HOT TOPICS IN MENTAL HEALTH & LAW: CIVIL COMMITMENT

"Civil Commitment 101: Overview of History and Current Practices"

Presented by Shadoe Jones, JD

November 12, 2024

CENTER FOR MENTAL HEALTH, POLICY & THE LAW
UNIVERSITY of WASHINGTON

LAND & LABOR ACKNOWLEDGEMENT

Based in Seattle, The University of Washington acknowledges the Coast Salish peoples of this land, the land which touches the shared waters of all tribes and bands within the Suquamish, Tulalip and Muckleshoot nations.

May we always honor their spirit and heritage while working for justice in these communities.

To identify the stewards of your land, visit https://native-land.ca/

We also acknowledge the unaddressed legacy of stolen labor and slavery, and we recognize our debt to exploited workers past and present. This legacy remains and is a current reality for many today.

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The Center for Mental Health, Policy, and the Law (CMHPL) is housed within the University of Washington (UW) Department of Psychiatry and Behavioral Sciences in the UW School of Medicine.

Our Center fosters integrative scholarship to advance empirical knowledge, training, and practice in forensic mental health. The CMHPL's mission is to address the most urgent issues arising at the interface of mental health and the law, in order to help justice-involved people with mental illness lead full and productive lives.

We have organized our center around three pillars of excellence: education and training, research and policy, and service. These pillars are intended to facilitate interdisciplinary collaboration and innovation by removing barriers between researchers, policymakers, educators, and clinicians.

HOT TOPICS IN MENTAL HEALTH & LAW: CIVIL COMMITMENT

November 12, 12:00–1:00 p.m. PT
"Civil Commitment 101: Overview of History and Current Practices"
Shadoe Jones, JD

December 13, 12:00–1:00 p.m. PT
"Civil Commitment Through the Ethics Lens: How We Got Here"
Philip Candilis, MD

January 7, 12:00–1:00 p.m. PT
Civil commitment in WA
Dawn Macready-Santos, LICSW, DCR, and Laura Pippin, MSP, SUDPT, DCR

February 4, 12:00–1:00 p.m. PT
Lived experience with civil commitment
Carolynn Ponzoha, Karen Schilde, Laura Van Tosh

March 4, 12:00–1:00 p.m. PT
"An Academic-State-Community Partnership to Create a CBT Continuum of Care for Involuntary Committees in Washington State"
Sarah Kopelovich, PhD, ABPP

April 1, 12:00–1:00 p.m. PT
Youth civil commitment in WA
Dawn Macready-Santos, LICSW, DCR

May 13, 12:00–1:00 p.m. PT
Civil commitment policy and reform in WA
Manka Dhingra, JD

June 10, 12:00–1:00 p.m. PT
Final panel and Q&A
Manka Dhingra, Shadoe Jones, Sarah Kopelovich, Dawn Macready-Santos, Laura Pippin, Laura Van Tosh

Learn more and register: bit.ly/cmhpl

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- The recording and presentation slides will be made available on our website within 1 week. We will email attendees with the link.
- Certificates of attendance will be available for attendees who indicated interest. You will receive an email from cmhpl@uw.edu with additional details.
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- To submit questions, please use the Q&A function on Zoom. Questions will be answered at the end.
- Please complete the evaluation poll at the end of this session.
- Reminder: The series will conclude with a panel discussion and Q&A on **June 6, 2025**.

SHADOE JONES, JD

Shadoe Jones, JD, advises on key policy considerations, collaborates with legislative partners, and provides legal counsel to advocate for the improvement of state and federal laws and systems of care to benefit individuals with severe mental illness (SMI) with the Treatment Advocacy Center. Previously, Jones served as a criminal defense attorney for those with SMI in Arizona. She advocated for resolutions that acknowledged the role of SMI, included treatment, and mitigated the impact of criminal charges on the individual's future and access to benefits. Jones has been active in grassroots efforts to reduce barriers to treatment and the criminalization of SMI within Arizona. Jones received her juris doctor from Sandra Day O'Connor School of Law and her bachelor's degree in criminal justice and sociology from the University of Delaware.

Civil Commitment 101

Overview of history and current practices

By Shadoe Jones, Legislative and Policy Counsel at TAC

Sponsored by the Center for Mental Health, Policy, and the Law
UW Department of Psychiatry and Behavioral Sciences

November 12, 2024

TAC
Treatment Advocacy Center

Learning objectives

1. Understand the development of and changes in civil commitment practices.

2. Identify the current civil commitment procedures and standards implemented across the United States, including variations and commonalities.

3. Analyze how civil commitment practices in Washington state differ from and align with those in other states.

Agenda

1. Civil commitment basics
2. History highlights
3. Present day
4. Washington state
5. Q & A

Rate your knowledge on civil commitment on a scale of 1 for none to 5 for expert.

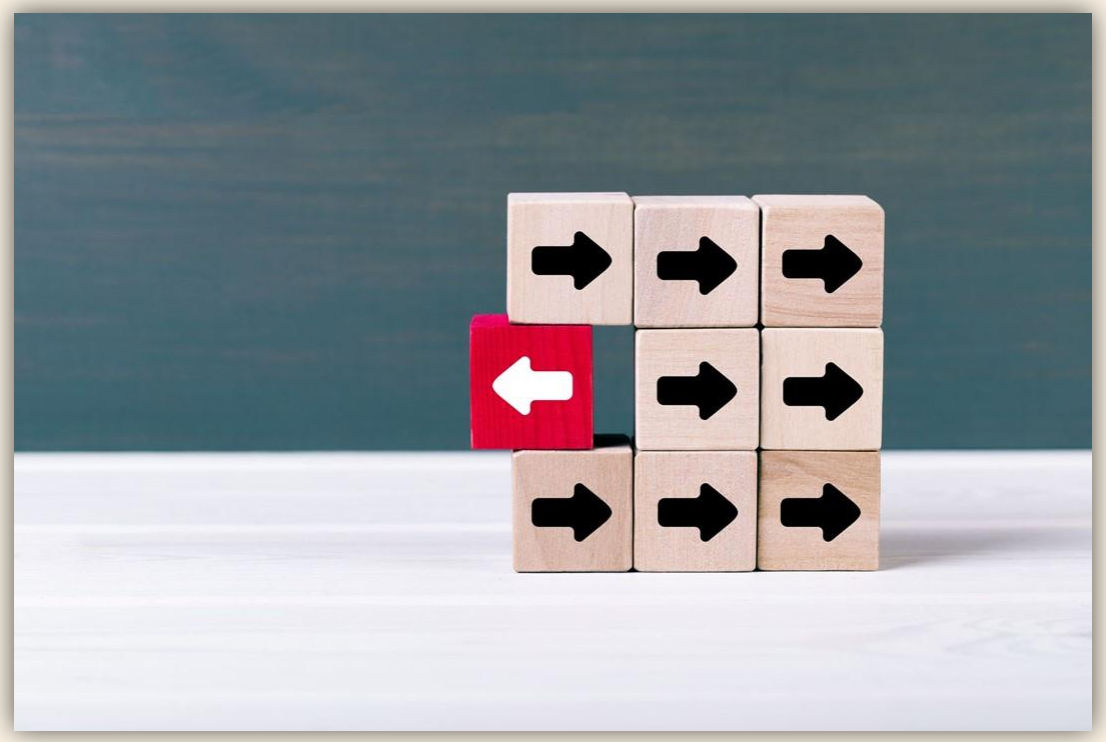
Civil commitment basics

Voluntary treatment

- Voluntary treatment is preferable, but not always ***accessible*** because of symptoms and level of illness.

- Treatment can restore autonomy, making voluntary services more accessible and life goals more achievable.

Involuntary treatment



- Court-supervised treatment makes services accessible to someone too ill to seek a self-guided solution.
- An unwillingness to seek and adhere to treatment is most often associated with **anosognosia**.

Anosognosia

- A neurological disability that impairs self-awareness.
- Blocks the brain from “seeing” that it has an illness.
- Keeps people with SMI from seeking treatment and adhering to medication.
- Occurs also with traumatic brain injury, stroke, and dementia.

Anosognosia is thought to be the most common reason people with SMI do not seek help voluntarily.

Nasrallah, H. (2022). Is anosognosia a delusion, a negative symptom, or a cognitive deficit? *Current Psychiatry, 21*(1). https://doi.org/10.12788/cp.0210

Silver, S., & Sinclair Hancq, E. (2023, October). *Anosognosia*. Treatment Advocacy Center. https://www.treatmentadvocacycenter.org/reports_publications/anosognosia/

What is civil commitment?

A civil court process to require an individual to undergo psychiatric evaluation and treatment — in a facility or through supervised outpatient care — against their objection, when the state's legal criteria are met.

Types of civil commitment

- Emergency psychiatric evaluation
- Inpatient commitment
- Outpatient commitment
- Medication over objection
- Conditional release

Disclaimer: This presentation excludes the civil commitment of individuals categorized as "sexually violent predators" or "sexually dangerous persons" from the general discussion on civil commitment.

What factors keep people with severe mental illness from voluntarily engaging in treatment? (select all that apply)

Legal foundations for civil commitment

Parens Patriae

(parent of the country)

Authority to act on behalf of individuals unable to protect themselves.

Police Power

Authority to act for public health, safety, and welfare.

History highlights

Brief history of civil commitment in the U.S.

Before 19th Century:
Individuals frequently confined in jails or poorhouses.

Pre-1800s

1801-1900

19th Century Institutionalization:
Establishment of asylums and psychiatric hospitals.

Mid-20th Century Deinstitutionalization:
Closure of state hospitals and start of community mental health centers.

1941-1989

1980-2000

Late 20th Century:
Recognition of unintended consequences.

21st Century:
Movement to modernize systems to improve outcomes.

2000-Present

Era of the asylum

- 1844: American Psychiatric Association is founded.
- Mass numbers of individuals are institutionalized.
- The “moral treatment movement,” led by reformers such as Dorothea Dix, urges a shift from jails and poorhouses to institutions for the care and treatment of individuals with mental illness.
- 1890: Every state has a public psychiatric hospital.
- Institutions are overcrowded and underfunded.
- Deep disparities in care develop in public versus private facilities.

Seeds for change

- 1946: National Mental Health Act is passed.
- 1949: National Institute of Mental Health (NIMH) is founded.
- 1954: FDA approved the first antipsychotic, chlorpromazine (Thorazine).
- 1955: The nationwide asylum population peaked, reaching a staggering 559,000, with rampant overcrowding.
- 1955: Mental Health Study Act is passed.
- 1961: Joint Commission on Mental Illness and Health published their report: "Action for Mental Health."

Influences on the end to the asylum

1950-1960s

- Abuse and neglect in institutions are publicly revealed.
- Effective antipsychotic medications are available.
- Cost of hospitalization rises dramatically.
- Civil rights movement influences SMI policy.

End to the asylum

- 1963: Kennedy signs the Community Mental Health Act.
- 1965: Medicaid and Medicare are legislated.
- 1975: O'Connor v. Donaldson case creates a standard of dangerousness for commitment.
- 1979: Addington v. Texas case establishes a standard of proof for civil commitment.
- 1980s: Massive budget cuts reduce SMI resources.
- 1999: Olmsted v. L.C. establishes least restrictive placement policies.

Unintended consequences

Trans-institutionalization:

- When state hospitals closed due to funding and civil liberty pressures, no coordinated plan or corrective measures existed.
- Thousands of patients shifted into alternative institutions: nursing homes, adult group homes, jails, prisons, shelters, and the streets.
- The shift to strict dangerousness criteria for civil commitment, while meant to protect rights, limited access to care for nondangerous individuals needing lifesaving treatment.

Commitment balances individual rights and societal safety

- Psychiatric developments, societal shifts, and economic factors drive policies and practices.
- The system is complicated by legal challenges, ethical debates, and disparities in treatment and outcomes.

Present day

Typical statutory procedure

Typical commitment criteria

All states have statutory authority to intervene and provide involuntary care if an individual is a danger to themselves or others.

General criteria for involuntary treatment:

- Danger to self
- Danger to others

Variations depend on how state laws define "dangerousness," particularly dangerous to self.

Typical dangerousness criteria

Danger to others

- Violence or bodily harm, including attempts.
- Threats or conduct demonstrating risk of violence or harm.
- Property damage.

Danger to self

- Suicide or bodily harm, attempts or threats.
- Failure to meet basic needs (grave disability).
- Failure to protect self from harm.
- Psychiatric deterioration or harm without treatment (need for treatment).

Data source

TAC has developed a grading system to analyze the laws governing involuntary treatment for psychiatric illness across the United States.

TAC's system evaluates key components of these laws, including the main areas of variability we will discuss over the next few slides.

We regularly update our qualitative data by reviewing relevant laws through Lexis Nexis and official state websites for currentness, and the date of our most recent review is noted on the slides.

You can find this data published on each state's page on our website:
https://www.tac.org/look-up-your-state/

Psychiatric deterioration standard

30 states

- Alabama
- Alaska
- Arizona
- Arkansas
- California
- Colorado
- Hawaii
- Idaho
- Illinois
- Indiana
- Kansas*
- Louisiana
- Maine
- Michigan
- Minnesota
- Mississippi
- Missouri
- Nevada
- New Hampshire
- North Carolina
- North Dakota
- Oklahoma
- Oregon
- South Carolina
- Utah
- Vermont
- Washington
- West Virginia
- Wisconsin
- Wyoming

21 states

- Connecticut
- Delaware
- Florida
- Georgia
- Iowa
- Kansas*
- Kentucky
- Maryland
- Massachusetts
- Montana
- Nebraska
- New Jersey
- New Mexico
- New York
- Ohio
- Pennsylvania
- Rhode Island
- South Dakota
- Tennessee
- Texas
- Virginia

+ District of Columbia

*Kansas – Psychiatric deterioration has been added to AOT statutes but has not been added to inpatient statutes.

As of August 2024

Grave disability standard

Four jurisdictions do not expressly include grave disability as a basis for commitment.

Delaware

District of Columbia

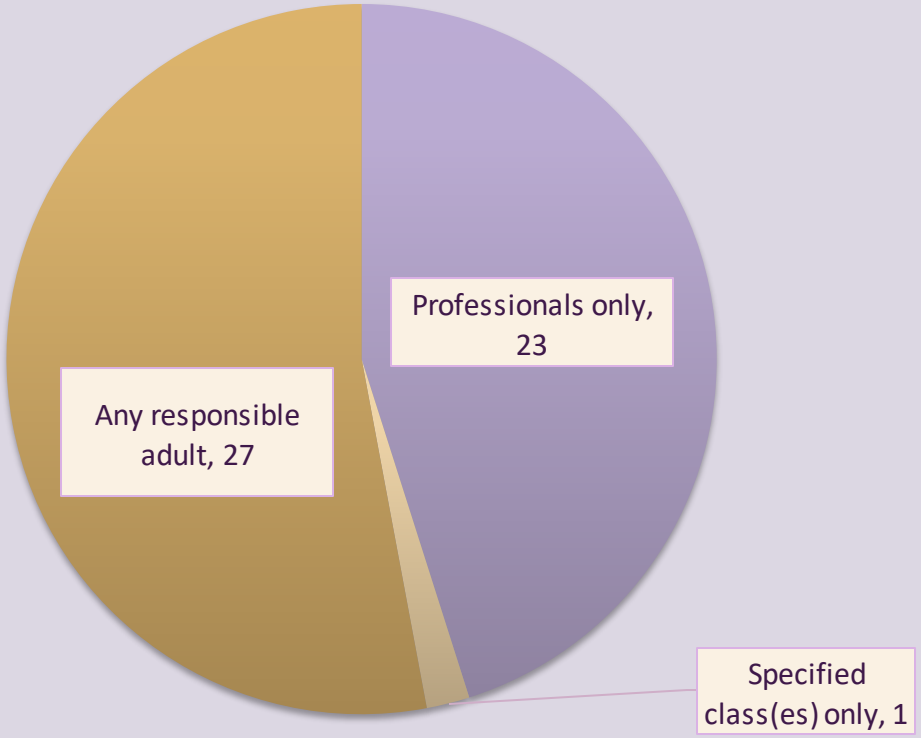
Maryland

New York

As of January 2024

Emergency custody and evaluation

Who can petition for emergency psychiatric evaluation?



Different names for the same thing:

- Involuntary hold
- Mental health or psychiatric hold
- Court-ordered evaluation
- 5150 (California)

Duration of emergency custody:

- The majority of states allow for emergency custody of at least 48 hours, with most providing for custody of 72 hours or more.
- Laws might say a hold is “up to” a time, allowing providers to discharge promptly.

As of July 2024

Inpatient civil commitment

Who can petition for inpatient commitment?

Names for the process:

- Involuntary treatment
- Court-ordered treatment

Duration of hospitalization:

- If a judge upholds the commitment, length of stay is enabled by state law and may end after 1-2 weeks or months.

As of January 2024

Outpatient civil commitment

Who can petition for outpatient commitment?

Names for the process:

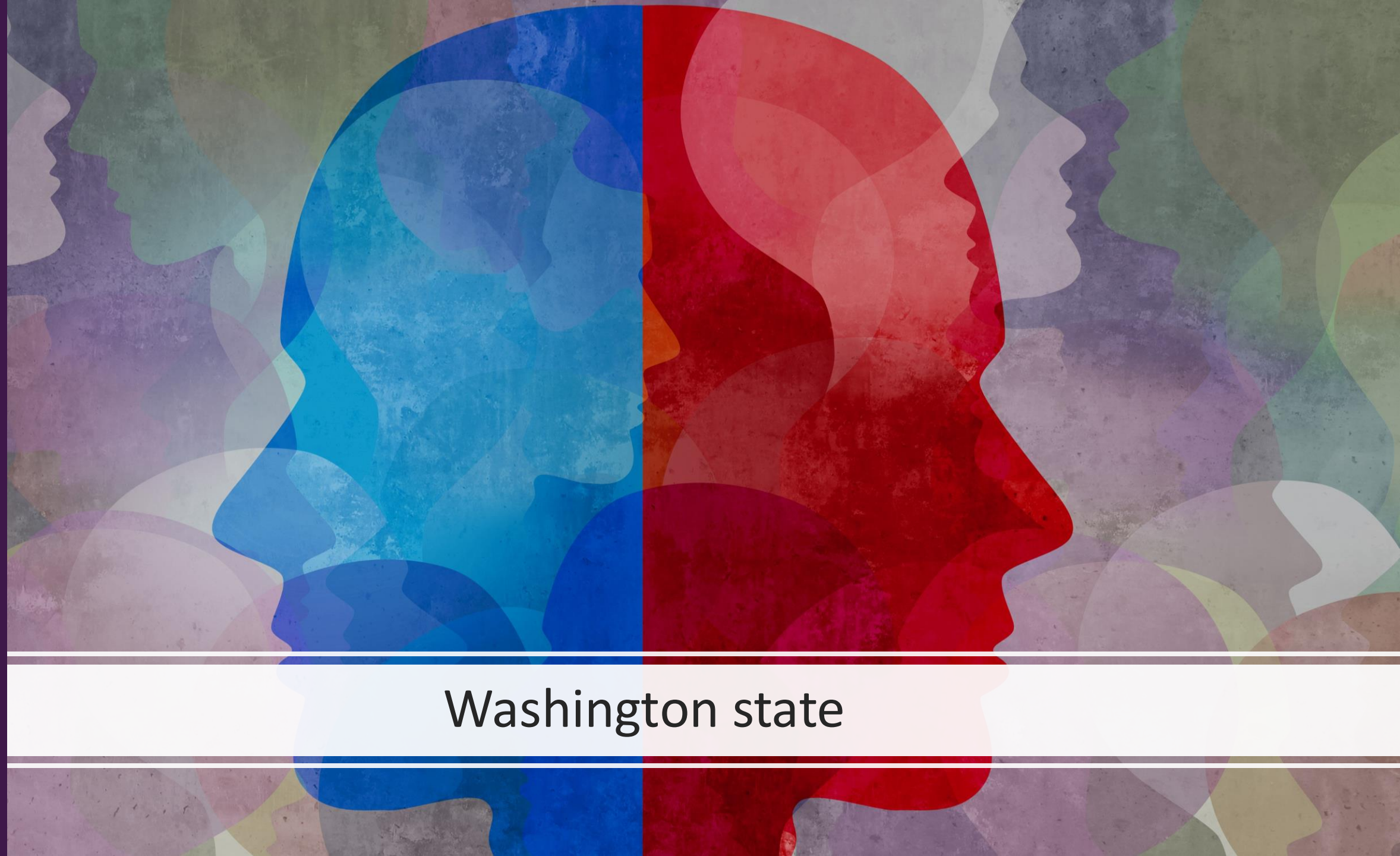
- Assisted Outpatient Treatment (AOT)
- Mandated Outpatient Treatment (MOT) (Tennessee, Virginia)

Prevalence:

- 48 states and D.C. have laws that allow for AOT, but many have not been implemented.
- Massachusetts and Connecticut do not have AOT laws.

As of January 2024

Why haven’t community mental health programs been able to adequately replace institutions to meet the needs of people with SMI? (Select all that apply.)



Washington state

Washington state fast facts

"Trend in inpatient data" source: WSHA. (2021, December). *Inpatient behavioral health treatment data project: Summary report of key findings. https://www.wsha.org/wp-content/uploads/WSHA-Inpatient-Treatment-Data-Project-Report.pdf*

212,308
Individuals with severe mental illness

88,079
individuals with SMI who receive treatment in a given year

15%
Prevalence of SMI in jails and prisons

2,190
Estimated number of inmates with SMI in 2021

2 to 1
Likelihood of incarceration versus hospitalization

Sources:

Ringeisen, H., Edlund, M. J., Guyer, H., Geiger, P., Stambaugh, L. F., Dever, J. A., Liao, D., Carr, C. M., Peytchev, A., Reed, W., McDaniel, K., & Smith, T. K. (2023). *Mental and Substance Use Disorders Prevalence Study: Findings report*. RTI International.

TAC. (2024, July 1). *Washington Severe Mental Illness Resources & Helpful Info.* https://www.tac.org/map_directory/Washington/

Washington state: Involuntary Treatment Act

Since the ITA's adoption in 1973, implementation has been shaped by:

- Amendments
- Court rulings
- Investigations and lawsuits

ITA Washington Revised Code § 71.05

Washington criteria for commitment

Danger to others:

- Substantial risk of violence or bodily harm, including attempts.
- Threats or conduct demonstrating risk of violence or harm.
- Property damage.

Danger to self:

- Substantial risk of suicide or bodily harm, including attempts or threats.
- Failure to meet essential human needs of health and safety (grave disability).
- Severe deterioration and need for care essential to health or safety (embedded in definition of grave disability).

Wash. Rev. Code §71.05.020

Need for change: WA psychiatric deterioration standard

Current Standard: Requires evidence of "repeated and escalating loss of cognitive or volitional control" before intervention.

Challenges:

- High bar necessitates significant suffering and documented harm.
- Delays treatment and intervention, leading to longer durations of untreated psychosis that worsen long-term outcomes.

New standard SB 5720 (2020):

- Creates opportunity for earlier intervention.
- Not yet implemented due to bed shortages.

WA emergency evaluation/initial hold

Initiation: Designated Crisis Responder (DCR)

If a DCR does not detain, immediate family or guardians may seek an emergency hold by filing a Joel's Law petition with the court.

Custody: With a finding of imminent harm or grave disability, a DCR can place the person on an emergency hold and request transport by ambulance or law enforcement to a designated facility for evaluation and treatment.

Wash. Rev. Code §71.05.153

Legal barrier to prompt care

Washington restricts petitioning for emergency evaluations to professionals only, with a unique delayed authorization for immediate family or guardians (Joel's Law).

- If the DCR does not detain the individual or act within 48 hours, immediate family, guardians, or federally recognized Indian tribes may petition the court for initial detention.
- This delay prevents citizens a direct *emergent* petition to the court.

Washington state health care authority. *How to file a petition for initial involuntary detention of a family member (Joel's Law)*. https://www.hca.wa.gov/assets/free-or-low-cost/joels-law-fact-sheet.pdf

Initial hold for evaluation and treatment

Timelines:

- Begin after medical clearance and exclude holidays and weekends.
- Evaluation team must examine the patient within 24 hours to petition for a judge to order a hold.
- Hold can last up to 120 hours if criteria continue to be met, during which the evaluation team may petition for inpatient commitment or discharge at any point.

Wash. Rev. Code §71.05.150

Washington inpatient commitment

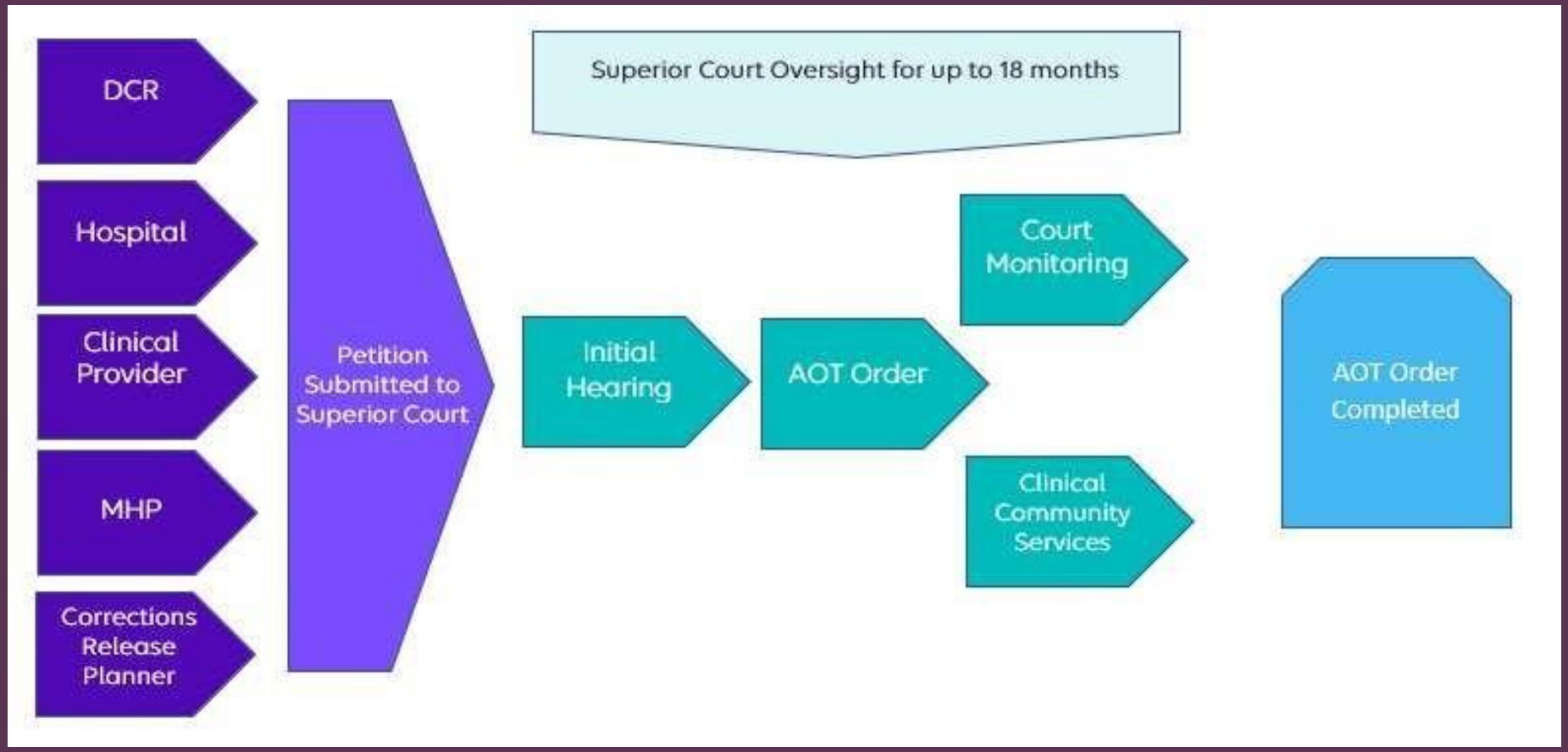
Washington is among a few states with staged durations for inpatient commitment.

- Initial commitment: up to 14 days.
- Extended commitment: up to 90 days.
- Renewal: up to 90 additional days.

Only professionals can petition for extended or renewal orders.

Wash. Rev. Code §71.05.150

Washington outpatient commitment (AOT)



Reproduced courtesy of Carelon Behavioral Health, 10116 36th Ave Ct, SW, Suite 304 Lakewood, WA 98499.

Washington AOT continued

Initiation: Qualified providers, DCRs, release planners in the correctional system, and emergency room physicians can petition for an AOT court order, which may be an alternative to involuntary inpatient care, or a less restrictive alternative treatment provided at discharge from an inpatient facility.

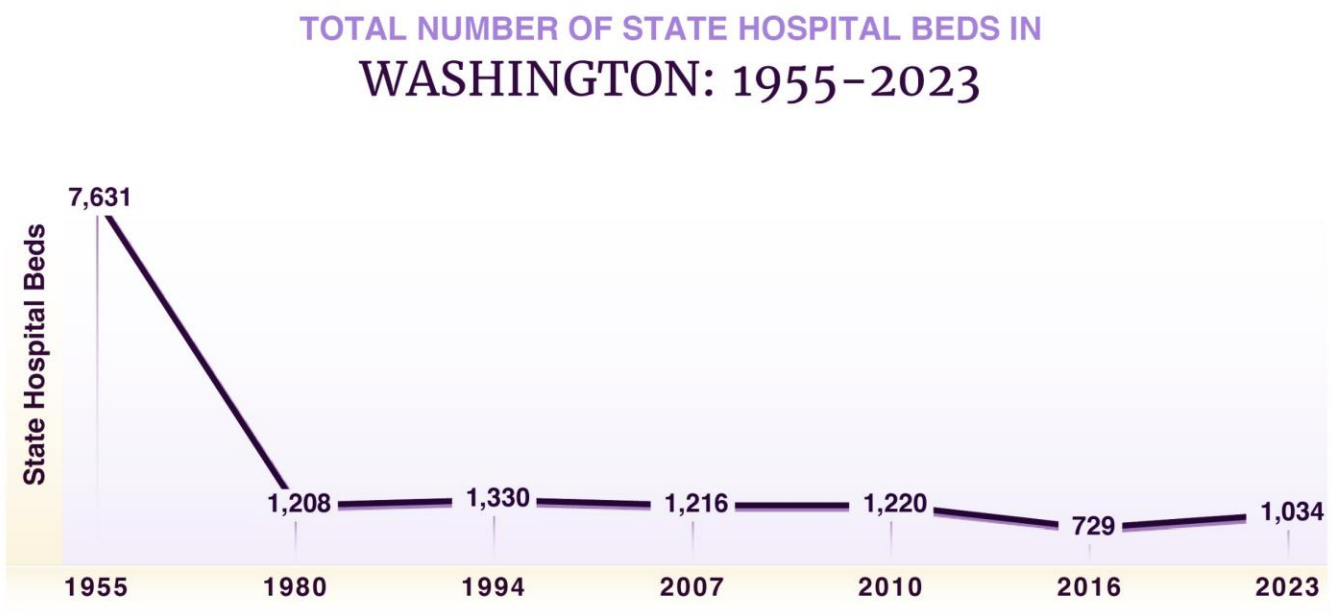
Duration: Up to 18 months.

Court authority: If an AOT client decompensates, the judge cannot order them directly into inpatient treatment but may refer them to a DCR for evaluation. The DCR can petition the court for AOT revocation to enable court-ordered inpatient treatment.

Wash. Rev. Code §71.05.148

Washington permits AOT by law but lacks programs and implementation.

Washington psychiatric hospital beds



2023

State beds: 1,034

- Civil beds: 431
- Forensic beds: 603

Per 100,000 people: 13.3

Source: Silver, S., & Sinclair Hancq, E. (2024, January). *Prevention over punishment: finding the right balance of civil and forensic state psychiatric hospital beds.* Treatment Advocacy Center. https://www.treatmentadvocacycenter.org/reports_publications/state-psychiatric-hospital-beds/

Click here for more information about state psychiatric hospital beds in Washington.

What problems are inherent in Washington state's involuntary treatment system? (Select all that apply.)

Additional resources

- TAC WA State statues and resources
- TAC Community Resource Center
- TAC state beds report (download to access WA page)

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QUESTIONS

To submit a question, please click the Q&A icon on Zoom.

CIVIL COMMITMENT THROUGH THE ETHICS LENS: HOW WE GOT HERE

December 13, 2024, 12:00–1:00 p.m. PT

Bruce Gage Lecture in Forensic Mental Health

Featured in Hot Topics in Forensic Mental Health: Civil Commitment and UW Dept of Psychiatry & Behavioral Sciences Grand Rounds series

Dr. Philip Candilis, MD will trace themes of ethics, policy, and social justice through the evolution of civil commitment in the U.S.

Learn more and get Zoom link: bit.ly/cmhpl

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