

The Use of Conservatorships and Adult Guardianships and Other Options in the Care of the Mentally Ill in the United States

By: Robert Barton, Esq., Stacie Lau Esq., and Lydia L. Lockett, Esq.*

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I. INTRODUCTION¹

Mental illness is a serious problem, with some studies estimating nearly a quarter of all adults in the United States suffered from mental illness in the past year.² Despite the prevalence of mental illness, many of those afflicted are unable to get the help they need, bouncing from hospital, prison, the street, or some combination of all three.³ Calls for fixing America's broken mental health system have grown louder in recent years.⁴ Unfortunately, not nearly enough has been done to address a problem of massive and growing proportions.

It is likely that at some point you will encounter a client, or a family member of a client, who is suffering from mental illness. However, this is an emotionally charged area of the law, and fraught with complexity and challenges. This article and the accompanying presentation are intended to help attorneys navigate some of the common issues that are of concern to clients dealing with mental illness.⁵

To that end, below, we will overview common types of mental illness and prevalence; examine common obstacles mentally ill patients have in obtaining treatment and survey the law surrounding civil commitment and guardianships, including why family members have difficulty using Conservatorships and Adult Guardianships⁶ to obtain care for the mentally ill. We will conclude by presenting some alternatives to commitment and/or guardianships and suggest some reforms which might improve care for the mentally ill.

II. PREVALENCE OF MENTAL ILLNESS IN THE UNITED STATES

A. Types of Mental Illness

The term “mental illness” is extremely broad and can encompass a wide and varied range of diseases. Among these are:

* Holland & Knight LLP, Los Angeles, California

¹ A version of this article was originally presented as part of a panel on contested guardianships at the 2014 American Bar Association Real Property Trust and Estate Spring Symposium.

² *The Numbers Count: Mental Disorders in America*, National Institute of Mental Health, <http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml> (last visited February 1, 2014).

³ See *July 2009 ECOSOC Meeting Discussion Paper: Mental Health, poverty and development*, World Health Organization, available at http://www.who.int/nmh/publications/discussion_paper_en.pdf; Kissinger, Meg, *Chronic Crisis, A System That Doesn't Heal*, Available at <http://www.jsonline.com/news/milwaukee/chronic-crisis-a-system-that-doesnt-heal-milwaukee-county-mental-health-system-210480011.html#!/emergency-detentions/>

⁴ See WORLD HEALTH ORGANIZATION, WHO MiNDbank, http://www.who.int/mental_health/mindbank/en/ (providing access to national mental health policies, strategies and laws); MENTAL ILLNESS POLICY ORGANIZATION, <http://mentalillnesspolicy.org/> (noting the serious issues surrounding mental illness and providing access to informational resources regarding the treatment and protection of the mentally ill).

⁵ The law, quality of available care and circumstances will differ substantially in each individual case. If you have a case involving someone affected by mental illness, please immediately consult with a knowledgeable doctor or mental health professional.

⁶ Terminology will differ depending on the jurisdiction. For instance, Conservator is the operative term in California, while in many other states, the term is “Guardianship”. Both terms are meant to refer to protective proceedings initiated for the protection of a third person. As “Guardian” is the more common term, it will be primarily used throughout the paper for convenience and clarity.

1. Anxiety disorders

Anxiety disorders are one of the most common mental illnesses in America, affecting around twenty percent of the population.⁷ An estimated forty million American adults suffer from anxiety disorders. Most people with anxiety disorder go untreated. Only about one-third of those suffering from an anxiety disorder receive treatment, even though the disorders are highly treatable.⁸

Anxiety disorders describe a group of mental illness that cause people to feel excessively frightened, distressed, or uneasy during situations in which most other people would not experience these same feelings. They can also cause physical changes like increased blood pressure.⁹ The most common type of anxiety disorders are panic disorder, obsessive compulsive disorder, posttraumatic stress disorder, phobias generalized anxiety disorder, and social anxiety disorder. People with other mental illnesses such as schizophrenia and depression may have symptoms of severe anxiety such as panic attacks or compulsions.¹⁰

If not properly treated, anxiety disorders can be severely impairing and negatively affect a person's daily activities including interaction with people, or the ability to study or work. In severe cases, anxiety disorders can make regular activities such as shopping, cooking or running errands incredibly difficult.¹¹ Further, people who suffer from anxiety disorders are more likely to abuse alcohol or other drugs, otherwise known as "self medication." There are many effective treatments for anxiety disorders. However, most people do not seek treatment because they are too ashamed to ask for help, or do not realize how severe their symptoms are.¹²

The cause of anxiety disorders can be biological or environmental. Some anxiety disorders, such as obsessive compulsive disorder have a very clear genetic link.¹³ Psychotherapy, aerobic exercise and medications can be very effective in treating anxiety disorders.¹⁴

2. Schizophrenia

Schizophrenia is a serious mental illness that affects 2.4 million American adults over the age of 18. Schizophrenia most often affects men in their late teens or early twenties, and women in their late twenties and early thirties.¹⁵ Schizophrenia interferes with a person's ability to think clearly, manage emotions, make decisions, and relate to others. However, the cause of schizophrenia is hard to determine.

⁷ *Mental Illnesses: Anxiety Disorders*, National Alliance on Mental Illness, http://www.nami.org/Template.cfm?Section=By_Illness&Template=/ContentManagement/ContentDisplay.cfm&ContentID=142543 (last updated April 2012).

⁸ *Understanding the Facts*, Anxiety and Depression Association of America, <http://www.adaa.org/understanding-anxiety> (last visited February 1, 2014).

⁹ *Anxiety*, American Psychological Association, <http://www.apa.org/topics/anxiety/index.aspx> (last visited February 1, 2014).

¹⁰ *Mental Illnesses: Anxiety Disorders*, *supra* note 7.

¹¹ *Id.*

¹² *Id.*

¹³ *Id.*

¹⁴ *Id.*

¹⁵ *What is Schizophrenia?*, National Alliance of Mental Illness, <http://www.nami.org/Template.cfm?Section=schizophrenia9> (last visited February 1, 2014).

There are many possible causes including brain chemistry and structure, as well as environmental causes.¹⁶ At the very least, there is a clear genetic link for people with schizophrenia. The illness affects about one percent of the general population, but occurs in ten percent of the people who have a first degree relative with this disorder.¹⁷

Schizophrenia is often mischaracterized as a disease associated with violent behavior. However, most people with schizophrenia are not violent. When treated, schizophrenia is a manageable disease. As high as fifty percent of people with schizophrenia have positive outcomes when they receive appropriate treatment.¹⁸ Suicide occurs at a much higher rate among people with schizophrenia, but the risk can be greatly reduced with the use of medication.¹⁹ It can be difficult treating a person for schizophrenia, because the person often does not believe they are sick as a result of a condition called anosognosia.²⁰

3. Dementia

Dementia is a term that describes a group of symptoms, caused by permanent damage or death of the brain's nerve cells or neurons. These symptoms, usually associated with old age, include loss of memory, judgment, language, complex motor skills, and other intellectual functions.²¹

Alzheimer's disease is the most common cause of dementia in persons over the age of sixty-five, and represents about sixty percent of all people with dementia.²² There are different causes for dementia, including Alzheimer's disease, vascular dementia, Lewy body dementia (a form of dementia that impairs cognition, movement and emotions such as Parkinson's disease),²³ alcohol induced dementia, and others.²⁴

Dementia is often a special ground for imposing a conservatorship or guardianship. With other mental illnesses, the court is unsure whether the person will get better and may be more inclined to impose a periodic review of the need for the conservatorship. However, dementia is a

¹⁶ *What Is Schizophrenia?*, National Institute of Mental Health, http://www.nimh.nih.gov/health/topics/schizophrenia/index.shtml?utm_source=publish2&utm_medium=referral&utm_campaign=www.kpbs.org (last visited February 1, 2014).

¹⁷ *What is Schizophrenia?*, National Alliance of Mental Illness, *supra*, note 15. <http://www.nami.org/Template.cfm?Section=schizophrenia9>

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ See discussion of Anosognosia, *infra*, Part III, Section B, 4.a.; *The Anatomical Basis of Anosognosia (Lack of Awareness of Illness)*, Treatment Advocacy Center, *available at* http://www.treatmentadvocacycenter.org/storage/documents/Research/anosognosia_backgrounder_may_2013.pdf (last updated May 2013). See also Section B4, *infra*.

²¹ *About Alzheimer's*, Alzheimer's Foundation of America, <http://www.alzfdn.org/AboutAlzheimers/definition.html> (last visited February 1, 2014).

²² *Id.*

²³ *Lean About LBD*, Lewy Body Dementia Association, Inc., <http://www.lbda.org/content/learn-about-lbd> (last visited February 1, 2014).

²⁴ *Facts About Dementia: Overview*, Dementia Care Central, <http://www.dementiacarecentral.com/aboutdementia/facts> (last visited February 1, 2014).

progressive disease, which means that it gets worse over time. Therefore, the court is often certain that the person will not get better.²⁵

4. Eating Disorders

Eating disorders are one of the most challenging mental illnesses to deal with and treat. Almost one in twenty people will experience symptoms of an eating disorder.²⁶ If left untreated, eating disorders can result in severe medical complications and even death. There are no specific tests that can diagnosis an eating disorder, therefore it is often underdiagnosed.²⁷ In most cases, psychopharmacological medications are not effective treatments for people struggling with eating disorders.²⁸

Females are often the victims of eating disorders, but there has been growing numbers of males diagnosed with eating disorders.²⁹ Different forms of eating disorders include anorexia nervosa and bulimia nervosa.³⁰ Eating disorders often occur in people with other mental illnesses such as depression, anxiety disorders and substance abuse issues.³¹

5. Addiction Disorders

Experts have long debated whether addiction is a “disease” or a true mental illness.³² Addiction is a condition where the body requires a drug to avoid physical and psychological withdrawal symptoms.³³ Drug use has been increasing in the United States. It is estimated that 22.5 million Americans age 12 or older (8.7 percent of the population) have used an illicit drug or abused a psychotherapeutic medication such as a pain reliever, stimulant or tranquilizer.³⁴

Addiction results when a person ingests a substance such as alcohol, cocaine or nicotine, and the need for the substance is compulsive and interferes with ordinary life and activities. The first stage of addiction is dependence, during which the search for a drug dominates the individual’s life. The second stage of addiction is the addict’s development of tolerance, which forces the person to consume larger and larger doses of the drug to achieve the same effect.³⁵

²⁵ *Id.*

²⁶ *Mental Illnesses: Eating Disorders*, National Alliance on Mental Illness, http://www.nami.org/Template.cfm?Section=By_Illness&Template=/ContentManagement/ContentDisplay.cfm&ContentID=65851 (last visited February 1, 2014).

²⁷ *Id.*

²⁸ *Id.*

²⁹ *Id.*

³⁰ *Id.*

³¹ *Eating Disorders*, National Institute of Mental Health, <http://www.nimh.nih.gov/health/publications/eating-disorders/index.shtml> (last visited February 1, 2014).

³² *Id.*

³³ *Addictions*, American Psychological Association, <http://www.apa.org/topics/addiction/index.aspx> (last visited February 1, 2014).

³⁴ *DrugFacts: Nationwide Trends*, National Institute on Drug Abuse, <http://www.drugabuse.gov/publications/drugfacts/nationwide-trends> (last revised January 2014).

³⁵ *Id.*; *Addiction*, Psychology Today, <http://www.psychologytoday.com/basics/addiction> (last visited February 1, 2014).

People with addiction disorders are often diagnosed with other mental disorders. Compared to the general population, people addicted to drugs are twice as likely to suffer from mood and anxiety disorders.³⁶ People who suffer from anxiety disorders often “self medicate” and rely on alcohol, tobacco and other drugs which may become an addiction.³⁷

B. Defining Mental Illness/Incapacity

1. Daily Activities v. Communicative Ability

Definitions of incompetency and incapacity differ among states. Some states focus on the person’s ability to understand or communicate, while other states focus on the person’s ability to communicate, as well as the ability to carry out activities of daily living.³⁸

For example, the Uniform Guardianship and Protective Proceedings Act (UGPPA, 1997) examines both communicative ability and the ability to carry out daily tasks, and considers an incapacitated adult as one who “is unable to receive and evaluate information or make or communicate decisions to such an extent that the individual lacks the ability to meet essential requirements for physical health, safety, or self-care, even with appropriate technological assistance....”³⁹

On the other hand, the National Guardianship Association (2007) takes into account only communicative ability, and defines an incapacitated individual as someone who “lacks sufficient understanding or capacity to make or communicate responsible decisions concerning the care of his person or financial affairs.”⁴⁰

Over half of states require impairments in activities of daily living and/or communication/decision-making skills to define the person as incompetent or incapacitated. These states are: Arizona, Alaska, Arkansas, Colorado, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Iowa, Kansas, Massachusetts, Minnesota, Mississippi, Missouri, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, Vermont, Virginia, West Virginia and Wisconsin.⁴¹

³⁶ *DrugFacts*, *supra* note 34.

³⁷ *Id.*

³⁸ G.J. Demakis, *State Statutory Definitions of Civil Incompetency/Incapacity: Issues for Psychologists*, 19 Psych. Pub. Pol’y & L. 331, 331 (August 2013); *see also North Carolina Guardianship Manual*, North Carolina Indigent Defense Manual Series, John Rubin, Editor, (2008), Chapter 6, *available at* <http://www.ncids.org/other%20manuals/Guardianship%20Manual/Chapter%206.pdf>.

³⁹ UNIFORM GUARDIANSHIP AND PROTECTIVE PROCEEDINGS ACT (“UGPPA”) § 560:5-102 (1997).

⁴⁰ *Guardianship Terminology*, National Guardianship Association, *available at* <http://www.guardianship.org/pdf/Terminology.pdf> (last visited February 1, 2014).

⁴¹ Demakis, *supra* note 38, at 337; Ariz. Rev. Stat. Ann. § 14-12102 (7); Alaska Stat. § 13.26.005; Ark. Code Ann. § 28-65-101 5(A); Colo. Rev. Stat. § 15-14-102 (5); Conn. Gen. Stat. § 45a-644 (c-d); Del. Code Annual § 3901; Ga. Code Ann. § 29-4-1 (a); Haw. Rev. Stat. Ann. § 560:5-102; Idaho Code § 15-5-101; Ill. Comp. Stat. Ann. § 755 11a-11; Iowa Code Ann. § 633.3 23; Kan. Stat. Ann. § 59-3051; Mass. Gen. Laws Ann. § 5-101 (9); Miss. Code SEC § 93-13-125; Mo. Ann. Stat. § 475.010; New York Code § 81.02 2b; N.C. Gen. Stat. § 35A-1101 (7); N.D. Cent. Code § 30 1-26-01 5-101; Okla. Stat. Ann. § 30-1-111 12; Or. Rev. Stat. § 12.005; Pa. Cons. Stat. § 5512.1 (a); R.I. Gen. Laws §§ 34-15-4 to 11; Vt. Stat. Ann. 14 § 3061 (1); Va. Code Ann. § 37.2-1000; W. Va. Code § 44A-1-1 (13); Wise. Stat. Ann. § 54.103(a)).

Statutes from the following states focus only on impairments in daily activities: California, Florida, Indiana, Kentucky, Louisiana, Maryland, Nevada, New Hampshire, New Jersey, New Mexico and Ohio.⁴²

Statutes in seven states focus solely on communication and/or decision making ability: Alabama, Maine, Michigan, Montana, Nebraska, South Carolina and Utah.⁴³

It is preferred that both standards be used because there are numerous ways people can have difficulty meeting their daily needs safely and these statutes have to apply to people with different cognitive, physical and psychological problems.⁴⁴

2. Undue influence

Although undue influence is traditionally considered in testamentary challenges, some states have also looked at it to define incompetency or incapacity.

Statutes from seven states specifically look at possible exploitation or undue influence: California, Delaware, Indiana, Kentucky, Louisiana, Vermont and Wisconsin.⁴⁵ For example, Wisconsin's statute states that a guardian of the estate would be necessary if the individual is "unable to prevent financial exploitation."⁴⁶ Louisiana's statute looks at whether the individual is "unable to manage his own resources, carry out activities of daily living, or protect himself from abuse, neglect or exploitation."⁴⁷

3. Isolated Events or Negligence

In California, Idaho and New Hampshire, isolated events or negligence are insufficient to determine whether a person is incompetent/incapacitated. For example, California's statute states "Substantial inability may not be proved solely by isolated incidents or negligence or improvidence."⁴⁸

4. Alcohol/ Drug Addiction

States also differ on whether drug and/or alcohol addiction or abuse is a form of incompetency or incapacity. Seventeen states consider drug/alcohol addiction as a form of

⁴² Demakis, *supra*, note 38, at 337.; Cal. Prob. Code § 1801 (a-b)); Fla. Stat. Ann. § 731.201 (21); Ind. Code § 29-3-1-7.5; Ky. Rev. Stat. § 209.020; Louisiana Rev. Stat. § 15: 1503; Md. Code Ann. § 13-201 (c); Nev. Rev. Stat. § 159.019; N.H. Rev. Stat. Ann. § 464-A: 2 XI; N.J. Permanent Stat. § 3B: 1-2; N.M. Stat. Ann. § 45-5-101 F-H; Ohio Rev. Code Ann. § 2111.01 (D).

⁴³ Demakis, *supra*, note 38, at 337; Ala. Code 1975 § 26-2A-20 (8); Me. Rev. Stat. § 5-101-1 (1); Mich. Stat. § 700.1105 (a); Mont. Code Ann. § 72-5-101 (1); Neb. Rev. Stat. § 30-2601 (1); S.C. Code Ann. § 62-5-101 (1); Utah Code Ann. § 75-1-201 (22).

⁴⁴ Demakis, *supra*, note 38, at 337.

⁴⁵ Demakis, *supra*, note 38, at 338; Cal. Prob. Code § 1801 (a-b); Del. Code Annual § 3901; Ind. Code § 29-3-1-7.5; Ky. Rev. Stat. § 209.020; Louisiana Rev. Stat. § 15: 1503; Vt. Stat. Ann. 14 § 3061 (1); Wise. Stat. Ann. § 54.103(a).

⁴⁶ Demakis, *supra*, note 38, at 338; Wis. Stat. Ann. § 54.103(a).

⁴⁷ Demakis, *supra*, note 38, at 338; LA Rec. Stat. § 15:1503.

⁴⁸ Demakis, *supra*, note 38, at 339; Cal. Prob. Code § 1801 (a-b); Idaho Code § 15-5-101; N.H. Rev. Stat. Ann. § 464-A: 2 XI.

incompetence/incapacity: Alabama, Arkansas, Indiana, Maine, Maryland, Michigan, Montana, Nebraska, New Jersey, New Mexico, New York, Ohio, Oklahoma, South Carolina, Utah, Washington and Wyoming.⁴⁹

5. Religious Exemptions

Kansas and Missouri have statutes which include a “religious exemption.” These statutes note that reliance on prayer for healing and/or the concomitant refusal of medical treatments cannot be used as evidence that the person is incompetent or lacks capacity.⁵⁰

III. ISSUES IN GETTING THE MENTALLY ILL ADEQUATE CARE AND TREATMENT

A. The Problem

The inability to get the mentally ill the treatment and care they need has resulted in a severe health crisis for a significant subset of the population. For instance:

- Nearly a quarter of all adults in the United States suffered from some sort of mental illness in the past year.⁵¹
- Approximately sixty percent of adults, and almost one-half of youths ages eight to fifteen with a mental illness received no mental health services in the previous year.⁵²
- Approximately twenty-five percent of the homeless population suffers from severe mental illness and over sixty percent of people who are chronically homeless have experienced lifetime mental health problems.⁵³
- Individuals with mental illness die on average fourteen to thirty-two years earlier than the general population.⁵⁴

⁴⁹ See Demakis, *supra*, note 38, at 338-39, Table 1; Ala. Code 1975 § 26-2A-20 (8); Ark. Code Ann. § 28-65-101 5(A); Ind. Code § 29-3-1-7.5; Me. Rev. Stat. § 5-101-1 (1); Md. Code Ann. § 13-201 (c); Mich. Stat. § 700.1105 (a); Mont. Code Ann. § 72-5-101 (1); Neb. Rev. Stat. § 30-2601 (1); N.J. Permanent Stat. § 3B: 1-2; N.M. Stat. Ann. § 45-5-101 F-H; New York Code § 81.02 2b; Ohio Rev. Code Ann. § 2111.01 (D); Okla. Stat. Ann. § 30-1-111 12; S.C. Code Ann. § 62-5-101 (1); Utah Code Ann. § 75-1-201 (22); Wash. Rev. Code Ann. § 11.88.010(a); Wy. Stat. § 3-1-101 (ix).

⁵⁰ Demakis, *supra*, note 38, at 339; Kan. Stat. Ann. § 59-3051; Mo. Ann. Stat. § 475.010.

⁵¹ *The Numbers Count: Mental Disorders in America*, *supra*, note 2.

⁵² See *Anxiety*, *supra* note 9 [citing *Results from the 2010 National Survey on Drug Use and Health: Mental Health Findings*, Substance Abuse and Mental Health Services Administration. NSDUH Series H-42, HHS Publication No. (SMA) 11-4667 (2012)]; *Use of Mental Health Services and Treatment Among Children*, National Institute of Mental Health, <http://www.nimh.nih.gov/statistics/1NHANES.shtml> (last accessed March 4, 2014.)

⁵³ Kristen Paquette, *Current Statistics on the Prevalence and Characteristics of People Experiencing Homelessness in the United States*, Homelessness Resource Center, (July 2011), <http://homeless.samhsa.gov/Resource/Current-Statistics-on-the-Prevalence-and-Characteristics-of-People-Experiencing-Homelessness-in-the-United-States-48841.aspx>

⁵⁴ Craig W. Colton, et al., *Congruencies in Increased Mortality Rates, Years of Potential Life Lost, and Causes of Death Among Public Mental Health Clients in Eight States*, Preventing Chronic Disease, (April 2006) available at http://www.cdc.gov/pcd/issues/2006/apr/05_0180.htm

- More than ninety percent of those who die by suicide had one or more mental disorders.⁵⁵
- Nearly two-thirds of all prisoners in the United States have a mental health problem.⁵⁶

A recent study examining why the mentally ill fail to obtain proper care and treatment set forth the problem this way: “A substantial proportion of adults with common mental disorders fail to receive any treatment even when these conditions are quite severe and disabling. Furthermore, many who do receive treatment drop out before completing treatment. Because individuals with psychiatric disorders would often benefit from a full course of treatment, the gap between the prevalence and treatment of disorders contributes to unmet need for care.”⁵⁷

Yet, treatment for mental illness, including medication, is available. Medication, when administered as part of a course of treatment, is usually effective. “Antipsychotic medications are not only an accepted but often essential, irreplaceable treatment for psychotic illnesses, as most firmly established for schizophrenia, because the benefits of antipsychotic medications for patients with psychoses, compared to any other available means of treatment, are so palpably great compared with their generally manageable side effects.”⁵⁸ For instance, the National Advisory Mental Health Council has estimated treatment success rates of forty-five percent for schizophrenia, sixty-five percent for major depression and eighty percent for bipolar disorder.⁵⁹

So why are the mentally ill not getting the treatment they need? As explained in further detail below, the reasons are complex and varied. The patient may be unwilling to seek help, or due to societal, economic or other factors, simply unable to get help. In addition, for important historical reasons, recent jurisprudence on the issue has afforded extreme deference to a patient’s right to refuse treatment. Unfortunately, it has also resulted in a significant portion of the mentally ill population not getting the treatment they need.

B. Unwillingness to Seek Help (Patient’s Rights)

The biggest issue in getting mentally ill patients the treatment and care they need is often the patients themselves.⁶⁰ In a recent study, over one-quarter of respondents with severe mental illness did not perceive a need for treatment and one in four of those who did perceive a need reported that they thought the problem was not severe or that it would get better on its own.⁶¹

⁵⁵ *Anxiety, supra*, note 9 [citing *Suicide in the USA Based on 2010 Data*, American Association of Suicidology (2012)].

⁵⁶ *Inmate Mental Health*, National Institute of Mental Health, <http://www.nimh.nih.gov/statistics/1DOJ.shtml> (last visited February 1, 2014).

⁵⁷ Ramin Mojtabai, et al., *Barriers to Mental Health Treatment: Results from the National Comorbidity Survey Replication (NCS-R)* [citing Kessler et al., 2005; President’s New Freedom Commission on Mental Health, 2005; Sareen et al., 2007; Wang et al., 2007; Wang et al., 2005; Wang et al., 2005), *Psychol Med.* 2011 August; 41(8): 1751–1761] available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3128692/>

⁵⁸ Brief for the American Psychiatric Association and American Academy of Psychiatry and the Law as Amici Curiae Supporting Respondent, *Sell v. U.S.* (Jan. 22, 2003) (No. 02-5664) 2003 WL 176630, at *13-14.

⁵⁹ National Mental Health Advisory Council. 1993. *Health Care Reform for Americans with Severe Mental Illnesses*, *Am. J. of Psychiatry* 150 (10) 1450-1452.

⁶⁰ Kissinger, *supra*, note 3, for several stories chronicling this issue.

⁶¹ Mojtabai, *supra*, note 57.

While the kneejerk response may very well be, “just force them to get help,” the historical context demonstrates the problems and limitations of this approach.

1. Historical Context

400 B.C.: Hippocrates treats mental disorders as diseases rather than reflection of the displeasure of gods or evidence of demonic possession.⁶²

Middle Ages: Treatment of the mentally ill varies, with some adopting a scientific approach while other cultures labeling the mentally ill as witches or inhabited by demons.⁶³

1600s: The mentally ill who are dangerous are placed in prisons, chained to stocks or beaten, while the non-violent were escorted out of town and left to fend for themselves.⁶⁴

1773: First Institution Devoted Exclusively to Treatment of Mental Illness.⁶⁵

1840s: In the United States, psychiatric hospitals spring up to care for the mentally ill, in an attempt to replace jails.⁶⁶

1883: Mental disorders are scientifically distinguished for the first time.

Early 1900s: Drugs, electro-convulsive therapy, and surgery are used to treat people with schizophrenia and others with persistent mental illnesses. Some are purposely infected with malaria; others are treated with repeated insulin-induced comas. Others have parts of their brain removed surgically (a lobotomy), or are sterilized involuntarily.⁶⁷

1952: Thorazine, the first drug to treat psychosis is discovered, with studies showing 70% of patients improve with its use.

1955: Peak for the number of mentally ill who are institutionalized (560,000 in the United States)

⁶² Timeline: Treatments for Mental Illness, PBS, <http://www.pbs.org/wgbh/amex/nash/timeline/index.html> (last visited February 1, 2014).

⁶³ *Id.*

⁶⁴ Joseph T. Carney, *America's Mentally Ill: Tormented Without Treatment*, 3 Geo. Mason U. C.R. L.J. 181, 184 (1992); Valerie J. Wilkinson, *1986 Amendments in Georgia's Mental Health Statutes: The Latest Attempt to Provide A Solution to the Problem of the Chronically Mentally Ill*, 36 Emory L.J. 1313, 1316 (1987)

⁶⁵ *Id.*

⁶⁶ Deanna Pan, *Deinstitutionalization and Its Consequences*, (April 29, 2013), available at <http://www.motherjones.com/politics/2013/04/timeline-mental-health-america>

⁶⁷ *Id.*; Timeline: Treatments for Mental Illness, *supra* note 62

2. The Modern Era, 60s-Present

a. Deinstitutionalization and the Reform Movement

Deinstitutionalization refers to the mass release of patients with mental illness from hospitals to the street beginning after World War II, and continuing to accelerate through the 1960s and 70s.

The roots of deinstitutionalization are often attributed to World War II conscientious objectors who worked in mental institutions as an alternative to armed service.⁶⁸ Those who served at the institutions were horrified to find facilities where patients lie about in their own urine and feces, terrible overcrowding, and remarkable understaffing, often with patients outnumbering staff several hundred to one. The conditions were described as hellish. In one account, a former staffer described what he saw to NPR:

“The “incontinent ward” was what the men called A Building. It was a large open room with a concrete slab for a floor. There were no chairs. There were no activities, no therapy, not even a radio to listen to. So hundreds of men — most of them naked — walked about aimlessly or hunched on the floor and huddled against the filthy bare walls.

Nearby was B Building; it was called the “violent ward” or the “death house,” because angry men sometimes violently attacked one another. In one room, rows and rows of men were strapped and shackled to their bed frames.”

In his book, *American Psychosis*, E. Fuller Torrey sets forth another account:

“He opened the door to another room. I stood frozen at what I saw. Here were two hundred and fifty men-- all of them completely naked--standing about the walls of the most dismal room I have ever seen. There was no furniture of any kind. Patients squatted on the damp floor or perched on the window seats. Some of them huddled together in corners like wild animals. Others wandered about the room picking up bits of filth and playing with it.”⁶⁹

As the war ended, many of those who had served in the institutions felt changes had to be made and enlisted the help of several well-known reformers and politicians, including Dorothy Dix and Eleanor Roosevelt to bring attention to the matter.⁷⁰

⁶⁸ Joseph Shapiro. WWII Pacifists Exposed Mental Ward Horrors. December 30, 2009. <http://www.npr.org/templates/story/story.php?storyId=122017757>; E. Fuller Torrey, *American Psychosis*, p. 19 (2014).

⁶⁹ Torrey, *supra*, at p. 22-23.

⁷⁰ Shapiro, *supra*.

From there, the movement continued to gain steam. Although there were many other significant developments which are unfortunately beyond the scope of this article, two worth mentioning are the novel and film “One Flew Over the Cuckoo’s Nest,” and Robert Plotkin’s influential article, “*Limiting the Therapeutic Orgy: Mental Patients’ Right to Refuse Treatment*,” 72 NW. U. L. REV. 461 (1978).”

One Flew Over the Cuckoo’s Nest features the story’s protagonist faking insanity to avoid prison. In the mental institution, he was subjected to cruel and inhumane treatment at the hands of Nurse Ratched. But the story “portrayed mental patients as fundamentally sane and implied that if they were simply allowed to leave the hospital, they would live happily ever after.”⁷¹ “The book’s publication contributed to a backlash against the entire psychiatric treatment system in the US in the 1960s.”⁷²

Robert Plotkin’s article also had a considerable amount of influence, particularly in the legal community. In his article, Mr. Plotkin argued strenuously against the use of forced treatments against psychiatric patients and advocated for stringent legal standards for the treatment of patients:

“Yet the fact remains that the Constitution has been ignored in state mental institutions. The void created by the judges and the legislators has been filled by the psychiatrists, and issues which are primarily social judgments have become matters of medical prerogatives, insulated from outside review or control by the legislature, the courts, or independent administrative agencies. This is especially true in psychiatrists’ selection of individual treatment methods for the patient.”

Other scholars latched onto Mr. Plotkin’s view, forming the bedrock of what scholars have called “doctrinal constitutional law scholarship.”⁷³ “The various constitutional bases for different rights were explored, and courts indeed closely followed the scholarship in this area.”⁷⁴

One of the earliest decisions was out of the D.C. Circuit in the case *Lake v. Cameron*, 364 F.2d 657, 660 (D.C. Cir. 1966). In *Lake*, the Court established the now-familiar standard of the “Least Restrictive Alternative.” The Court noted that “deprivations of liberty solely because of dangers to the ill persons themselves should not go beyond what is necessary for their protection.”⁷⁵

At the same time, other Court decisions were making it harder to get patients into treatment. The previous standard for institutionalization, a “need for treatment” had been done away with in favor of a standard which only allowed institutionalization where the patient was a “danger to

⁷¹ Torrey, *supra*, at p. 45.

⁷² Jon Swaine. How One Flew Over the Cuckoo’s Nest Changed Psychiatry. February 1, 2011. <http://www.telegraph.co.uk/news/worldnews/northamerica/usa/8296954/How-One-Flew-Over-the-Cuckoos-Nest-changed-psychiatry.html>

⁷³ Elyn R. Sazks, *Mental Health Law: Three Scholarly Traditions*, 74 U.S.C. L.Rev. 295 (2000).

⁷⁴ *Id.* at p. 297

⁷⁵ *Lake, supra*, at p. 660; see also Torrey, *supra* at pp. 71-72.

self or others” and raised the evidentiary standard in commitment proceedings to “clear and convincing” from the previous standard of “preponderance of the evidence.”⁷⁶

b. The Prison Boom 1980s- Present

Unfortunately, while the intentions behind the deinstitutionalization movement were good, there was little to no coordination for continuing the treatment and rehabilitation of those patients who were released.⁷⁷ And, these decisions had a big impact. Hundreds of thousands of mental health treatment beds were lost.⁷⁸ Unsurprisingly, there was an explosion in prisoners with mental illness.⁷⁹ “These days, the largest single provider of housing for people with severe mental illness is the criminal justice system.” and police and prison officials have become “armed social workers”⁸⁰

c. Other Developments

(i) 1990s: Second Generation of Anti-psychotic drugs introduced with fewer side-effects for patients.⁸¹

(ii) The Funding Crisis

Our recent recession has hit mental health funding hard, making it even more difficult to get resources and treatment to those who need it. As of 2009, an estimated \$4.35 billion in mental health spending cuts were made across the country. And today, there is the same ratio for psychiatric beds as in 1850.⁸²

3. Modern Legal Underpinnings

a. Sources of State Power to Care for Mentally Ill

The source of state power to care for the mentally ill can be traced back primarily to two sources. First, the police power, which accords the states “a plenary power to make laws and regulations for the protection of the public health, safety, welfare and morals” and “bestows upon states the responsibility to involuntarily commit mentally disordered persons whose behaviors demonstrate that they are a danger to self or others.”⁸³

And second, the *parens patriae* power under which, “...states are entrusted with civilly confining persons against their will when they are unable to care for themselves. This is

⁷⁶ See *Addington v. Texas*, 441 U.S. 418, 99 S. Ct. 1804 (1979).

⁷⁷ *Id.*

⁷⁸ Torrey, *supra*, at p. 117.

⁷⁹ *Id.* at pp. 117-123.

⁸⁰ *Id.*

⁸¹ *Second Generation Antipsychotic Medications*, National Alliance on Mental Illness, https://www.nami.org/Content/NavigationMenu/Hearts_and_Minds/Second_Generation_Antipsychotic_Medications.htm (last visited March 4, 2014).

⁸² Pan, *supra*.

⁸³ Bruce A. Arrigo, *Paternalism, Civil Commitment and Illness Politics: Assessing the Current Debate and Outlining A Future Direction*, 7 J.L. & Health 131, 136 (1993).

generally understood to include an inability to provide for one's basic needs; e.g., food, clothing, safety and shelter."⁸⁴

b. Backlash

- Every human being of adult years and sound mind has a right to determine what shall be done with his own body. Justice Cardozo, *Schloendorff v. Soc'y of New York Hosp.* (1914) 211 N.Y. 125, 129, *abrogated by Bing v. Thunig* (1957) 2 N.Y.2d 656, 143 N.E.2d 3 (1957).⁸⁵
- A finding of 'mental illness' alone cannot justify a state's locking a person up against his will and keeping him indefinitely in simple custodial confinement. Assuming that the term "mental illness" can be given a reasonably precise content and that the 'mentally ill' can be identified with reasonable accuracy, there is still no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom. (*O'Connor v. Donaldson* (1975) 422 U.S. 563, 575.)
- Patients have a right to refuse medication. (See e.g. *Washington v. Harper* (1990) 494 U.S. 210, 222-23, 229 (1990); *Mills v. Rogers* (1982) 457 U.S. 291, 299.)
- Similar or Stronger Protections of Patient Rights at State Level⁸⁶

c. Counterpoint- "The Right to Rot" and "Dying with Their Rights On"

- "Under this law, a 49-year-old anorexic woman starved herself to death; a 70-year-old man died a self-perpetuating metabolic, toxic death; and a 19-year-old student, while unable to qualify for commitment under the new guidelines, was able to hang herself. Each of these patients needed commitment; none qualified. Each outcome was entirely predictable. Each of these patients went to his or her grave with his rights entirely intact...."⁸⁷

⁸⁴ *Id.*

⁸⁵ Mary C. McCarron, *The Right to Refuse Antipsychotic Drugs: Safeguarding the Mentally Incompetent Patient's Right to Procedural Due Process*, 73 Marq. L. Rev. 477, 478 (1990).

⁸⁶ See e.g., Catherine E. Blackburn, *The "Therapeutic Orgy" and the "Right to Rot" Collide: The Right to Refuse Antipsychotic Drugs Under State Law*, 27 Hous. L. Rev. 447, 513, n. 8 (1990)

⁸⁷ "Dying with Their Rights On" DAROLD A. TREFFERT. Am J Psychiatry 1973;130:1041-1041.

4. Further Complications

Anosognosia (Lack of Insight)

Anosognosia is a condition in which the patient lacks awareness of his or her illness and is caused by damage to the brain by the disease process.⁸⁸ Psychological denial is not the cause of anosognosia.⁸⁹

Although it has only relatively recently been the subject of study, the existence of the condition has been confirmed by numerous studies and is reported to affect approximately fifty percent of individuals with schizophrenia and forty percent of individuals with bipolar disorder.⁹⁰

The condition is also common among people with Dementia/Alzheimer's, and stroke victims.⁹¹

In some situations, a person's lack of insight can be dangerous. In such cases, it often requires intervention, through commitment or outpatient treatment. Unfortunately, historic legal doctrines have not adapted their approach for this medical reality and continue to rely on the patient's "choice" for determining treatment outcomes.

a. Medicine Side Effects

Patients often complain about the adverse side effects of anti-psychotic medications. Common side effects include cognitive dulling ("lifelessness"), restlessness, tremors, twitching, and weight gain. Such adverse side effects can make it more difficult to get patients to take their medications.

C. **Stigma/Attitude**

The portrayal of mental illness in mass media has been less than flattering, to say the least.⁹² "These depictions seem to contain two main fallacies that can taint reputability and reinforce negative stigma: (1) inaccurate representations of the mental illness and (2) frequent depiction of mainly negative symptomology of the mental illness."⁹³ "People who commit a violent crime are

⁸⁸ The Anatomical Basis of Anosognosia (Lack of Awareness of Illness), *supra* at note 20.

⁸⁹ *Anosognosia*, National Alliance on Mental Illness, http://www.nami.org/Template.cfm?Section=By_Illness&Template=/ContentManagement/ContentDisplay.cfm&ContentID=149098 (last visited February 1, 2014).

⁹⁰ *Anosognosia*- Frequently Asked Questions. <http://treatmentadvocacycenter.org/component/content/article/1790>

⁹¹ PATRIK VUILLEUMIER, ANOSOGNOSIA: THE NEUROLOGY OF BELIEF AND UNCERTAINTIES, 40, 9-17, (Cortex) (2004); George P. Prigatano, *Anosognosia: Clinical and Ethical Considerations*, *Current Opinion In Neurology* 2009, 22:606-611; *Anosognosia*, *supra* note 89; see also *Impaired awareness of illness: Anosognosia*, Mental Illness Policy Organization, <http://mentalillnesspolicy.org/medical/anosognosia-studies.html> (last visited February 1, 2014); Archives of General Psychiatry 1994 (51): 826-836 Amador XF, Flaum M, Andreasen NC, Strauss DH, Yale SA, Clark CC, & Gorman JM.

⁹² M. Tartakovsky, *Media's Damaging Depictions of Mental Illness*, *Psych Central*, (2009), <http://psychcentral.com/lib/medias-damaging-depictions-of-mental-illness/0002220> (last accessed March 4, 2014).

⁹³ R. Holliday, *Changing Media Depictions of Mental Illness*, *Psych Central*, (2011), <http://psychcentral.com/lib/changing-media-depictions-of-mental-illness/0008213> (last accessed March 4, 2014) [citing O. Wahl, *Media madness: Public images of mental illness*, (2009), New Jersey: Rutgers University Press].

frequently labeled ‘psychos,’ or “‘maniacs’...inaccurately linking violence and mental illness in the public mind.”⁹⁴

Not surprisingly, these attitudes have had a less than positive effect on those suffering from mental illness.⁹⁵ “Citizens are less likely to hire persons with mental illness, less likely to rent them apartments, and more likely to falsely press charges for violent crime.”⁹⁶ “Some people with mental illness may accept the common prejudices about mental illness, turn them against themselves, and lose self-confidence...referred to as ‘self-stigma’.”⁹⁷

D. Lack of Housing

A lack of stable housing can be a frequent impediment to getting the mentally ill treatment they need.⁹⁸ “People with mental illness leave acute or chronic care facilities without adequate provisions for their housing or support, and end up sliding into homeless shelters or the criminal justice system.”⁹⁹

E. Lack of Family Support

Individuals with undiagnosed mental illnesses can frequently become estranged from their families. “Family members, including those who might otherwise provide help, may reject or “disown” them due to overall family strain, a perceived history of untrustworthiness, or failure to attend critical social events.”¹⁰⁰ This isolation or “social punishment can cause an individual with a mental illness to withdraw, delay treatment and even develop other mental health issues such as depression.”¹⁰¹

F. Lack of Resources

1. Rural Areas: Proper care may be unavailable

In many rural areas the “only option for mental health care is through [a] local primary care provider[]—family physicians, nurse practitioners and physicians’ assistants. Primary care providers often face the challenge of being asked to treat mental health conditions without

⁹⁴ Aaron Levin, *Media Cling to Stigmatizing Portrayals of Mental Illness*, (December 16, 2011), Psychiatric News, <http://psychnews.psychiatryonline.org/newsarticle.aspx?articleid=181080>

⁹⁵ Nicolas Rüsch, Matthias C. Angermeyer, Patrick W. Corrigan. Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma; (2005) 20 EERPSY 8 529-539.

⁹⁶ *Id.* at 2.

⁹⁷ *Id.* at 1.

⁹⁸ Reed Karaim, *People with Mental Illness*, NPR, <http://www.npr.org/news/specials/housingfirst/whoneeds/mentallyill.html> (last visited March 4, 2014).

⁹⁹ *Id.*

¹⁰⁰ PIRE, “EVERYTHING THAT I THOUGHT THAT THEY WOULD BE, THEY WEREN’T:” FAMILY SYSTEMS AS SUPPORT AND IMPEDIMENT TO RECOVERY; (2011) 73 ESSMMD 8 1222-1229

¹⁰¹ Hope Gillette, *Mental Illness Stigma: Cause of Isolation and Treatment Delay*, Saludify, (April 22, 2013), <http://voxxi.com/2013/04/22/mental-illness-stigma-treatment/> (last accessed March 4, 2014).

adequate training or support.”¹⁰² In a recent survey, among “1253 rural counties with populations of 2,500 to 20,000, nearly three-fourths of these rural counties lack a psychiatrist....”¹⁰³

2. Overburdened Urban Care

Meanwhile, in urban areas, service providers are bursting at the seams with patients and cannot reasonably be expected to keep up with demand, to the detriment of the mentally ill and the community alike, often resulting in prisons becoming the main mental health service providers.¹⁰⁴

IV. **OPTIONS FOR ATTORNEYS WITH CASES INVOLVING MENTALLY ILL PATIENTS**

A. **Emergency Commitment**

In general, the procedures for involuntary treatment of individuals¹⁰⁵ suspected to be suffering from mental illness can be divided into two categories:

- (1) **emergency commitment procedures**, which allow a person to be held for a limited time for treatment for and/or evaluation of a suspected mental illness; and
- (2) **civil commitment procedures**, which may result in the institutionalization (inpatient commitment), or involuntary treatment (medical treatment undertaken without consent) outside of an institution (outpatient commitment) of a person suspected of suffering from mental illness.

Emergency commitment and civil commitment address different problems associated with mental illness. Accordingly, depending on whether emergency or civil commitment is sought, the relief afforded by these different procedures can vary greatly, as can the requirements for who can initiate commitment proceedings. Therefore, in determining whether emergency or civil commitment is appropriate, it is important to keep the following questions in mind:

- (1) What is the situation to be addressed by/the purpose of commitment? (Diagnosis, prevention of harm to self or others, treatment?)
- (2) What type of relief is available?

¹⁰² Mike Mulder, Rhonda Wiering <http://www.health.state.mn.us/divs/orhpc/pubs/mentalhealth.pdf>

¹⁰³ Larry Gamm, et al., *Mental Health and Mental Disorders—A Rural Challenge: A Literature Review*, available at <http://srph.tamhsc.edu/centers/rhp2010/08Volume2mentalhealth.pdf> (last accessed March 4, 2014).

¹⁰⁴ Emily DePrang, *Barred Care: Want Treatment for Mental Illness in Houston? Go to Jail*, TEXAS OBSERVER, Jan. 13, 2014, available at <http://www.texasobserver.org/want-treatment-mental-illness-go-to-jail/>.

¹⁰⁵ The following discussion is limited to commitment procedures in place for adults. In many jurisdictions, commitment procedures for juveniles are governed by different rules, as courts have held that the constitutional rights of juveniles are not equivalent to those of adults. See e.g., Calif. Welf. & Inst. Code §§ 5585 et seq., 6250 et seq. (distinguishing between juvenile wards and persons with intellectual disabilities for civil commitment). For a general discussion of commitment proceedings for juveniles, please see Bruce J. Winick, Ginger Lerner-Wren, *Do Juveniles Facing Civil Commitment Have a Right to Counsel?: A Therapeutic Jurisprudence Brief*, 71 U. Cin. L. Rev. 115 (2002).

- (3) Who is seeking court-ordered intervention? (Family members, friends, law enforcement, social workers?)
- (4) What type of procedures must be followed in order for involuntary treatment to be ordered?

1. Emergency Commitment

- a. The Purposes of Emergency Commitment

Emergency commitment is generally appropriate where there is an immediate need for psychiatric intervention to address what is currently, or soon to become, an emergency situation.¹⁰⁶

- b. Threat of Imminent Harm Required

What constitutes an “emergency situation” varies slightly from state to state, but almost all jurisdictions require a showing that imminent or immediate harm is likely to occur such that temporary confinement is necessary.¹⁰⁷ This may come in the form of a threat of immediate harm to the individual who is suspected to suffer from a mental illness (e.g., suicide or self-endangerment), or a threat of immediate harm to others.¹⁰⁸

- c. Mental Illness and/or Grave Disability Required

While in almost all states the threat of imminent harm must appear to be the result of a “mental illness,”¹⁰⁹ there are some states that also allow the appearance of “grave disability” to provide the basis for emergency commitment.¹¹⁰ As discussed *infra*, the definition of “mental illness” varies from state to state, and can range from psychiatric disorders such as schizophrenia and

¹⁰⁶ John A. Menninger, M.D., *Involuntary Treatment: Hospitalization and Medications*, available at www.brown.edu/Courses/BI_278/Other/Clerkship/Didactics/Readings/INVOLUNTARY%20TREATMENT.pdf (last accessed Jan. 26, 2014).

¹⁰⁷ See e.g., Ala. Code § 22-52-91(a); Alaska Stat. § 47.30.705(a); Ark. Code. Ann. § 20-47-210(a); CA Welf. & Inst. Code § 5150; Colo. Rev. Stat. § 27-65-105(1); Del. Code. Ann. Tit. 16 §§ 5003, 5122; D.C. Code Ann. § 21-521; Fla. Stat. § 394.463(1); Haw. Rev. Stat. § 334-59(a)(1)-(2); Idaho Code § 66-326(1)-(2); 405 Ill. Comp. State. 5/3-600; Ind. Code Ann. § 12-26-5-1(b); Iowa Code §§ 229.11(1), 229.22(1)-(2a); Kan. Stat. Ann. §§ 59-2952(a), 59-2952(c)(3); KY Rev. State. Ann. §§ 202A.041(1), 202A.028(1); LA. Rev. Stat. Ann. §§ 28.53, 28.54(D)(3); ME Rev. Stat. Ann. Tit. 34B §§ 3862, 3863, 10-622(a); Minn. Stat. § 253B.05(1)(a)-(2); Miss. Code Ann. §§ 41-21-65(2), 41-21-67(5); Mont. Code Ann. § 53-21-29(2); Neb. Rev. Stat. § 71-919(1); NH Rev. Stat. Ann. §§ 135-C:27-28; N.M. Stat. Ann. § 43-1-10 (A), (C); N.C. Gen. Stat. §§ 122C-261(a), 122C-262(a); N.D. Cent. Code §§ 25.03.1-25.1-2; Ohio Rev. Code Ann. § 5122.10; 43A Okl. St. § 5-207; Or. Rev. Stat. § 426.228(1); 50 PA Cons. Stat. Ann. § 7301; R.I. Gen. Laws § 40.1-5-7(a) (1); S.C. Code Ann §§ 44-17-430, 44-17-410; S.D. Codified Laws § 27A-10-1; Tenn. Code Ann. §§ 33-6-401, 33-6-403; Tex. Health & Safety Code §§ 573.001(a), 573.011; Utah Code Ann. § 62A-15-629; VT. Stat. Ann. Tit. 18 § 7505(a); VA Code Ann. §§ 37.2-808(A), 37.2-809(B); Rev. Code Wash. § 71.05.153; W. Va. Code § 27-5-2.(a).

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

¹¹⁰ See e.g., Alaska Stat. § 47.30.705(a), CA Welf. & Inst. Code § 5150, Colo. Rev. Stat. § 27-65-105(1), Fla. Stat. § 394.463(1), Haw. Rev. Stat. § 334-59(a)(1)-(2), Idaho Code § 66-326(1)-(2), Ind. Code Ann. § 12-26-5-1(b), Miss. Code Ann. §§ 41-21-65(2), 41-21-67(5), 50 PA Cons. Stat. Ann. § 7301, Rev. Code Wash. § 71.05.153.

dementia, to psychological disorders, such as eating disorders, and even substance abuse.¹¹¹ In contrast to “mental illness,” which can be defined by specific, diagnosable psychiatric or psychological conditions, “grave disability” is defined as the general inability to care for oneself without the assistance of others.¹¹²

Finally, in contrast to civil commitment, discussed in further detail below, the need for treatment alone is rarely a sufficient basis for emergency commitment.¹¹³

2. The Relief Available with Emergency Commitment

a. Detention

In order to address the exigency of a situation where emergency commitment is required, states generally allow the limited detention of a person suspected to be suffering from mental illness or grave disability. Authorized periods of detention can vary and include:

- the time it takes for law enforcement to deliver a person to a mental health facility for evaluation;¹¹⁴
- the time it takes for a hospitalization hearing;¹¹⁵
- the period of time necessary for treatment to alleviate the threat of immediate harm.¹¹⁶

¹¹¹ See discussion of “mental illness,” *infra*.

¹¹² John A. Menninger, M.D., *supra* note 106.

¹¹³ See e.g., Ala. Code § 22-52-91(a); Alaska Stat. § 47.30.705(a); Ark. Code. Ann. § 20-47-210(a); CA Welf. & Inst. Code § 5150; Colo. Rev. Stat. § 27-65-105(1); Del. Code. Ann. Tit. 16 §§ 5003, 5122; D.C. Code Ann. § 21-521; Haw. Rev. Stat. § 334-59(a)(1)-(2); Idaho Code § 66-326(1)-(2); 405 Ill. Comp. State. 5/3-600; Ind. Code Ann. § 12-26-5-1(b); Iowa Code §§ 229.11(1), 229.22(1)-(2a); Kan. Stat. Ann. §§ 59-2952(a), 59-2952(c)(3); KY Rev. Stat. Ann. §§ 202A.041(1), 202A.028(1); LA. Rev. Stat. Ann. §§ 28.53, 28.54(D)(3); ME Rev. Stat. Ann. Tit. 34B §§ 3862, 3863, 10-622(a); Minn. Stat. § 253B.05(1)(a)-(2); Miss. Code Ann. §§ 41-21-65(2), 41-21-67(5); Mont. Code Ann. § 53-21-29(2); Neb. Rev. Stat. § 71-919(1); NH Rev. Stat. Ann. §§ 135-C:27-28; N.M. Stat. Ann. § 43-1-10 (A), (C); N.C. Gen. Stat. §§ 122C-261(a), 122C-262(a); N.D. Cent. Code §§ 25.03.1-25.1-2; Ohio Rev. Code Ann. § 5122.10; 43A Okl. St. § 5-207; Or. Rev. Stat. § 426.228(1); 50 PA Cons. Stat. Ann. § 7301; R.I. Gen. Laws § 40.1-5-7(a) (1); S.C. Code Ann §§ 44-17-430, 44-17-410; S.D. Codified Laws § 27A-10-1; Tenn. Code Ann. §§ 33-6-401, 33-6-403; Tex. Health & Safety Code §§ 573.001(a), 573.011; Utah Code Ann. § 62A-15-629; VT. Stat. Ann. Tit. 18 § 7505(a); VA Code Ann. §§ 37.2-808(A), 37.2-809(B); Rev. Code Wash. § 71.05.153; W. Va. Code § 27-5-2.(a). *But see* Fla. Stat. § 394.463(1) (permitting emergency commitment if a “person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; or the person is unable to determine for himself or herself whether examination is necessary.”); Wis. Stat. Ann. § 51.15(1)(a) (allowing emergency commitment if the subject is “unable to satisfy basic needs for nourishment, medical care, shelter, or safety.”).

¹¹⁴ See e.g., Alaska Stat. § 47.30.705(a); G.A. Code Ann. § 37-3-42(a); KY. Rev. Stat. Ann. § 202A.041(1); N.J. Stat. Ann. § 30:4-27.6; N.M. Stat. Ann. § 43-1-10(A).

¹¹⁵ See e.g., Iowa Code § 229.11(1).

¹¹⁶ See e.g., Calif. Welf. & Inst. Code § 5150; Colo. Rev. Stat. § 27-65-105(1).

b. Observation/Diagnosis

In most states, the purpose of detention is to allow a medical institution to evaluate or diagnose the seriousness of the suspected mental illness.¹¹⁷ In some states, the period of observation and diagnosis is limited to 72 hours.¹¹⁸

c. Treatment

In certain jurisdictions, treatment of the suspected mental illness is also authorized.¹¹⁹ Treatment may include the forced medication of anti-psychotic drugs or therapy.

3. Those Who Can Seek Emergency Commitment

Due to the exigent nature of the circumstances giving rise to the need for emergency commitment, there are often very few limitations on who may seek emergency commitment, and in many jurisdictions, there may be little to no court involvement before a person is detained for emergency commitment.¹²⁰

a. Law Enforcement

Almost all jurisdictions authorize law enforcement to initiate emergency commitment.¹²¹ This may take the form of taking the person suspected to be suffering from mental illness into protective custody,¹²² or transporting the person to a mental health facility or hospital for screening or treatment.¹²³ In most of these jurisdictions, officers may initiate emergency commitment without a warrant as long as there is either probable cause or a reasonable belief that a person is mentally ill and poses an imminent danger to himself/herself or others.¹²⁴ In a few jurisdictions, law enforcement officials must submit a petition or application to a court or mental health agency before they are authorized to detain a person for emergency commitment.¹²⁵ Other jurisdictions require that the person to be detained have committed a penal offense,¹²⁶ or

¹¹⁷ See e.g., Calif. Welf. & Inst. Code § 5150; Colo. Rev. Stat. § 27-65-105(1); Miss. Code Ann. § 41-21-65(2); Fla. Stat. § 394.463(1).

¹¹⁸ See e.g., Calif. Welf. & Inst. Code § 5150; Colo. Rev. Stat. § 27-65-105(1); KY. Rev. Stat. Ann. § 202A.028(1); Miss. Code Ann. § 41-21-65(2).

¹¹⁹ See e.g., Calif. Welf. & Inst. Code § 5150; Colo. Rev. Stat. § 27-65-105(1); Mo. Ann. Stat. § 632.305(2); Nev. Rev. Stat. § 433A.160; N.Y. Mental Hyg. Law § 9.39(a).

¹²⁰ See e.g., N.Y. Mental Hyg. Law § 9.39 (a).

¹²¹ See note 107, *supra*.

¹²² La. Rev. Stat. Ann. § 28.53; Me. Rev. Stat. Ann. Tit. 34B § 3862; Mich. Comp. Laws §§ 330.1427(1), 330.1438; Neb. Rev. Stat. § 71-919(1); N.H. Rev. Stat. Ann. § 135-C:28; 43A Okl. St. § 5-207; Utah Code Ann. § 62A-15-629.

¹²³ Ky. Rev. Stat. Ann. § 202A.041(1); Mich. Comp. Laws §§ 330.1427(1), 330.1438; Minn. Stat. § 253B.05; N.M. Stat. Ann. § 43-1-10.

¹²⁴ Del. Code Ann. Tit. 16 § 5122; D.C. Code Ann. § 21-521; Iowa Code § 229.22(1)-(2a); Kan. Stat. Ann. § 59-2953(a); KY. Rev. Stat. Ann. § 202A.041(1); ME. Rev. Stat. Ann. Tit. 34B § 3862, § 3863; Miss. Code Ann. § 41-21-65(2); Nev. Rev. Stat. § 433A.160; N.H. Rev. Stat. Ann. § 135-C:28; Tex. Health & Safety Code § 573.001(a); VT. Stat. Ann. Tit. 18 § 7505(a).

¹²⁵ Ariz. Rev. Stat. § 36-524; Ark. Code Ann. § 20-47-102.

¹²⁶ See e.g., GA. Code Ann. § 37-3-42(a).

that circumstances prevent the procurement of a court order¹²⁷ in order for law enforcement to initiate emergency commitment.

b. Health Care Providers

Some states authorize mental health professionals, such as psychologists,¹²⁸ psychiatrists,¹²⁹ physicians,¹³⁰ registered nurses,¹³¹ or county or clinical social workers,¹³² or family or marital therapists to seek emergency commitment. Some jurisdictions require such health care providers to issue an affidavit or certificate attesting to their belief that a person requires emergency commitment.¹³³ Others require such health care providers to submit written or oral application to the court in order for an ex parte order to issue.¹³⁴

c. Court Order

Some states have more restrictive requirements for who can seek emergency commitment, and only permit emergency commitment by court order.¹³⁵

d. Any Person/Interested Persons

Some jurisdictions place very few limitations on who can seek emergency commitment,¹³⁶ and will generally allow any person 18 years or older to do so.¹³⁷ However, in such cases, many of these states require some additional assurance that emergency commitment is necessary and appropriate. This may take the form of an application to a mental health facility,¹³⁸ a petition to a probate court or other court of competent jurisdiction,¹³⁹ which contain affidavits by persons with

¹²⁷ Alaska Stat. § 47.30.705(a); Iowa Code § 229.22(1)-(2a); Vt. Stat. Ann. Tit. 18 § 7505(a).

¹²⁸ Conn. Gen. Stat. Ann. § 17a-503(a); D.C. Code Ann. § 21-521; Haw. Rev. Stat. § 334-59(a)(2); Nev. Rev. Stat. § 433A.170; N.M. Stat. Ann. § 43-1-10(C).

¹²⁹ Nev. Rev. Stat. § 433A.170.

¹³⁰ D.C. Code Ann. § 21-521; Haw. Rev. Stat. § 334-59(a)(2).

¹³¹ Conn. Gen. Stat. Ann. § 17a-503(a).

¹³² Conn. Gen. Stat. Ann. § 17a-503(a); Del. Code Ann. Tit. 16 § 5122; D.C. Code Ann. § 21-521; Haw. Rev. Stat. § 334-59(a)(2).

¹³³ Conn. Gen. Stat. Ann. § 17a-503(a); La. Rev. Stat. Ann. § 28:54(D)(3); Minn. Stat. § 53B.05(1)(a); Nev. Rev. Stat. § 433A.170.

¹³⁴ Haw. Rev. Stat. § 334-59(a)(2).

¹³⁵ Ark. Code Ann. §§ 20-47-102, 20-47-103; Mass. Gen. Laws Ann. Ch. 123, § 12.

¹³⁶ Del. Code Ann. Tit. 16 § 5122; Ga. Code Ann. § 37-3-61(1); Mass. Gen. Laws Ann. Ch. 123, § 12; S.D. Codified Laws § 27A-10-1. *But see* Miss. Code Ann. § 41-21-65(2) (limiting standing to seek emergency commitment to relatives and “interested persons,” which may include public officials, legal guardians, spouses, parents, legal counsel, adult, child, next of kin, or person designated by the patient).

¹³⁷ Miss. Code Ann. § 41-21-65(2); S.D. Codified Laws § 27A-10-1; W. Va. Code § 27-5-2.(a).

¹³⁸ Ariz. Rev. Stat. § 36-524; Ga. Code Ann. § 37-3-61(1); Kan. Stat. Ann. § 59-2954(c)(3); R.I. Gen. Laws § 40.1-5-7(a)(1); VT. Stat. Ann. Tit. 18 § 7504(a); W. Va. Code § 27-5-2.(a).

¹³⁹ Ark. Code Ann. §§ 20-47-102, 20-47-103; Colo. Rev. Stat. § 27-65-105(1); Conn. Gen. Stat. Ann. § 17a-503(a); Ga. Code Ann. § 37-3-61(1); Mass. Gen. Laws Ann. Ch. 123, § 12; Miss. Code Ann. § 41-21-65(2); S.D. Codified Laws § 27A-10-1; S.C. Code Ann. § 44-17-430.

knowledge of facts giving rise to the need for emergency commitment,¹⁴⁰ or certificates from physicians and/or psychiatrists attesting to the need for emergency commitment.¹⁴¹

4. The Procedures for Seeking Emergency Commitment

The procedures for seeking emergency commitment vary, and usually depend on whom the state authorizes to initiate emergency commitment. For instance, the circumstances may be such that court involvement is not feasible before detention or treatment occurs. In such instances, some states authorize detention without court-involvement, and a person may be authorized to initiate emergency commitment if he or she has probable cause or a reasonable belief that a person is mentally ill and/or gravely disabled and that imminent harm is likely to occur absent emergency commitment.¹⁴² However, in states where court-involvement is required, a person seeking emergency commitment often must file a petition with the court with accompanying affidavits in order for emergency commitment to occur.¹⁴³ Some states have a mixed approach to emergency commitment procedures, requiring no court approval for law enforcement officers seeking emergency commitment, and requiring formal court approval for non-law enforcement seeking emergency commitment.¹⁴⁴

B. Civil Commitment

1. The Purposes of Civil Commitment

The purposes of civil commitment vary depending on whether inpatient commitment or outpatient commitment is sought. Both are longer-term solutions to mental illness or grave disability than emergency commitment.¹⁴⁵ However, like emergency commitment, the circumstances necessitating inpatient commitment, or institutionalization, are generally characterized by the risk of imminent harm to the individual in question or others. Furthermore, lack of adequate available alternatives to address the imminent threat of harm tends to be the basis for inpatient commitment.

¹⁴⁰ Colo. Rev. Stat. § 27-65-105(1); La. Rev. Stat. Ann. § 28.54(D)(3); Miss. Code Ann. § 41-21-65(2); S.C. Code Ann. § 44-17-430.

¹⁴¹ Nev. Rev. Stat. § 433A.170; VT. Stat. Ann. Tit. 18 § 7504(a).

¹⁴² Ala. Code § 22-52-91(a); Alaska Stat. § 47.30.705(a); Calif. Welf. & Inst. Code § 5150; Colo. Rev. Stat. § 27-65-105(1); Conn. Gen. Stat. Ann. § 17a-503(a); Del. Code Ann. Tit. 16 § 5003; D.C. Code Ann. § 21-521; Fla. Stat. § 394.463(1); Haw. Rev. Stat. § 334.59(a); Idaho Code § 66-326(1); Iowa Code § 229.22(1)-(2a); Ky. Rev. Stat. Ann. § 202A.041(1); La. Rev. Stat. Ann. § 28.53; Me. Rev. Stat. Ann. Tit. 34B § 3862; Mich. Comp. Laws § 330.1427(1); Minn. Stat. § 253B.05(1)(a); Miss. Code Ann. § 41-21-65(2); Mo. Ann. Stat. § 632.305(3); Neb. Rev. Stat. § 71-919(1); Nev. Rev. Stat. § 433A.160; N.H. Rev. Stat. Ann. § 135-C:28; N.J. Stat. Ann. § 30:4-27.6; N.M. Stat. Ann. § 43-1-10(A); N.Y. Mental Hyg. Law § 9.39(a); N.D. Cent. Code § 25-03.1-25.1; Okl. St. § 5-207; Or. Rev. Stat. § 426.228(1); R.I. Gen. Laws § 40.1-5-7(a)(1); Tex. Health & Safety Code § 573.001(a); Utah Code Ann. § 62A-15-629(2); Vt. Stat. Ann. Tit. 18 § 7505(a); Wyo. Stat. Ann. § 25-10-109(a).

¹⁴³ See notes 125, 135, *supra*.

¹⁴⁴ See e.g., Colo. Rev. Stat. § 27-65-105(1).

¹⁴⁵ However, like emergency commitment, a showing of mental illness or grave disability is a prerequisite for civil commitment. In fact, in many jurisdictions where a showing of grave disability would be insufficient for emergency commitment, a showing of grave disability is sufficient for civil commitment.

In contrast, while outpatient commitment also seeks to address the threat of harm, either the imminence of the threat is less prevalent, or treatment options that are less restrictive than institutionalization are available, such that inpatient commitment is rendered unnecessary.

However, whether inpatient or outpatient commitment is sought, these remedies generally seek to address:

- The Threat of Substantial Harm to Self, Others, Property¹⁴⁶
- The Refusal of Treatment/Inability to Make a Rational Informed Decision Regarding Treatment¹⁴⁷
- The Likelihood of Continued Suffering, Relapse, or Deterioration of Physical and/or Mental Health¹⁴⁸

2. The Relief Available with Civil Commitment

With the exception of Connecticut, Maryland, Massachusetts, Nevada, New Mexico, and Tennessee,¹⁴⁹ all jurisdictions provide procedures for both inpatient and outpatient commitment.¹⁵⁰ Unlike emergency commitment, where the relief available state to state could vary from temporary custody to involuntary treatment, the relief available through civil commitment is generally uniform among states—if inpatient treatment is ordered, the mentally ill or gravely disabled person is institutionalized for treatment for his/her illness; if outpatient treatment is ordered, the person is ordered to undergo outpatient treatment as appropriate for his/her illness.

3. Those Who Can Seek Civil Commitment

Unlike the case in some states where emergency commitment could occur absent a court order, almost all states require a hearing or some type of judicial review before civil commitment can occur.¹⁵¹ Thus, civil commitment proceedings are typically initiated by submitting a petition to a court of competent jurisdiction. However, like emergency commitment, who can initiate civil commitment proceedings varies from state to state, and can include:

¹⁴⁶ See e.g., Ala. Code § 22-52-10.4; Alaska Stat. §§ 47.30.735(c), 47.30.915(10); Ariz. Rev. Stat. § 36-540(A); Ark. Code Ann. § 20-47-207(c);

¹⁴⁷ See e.g., Ala. Code § 22-52-10.4; Ariz. Rev. Stat. § 36-540(A); Ark. Code Ann. § 20-47-207(c); Calif. Welf & Inst. Code § 5250;

¹⁴⁸ See e.g., Ala. Code § 22-52-10.4; Alaska Stat. § 47.30.735(d); Ariz. Rev. Stat. § 36-501(32); Ark. Code Ann. § 20-47-207(c); Calif. Welf. & Inst. Code § 5346; Colo. Rev. Stat. § 27-65-102(9); Haw. Rev. Stat. § 334-121;

¹⁴⁹ *State Standards for Assisted Treatment: Civil Commitment Criteria of Inpatient or Outpatient Psychiatric Treatment*, Treatment Advocacy Center, p. 2, available at: http://treatmentadvocacycenter.org/storage/documents/Standards_-_The_Text-_June_2011.pdf (last updated January 2013).

¹⁵⁰ *Id.*

¹⁵¹ *But see* N.Y. Mental Hyg. Law § 9.37(a) (inpatient commitment may occur without a court order if a director of a hospital determines, based on the certificates of two examining physicians accompanying the application for admission, inpatient treatment is appropriate).

- Any Person,¹⁵²
- Mental Health Department/Officials,¹⁵³
- Mental Health Care Providers,¹⁵⁴
- Immediate Family, Guardians,¹⁵⁵
- Law Enforcement.¹⁵⁶

4. The Procedures for Seeking Civil Commitment

In accordance with *Addington v. Texas*,¹⁵⁷ the need for civil commitment must be proved by at least “clear and convincing evidence” in order to satisfy due process.¹⁵⁸ Accordingly, almost all jurisdictions abide by this standard of proof in determining whether civil commitment is appropriate. However, aside from the standard of proof and the general requirement that a petition be filed, the procedures vary widely between states.

Alaska for instance, has an in-depth statutory framework in place for petitions for 30-, 90-, and 180-Day Involuntary Commitments.¹⁵⁹ The hearing for involuntary commitment must then take place within 72 hours of either admission of the respondent into a treatment facility, or the time the patient files notice that his treatment is no longer voluntary.¹⁶⁰ Similar requirements exist for petitions for 90- and 180-day commitment, with elevated showings required for the prolonged period of confinement or treatment.¹⁶¹ Once commitment is ordered, a respondent may appeal or file a writ of habeas corpus.¹⁶²

In contrast to Alaska, there is an additional step required in California before a petition can be filed with the court for outpatient commitment, if filed by a person other than a county mental health director. When a petition for outpatient commitment is filed by a person other than a county mental health director, the petition is filed with the county health department.¹⁶³ At that point, a county mental health director investigates the appropriateness of filing the petition with the court, and will only do so if he or she determines that there is a reasonable likelihood that all the necessary elements to sustain the petition can be proven in a court of law by clear and convincing evidence.¹⁶⁴ If the director finds that filing the petition is appropriate, and files it, the

¹⁵² *E.g.*, Ala. Code § 22-52-1.2(a); Ark. Code Ann. § 20-47-210(a); Conn. Gen. Stat. Ann. § 17a-497(a); GA. Code Ann. § 37-3-61(2); Haw. Rev. Stat. §§ 334-60.3(a), 334-123(a)

¹⁵³ *E.g.*, Ariz. Rev. Stat. § 36-531(B); Calif. Welf. & Inst. Code § 5346.

¹⁵⁴ *E.g.*, Colo. Rev. Stat. §§ 27-65-107, 27-65-108, 27-65-109; D.C. Code Ann. § 21-541(a); Fla. Stat. §§ 394.467(3), 394.4655(3).

¹⁵⁵ *E.g.*, D.C. Code Ann. § 21-541(a); Idaho Code § 66-326.

¹⁵⁶ *E.g.*, D.C. Code Ann. § 21-541(a); GA. Code Ann. § 37-3-42(a).

¹⁵⁷ *Addington v. Texas*, 441 U.S. 418 (1979).

¹⁵⁸ *Id.* at 433.

¹⁵⁹ AS §§ 47.30.725-.735.

¹⁶⁰ AS § 47.30.805(e).

¹⁶¹ AS §§ 47.30.740, 47.30.770.

¹⁶² AS §§ 47.30.765, 47.30.810.

¹⁶³ Calif. Welf. & Inst. Code § 5346(b)(2).

¹⁶⁴ Calif. Welf. & Inst. Code § 5346(b)(3).

court must set the matter for hearing within five days of its receipt of the petition.¹⁶⁵ At the hearing, the court may not order outpatient treatment unless an examining licensed mental health treatment provider, who has personally examined, and has reviewed the available treatment history of the respondent within ten days before the filing of the petition, testifies in person at the hearing.¹⁶⁶ If the court finds that the respondent meets the criteria for assisted outpatient treatment, and no appropriate and feasible less restrictive alternative exists, the court may order outpatient treatment for an initial period not to exceed six months.¹⁶⁷

New York represents a departure from most states, at least in the context of inpatient commitment, in that the court is not involved in the initial determination of whether inpatient commitment is appropriate.¹⁶⁸ Instead, New York Mental Hygiene Law section 9.27(a) authorizes a director of a hospital to admit, retain, and treat a person alleged to be mentally ill upon the certificates of two examining physicians, accompanied by an application for the admission of such a person.¹⁶⁹ However, such inpatient commitment is limited to sixty days.¹⁷⁰ The court's role comes into play if, at any time prior to the expiration of the sixty day commitment period, the patient, a relative, friend, or mental hygiene legal services gives notice to the hospital director of a request for a hearing on the need for involuntary care and treatment.¹⁷¹ As in California, once the court receives notice of the request for hearing, it must set the hearing within five days.¹⁷² At that point, the court must determine whether retention is appropriate.¹⁷³

Ultimately, while civil commitment addresses the clinical need for treatment, it frequently comes into conflict with the individual's right to self-autonomy. Accordingly, it may be appropriate to consider less contentious alternatives that have the potential to strike a balance between the clinical need for treatment and the individual's right to consent to or refuse treatment, which in turn may lead to less relapses and a more cooperative process between the community at large and the mentally ill.

C. Adult Guardianships/Conservatorships

1. The Purposes of Adult Guardianship/Conservatorship

Under an adult guardianship or conservatorship, a person or agency (the guardian) is appointed by a court to make decisions and act on behalf of an incapacitated adult with respect to the incapacitated adult's personal and/or financial affairs.

The general purpose of a guardianship is to replace, in whole or in part, the incapacitated adult's authority to make personal decisions with the guardian's authority to make decisions on the incapacitated adult's behalf when the incapacitated adult lacks sufficient mental capacity to make

¹⁶⁵ Calif. Welf. & Inst. Code § 5346(d).

¹⁶⁶ Calif. Welf. & Inst. Code § 5346(d)(2).

¹⁶⁷ Calif. Welf. & Inst. Code § 5346(d)(5)(B).

¹⁶⁸ See N.Y. Mental Hyg. Law § 9.27(a).

¹⁶⁹ *Id.*

¹⁷⁰ N.Y. Mental Hyg. Law § 9.31.

¹⁷¹ *Id.*

¹⁷² *Id.*

¹⁷³ *Id.*

those decisions. While under a guardianship, a person suspected of suffering from mental illness may still be subjected to involuntary treatment for his/her mental illness, but a guardian can still seek to preserve for an incapacitated adult the opportunity to make those decisions and exercise those rights that are within the incapacitated adult's comprehension and judgment. Furthermore, even when a guardian has been appointed, the incapacitated adult can still be allowed to participate, as permitted by their capabilities, in all decisions that will affect him or her.

While a guardianship necessarily limits the personal autonomy and legal rights of an incapacitated ward, the guardian has the opportunity to strike a balance between preserving the rights, freedom, and personal autonomy of adults and the state's duty to protect incapacitated adults from harm resulting from their inability to act in their own best interest.

Recognizing the need for that balance, the Uniform Law Commission enacted the Uniform Guardianship and Protected Proceedings Act (UGPPA), which attempts to strengthen due process protections for persons who are subject to guardianship proceedings.¹⁷⁴ First, the UGPPA emphasizes the use of guardianships and conservatorships as a last resort in the event that less restrictive alternatives are unavailable.¹⁷⁵ Second, the UGPPA has procedural requirements similar to some civil commitment statutes in that it requires a petition containing specific information to be presented to the court and entitling the person subject to guardianship proceedings to notice of the proceedings and a hearing.¹⁷⁶ Third, it highlights the use of limited guardianships and conservatorships where circumstances permit.¹⁷⁷ Most importantly for the purposes of this discussion, the UGPPA requires that the guardian or conservator take the views of the ward or protected person into account when making decisions, by requiring the guardian or conservator to:

- “[E]ncourage the ward or protected person to participate in decisions, to act on his or her own behalf, and to develop or regain capacity to manage person or financial affairs;”¹⁷⁸

and

- “[C]onsider the ward's expressed desires and personal values when making decisions.”¹⁷⁹

While the UGPPA has only been adopted by seven jurisdictions as of January 1, 2014,¹⁸⁰ several elements common to many states' guardianship proceedings serve to safeguard the personal autonomy and rights of individuals subject to those proceedings.¹⁸¹

¹⁷⁴ See Uniform Guardianship and Protective Proceedings Act (1997), Uniform Law Commission, available at http://www.uniformlaws.org/shared/docs/guardianship%20and%20protective%20proceedings/ugppa_final_97.pdf; Guardianship State Laws, Center for Elders and the Courts (National Center for State Courts), available at <http://www.eldersandcourts.org/Guardianship/Guardianship-Basics/State-Laws.aspx>, last accessed Jan. 27, 2014.

¹⁷⁵ See “Prefatory Note” and § 311(a)(1)(B) of the Uniform Guardianship and Protective Proceedings Act (1997), Uniform Law Commission, available at http://www.uniformlaws.org/shared/docs/guardianship%20and%20protective%20proceedings/ugppa_final_97.pdf.

¹⁷⁶ *Id.* §§ 304, 403, 113, 309, 404.

¹⁷⁷ *Id.* §§ 311(b), 409(b).

¹⁷⁸ *Id.* §§ 207(b)(1), 314(b)(1),

¹⁷⁹ *Id.* § 314(a).

For instance, many jurisdictions:

- Require guardians to file regular reports of their ward's general condition, health status, and continued need for a guardianship;¹⁸²
- Authorize the court to appoint a third party to monitor and report on the condition of the person over which a guardianship is ordered;¹⁸³
- Allow the court to order limited guardianships and limited conservatorships where appropriate to fit the needs of the incapacitated person;¹⁸⁴
- Authorize the court to remove a guardian that is not performing his or her duties to protect the best interests of the person over which a guardianship is ordered.¹⁸⁵

Furthermore, from the standpoint of a person objecting to involuntary treatment, the “best interests” standard used by most jurisdictions to determine the appropriateness of actions undertaken by the guardian, and even the existence of the guardianship itself, is arguably preferable to the clinical “clear and convincing” standard used to impose civil commitment. Because a guardian is typically charged with the care of a limited number of incapacitated persons, the guardian may have in-depth knowledge of a particular ward's needs and wishes, and can therefore take those wishes into account when determining how to act in that person's best interests. In contrast, mental health professionals, clinical or county social workers, law enforcement, and the courts may encounter numerous individuals suffering mental illness on a daily basis, and thus may not be able to devote the time or resources to conduct an in-depth assessment of what is truly in the “best interests” of a particular person. Instead, they need only show by clear and convincing evidence that the person poses a substantial threat of harm to himself/herself, or others, without further inquiry as to whether involuntary treatment is truly in that person's best interests.

While the need to protect the public and the incapacitated person from harm arising from mental illness will ultimately outweigh the desires of the incapacitated person upon the requisite showing, the contentiousness of forced treatment may be rendered unnecessary by the use of a guardianship in certain instances. Because a guardian may have more time to interact with his or her ward, the guardian may be able work with his or her ward to initiate treatment without resort to civil commitment. If such a strategy fails, the guardian can then fall back on his or her authority as a guardian to initiate involuntary treatment.

¹⁸⁰ Guardianship and Protective Proceedings Act, Uniform Law Commission, available at <http://www.uniformlaws.org/Act.aspx?title=Guardianship%20and%20Protective%20Proceedings%20Act>, last accessed Jan. 27, 2014.

¹⁸¹ Guardianship State Laws, Center for Elders and the Courts (National Center for State Courts), available at <http://www.eldersandcourts.org/Guardianship/Guardianship-Basics/State-Laws.aspx>, last accessed Jan. 27, 2014.

¹⁸² *Id.*

¹⁸³ *Id.*

¹⁸⁴ *Id.*

¹⁸⁵ *Id.*

2. The Relief Available with Adult Guardianships and Conservatorships

As stated previously, guardianships and conservatorships seek to address issues arising from an individual's inability to make sound decisions on his or her own behalf resulting from his or her lack of capacity. To that end, guardianships and conservatorships allow guardians and conservators to exercise "substituted judgment" or act in the "best interests" of their wards. The extent to which a guardian or conservator may act on behalf on his or her ward is dictated by the type of guardianship or conservatorship that is ordered by the court.

Many jurisdictions allow, if not direct, courts to narrowly tailor the authority granted to a guardian or conservator based on the extent a person is incapacitated.¹⁸⁶ To that end, many states differentiate between the types of guardianships or conservatorships that may be sought.

a. General/Plenary Guardianships/Conservatorships

A general or plenary guardianship/conservatorship is typically appropriate where the person subject to guardianship/conservatorship proceedings lacks the capacity to perform all the necessary tasks to properly provide for his or her personal needs or manage his or financial affairs. Generally, most jurisdictions distinguish between the inability to care for oneself and the inability manage one's financial affairs. This stems from the fact that a person may have the capacity to care for one's basic needs, but may also at the same time be susceptible to undue influence as to his or her financial affairs as a result of a mental impairment. Because of this and most states' general desire to narrowly tailor guardianships and conservatorships to fit the exact needs of the person over whom a guardianship/conservatorship is sought, courts can elect to order either or both of the following depending on the extent of incapacitation:

(i) Guardianship/Conservatorship of the Person

A guardianship/conservatorship of the person removes from the incapacitated person all decision-making authority and responsibility for personal decisions including such decisions as choosing a residence, consenting to medical treatment, and making end-of-life decisions.¹⁸⁷

(ii) Guardianship/Conservatorship of the Estate

A guardianship/conservatorship of the estate removes from the incapacitated person all control over that person's assets and financial affairs.¹⁸⁸

¹⁸⁶ See e.g., N.Y. Mental Hyg. Law § 81.01; Pa. Con. Stat. § 5502.

¹⁸⁷ See "General Information Regarding Guardianships and Conservatorships," available at <http://www.mass.gov/courts/courtsandjudges/courts/probateandfamilycourt/info-sheet-060909.pdf>, last accessed Jan. 28, 2014; "Conservatorships," California Courts: The Judicial Branch of California, available at <http://www.courts.ca.gov/selfhelp-conservatorship.htm>, last accessed Jan. 28, 2014; "What Is Guardianship," National Guardianship Association, Inc., available at http://www.guardianship.org/what_is_guardianship.htm, last accessed Jan. 28, 2014.

¹⁸⁸ See *id.*

b. Limited Guardianships/Conservatorships

A guardian/conservator's authority under a limited guardianship/conservatorship is narrower in scope than the authority granted under a general guardianship/conservatorship. In most states, this type of guardianship/conservatorship is generally appropriate when the ward's incapacities are limited in scope and whose ability to function is only partially diminished.¹⁸⁹ Because of the importance of self-autonomy and the fact that limited self-autonomy can be attained in these instances, often the goal of a limited guardianship/conservatorship is to assist the incapacitated person to develop and attain maximum self-reliance and independence.¹⁹⁰

Some states only require a showing of less than total incapacity (i.e., that certain decisions are within the ward's comprehension and judgment),¹⁹¹ while some states reserve limited guardianships for developmentally disabled persons.¹⁹² Accordingly, the powers and duties of a limited guardian/conservator can vary from state to state.

For instance, New York gives the court full discretion to determine the rights and duties of a limited guardian.¹⁹³ In comparison, a limited conservator in California, unless expressly authorized, does not have the power to:

- Decide the residence of the conservatee;
- Gain access to the confidential records and papers of the conservatee;
- Control the conservatee's social and sexual relationships;
- Control the conservatee's financial resources;
- Make decisions concerning the conservatee's education.¹⁹⁴

Furthermore, some state statutes require the court and the guardian/conservator to encourage the incapacitated person to participate as fully as possible in decisions of which he or she is capable.¹⁹⁵

c. Temporary/Emergency Guardianships/Conservatorships

A temporary or emergency guardianship/conservatorship seeks to address the immediate needs of an allegedly incapacitated person, and is typically appropriate where there is an imminent

¹⁸⁹ See "General Information Regarding Guardianships and Conservatorships," available at <http://www.mass.gov/courts/courtsandjudges/courts/probateandfamilycourt/info-sheet-060909.pdf>, last accessed Jan. 28, 2014; http://www.courts.ca.gov/documents/conservatorship_handbook.pdf

¹⁹⁰ See e.g., Ariz. Rev. Stat. § 14-5312(A)(7); Ark. Code Ann. § 28-65-105(2); Ca. Prob. Code § 1801(c); Fl. Stat. § 744.1012; Ga. Code Ann. § 29-4-1; see also http://www.americanbar.org/content/dam/aba/migrated/aging/legislativeupdates/pdfs/chart_limited.authcheckdam.pdf.

¹⁹¹ See e.g., N.C. G.S. 35A-1215(b); North Carolina Guardianship Manual, available at <http://www.ncids.org/other%20manuals/guardianship%20manual/Chapter%201.pdf>.

¹⁹² See e.g., Cal. Prob. Code § 1801.

¹⁹³ N.Y. Mental Health Law §§ 81.01, 81.20(7), 81.29(a); see also Mont. Code Ann. § 72-5-321(1); Md. Code Ann. § 13-708(a)(1).

¹⁹⁴ Handbook for Conservators, Judicial Council of California, available at http://www.courts.ca.gov/documents/conservatorship_handbook.pdf (last accessed March 4, 2014); Cal. Prob. Code § 2351.5.

¹⁹⁵ See e.g., Idaho Code Ann. § 15-5-303(a).

threat of immediate or substantial harm to the health, safety or welfare of the alleged incapacitated person.¹⁹⁶ In Massachusetts, for instance, such a temporary guardianship is appropriate where a petition for the appointment of a guardian or conservator is pending, the incapacitated person presently has no guardian or conservator, and where an emergency exists that will likely result in immediate or substantial harm to the health, safety or welfare of the alleged incapacitated person.¹⁹⁷

Guardianships/conservatorships of this nature are typically very limited in duration, ranging from ten days to ninety days depending on the state, with extensions to be granted in the court's discretion.¹⁹⁸ However, some states allow such guardianships/conservatorships to last up to six months.¹⁹⁹ In most jurisdictions that authorize emergency guardianship/conservatorship, the scope of the guardian/conservator's authority is limited to that which is necessary to address the threat of imminent harm.²⁰⁰

d. Mental Health Guardianships/Conservatorships

In California, a special type of guardianship/conservatorship exists to directly address the issues that arise from and are specific to incapacity resulting from mental illness.²⁰¹ California's Lanterman-Petris-Short Act ("LPS Act") authorizes a special limited conservatorship in the narrow context of dealing with those suffering from a mental disorder or chronic alcoholism.²⁰² The legislative purpose in authorizing LPS conservatorships was to provide an alternative to ordinary guardianships and civil commitment that would better address the needs of the gravely disabled suffering from mental disorders or chronic alcoholism.²⁰³ To that end, LPS conservatorships specifically address the issue of medical treatment when the incapacitated person refuses to consent.²⁰⁴ In such cases where emergency treatment is not required, the LPS conservator must obtain a court order to impose treatment.²⁰⁵ If the conservatee chooses to contest the request for a court order, he or she may do so by petitioning the court for a hearing on the matter.²⁰⁶

¹⁹⁶ See UGPAA 2007 § 312; Alabama Code § 26-2A-107; AS § 13.26.140; Ariz. Rev. Stat. § 14-5310; Ark. Code Ann. § 28-65-218; Cal. Probate Code § 2250; Colo Rev. St. Ann. § 15-14-312; Conn. Gen. Stat. Ann. § 45a-654; Del. Code Ann. 12 § 3901(d); D.C. Stat. § 21-2046; Flor. Stat. Ann. § 744.3031.

¹⁹⁷ See Mass. Ann. Laws § 14; "General Information Regarding Guardianships and Conservatorships," available at <http://www.mass.gov/courts/courtsandjudges/courts/probateandfamilycourt/info-sheet-060909.pdf>, last accessed Jan. 28, 2014.

¹⁹⁸ See ABA chart emergency guardianship statutes, available at http://www.americanbar.org/content/dam/aba/migrated/aging/legislativeupdates/pdfs/angela_emerg_gd_chart_final_2_09.authcheckdam.pdf

¹⁹⁹ See e.g., Ariz. Rev. Stat. § 14-5310; Colo Rev. St. Ann. § 15-14-312.

²⁰⁰ See ABA chart emergency guardianship statutes, available at http://www.americanbar.org/content/dam/aba/migrated/aging/legislativeupdates/pdfs/angela_emerg_gd_chart_final_2_09.authcheckdam.pdf

²⁰¹ See Lanterman-Petris-Short Act, Calif. Welf. & Inst. Code §§ 5000-5120.

²⁰² See Calif. Welf. & Inst. Code §§ 5000-5120, 5350 et seq.

²⁰³ Calif. Welf. & Inst. Code § 5001.

²⁰⁴ Calif. Welf. & Inst. Code § 5358.

²⁰⁵ *Id.*

²⁰⁶ *Id.*

LPS conservatorships automatically terminate one year after appointment of the conservator.²⁰⁷

Finally, while some states do not make express statutory distinctions between the types of guardianships/conservatorships that are available, the discretion granted to the court in tailoring a guardian's authority may result in what is essentially either a temporary, limited, or mental health guardianship or conservatorship.

3. Those Who Can Initiate Adult Guardianship/Conservatorships

Those who can initiate guardianship/conservatorship proceedings vary from state to state, and can also vary according to the type of guardianship/conservatorship sought. For instance, while in most cases any person can initiate guardianship/conservatorship proceedings by filing a petition with the court, in California, only a Public Guardian may petition the court for an LPS conservatorship.²⁰⁸

4. The Procedures for Seeking an Adult Guardianship/ Conservatorship

Almost all jurisdictions require the following general procedures to be followed in order for a guardian or conservator to be appointed:

- Petition to the Court for Appointment of Guardian/Conservator
- Notice to Proposed Ward
- Hearing within the Statutory Timeframe

In addition, some jurisdictions also require an investigation be made into the propriety and necessity of conservatorship prior to hearing.²⁰⁹

D. Advance Health Care Directives

An advance health care directive is a legally binding document that allows a person to direct his or her own health care in the event the person becomes mentally incapacitated.²¹⁰ Typically, an advance health care directive is comprised of two components:²¹¹

- The Appointment of a Designated Agent for Health Care Decisions; and
- Individual Health Care Instructions

The designated agent is responsible for making health care decisions for the person executing the directive in the event that person loses the ability to make those decisions. Like a power of attorney, advance health care directives can be drafted to limit the agent's authority to make certain decisions on behalf of the person executing the directive. Furthermore, in some jurisdictions, an advance directive can be used to nominate a person to act as a conservator or guardian in the event a conservatorship or guardianship should become necessary.

²⁰⁷ Calif. Welf. & Inst. Code § 5361.

²⁰⁸ Calif. Welf. & Inst. Code § 5352.5.

²⁰⁹ See e.g., Calif. Welf. & Inst. Code §§ 5350(f), 5354.

²¹⁰ Advanced Health Care Directives for Mental Health—A Trainer's Manual, *available at* http://www.disabilityrightsca.org/pubs/540701.htm#_Toc122837730 (last accessed March 4, 2014).

²¹¹ See e.g., Cal. Probate Code § 4600 et seq.

In the context of treating mental illness, an advance directive can serve as an important tool in honoring an individual's wishes not to be treated. For instance, as noted above, an advance directive can limit an agent's ability to "consent or refuse to consent to any care treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental health condition."²¹² It can also limit an agent's ability to approve diagnostic tests, or medicine regimens.²¹³ Furthermore, an agent is required to make health care decisions in the way the person would have made them.²¹⁴ Additionally, there are some statutory restrictions on what an agent can authorize, regardless of the powers granted in the advance directive, such as:

- Treatment over the person's objection;
- Placement in a mental health facility, Electro Convulsive Therapy, psychosurgery, sterilization, or abortion.²¹⁵

It is important to note that capacity is a prerequisite for a legally enforceable advance directive. As such, advance directives may not be a viable substitute in many cases due to the fact that the need for an advance directive regarding psychiatric treatment may not be apparent until after symptoms of severe mental illness present themselves. However, in some jurisdictions, such as California, neither the existence of a mental disability nor hospitalization alone is sufficient for a finding of incapacity for the purposes of executing an advance directive.²¹⁶ Therefore, where an individual has begun to exhibit signs of mental illness or disability, but has not yet lost complete capacity, an advance directive prohibiting the use of psychiatric medications may be an appropriate avenue to explore.

However, like guardianships and conservatorships, advance directives may be overridden in emergency situations,²¹⁷ or where emergency or civil commitment is necessary to prevent substantial harm to the person or others.²¹⁸

Finally, twelve states have established psychiatric specific directives.²¹⁹ "All of these laws establish the right of persons with mental illnesses to write directives, when competent,

²¹² Advanced Health Care Directives, *supra*, note 210.

²¹³ *Id.*

²¹⁴ *Id.*

²¹⁵ *Id.*; see e.g., Cal. Probate Code §§ 4652, 4689.

²¹⁶ Cal. Probate Code § 4657.

²¹⁷ See e.g., Cal. Code of Regulations, Title 9 § 853 ("An emergency exists when there is a sudden marked change in the patient's condition so that action is immediately necessary for the preservation of life or the prevention of serious bodily harm to the patient or others, and it is impracticable to first gain consent."); Cal. Welf. & Inst. Code § 5008(m) ("'Emergency' means a situation in which action to impose treatment over the person's objection is immediately necessary for the preservation of life or the prevention of serious bodily harm to the patient or others, and it is impracticable to first gain consent. It is not necessary for harm to take place or become unavoidable prior to treatment.").

²¹⁸ See e.g., Cal. Code of Regulations, Title 9, § 853 (A physician may take 'appropriate action in an emergency . . . If antipsychotic medication is administered during an emergency, such medication shall be only that which is required to treat the emergency condition and shall be provided in ways least restrictive of the personal liberty of the patient.").

²¹⁹ States that have established psychiatric-specific directives include Minnesota, Alaska, Hawaii, Idaho, Illinois, Maine, North Carolina, Oklahoma, Oregon, South Dakota, Texas and Utah. See Ron S. Honberg, *Advance Directives*, National Alliance on Mental Illness, http://www.nami.org/Content/ContentGroups/Legal/Advance_Directives.htm (last accessed March 4, 2014).

indicating their wishes concerning acceptance or refusal of psychiatric treatment. Some of these laws (e.g. Alaska and Oregon) apply only to written declarations concerning inpatient psychiatric treatment, psychotropic medications, and ECT. Others apply more generally to all forms of psychiatric treatment.”²²⁰ Of course, one obvious limitation of such directives is that it would be the rare teenager or college student who gave such forethought to their estate plan that they would have a directive prior to a diagnosis of difficult to manage psychiatric conditions like schizophrenia.

E. Supported Decision Making

Many scholars have suggested alternatives or supplements to the existing guardianship system.²²¹ Supported decision-making models are one such alternative and are being used in other countries. A person participating in supported decision-making “receives support from a trusted individual, network of individuals, or entity to make personal, financial, and legal decisions.”²²² After these decisions are made, a court will formally recognize these decisions.²²³

These supported decision-making processes allows people to rely on their family and close friends to make decisions for them if necessary, instead of courts or other public agencies who do not know the individuals on a personal level.²²⁴ These alternatives are usually designed to be nonadversarial, as opposed to a guardianship which is designed and implemented as an adversarial process.²²⁵

Two types of supported decision making models:

1. Legal “mentor” or “friend model” - employed by Sweden²²⁶

Sweden abolished its formal guardianship system for adults with disabilities in 1989. It replaced the system with a two-tiered system, assisting disabled adults with their decision-making process. The decision making process can be made through a legal “mentor,” or by an administrator who acts like a guardian.²²⁷

In the “mentor” model, the court first makes an adjudication of an individual as being incapable of managing his or her own affairs.²²⁸ The court then appoints a support person to assist the individual in making decisions. The support person acts as an intermediary, and balances

²²⁰ *Id.*

²²¹ Meta S. David, *Legal Guardianship of Individuals Incapacitated by Mental Illness: Where do We Draw the Line?*, 45 Suffolk U. L. Rev. 465 (2013); Leslie Salzman, *Rethinking Guardianship (Again): Substituted Decision Making as a Violation of the Integration Mandate of Title II of the Americans with Disabilities Act*, 81 U. Colo. L. Rev. 157 (2010) (stating guardianship presents challenges affecting important individual freedoms).

²²² Salzman, *supra*, note 221 at 232.

²²³ *Id.* at 233-234.

²²⁴ Alternatives to Guardianship, PAAG MD-CLE 15, at 2.

²²⁵ *Id.*

²²⁶ *Id.* at 235.

²²⁷ *Id.* at 236.

²²⁸ *Id.*

between allowing the individual absolute autonomy and requiring the individual to surrender all decision-making authority to a guardian or conservator.²²⁹

The support person is only appointed to assist with the decision-making process with the consent of the individual.²³⁰ The goal of the program is to preserve the individual's rights and abilities to make decisions, and to involve the individual's participation in the decision-making process.²³¹ However, depending on the court's order regarding the scope of the decision-making assistance, the support person may have significant discretion in making decisions, and can act with or without the individual's consent.²³²

2. "Canadian" model

Rather than a judicial instrument imposed by the court, the Canadian model creates a private arrangement between two parties called a "Representation Agreement."²³³ Representation Agreements are executed between individuals, authorizing another person or persons to assist with the decision making process.²³⁴ The individual does not give up any existing legal capacity by entering into these agreements.²³⁵

These "Representation Agreements" are similar to a power of attorney. However, the concept of "legal capacity" to enter into such a contract is much more flexible.²³⁶ These "Representation Agreements" may be entered into even if the person does not have the general legal capacity to enter into contracts. Consenting individuals are not required to demonstrate "capacity to understand, appreciate consequences, act voluntarily, or communicate decisions."²³⁷

The contract is flexible and can grant or limit powers of the support person in making decisions for the individual as they wish.²³⁸ These agreements could even include provisions describing the individual's preferences.²³⁹

F. Mental Health Courts

Mental health courts are courts that combine judicial supervision with community mental health treatment and other support services in order to reduce criminal activity and improve the quality of life of participants.²⁴⁰ Mental health courts connect individuals to treatment and other social

²²⁹ *Id.*

²³⁰ *Id.*; David, *supra*, note 221 at 481.

²³¹ Michael Bach, *Supported Decision Making Under Article 12 of the U.N. Convention on the Rights of Persons with Disabilities: Elements of a Model*, 21-23 (Nov. 2007), at 7.

²³² Salzman, *supra*, note 221 at 235.

²³³ See generally British Columbia's Representation Agreement Act (RAA), R.S.B.C. 1996.

²³⁴ *Id.* at p. 237; British Columbia's Representation Agreement Act (RAA), R.S.B.C. 1996, c. 405 (Can.). This statute was enacted in 1966, allowing individuals to enter into agreements for assisted decision-making process.

²³⁵ RAA, at s. 6(36).

²³⁶ Salzman, *supra*, note 221 at 238-39.

²³⁷ *Id.* at 237.

²³⁸ *Id.*

²³⁹ *Id.*

²⁴⁰ Mental Health Courts, California Courts, The Judicial Branch of California, <http://www.courts.ca.gov/5982.htm> (last accessed March 4, 2014); Kristin M. Kraemer, *Tax-Funded Washington Mental Health Courts Seeing Success*,

services in the community with the intention of improving outcomes for offenders with mental illness in the criminal justice system, to respond to public safety concerns, and to address jail overcrowding and the disproportionate number of people with mental illness in the criminal justice system.²⁴¹

At least one study found that mental health courts reduce recidivism and increase engagement in community treatment.²⁴²

The GAINS Center has a comprehensive database to identify the existing mental health courts in the United States available at http://gainscenter.samhsa.gov/grant_programs/adultmhc.asp.

G. Representative Payees

Recipients of supplemental security income or social security disability insurance who are incapable of managing their benefits may be assigned a representative payee. A representative payee is an individual or organization appointed by the Social Security Administration to receive Social Security and/or SSI benefits to “pay for the current and foreseeable needs of the beneficiary and properly save any benefits not needed to meet current needs. A payee must also keep records of expenses. When SSA requests a report, a payee must provide an accounting to SSA of how benefits were used or saved.”²⁴³

Representative payee programs are intended to improve the lives of those with mental illness by ensuring that their basic needs, such as housing, are met.²⁴⁴ More information is available from the Social Security Administration at <http://www.socialsecurity.gov/payee/>.

H. Special Needs Trusts

A “Special Needs Trust” is a specific planning technique in which a Trust can be established for someone with disabilities without a loss in need-based government benefits.²⁴⁵ “Careful drafting of the [Special Needs Trust] can allow the disabled beneficiary to become and remain eligible for need-based government benefits, such as Medicaid and Supplemental Security Income, which often serve as significant sources of funding for the disabled beneficiary’s special needs.”²⁴⁶ The proper establishment and administration of Special Needs Trusts requires adherence to strict legal requirements. As a result, consultation with an estate planner with experience in this field is a necessity.

Tri-City Herald, (March 1, 2014), *available at* <http://www.tri-cityherald.com/2014/03/01/2854478/tax-funded-washington-mental-health.html#storylink=cpy>

²⁴¹ *Id.*

²⁴² MacArthur Mental Health Court Studies, SAMHSA, http://gainscenter.samhsa.gov/grant_programs/adultmhc.asp (last updated August 2013).

²⁴³ FAQs for Representative Payees, Office of Social Security, <http://www.socialsecurity.gov/payee/faqrep.htm#a0=0> (last accessed March 4, 2014).

²⁴⁴ Patricia Hanrahan, et al., *Representative Payee Programs for Persons With Mental Illness in Illinois*, Psychiatric Services, (2002), <http://ps.psychiatryonline.org/article.aspx?articleid=87051>

²⁴⁵ Kristen L. Denzinger, *Financial Planning: Special Needs Trusts*, American Bar Association, (February 2005), http://www.americanbar.org/newsletter/publications/law_trends_news_practice_area_e_newsletter_home/0501_estate_financialplanning.html (last accessed March 4, 2014).

²⁴⁶ *Id.*

I. Supportive Housing

As discussed above, a lack of stable housing can be an impediment to getting treatment to the mentally-ill. One solution is supportive housing which provides subsidized cost-effective housing for people with mental illness or other persistent issues in order to provide them a safe and stable place to live with as much independence as possible.²⁴⁷ These programs are often run by local community organizations and may take a variety of forms including transitional housing, permanent housing, “safe havens” or supportive services.²⁴⁸ Some “[a]dvocates believe all but the most severely mentally ill can succeed in such a setting.”²⁴⁹

J. Improving Care in the Future: Suggested Reforms

As lawyers there is a tremendous opportunity to effect positive change in the care of the mentally ill through changes to law. This section examines several (non-exhaustive) reforms to the law which could improve how the mentally ill receive treatment.²⁵⁰

1. Implement Existing Laws

The low-hanging fruit to improve mental health treatment is to encourage the implementation of laws already in place. For instance, in California, “Laura’s Law” was passed to allow court-ordered treatment of patients with a history of non-compliance with treatment and who are in need in treatment (as well as other factors).²⁵¹ Yet, despite passage of the law in 2002, only one county in California implemented the law as of this writing.²⁵² Other jurisdictions have enacted AOT laws but failed to fully implement them for financial reasons or political resistance.²⁵³

The efficacy and cost-savings of AOT laws have been well-documented. Therefore, the implementation of these laws should be a no-brainer and would lead to improved outcomes for mental health patients.

²⁴⁷ Supportive Housing Program, U.S. Department of Housing and Urban Development, http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/homeless/programs/shp (last accessed March 4, 2014).

²⁴⁸ Understanding SHP, U.S. Department of Housing and Urban Development, (January 2001), *available at* <https://www.onecpd.info/resources/documents/Understanding-SHP.pdf>

²⁴⁹ Housing First: A Special Report. <http://www.npr.org/news/specials/housingfirst/whoneeds/mentallyill.html>

²⁵⁰ Although the variances in the law across jurisdictions make it someone difficult to generalize, the ideas in this section are the authors’ view of some of the best existing ideas for reform. These ideas are drawn heavily from the excellent work of others and interested readers are encouraged to check out the following sources for additional discussion: Kissinger, Meg, “How Can Milwaukee County’s Broken Mental System Be Fixed,” accessible at <http://www.jsonline.com/news/milwaukee/chronic-crisis-how-can-milwaukee-countys-broken-mental-health-system-be-fixed-229974841.html>; Torrey, *supra*, at p. 148.

²⁵¹ Paloma Esquivel, *Kelly Thomas Case Prompts Counties To Take Fresh Look at Laura’s Law*. Los Angeles Times, March 9, 2014.

²⁵² Nevada County is where the incident that occurred which was the impetus for the passage of the bill. Los Angeles and Orange Counties are making plans for implementation but are expected to face opposition from patient’s rights groups. *See id.*

²⁵³ *See e.g.*, Jim Balloch, *New Knox County mental health law slow to be implemented*, Knox News, <http://www.knoxnews.com/news/2013/may/26/new-knox-county-mental-health-law-slow-to-be/?partner=RSS> (last accessed Apr. 1, 2014); Adrienne Lu, *N.J. Delays Outpatient Commitment Law, Sued Over Forced Meds in Hospital*, Philadelphia Inquirer, Aug. 11, 2010, available at <http://www.nyaprs.org/e-news-bulletins/2010/002839.cfm>.

2. Utilize Court Models Which Facilitate Patient Buy-In

The commitment process is structured to follow the criminal model. In many states, public defenders are appointed to represent the patient and a prosecutor advocates for treatment, even where the patient's only "crime" is being sick. This structure is needlessly adversarial and the result is damaged relationships and emotional turmoil for families and patients alike. Nor does this process invite any sort of buy-in from the patient. For those in the criminal system, many rotate through the system time after time, never getting the treatment they need and burdening the court and prison system.

A more effective model would bring families, patients and care providers together in a collaborative way. Two possible alternatives are the Canadian and Swedish models discussed above, or the implementation/expansion of mental health courts.

Research has found that specialty courts, such as the mental health courts discussed above, lead to better treatment outcomes for those criminal defendant's whose cases are diverted into them, ultimately leading to reduced homelessness, substance abuse and recidivism. As a result, every jurisdiction should study and consider utilizing mental health courts as a tool in reducing the criminal docket and improving the lives of those suffering from mental illness.

3. Binding Permission for Psychiatric Care

As mentioned above, advanced directives for psychiatric care are a relatively new development, specifically enacted in twelve states (although the majority of states encompass psychiatric care already in their health care directive statutes).²⁵⁴

The distinguishing factors between advanced directives for psychiatric case and regular advanced directives is that most states set strict limits on when the directive may be revoked, often requiring a determination by two or more doctors that a person is competent.²⁵⁵ This allows a person to be treated in accordance with advance informed consent obtained when the patient is competent, while avoiding the problem that the directive will be revoked when the patient needs treatment most.²⁵⁶ These directives allow the patient to control all aspects of their psychiatric care, including designating a proxy for decisions, setting treatment limits in advance, and naming a primary physician, while also recognizing there are certain circumstances in which the need for treatment is going to be made the primary focus for the patient.

4. Keep Laws Current with Medicine

In many jurisdictions, the law has not kept pace with modern psychiatric medicine. Some states still rely on a standard that refuses to provide care unless the person is a "danger." These states

²⁵⁴ See Section IV, D, *infra*.

²⁵⁵ More information, including state by state legal analysis and resource material is available at <http://www.nrc-pad.org/>

²⁵⁶ *Questions About Psychiatric Advance Directives*, accessible at <http://www.nrc-pad.org/images/stories/PDFs/overview%20of%20pads%20in%20the%20us.pdf>

also tend to use court-ordered treatment infrequently; by the time an individual's condition has deteriorated to the level of dangerousness, inpatient hospitalization is often necessary for care and treatment.²⁵⁷ This is bad for both the patient and for society and fails to account for the medical reality that many patients will be unable to recognize the effects of their illness.

Further, many courts draw an artificial distinction between those who suffer from dementia, and those who suffer from other forms of mental illness, ordering treatment and confinement in the first instance and deferring to individual "choice" in the latter. This distinction makes no sense and is a disservice to those with mental illness.

Mental health professionals should be consulted and participate in the enactment of those laws which impact their constituency to make sure the laws are working as intended and helping those who need it most.

5. End Reliance on Emergency Care

Emergency care is an ineffective and tremendously expensive way to provide mental health care. Despite this, emergency care is gross over utilized in the care of the mentally ill. For instance, in San Francisco, authorities used psychiatric holds (5150s), on 10,849 occasions last year.²⁵⁸ In Nevada, hospitals have had to close their doors repeatedly to other types of emergencies because its beds are filled with mentally ill patients.²⁵⁹ Due to overtaxed resources, those patients who are hospitalized get only the bare minimum of care.

Some jurisdictions are instituting pilot programs, diverting those who would normally go to hospitals to private psychiatric facilities where the patient is more likely to get the care they need, and at lower cost.²⁶⁰

Instituting community based alternatives, mandated reporting of chronic patients and assignment of social workers to these patients who repeatedly utilize emergency services would identify those patients who could benefit most from treatment and hopefully start the patient on a more continuous level of care.

²⁵⁷ Torrey, *supra*, at p. 148.

²⁵⁸ Vivian Ho, "Laura's Law Mental-Health Debate Rages in Bay Area," Feb. 27, 2014, accessible at <http://www.sfgate.com/bayarea/article/Laura-s-Law-mental-health-debate-rages-in-Bay-Area-5271446.php>

²⁵⁹ Yesenia Amaro, "Officials Scramble to Resolve Emergency Room Closures Spurred by the Mentally-Ill," Feb. 27, 2014, accessible at <http://www.reviewjournal.com/news/officials-scramble-resolve-emergency-room-closures-spurred-mentally-ill>

²⁶⁰ Julie Creswell, "E.R. Costs for Mentally Ill Soar, and Hospitals Seek Better Way," Dec. 25, 2014, accessible at http://www.nytimes.com/2013/12/26/health/er-costs-for-mentally-ill-soar-and-hospitals-seek-better-way.html?_r=0