged, and more likely to be white, when compared with those with severe mental illness who have ended up in jails and prisons.²⁴⁴ In addition, they argue, the relative proportion of criminal offenders with serious mental illnesses has not increased in response to the decline in state hospital populations; rather, the increase in mentally ill inmates appears to be tied to the increase overall in the incarceration rate.²⁴⁵ One measure of this claim is derived from data showing that the proportion of individuals with serious mental illness living in the community has remained relatively stable in recent decades at about 80%.²⁴⁶ To be sure, many more people with serious psychiatric disorders are now incarcerated, but it

242. Prins, *supra* note 1, at 720.

243. *See id.* at 719.

244. *See id.*

245. *See id.*

246. *See id.*

appears this increase has more to do with broader shifts in the use and composition of jails and prisons than it does with a declining reliance on long-term inpatient treatment within the behavioral health care system.²⁴⁷

Critics of the transinstitutionalization thesis make three additional arguments. First, they point to research suggesting that mental illness, taken alone, is not a significant risk factor for criminal justice system involvement.²⁴⁸ While severe psychiatric disability may be associated with a range of “criminogenic” factors,²⁴⁹ including substance misuse, unemployment, and the like, it is not at all clear that it functions in most instances independently as a driver of criminal conduct.²⁵⁰ Second, critics argue that the great majority of patients discharged from inpatient treatment in state hospitals are not arrested, charged criminally, or incarcerated.²⁵¹ Longitudinal studies that have followed discharged state psychiatric inpatients have found surprisingly low arrest rates in the years following release from hospitals.²⁵² Finally, those skeptical of the transinstitutionalization account question the idea that most deinstitutionalized individuals ended up in unstructured settings in the commu-

247. For a discussion on the overall increase in rates of incarceration and the special impact of the war on drugs on jail and prison populations in the United States, see Richard C. Boldt, *Drug Policy in Context: Rhetoric and Practice in the United States and the United Kingdom*, 62 S.C. L. REV. 261 (2010).

248. For a discussion on the lack of a direct relationship between mental illness and criminal involvement, see generally Edward P. Mulvey & Carol A. Schubert, *Mentally Ill Individuals in Jails and Prisons*, 46 CRIME & JUST. 231 (2017) (stating that mental illness rarely directly relates to involvement in crime).

249. E. Lea Johnston, *Theorizing Mental Health Courts*, 89 WASH. U. L. REV. 519, 553 (2012).

250. See *id.* at 572. One group of researchers has reported that less than 10% of offenders with mental illness engage in criminal conduct as a direct consequence of their disability. See Jennifer L. Skeem et al., *Correctional Policy for Offenders with Mental Illness: Creating a New Paradigm for Recidivism Reduction*, 35 LAW & HUM. BEHAV. 110, 117–18 (2010) (stating that out of 113 arrestees with mental illness, “8% had been arrested for offenses that their psychiatric symptoms probably-to-definitely caused, either directly (4%) or indirectly (4%)”).

251. See Prins, *supra* note 1, at 719.

252. See John H. McGrew et al., *The Closing of Central State Hospital: Long-Term Outcomes for Persons with Severe Mental Illness*, 26 J. BEHAV. HEALTH SERVS. & RES. 246, 246 (1999) (finding fewer than 4% of discharged psychiatric patients were homeless or in jail); Aileen B. Rothbard et al., *Service Utilization and Cost of Community Care for Discharged State Hospital Patients: A 3-Year Follow-Up Study*, 156 AM. J. PSYCHIATRY 920, 925 (1999).

nity, where they were at risk of criminal justice system involvement.²⁵³ Instead, they emphasize the point noted earlier that the availability of Medicaid encouraged many states to send a significant portion of their institutionalized psychiatric patients into nursing homes and general hospitals where they “were still institutionalized, not in their communities unsuccessfully attempting to access treatment for behaviors that might draw the attention of law enforcement officers.”²⁵⁴

Perhaps the point of greatest disagreement between those who view deinstitutionalization as a spectacular failure and those who take a more circumspect view of the respective benefits and costs of the policy is whether most individuals with serious mental illness who formerly would have been treated as inpatients in state hospitals can successfully “function in the community without repeated and lengthy hospitalizations or returns to [inpatient facilities].”²⁵⁵ Advocates for more inpatient treatment slots and more aggressive admissions practices acknowledge that community-based strategies, such as assertive community treatment and intensive case management, can be effective for some patients with severe mental disabilities but argue that a substantial portion of this population is sufficiently treatment-resistant such that only periodic hospitalization will prevent their decompensation, criminal acting-out, or both.²⁵⁶

On the other side, those who take the more circumspect view emphasize that the universe of patients with severe mental illness is not a homogenous group and that the subset of patients who require periodic acute care in a hospital setting – and who are likely to be drawn into the criminal justice system if that inpatient treatment is unavailable or difficult to engage – is relatively small.²⁵⁷ Their policy prescription is for more com-

253. See Prins, *supra* note 1, at 719.

254. *Id.*

255. *Id.* at 718.

256. See H. Richard Lamb & Linda E. Weinberger, *The Shift of Psychiatric Inpatient Care from Hospitals to Jails and Prisons*, 33 J. AM. ACAD. PSYCHIATRY & L. 529, 530–33 (2005).

257. See Prins, *supra* note 1, at 720.

munity-located treatment and other supportive services for the great majority of psychiatric patients and for a civil commitment system that is carefully calibrated to identify only those within the smaller group of more difficult to manage high-risk individuals who do need involuntary hospitalization.²⁵⁸ They caution against any significant rebalancing of the current system that would redirect scarce resources away from community-based clinical settings in order to build up a greater inpatient treatment capacity and against any significant revision either in the substantive or procedural rules that would improvidently widen the net of those swept involuntarily into inpatient treatment.²⁵⁹

B. National Task Force on Guidelines for Involuntary Civil Commitment: Mapping the Road Ahead

Nearly thirty years ago, the National Task Force on Guidelines for Involuntary Civil Commitment—a blue-ribbon group of judges, clinicians, academics and other experts supported by the John D. and Catherine T. MacArthur Foundation and the National Center for State Courts—set out an approach very much aligned with this latter set of policy choices.²⁶⁰ Crucially, the Task Force began its report with the observation “that the tendencies to view the complexities of the involuntary civil commitment process in abstract, polar terms—e.g., doctors versus lawyers, the legal model versus the medical model, police power of the state versus the *parens patriae* function of the state, or personal liberties versus treatment needs—are counterproductive.”²⁶¹

In place of these dichotomous perspectives, the guidelines developed by the Task Force sought to balance the competing interests by offering a process for making involuntary treatment decisions that recognized the heterogeneity of the popula-

258. *See id.* at 719–20.

259. *See id.* at 720.

260. *See Nat'l Ctr. for State Courts, supra* note 14, at 413.

261. *Id.* at 416.

tion of persons with mental disabilities, the limited resources available for serving this population—both in the community and in publicly supported inpatient settings—and the urgent need for systematic “[c]ooperation among the various disciplines, groups, agencies, and components of mental health-justice systems.”²⁶² The Task Force frankly acknowledged that its recommendations had to account for the following factors, all of which have continued to the present: (1) the dramatic decline in the number of beds in public psychiatric hospitals; (2) the dramatic increase in the poor, often uninsured, chronically mentally ill population; (3) the increased reliance on other institutions—including nursing homes, temporary shelters, and jails—as sites for treatment and other supportive services; (4) the persistent shortage of outpatient treatment resources, transitional housing services, and other related social services; and (5) the likelihood of increasing pressure on the behavioral health system from ongoing efforts to control public spending.²⁶³ Perhaps most importantly, in light of these challenging circumstances, the Task Force cautioned decision makers to avoid “[u]sing the leverage of commitment to secure needed services that may otherwise not be readily available, when no legal grounds exist for commitment.”²⁶⁴

While the challenging political, fiscal, and practical environment for managing persons with severe mental disabilities described by the Task Force years ago has continued unabated in the intervening period, the impact of ongoing changes in the nature of acute inpatient care—particularly the fact that psychiatric hospitalizations often are shorter in duration now than they were even in the 1980s—only sharpens the compelling logic of that group’s recommendations.²⁶⁵ In fact, the framework offered by the guidelines provides an excellent roadmap for

262. *See id.* at 417.

263. *See id.* at 416.

264. *See id.* at 494.

265. *See e.g.*, Sharfstein & Dickerson, *supra* note 1, at 685–87 (describing the shortened length of inpatient treatment in recent years).

thinking through these challenges and for assessing the various state statutory approaches described earlier.

At the front end, the framework set out in the guidelines operates on “an implicit assumption that mental health screening and evaluation before a person is involuntarily detained in a hospital is preferable to a review of allegations supporting commitment and screening only after he or she is admitted to a hospital.”²⁶⁶ The Task Force acknowledged that some states, either by statute or practice, recognize the value of screening and possible diversion even before an individual is detained, but few have in place the necessary mechanisms to accomplish this function.²⁶⁷ Moreover, they also noted that pre-admission screening and evaluation is particularly difficult for the large number of persons who come into the civil commitment system under a state’s emergency detention provisions.²⁶⁸ Nevertheless, the guidelines recommend that screening and evaluation occur as early in the process as feasible, even for emergency detainees,²⁶⁹ and that delayed screening be the exception to this rule, reserved only for those instances where patients “require immediate attention by hospital staff.”²⁷⁰

[I]f a law enforcement officer has taken a respondent into custody and is unable, because of an emergency, to contact a mental health screening officer before the respondent is transported to an emergency unit of a hospital, a hospital staff member should contact the mental health screening officer as soon as possible after the emergency has abated. Hospitalization should not preclude investigation of the case by the mental health

266. See Nat’l Ctr. for State Courts, *supra* note 14, at 427.

267. See *id.*

268. See *id.*

269. See *id.* at 435.

270. See *id.* at 434.

screening officer, screening in the hospital, and exploration of alternatives to commitment.²⁷¹

The rationale for this recommendation—that screening and evaluation be made available to all those who enter the system and that it be accomplished as early as possible—is straightforward; early screening, explained the Task Force, is required “to avoid unnecessary infringement of liberty, to ensure that persons are guided quickly and effectively toward the placement and treatment indicated by their presenting problems, and to minimize needless waste of limited resources.”²⁷²

The importance the Task Force placed on front-end screening and evaluation rested on their observation that “[f]or many persons, the early stages in the involuntary civil commitment process constitute the entire extent of their involvement in the process.”²⁷³ As emergency departments become more active in delivering acute psychiatric care, and as the average duration of most inpatient treatment episodes is further reduced, the significance of this observation has grown.²⁷⁴ Indeed, in many jurisdictions, “the great majority” of individuals who pass through the system “never see the inside of a courthouse” and properly ought to be “screened and diverted to more suitable alternatives.”²⁷⁵ For upfront screening and diversion to take place, however, states and their localities must establish the institutional capacity and organizational structure necessary to support the enhanced responsibilities that pre-detention screening and evaluation requirements impose on them. Accordingly, the guidelines recommend creating “interdisciplinary community coordinating councils” made up of representatives from the various components of the behavioral health and justice systems involved in involuntary civil commitment and

271. *Id.* at 435.

272. *Id.* at 428.

273. *Id.* at 427.

274. *See id.*

275. *Id.*

creating “a comprehensive continuum of mental health and related social services available to individuals who become subjects of involuntary civil commitment.”²⁷⁶ Most importantly, however, the guidelines recommend that each locality establish a screening agency to serve as “the single point of entry for all candidates for involuntary civil commitment and the referral point for all inquiries regarding the initiation of involuntary civil commitment.”²⁷⁷ To function effectively in this respect, these local screening authorities must have at the ready trained mental health professionals who have clinical expertise in the diagnosis and treatment of mental disabilities and knowledge about the continuum of treatment and supportive services available in the community.²⁷⁸

When a patient who has been involuntarily detained is admitted to an emergency room or other hospital facility, most state laws require the facility to examine the individual to determine whether the statutory criteria for detention are met, to form the basis for initial decision making regarding release or diversion, and to initiate the process of stabilizing and treating the presenting psychiatric condition.²⁷⁹ This statutorily required threshold assessment ordinarily applies even if the jurisdiction has a pre-screening mechanism operated by a community screening agency.²⁸⁰ Often, state laws require additional evaluations as the process moves ahead.²⁸¹ The guidelines’ framework seeks to leverage the threshold evaluation and any subsequent evaluations performed by physicians or others in the admitting facility to minimize unnecessary inpatient admissions and to encourage the diversion of appropriate patients to other forms of treatment in the community. Indeed, the Task Force urges all of the actors in the system, particularly at the initial stages, to adopt a

276. *Id.* at 421.

277. *Id.* at 429.

278. *See id.* at 433.

279. *See, e.g.,* VA. CODE ANN. § 37.2-809 (2017).

280. *See, e.g., id.*

281. *See, e.g., id.* § 37.2-815(B).

view of involuntary civil commitment that “eschews ‘all or nothing’ and ‘once and for all’ decisionmaking and acknowledges the possibility (if not the practical availability) of a continuum of services available to a respondent.”²⁸²

Assuming that an individual has not been screened and diverted to care in the community either by a pre-screening agency or by clinicians at an admitting facility, the next step in the process contemplated by the guidelines is a “[p]rompt court hearing.”²⁸³ The Task Force’s framework calls for such a hearing to be scheduled within “one business day” after an individual has been taken into custody or a petition for involuntary commitment has been filed,²⁸⁴ and to be held within “three court days.”²⁸⁵ Crucially, the guidelines recommend that this promptly arranged hearing be “[a]utomatic,” and not be made dependent on the affirmative request of the patient, her counsel, friends, or family.²⁸⁶

The timing of this automatic hearing was the subject of considerable discussion by the Task Force. A detained individual’s interest in being released from custody as quickly as possible, as well as concerns about the “intense institutional pressures on a respondent to convert to voluntary patient status” that often builds in the period leading up to a hearing, weighed in favor of requiring the intervention of a judicial decision maker even earlier in the process.²⁸⁷ On the other side was the recognition that extremely agitated patients would be well served by a delayed hearing so that measures could be taken to stabilize their condition, and so that both sides would have sufficient

282. Nat’l Ctr. for State Courts, *supra* note 14, at 450.

283. *Id.* at 478.

284. *Id.* at 479.

285. *Id.* at 480.

286. *Id.*

287. *See id.* For the classic study of the systematic pressures on patients to consent to “voluntary” inpatient care, see Janet A. Gilboy & John R. Schmidt, “Voluntary” Hospitalization of the Mentally Ill, 66 NW. U. L. REV. 429 (1971); Susan G. Reed & Dan A. Lewis, *The Negotiation of Voluntary Admission in Chicago’s State Mental Hospitals*, 18 J. PSYCHIATRY & L. 137 (1990).

time to prepare adequately for an adversarial proceeding.²⁸⁸ In the end, the Task Force concluded that requiring an automatic hearing within three days of custody or the filing of a petition constituted a sensible balance between these competing considerations.²⁸⁹ This compromise position was premised, however, on the “stringent prehearing screening procedures” proscribed in the guidelines, which contemplate the active involvement of a community screening agency capable of identifying and diverting appropriate candidates to community-based outpatient services.²⁹⁰ The combination of an effective preliminary community screening function and an automatic three-day judicial hearing also obviated the need for a preliminary probable cause hearing because, in the Task Force’s view, individuals who would be unlikely to satisfy the commitment criteria would be effectively diverted at the front end and those who presented a closer case would receive judicial consideration early enough in the process to satisfy the demands of due process.²⁹¹

The final set of recommendations offered by the Task Force relevant to the present discussion relate to the nature of the hearing the guidelines require. First, the Task Force recommends that “lawyers—preferably judges,” preside over commitment hearings.²⁹² Professional training and experience is crucial, given the insistence in the guidelines that decisions be based on a strict application of the legal criteria for commitment.²⁹³ More specifically, the Task Force explained that, however configured in a given jurisdiction, civil commitment criteria are almost always organized around three legal elements: a diagnostic element; a predictive element; and a

288. See Nat’l Ctr. for State Courts, *supra* note 14, at 480.

289. See *id.*

290. *Id.*

291. See *id.* at 480–81.

292. *Id.* at 482.

293. See *id.* at 482–83, 492–93.

prescriptive element.²⁹⁴ The diagnostic element, that the person subject to civil commitment is mentally ill, is “jurisdictional.”²⁹⁵ The predictive element, that the individual’s mental disability renders her dangerous or unable to take care of basic needs, is “the basis for liability” because it supports the deployment of the state’s police power or *parens patriae* authority.²⁹⁶ Finally, the prescriptive element, that the proposed treatment intervention is appropriate, provides the basis for the relief sought by the petitioner.²⁹⁷

The Task Force’s insistence on a law-trained hearing decision maker turns on the observation that civil commitment determinations too often result from an untoward mixing of eligibility and dispositional evidence.²⁹⁸ That is, in the absence of a careful matching up of appropriate evidence to each of the elements for commitment—a process that may require legal training and professional judgment—there is a danger that an individual will be committed because she would benefit from services, even if there is an insufficient showing to satisfy the predictive element in the legal criteria.²⁹⁹ As the Task Force put it:

[A]lthough there may be no magical answer for a small number of respondents who may need some type of mental health intervention but who resist attempts to provide such care on a voluntary basis, it is inappropriate to use the leverage

294. *See id.* at 494–95.

295. *Id.* at 495.

296. *Id.* The Guidelines recognize that this predictive element is most often based on the judgment of clinicians and that the predictions, “especially about future dangerous behavior, are difficult to make within acceptable levels of reliability and accuracy.” *Id.* at 493. Consequently, the guidelines call on clinicians offering testimony to take into account a list of factors, including “recent overt acts” or threats of harm by the respondent, “verifiable observations of events or behaviors . . . indicating that he or she is unable to provide for basic needs, . . . precipitating events and situations, . . . relevant demographic characteristics[,] . . . the sources of stress in the respondent’s environment[,] and . . . the availability and proximity of likely victims.” *Id.*

297. *See id.* at 495.

298. *See id.*

299. *See id.* (citing INGO KEILITZ & BRADLEY D. MCGRAW, AN EVALUATION OF INVOLUNTARY CIVIL COMMITMENT IN MILWAUKEE COUNTY 94–95 (1983)).

of involuntary civil commitment when there are inadequate grounds for commitment.³⁰⁰

C. Assessing State Laws

Proponents of the transinstitutionalization thesis suggest patients in need of services who fail to meet demanding legal criteria for involuntary admission are at elevated risk of falling into the criminal justice system or of becoming homeless. Notwithstanding this thesis, the Task Force's approach is to hold the line on adjusting the criteria for involuntary hospitalization and instead urge the use of better screening and diversion mechanisms and the development of treatment services in the community.³⁰¹ Some states, consistent with their *parens patriae* interests, have adjusted the predictive element in their commitment laws to include the American Psychiatric Association's imminent collapse standard in cases where a strong showing can be made that inpatient care is inevitable and that moving up the timing of hospital admission would save resources and the pain of decompensation.³⁰² The aim is to have an effective decision-making process that calls upon the professional redundancy of the interdisciplinary components in the process to identify the small subset of chronic mentally ill persons who would benefit most from immediate hospital care and to exclude the larger group of patients who can be managed effectively in the community if adequate services are available.³⁰³

The notion that individuals who are potentially subject to

300. *Id.* at 494.

301. *See id.* at 416, 427-28, 494-95 (suggesting using assertive team-based care and related services, such as supportive housing, to help prevent chronic mentally ill persons who do not meet the standard for involuntary commitment from being drawn into alternative systems of control).

302. *See* Am. Psychiatric Ass'n, *supra* note 36, at 672, 674; *see also, e.g.*, ALA. CODE § 22-52-10.2 (2017); N.C. GEN. STAT. § 122C-263(d) (2017); OR. REV. STAT. § 426.005(1)(f)(C)(iv) (2015); TEX. HEALTH & SAFETY CODE ANN. § 574.034 (West 2017).

303. *See* Prins, *supra* note 1, at 719 ("The small group for whom community-based treatment is not effective represents only a portion of the people with [serious mental illness] in jails and prisons; for most others, the problem may be that they do not have access to the high-quality services and evidence-based practices associated with better community outcomes . . .").

involuntary hospitalization should be entitled to a rigorous determination of eligibility defined by the diagnostic and predictive elements of the commitment criteria, even if they would benefit from an inpatient disposition, is no less pressing when their hospitalization lasts hours or days rather than weeks or months.³⁰⁴ Together, the preadmission screening and diversion function and the prompt, automatic judicial hearing requirement in the guidelines serve to minimize inappropriate use of the state's coercive power.³⁰⁵ Even the best state law approaches described in Part I of this Article at best only partially meet these requirements.

Virginia's provisions come closest to the Task Force's recommendations.³⁰⁶ Consistent with the guidelines, Virginia provides for judicial review automatically within three days, unlike the approach in California, New York, and Massachusetts, where a prompt judicial hearing is made available only if the patient or her representative requests it.³⁰⁷ With respect to emergency detentions, the Virginia law authorizes individuals to be taken into emergency custody without a prior evaluation or community screening.³⁰⁸ Once so detained, the person may be held for up to eight hours, during which time a representative of the local community behavioral health services board must determine if the criteria for a "temporary detention" order are met.³⁰⁹ While this scheme does not ensure that community eval-

304. See Nat'l Ctr. for State Courts, *supra* note 14, at 480.

305. See *id.* at 480-81.

306. See *supra* Section I.C.

307. See *supra* notes 164-65 and accompanying text.

308. See VA. CODE ANN. § 37.2-808 (2017). This section permits a magistrate to issue an emergency custody order based on "the sworn petition of any responsible person" or a treating physician, or on the magistrate's own motion, if there is probable cause to believe that an individual is mentally ill, imminently dangerous, in need of treatment, and unwilling or incapable of volunteering for hospitalization or treatment. *Id.* § 37.2-808(A). The section also permits a law enforcement officer to take an individual into custody and to transport him or her for evaluation without prior authorization by a magistrate if the officer has probable cause, based on personal observation or the reliable reports of others, to believe that the person meets the criteria for emergency custody. *Id.* § 37.2-808(G).

309. *Id.* § 37.2-809.

uation for possible diversion must always take place prior to the initiation of custody, it does follow the guidelines' recommendation in mandating community screening and evaluation as soon as practicable after emergency detention has occurred.³¹⁰

As noted earlier, while temporary detention can result from the emergency custody process and evaluation, the Virginia Code also permits a magistrate to issue a temporary detention order prompted by the filing of a sworn petition by a "responsible person" or treating physician.³¹¹ In these instances, before an order can issue the individual generally must be evaluated by an authorized agent of the local community services board to determine whether she has a mental illness creating a "substantial likelihood" that she is imminently dangerous to herself or others, is in need of hospitalization or treatment, and is unwilling or incapable of voluntarily consenting to care.³¹²

Under Virginia law, a "commitment hearing for involuntary admission" must be held at the conclusion of the seventy-two-hour temporary detention period, unless the individual is released or agrees to voluntary hospitalization.³¹³ A district court judge or special justice presides over the hearing, and the decision maker must consider an independent examination conducted by a psychiatrist or psychologist and a "preadmission screening report" prepared by the local community services board.³¹⁴ The statute thus ensures that information relevant to all three elements identified by the Task Force—the diagnostic, predictive, and prescriptive elements—will be made available to the decision maker.³¹⁵ In particular, the independent examination must contain: (1) a clinical assessment; (2) a "substance abuse screening"; (3) an evaluation of risk; (4) an assessment of the person's capacity to consent to treatment; (5) a review of the

310. *See id.*

311. *See id.* § 37.2-809(B).

312. *See id.*

313. *See id.* § 37.2-814(A)-(B).

314. *See id.* § 37.2-808.

315. *See supra* notes 280-83 and accompanying text.

treatment records from the temporary detention facility; (6) a discussion of the individual's treatment preferences; (7) an assessment of whether the individual meets criteria for "discharge to mandatory outpatient treatment following a period of inpatient treatment"; (8) an assessment of the suitability of alternatives to inpatient treatment; and (9) "recommendations for placement, care, and treatment of the person."³¹⁶

The California approach, by contrast, does not mandate an automatic judicial hearing within the first few days of detention.³¹⁷ It does, however, set out a "pre-petition screening" process that actively engages local officials in investigating the circumstances surrounding a requested involuntary admission to determine whether an alternative arrangement in the community could promote the individual's well-being and the safety of the community.³¹⁸ This pre-petition process can direct chronic mentally ill individuals who do not meet the predictive element of the civil commitment standard—but whose past history of hospitalizations and/or criminal justice system involvement and current distress suggest the need for crisis intervention and other therapeutic measures—to alternative resources in the community that may prevent decompensation and a resulting psychiatric emergency.³¹⁹

The best approach would combine this sort of systematic community screening and diversion apparatus with a mandatory judicial hearing requirement, as found in Virginia's statute. As the Task Force noted some years ago, the availability of careful pre-detention screening combined with reasonably prompt court review of involuntary admissions would obviate the need for a preliminary probable cause hearing because patients whose circumstances do not satisfy the predictive element would likely be diverted, and others brought into the system

316. See VA. CODE ANN. § 37.2-815(B).

317. See CAL. WELF. & INST. CODE § 5202 (West 2017) (requiring a pre-petition screening process prior to detention).

318. See *id.*

319. See *supra* notes 117–24 and accompanying text.

would receive judicial consideration early enough in the process to satisfy the demands of due process.³²⁰

For this optimized process to function effectively, a full continuum of treatment resources must be maintained in the community to serve the majority of chronically mentally ill individuals who can succeed without protracted inpatient care. Many in this group are difficult to retain in treatment in outpatient settings without adequate case management and other supportive services.³²¹ But, as the Task Force forcefully argued, the absence of appropriate community-based resources, and the concomitant failure of these individuals in outpatient treatment, is no basis for eroding the substantive and procedural framework that properly seeks to limit involuntary hospitalization to the smaller set of patients whose acute psychiatric needs must be met through inpatient services.³²² “Sympathy and compassion for the plight of mentally ill persons and their families are certainly to be encouraged, and inadequate mental health and social services cannot be ignored by individuals of good conscience,” explained the Task Force, but “involuntary civil commitment is an inappropriate expression of such concerns.”³²³

Organizing the decision-making process so that clinical judgments are made in the first instance by behavioral health experts in the community – subject to reasonably timed judicial review organized according to the diagnostic, predictive, and dispositional elements that make up the commitment standard – provides a framework for optimizing the use of coercive treatment interventions.³²⁴ Clinicians naturally are inclined to seek such care for individuals whose mental disabilities are disruptive to their own functioning and disturbing to others. But “[u]sing the leverage of commitment to secure needed services

320. See Nat'l Ctr. for State Courts, *supra* note 14, at 480–81.

321. See *id.* at 494.

322. See *id.*

323. *Id.*

324. See *id.* at 494–95.

that may otherwise not be readily available, when no legal grounds exist for commitment, subverts the commitment process and, more importantly, undercuts pressure toward meaningful change.”³²⁵ Community-based screening and diversion, coupled with judicial oversight structured and informed by the insights of clinicians and inserted early enough in the process to be meaningful, provides the interdisciplinary sorting mechanisms called for under these difficult circumstances.

CONCLUSION

There are significantly fewer inpatient beds in state psychiatric hospitals today than there were fifty years ago, and many of the beds that remain are occupied by forensic patients and others receiving long-term care.³²⁶ Most individuals with severe mental illness in the United States now receive the bulk of their treatment in outpatient settings.³²⁷ Given the chronic relapsing nature of these diseases, however, many of these patients periodically find themselves in short-term inpatient settings as a result of psychiatric emergencies that require acute care.³²⁸ Indeed, although the total number of state hospital patients has declined dramatically over the years, the number of psychiatric hospital admissions each year remains high.³²⁹

Psychiatric emergency departments have been asked to shoulder a significant portion of the acute caregiving provided by the behavioral health care system.³³⁰ Research has demonstrated that a small but identifiable group of patients admitted to emergency departments are retained for extended periods in these acute care settings because, although they require inpatient hospitalization and present a significant risk of harm to

325. *Id.* at 494.

326. *See supra* notes 1–3 and accompanying text.

327. *See Sharfstein & Dickerson, supra* note 1, at 686.

328. *See id.*

329. *See id.*

330. *See id.* at 685.

themselves or others, they lack the financial resources to support admission to other inpatient facilities such as private psychiatric hospitals or specialized units within general hospitals.³³¹

The system of legal regulation that traditionally governed the emergency detention and longer-term involuntary hospitalization of severely mentally ill individuals has been adjusted in many jurisdictions to reflect the changing clinical and fiscal realities that characterize the contemporary behavioral health care system. Most states, however, still do not invest sufficiently in community-based screening and diversion mechanisms designed to link patients to adequate outpatient treatment and case management services that could prevent the psychiatric emergencies that often bring these individuals into emergency departments in the first place.³³² If more effective front-end screening and diversion were in place, and a full continuum of treatment and supportive services were available in the community, the smaller number of individuals with severe mental illness requiring occasional inpatient hospitalization could be cared for in appropriate settings and would be less likely to become stuck in psychiatric emergency departments, jails, or prisons.³³³

In any case, when individuals in need of acute psychiatric care and observation come into the system, either through an emergency department or through alternative legal routes that permit the temporary detention of psychiatric patients, state law should provide a reasonably prompt mandatory review by a judicial officer. This review should not depend upon the voluntary election of patients or their representatives and should be available early enough in the process to be meaningful. This judicial oversight can still serve the goals identified by Judge Bazelon a generation ago, even though the duration and nature

331. See Park et al., *supra* note 219, at 306.

332. See Prins, *supra* note 1, at 718.

333. See *id.* at 719.

of the care provided to most involuntarily hospitalized patients has changed dramatically over the years.³³⁴ Psychiatrists and other experts in the behavioral health care system have an important role to play in making the diagnostic and clinical judgments that often determine what interventions a patient receives and in what setting; however, timely judicial review of those decisions, structured according to the legal elements set out in the substantive standards and informed by the information mental health experts provide, is essential to “determine whether there has been a full exploration of all relevant facts, opposing views and possible alternatives, whether the results of the exploration relate rationally to the ultimate decision, and whether constitutional and statutory procedural safeguards have been faithfully observed.”³³⁵

334. *See supra* text accompanying notes 208–09.

335. Bazelon, *supra* note 162.