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State Laws on the Court Involvement during Initial Civil Commitment Proceedings and Rates of Psychiatric Inpatient Admissions in the United States

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State Laws on the Court Involvement during Initial Civil Commitment Proceedings and Rates of Psychiatric Inpatient Admissions in the United States

A dissertation submitted in partial satisfaction of the

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in Social Welfare

by

Gi Hye Lee

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ABSTRACT OF THE DISSERTATION

State Laws on the Court Involvement during Initial Civil Commitment Proceedings and Rates of Psychiatric Inpatient Admissions in the United States

by

Gi Hye Lee

Doctor of Philosophy in Social Welfare

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Professor David Cohen, Chair

This dissertation is the first present-day study to systematically examine and describe laws governing the court involvement during the initial or emergency civil commitment proceedings across all US states and to attempt to link their specific provisions regarding the timing of court hearings to the rates of psychiatric inpatient admissions in different states, used in this study as a proxy for their rates of longer-term commitment. Although commitment laws are generally known to vary across states, there is very limited empirical evidence on whether and how legal procedures associated with initial commitment proceedings vary across states. The study was undertaken to begin to fill a large gap in the empirical study of the two phases in the basic typology of involuntary civil commitment in the US and to account for the substantial inter-state variations in their recently estimated rates.

Focusing on the potential role of state statutes in accounting for actual variations in commitments from state to state, texts of laws that authorize the court to order involuntary psychiatric detentions in 50 states and the District of Columbia were systematically coded to describe the involvement of different designated parties in the process, including the involvement of the court and its timing. The reliability of key codes was checked by expert readers. It was found that only four states do not authorize the court to act as one of the designated authorities that may order emergency detention, evaluation, and/or involuntary commitment. In 36 states, a non-professional person may directly petition the court for emergency detention, evaluation, or involuntary commitment without a clinical certificate (a written statement from a designated mental health professional(s) attesting that the individual was examined and met commitment criteria). While only two states did not require some form of hearing to extend emergency detention into a longer-term commitment, across the 51 jurisdictions a substantial variation was found in the statutory timings of the hearings (ranging from 1 to 34 days) from the time a person initially enters emergency detention. In a regression analysis of 36 states submitting data to the Substance Abuse and Mental Health Administration's annual Uniform Reporting System on mental health services in 2018, the year with the most states with complete data, it was found that a longer statutory timing of hearing in a state—i.e., the longer a person can be legally detained without a court order—was statistically significantly associated, controlling for number of adults served in community mental health centers per 100,000 adults and number of inpatient psychiatric beds or psychiatric facilities per 100,000 people in the state, with a lower rate per 100,000 adults of admission to inpatient psychiatric facilities in the state, in the order of 7% to 10% fewer admissions for each additional day until a court hearing. This finding illustrates how, beyond their consecutiveness in the basic typology of

civil commitment, emergency detention and longer-term commitment may be currently associated at the population level.

Due to the limitations of this dissertation, such as ambiguities in the text of several states' laws, the relatively small sample of states used in the regression analyses, and the unknown reliability and validity of the psychiatric admissions data obtained for the regression analyses, results cannot be considered conclusive. Moreover, their interpretation, given the near-absence of data on real-world timings of court hearings and durations of detentions, and the lack of consistent definitions in the literature for basic terms such as commitment or psychiatric admission, remains restricted. However, by specifying operational definitions for the different phases of commitment, by quantifying the statutory timing of court involvement in emergency detention, and by testing the real-world relevance of this variable on all states submitting psychiatric inpatient admission data to a federally administered database, this study adds new and possibly firmer grounding to the study of relations between commitment laws and the practice of commitment.

This dissertation of Gi Hye Lee is approved.

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CHAPTER 1

Introduction

Involuntary civil commitment is a legal intervention used in the US and around the world to involuntarily detain and treat[1] people believed to have mental illness outside of the criminal justice setting.[2,3] While each state has its own set of commitment laws, commitment typically involves two stages: emergency detention and longer-term commitment. Emergency detention laws permit a law enforcement officer[4] and/or designated mental health professional[5] legal authority to detain a person (or have them detained) for a psychiatric evaluation or a course of psychiatric treatment. After the person has been admitted to a designated facility under emergency detention, if an examining mental health professional determines that the person needs further detention and treatment, the person is subjected to longer-term commitment, which requires court[6] review. This dissertation follows the basic typology of involuntary commitment,

[1] Treatment usually refers to biological interventions, such as neuroleptic medications, which are sometimes accompanied with psychotherapy ("talk" therapy). Electroconvulsive therapy (ECT), also known as "shock" therapy or "electroshock," is still employed in the US. Colorado, which is one of just a few states to publish incidences of ECT, reported that ECT was administered 8,624 times to 694 individuals in 2016 (Colorado Department of Human Services, 2017).

[2] In the criminal setting, forensic or criminal commitment either confines a person who is accused of a crime but is found incompetent to stand trial, or confines a person found not guilty by reason of insanity, or a person who has completed a jail sentence for a sexual offense but whom authorities do not wish to release, to a psychiatric institution or the psychiatric wing of a jail.

[3] Civil commitment typically refers to detention in inpatient psychiatric settings. It differs from outpatient commitment (also called community treatment order or assisted outpatient treatment), a court-ordered treatment in community-based settings.

[4] I use "law enforcement officers" to refer to police officers, peace officers, parole officers, and any other officers authorized by the state to make arrests. When required by the context, I specify which category of professionals I am discussing.

[5] I use "mental health professionals" to refer to psychologists, social workers, psychiatric nurses, physicians, psychiatrists, marriage and family therapists, and any other mental health and medical professionals that are authorized by the state to make decision regarding detention. When required by the context, I specify which category of professionals I am discussing.

[6] I use "court" as an institution/entity that generally includes circuit, probate, district, and superior courts, which, depending on the state, have jurisdiction over civil commitment proceedings. The court consists of judges and

where emergency detention is the initial commitment phase that may overlap with or extend into longer-term commitment (Boldt, 2017; Lee & Cohen, 2021).

Depending on the state, the statutory criteria authorize commitment of individuals who, as a result of mental illness, are believed to be dangerous to self or others, to be unable to meet basic needs for survival (typically referred to as "grave disability" in some state statutes),[7] to be in "need of treatment" due to the lack of capacity to make informed decisions about treatment or to protect the person from physical harm,[8] or some combination thereof. In some jurisdictions, the non-availability of a "less restrictive alternative to hospitalization" applies as one of the commitment criteria.

Although commitment laws are generally known to vary across states, there is very limited empirical evidence on whether and how legal procedures associated with the initial commitment phase vary across states. Hedman et al.'s (2016) study is the only empirical study to describe how the laws governing "emergency commitment" procedures vary across 51 jurisdictions (including the District of Columbia [DC]) in the US. Another underexplored area of involuntary commitment research is what factors might account for variations in rates of commitment (Lee & Cohen, 2021), specifically, whether variations in legal procedures associated with the initial commitment phase might be associated with variations in rates of longer-term commitment across states. PubMed-indexed literature consists only of studies from the late 1980s that evaluated commitment legislative reform of the 1960s and 1970s and its

judicial officers such as magistrates, special justices, and justice of the peace. Whether a formal legal education is needed for judicial officers depends on the state. In North Dakota, magistrate means "the judge of the appropriate district or juvenile court or a judge assigned by the presiding judge of the judicial district" (N.D. Cent. Code, § 25-03.1-02), while in Virginia, a person appointed as a magistrate is only required to have a bachelor's degree from an accredited institution (Va. Code Ann. § 19.2-37).

[7] For example, see Alaska Stat. § 47.30.710(b)(1), Ariz. Rev. Stat. § 36-501(32), and Conn. Gen. Stat. § 17a-502(a).

[8] For example, see Mich. Comp. Laws § 330.1401.

impact on admissions to state mental hospitals. These studies are outdated; emergency departments, general hospital psychiatric units, and private psychiatric hospitals are more likely to be used these days than state psychiatric hospitals (Lutterman et al., 2017). Questions also remain because these studies mainly assessed admission rates before and after legislative changes in the substantive criteria and legal procedures were made in a single or few states.

The purpose of this dissertation is, first, to systematically explore variations in legal procedures, specifically the court decision-making authority during initial commitment proceedings, in 50 states and DC. Second, given that no valid figures of involuntary commitment exist in the US, this dissertation quantitatively examines how the variation in statutory timings of hearings from the time of initial emergency detention might be associated with rates of admissions to inpatient psychiatric facilities across 36 states with available admission data. According to SAMHSA (2019a), 41.2% of individuals were admitted to inpatient psychiatric settings with an involuntary non-forensic legal status, 42.7 % were admitted with a voluntary legal status, and 16.2% with an involuntary forensic legal status on April 30, 2018.

This chapter begins with brief discussions of some basic clinical, ethical, and social issues and debates, such as ontological and epistemological beliefs regarding mental disorders, and whether involuntary commitment laws are justified.

Perspectives on Mental Disorders/Mental Illnesses

In most state commitment laws, mental illness is defined in terms of when "the capacity of a person to exercise self-control or judgment in the conduct of his or her affairs and social relations, or to care for his or her own personal needs, is significantly impaired" (R.I. Gen. Laws § 40.1-5-2) or when "substantial disorder of thought, mood, perception, orientation, or memory… grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet

the ordinary demands of life" (18 Vt. Stat. tit. § 7101). Some states include a definition of mental illness that is circular, dependent on commitment criteria themselves. In Oregon, a person with mental illness means "a person who, because of a mental disorder, is one or more of the following: (A) Dangerous to self or others; (B) Unable to provide for basic personal needs that are necessary to avoid serious physical harm in the near future, and is not receiving such care as is necessary to avoid such harm" (Or. Rev. Stat. § 426.005).

In clinical and legal settings where the laws are applied, mental disorders are diagnosed using the *Diagnostic and Statistical Manual of Mental Disorders* (DSM)—the current diagnostic tool that has been used widely in the US and internationally. Published first in 1952 by the American Psychiatric Association (APA), a professional organization of psychiatrists that views mental disorders as biological abnormalities that can be treated with pharmacological intervention (Deacon, 2013), the DSM has been modified several times since its first release. DSM-5-TR, the latest version published in 2022, contains classifications, descriptions, and categorizations of hundreds of mental disorders.

Different perspectives on mental disorders appear in critiques levelled at the DSM, which has been the center of continuous debate over whether its diagnostic categories are social constructs or actual diseases. This topic was extensively revisited in a paper before the publication of DSM-5, in which invited commentators from different academic fields offered their ontological and epistemological beliefs about mental disorders: what they are and how we know them (Phillips et al., 2012). There was a wide range of definitions and viewpoints on the nature of psychiatric disorders, loosely divided by Phillips et al. into three different philosophical stances: a "realist" position that the diagnostic clusters represent real diseases and conditions; a middle, "nominalist" position that psychiatric disorders exist, but the diagnostic categories are

constructs that may or may not accurately represent the disorders; and a "constructivist" position that asserts that diagnostic categories are simply constructs with no proof of actual psychiatric disorders (genuine kinds) in the real world (despite plenty of evidence of deviance, distress, and sorrow). Allen Frances, who chaired the task force that produced the DSM-IV but who became critical of DSM-5, embraced the nominalist stance (Phillips et al., 2012). Frances believed in the existence of psychiatric disorders but was not confident that diagnostic constructs could accurately represent these disorders. For instance, Frances argued that the inclusion of new diagnoses of mixed anxiety-depression, an expansion of addictive disorders, and overly inclusive criteria sets in the DSM-5 were not supported by scientific evidence. The APA made these changes to expand the population of individuals diagnosable with mental disorders, which consequently would expose many of them unnecessarily to psychiatric medications.

An organization that endorses the realist position is the National Institute of Mental Health (NIMH). Similar to the APA, it supports the biological model of mental illness, well reflected in Kandel's (1998) position that all mental processes stem from the brain, and mental disorders are disturbances of brain processes. Combinations of genes are believed to exert control over behaviors and therefore shape development of mental disorders. Kandel placed great emphasis on biology but did not rule out the role of nonbiological factors in the development of mental disorders. That is, environmental factors could interact with genes to produce significant alterations in gene expression—but the root of mental illness is, nonetheless, biology.

Though the APA and NIMH agree on biology as the cause of mental illness, the NIMH does not support the DSM. Thomas Insel, then director of NIMH, wrote a letter shortly before the publication of DSM-5 announcing the agency's decision to cease supporting research that relies exclusively on DSM diagnoses. Insel argued that the DSM does not provide any evidence

of the etiology and psychopathological or neurobiological mechanisms of mental disorders, since the diagnoses are based on a "consensus about clusters of clinical symptoms" rather than on any objective measures (Insel, 2013). Dissatisfied with the current diagnostic system, the NIMH developed the Research Domain Criteria (RDoC) framework, which organizes information about presumably basic biological and cognitive mechanisms that lead to mental illness. The RDoC aims to inform the creation of mental health screening tools, diagnostic systems, and treatments. The NIMH recently celebrated the 20th anniversary of the RDoC framework. However, the fact that we still do not have a classification system based on the RDoC framework to replace the DSM suggests the lack of evidence to show the biological cause of, or biomarker for, any mental illness (Deacon, 2013; Kirk et al., 2015).

Unlike those who believe in the existence of mental illness, Thomas Szasz (1974) insisted that mental illness was a myth and metaphor. Szasz did not consider mental disorders to be putative brain diseases—nor abnormal behaviors to be the products of abnormal brains—unless brain abnormality was demonstrated. Thus, mental disorders could not be represented in the DSM as actual illnesses because, unlike brain diseases, they were not based on underlying pathology or physiological abnormalities but instead represented an infinite repertoire of "problems in living." Szasz was highly critical of psychiatrists pretending that DSM diagnoses were diseases when in fact the DSM was a list of officially accredited psychiatric diagnoses, constructed and invented by consensus groups and task forces appointed by the APA. Szasz argued that DSM diagnoses were stigmatizing labels legitimized by the APA that psychiatrists use to control unacceptable or socially deviant behavior (or to make such behavior treatable or more acceptable). Under the pretense of medicine, psychiatrists were medicalizing often difficult problems and interpersonal conflicts that people experienced in their daily lives.

Rather than disputing the biological and genetic contributions of psychopathology, most sociological research focuses on how social structures affect the onset of mental, emotional, or behavioral problems (variously named by sociologists as illness, distress, or deviance). These sociologists emphasize that the experience of living with a mental illness is embedded within a social context (Aneshensel et al., 2013). One particular subfield of the sociology of mental illness applies the sociology of social stress, specifically Pearlin's stress process framework (Pearlin 1989, 1999; Pearlin & Bierman 2013; Pearlin et al. 1981), which provides a complex conceptual model that can be and has been used to empirically examine the relationship between exposure to stressors and psychological distress (Aneshensel & Avison, 2015).

At the heart of this framework lies the assumption that stress does not follow one single pathway. Rather, the sources of stress and the manifestations of stress interconnect to form a stress process (Pearlin et al. 1981). Two major sources of stress—life events and chronic strains (stressors that produce enduring problems)—arise out of the social conditions in which people live. Pearlin emphasized that stressful life experiences had social structural origins:

> …when we look at the etiology of mental health, we are able to see a convincing example of how personal problems may often have their beginnings in social problems. This message needs to be underscored and repeated, for when the political climate of society shifts to the right, a contrary message tends to arise, namely, that social problems start as personal problems. We can assert that what has been learned and what will be learned in the future will continue to go directly against the grain of such a claim. Personal problems can be and often are reflections of structures and contexts in which people lead their lives (Pearlin & Bierman, 2012, p. 338).

In this way, Pearlin differentiated the sociological orientation of mental illness from the biological model that assumes the source of one's distress, suffering, and misery lies within the body. Other parts of the stress process are mediators and moderators of stress, such as social supports, institutional resources, personal coping behaviors, access to care, and so forth. These factors can operate as a mechanism by which the exposure to stressors is related to stress

outcomes (mediators), or they can modify the relationship between exposures and outcomes (moderators) (Pearlin, 1999).

Pearlin (1989) also highlighted that people who are exposed to relatively similar stressful events do not necessarily experience them the same way. In other words, some stressors seem to have stronger effects on certain people than others. Part of this explanation, according to Pearlin, is related to social values. By values, Pearlin refers to "what is defined socially as good, desirable, and prized or as something to be eschewed" (p. 249). Values play an important role of shaping the meaning and importance of experiencing the perception of threat that usually arises during stressful conditions. To put it differently, the threat that people experience from a set of circumstances depends on the level of importance they place on the certain value associated with the circumstances. For instance, though unemployment is generally a stressful event, it could feel more threatening to a person who places importance on status enhancement than a person who does not. Given this variability and complexity in experiences of social stress, is it fair to reduce manifestations of stress simply into diagnostic labels?

While the term "mental illness" will be used throughout, this dissertation views the phenomenon of mental illness through a sociological orientation by treating it as psychological distress or reactions to stressors and treating involuntary commitment as a moderator of stress. Involuntary commitment, as a legal or clinical intervention, can have consequential impacts on people. Some have argued that strict confinement, forced treatment, loss of privacy, lack of control over one's life, isolation from a support system, stigma, and trauma experienced during confinement could be harmful for anyone, especially someone who is already emotionally and psychologically vulnerable (Large & Ryan, 2014; Stefan, 2016). Akther et al. (2019) showed that people who had been involuntarily hospitalized reported decreased feelings of self-worth and

increased concerns about stigma. The impact of these experiences could carry over beyond discharge (Large & Kapur, 2018) and contribute to the high suicide rates observed among individuals in the weeks following a discharge from psychiatric hospitalizations (Chung et al., 2010).

What these and other arguments suggest is that involuntary commitment turns psychiatric hospitals into places like jails, that add to or create new trauma and stigmatizing experiences. Within Pearlin's stress process framework, confinement could moderate the relationship between stressors and reactions to stressors by strengthening the negative effects of stressors that prompted individuals to be committed, compared to those who are not committed. This is not likely to occur with everyone who is committed, since the meaning and importance of experiences related to stressors and involuntary commitment are shaped by social values. Commitment could intensify the effects of stressors on psychological distress instead of buffering them because psychiatric hospitals are not fundamentally designed to address the underlying causes of individuals' stressors that led them to be committed. Instead, commitment laws provide additional settings for the occurrence of medicalization, in which severe psychological distress (which could have originated from social problems) of confined individuals is officially transformed into "mental illness" that in turn is used as rationale for commitment and third-party reimbursement (or billing). In this way, involuntary commitment not only functions as an additional source of psychiatric distress but also shifts the sources of psychiatric distress from political, economic, or environmental problems to the individual.

Are Involuntary Commitment Laws Justified?

Substantive law refers to the body of written or statutory laws that determine the rights and obligations of everyone within its jurisdiction (Cornell Law School, n.d.-a). It defines crimes

and punishments as well as rights and duties of the citizens. In involuntary commitment, substantive law refers to the legal criteria that are applied to commit individuals suspected to have mental illness. As the Substance Abuse and Mental Health Services Administration ([SAMHSA], 2019b) wrote, the criteria for involuntary commitment today consist of several parts:

> Mental illness—required in every state; generally defined in terms suggesting serious mental illness (e.g., substantial disorder of thought or mood that grossly impairs judgment, behavior, or ability to negotiate demands of life), usually excluding substance use disorders, intellectual disabilities, and dementia;
>
> Dangerousness to self or others—appearing in the law in nearly every state, although no longer as an exclusive criterion in most; defined in various ways…
>
> Grave disability—part of the law in most states; generally defined as inability to provide for basic personal needs…
>
> Need for treatment—required in nearly every state, either as an explicit criterion or as part of the definition of mental illness, and certainly contemplated in every state by commitment's essential purpose, which is treatment; no longer an exclusive criterion for commitment in any state, except where defined to encompass risk of harm or some other commitment criterion;
>
> Deterioration—beginning to appear as a distinct criterion in some states' laws, or as part of the definition of grave disability, as discussed above; never an exclusive criterion; and Incompetence—part of the law in a few states; never an exclusive criterion…
>
> In addition to these criteria, most states require that commitment comport with the principle of the least restrictive means, providing either (i) that a person may not be committed if his or her needs can be met in a less restrictive setting, or (ii) that a person whose needs can be met in a less restrictive setting may be committed to services in that setting but may not be committed as an inpatient… (pp. 11-12)

The controversy surrounding involuntary commitment laws has always been whether substantive law is justified given the deprivation of liberty. The state's interest in substantive law rests on two legal principles: *parens patriae*, the power of the state to act as guardian for individuals who are unable to take care of themselves; and police power, the power of the state to establish and enforce laws protecting the welfare, safety, and health of all citizens within its

boundaries. When the state commits an individual believed to have a mental illness on the ground that they are dangerous to others, the justification for this deprivation of liberty is considered an exercise of police power. The justification for the commitment of individuals for reasons other than posing a risk of harm to others is considered *parens patriae* (Slobogin et al., 2020). In the following sections, I briefly cover arguments that have been made for and against the state use of *parens patriae* and police power to commit an individual believed to have a mental disorder.

Parens Patriae Power

The *parens patriae* doctrine, or paternalism, originates from the idea that the state has authority to act as "parent" toward its citizens. Every state permits commitment of individuals who, as a result of mental illness, are "dangerous to self," "gravely disabled," and/or "unable to care" for themselves. The usual justification for these provisions is that individuals with mental illness are believed to lack the capacity[9] to make decisions for themselves about treatment and hospitalization and, therefore, the state has the authority to make those decisions for them (Slobogin et al., 2020).

The constitutional requirement of substantive due process demands that the state must have a compelling reason to execute actions that will result in deprivation of individual liberties. The benevolent intention of the state has long raised the question of whether the state has a compelling reason to act as *parens patriae* in order to commit individuals believed to have a mental illness (Harvard Law Review Association, 1974). To justify, the state would argue that under the *parens patriae* doctrine, commitment of individuals believed to have a mental illness

[9] "Capacity" is a medical term that refers to the "ability to understand, appreciate the relevance of, and use, weigh or reason with the information relevant to a decision, in the light of what is important to the individual; and, to communicate a decision" (Szmukler, 2020, p. 231). In healthcare scholarship, capacity is used interchangeably with "competence," which is a legal construct (Stefan, 2016).

does not involve significant deprivation of liberty because one cannot appreciate personal liberty meaningfully unless one has the capacity to do so; the state would be acting as a substitute decisionmaker, instead of imposing deprivation.

Some have posited that the assumption that individuals believed to have a mental illness lack capacity to make decisions for themselves discriminates unfairly against them because their autonomy and self-determination are not respected in the same way that they are for people who have nonpsychiatric or physical disorders (Szmukler & Kelly, 2016). While the latter group of individuals (who presumably have decision-making capacity) can freely make treatment decisions even if they pose a serious risk to their health or life, in general, a person believed to have a mental illness cannot easily refuse treatment imposed upon them, regardless of whether they have decision-making capacity or not. The argument does not consider that individuals' capacity to make autonomous decisions is rarely, if ever, at issue when individuals agree to pursue a medically recommended treatment (Kirk et al., 2015).

According to Matthews (2000), mental illnesses should be treated differently than physical illnesses because some mental illnesses involve psychoses, which disturb personal identity: a sense of who one is, one's place in the world, and one's relatively coherent and realistic set of beliefs about the world. In most extreme cases, a person may be incapable of "self-government," and the person in this condition would make choices that they would not have made if not for the psychosis. Matthews provided an example of how a person with paranoid schizophrenia who refuses treatment because of the belief that they are being pursued by an agent of MI5 (the British Security Service) cannot be considered to make a truly "autonomous" choice to refuse treatment; it is their psychosis that governs their choices, not the self. In these cases, the justification for commitment and imposing treatment would be to

reinstate the self or restore autonomy. However, just as the argument that treatment will lead to the restoration of autonomy is conjectural (Donnelly, 2008), the idea that the psychosis is not the "self" is also speculative.

Several authors have argued in favor of limiting commitment to those who lack capacity to make decisions autonomously (Dawson & Szmukler, 2006; Steinert, 2016). Stefan (2016) made similar arguments specifically in relation to the criterion of being dangerous to oneself. Because the *parens patriae* power assumes that an individual with mental illness makes unreasonable decisions for oneself, and self-harming behaviors are believed to be caused by mental illness, the "danger to self" criterion treats any threats or actions of self-directed harm as "irrational." However, Stefan contended that most people who are thinking about suicide, attempting suicide, or committing suicide are rational, autonomous decision-makers, and the vast majority of individuals believed to have a mental illness do not commit suicide. Treating "suicidal" individuals as *in fact* incompetent or mentally ill is detrimental not only because it delegitimizes their suffering and struggles, but also because it prevents them from having extended conversations about the topic of suicide and from voluntarily seeking help due to the fear of being committed. Therefore, Stefan argued that commitment should be restricted to individuals who lack decision-making capacity, and the commitment of people perceived to be at risk of suicide who nonetheless exhibit decision-making capacity is insufficient to justify restricting their liberty.

Police Power

The police power used to justify the "dangerous to others" commitment criterion is a principle that originated from the criminal justice system. It authorizes the state to protect society from dangerous conduct. Involuntary commitment law resembles criminal law in that they both

involve deprivation of individual liberty but is also distinct. As Slobogin et al. (2020) described, while the primary purpose of criminal law is to punish based on already committed conduct, the primary purpose of commitment is to prevent future acts. These authors did not mean to indicate that commitment does not function as a sanctioning device or that criminal law does not function as a control mechanism; instead, they suggested that, in theory, the criminal system is reserved for punishing those who commit crimes, and commitment is reserved for those whom the state cannot, or will not, punish but who nonetheless need to be controlled for their own good or the good of others. Overall, criminal law focuses on past conduct, while commitment law relies on predictions of future conduct.

Preventive detention (the confinement of an individual based on a prediction of violence toward self or others) can be challenged for the following reason: predicting behavior is generally quite difficult. The assessment of whether a person with mental illness is likely to commit acts of violence has until very recently been solely based on clinical judgements; because of this, the APA (2017) repeatedly acknowledged that psychiatrists "cannot predict dangerousness with definitive accuracy." Nevertheless, high profile events like the 2007 Virginia Tech mass shooting, in which the gunman was previously involved with a mental health center, revitalize the discussion of whether a mental health professional could predict and prevent a person suspected of mental illness from committing an act of violence (Virginia Tech Review Panel, 2007).

In the late 2000s, the APA started a trend to incorporate violence risk assessment tools to help clinicians increase the accuracy of their judgment (Lamberg, 2007). These methods are typically known as actuarial, in which the prediction derives from a mathematical combining of an individual's known predictors associated with violence (Buchanan, 2008). The predictive

accuracy of these risk assessment tools has, however, raised some questions, specifically over false positive predictions (predictions of violent behavior that turn out to be nonviolent). Large et al. (2011) found that a risk categorization tool had a relatively high predictive accuracy, but still incorrectly classified a large proportion of individuals with schizophrenia as being at high risk of violence toward themselves and others (50% to 99.97% false positive rates). Others have raised questions of what cutoff point should be applied between violent and nonviolent behaviors for risk assessment instruments, and whether commitment can be justified if the risk assessment tool has only partial predictive accuracy of violent behavior (Slobogin et al., 2020).

One Way Forward

Involuntary commitment is a delicate topic to cover because of opposing reasonable ontological and epistemological beliefs regarding mental disorders, as well as reasonably divergent views on the right to suicide and whether state commitment laws are justified to prevent suicide (if individuals are rational decision-makers). These issues have been debated for decades. Yet very few empirical findings on the US involuntary commitment can be found in relatively recent published papers. The absence of convincing evidence that supports the state's justification for depriving a person of their liberty (i.e., decisive empirical findings on the impacts of commitment as an answer to mental health crises) only brings us back to the ethical and moral debates on the issue. In order to move forward with these debates and perhaps arrive at more enlightened policies, it may be that more research is required about the impact of involuntary commitment at the individual and societal levels in the US. If we were to accept that determining whether a person meets substantive criteria for commitment is difficult, then some questions to be considered are what measures the state must take to protect against arbitrary commitment decisions, and whether the answer to this question depends on the state's laws on

commitment procedures. The following chapter begins to explore these questions with a brief history of involuntary commitment laws in the US.

CHAPTER 2

Brief History of Involuntary Commitment Laws in the US

Much of the history of asylum, or confinement of the insane, in Western countries has been described in relation to the history of psychiatry (Foucault, 1965), because psychiatry as a profession emerged out of institutional control of the insane (Grob, 1983). Using the framework of social control and professionalization of psychiatry, historians focused on how medical professionals played a central role in the process of confinement. They had the discretionary power to keep individuals confined for very long periods of time. These historians also described that "madness" came to be defined as a medical illness and that institutions, such as asylums, became society's response to the problem of the mentally ill starting around the 1700s (Wright, 1997).

In re-examining the history of confinement, Wright (1997) offered to take into consideration the role of the family as well. The family unit was primarily responsible for taking care of their "dependent" members prior to the constructions of public institutions, and then became central to the decision-making process of confinement following the constructions of public institutions. Wright contended that the family's decision to confine a "dependent" family member in an institution was the strategic response to broad social and economic changes, the lack of institutional and informal caring resources, and a cultural acceptance towards institutionalizing unwanted and "difficult" individuals.

Up until the end of World War II, state mental hospitals served as the main public institution in the US where individuals who could not take care of themselves and lacked family support were institutionalized or committed for an indefinite period of time (Grob, 1983). The role of public institutions and the state's use of *parens patriae* power to act as custodians of the

mentally ill and other "socially undesirable" groups of individuals remained uncontested. However, humanitarian concerns over institutional abuse at state mental hospitals grew during the post-World War II era, and the abuse was documented in several different ways. Among these ways was a journalistic exposé published in *Life* magazine of two state mental hospitals in Ohio and Pennsylvania (Jerry Cooke Archives, Inc., 2021; Maisel, 1946, as cited in PBS, n.d.). It included pictures of dehumanizing living conditions and confined individuals as objects of deplorable treatment. In an ethnographic fieldwork of a mental institution in Washington, DC, Goffman (1961) described mental hospitals as "total institutions," like prisons. Institutionalized individuals, segregated from the outside world, had their lives under constant surveillance and completely dictated by institutional routine. Goffman argued that these total institutions were designed to engage individuals in the process of "mortification of self." Through humiliating treatments and physical abuse, individuals were removed of their former selves and assumed the institutional identity as inmates.

Additionally, a 1961 Joint Commission on Mental Illness and Health report, titled "Action for Mental Health," described state mental hospitals as large-scale custodial warehouses that provided costly stays and ineffective or nonexistent treatment (Rose, 1979). The Commission recommended that admissions to state mental hospitals be reduced and that confined individuals be returned to community life where, ideally, they would be rehabilitated in the least restrictive settings—a process that came to be known as deinstitutionalization. In 1963, President John F. Kennedy proclaimed deinstitutionalization a policy goal by signing the Community Mental Health Act, which aimed to provide states federal funding for the establishment of community mental health centers that would offer partial hospitalization, outpatient and rehabilitative services, supported housing, and other social services (Rose, 1979).

The US observed a decline in the resident census of both state and county mental hospitals, from 559,000 in 1955 to approximately 138,000 in 1980 (Goldman et al., 1983). More recent data show that of the 129,115 individuals who received mental health treatment services in inpatient settings on April 30, 2018, 31% were in general hospitals, 26% were in public psychiatric hospitals, and 39% were in private psychiatric hospitals (SAMHSA, 2019a). Additionally, another 58,762 were in 24-hour residential treatment settings on that same day.

As opposed to attributing deinstitutionalization to the change in attitudes toward institutional care or liberal humanitarian concerns for institutionalized individuals, some believed that deinstitutionalization had more to do with economic factors. Gronfein (1985) particularly argued that the passage of Medicaid in 1965 and its cost-shifting opportunities was the primary motivation behind the states' movement towards deinstitutionalization. Since its inception, the federal Medicaid match has denied coverage for inpatient services for individuals between the ages of 21 and 65 at psychiatric hospital settings with more than 16 beds (also referred to as the Institutions for Mental Disease [IMD] Exclusion rule), while it allowed coverage of nursing homes or psychiatric units in general hospitals. Medicaid, therefore, provided an incentive for states to shift the fiscal responsibility to the federal government by "transinstitutionalizing" discharged individuals to nursing homes (or other similar institutions) and encouraging the use of psychiatric units of general hospitals instead of state mental hospitals (Frank et al., 2003).

Others like Warren (1981) contended that deinstitutionalization was a myth. The reality was that "transinstitutionalization" created a new form of social control through various combined welfare-private profit systems; these provided numerous entrepreneurial opportunities in both private and public sectors, a phenomenon that Warren referred to as "social control entrepreneurialism." In addition to Medicaid, the establishment of other fiscal and legal

incentives—such as Supplemental Security Income (SSI) and Social Security Disability (SSDI) insurance programs—transformed both institutional settings (such as nursing homes and board and care homes) as well as private, profit-making facilities into custodians of socially undesirable groups of individuals, which was the function that state mental hospitals used to serve. Warren argued that, under transinstitutionalization, socially undesirable individuals remained objects of institutional control. What was different was that they became sources of revenue that others could profit from.

These changes in the mental health system coincided with legal advocacy efforts to challenge the constitutionality of involuntary commitment laws. In 1972, Alberta Lessard was picked up by two police officers and detained on an emergency basis in Wisconsin. Lessard then acquired counsel through Milwaukee Legal Services to file a class action suit on behalf of all adults committed under the state's involuntary civil commitment law (*Lessard v. Schmidt*, 1972). The suit alleged that Wisconsin commitment statute § 51.02(5), which permitted commitment of an individual if they are "mentally ill or infirm or deficient and that [they are] a proper subject for custody and treatment…", was vague and broad, and that the state's commitment law lacked due process protections under the Fourteenth Amendment that guarantees fair procedures. While the District Court for the Eastern District of Wisconsin recognized that the state had a legitimate interest under its *parens patriae* power to commit individuals who were unable to take care of themselves, it required that the state must also bear the burden of proving that "there is an extreme likelihood that if the person if not confined he will do immediate harm to himself or others" (*Lessard v. Schmidt*, 1972). In addition, the court required that commitment proceedings include procedural safeguards that were guaranteed to a criminal suspect, such as a right to

counsel, a right to prior notice, and a right to a preliminary hearing within 48 hours of being detained as well as a full hearing within 10-14 days after the initial detention.

In another court case, a man named Kenneth Donaldson, who was involuntarily committed in a Florida State Hospital for 15 years and whose requests for release were rejected multiple times, filed a lawsuit against the hospital superintendent and staff claiming that "they had intentionally and maliciously deprived him of his constitutional right to liberty" (*O'Connor v. Donaldson*, 1979). The superintendent's defense was that they had simply followed the state commitment law, which they believed authorized indefinite custodial confinement of the "sick." The jury trial found in favor of Donaldson. Additionally, the Supreme Court ruled that "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" and that the state cannot constitutionally confine an individual against their will if they do not pose a danger to self or others.

Overall, the interplay of different factors and events, including the change in the role of institutional care, the reconfiguration of the mental health system (the shift in the responsibility for people believed to have mental illness from state mental hospitals to various welfare-private profit systems), and the concerns for the civil rights of individuals subjected to commitment, shaped many states' decision to adopt involuntary commitment laws beginning in the 1960s and 1970s.

California's Lanterman-Petris-Short Act of 1967

California was one of the first states to adopt these more rights protective commitment laws by enacting the Lanterman-Petris-Short (LPS) Act, signed by Governor Ronald Reagan in 1967. It was primarily intended to "end the inappropriate, indefinite, and involuntary commitment of persons with mental health disorders, developmental disabilities, and chronic

alcoholism, and to eliminate legal disabilities" (Cal. Welf. & Inst. Code § 5001). It restricted the substantive basis for commitment to an individual who, "as a result of a mental health disorder, is a danger to others, or to himself or herself, or [who is] gravely disabled." LPS limited the length of commitment from an indefinite period of time to 72 hours for evaluation and treatment (Cal. Welf. & Inst. Code § 5150), 14 days for "intensive commitment" (Cal. Welf. & Inst. Code § 5250), which could be renewed for additional 14 days if the person continues to pose danger to themself (Cal. Welf. & Inst. Code § 5260) or 90 days[10] if they pose a danger to others (Cal. Welf. & Inst. Code § 5300). Additionally, it required that persons facing a 90-day commitment have the right to legal representation, the right to call witnesses, and the right to remain silent during judicial proceedings.

Although the enactment of LPS was praised as a progressive achievement, some have questioned whether it actually protected the rights of people subjected to commitment. According to Lenell (1977), the term "gravely disabled," defined in the statute as a "condition in which a person, as a result of a mental disorder, is unable to provide for his basic personal needs for food, clothing, or shelter" (Cal. Welf. & Inst. Code § 5008 (h)(1)(A)), set no objective guidelines that could be used to determine: (1) the nature of the inability to provide for one's basic personal needs, (2) the degree of inability to provide for such needs, or (3) what basic needs are. Lenell believed that the impreciseness of the term allowed the authorities to commit an individual based on whether this person's status or behavior conformed to normative expectations. Therefore, the decision to commit someone who was gravely disabled fell upon psychiatric judgments as to what constituted basic needs. Additionally, the term "dangerous" was largely undefined in the provision in terms of the four-factor analysis of dangerousness as

[10] Current provision states "an additional period, not to exceed 180 days" for danger to others.

proposed by Brooks (1973, as cited in Lenell, 1977): (1) magnitude of the harm threatened (including whether the harm is physical or psychological, or if the harm is to property), (2) probability that the harm will occur, (3) frequency of harm (whether the harm is likely to reoccur, and (4) imminence of harm (whether the harm will occur within a day, a week, or so forth). As a result, the lack of precision in the statute left room for interpretation for the authorities to commit individuals for any number of acts, beliefs, or thoughts that might seem dangerous to them. Lenell argued that, because of the vague commitment standards, many people could be committed based on personal opinions or psychiatric judgments that are neither reliable nor free of normative cultural biases, casting serious doubt on whether the LPS afforded adequate protection of the rights to the "mentally disabled" individuals.

Revision of the Involuntary Commitment Criteria

Following California, other states adopted the danger to self or others model. Nebraska, for instance, passed the Mental Health Commitment Act in 1976 that required commitment of an individual who, as a result of mental illness, is a danger to others or self, or is unable to provide basic needs for oneself as a result of mental illness (Luckey & Berman, 1979). Similarly, danger to self or others was incorporated into Washington's "grave disability" criteria, defined in the Involuntary Treatment Act (ITA) of 1973 as a "condition in which a person, as a result of a mental disorder, is in danger of serious physical harm resulting from a failure to provide for his essential human needs" (Durham & Pierce, 1982, p. 217).

The danger to self or others model drew criticism when it was first introduced, especially from psychiatry, claiming that the criteria created unnecessary barriers to commitment of individuals who were not "dangerous" but were still in "need of treatment" due to signs of mental or health deterioration (Stromberg & Stone, 1983). Despite the criticism, a 1989 study by

Cleveland et al. did not find evidence to support this claim. They examined 390 individuals who were evaluated at an urban psychiatric hospital in Pennsylvania for an emergency detention. At the time when this study was conducted, the Pennsylvania statute authorized commitment of individuals who are deemed dangerous to self or others, and the evidence of danger to self must consist of "suicidality," self-mutilation, or an "inability to care for self." For the study, clinicians rated whether the participants were dangerous to self or others, were unable to take care for themselves, and needed treatment, among other characteristics. The findings showed that individuals whom clinicians deemed "non-dangerous" were not prevented from being committed. They were either admitted on a voluntary basis or on an involuntary basis under the "inability to care for self" provision.

What Cleveland et al.'s (1989) findings suggest is not necessarily that the laws are not applied in the way they are written, but that the statutory language on danger to self or others in most states is broad enough to include those who are "unable to take care for themselves." In Washington, for instance, the statutory definition of "grave disability" was expanded in 1979, six years after the enactment of the ITA and following a highly publicized double murder by a person presumed to be mentally ill who had been refused voluntary admission to a state mental hospital ("MacFarlane murder"). From then on, the state would authorize commitment of an individual who, "as a result of a behavioral health disorder: (a) Is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety; or (b) manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety" (Wash. Rev. Code § 71.05.020). While retaining danger to self or others, Washington expanded the "grave disability" criteria beyond commitment of

persons who could not satisfy "basic human needs" to those who manifested "severe deterioration in routine functioning." This criterion has been adopted in only a minority of states.

Cleveland et al.'s (1989) findings also highlight how clinicians can resort to voluntary admission if they determine that hospitalization is necessary for someone whose behaviors might not strictly meet the commitment criteria. Voluntary admission is important to take into consideration when discussing involuntary commitment. Typically, the difference between individuals who are involuntarily and voluntarily admitted seems to be that the former are hospitalized "against their will" while the latter are agreeing to or not actively resisting their commitment. Some jurisdictions maintain two different forms of voluntary admissions: a statute on "pure" voluntary admissions permits individuals to depart the hospital without notice and whenever they want, while the one on "conditional" voluntary admissions prohibits individuals from leaving the hospital without notice and a waiting period (Boldt, 2015).

Voluntary admissions are generally preferred over involuntary commitment by law in some states such as Florida, Louisiana, Minnesota, and New York, and mostly preferred by mental health professionals as the means of hospitalizing individuals suspected to have mental illness (Boldt, 2015). It is important to note that authorities could and are reported to exert pressure on individuals to agree to "pure" or "conditional" voluntary admission by using some forms of coercion, and those who are voluntarily admitted sometimes perceive coercion similar to most individuals who are involuntarily committed (Bindman et al., 2005; O'Donoghue et al., 2014). Moreover, in many "conditional" voluntary admissions, individuals so admitted do not have their options fully explained. If these individuals wish to be released, they still need permission from the hospital, just like individuals who are admitted involuntarily. The actual difference between the voluntarily and involuntarily admitted therefore could be that the former

are more likely to be compliant with authorities or acquiesce to avoid the threat of a longer detention or stigma associated with involuntary detentions. Besides the broadness of statutory definitions of commitment criteria, the legal option of voluntary admissions could allow clinicians to exercise their professional authority to hospitalize any individuals they deem necessary to commit.

Current Statutory Language on Danger to Self or Others

Danger to self or others continues to serve as the primary ground for involuntary commitment in every state. The majority of state laws define danger as a risk of physical harm or injury. Danger to self is defined in most states as threats of and attempts at suicide or self-directed physical harm, and danger to others in terms of threats and attempts to physically harm others. Various states include descriptions of "grave disability" as a form of danger to self (Wyo. Stat. § 25-10-101)[11] and property damage (N.J. Stat. § 30:4-27.2)[12] or emotional injury on members of the person's family (Iowa Code § 229.1)[13] as a form of danger to others. In some

[11] "(a)(ii) 'Dangerous to himself or others" means that, as a result of mental illness, a person: (A) Evidences a substantial probability of physical harm to himself as manifested by evidence of recent threats of or attempts at suicide or serious bodily harm; or (B) Evidences a substantial probability of physical harm to other individuals as manifested by a recent overt homicidal act, attempt or threat or other violent act, attempt or threat which places others in reasonable fear of serious physical harm to them; or (C) Evidences behavior manifested by recent acts or omissions that, due to mental illness, he is unable to satisfy basic needs for nourishment, essential medical care, shelter or safety so that a substantial probability exists that death, serious physical injury, serious physical debilitation, serious mental debilitation, destabilization from lack of or refusal to take prescribed psychotropic medications for a diagnosed condition or serious physical disease will imminently ensue, unless the individual receives prompt and adequate treatment for this mental illness…"

[12] "i. 'Dangerous to others or property' means that by reason of mental illness there is a substantial likelihood that the person will inflict serious bodily harm upon another person or cause serious property damage within the reasonably foreseeable future. This determination shall take into account a person's history, recent behavior and any recent act, threat or serious psychiatric deterioration."

[13] "20. 'Seriously mentally impaired' or 'serious mental impairment' describes the condition of a person with mental illness and because of that illness lacks sufficient judgment to make responsible decisions with respect to the person's hospitalization or treatment, and who, because of that illness meets any of the following criteria:…b. Is likely to inflict serious emotional injury on members of the person's family or others who lack reasonable opportunity to avoid contact with the person with mental illness if the person with mental illness is allowed to remain at liberty without treatment."

states, the statutory definition of danger to self or others is also used to define "mental illness" (Neb. Rev. Stat. § 71-908)[14].

Most statutory definitions lack precision of the probability, frequency, and imminence of harm described in the statutes—the elements that could be helpful to establish that an individual poses a danger to self or others. The majority of states uses some type of language in their statutes to indicate that there should be a "substantial likelihood or probability" that harm will occur within the "near or immediate future" or "imminently" (Colo. Rev. Stat. § 27-65-105;[15] Haw. Rev. Stat. § 334-59;[16] Mont. Code § 53-21-129[17]) if the person is not detained, and that this prediction of harm needs to be based on "recent" acts or threats of violence (Neb. Rev. Stat. § 71-908;[4] Va. Code § 37.2-808[18]). On the other hand, a few states actually include a timeframe in their commitment laws. In New Hampshire, for instance, threats or actions of harm to self or

[14] "Mentally ill and dangerous person means a person who is mentally ill or substance dependent and because of such mental illness or substance dependence presents: (1) A substantial risk of serious harm to another person or persons within the near future, as manifested by evidence of recent violent acts or threats of violence or by placing others in reasonable fear of such harm; or (2) A substantial risk of serious harm to himself or herself within the near future, as manifested by evidence of recent attempts at, or threats of, suicide or serious bodily harm or evidence of inability to provide for his or her basic human needs, including food, clothing, shelter, essential medical care, or personal safety."

[15] "(1) Emergency procedure may be invoked under either one of the following two conditions: (a)(I) When any person appears to have a mental illness and, as a result of such mental illness, appears to be an imminent danger to others or to himself or herself or appears to be gravely disabled, then a person specified in subparagraph…"

[16] "(a) Initiation of proceedings. An emergency admission may be initiated as follows: (1) If a law enforcement officer has reason to believe that a person is imminently dangerous to self or others, the officer shall call for assistance from the mental health emergency workers designated by the director…"

[17] "(1) When an emergency situation as defined in 53-21-102 exists, a peace officer may take any person who appears to have a mental disorder and to present an imminent danger of death or bodily harm to the person or to others…"

[18] "A. Any magistrate shall issue, upon the sworn petition of any responsible person, treating physician, or upon his own motion, an emergency custody order when he has probable cause to believe that any person (i) has a mental illness and that there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future, (a) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any…"

others must have occurred within 40 days of the filing the petition for emergency commitment (N.H. Rev. Stat. § 135-C:27).[19] In Pennsylvania, danger to others is established based on evidence of the person inflicting or attempting to inflict serious bodily harm on self or others within the past 30 days and that there is a reasonable probability that such conduct will be repeated. For individuals believed to be "gravely disabled," a reasonable probability must exist that "death, serious bodily injury or serious physical debilitation would ensue within 30 days unless they are detained" (50 PA. Cons. Stat. § 7301).[20]

Although Lenell's (1977) previously discussed arguments were based only on California's LPS Act and made 45 years ago, statutory definitions of dangerous to self or others remain vague and broad across states. While states vary on which terms are used in their statutes regarding danger, all states seem to accomplish the same goal of generalizing what dangerous actions or threats are with broad definitions. Due to the impreciseness and broadness of the terms, the decision to commit someone typically falls upon personal judgments of authorities as to what constitute dangerous behaviors.

[19] "I. As used in this section 'danger to himself' is established by demonstrating that: (a) Within 40 days of the completion of the petition, the person has inflicted serious bodily injury on himself or has attempted suicide or serious self-injury and there is a likelihood the act or attempted act will recur if admission is not ordered; (b) Within 40 days of the completion of the petition, the person has threatened to inflict serious bodily injury on himself and there is likelihood that an act or attempt of serious self-injury will occur if admission is not ordered; or… II. As used in this section "danger to others" is established by demonstrating that within 40 days of the completion of the petition, the person has inflicted, attempted to inflict, or threatened to inflict serious bodily harm on another."

[20] "(b) Determination of Clear and Present Danger.--(1) Clear and present danger to others shall be shown by establishing that within the past 30 days the person has inflicted or attempted to inflict serious bodily harm on another… (2) Clear and present danger to himself shall be shown by establishing that within the past 30 days: (i) the person has acted in such manner as to evidence that he would be unable, without care, supervision and the continued assistance of others, to satisfy his need for nourishment, personal or medical care, shelter, or self-protection and safety, and that there is a reasonable probability that death, serious bodily injury or serious physical debilitation would ensue within 30 days unless adequate treatment were afforded under this act; or (ii) the person has attempted suicide and that there is the reasonable probability of suicide unless adequate treatment is afforded under this act… (iii) the person has substantially mutilated himself or attempted to mutilate himself substantially and that there is the reasonable probability of mutilation unless adequate treatment is afforded under this act…"

Less Restrictive Alternatives to Commitment

In some jurisdictions, the unavailability of a "less restrictive alternative to hospitalization" applies as one of the commitment criteria. In *Lessard v. Schmidt* (1972), the court ruled that no person could be committed unless all available less restrictive alternatives were explored and deemed unsuitable prior to an involuntary commitment decision, including voluntary or court-ordered out-patient treatment, day treatment in a hospital, night treatment in a hospital, placement in the custody of a friend or relative, placement in a nursing home, referral to a community mental health clinic, and home health aide services. Although "less restrictive alternatives" has become a concept in mental health law that is often talked about, little is known about it. Indeed, it is unclear how many states even have adopted least restrictive alternatives as a legal or operational criterion and exactly what constitutes least restrictive alternatives in each state.

While a few US studies have looked at this variable, only one study conducted in Virginia defined alternatives to hospitalization in terms of short-term crisis intervention, residential crisis stabilization, and in-home crisis stabilization (McGarvey et al., 2013). The study found that the unavailability of these services was a significant predictor of clinicians' decision to commit an individual, among 2,464 individuals who were evaluated for emergency detention. In another study that examined 583 individuals who were held for emergency detention in California, the availability of a less restrictive alternative to hospitalization was associated with a 54 percent reduction in the clinicians' decision to commit (Segal et al., 2001). More studies are needed to understand potential impacts of the availability of less restrictive alternatives on the decision for commitment, and whether the mere existence of a criterion by law makes a difference in commitment decisions.

Procedural Due Process

Procedural due process under the Fourteenth Amendment refers to the legal procedures the state must follow—including notice, opportunity for hearing, confrontation and cross-examination, discovery, basis of decision, and availability of counsel—before it deprives an individual of life, liberty, or property (Library of Congress, n.d.). *Lessard v. Schmidt* (1972) was an early and highly influential case that raised the issue of the severe lack of procedural due process for involuntary commitment. In its decision, the court recognized that the Wisconsin procedure for commitment denied due process by (1) failing to require effective and timely notice of the "charges" to the person subjected to commitment; (2) failing to require adequate notice of all rights; (3) permitting detention longer than 48 hours without a probable cause hearing; (4) permitting detention longer than two weeks without a full hearing on the necessity for commitment; (5) failing to provide the right to be represented by a counsel; (6) failing to provide for the exclusion of hearsay evidence and for the privilege against self-incrimination; (7) permitting commitment without proof beyond a reasonable doubt that the patient is both "mentally ill" and "dangerous;" and (8) failing to consider less restrictive alternatives to commitment. Because portions of the *Lessard* decision were eventually overturned and did not stand as a binding precedent, it is not a marker in the law that would hold other states to enforce procedural due process requirements during commitment proceedings (Stone, 2016). As a result, there is no consensus among jurisdictions about which due process protections are required during commitment proceedings.

All of these due process requirements are typically afforded to a person charged with a criminal offense. Some have argued that, although people subjected to commitment are deprived of liberty just like criminal defendants and confinement against one's will more closely

resembles the consequences of criminal punishment than of treatment, the individual subjected to commitment is not provided with the procedural safeguards that a criminal defendant is provided (Stone, 2016; Tsesis; 2011). Stone specifically recommended that all state laws should extend the *Miranda* protections to individuals detained by police (including being warned prior to questioning, as well as the right to remain silent and not say anything that can be used against them in commitment hearings), require the burden of proof to be the beyond a reasonable doubt standard and hearsay to be inadmissible during commitment hearings, and provide persons facing commitment hearings a right to an independent psychiatric evaluation.

One due process right that all 51 jurisdictions provide to individuals subjected to commitment is the right to be represented by counsel in their defense during a court hearing, which is held to determine whether the person should be committed. In criminal proceedings, the lawyer typically adopts the adversarial model of representation, which is characterized by advocating for the client's expressed desires, even if the lawyer deems it is against the client's best interest (Cook, 2000). In commitment hearings, however, the role and responsibility of counsel are often confused, because, unlike other types of attorneys, the standards set by the American Bar Association provide little guidance on the duty of an attorney representing an individual who may not be "competent" to make decisions for oneself due to symptoms of psychosis (Stone, 2002). There are two styles of representation that an attorney typically adopts in commitment hearings: the adversarial approach and the best interest approach (Cook, 2000; Ferris, 2008). The attorney adopting the adversarial model would advocate for the client's maximum liberty, despite the doctor's recommendation and family desires for commitment. The other model of representation is the "best interests" approach, which, based on the *parens patriae* model, assumes that the "mentally ill" individual is unable to make a decision for oneself and,

therefore, the attorney is in the best position to make a decision the individual would make if they were not "mentally ill" (Cook, 2000).

While due process theory requires a formal adversarial judicial hearing, a large gap exists between law theory and practice of commitment (Winick, 1999). The reality has been that lawyers rarely take an adversary role to pursue release of individuals subjected to commitment—they predominantly assume a paternalistic role by using the best interest approach to secure commitment of the individual they are representing. In an empirical study that observed 479 commitment hearings in North Carolina, Hiday (1981) found that lawyers, most of whom were appointed, were less likely to challenge the medical affidavit and were more likely to have either stipulated to it or said nothing about it. Furthermore, while failure to record appropriate facts on the medical affidavit could be cause for dismissal of the action, counsel rarely argued for dismissal or challenged the medical reports. In another North Carolina study that examined 388 commitment hearings, Miller et al. (1983) found that the attorneys represented the clients' wishes of being released in just 48% of cases and instead recommended outpatient commitment. Perlin (2008) concluded that very little has changed in this reality of counsel representation during commitment hearing since the 1980s, when this topic began to receive attention in the literature, stating "it is the near-universal reality that counsel assigned to represent individuals at involuntary civil commitment cases is likely to be ineffective" (p. 241).

Studies have also shown that judges defer to psychiatric judgments, instead of taking an adversarial approach. A study that analyzed commitment decisions made by five judges in Massachusetts found that 32 (91%) out of 35 hearings resulted in commitment, two "continued," and one unknown (Bursztajn et al., 1986). The psychiatrist's opinion was reported to have the greatest impact on the judicial commitment decision in this study. Another study in Colorado

showed one judge committed 24 (89%) of the 27 people whom psychiatrists petitioned for commitment, denied psychiatrist's petition for commitment in two cases, and "continued" one case (Bursztajn et al., 1997). According to Brooks (2010), judges defer to psychiatric opinion because most jurisdictions give judges little or no training in mental health and, thus, judges feel they lack the necessary expertise to independently assess whether a person meets the commitment criteria. Judges are also more likely to take a non-adversarial approach to the commitment process because it is the safest course of action: just as the doctor could face negative consequences if something happens to the person whom the doctor releases, so could a judge. While the court is supposed to serve as a check on psychiatric decision-making, Brooks argued, all too often it fails to serve this function.

In Virginia, it was found that mental health professionals are most likely to seek involuntary commitment and court hearings are most likely to result in either involuntary commitment or voluntary admission (University of Virginia, 2008). During the temporary detention order (TDO) period, an "independent examiner" (IE)[21] is statutorily required to conduct an evaluation to determine whether the person meets the commitment criteria and to submit a certification of their finding to the court before the hearing. About 84% of the IE commitment certifications were positive for a probable cause to involuntarily commit the person ("positive to commit"). If the IE certification is negative for a probable cause to involuntarily commit the person ("negative to commit"), some judges or special justices do not convene a hearing at all, while others do. Among cases in which IE certification was "positive to commit," 58% of hearings resulted in an involuntary inpatient commitment, 30% resulted in a voluntary inpatient admission, 6% of cases were dismissed, 5% resulted in an involuntary outpatient commitment,

[21] A physician, psychologist, or other licensed mental health professional.

and less than one percent resulted in a voluntary outpatient commitment. When the IE certified negative to commit, more than half of the cases were dismissed and the person was released (65%).

The lack of formality could also be the reason why commitment hearings are less adversarial. Unlike other types of hearings, commitment hearings are usually held in psychiatric facilities instead of the courthouse and tend to be very brief; the hearing occurred in the hospital in 91% of cases and lasted 15 minutes or less in 57% of cases (University of Virginia, 2008). In some states (even before the COVID-19 pandemic), the physical presence of a judicial officer is not required and judicial telepresence at commitment hearings is permitted (Pearson & Ciccone, 2018). When it comes to lay witness testimony, a study found that it was used only in 83 hearings (out of 388), and 214 potential witnesses were prevented from testifying by the presiding judge (Miller et al., 1983). What is more troubling is a 2017 investigation reporting that nearly 98 percent of people who were subjected to commitment in Duval County, Florida, did not even receive hearings they were entitled to by law (Bourne, 2017). Overall, the lack of an adversarial approach and formality in commitment hearings appear to undermine the procedural protections mandated by procedural due process.

Involuntary Commitment Laws and Admissions to Psychiatric Hospitals

Appelbaum (1994) wrote an oft-cited book on mental health law reforms in the US. One of its main topics was the first wave of reform in involuntary civil commitment law from the late 1960s through the late 1970s. Appelbaum described how every single state changed or introduced new laws restricting commitment to persons evaluated to be dangerous to themselves as a result of mental illness, in contrast to a discretionary medical decision that characterized

admission to state hospitals since the mid-1800s (all of which was involuntary), as well as the states' adoption of more procedural protections of the criminal model to commitment.

Appelbaum (1994) argued that the changes initially seemed revolutionary and progressive. However, it was revealed over time that the changes in the law did not end up having as much impact on the functioning of the mental health system as had been expected. Particularly, Appelbaum's review of studies demonstrated inconsistent findings on the aggregate effects of new commitment statutes, usually of a single jurisdiction, on rates of commitment: while some states experienced decreases in rates, others experienced no changes or reported immediate decreases but subsequent increases. As Appelbaum described, it was possible that the relevant actors in the commitment system, such as mental health professionals, judges, and lawyers, practiced the law differently than how it was written—they bent and interpreted the laws to commit individuals presumed to be mentally ill regardless of whether they actually met the criteria. Therefore, Appelbaum concluded that the reform in mental health law from the late 1960s through the late 1970s was "almost a revolution."

To understand the current literature on the association between involuntary commitment laws and rates of commitment, a broad PubMed literature search was conducted for articles written in English and published before January 1, 2021, using the following search terms: ("involuntary commitment" OR "involuntary hospitalization" OR "involuntary hospitalizations" OR "civil commitment" OR "emergency detention" OR "emergency detentions") AND (law OR legal OR statute). This search produced 952 results. After reviewing the titles and abstracts, nine studies were selected because of their relevance to involuntary commitment laws and rates.

The nine studies evaluated the impact of the legislative changes of the 1960s and 1970s on admissions to state mental hospitals. These studies, which might overlap with those included

in Appelbaum's (1994) review, compared changes in number and/or percentage of admissions to state mental hospitals (overall and/or by involuntary vs. voluntary) in a single state or few states before and after the legislative changes were made during the first or second wave of reform. Miller's (1992) was the latest study that examined admissions to the state mental hospitals of eight states that added need for treatment criteria to their commitment laws between 1975 and 1990 (during the second wave of reform).

The findings of the nine studies were ambiguous, coinciding with Appelbaum's (1994) results. Using an interrupted time-series design, Peters et al. (1987) found that involuntary admissions to state hospitals in Florida decreased for the three years following the enactment of the Baker Act. In a series of articles, Durham and colleagues' analysis of the Washington commitment law—before and after the enactment of the expanded statutory definition of grave disability during the second wave of reform—showed that involuntary admissions in two state mental hospitals increased between 1977 and 1980 (Durham & Pierce, 1982; Durham, 1985; Durham & La Fond, 1985; Durham & Pierce; 1986). Other studies showed a temporary decrease in involuntary admissions; in several states, the enactment of new commitment law was immediately followed by a return to the level under the previous statute during both the first and second waves of reform (Faulkner et al., 1982; Frydman, 1980; Miller, 1992; Wanck, 1984). A number of states also showed an increase or decrease in voluntary admissions to state mental hospitals after changes in the law were made (Faulkner et al., 1982; Frydman, 1980; Peters et al., 1987; Wanck, 1984).

Based on the existing literature, the specific impact of legislation on rates of commitment cannot not be determined. Besides methodological limitations such as the lack of use of an interrupted time-series analysis, which would be the most appropriate study design to use, the

studies failed to take into consideration deinstitutionalization and other sociodemographic and economic characteristics of states. In regard to the impacts of laws specifically, (1) the substantive criteria, such as the danger to self or others, might not have had any impact on admissions because the statutory language did not end up being explicit or precise, and instead allowed the criteria to be flexibly or arbitrarily applied; and (2) the impacts of procedural rules on admissions could depend on how admission is defined. If admission is defined in terms of when a person is admitted under emergency detention, procedural rules might not be associated with admission rates because they are afforded to the person after the detention. Most important, since few or no studies have been conducted in recent decades, whether the older findings might hold in the current time is unknown.

Significance of Revisiting the Research

Research on the association between involuntary commitment laws and incidences of commitment should be revisited now for several reasons. First, compared to the 1960s and 1970s, state mental hospitals are no longer the dominant institution in the mental health system. The enactment of various health and social disability insurance programs, such as Medicaid, Medicare, SSI, and SSDI, transformed the delivery, management, and funding of mental health services by diverting much of the state responsibility for individuals assumed to be mentally ill to a diverse array of for-profit and not-for-profit providers and contractors, including nursing homes, board and care homes, adult homes, and other institutional and residential settings in the community (Morrissey & Goldman, 2020). Furthermore, Medicare and Medicaid funding, as well as the third-party reimbursement and managed care plans, have encouraged the use of inpatient psychiatric services in general hospitals rather than state mental hospitals. Currently, many states restrict access to their state mental hospitals to forensic commitment or to

individuals who have already had an initial psychiatric hospitalization at a general hospital or private psychiatric hospital and require longer-term commitment (Lutterman et al., 2017).

The passage of the Affordable Care Act (ACA) in 2010 also allowed greater financial security and access to treatment for people with mental illnesses and substance use disorders by expanding the Medicaid program (Glied & Frank, 2020). To date, 39 states (including DC) have adopted the Medicaid expansion under the ACA (Kaiser Family Foundation, 2021). The ACA requires all health plans to cover mental and behavioral health inpatient services. It also helps to cover healthcare costs for a large number of low-income individuals who might have mental health issues but who do not qualify for disability-based insurance. It does this by making subsidies available to cover the cost-sharing requirements in health plans for those with incomes below 250% of the federal poverty line (Glied & Frank, 2020). Subsidized private insurance has also been made available to people whose incomes do not qualify for Medicaid under the ACA. As a result of the ACA, more people have access to mental health and addiction services these days compared to the 1960s.

Besides the different mental health system, society is faced with different social problems that are interrelated with the mental health system than it did in the 1960s and 1970s. The current concerns of society include suicide, homelessness, and mass shootings, all of which can be related to the relevance of the involuntary commitment system. Although involuntary commitment is designed to address behaviors due to mental illness that are deemed dangerous to self, suicide rates continue to rise in the US, with the age-adjusted suicide rate increasing 33%—from 10.5 per 100,000 in 1999 to 14.0 per 100,000 people in 2017 (Hedegaard et al., 2018). As a way of addressing California's rise in homelessness, Governor Gavin Newsom recently called for the expansion of involuntary treatment to grant officials more authority to control homeless

individuals, some of whom are deemed unable to care for themselves due to mental illness (Thomson, 2020). Furthermore, mass shootings often reignite a call to reform the mental health system. In response to 2019's twin mass shootings in El Paso, Texas and Dayton, Ohio, President Trump remarked in his speech, "We must reform our mental health laws to better identify mentally disturbed individuals who may commit acts of violence and make sure those people not only get treatment but, when necessary, involuntary confinement. Mental illness and hatred pulls the trigger, not the gun" (as cited in Kenigsberg, 2019). Given a different set of social forces and social attitudes that are interrelated with attitudes about mental illness and the mental health system, examining the association between commitment laws and rates of commitment at this time is warranted.

CHAPTER 3

State Data on Involuntary Commitment

Incidences of Involuntary Commitment

There is no national database that periodically tracks involuntary commitment in the US. Until recently, no one could answer the question of how often commitment occurs. Lee and Cohen (2021) published an article that estimated the incidence of commitment using counts obtained from states that made them publicly available (mostly from websites of each state's department of mental health or court system). Using data from 24 states that make up 52% of the country's population, they counted a total of 591,000 detentions in 2014 and estimated a rate of 357 emergency detentions per 100,000 people that year. They also found that, between 2011 and 2018, all-ages emergency detention per 100,000 people ranged from 29 in Connecticut to 966 in Florida (a 33-fold variation). Across only eight states that made longer-term commitment data publicly available, average annual state rates per 100,000 people ranged from 25 in Oklahoma to 159 in California during the same study years.

In discussing limitations of their findings, Lee and Cohen (2021) pointed out that the validity of the estimates was weakened by the low interpretability of the data sources, as these tended to contain vague descriptions or little accompanying information. For instance, 15 states did not specify whether the counts corresponded to emergency detention or longer-term commitment, in which case the authors treated them as emergency detentions. Despite these limitations, Lee and Cohen's findings suggest that involuntary commitment rates could vary substantially across states. However, the absence of a national database and the states' release of incomplete counts with vague information impede efforts to gain an accurate understanding of

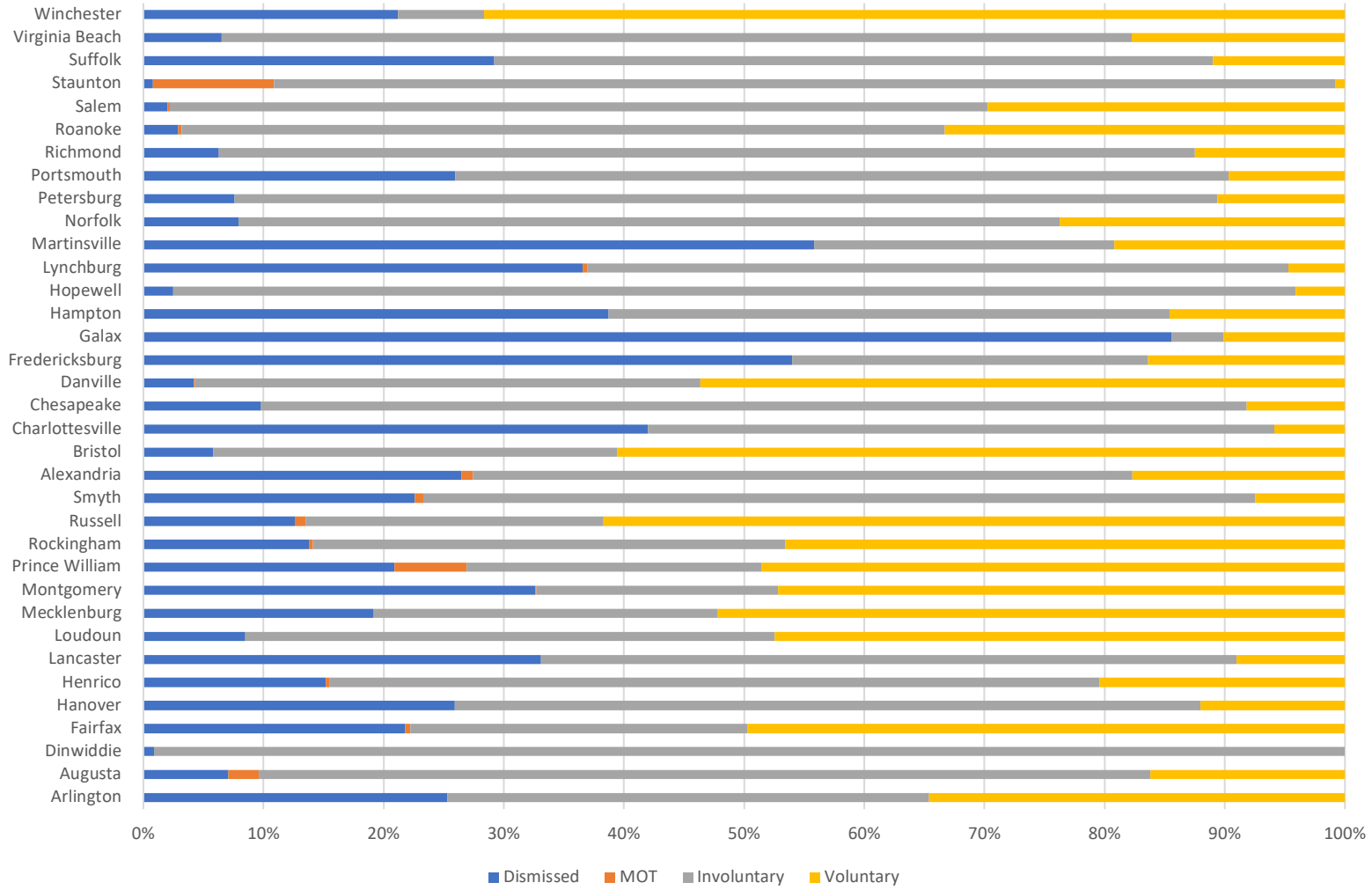
the variation in rates of involuntary commitment, including why the variation might exist across the country.

Variations in rates of commitment have also been observed within a single state, in terms of hearing outcomes. In Virginia, among 21,549 commitment hearings conducted in FY 2010, 57.4% of hearings resulted in involuntary commitment, 22.7% resulted in voluntary hospitalization, 19.5% of these hearings resulted in dismissal, and less than 1% resulted in mandatory outpatient treatment (MOT) orders (Commission on Mental Health Reform, 2010). Created for this dissertation, Figure 3.1[22] is a visual representation of the distribution of the four outcomes of the hearings across Virginia's 35 district courts (where these hearings were held), adapted from the numbers in the Commission on Mental Health Reform's report. It shows some variations in how the outcomes of commitment hearings are distributed, although it appears that hearings resulted in involuntary commitment or voluntary hospitalization in most district courts.

[22] This graph was created using Excel.

Figure 3.1

Distribution of the Four Different Hearing Outcomes Across Virginia District Courts (Adapted from Commission on Mental Health Reform, 2010, pp 7-8)



Admissions to Inpatient Psychiatric Facilities

Unlike involuntary commitment numbers, the number of admissions to inpatient psychiatric facilities at the state level is tracked by SAMSHA with its Uniform Reporting System (URS). This is part of the Community Mental Health Block Grant that requires states receiving the grant to compile and report aggregate data related to the state mental health system, such as numbers and sociodemographic characteristics of individuals served by the states, outcomes of care, use of selected evidence-based practices, assessment of care, insurance status, living situation, employment status, and readmission to state psychiatric hospitals within 30 and 180 days (NRI, 2020a; SAMHSA, 2022). Based on these data, the SAMHSA creates yearly URS output tables for each state. These annual URS data are available from 2014 to 2021 and can be accessed online by the public (SAMHSA, n.d.). Because states are not required to report data on all measures, some measures might have missing data.

An annual URS output table provides state-level numbers of admissions to inpatient psychiatric settings, including state psychiatric hospitals and "other psychiatric inpatient care," for adults and children. Although the output tables provide no detailed descriptions of the data, according to the NRI's "2020 URS Data Definitions," "other psychiatric inpatient care" is defined as follows:

> Other psychiatric inpatient care refers to inpatient psychiatric services provided in a private psychiatric hospital, a psychiatric bed in a general hospital, or any other psychiatric inpatient bed that is not part of state psychiatry hospital. Examples of Other Psychiatric Inpatient Care settings include:
>
> Private psychiatric hospital: a facility licensed and operated as a private psychiatric hospital that primarily provided 24-hour inpatient care to persons with mental illness.
>
> Separate inpatient psychiatric unit of a general hospital: a licensed general hospital (public or private) that provides inpatient mental health services in at least one separate psychiatric living unit. This unit must have specifically allocated staff and space (beds) for the treatment of persons with mental illness. The unit may be located in the hospital

> itself or in a separate building, either adjacent or more remote, and is owned by the hospital. It may also provide 24-hour residential care and/or less than 24-hour care (e.g., outpatient, day treatment, partial hospitalization), but these additional service setting are not requirements (NRI, 2020b, p. 9).

In terms of "admission," the only definition provided is "the number of persons admitted, readmitted, or transferred to a specified service setting during the reporting period" (NRI, 2020b, p. 1). The URS does not report whether admissions are voluntary or involuntary.

Another possible source of admission data is the State Inpatient Databases (SID), collected by the Agency for Healthcare Research and Quality (AHRQ) as part of the Healthcare Cost and Utilization Project (HCUP). The SID, which are derived from hospital billing data, contain a "core file" containing common variables and state-specific variables (AHRQ, 2021a). Variables common to all SID include patient demographics, diagnoses and procedures, expected payer, length of stay, admission source and type, and admission month. State-specific variables (information that may not be available from all participating states) include race and ethnicity, patient county and ZIP Code, severity of illness, primary payer details, secondary payer, and physician specialty.

When participating states submit their data to the HCUP, it processes the data into a uniform set, making State-by-State comparisons feasible (AHRQ, 2021a). The SID are made available only by purchase through the online HCUP Central Distributor. Each state that participates sets its own price for the SID, and the prices may also vary depending on who is purchasing the data (AHRQ, 2022a). As of 2022, 36 states have participated in the SID, but that number varies yearly, and some measures might have missing data (AHRQ, 2022b).

The types of hospitals included in the SID depend on the information provided by the state data source. Most provide information on community hospitals, defined by the American Hospital Association as "all nonfederal, short-term, general and other specialty hospitals,

excluding hospital units of institutions" (AHRQ, 2021b). If reported by the state data source, facilities such as psychiatric facilities, alcohol and drug dependency facilities, and State, Federal, and Veterans Affairs hospitals will be included in the SID (AHRQ, 2021b). The SID does not collect information about whether a psychiatric inpatient admission is voluntary or involuntary (Lutterman et al., 2017; Singh, 2020). However, two variables in SID, "admission source" (AHRQ, 2008a) or "point of origin" (AHRQ, 2008b), which report whether an inpatient admission is requested by a law enforcement authority and/or a court order, may be used as a proxy measure for involuntary psychiatric inpatient admission, if states provide such information (Singh, 2020).

Despite Lee and Cohen's (2021) findings that provide useful insight into how rates of commitment could vary by state, comparing these rates is limited by the fact that they are not available from every state. Other currently available data relevant to involuntary commitment are the numbers of admissions to inpatient psychiatric facilities collected by different federal agencies, such as the SAMHSA (freely available) and AHRQ (via purchase). These data have limitations: they do not have annual data from all 51 jurisdictions, nor do they differentiate the admission type by voluntary and involuntary.

CHAPTER 4

State Laws on the Court Involvement during Initial Commitment Proceedings: Literature Review

Although commitment laws in general are known to vary across states, there is very limited evidence on whether and how commitment proceedings vary across 51 jurisdictions. Under the Fourteenth Amendment, procedural due process requires the state to follow certain legal procedures before it deprives an individual of life, liberty, or property. At minimum, it guarantees the person notice, the opportunity to be heard, and a decision by a neutral decision-maker (Cornell Law School, n.d.-b). In this chapter, I review a few existing reports and empirical studies on state statutes governing the court involvement during the initial commitment phase.

Emergency Detention Laws

Hedman et al.'s (2016) study is the only peer-reviewed empirical study to describe how the laws governing "emergency commitment" procedures vary across 51 jurisdictions (including DC) in the US. These authors built a dataset of all 51 states' statutes governing emergency commitment,[23] which was made publicly available by Temple University's Center for Public Health Law Research, as part of their LawAtlas project under the Policy Surveillance Program (n.d.-a). According to its website, "The Policy Surveillance Program is dedicated to increasing the use of policy surveillance and scientific legal mapping as tools for improving the nation's health" (Temple University, 2017). The LawAtlas projects are primarily funded by the Robert Wood Johnson Foundation. Other funders include the US Centers for Disease Control and Prevention, the World Health Organization, Pew Charitable Trusts, and Arnold Ventures.

[23] Policy Surveillance Program also published a separate legal dataset for longer-term commitment (Policy Surveillance Program, n.d.-b).

Hedman et al. (2016) applied public health law research (PHLR), defined as the "scientific study of the relation of law and legal practices to population health" (Wagenaar & Burris, 2013, p. 4). In general, PHLR examines how the policy-making process, patterns and distributions of law across jurisdictions and over time, and implementation of policy, all affect physical and social environments, individual behavior, and population health. It consists of five types of studies—policymaking, mapping, implementation, intervention, and mechanism studies—which entail different methods. Hedman et al. specifically employed the methods used for mapping studies to create a legal dataset for emergency detentions. While traditional legal research provides narrative descriptions of how one or more laws differ in both their text and their meaning, mapping studies involve coding of legal texts, classifying features of laws into categories to examine the variation in laws across different geographical areas.

Hedman et al. (2016) coded legal texts of emergency commitment statutes of all 50 states and DC into 11 categories or variables representing key features, including legal criteria, duration of emergency hold, who can initiate emergency detention, and whether judicial review of an emergency detention is required. Among different findings, they showed that the length of emergency detentions ranged from 23 hours in North Dakota to 10 days in New Hampshire and Rhode Island. Additionally, Hedman et al.'s assessment of the court involvement during emergency detention showed that 22 states require court approval for an emergency detention (the authors use "detention" interchangeably with "admission"). Nine states (Arkansas, Colorado, Florida, Kentucky, Maryland, Mississippi, New York, Virginia, and Vermont) require court approval before the detention, by means of an *ex parte* hearing (i.e., without the presence of the person subject to detention or their attorney). In these same nine states, the authors also indicated that the person could be placed under an emergency detention if the "health care

professional" determines that the person meets the commitment criteria. In the other 13 states (DC, Iowa, Idaho, Indiana, Kansas, Maine, North Dakota, New Hampshire, Nevada, South Carolina, Tennessee, Texas, and Wyoming), court approval is required after the admission. It was also found that, of 51 jurisdictions, emergency detention could be extended into longer-commitment without a court order in eight states (Georgia, Hawaii, Iowa, Louisiana, New York, Tennessee, Vermont, and Washington).

Hedman et al.'s (2016) findings on the court approval of emergency detention raise some questions because of the lack of clear descriptions of their findings. They found that nine states require court approval before emergency detention, but that health care professionals can also order such detention if they believe that the person meets commitment criteria. This finding can be misleading since the authors did not clarify whether this meant that no state authorizes the court as the sole decision maker for emergency detention.

Besides Hedman et al.'s (2016) peer-reviewed study, the Treatment Advocacy Center (TAC) published a (non-peer reviewed) report on its website that assessed statutes authorizing "emergency psychiatric evaluation" and "inpatient commitment" for the same 51 jurisdictions (TAC, 2020). TAC is a nonprofit organization that promotes reforming state involuntary commitment laws, implementing outpatient commitment in each state, and expanding the number of inpatient psychiatric beds across the US. According to its website, TAC is "dedicated to eliminating legal and other barriers to the timely and effective treatment of severe mental illness" (TAC, 2018).

The purpose of TAC's (2020) report was to give each state a score and grade (based on a 100-point grading scale) for inpatient commitment (including emergency evaluation) and outpatient commitment, each accounting for 50 points. TAC first described their own policy

recommendations for how state commitment laws could be revised. They then arbitrarily awarded or subtracted points if the state law included or omitted specific components that align with TAC's own policy recommendations. Figure 4.1, reproduced from TAC's report, shows which statutory components TAC measured and how the scoring was computed for inpatient commitment.

Figure 4.1

TAC's Scoring System of Emergency Evaluation and Inpatient Commitment Laws (Reproduced from TAC, 2020, p. 27)

Inpatient commitment / emergency detention: 50 points

Emergency evaluation: Up to 15 points	
Citizen access to court (emergency evaluation):	Authorizes family / enumerated adults to petition (3 points) Authorizes any responsible adult to petition (2 points)
Quality of petition process:	Procedures clear (2 points) Timelines clear (2 points) Responsible entities clear (1 point)
Potential demerits:	Requires dual certification (-2 points) Inconsistent with inpatient standard (-5 points)
Emergency hold duration:	At least 48-hour hold allowed (3 points) At least 72-hour hold allowed (2 points)
Inpatient commitment: Up to 35 points	
Citizen access to court (inpatient petition):	Authorizes family/enumerated adults to petition (3 points) Authorizes any responsible adult to petition (2 points)
Quality of criteria for danger to self/others:	Criteria for danger to self or others (10 points)
Potential demerits:	Vague/ambiguous language (-3 points) Harm must be imminent (-3 points)
Quality of criteria for grave disability:	Expressly includes criteria for grave disability (10 points)
Potential demerits:	Vague/ambiguous language (-3 points) Endangerment must be imminent (-3 points) Requires family/friends to refuse assistance (-3 points) Unreasonably severe harm required (-3 points)
Quality of criteria for psychiatric deterioration:	Expressly includes criteria for psychiatric deterioration (10 points)
Potential demerit:	Vague/ambiguous language (-3 points)
Extra credit:	Specifies court of petition (1 points)

TAC (2020) also assessed state statutes governing the court approval of emergency evaluation and inpatient commitment in 50 states and DC, but they framed it in terms of "citizen access to court." One of TAC's policy recommendations is that "any responsible adult or, at a minimum, a guardian or family member, should be authorized to petition the court for both emergency evaluation and inpatient civil commitment" (p. 16). TAC believes that "empowering" citizens to petition would allow family members, who might have the most complete knowledge of their circumstances, to be involved in the decision-making process, ensure that the commitment decision is made or reviewed by an impartial judicial officer, and prevent 911 response or police involvement. Another TAC recommendation is that states should not require "certification" by more than one professional in order to initiate emergency evaluation. TAC does not specify in their report what they mean by certification, but in state commitment laws, a "certificate" typically means a written statement affirming that a mental health professional(s) has personally examined the person subjected to detention and believes that the person meets the state's commitment criteria.

TAC (2020) measured whether states permit (1) family/enumerated adults and (2) any responsible adult to petition the court for emergency detention and longer-term commitment. Their findings are displayed in Figure 4.2, reproduced from TAC's report. The description of the findings states:

> Many states allow only professionals to initiate involuntary evaluation or treatment. We found that statutes authorizing only professionals (no citizens) to initiate proceedings were most common for emergency evaluation, with 20 states failing to provide access to the courts for citizens (p. 33).

Although TAC's descriptions of the findings are not clear, it appears that only professionals are permitted to initiate emergency detention in 20 states, while enumerated citizens/any responsible adult may petition the court for emergency detention in 31 states. Similarly, only professionals

are permitted to order inpatient commitment in 18 states and enumerated citizens/any responsible adult may petition the court for inpatient commitment in 33 states. Hedman et al. (2016) also coded which individuals can petition the court among 22 states that require court approval of emergency commitment. Their findings suggest that any interested person can initiate emergency commitment with the court in 12 states.

Figure 4.2

TAC's Findings on "Access to Courts for Citizens" (Reproduced from TAC, 2020, p. 38)

WHO CAN PETITION – EMERGENCY EVALUATION		
Only professionals	**Enumerated class(es) only**	**Any responsible adult**
Alabama, California, Delaware, District of Columbia, Hawaii, Idaho, Illinois, Indiana, Kentucky, Minnesota, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, Oklahoma, Oregon, Rhode Island, Tennessee, Washington	Nevada	Alaska, Arizona, Arkansas, Colorado, Connecticut, Florida, Georgia, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, New York, North Carolina, North Dakota, Ohio, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin, Wyoming
WHO CAN PETITION – INPATIENT COMMITMENT		
Only professionals	**Enumerated class(es) only**	**Any responsible adult**
Alaska, Arizona, California, Colorado, Delaware, Florida, Illinois, Maine, Maryland, Massachusetts, Missouri, Montana, Nebraska, New Jersey, New Mexico, New York, North Carolina, Washington	District of Columbia, Nevada, Oklahoma, Rhode Island, Tennessee	Alabama, Arkansas, Connecticut, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Michigan, Minnesota, Mississippi, New Hampshire, North Dakota, Ohio, Oregon, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin, Wyoming

While Hedman et al.'s (2016) study and TAC's (2020) report are the only papers to address emergency detention laws of all 50 states and DC, neither is clear on findings nor seems to have assessed the variables in the same way, which makes it difficult to see clearly whether and how legal procedures associated with emergency detention vary across states. Another inconsistent finding relates to the variations in the duration of emergency detention across states. The duration in New Hampshire (6 hours) was shortest in TAC's (2020) report, while it was the longest (10 days) in Hedman et al.'s study; whereas the duration in North Dakota was shortest (23 hours) in Hedman et al.'s study but 4 days in TAC's report. These discrepancies could result from Hedman et al. and TAC applying different definitions of emergency detentions, but both failed to provide their definition. Under section 135-C:28 of New Hampshire's Revised Statutes, when a peace officer has probable cause to believe that someone poses an immediate danger of bodily injury to self or others unless placed in protective custody, the police officer may do so and transport them directly to a designated facility to determine whether an involuntary emergency admission should be ordered. The period of protective custody ends when the examining professional makes this determination, or at the end of *6 hours*, whichever occurs first. According to section 135-C:32, once placed under involuntary emergency admission, the person may not be detained for longer than *10 days*, excluding Saturdays and Sundays.

Technically, both Hedman et al. (2016) and TAC (2020) are correct about New Hampshire's duration of emergency detention. TAC's 6 hours is the "preliminary evaluation" period authorized for the professionals to determine whether emergency admission is required. Hedman et al., on the other hand, counted the maximum length of the state's involuntary emergency admission period as the duration of emergency detention. Still, others could perceive New Hampshire's *3-day* involuntary emergency admission period under section 135-C:31 as the

correct duration. According to this section, within 3 days after an involuntary emergency admission, excluding Sundays and holidays, a hearing is held to determine if there is probable cause for the emergency admission. Without considering that not all states strictly divide their commitment proceedings into emergency detention and longer-term commitment, definitions of emergency detention could vary based on who interprets the law. Given that states may have more than one detention period before longer-term commitment is ordered, it seems more meaningful to conceive the period before longer-term commitment broadly as the initial detention period.

State Laws on Detention Court Hearings

A law review article by Boldt (2017) assessed state laws governing the court involvement during the initial commitment period. It is different than Hedman et al.'s (2016) study and TAC's (2020) report because it reviewed a purposeful sample of state statutes to illustrate differing approaches to the court's decision-making authority at the "front end of the commitment process": Virginia's comprehensive approach; California, New York, and Massachusetts's judicial review by request; and Maryland's approach that lacks systematic judicial oversight.

Boldt's (2017) findings showed that law enforcement officers and designated mental health professionals are authorized to make initial detention determinations without judicial approval in California, Massachusetts,[24] and New York. A judicial hearing is available in these states only if the person or their representative requests it after the detention by way of *habeas corpus*. Unlike Massachusetts and New York, however, California relies on a default process that

[24] For Massachusetts, Boldt compared statutory provisions before and after the statutory reform. Before the reform, a qualified physician was permitted to "admit" a person involuntarily for up to 24 days before a judicial hearing would be required. Boldt explained that the revised statute requires a petition for longer-term commitment to be filed within three days of the emergency detention and a hearing within the following five days.

authorizes a certification review hearing. Boldt described that after a person is detained for 72 hours under California's emergency detention provision, two physicians or one physician and one psychologist may certify the individual for up to 14 days of intensive treatment. If the person is certified, a certification review hearing is conducted by a non-judicial officer, instead of a judicial officer, to determine if the person should continue to be detained for the 14-day intensive treatment. There are two ways that the court can make a detention decision under California's commitment statutes: (1) a person certified for intensive treatment may request to have judicial review of the certification by way of *habeas corpus*; (2) under the provision guiding "court-ordered evaluation," the court may order that an individual undergo a mandatory evaluation if a petition is filed, and if the court finds the individual meets the state commitment criteria.

In contrast to California, Massachusetts, and New York, Boldt (2017) described that Virginia statutory provisions governing commitment require a judicial officer to be the decision-making authority at the very front end of the commitment process. A magistrate is permitted to issue an emergency custody order based on the petition of any responsible person or a treating physician, or on the magistrate's own motion. However, a law enforcement officer is also authorized to take an individual into custody and transport them for evaluation without the magistrate's order. Once the person is detained at a designated facility, they may be released at any point during or upon the expiration of the 8-hour emergency custody period, or they may be detained beyond the 8-hour limit upon the issuance of a temporary detention order by a magistrate. Before the 72-hour temporary detention period expires, a judge or special justice conducts a hearing for longer-term commitment if the detained individual is determined to be in need of further detention.

Boldt (2017) described Maryland's approach as one lacking systematic judicial oversight. In Maryland, a person may be transported to a designated facility for evaluation on the basis of a petition submitted by a health professional or law enforcement officer without a judicial endorsement. However, if the petition is submitted by any other interested party, including family, neighbors, or friends of the individual, the court needs to endorse it. Regardless of whether the petition is endorsed or not, within 6 hours after the person is brought to an emergency facility, a physician examines the person to determine whether they meet the criteria for involuntary admission. After the examination, the person can be released unless they ask for voluntary admission or meet the criteria for involuntary admission. If the person is not released, they may not be kept at an emergency facility for more than 30 hours. If the person continues to be detained, a hearing before a judicial officer is held within 10 days of initial detention, which may also be postponed for good cause up to 7 additional days. Therefore, Boldt suggested that an individual taken into custody and transported to a facility based on an unendorsed petition could conceivably be held for 17 days without judicial review.

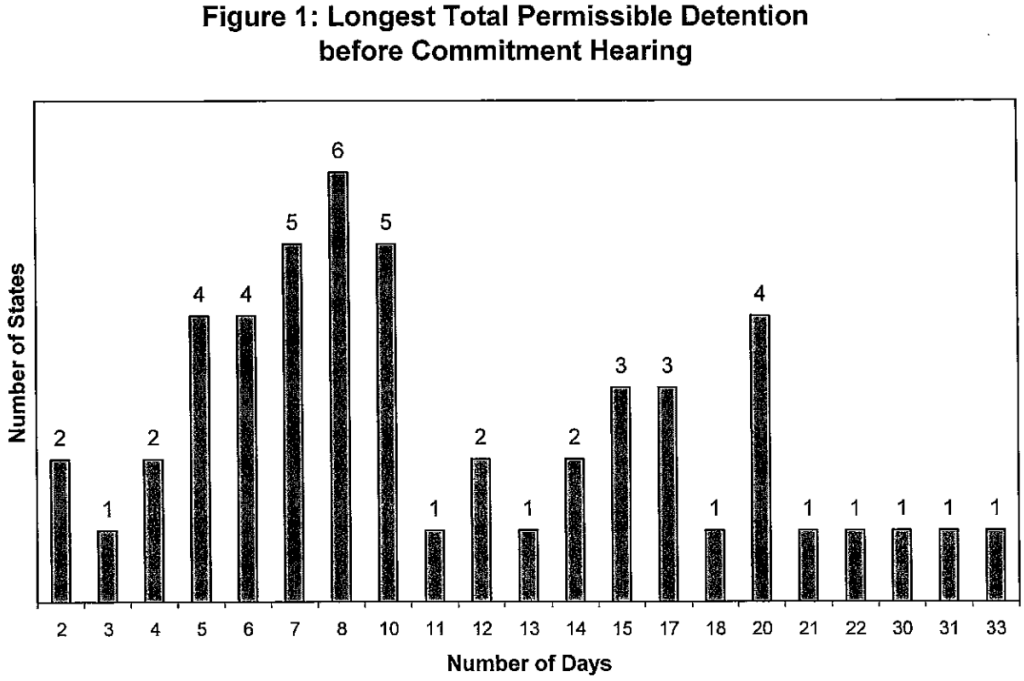
One way to interpret Boldt's (2017) findings is that states seem to have exceptions to their commitment laws. In Virginia, court approval of emergency detention is required, except if a law enforcement officer believes that the person meets commitment criteria. In Maryland, court approval of emergency detention is not required, except if the petition is submitted by an interested citizen. In California, a court hearing for continued detention is not required, except that a hearing conducted by a non-judicial officer is available and a judicial hearing can be requested. These important exceptions were not clearly captured or described in Hedman et al.'s (2016) study.

Boldt's (2017) findings suggest that state laws on the availability of hearings could vary. In states like Virginia, unless waived by the person subjected to commitment or their attorney, a hearing is scheduled and held with the presence of the person and their attorney if a designated mental health professional files a petition for continued detention. Other states like California, Massachusetts, and New York provide a judicial hearing only when the person subjected to commitment or their attorney files a petition for a hearing. State provisions could also differ on whether the hearing is statutorily required to be held by the court or non-judicial officers. Furthermore, while states like Maryland require a separate timing for a hearing that is not part of the statutory emergency detention period, a commitment hearing can be required before the expiration of the statutory emergency detention period in other states.

To my knowledge, Figure 4.3, reproduced from Barclay's (2008) report, is the only evidence that suggests variations in when the hearing is required to be held across 51 states. The figure displays that the total permissible number of days ranges from 2 to 33. According to the report, almost half of states (though they are not specified) allow for a time period ranging from five to 10 days, while the remaining states, except for five, have total maximum time periods over 10 days. Because no description accompanies the figure, it is unclear how the data were collected and whether "the permissible number of days" means the legally required number of days before the hearing.

Figure 4.3

"Longest Total Permissible Detention Before Commitment Hearing" (Reproduced from Barclay, 2008, p. 5)



Source: Pre-hearing Detention, provided to author by Professor Richard Bonnie.

One report that assessed Virginia's commitment hearings showed variations in when the hearings were actually conducted within the state (University of Virginia, 2008). Under the statute in effect during the report period, a commitment hearing was required to be held within 48 hours of TDO, unless the TDO period fell over a weekend or holiday (then it could be extended to the next business day). Among, 1,296 commitment proceedings involving adults in custody under TDO in May 2007, 37.6% of hearings were held between 24 and 48 hours of TDO and 30.1% were held within 24 hours. In 24.9% of the cases, the person was held longer than 48 hours due to the fact that it was on a weekend or holiday. About 7.5% of hearings were held more than 48 hours after the TDO was ordered even though the TDO period did not fall over a weekend or holiday. This was because a judge could delay a hearing beyond the required 48-

hour time frame if a continuance (postponement) were granted. Overall, 67.7% of hearings were held within the legislated time limits, while the other 32.4% were not (there were legal justifications for the delay).

The Association Between Initial Commitment Procedures and Incidences of Commitment

Only one US study has so far examined an association between the initial detention procedures and the likelihood of the court ordering commitment. Wancheck and Bonnie (2012) conducted an empirical study to examine the association between (1) the length of TDO and the probability of the court ordering commitment, and (2) the length of TDO and the length of commitment. They linked individual-level Medicaid hospitalization data on 500 people who had at least one TDO with known outcomes during 2008-2009 in Virginia. First, they found that a longer TDO period was associated with a lower probability (about 5-10% lower for each additional day of detention after one day) of any "hospitalization" (which included both voluntary hospitalization and commitment) compared to dismissal of petition, after controlling for sociodemographic factors. Second, they found that a longer period of days of TDO was associated with reduced days of subsequent hospitalization, after controlling for sociodemographic factors. Increasing the length of TDO from less than one to two days and less than one to three days was associated with a reduction in subsequent hospitalization of 1.25 and 2.22 days, respectively. However, total hospitalization time, including the TDO period and the subsequent hospitalization, generally increased as TDO length increased.

If commitment were characterized in terms of both TDO and longer-term commitment (not just the latter), then Wanchek and Bonnie's (2012) findings mean that more days of initial detention did not have an impact on reducing the total length of commitment. Lengthening the initial phase of detention may be associated with reducing the length of the later phase of

detention, but the total length of commitment increased as the length of initial detention period increased. However, their findings also provide some evidence that the legal procedures associated with the initial phase of commitment could be related to incidences of the later phase of commitment. A longer time to a hearing could reduce the pressure by the mental health professionals to release the person early from their emergency detention. This could allow them to treat the person who has been detained, perhaps improving the likelihood of stabilizing the person during the initial detention period.

Conceptual Framework

Although commitment law is arguably the main or oldest mental health policy that addresses inpatient psychiatric hospitalization in the US, there is still very limited understanding of commitment laws: whether and how they vary across states, how they are implemented, and how they relate to the actual practice of commitment. Findings of Hedman et al. (2016) and TAC (2020), the only known studies to review the laws of all 50 states and DC, suggest that state laws requiring a court approval of emergency detention and longer-term commitment vary across states, as does participation of non-professionals in this process. However, findings cannot be clearly interpreted because neither study is clear on their findings nor seems to have assessed the variables in the same way. Findings of Boldt's (2017) law review suggest variations in timings of when the hearing is required to be held by law across states—some states may require holding a commitment hearing before the expiration of their emergency detention period, while others may have a separate timing for a hearing that is not part of their emergency detention period. Boldt also provided other information relevant to hearings, such as whether the court hearing is available only by request and whether the hearing is required to be held by the court or non-

judicial officers. However, it is unknown whether Boldt's findings on a purposeful sample of five states could be extended to all 51 jurisdictions.

Existing literature on the association between involuntary commitment laws and rates of commitment consists only of the studies that evaluated the impact of the legislative changes of the 1960s and 1970s on admissions to state mental hospitals. Since then, the structure, users, public-private mix of mental health systems, and inpatient length-of-stays, have changed, making the studies outdated. Additionally, they mainly assessed admission rates in a single or few states before and after legislative changes in the substantive criteria and procedural protections were made.

A major challenge in conducting research on relations between commitment laws and incidences of commitment is that no standardized state-level data on involuntary commitment exist in the US. Despite Lee and Cohen's (2021) findings that provide useful insight into how rates of commitment could vary by state, comparing rates of involuntary commitment is limited by the fact that they are not available from every state in the US. The only form of currently available data relevant to involuntary commitment are the numbers of admissions to inpatient psychiatric facilities by state collected by different federal agencies, such as the SAMHSA, which are freely available online and AHRQ, available by purchase. These data do not cover all 51 jurisdictions and do not differentiate between voluntary and involuntary admission. However, admissions to inpatient psychiatric facilities could generally be used as a proxy measure for involuntary commitment. According to SAMHSA (2019a), 41.2% of individuals were admitted to inpatient psychiatric settings with an involuntary non-forensic legal status, 42.7 % were admitted with a voluntary legal status, and 16.2% with an involuntary forensic legal status on April 30, 2018.

To date, no studies have examined what might account for variations in rates of commitment across the country, particularly, whether the differences in rates of commitment could be contributed by the differences in state laws on commitment. If the basic typology of involuntary civil commitment in the US—emergency detention and longer-term commitment—is applied, where emergency detention is the initial commitment phase and longer-term commitment is the later commitment phase, then the legal procedures associated with the right to hearing, which are afforded during the initial commitment proceedings and which are held to determine if the later phase of commitment is necessary, could affect incidences of the later phase of commitment.

Research Questions

This dissertation is guided by two questions: (1) Is a court order statutorily required for involuntary psychiatric detention in each of the 51 American states (including DC)?; (2) Are state statutory timings of court hearings associated with state rates of admissions to inpatient psychiatric facilities?

CHAPTER 5

State Laws on the Court Involvement during Initial Commitment Proceedings: Methods and Results

Methods

The first aim of this dissertation was to systematically describe whether the court has the sole authority to order involuntary psychiatric detention in each of the 51 states (including DC). Specifically, the two goals of this chapter were to describe for each state (1) whether a court approval or order of the detention is required, and (2) and when a court hearing is statutorily required to be held, measured from the time a person is initially detained under emergency detention.

Legal Data Collection

The initial step was to create a legal dataset. I decided to first obtain the numbers of the sections addressing emergency detention in the statutes of all 51 US jurisdictions because they were already compiled by the Policy Surveillance Program as part of Hedman et al.'s (2016) article and were publicly available from its website. I determined that these section numbers were valid given that they were used to collect legal data for Hedman et al.'s study. I then accessed the texts of these sections via the legal database Nexis Uni (part of LexisNexis), which contains extensive legal sources including full texts of all state laws. I verified whether these sections specifically govern emergency detentions based on the terms used to indicate emergency detention in the section headings/titles or in the texts (these terms are listed in Appendix A). I was able to locate the sections guiding other commitment procedures because they are typically under the same statute that covers emergency detention. Next, I extracted the texts of these sections, which were effective in their jurisdictions as of September/October 2021. Because

states typically have separate commitment statutes for minors, the sections that I reviewed for this dissertation are assumed to apply to adults only.

Court Approval/Order of the Detention. I extracted from Hedman et al.'s (2016) study information on whether states require a court approval of the detention prior to detention and after a person is detained for emergency detention. Similarly, I extracted from TAC's (2020) report information on who may petition the court for the detention and whether states require a clinical certificate (a written statement stating that the mental health professional(s) has personally examined the person subjected to detention and believes that the person meets the state's commitment criteria) to accompany the petition.

Statutory Timings of Detention Court Hearings. To describe when a court hearing may be available from the time a person is initially detained for emergency detention, I targeted sections that specifically contained the word "hearing." "Court hearings" in this dissertation refers to hearings conducted by a judge or judicial officer such as a magistrate or justice of the peace.

Involuntary commitment proceeding may not be clearly divided into emergency detention and longer-term commitment in state statutes. For instance, some statutes may have a provision for a preliminary evaluation/detention period that is applied when a person arrives at a facility to determine whether the person should be admitted for emergency detention. Similarly, other statutes may permit the emergency detention of a person when they arrive at the facility pending a court order. For this reason, I define the initial emergency detention as the time when a person is taken into custody by a law enforcement officer for emergency detention, or arrives at a facility for emergency detention or pending admission for emergency detention.

Some statutes specify when a hearing must be available from the time of the initial emergency detention. For instance, in Wisconsin, a probable cause hearing is to be held within 72 hours after the individual is taken into custody under emergency detention, excluding Saturdays, Sundays and legal holidays (Wis. Stat. § 51.20). Most statutes indicate when a hearing is held from the time a petition is filed with the court. For these states, I went backward to compute when a hearing is available from the time of the initial emergency detention. For example, section 5254 of the California Welfare and Institutions Code describes that a hearing is held within 4 days of the date on which the person is certified for intensive treatment. According to section 5250, the person is certified before the expiration of the 72-hour emergency detention period. Therefore, I added 3 days (72 hours) and 4 days to suggest that a hearing is held within 7 days of the initial emergency detention in California.

Only approximate timings could be computed for some states because of missing information in their statutes. Under section 5-208 of Oklahoma Statutes, for example, a person receives an initial assessment at the appropriate facility by a mental health professional within 12 hours of being placed in protective custody for the purpose of determining whether emergency detention is warranted. If, upon examination, the mental health professional determines that emergency detention is warranted, the person is detained for a period not to exceed 120 hours or 5 days, excluding weekends and holidays, unless a petition requesting involuntary commitment or treatment is filed. However, under section 5-415 of Oklahoma Statutes that guides hearing procedures, it states, “upon receiving a petition alleging a person to be a person requiring treatment, the court shall set a day and time for the hearing.” Because I could not determine exactly when the hearing must be held based on this description, I added 12 hours (the

preliminary evaluation period) and 5 days of detention to suggest that the hearing can be held at least after 5.5 days of the initial emergency detention.

Additional information related to statutory timings of hearings was obtained. Based on Boldt's (2017) findings, I collected information on whether a state permits a court hearing by request, and when this hearing must be conducted once requested by the detained person or their attorney, and whether the hearing is held by non-judicial officers. Using findings from Virginia's commitment hearings (University of Virginia, 2008), I also collected information on whether states permit a postponement of the hearing at the request of one of the parties, and whether states include or exclude Saturdays, Sundays, and legal holidays in their timings of the hearings, if this information were available in the statutes. Lastly, while reviewing the laws, I learned that some states require more than one hearing for the court (or non-judicial officers) to order longer-term commitment: a preliminary (probable cause) hearing and a final (full) hearing. I computed statutory timings of the additional hearing from the time of the initial emergency detention if the relevant information was available in the statutes.

Reliability Check on the Statutory Timings of the Hearings

Two of the dissertation committee members, DC and RB, each randomly assigned to 12 different states, independently verified my results on the statutory timings of the hearings. They were provided with the access to the legal texts that I retrieved from Nexis Uni. They were instructed to compute the statutory timings of the hearings for the states that required computation, or to provide the timings as written in the sections for the states that required no computation. DC and I agreed on the results of five states, and RB and I agreed on the results of six states. By discussion, I resolved disagreements with them separately. I ended up revising the original timings of five states. The discussion revealed that most disagreements centered on the

timings that needed computation, instead of the ones provided in the sections, because of the difficulty in navigating and differentiating the sections guiding emergency detention from the ones guiding other commitment procedures. It was also revealed that the process of resolving disagreements was faster if the rater had documented which section numbers they used to obtain their findings.

Results

Court Approval/Order of the Detention

Table 5.1 displays, for all states and DC, whether court approval is required for the different types of detentions: emergency detention, "court-ordered evaluation," and involuntary commitment. Procedures associated with each type are described after the table. The specific sections used to obtain these findings are provided in Appendix B (columns A-C). It is important to remember that the findings reflect what the state laws require, not how they are practiced or enforced on the ground (some of the findings are described using the terms such as "must" or "require").

Table 5.1

States Requiring Court Approval of Different Forms of Detention

State	Emergency Detention	"Court-ordered Evaluation"	Involuntary Commitment
Alabama			x
Alaska			x
Arizona		x	
Arkansas	x		x
California		x	
Colorado	x	x	
Connecticut	x		x
Delaware			
District of Columbia			x
Florida	x		
Georgia	x	x	

State	Emergency Detention	"Court-ordered Evaluation"	Involuntary Commitment
Hawaii	x		x
Idaho			x
Illinois	x		x
Indiana			x
Iowa	x		x
Kansas	x		x
Kentucky			x
Louisiana	x		x
Maine			
Maryland	x		x
Massachusetts	x		
Michigan			x
Minnesota			x
Mississippi			x
Missouri	x		
Montana			x
Nebraska			
Nevada			x
New Hampshire	x		x
New Jersey			x
New Mexico			x
New York	x		
North Carolina			x
North Dakota	x		x
Ohio			x
Oklahoma			x
Oregon			x
Pennsylvania			x*
Rhode Island	x		x
South Carolina			x
South Dakota			
Tennessee			x
Texas	x		x
Utah			x
Vermont	x		x
Virginia	x		
Washington			x
West Virginia			x*
Wisconsin			x

State	Emergency Detention	"Court-ordered Evaluation"	Involuntary Commitment
Wyoming	x		

*Besides a judicial officer, a non-judicial officer, such as a mental health review officer, the chair of the county board of mental illness, or a mental hygiene commissioner, is authorized to conduct a hearing.

Emergency Detention. While all 51 jurisdictions have laws on emergency detention, this dissertation found that no state requires law enforcement officers and/or designated mental health professionals to obtain a court approval of emergency detentions before a person is detained. However, 21 states permit the court to act as *one* of the designated authorities to order emergency detentions. In these states, besides the law enforcement officers and/or designated mental health professionals, the court may make a decision to order an emergency detention before detaining a person. In three states of these, Arkansas (A.C.A. § 20-47-210(a)(2)), Iowa (Iowa Code § 229.11), and North Dakota (N.D. Cent. Code § 25-03.1-25(2)), the court approval of immediate detentions may occur when the petitioner for involuntary commitment requests the immediate confinement or custody of the person who is the subject of the petition.

To initiate a court-ordered emergency detention or immediate confinement, a petition/application/affidavit/verified statement (written or oral), made under oath, may be submitted to the court. Table 5.2 shows which groups of individuals can submit a petition for an emergency detention in these 21 states according to their statutes. In five states, only a designated authority can submit a petition to the court (group 1). In 16 states, a non-professional can petition the court for an emergency detention (groups 2, 3, and 4). In 15 of these states, there is no requirement that a petition be accompanied by a clinical certificate (groups 2 and 3). In one state, the petition must be accompanied by a "written statement" of a licensed physician or mental health professional (group 4). While Georgia and Kansas (group 3) require the petition to accompany a certificate, they have exceptions. In Georgia, affidavits of two people can be submitted instead of a certificate. In Kansas, the court can allow the petition to be accompanied

by a verified statement by the petitioner that the person subjected to detention could not be examined for a certificate.

Table 5.2

Groups of Individuals that may Petition the Court for Emergency Detention in 21 States

Group 1 (Designated Professionals)	
Hawaii	Licensed physician, advanced practice registered nurse, psychologist, attorney, member of the clergy, health or social service professional, or any state or county employee in the course of employment
Louisiana	Peace officer or other credible person, physician, psychiatric mental health nurse practitioner, psychologist, or assigned case manager
North Dakota	State's attorney or retained attorney
Rhode Island	Physician, qualified mental health professional, or medical director
Vermont	Law enforcement officer or mental health professional
Group 2 (Any Person)	
Arkansas	Any person
Colorado	Unspecified
Connecticut	Any person
Florida	Unspecified
Illinois	Unspecified
Maryland	Any interested person, physician, psychologist, clinical social worker, licensed clinical professional counselor, clinical nurse specialist in psychiatric and mental health nursing, psychiatric nurse practitioner, licensed clinical marriage and family therapist, or health officer or designee of a health officer, or peace officer
Massachusetts	Any person
Missouri	Any adult
New Hampshire	Any individual
New York	Unspecified
Texas	Any adult
Virginia	Any responsible person, treating physician, or the court's own motion
Wyoming	Any interested party or the court's own motion
Group 3 (Any Person, Certificate Not Required)	
Georgia	Unspecified (the court order may only be issued if based either upon a physician's certificate **OR** upon the affidavits of at least two persons)
Kansas	Unspecified (the petition can be accompanied by a signed certificate from a physician, psychologist, or qualified mental health professional designated by the head of a participating mental health center, **UNLESS** the court allows the petition to be accompanied by a verified statement by the petitioner that examination could not be conducted)
Group 4 (Any Person, "Written Statement" Required)	
Iowa	Any interested person (the application must include a written statement of a licensed physician or mental health professional in support of the application)

In all 21 states, the court order for an emergency detention or immediate confinement is made without a hearing. Florida (Fla. Stat. § 394.463(2)(a)(1)), Hawaii (HRS § 334-59(a)(2)), Kansas (K.S.A. § 59-2957(d)), Missouri (R.S.Mo. § 632.305(2)), Rhode Island (R.I. Gen. Laws § 40.1-5-7(e)), and Wyoming (Wyo. Stat. § 25-10-109(a)(ii)) specifically use the legal phrase *ex parte* order in their sections guiding court-ordered emergency detention proceedings, which refers to the court order being made without conducting a hearing with the person subjected to the detention being represented or present. The remaining states do not specify any hearing procedures in their sections, except for three states. Illinois (405 ILCS 5/3-607), Massachusetts (ALM GL ch. 123, § 12 (e)), and New York (NY CLS Men Hyg § 9.43) require the person subjected to emergency detention to appear before the court (these states do not specifically use the word "hearing" in their statutes to describe the procedure). In New York, whenever the court is informed by verified statement that a person meets commitment criteria, the court may issue a warrant directing that such person be brought before it. If it appears to the court that such person meets the detention criteria, the court may issue an order for emergency detention. In Massachusetts, after the person is brought before the court, it can have the person examined by a designated physician or a qualified advanced practice registered nurse. If the examining professional determines that the person meets the commitment criteria, the court may order the person committed to a facility for a period not to exceed 3 days.

Overall, all 51 jurisdictions have a mechanism to allow emergency detentions without a court approval. In 21 of these states, besides the law enforcement officers and/or designated mental health professionals, the court may also order an emergency detention or immediate detention before the person is detained. Only three states require the person subjected to emergency detention to appear before the court. In 16 states, a non-professional person can

petition the court, with only one state requiring a "written statement" of a licensed physician or mental health professional to be accompanied by the petition. While 30 states may not have laws on court-ordered emergency detentions, the court may still order detentions via other pathways to commitment, such as court-ordered evaluations and involuntary commitment.

"Court-ordered Evaluation". "Court-ordered evaluation" is another pathway to commitment involving the court, which may occur when the court orders a person be taken into custody and evaluated at a designated facility. This commitment procedure is specifically referred to as court-ordered evaluation in four states' sections that guide this procedure. Colorado (Colo. Rev. Stat. § 27-65-106) and Georgia (O.C.G.A. § 37-3-61) authorize court-ordered evaluations in addition to court-ordered emergency detentions. In Arizona and California, only court-ordered evaluations are permitted (A.R.S. § 36-521 and Cal Wel & Inst Code § 5200, respectively), and no sections guiding court-ordered emergency detention procedures were found.

Court-ordered emergency detentions differ from court-ordered evaluations in that the latter always involves a pre-petition screening. Under section 27-65-106 of Colorado Revised Statutes, any individual can petition for a court-ordered evaluation of a person alleged to meet the commitment criteria. Upon receipt of a petition, the court designates a facility to screen the person to determine whether there is probable cause to believe the allegations. Based on the recommendation submitted by the screening facility, the court may authorize a certified peace officer to take the individual into custody and place them in a facility designated for 72-hour treatment and evaluation.

In Arizona and California, the individual needs to apply for a court-ordered evaluation to a designated screening agency, instead of directly filing a petition with the court. Once it

receives an application, the screening agency conducts an investigation. Based on the findings, the agency determines whether to file a petition for a court-ordered evaluation. In Georgia, besides a screening agency, any individual can directly file a petition with the court if the petition is accompanied by a certificate.

Only Georgia requires a hearing on a petition for court-ordered evaluation, and before detaining the person (O.C.G.A. § 37-3-62). Once a petition is filed, the court holds a hearing on the petition no sooner than ten days and no later than 15 days after such petition is filed. After the hearing or, if the hearing is waived, the court may issue an order to any peace officer to deliver the person to the evaluating facility designated by the department to admit persons ordered by that court to be evaluated. A person who has been admitted to an evaluating facility under this section is detained for a period not to exceed five days, Saturdays, Sundays, and holidays excluded, which is the length also applied to emergency detention.

In sum, among the 51 jurisdictions, 23 states permit the court to either act as one of the authorities to order emergency detention or order that a person be taken into custody and evaluated at a designated facility (Colorado and Georgia were counted once because they authorize both court-ordered emergency detentions and evaluations). Of these states, four require a hearing or appearance before the court. In contrast to court-ordered emergency detentions, court-ordered evaluations involve a pre-petition screening before the court can order the detention. In three states, a non-professional person can first apply to a screening agency to petition the court, while in one state, a non-professional can directly petition the court.

Involuntary Commitment. In addition to court-ordered emergency detentions and/or court-ordered evaluations, in 37 states, a petition may be filed to the court requesting involuntary commitment of another person (see Table 5.1). Involuntary commitment is also referred to as

judicial commitment, involuntary treatment, or involuntary hospitalization in some state statutes. The involuntary commitment proceeding shares some similarities with court-ordered emergency detentions and court-ordered evaluations. Once a petition for involuntary commitment is filed and if the court determines that the person should be detained pending the outcome of the hearing or for an examination (also known as "prehearing detention"), it may issue a warrant to detain the person.[25] Other states may require a pre-petition screening once a petition for involuntary commitment is filed.

Kentucky Revised Statutes section 202A.051 shows what the entire proceeding for involuntary commitment may consist of. An unspecified individual may petition the court for involuntary commitment of another individual. The petition must be accompanied by a certificate unless the court allows the petition to be accompanied by a verified statement by the petitioner that examination could not be conducted. If after reviewing the petition, it appears to the court that there is probable cause to believe the person should be involuntarily hospitalized, the court may order that the sheriff of the county or other peace officer transport the person to a hospital or psychiatric facility for the purpose of the evaluation (which may not exceed 72 hours, excluding weekends and holidays). The court may also set a date for a preliminary hearing within 6 days from the date of holding the person. If upon completion of the preliminary hearing, the court finds there is probable cause to believe the person should be involuntarily hospitalized, the court may order a final hearing within 21 days from the date of holding the person. If the court finds there is no probable cause, the case may be dismissed, and the person is released. If upon completion of the final hearing, the court finds the person should be involuntarily hospitalized, the court may order the person hospitalized in a hospital for a period not to exceed

[25] It is also possible that that some states may not require prehearing detention (this dissertation did not collect information on whether states require prehearing detention when a petition for involuntary commitment is filed).

60 consecutive days from the date of the court order or a period not to exceed 360 consecutive days from the date of the court order, depending on the period of time requested in the petition.

In four of 37 states, only a designated authority figure can submit a petition to the court (group 1 in Table 5.3). In 33 states, a non-professional can petition the court for involuntary commitment (groups 2, 3, and 4). Among these states, a petition is not required be accompanied by a certificate in 24 states (groups 2 and 3) and is required to be accompanied by a certificate in nine states (group 4).

Table 5.3

Groups of Individuals that may Petition the Court for Involuntary Commitment in 37 States

Group 1 (Designated Professionals)	
Montana	County attorney
New Mexico	District attorney
North Dakota	State's attorney or retained attorney
Washington	Designated crisis responder
Group 2 (Any Person)	
Alabama	Any person
Alaska	Any adult
Arkansas	Any person
Connecticut	Any person
Kentucky	Any interested person, qualified mental health professional, peace officer, county attorney, Commonwealth's attorney, spouse, relative, friend, or guardian
Louisiana	Any person of legal age
Mississippi	Any interested person or any relative of the person
North Carolina	Anyone
Oklahoma	Father, mother, husband, wife, grandparent, brother, sister, guardian, child over the age of 18 years, licensed mental health professional, person in charge of any correctional institution, peace officer, or district attorney
Oregon	Two persons, local health officer, or any magistrate or judge
Pennsylvania	Any responsible party
West Virginia	Any adult person
Group 3 (Any Person, Certificate Not Required)	
District of Columbia	Spouse, parent, or legal guardian, by a physician or a qualified psychologist, by a duly accredited officer or agent of the Department, by the Director of the Department or the Director's designee, or by an officer authorized to make arrests in the District of Columbia (the petition can be accompanied by a certificate of a physician or qualified psychologist **OR** a sworn written statement by the petitioner that the person has refused to submit to examination)

Hawaii	Any person (the petition can include a certificate of the licensed physician, advanced practice registered nurse, or psychologist who has examined the person within two days before submission of the petition, **UNLESS** the person whose commitment is sought has refused to submit to medical or psychological examination)
Idaho	Friend, relative, spouse or guardian of the proposed patient, by a licensed physician, by a physician assistant or advanced practice registered nurse practicing in a hospital, by a prosecuting attorney or other public official of a municipality, county or of the state of Idaho, or the director of any facility (the application can include a certificate of a designated examiner **OR** a written statement by the applicant that the person has refused to submit to examination)
Kansas	Unspecified (the petition can be accompanied by a signed certificate from a physician, psychologist, or qualified mental health professional designated by the head of a participating mental health center, **UNLESS** the court allows the petition to be accompanied by a verified statement by the petitioner that examination could not be conducted)
Michigan	Any individual 18 years of age (the petition can be accompanied by a clinical certificate of a physician or a licensed psychologist, **UNLESS** after reasonable effort the petitioner could not secure an examination)
Nevada	Spouse, parent, adult children or legal guardian of the person to be treated or by any physician, physician assistant, psychologist, social worker or registered nurse or by any officer authorized to make arrests in the State of Nevada (the petition can be accompanied by a certificate of a physician, a licensed psychologist, a physician assistant under the supervision of a psychiatrist, a clinical social worker, or an advanced practice registered nurse **OR** a sworn written statement by the petitioner that the person alleged to meet the commitment criteria has refused to submit to examination or treatment)
Ohio	Any person (the affidavit can include a certificate of a psychiatrist, or a certificate signed by a licensed clinical psychologist and a certificate signed by a licensed physician **OR** a written statement by the applicant that the person has refused to submit to an examination)
Rhode Island	Any person with whom the subject of the petition may reside, or at whose house he or she may be, father or mother, husband or wife, brother or sister, or adult child of the person, the nearest relative if none of the above are available, guardian, attorney general, local director of public welfare, director of the department of behavioral healthcare, developmental disabilities and hospitals, director of the department of human services, director of the department of corrections, director of the department of health, warden of the adult correctional institutions, superintendent of the boys training school for youth, or his or her designated agent, director of any facility, or designated agent (the petition can be accompanied by certificates of two physicians, **UNLESS** the petitioner is unable to afford, or is otherwise unable to obtain, the services of a physician or physicians qualified to make the certifications)
South Carolina	Any interested person or the superintendent of any public or private mental institution (the petition can include a certificate of a designated examiner **OR** a written statement by the petitioner that the person has refused to submit to an examination)
Tennessee	Unspecified (the complaint can include certificates of certifying professionals **OR** a sworn statement by the plaintiff that the defendant has refused to be examined)
Utah	A responsible individual (the application can include a certificate of a licensed physician or a designated examiner **OR** a written statement by the applicant that the person has been requested to, but has refused to, submit to an examination)
Vermont	An interested party (the application can be accompanied by a certificate of a licensed physician **OR** a written statement by the applicant that the person refused to submit to an examination)
Group 4 (Any Person, Certificate Required)	

Illinois	Any person 18 years of age or older (the petition must be accompanied by a certificate of a physician, qualified examiner, psychiatrist, advanced practice psychiatric nurse, or clinical psychologist)
Indiana	Any person at least 18 years of age (the petition must include a physician's written statement)
Iowa	Any interested person (the application must include a written statement of a licensed physician or mental health professional)
Maryland	Any person (the application must include certificates of 1 physician and 1 psychologist, 2 physicians, or 1 physician and 1 psychiatric nurse practitioner)
Minnesota	Any interested person (the petition must be accompanied by a written statement by an examiner)
New Hampshire	Any responsible person (the petition must be accompanied by a certificate from a physician, physician assistant, or advanced practice registered nurse)
New Jersey	Short-term care or psychiatric facility submits to the court a screening certificate and clinical certificate (court proceedings for commitment of any person not referred by a screening service can be initiated by the submission to the court of two clinical certificates, at least one of which is prepared by a psychiatrist)
Texas	County or district attorney or other adult (only the district or county attorney can file an application that is not accompanied by a certificate of medical examination)
Wisconsin	Unspecified (any health care provider and any law enforcement officer can make a disclosure of information evidencing that an individual meets the commitment criteria)

In conclusion, only four states do not have laws guiding court-ordered emergency detentions, court-ordered evaluations, or involuntary commitment. While Nebraska and South Dakota have laws on involuntary commitment, the proceedings are presided by non-judicial officers, not the court. In Delaware and Maine, the court gets involved only when a designated mental health professional files a petition for the continued detention (longer-term commitment) of the person who has been detained under emergency detention. As displayed in Table 5.4, among 47 states that have laws guiding court-ordered emergency detentions, evaluations, or involuntary commitment, six states permit only authorities to petition the court, while 41 other states permit non-professionals to petition the court (states that have laws on more than one type of detention were counted once). In 36 of 41 states, a non-professional person can directly petition the court without accompanying a certificate or applying to a designated agency or person for a pre-petition screening.

Table 5.4

States Permitting Non-professionals to Petition the Court for Detention

State	Emergency Detention	"Court-ordered Evaluation"	Involuntary Commitment
Alabama			Non-professional
Alaska			Non-professional
Arizona		x	
Arkansas	Non-professional		Non-professional
California		x	
Colorado	Non-professional	Non-professional	
Connecticut	Non-professional		Non-professional
Delaware			
District of Columbia			Non-professional
Florida	Non-professional		
Georgia	Non-professional	x	
Hawaii	x		Non-professional
Idaho			Non-professional
Illinois	Non-professional		Non-professional
Indiana			Non-professional
Iowa	Non-professional		Non-professional
Kansas	Non-professional		Non-professional
Kentucky			Non-professional
Louisiana	x		Non-professional
Maine			
Maryland	Non-professional		Non-professional
Massachusetts	Non-professional		
Michigan			Non-professional
Minnesota			Non-professional
Mississippi			Non-professional
Missouri	Non-professional		
Montana			x
Nebraska			
Nevada			Non-professional
New Hampshire	Non-professional		Non-professional
New Jersey			Non-professional
New Mexico			x
New York	Non-professional		
North Carolina			Non-professional
North Dakota	x		x
Ohio			Non-professional

State	Emergency Detention	"Court-ordered Evaluation"	Involuntary Commitment
Oklahoma			Non-professional
Oregon			Non-professional
Pennsylvania			Non-professional
Rhode Island	x		Non-professional
South Carolina			Non-professional
South Dakota			
Tennessee			Non-professional
Texas	Non-professional		Non-professional
Utah			Non-professional
Vermont	x		Non-professional
Virginia	Non-professional		
Washington			x
West Virginia			Non-professional
Wisconsin			Non-professional
Wyoming	Non-professional		

Shaded gray = States require a non-professional to include a certificate when filing a petition.
x = States require only the designated authorities to petition the court.

Court Approval of Emergency Detention and Statutory Timings of Detention Court Hearings

A court approval of detention may also be required when, (1) after a person is detained for emergency detention, the court is made aware of their emergency detention and must decide whether that person should continue to be detained, and (2) after a person is detained for emergency detention and if the examining mental health professional determines that the person should continue to be detained beyond the initial emergency detention period. Hearings differ from *ex parte* hearings in that they are held in the presence of the detained person and/or their counsel. The hearings may also be waived by the detained person and/or their counsel. It is important to remember that the findings reflect what the laws require, not how they are practiced or enforced on ground (some of the findings are described using the terms such as "must" or "require").

Column A of Table 5.5 describes whether a court approval of emergency detention is required after a person is detained. Among the 10 states that require the court to approve emergency detention, five states (Alaska, Arizona, Idaho, Iowa, and South Carolina) do not specify when, after the emergency detention, a court approval must be issued. The other five (DC, Indiana, Maine, Tennessee, and Texas) specify when. In all ten states, the approval is made without a hearing. It is possible that the states requiring the court to approve emergency detention after the person is detained have a longer timing to the first hearing, since the court approved of the detention. Another possibility is that the court approval of emergency detention is required in states that mandate non-judicial officers to conduct a hearing for continued detention. However, these instances were not observed.

Table 5.5

Court Order for Emergency Detention and Statutory Timings of the Hearings in 50 States and DC Based on the Statutes Effective in their Jurisdictions as of September/October 2021[26]

	A	B	C
State	**Is court order of the emergency detention required after the person is detained?**	**When (in days) is a hearing held from the time of the initial emergency detention?**	**If there is an additional hearing, when (in days) is it held from the time of the initial emergency detention?**
Montana		A hearing must be held at least 1 day after the person is detained as a result of an emergency situation.	A second hearing must be held at least 6 days after the person is detained as a result of an emergency situation.
Alaska	The mental health professional may apply for an *ex parte* order authorizing 72-hour hospitalization for evaluation after an emergency examination, but the procedure is not clearly described.	A commitment hearing must be held at least 3 days after an emergency examination.	
Kansas		A hearing for temporary custody order must be held at least 3 days after the person is admitted for emergency observation and treatment.	A "trial" for commitment must be held between 7 and 14 days after the filing of the petition.

[26] Listed in ascending order by column B.

	A	B	C
State	**Is court order of the emergency detention required after the person is detained?**	**When (in days) is a hearing held from the time of the initial emergency detention?**	**If there is an additional hearing, when (in days) is it held from the time of the initial emergency detention?**
Wisconsin		A probable cause hearing must be held "within 72 hours [3 days] after the individual is taken into custody" for emergency detention. [Upon request, the hearing may be postponed, but in no case may the postponement exceed 7 days from the date of detention.]	A final commitment hearing must be held "within 14 days from the time of detention of the subject individual." [If a postponement has been granted for the probable cause hearing, the final hearing must be scheduled within 21 days from the time of detention of the individual.]
Wyoming		A hearing must be conducted "within 72 hours [3 days], excluding Saturdays, Sundays and legal holidays, of the initial detention to determine whether continued detention is required pending directed outpatient commitment or involuntary hospitalization proceedings."	Upon receipt of an application for involuntary hospitalization, the court may appoint one or more examiners to examine the person. If the examiner reports the person is "mentally ill," the court fixes a date for a hearing to be held as soon as possible.
New Hampshire		A probable cause hearing for involuntary emergency admission must be held within 3.25 days after the person is placed in protective custody. [The person or the petitioner may request a continuance of the probable cause hearing. In no case shall continuance be granted for more than 2 days.]	A hearing for involuntary admission must be held within 25.25 days after the person is placed in protective custody.
Virginia		A commitment hearing must be held within 3.3 days from the time a law enforcement officer takes the person into custody or emergency custody order is issued.	
North Dakota		A preliminary hearing must be held "within 4 days, exclusive of weekends and holidays," after the person is detained for emergency evaluation and treatment.	An involuntary treatment hearing must be held within 18 days after the person is detained for emergency evaluation and treatment.
Iowa	After a peace officer delivers the person to a facility, the magistrate may authorize the person's detention based on the examination by a	An involuntary hospitalization hearing must be held at least 5 days after a peace officer delivers the person to a facility.	A placement hearing must be held upon request, which must be held no sooner than 4 days and no later than 7 days after the request is filed.

	A	B	C
State	**Is court order of the emergency detention required after the person is detained?**	**When (in days) is a hearing held from the time of the initial emergency detention?**	**If there is an additional hearing, when (in days) is it held from the time of the initial emergency detention?**
	designated professional.		
Ohio		An initial hearing must be conducted "within 5 court days from the day on which the respondent is detained or an affidavit is filed, whichever occurs first." [The court may order a continuance of the hearing, which must be for no more than 10 days from the day on which the respondent is detained or on which an affidavit is filed, whichever occurs first].	A full commitment hearing must be held by "the 30th day after the original involuntary detention of the respondent."
South Dakota		"Within 5 days after the person is taken into custody, within 6 days if there is a Saturday, Sunday, or holiday within that time period, or within 7 days if there is a Saturday, Sunday, and holiday within that time period," the person is provided an involuntary commitment hearing. [The hearing is conducted by the board of mental illness.]	
Texas	The judge or designated magistrate may issue a protective custody order before the 48-hour period for a preliminary examination expires.	A probable cause hearing to determine if protective custody order should be continued pending the hearing on court-ordered mental health services must be held within 5 days after a person is accepted for a preliminary examination.	A court hearing must be held within 14 days (and no later than 30 days) from the filing of an application for court-ordered mental health services.
Washington		A probable cause hearing for involuntary treatment must be held "within 5 days of initial detention." [If requested by the person or attorney, the hearing may be postponed for a period not to exceed 48 hours.]	The petition for 90-day treatment is filed at least 3 days before expiration of the 14-day period of intensive treatment. At the time of filing, the clerk sets a time for the person to come before the court on the next judicial day after the day of filing. The court must conduct a hearing within 5 judicial days of the trial setting hearing.

	A	B	C
State	**Is court order of the emergency detention required after the person is detained?**	**When (in days) is a hearing held from the time of the initial emergency detention?**	**If there is an additional hearing, when (in days) is it held from the time of the initial emergency detention?**
Oklahoma		A commitment hearing must be held at least 5.5 days after the person is placed in protective custody.	
Arkansas		An initial hearing must be held within 6 days after the person arrives at a facility for immediate confinement without a court order.	Within 7 days of the person's detention, the court must conduct a hearing for involuntary admission.
Illinois		A commitment hearing must be held within 6 days from the time of admission.	
Kentucky		A preliminary hearing must be held "within 6 days from the date of holding the person under the provisions of this section," excluding holidays and weekends.	A final hearing for involuntary hospitalization must be held "within 21 days from the date of holding the person under the provisions of this section."
Missouri		A first hearing must be held within 6 days after the person is accepted for admission by a facility providing 96-hour evaluation and treatment.	A second hearing must be held within 27 days after the person is accepted for admission by a facility providing 96-hour evaluation and treatment.
Pennsylvania		An informal hearing must be held within 6 days after the person arrives at a facility for emergency examination. [If the hearing is held by a mental health review officer, the person can petition for a judicial hearing to challenge the mental health review officer's decision, which is held within 72 hours of the filing of the petition.] [The hearing is conducted by a judge or by a mental health review officer.]	A hearing on the petition for court-ordered involuntary treatment must be held within 26 days after the person arrives at a facility for emergency examination. [The hearing is conducted by a judge or by a mental health review officer.]
Tennessee	After the person is admitted for emergency diagnosis, evaluation, and treatment, a hospital may detain the individual for up to 24 hours in order to obtain a judicial order authorizing admission.	A probable cause hearing must be held within 6 days after admission for emergency diagnosis, evaluation, and treatment.	A full commitment hearing must be held within 41 days after admission for emergency diagnosis, evaluation, and treatment.
Minnesota		A preliminary hearing must be held within 6.5 days after the person's arrival.	A commitment hearing must be held within 17.5 days after the person's arrival. [For

	A	B	C
State	**Is court order of the emergency detention required after the person is detained?**	**When (in days) is a hearing held from the time of the initial emergency detention?**	**If there is an additional hearing, when (in days) is it held from the time of the initial emergency detention?**
			good cause shown, the court may extend the time of hearing up to an additional 30 days.]
Alabama		A probable cause hearing must be held "within 7 days from the date of the initial confinement."	A final commitment hearing must be held "within 30 days from the date of the initial detention."
California		A certification review hearing for intensive treatment must be held within 7 days from the time the person is admitted to a facility for 72-hour evaluation and treatment. [Hearings may be postponed for 48 hours or, in counties with a population of 100,000 or less, until the next regularly scheduled hearing date.] [The individual may request a judicial hearing to determine whether or not probable cause exists to detain the person for intensive treatment, which must be held within 2 judicial days after the petition is filed.] [The hearing is conducted by a court-appointed commissioner or a referee, or a certification review hearing officer (who is either a state qualified administrative law hearing officer, a physician and surgeon, a licensed psychologist, a registered nurse, a lawyer, a certified law student, a licensed clinical social worker, a licensed marriage and family therapist, or a licensed professional clinical counselor).]	Another certification review hearing must be held within 25 days from the time the person is admitted to a facility for 72-hour evaluation and treatment, if the person who has been certified for intensive treatment is certified for an additional 30 days of intensive treatment pursuant for "grave disability." [Hearings may be postponed for 48 hours or, in counties with a population of 100,000 or less, until the next regularly scheduled hearing date.] [The individual may request a judicial hearing to determine whether or not probable cause exists to detain the person for intensive treatment, which must be held within 2 judicial days after the petition is filed.] [The hearing is conducted by a court-appointed commissioner or a referee, or a certification review hearing officer (who is either a state qualified administrative law hearing officer, a physician and surgeon, a licensed psychologist, a registered nurse, a lawyer, a certified law student, a licensed clinical social worker, a licensed marriage and family therapist, or a licensed professional clinical counselor).]

	A	B	C
State	**Is court order of the emergency detention required after the person is detained?**	**When (in days) is a hearing held from the time of the initial emergency detention?**	**If there is an additional hearing, when (in days) is it held from the time of the initial emergency detention?**
Idaho	The court may issue a temporary custody order requiring the person to be held in a facility within or after 24 hours from the time an individual is placed in custody or detained.	A hearing must be held at least 7 days after the time the individual is placed in custody or detained to determine if continued detention is deemed necessary pending commitment proceedings.	
Indiana	After 5 days from the time of admission under immediate detention, the court may order the individual's continued detention pending a preliminary hearing.	A preliminary hearing must be held within 7 days from the time of admission under immediate detention.	A final commitment hearing must be held within 17 days from the time of admission under immediate detention.
Nebraska		A hearing must be held "within 7 calendar days after the person has been taken into emergency protective custody." [The hearing is held by the mental health board.]	
New Mexico		A hearing must be conducted "within 7 days" after the person's arrival at an evaluation facility.	
Florida		A hearing for involuntary inpatient placement must be held at least 8 working days after the person is taken to a receiving facility for involuntary examination. [The individual may request at least one continuance of the hearing for up to 4 weeks.]	
Massachusetts		A commitment hearing must be held within 8 days of admission. [A hearing can be requested during the 3-day commitment, which must be held on the day the request is filed with the court or not later than the next business day.]	
Nevada		A hearing for involuntary court-ordered admission must be held within 9 days after the person is detained under an emergency admission for	

	A	B	C
State	**Is court order of the emergency detention required after the person is detained?**	**When (in days) is a hearing held from the time of the initial emergency detention?**	**If there is an additional hearing, when (in days) is it held from the time of the initial emergency detention?**
		evaluation, observation and treatment. [If an application for a writ of *habeas corpus* is made before the initial hearing on a petition for the involuntary court-ordered admission of the person to a mental health facility, the court must conduct a hearing on the application as soon as practicable.]	
Arizona	The person taken into custody for emergency admission may not be detained longer than 24 hours excluding weekends and holidays following such detention unless a petition for 72-hour court-ordered evaluation is filed. The court may order continued detention pending a hearing for court-ordered treatment.	A hearing for court-ordered treatment must be held at least 10 days from the time the person is taken into custody for emergency admission. [The hearing may be continued for a maximum of 30 days and 3 business days, respectively, at the request of the individual and the petitioner.] [If the person requests a hearing to determine whether the person should be involuntarily hospitalized during evaluation, the court must schedule a hearing at its first opportunity.]	
Maryland		A hearing on admission must be held "within 10 days of the date of the initial confinement of the individual." [The hearing may be postponed for good cause for no more than 7 days.]	
Michigan		A hearing for involuntary hospitalization must be held within 10 days from the time the person is detained without the 2 clinical certificates.	
North Carolina		A commitment hearing must be held "within 10 days of the day the respondent is taken into law enforcement custody."	

	A	B	C
State	**Is court order of the emergency detention required after the person is detained?**	**When (in days) is a hearing held from the time of the initial emergency detention?**	**If there is an additional hearing, when (in days) is it held from the time of the initial emergency detention?**
West Virginia		A commitment hearing must be held at least 10 days after the date of admission. [The hearing is held by a mental hygiene commissioner, a magistrate, or circuit judge.]	
Delaware		A probable cause hearing must be held at least 11 days after the person is emergently detained.	A commitment hearing must be held at least 19 days after the person is emergently detained.
Utah		A commitment hearing must be held within 11 days after the person is temporarily committed.	
Hawaii		A hearing for involuntary hospitalization must be held at least 12 days after the person is hospitalized on an emergency basis.	
Mississippi		A commitment hearing must be held within 13 days after the person is admitted without a civil order or warrant.	
Vermont		A hearing for involuntary treatment must be held within 14 days after an initial certificate for emergency examination is issued. [Within 5 days after the person is admitted to a designated hospital for emergency examination, the individual may request the superior court to conduct a preliminary hearing, which is held within 3 working days of the filing of the request.] [The court may grant each party a onetime extension of up to 7 days for good cause.]	
South Carolina	Five days after the judge places the person under custody for immediate hospitalization, the court conducts preliminary review.	A full hearing must be held within 16 days from the date of admission.	

	A	B	C
State	**Is court order of the emergency detention required after the person is detained?**	**When (in days) is a hearing held from the time of the initial emergency detention?**	**If there is an additional hearing, when (in days) is it held from the time of the initial emergency detention?**
Maine	The initial application for hospital admission is reviewed and may be endorsed by a judge within 24 hours from the date of admission on an emergency basis (the person may be held for two additional 48-hour periods pending a judicial endorsement if a certificate has been executed).	A commitment hearing must be held within 17 days from the date of admission on an emergency basis (if the judge endorses the detention within 24 hours). [On good cause, the hearing may be continued for a period not to exceed 21 additional days.]	
Oregon		A commitment hearing must be held within 18 days after the person is detained for emergency admission. [The person consenting to 14 days of treatment may request a court hearing, which is held within 5 days of the request.]	
Rhode Island		A preliminary hearing must be held within 18 days after the person is seen by a psychiatrist or physician for a preliminary examination and evaluation.	A final hearing for civil court certification must be held within 39 days after the person is seen by a psychiatrist or physician for a preliminary examination and evaluation.
Georgia		A hearing for involuntary hospitalization must be held within 20 days after the person is admitted to an emergency receiving facility.	
New Jersey		A hearing for continued need for involuntary commitment must be held within 21 days after completion of the screening certificate.	
Connecticut		A commitment hearing must be held within 25 days of confinement under emergency certificate. [The person may request a judicial hearing, which must be held within 72 hours of the request.]	

	A	B	C
State	**Is court order of the emergency detention required after the person is detained?**	**When (in days) is a hearing held from the time of the initial emergency detention?**	**If there is an additional hearing, when (in days) is it held from the time of the initial emergency detention?**
DC	Within 3 days after the person is admitted and detained for purposes of emergency observation and diagnosis, the court may order the person's hospitalization. [If the court orders hospitalization, the person may request a hearing, which is held within 24 hours after receipt of the request.]	A commitment hearing must be held at least 31 days after the person is admitted and detained for purposes of emergency observation and diagnosis. [The hearing is conducted by the commission on mental health].	Upon the receipt by the court of the commission's report, the superior court "promptly" sets the matter for hearing. [The hearing is conducted by the court].
Louisiana		A commitment hearing must be held within 34 days from the time the person is taken into protective custody, issued by a coroner or judge. [Prior to or during confinement, a judicial hearing may be requested to determine if probable cause exists for continued confinement under an emergency certificate. The hearing is held within 5 days of the filing of the petition.]	
Colorado		**A hearing is conducted only upon request.** Within 5 days, excluding Saturdays, Sundays, and holidays, after being admitted to a 72-hour treatment and evaluation facility, the person and their attorney can a request that the certification for short-term treatment be reviewed by the court. The court must hear the matter within 10 days after the request.	
New York		**A hearing is conducted only upon request.** After the person is received into the program's emergency room, the person may be retained for up to 72 hours after an examination. During the 72-hour detention, a court hearing can be requested, which must be held within 5 days after such request is received.	

Column B describes when, after a person is detained for emergency detention, a court hearing is required to be held. Of 51 jurisdictions, in Colorado and New York, a hearing is not provided unless the detained person or their attorney requests one. Among states that mandate hearings, California, Nebraska, and South Dakota permit a non-judicial officer to conduct a hearing, while Pennsylvania and West Virginia permit either a non-judicial officer or the court to hold the hearing. In DC, the first hearing is held by a non-judicial officer while the second hearing is held by the court.

Regardless of which institution conducts the hearing, no computations were needed for 12 states that statutorily require hearings because they specified the timings in their laws (indicated by quotation marks in Table 5.5). Statutory timings were computed for 28 states that provided all the necessary information. Only approximate timings could be computed for the other 11 states because of some missing information (indicated by the use of the phrase "at least" in Table 5.5).

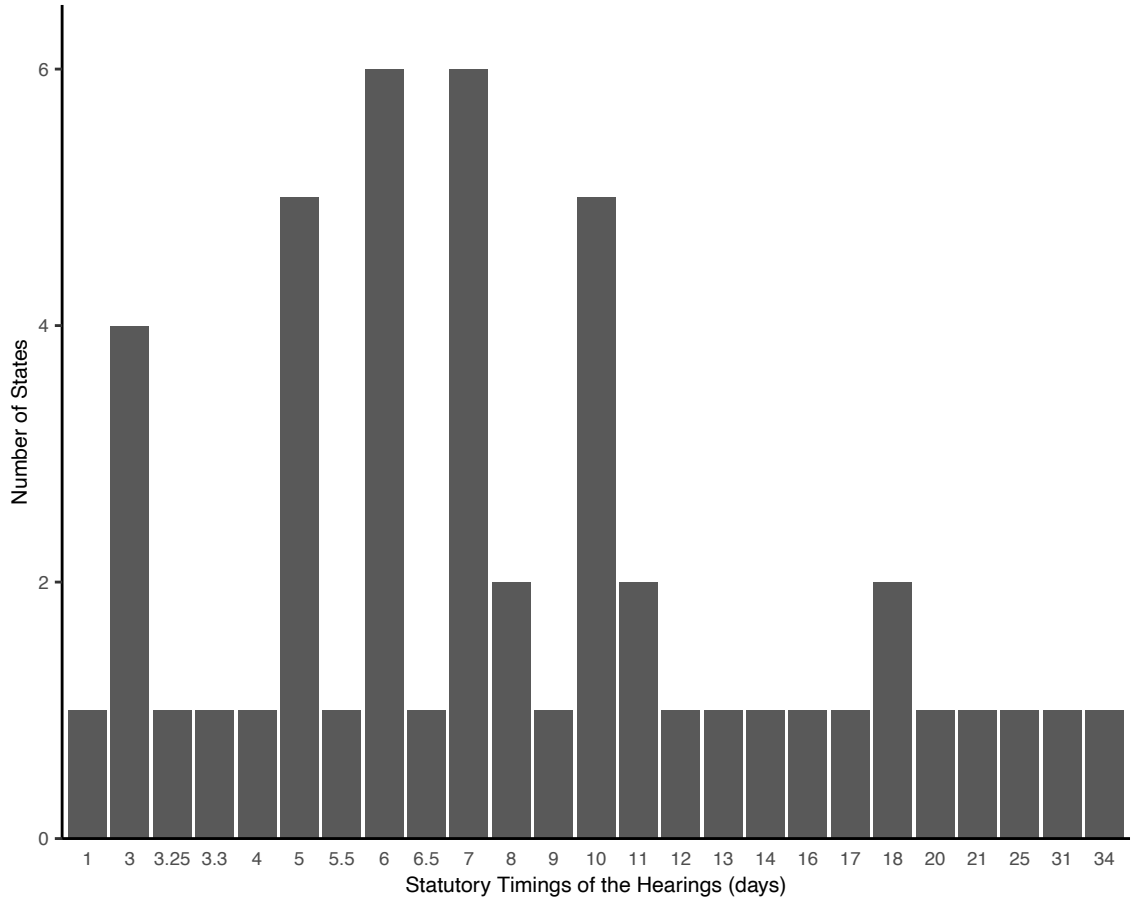
The statutory timings of detention hearings in column B ranged from 1 to 34 days (Figure 5.1[27]). Statutory timings of 27 states ranged from five to 10 days, while the remaining states, except for seven, permit a time period over 10 days (14 states). The variation in statutory timings in column B of Table 5.5 was mostly created by the variations in legislated time limits on emergency detention, when the hearing is required to be held from the time of filing the petition, and the availability of preliminary evaluation period. Some statutes require that a court hearing be held before the expiration of emergency detention, while others require that a petition be filed (which automatically authorizes continued detention) and specifies when the hearing must be held from the time of filing of the petition. Additionally, some statutes require a preliminary

[27] This figure was created with RStudio version 2022.02.1.

evaluation/detention period upon arrival at the facility, which is typically limited to 1 or less than 1 day.

Figure 5.1

Statutory Timings of Hearings Among 51 Jurisdictions



Column C shows that 21 states require more than one hearing for the court (or non-judicial officers) to order longer-term commitment: a preliminary (probable cause) hearing and a final (full) hearing. It is important to note that this additional hearing is still required to be held during the initial commitment proceeding.[28] For example, in Ohio, the initial hearing must be conducted "within five court days from the day on which the respondent [person subjected to

[28] Although states may mandate a court hearing or review of commitment after longer-term commitment is ordered, this information was not collected in this dissertation.

commitment] is detained" (ORC Ann. § 5122.141). If the court does not find that the respondent is "a mentally ill person subject to court order," it may order the respondent's immediate discharge. If the court finds that the respondent is "a mentally ill person subject to court order," the court may issue an interim order of detention authorizing any health or police officer or sheriff to take into custody and transport such person to a designated facility. Unless the person has been discharged, a mandatory full hearing must be held by the 30th day after the original involuntary detention of the respondent. If, upon completion of the hearing, the court finds by clear and convincing evidence that the respondent is "a mentally ill person subject to court order," the court may order the respondent for a period not to exceed 90 days to any of the designated facilities (ORC Ann. § 5122.15).

The statutory timings of full hearings could not be computed for some states because of the lack of information or clarity in the statutes describing the procedures. Instead, information on when the hearing must be available was provided. It appears that the states with shorter timings to the first hearing mandate an additional hearing. Among 21 states that require two hearings, 17 states that mandate an additional hearing require the first hearing to be held within 7 days of the initial emergency detention (which is the median timing of the first hearing).

Finally, information that may lengthen or shorten the hearing timings is presented inside brackets. First, some states permit a postponement of hearing at the request of a petitioner, or the person subjected to commitment, which could lengthen the hearing timings. Second, some statutes specify timings of when the hearing that is requested by the detained person or their attorney must be held, which could shorten the hearing timings. For instance, while a commitment hearing is required to be held within 25 days of initial confinement under emergency certificate in Connecticut, the detained person may also request a court hearing,

which must be held within 72 hours, excluding Saturdays, Sundays and holidays, of the request (Conn. Gen. Stat. § 17a-502). Third, states differ on whether they include or exclude Saturdays, Sundays, and legal holidays in their timings of the hearings, or whether they provide this information in their laws. Because this information was not provided consistently across different time points needed to compute the timings of the hearings by states, it was excluded from the computation.

CHAPTER 6

The Association Between Statutory Timings of Detention Hearings and Rates of Admissions to Inpatient Psychiatric Facilities: Methods and Results

Methods

The second aim of this dissertation was to examine the association between the statutory timing of involuntary psychiatric detention hearings and rates of admissions to inpatient psychiatric facilities. Cross-sectional primary data (collected as described in Chapter 5) and secondary data (collected by the SAMHSA in 2018 and 2019) were analyzed with regression models. The unit of analysis was the individual state. The sample size depended on the availability of the state-level data for the outcome and predictor variables.

Measures and Data

Admissions to Inpatient Psychiatric Facilities. The outcome variable was the state-level numbers/counts of admissions to inpatient psychiatric facilities, obtained from the SAMHSA's URS output tables. The SAMHSA operates the URS as part of the Community Mental Health Block Grant, which requires states receiving the grant to compile and submit their aggregate data in 21 URS Excel tables (SAMHSA, 2022). The data include numbers and sociodemographic characteristics of individuals served by the states, outcomes of care, use of selected evidence-based practices, assessment of care, insurance status, living situation, employment status, and readmission to state psychiatric hospitals within 30 and 180 days (NRI, 2020a). Based on these data, the SAMHSA creates URS output tables for each state, which are publicly available and can be accessed online (SAMHSA, n.d.).

An annual URS output table provides state-level numbers of admissions to inpatient psychiatric settings, including state psychiatric hospitals and "other psychiatric inpatient care,"

for adults and children. Although the output tables provide no detailed descriptions of the data, according to the NRI's "2020 URS Data Definitions," "admission" is "the number of persons admitted, readmitted, or transferred to a specified service setting during the reporting period" (NRI, 2020b, p. 1). Additionally, NRI defines "other psychiatric inpatient care" as follows:

> Other psychiatric inpatient care refers to inpatient psychiatric services provided in a private psychiatric hospital, a psychiatric bed in a general hospital, or any other psychiatric inpatient bed that is not part of state psychiatry hospital. Examples of Other Psychiatric Inpatient Care settings include:
>
> Private psychiatric hospital: a facility licensed and operated as a private psychiatric hospital that primarily provided 24-hour inpatient care to persons with mental illness.
>
> Separate inpatient psychiatric unit of a general hospital: a licensed general hospital (public or private) that provides inpatient mental health services in at least one separate psychiatric living unit. This unit must have specifically allocated staff and space (beds) for the treatment of persons with mental illness. The unit may be located in the hospital itself or in a separate building, either adjacent or more remote, and is owned by the hospital. It may also provide 24-hour residential care and/or less than 24-hour care (e.g., outpatient, day treatment, partial hospitalization), but these additional service setting are not requirements (NRI, 2020b, p. 9).

This dissertation only analyzed the number of admissions to "other psychiatric inpatient care" because many states use their state psychiatric hospitals for forensic commitment. According to SAHMSA (2019c), the legal status of 53.8% of individuals in public psychiatric hospitals on April 30, 2018 was involuntary forensic, compared to 3.2% and 3.8% in private psychiatric hospitals and psychiatric units of general hospitals, respectively. Only the adult figures were analyzed in this dissertation because separate statutes could govern commitment proceedings for adolescents, which were not reviewed for this dissertation.

Because the number of admissions to "other psychiatric inpatient care" was not available from all 51 jurisdictions, the FY 2018 data (SAMHSA, 2019c) was selected for the main analysis. It was the latest data with the most states providing numbers of admissions to other psychiatric inpatient care for adults (from 37 states). The FY 2019 data (SAMHSA, 2020), which

contained the admission data from 34 states, was used in a separate analysis. While the FY 2020 report is the latest available, it was not used for the analysis because the COVID-19 pandemic could have affected the number of admissions to inpatient psychiatric facilities in ways too difficult to gauge at this time. Clerici et al. (2020), in examining rates of involuntary and voluntary admissions to seven general hospital psychiatric wards in Italy in the 40 days after the start of the spread of COVID-19 (February 21-March 31, 2020) and the 40 days prior to February 21 and two other 40-day periods in 2019, found a significant reduction in overall admission rates in the 40-day period after the start of the spread of COVID-19, compared to the periods prior to the pandemic.

Statutory Timings of the Detention Hearings. The predictor variable was the time (in days) to the first/initial hearing from the time an individual is initially detained under emergency detention, which was collected in Chapter 5. The statutory timings for the additional hearing (after the first hearing) were not included in the analysis because they could not be computed for some states, not even approximately. Hearings conducted by the court and/or non-judicial officers were all included. Out of the 37 states that had admission data available in the FY 2018 URS output tables, New York was excluded because a hearing is held only upon request. The final sample included 36 states for 2018 data.

The statutes used to compute the timing for the hearing for Chapter 5 were effective in their jurisdictions as of September/October 2021. Since the FY 2018 admission data were used in the analysis, the legislative history of the statutes used to compute the hearing timings were reviewed to ensure that the same timings could be applied to 2018. Only three states, Minnesota, West Virginia, and Washington, amended their statutes in 2020 or 2021 in ways that affected the timings computed for Chapter 5. Because admission data were available for these states, their

statutory timings were recomputed. Table 6.1 lists these timings for the 36 states making up the sample of states in the analysis in ascending order.

Table 6.1

Statutory Timings of the Detention Hearings (N = 36 States)[29]

State	Statutory timings of hearings (days)
Montana	1
Alaska	3
Washington	3
Wisconsin	3
Virginia	3.3
Iowa	5
Ohio	5
Texas	5
Oklahoma	5.5
Arkansas	6
Minnesota	6
Missouri	6
Pennsylvania	6
Tennessee	6
Alabama	7
California	7
Idaho	7
Indiana	7
Nebraska	7
New Mexico	7
Florida	8
Massachusetts	8
Arizona	10
Maryland	10
Michigan	10
North Carolina	10
Delaware	11
Utah	11
Hawaii	12

[29] Listed in ascending order.

Vermont	14
West Virginia	15
Oregon	18
Georgia	20
New Jersey	21
Connecticut	25
DC	31

Control Variables. Since deinstitutionalization, a common argument has been that a decrease in the availability of psychiatric inpatient beds and an increase in access to community mental health services would reduce the admissions to psychiatric hospitals. Because of their conceptual relevance to admissions to inpatient psychiatric facilities, the state-level numbers of adults served in community mental health programs, inpatient psychiatric beds, and inpatient psychiatric facilities were included in the analysis as control variables.

Adults Served in Community Mental Health Programs. There is a lack of studies that have examined the access to and utilization of community mental health centers in relation to the rates of admissions to inpatient psychiatric facilities in the US. A few individual-level studies showed the unavailability of alternatives to hospitalization, such as short-term crisis intervention, residential crisis stabilization, and in-home crisis stabilization, was a significant predictor of clinicians' decision to commit in Virginia (McGarvey et al., 2013), and the availability of a less restrictive alternative to hospitalization was associated with a lower probability of the clinicians seeking commitment in California (Segal et al., 2001). For this dissertation, the number of adults "served in community mental health programs" were obtained from the same 2018 URS output tables. The numbers were presented for different age groups (0-17, 18-20, 21-64, 65+ years). The numbers for the adult groups (18 years and over) were summed up and included in this study.

Inpatient Psychiatric Beds and Inpatient Psychiatric Facilities. Not much is known about the association between the availability of inpatient psychiatric beds and/or psychiatric facilities and rates of inpatient psychiatric admissions in the US. A longitudinal study conducted in England found that the annual reduction in inpatient psychiatric beds was associated with increased rates of involuntary admission per 100,000 adults between 1988-2008 (Keown et al., 2011). Another study showed that, among 22 countries, those with a higher number of inpatient psychiatric beds per 100,000 individuals had a higher rate of involuntary hospitalization per 100,000 individuals (Rains et al., 2019). For this dissertation, the number of inpatient psychiatric beds was measured with the number of "beds in 24-hour psychiatric hospital inpatient treatment settings," which were obtained from the 2018 SAMHSA's survey of public and private mental health services: the National Mental Health Services Survey (N-MHSS) (SAMHSA, 2019a). It is a voluntary survey designed to collect data on the location, characteristics, and utilization of mental health treatment services for facilities in the US. The data were collected between March and November 2018 and the reference date was April 30, 2018. Of the 13,354 facilities eligible for the survey, 90% completed the survey. The N-MHSS provides the number of beds in the following 24-hour hospital inpatient treatment settings:

> Psychiatric hospitals are facilities licensed and operated as either state/public psychiatric hospitals or as state-licensed private psychiatric hospitals that primarily provide 24-hour inpatient care to persons with mental illness. They may also provide 24-hour residential care and/or less- than-24-hour care (i.e., outpatient, partial hospitalization/day treatment), but these additional service settings are not requirements.
>
> General hospitals with a separate inpatient psychiatric unit are licensed general hospitals (public or private) that provide inpatient mental health services in separate psychiatric units. These units must have specifically allocated staff and space for the treatment of persons with mental illness. The units may be located in the hospital itself or in a separate building that is owned by the hospital (SAMHSA, 2019a, p. 4).

The N-MHSS only provides the number of beds in *all* 24-hour hospital inpatient treatment settings and does not distinguish the number of beds in public psychiatric hospitals

from the number of beds in private and general hospitals. However, it provides the number of public psychiatric hospitals, private psychiatric hospitals, and general hospitals with inpatient psychiatric units separately for each state. Given that this dissertation excluded admissions to state psychiatric hospitals from the outcome measure, a variable was created for this dissertation by summing up only the numbers of private psychiatric hospitals and general hospitals with inpatient psychiatric units for each state (referred to as the number of inpatient psychiatric facilities).

Statistical Analysis

Regression Analysis. Regression analysis is a statistical method that is used to analyze quantitative variables. One of the goals of regression is to *predict* values of an outcome variable ("dependent variable") with values of one or more predictor variables ("independent variables") (Afifi et al., 2012). It can also be used to *describe/explain* the relationship between these variables.

Simple regression refers to an analysis of two variables: a single predictor variable and an outcome variable. Multiple/multivariable regression analyzes multiple predictor variables and an outcome variable, which can be more useful since it examines how one predictor variable is associated with the outcome variable while controlling for the possible effect of other variables in the same model. The purpose is to take into account other factors that can have impact on the outcome variable. There can be one main predictor in a multivariable regression, and other predictors can be referred to as control variables. Simple regression typically shows a significant association between two conceptually related variables. Only when the association remains significant in a multiple regression can one draw a stronger conclusion about the association between the two variables.

Regression analysis can be conducted using different techniques; ordinary least squares (OLS) regression being one of the most commonly used (Hutcheson, 2011). OLS achieves the goals of regression by using the data from a sample to construct a linear line that best fits the data (which is the line that has the least amount of error). An error or residual is calculated by subtracting an observed outcome value from its corresponding predicted or fitted outcome value.

The outcome variable in OLS regression must be continuous (any numbers, including negative values and non-integers), while the predictor variable(s) can either be continuous or discrete (integers/whole numbers). Discrete variables are finite and can measure categories. Since statistical analysis can only be conducted with numbers, categories are generally assigned to whole numbers (e.g., categories that are binary/dichotomous [0 = No, 1 = Yes] or multi-categorical [0 = No hearing; 1 = Court hearing, 2 = Non-judicial hearing]). The data must also be checked to see if they meet the underlying assumptions of OLS regression: that 1) the relationships between the predictors and the outcome variable are linear, 2) the residuals are normally distributed, 3) the variance of residuals is constant (homogeneity of variance or "homoscedasticity"), and 4) the errors associated with one observation are not correlated with the errors of any other observation (UCLA, n.d.-a). Violations of these assumptions may lead to misleading results.

Poisson and Negative Binomial Regressions. Outcome variables that are not continuous, such as discrete outcomes, can alternatively be analyzed using generalized linear models (GLM), such as logistic regression (where the outcome variable is binary/dichotomous), multinomial regression (where the outcome variable is multi-categorical), or ordinal regression (where the outcome variable is ordinal data [categorical variables where there must be an ordering of the categories]). The other GLMs include Poisson regression and negative binomial

regression, which are used to predict count outcomes, or the number of times an event occurs within a defined period of time (Coxe et al., 2009). A count variable can only take on positive integer values of zero or greater.

Poisson regression, which is the foundation for other count models, is more flexible than OLS regression in that it does not assume the relationships between predictor and outcome variables are linear, the residuals are normally distributed, or the variance of residuals is constant (Coxe et al., 2009; Long & Freese, 2014). One of the intriguing assumptions of Poisson regression is that the conditional mean and variance are equal. In real data situations, however, the variance tends to be larger than the mean. This condition, referred to as overdispersion, may occur because of extra variability in the count data, omission of key predictors in the model, or outliers (Coxe et al., 2009; Payne et al., 2017). If overdispersion is not adjusted, the variables may appear to be statistically significant when they are in fact not statistically significant (Hillbe, 2011). To overcome the problem with overdispersion, negative binomial regression can be used instead of Poisson regression. It has been shown to effectively adjust for the overdispersed count data (Payne et al., 2017).

The regression coefficient in count models represents the change in the log of the expected count for every one unit increase in the predictor (Long & Freese, 2014). In some discussions of count models, the count outcome is referred to as the incidence rate because rate is also defined as the number of events per time or space, and incidence rate is the rate at which events occur (Long & Freese, 2014; UCLA, n.d.-c). If we want to adjust for different time period or area of measurement, an exposure variable can be included in the count models (Penn State, n.d.-a). The exposure variable, which can be the time, space or etc., only adjusts counts on the outcome variable. For this reason, it is possible to include different kinds of rates, indexes, or per

capita measures as predictors (UCLA, n.d.-b). Additionally, even though the exposure variable is included in the model along with the other predictors, it is not treated as another predictor, and no coefficient is estimated for the exposure variable (Penn State, n.d.-b).

Because interpreting regression coefficients in terms of log can be difficult, the incidence rate ratio (IRR) is often used instead (Long & Freese, 2014). The IRR is the ratio of the expected number of events for a unit increase in the predictor to the expected number of events (UCLA, n.d.-c). The IRRs, which are obtained by exponentiating the estimated regression coefficients, can be used to interpret the results in terms of factor (multiplicative) change. An IRR greater than 1 means that the rate is expected to increase by a factor of IRR for every one unit increase in the predictor variable; a value less than one means the rate is expected to decrease by a factor of the IRR for every one unit increase in the predictor. With the IRR, the percent change can also be calculated using the following formula: 100*(IRR-1) (Long & Freese, 2014). An IRR greater than 1 means that the rate is expected to increase by 100*(IRR-1)% for every one unit increase in the predictor variable; a value less than one means the rate is expected to decrease by 100*(IRR-1)% for every one unit increase in the predictor.

Analysis Preparation/Data Assessment

Because the outcome variable of this dissertation was the counts/numbers of admissions to inpatient psychiatric facilities, either Poisson regression or negative binomial regression was considered appropriate for the analysis. Before conducting any statistical analysis, counts were first adjusted for differing state populations. In order to produce the results in terms of rates per 100,000 adults, the 2018 adult population estimates from the US Census Bureau was first divided by 100,000 for each state. These figures were then included as an exposure variable in the Poisson and negative binominal models. For descriptive purposes, using the 2018 age-specific

estimates from the US Census Bureau, the number of admissions to inpatient psychiatric facilities for adults were transformed to rates per 100,000 adult population by state, using the following equation: (state adult number of admissions to inpatient psychiatric facilities / state adult population) x 100,000.

Using the 2018 age-specific estimates from the US Census Bureau, the numbers of adults served in community mental health programs were transformed to numbers of adults served per 100,000 adult population by state, using the following equation: (state number of adults served in community mental health programs / state adult population) x 100,000.

Using the 2018 total-population estimates from the US Census Bureau, the numbers of inpatient psychiatric beds and of inpatient psychiatric facilities were similarly transformed into numbers per 100,000 population by state, using the following equation: (state number of inpatient psychiatric beds or state number of inpatient psychiatric facilities / total state population) x 100,000. Total population rather than adult population was used in these calculations because the N-MHSS does not specify whether the facilities are used for adults or adolescents.

The second step was to confirm that OLS regression was not a good fit for the data. STATA version 17.0 (StataCorp) was used to conduct all analyses for this part of the dissertation. The significance level, $\alpha = .05$, was used to determine the significance of results.

First, the distribution of each variable was observed using histograms. The distributions of counts of admissions to inpatient psychiatric facilities, statutory timings for the hearing, number of adults served in community mental health programs per 100,000 adults, number of inpatient psychiatric beds per 100,000 people, and number of inpatient psychiatric facilities per 100,000 people were all skewed to the right. Then, linear relationships between the variables

were checked using Pearson correlation. Except for the numbers of inpatient psychiatric beds and of inpatient psychiatric facilities per 100,000 people, the variables were not significantly correlated with each other (Appendix C). The normality of residuals were also assessed. The P-P plot (a standardized normal probability plot) showed an indication of the non-normal distribution of the residuals. The statistical significance of the Shapiro-Wilk test ($p < 0.001$) for normality confirmed that the residuals were not normally distributed. Finally, to check for homoscedasticity (constant variance) of residuals, these were plotted against fitted (predicted) values. If the variance of the residuals is constant, there should be no patterns to the residuals in the graph as the fitted values increase, and the residuals should be randomly and evenly distributed around zero. The plot displayed a fan-shaped pattern (i.e., as the fitted values increased, the spread of residuals increased as well), which is an indication of heteroscedasticity (non-constant variance of the residuals).

The final step was to determine which count model, Poisson or negative binomial, is appropriate to fit the data. First, a multivariable Poisson model was constructed with the number of admissions to inpatient psychiatric facilities as the outcome variable, statutory timings for hearings as the main predictor variable, and numbers of adults served in community mental health programs per 100,000 adults and of inpatient psychiatric beds per 100,000 people as the two control variables. Another multivariable Poisson model was constructed that replaced the population-adjusted number of inpatient psychiatric beds with the population-adjusted numbers of inpatient psychiatric facilities. The results are displayed in Appendix D, which showed that all variables were significantly associated with the rates of admissions to inpatient psychiatric facilities. However, these results could be due to the presence of the overdispersion in the count outcome variable, which can overestimate the statistical significance if a Poisson model is used.

When the goodness-of-fit chi-squared test was conducted to assess whether the Poisson model fitted the data, the statistically significant results ($p < 0.001$) indicated that the data were not a good fit for the model.

The same two models (shown in Appendix D) were performed again but with a negative binomial model to test whether overdispersion was present in the outcome variable. If the likelihood-ratio chi-square test of alpha in the negative binomial model is statistically significant, it indicates the presence of overdispersion. The results showed that the test was statistically significant ($p < 0.001$). Given the overdispersed count outcome, which violates the assumption of the Poisson model that the variance and mean are equal, the negative binomial regression model was chosen to conduct analyses for this dissertation.

To analyze the FY 2019 URS data, the same steps for data and model assessments were taken to confirm that a negative binomial model was appropriate to use for the analysis. From the 36 states included in the analysis of the 2018 data, Alaska, Iowa, and Kansas were excluded because they did not have the admission data in FY 2019. The final sample included 33 states. The numbers of adults served in community mental health programs, inpatient psychiatric facilities, adult population, and total population for 2019 were all obtained from the same data sources. The number of inpatient psychiatric beds was not included in the analysis of 2019 data because they were not available.

Analysis Procedures

To examine the association between statutory timings of the hearings and rates of admission to inpatient psychiatric facilities, three multivariable negative binomial regressions were constructed. Using 2018 data, the first model analyzed the number of admissions to inpatient psychiatric facilities as the outcome variable, statutory timings of detention court

hearings as the main predictor variable, and the numbers of adults served in community mental health programs per 100,000 adults and of inpatient psychiatric beds per 100,000 people as the control variables. The second model was constructed the same way as the first model except it replaced the number of inpatient psychiatric beds per 100,000 people with the number of inpatient psychiatric facilities per 100,000 people. Lastly, the third model was constructed the same way as the second model except it analyzed 2019 data. For each model, IRR coefficients were obtained to interpret the results in terms of the percent changes, which were calculated using the following formula: 100*(IRR-1)%.

Results

In 2018, there were 293,479 admissions to inpatient psychiatric facilities among 36 states (M = 8,152.2, SD = 11,215, Mdn = 2,425.5).[30] The overall admission rate was 145.7 per 100,000 adults. Figure 6.1[31] lists the rates of admissions to inpatient psychiatric facilities per 100,000 adults and statutory timings of the hearing by descending order of the state admission rates. The statutory timings of the hearings ranged from 1 day in Montana to 31 days in DC, with a median of 7 days (M = 9.4, SD = 6.5).

[30] The mean and median are both provided because of the skewed distribution.
[31] This figure was created with RStudio version 2022.02.1.

Figure 6.1

Statutory Timings of Hearings and Rates of Admissions to Inpatient Psychiatric Facilities (N = 36 States)

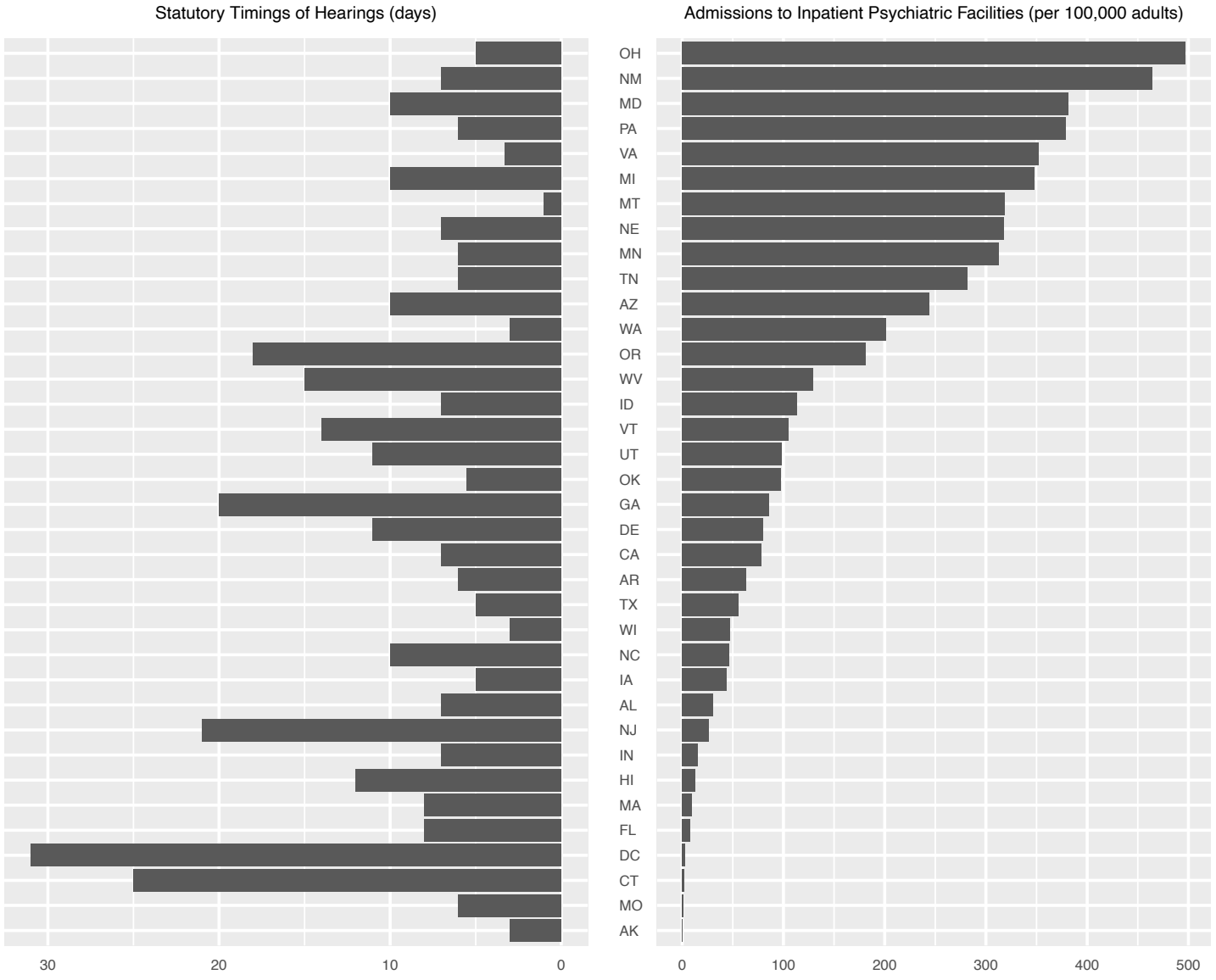


Table 6.2 shows the results of the multivariable negative binomial regressions. Models 1, 2, and 3, respectively, show every one day increase in statutory timings of the hearings was associated with 7% ($p = 0.028$), 8% ($p = 0.022$), and 10% ($p = 0.009$) decrease in the rates (per 100,000 adults) of admission to inpatient psychiatric facilities, adjusting for other predictors. One unit increase in the number of adults served in community mental health programs per 100,000 adults was also associated with 0.04% increase in the rates of admission in Models 1 and 2 ($p = 0.012$ and 0.009, respectively), controlling for other predictors. Lastly, one unit increase in the number of inpatient psychiatric facilities per 100,000 people was associated with 88% decrease in the rates of admission in Model 2 ($p = 0.021$), adjusting for other predictors.

Table 6.2

Results of Multivariable Negative Binomial Regression Analysis

Model 1 (N = 36 states)	IRR	95% CI	*p*
Statutory timing of hearings in days	0.93	0.86-0.99	0.028*
Number of adults served in community mental health programs per 100,000 adults	1.0004	1.00008-1.0007	0.012*
Number of inpatient psychiatric beds per 100,000 people	0.98	0.95-1.005	0.105
Model 2 (N = 36 states)			
Statutory timing of hearings in days	0.92	0.85-0.99	0.022*
Number of adults served in community mental health programs per 100,000 adults	1.0004	1.0001-1.0007	0.009*
Number of inpatient psychiatric facilities per 100,00 people	0.12	0.021-0.73	0.021*
Model 3 (N = 33 states)			
Statutory timing of hearings in days	0.90	0.83-0.97	0.009*
Number of adults served in community mental health programs per 100,000 adults	1.0002	0.9999-1.0005	0.101
Number of inpatient psychiatric facilities per 100,000 people	0.19	0.021-1.75	0.144

*$p < 0.05$, CI = Confidence interval

CHAPTER 7

Discussion

This is the first present-day study to systematically examine and describe state statutes governing initial commitment procedures across all US states and to attempt to link their provisions regarding the timings of the detention hearings to the rates of admissions to psychiatric facilities in different US states. Across 51 jurisdictions, it was found that only four states do not authorize the court to act as one of the designated authorities to order emergency detention, evaluation, or involuntary commitment. While only two states did not statutorily require some form of hearing to extend emergency detentions into longer-term commitment, the statutory timings of the hearings from the time a person is initially detained under emergency detention varied substantially across 51 states, ranging from 1 to 34 days. In a regression analysis of 36 states using data from 2018, it was found that a longer statutory timing of the hearing in a state was associated with a lower rate of admission to inpatient psychiatric facilities in the state. Given that this dissertation is a state-level study and analyzed a small sample, the quantitative findings should be interpreted with caution.

Court Approval/Order of the Detention

This dissertation found that no US state permits the court to be the only authority to order emergency detentions before detaining a person. In 21 states, however, besides law enforcement officers and/or designated mental health professionals, the court may order emergency detentions or immediate detentions without a formal hearing. Among these states, only three states require the person subjected to emergency detention to appear before the court. Some of these results are inconsistent with findings from Hedman et al.'s (2016) study, which is the only peer-reviewed study to assess the state statutes on the court approval of the detention across 51 jurisdictions.

Hedman et al. reported that court approval is required prior to the detention in nine states with *ex parte* hearings (Arkansas, Colorado, Florida, Kentucky, Maryland, Mississippi, New York, Virginia, and Vermont). Excluding two of these states (Kentucky and Mississippi), this dissertation found 14 additional states that authorize the court to act as one of the designated authorities to order emergency detention. Given that Hedman et al. were the first to consolidate emergency detention laws, they might have overlooked the sections guiding court-ordered emergency detentions for 14 states. Unlike Hedman et al., this dissertation did not find laws guiding court-ordered emergency detentions in Kentucky and Mississippi. Although section 202A.028 of Kentucky Revised Statutes is entitled "Hospitalization by court order…", it appears to describe the procedures that follow when a petition is submitted for involuntary commitment under section 202A.051. Hedman et al. may have mistakenly obtained their finding from section 202A.028 of Kentucky Revised Statutes, which does not seem to address court-ordered emergency detentions. Mississippi's statute was also rechecked. Still, the section guiding a court-ordered emergency detention could not be located.

This dissertation also found that ten states require the court to approve emergency detentions after the person is detained, and this decision is made without a hearing in all ten states. Hedman et al. (2016) reported that 13 states (DC, Iowa, Idaho, Indiana, Kansas, Maine, North Dakota, New Hampshire, Nevada, South Carolina, Tennessee, Texas, and Wyoming) require a court approval of emergency detention with an *ex parte* hearing after the detention. Unlike Hedman et al.'s findings, this dissertation did not find that a court approval of emergency detention is required after the detention in Kansas, North Dakota, New Hampshire, Nevada, and Wyoming, but is required in Alaska and Arizona (the last two states were not included in Hedman et al.'s findings).

TAC (2020) recommended that all states should authorize any individual to petition the court for both emergency detention *and* inpatient commitment, and that states should not require "certification" by more than one professional in order to initiate emergency evaluation. They found that "enumerated citizens"/any responsible adult may petition the court for emergency detention in 31 states and for inpatient commitment in 33 states. Hedman et al. (2016) found that any interested person can initiate emergency commitment with the court in 12 states. This dissertation found that, among 47 states that have laws guiding court-ordered emergency detentions, court-ordered evaluations, and/or involuntary commitment, only the designated authorities, such as screening agencies, crisis responders, and county/district/state attorneys, can petition the court in six states, whereas non-professionals can petition the court in 41 states. In 36 of 41 states, non-professionals are permitted to petition the court without accompanying a clinical certificate or applying to a designated agency or person for a pre-petition screening. These findings suggest that most states permit a non-professional to have another person detained for a psychiatric evaluation and/or treatment without placing "legal barriers." Whether the court would be more likely to deny the petition of non-professionals if it is not accompanied by a certificate, and how much of the impact a certificate has on the court's decision, is unknown. Determining this can help to understand whether or not the law provides an easy pathway for any individual to have another person detained for a psychiatric evaluation or treatment.

The inconsistent findings suggest that that it is very difficult to accurately determine what the statutes say. As the reliability check on the statutory timings of hearings demonstrated, interpreting a statute's imbricated and sometimes convoluted sections, each guiding a different pathway to commitment, is challenging. The reliability check also revealed the importance of

documenting the section numbers of the legal texts that are being analyzed. What made the process of checking Hedman et al.'s (2016) findings difficult was the absence of sources, specifically the section numbers, on which the findings are based. While TAC's (2020) report did provide section numbers in its appendix, their lack of clear descriptions and operational definitions weakened the ability to interpret their findings meaningfully in relation to their ensuing policy recommendations. It is crucial that any future study examining legal texts include the section numbers and clear description of their findings to enhance comparability and improve confidence in results.

This dissertation addresses more clearly whether state laws authorize court approval of detention and whether they provide an easy pathway for any individual to have another person detained for psychiatric evaluation and/or treatment. First, it listed the section numbers as well as the excerpts of the legal texts that were used to obtain the results. It also presented the exceptions that the states have on their legal procedures more clearly, in order to enhance the interpretability of the findings. Furthermore, it assessed the accuracy of results by checking them against TAC (2020) and Hedman et al.'s. (2016) findings.

Overall, the findings suggest the lack of procedural protections afforded to the person subjected to emergency detention. While 49 states require a hearing for longer-term commitment after the person is detained, no states require a hearing for an emergency detention prior to the detention. Therefore, a person subjected to emergency detention is afforded procedural protections after the detention. While states have their own legal rules on emergency detentions, this lack of procedural protections suggests that states may not necessarily treat emergency detentions as a form of deprivation of liberty. There is a tacit or explicit acceptance by almost every party that the main purpose of an emergency detention statute is to facilitate immediate

detention and treatment/evaluation of individuals so identified as needing it by mental health professionals. This acceptance could be related to the assumptions that deprivation of liberty more truly refers to longer-term commitment because it theoretically lasts longer than emergency detention.

It is important to note that proceedings could also be initiated by calling 911 or bringing a person or presenting to an ED for a psychiatric consultation, without first being placed under emergency detention. Among 2,503 people who arrived at an ED for psychiatric evaluation in Los Angeles, California, 535 people walked in, 982 arrived by car, 846 arrived by an ambulance, and 43 were brought in by police, and 47.9% of those who walked in, 47.4% arriving by car, 51.7% by ambulance, and 76.7% brought by police were "involuntarily admitted to inpatient psychiatry" (Bhalla et al., 2021). If it is determined that the individual at the ED for mental health issues requires an admission to a psychiatric facility and the hospital does not have a psychiatric unit, an open bed at another facility must be found so that the individual can be transferred to that facility (Mark et al., 2019). If available beds cannot be found, the individual would need to wait in the ED until an appropriate opening is found, instead of being discharged. Because locating beds in psychiatric units or psychiatric hospitals is said to be difficult due to the shortage of inpatient beds, individuals often stay in EDs for several days or longer, before they can be moved to a psychiatric unit or hospital (a phenomenon known as ED boarding) (Gold, 2011). Nolan et al. (2015) found that the odds of ED boarding for individuals visiting an ED for mental health issues were 4.78 times higher than for individuals visiting for non-mental health related issues. In sum, specific short-term pathways or mechanisms through which an individual enters the commitment system may not necessarily transpire according to how it is laid out in the law. Because so little research describes actual commitment practices, it remains difficult to

properly evaluate the impact of commitment laws, or even how the laws are translated into administrative mechanisms and procedures which may, or may not, express the intent of the law.

Statutory Timings of Detention Hearings

Whether a court hearing is required for longer-commitment does not vary much across states: 46 states require a court approval for continued detention/longer-term commitment. The most notable variation in state laws governing the initial commitment proceeding was found with when a hearing is statutorily required to be held after a person is detained from the time of the initial emergency detention, regardless of whether it is conducted by the court or not. It was also found that 21 states mandate an additional hearing. In these states, longer-term commitment is ordered during the second (full) commitment hearing. Both the substantive and procedural criteria for decision may be different at an initial preliminary hearing versus a subsequent full commitment hearing.

Some similarities were observed between the Figure 4.3, "Longest Total Permissible Detention Before Commitment Hearing" (reproduced from Barclay, 2008, p. 5), and the findings of this dissertation on statutory timings of hearings for all 51 jurisdictions (Figure 5.1). As described in Barclay's report, 24 states allow for a time period ranging from five to 10 days, while the remaining states, except for five, have total maximum time periods over 10 days. This dissertation found that statutory timings of the hearings for 27 states ranged from five to 10 days, while the remaining states, except for seven, allow for a time period over 10 days. While no information is provided in Barclay's report on how the findings were obtained and the operational definition of the longest total permissible detention before commitment hearing, Barclay's figure and the findings of this dissertation both suggest that a hearing could be held

between 5 to 10 days in about half of states. These consistencies suggest that similar methods may have been used to obtain both sets of findings.

Statutory timings of the hearings do not reflect when the hearings are actually held. In reality, there could be a substantial variation in when the hearing is held within the same state because of three factors. First, the hearing may be postponed at the request of one of the parties, including the detained person. Second, the hearing could be held earlier than statutorily required if this is requested by the detained person or their attorney. Third, Saturdays, Sundays, and legal holidays may or may not be excluded in the statutory timings of the hearings. There is no known inter-state data, or even publicly-available within-state data, on the actual timings (and dispositions) of court hearings during the commitment process, except for one report that described Virginia's commitment hearings (University of Virginia, 2008). It showed 67.7% of hearings were held within the legislated time limits, while the other 32.4% were not (there were legal justifications for the delay) in May 2007.

Some state statutes were more complex and difficult to interpret than others, which raises a question of how the legal rules and procedures are implemented by the authorities. Virginia's hearing procedure is relatively easy to understand because the hearing is required within the legislated emergency detention period. Some statutes, on the other hand, are either not written clearly or consist of complex statutory schemes, for example involving multiple detention periods within the initial detention stage. Therefore, discrepancies between the statutory and the actual timings of hearings could be related to legal rules and procedures that seem complex to interpret.

The Association Between Statutory Timings of Detention Hearings and Rates of Admissions to Inpatient Psychiatric Facilities

In a regression analysis of 36 states using data from 2018, this dissertation found that a longer statutory timing of court hearing in a state was associated with a lower rate of admission to inpatient psychiatric facilities per 100,000 adults in the state, controlling for numbers of adults served in community mental health programs per 100,000 adults, of inpatient psychiatric beds per 100,000 people, and of inpatient psychiatric facilities per 100,00 people (in a separate regression analysis). The same results were obtained in an analysis of 33 states using data from 2019. It is important to note this quantitative portion of the dissertation was an ecological and cross-sectional study that lacks control variables and, therefore, could not determine cause-and-effect relationship. Regression analysis was conducted to describe whether variations in statutory timings of hearings could be used to predict variations in rates of admission.

Using data from 2018, it was also found that a higher number of adults served in community mental health programs per 100,000 adults in a state was associated with an increase in the rate per 100,000 adults of admissions to inpatient psychiatric facilities in the state. This could be due to the increased surveillance on individuals receiving community-based mental health services. Although some have argued that increasing access to community-based services would prevent or shorten hospitalizations (Mathis, 2019), the finding of this dissertation suggests that individuals who are receiving community-based mental health services could be more likely to be admitted. This dissertation also found that a higher number of inpatient psychiatric facilities per 100,000 people in a state was associated with a decrease in the rate of admissions in the state, while the number of inpatient psychiatric beds per 100,000 people was not a statistically significant variable. The latter finding could be due to the fact that the number of

inpatient psychiatric beds in state psychiatric hospitals could not be excluded from the analysis. It is important to mention that the significance of the associations depended on which data were used; both the numbers of adults served in community mental health programs per 100,000 adults and of inpatient psychiatric facilities per 100,000 people were not statistically significant variables when 2019 data were analyzed. Further studies are needed to understand the role of the availability of community mental health services, inpatient psychiatric facilities, and inpatient psychiatric beds on rates of inpatient psychiatric admissions.

The small sample size used in the analysis must be highlighted. Given the lack of data in the state number of admissions to inpatient psychiatric facilities, only 36 states were included in the main analysis, which is considered a small number for any type of regression analysis. In general, a limitation of studies that use state-level data is the small sample size (the maximum number is 51 jurisdictions, which may still be considered small). However, in the absence of access to individual-level data, researchers may have to resort to analyzing state-level data. Much of the research on gun violence using regression analysis has analyzed state-level data (Fleegler et al., 2013; Miller et al., 2002; Miller et al., 2007; Miller et al., 2013). This could be related to "a scarcity of detailed data and a near total lack of federal funding support" that have created barriers to better understand gun violence issues (Krisberg, 2018). Given the lack of access to commitment data for non-insiders, the substantial variation found here in statutory timings of court hearings, and variations in rates of commitment found in Lee and Cohen's (2021) study, this dissertation used the available state-level data to describe whether variations in statutory timings of hearings could be used to predict variations in rates of admission.

Limitations

One of the key limitations of this dissertation is the lack of detailed information on how "admission" is defined in the SAMHSA's URS report. Because this dissertation collected data on the statutory timings of hearings that may be held after an initial detention in a facility has begun, the findings could only be interpreted meaningfully if SAMHSA's URS data consist of the number of admissions that occurred *after* some form of hearing (i.e., after the initial detention period). In psychiatric settings, the term "commitment" differs from "admission" or "hospitalization" because the former specifies that a person is detained against their will, while the latter does not. While some scholars use involuntary admission or hospitalization instead when discussing commitment, there is a general confusion on what scholars mean by involuntary admission, involuntary hospitalization, or commitment. Specifically, confusion arises over whether commitment and/or admission/hospitalization start from the time when a person is admitted to a facility under emergency detention (what in this dissertation has been called emergency or initial detention), or from the time when a person is admitted to a hospital under longer-term commitment. Most of the European studies on involuntary psychiatric admissions (especially those conducted in the UK) specify that individuals who start on longer-term detentions are included and individuals who are released after emergency detention are excluded from their analysis (Bindman et al., 2002; Keown et al., 2011; Keown et al., 2018; Weich et al., 2017). Some other studies simply do not state who is included or excluded from their samples of "civilly committed" individuals. These studies should be viewed with great caution because disregarding the first phase provides a truncated view of the phenomenon.

In the US, it is possible that some states define admissions in terms of when a person is admitted to a facility under emergency detention. As shown in the Appendix, 16 states use the

term “admission” or “hospitalization” in the titles of statute sections guiding emergency detention. In describing the emergency detention procedures, some states such as California and South Carolina, respectively, state, “Each person *admitted* to a facility for 72-hour treatment and evaluation under the provisions of this article shall receive an evaluation as soon as possible after he or she is *admitted*....” (Cal Wel & Inst Code § 5152); and “A person may be *admitted* to a public or private hospital, mental health clinic, or mental health facility for emergency admission upon…” (S.C. Code Ann. § 44-17-410, emphases added). Whether or not states apply these legal descriptions or definitions, there is no other general way to understand how admission might be defined in psychiatric settings in the US.

While scholars use involuntary admission/hospitalization and commitment interchangeably, “admission” could be used differently than “commitment” at the state and federal levels in the US. The former may be used as a medical term for reimbursement/billing purposes to consider admission in terms of the time when a person is admitted under emergency detention, while the latter may be used as a legal term to limit the person who has been ordered by the court for commitment from accessing guns. The difference between admission and commitment was discussed in a podcast in the context of mass shootings (Barbaro, 2022). In this episode, a psychiatrist from California described how she “admitted” a man who showed signs of danger to others to a psychiatric hospital, but the man was not “committed” after the hearing because the judge did not certify his commitment in court. As a result, the man was not entered in the federal background system’s list of persons prohibited from owning or possessing a firearm. However, because the man was “admitted” to the hospital, he met the five-year state ban on owning, possessing or attempting to purchase a gun within California (which meant this

person was not prohibited from purchasing guns in other states).[32] The typology of commitment is not only important in commitment research, but also it raises related questions on gun control measures: if it is decided that people who have been committed should not have access to guns, whether these individuals include anyone who has been detained under emergency detention or only those who are committed after the court hearing.

The second limitation relates, in conducting the quantitative analysis, to using the first statutorily required (preliminary) hearing timings instead of the second (full) hearing timings in 21 states that mandate two hearings. Because of unclear descriptions provided in the statutes, the timings of the second hearing could not be computed for many states that require it. The substrative criteria and the burden of proof may differ depending upon whether the first hearing a person receives is a preliminary review hearing or whether it is a full commitment hearing. Given that longer-term commitment may be ordered after a second hearing in these states, the results could be biased if SAMHSA's URS data consist of admissions that occurred after some form of hearing.

Third, the results could be different if the number of admissions to state/public psychiatric hospitals were included in the quantitative analysis. This dissertation excluded the number of admissions to state psychiatric hospitals because they are increasingly responsible for admitting individuals under forensic commitment (Lutterman et al., 2017). Depending on the state, however, a large number of individuals under involuntary civil commitment could still be admitted to state psychiatric hospitals. While the state-by-state differences could be substantial,

[32] Under California Welfare and Institutions Code § 8103(f)(1)(A), a person who has been taken into custody under Section 5150 (72-hour detention) shall not own, possess, control, receive, or purchase, or attempt to own, possess, control, receive, or purchase, any firearm for a period of five years after the person is released from the facility.

the state-level data that differentiate admissions by different legal status are not currently available in the US. The final limitation relates to the lack of control variables included in the analysis. The association observed in the quantitative analysis could have been confounded by other unaccounted factors, such as sociodemographic characteristics of the state. Because of the small sample size, additional control variables were not included to avoid overfitting the regression models.

Despite these limitations, this dissertation specified operational definitions for the different phases of commitment, quantified the statutory timing of court involvement in initial detention, and tested the real-world relevance of this variable on all states submitting psychiatric inpatient admission data to a federally administered database. As a result, this dissertation contributes to the understanding of how commitment laws might be associated with the practice of commitment.

Directions for Future Research

Since this dissertation focused only on what the law requires, next steps for this line of research would include assessing how these laws are applied in reality. In some states, the operation of these statutes is done through the implementation of administrative regulations. Future research should explore the regulatory material governing practice on the ground. Future research is also needed to understand more about how often non-professionals file a petition to the court for the detention of another person and the outcomes of these petitions (whether the petition is denied or granted). Additionally, whether the court would be more likely to deny the petition of non-professionals if it is not accompanied by a certificate of a mental health professional and how much of the impact a certificate has on the court's decision can add support for understanding whether the law provides an easy access for any individual to have another

person detained for psychiatric evaluation and/or treatment. Future research should also identify, at the individual level, the length of detention till the hearing is held, which can be used to examine the association between the individuals' length of detention till a hearing is held and the outcomes of court decisions, across multiple jurisdictions. Another question that future research could address is how often court hearings are held upon request, especially in Colorado and New York where hearings are available only by request. This dissertation excluded these two states from the quantitative analysis because their statutory hearing timings could not be determined. It is important to highlight that New York had the highest rate of admissions to inpatient psychiatric facilities (667.5 per 100,000 adults) among states included in the 2018 URS data (Colorado did not have the available admission data).

Implications and Conclusion

Debates about involuntary commitment, whether it is justified or not, or whether to increase or decrease recourse to involuntary commitment, often occur without empirical evidence in the US. As the first present-day study to quantitatively evaluate commitment laws of multiple jurisdictions, this dissertation fills part of a recognized huge gap in the empirical assessment of commitment laws and their outcomes. The findings illustrate how some legal procedures associated with the initial commitment proceedings vary across states, and how legal procedures could be associated with rates of commitment, but due to various limitations cannot be considered conclusive. Many of the limitations have to do with the lack of real-world evidence concerning civil commitment, which only deepen the already existing gap between laws on commitment and the practice of commitment. The findings signal the need for comprehensive data on commitment to conduct further research on this topic and inform policy.

The findings also illustrate how the basic typology of commitment used in this dissertation—that of an emergency detention phase which may be followed by a longer-term commitment—may be fleshed out via quantitative analysis grounded on close qualitative analysis of the legal texts from which the typology arose (Boldt, 2017; Burley & Morris, 2015). The findings might be seen to illustrate that the incidence of the second phase is related to the length of the first phase, and in that sense the findings reinforce the descriptive value of the basic typology of commitment. It is important to remember that both phases constitute civil commitment—the detention of an individual on the basis of mental illness. Therefore, policy discussions regarding lengthening the duration of the first phase in order to reduce the incidence of the second phase may be misleading, if commitment is properly understood to comprise both, and if reform aims to increase the benefits and reduce the harms of commitment.

APPENDICES

Appendix A

Term used in the Headings of Sections guiding Emergency Detentions

Alabama	"temporary custody"
Alaska	"emergency detention for evaluation"
Arizona	"emergency admission"
Arkansas	"immediate confinement"
California	"detention upon probable cause"
Colorado	"emergency procedure"
Connecticut	"detention by police officer prior to commitment"; "emergency certificates"
Delaware	"emergency detention"
DC	"emergency hospitalization"
Florida	"involuntary examination"
Georgia	"emergency admission"
Hawaii	"emergency hospitalization"
Idaho	"detention without a hearing"
Illinois	"emergency admission by certificate"
Indiana	"emergency detention"

Iowa	"emergency procedure"
Kansas	"emergency observation and treatment"
Kentucky	"emergency admission"
Louisiana	"order for custody"
Maine	"emergency procedure"
Maryland	"emergency involuntary admission"
Massachusetts	"commitment by physicians or police officers"
Michigan	"admission by medical certificate"
Minnesota	"emergency admission"
Mississippi	"emergency patient status"
Missouri	"detention for evaluation and treatment"
Montana	"emergency situation"
Nebraska	"emergency protective custody"
Nevada	"emergency admission/detention for evaluation, observation and treatment"
New Hampshire	"involuntary emergency admission examination"
New Jersey	"involuntary commitment"
New Mexico	"emergency mental health evaluation and care"
New York	"emergency observation"
North Carolina	"special emergency procedure for individuals needing immediate hospitalization"

North Dakota	"emergency procedure"
Ohio	"emergency hospitalization"; "temporary detention"
Oklahoma	"emergency detention"
Oregon	"emergency admission"
Pennsylvania	"involuntary emergency examination and treatment"
Rhode Island	"emergency certification"
South Carolina	"emergency admission"
South Dakota	"involuntary commitment"
Tennessee	"emergency involuntary admission to inpatient treatment"
Texas	"emergency detention"
Utah	"temporary commitment"
Vermont	"emergency examination"
Virginia	"emergency custody order"
Washington	"emergency detention"
West Virginia	"admission under involuntary hospitalization for examination"
Wisconsin	"emergency detention"
Wyoming	"emergency detention"

Appendix B

Sections of Statutes on Court-ordered Emergency Detention, "Court-ordered Evaluation," Involuntary Commitment, and Longer-term Commitment

	A	B	C	D
State	**Emergency Detention**	**"Court-ordered evaluation"**	**Involuntary commitment**	**Longer-term commitment**
Alabama			Code of Ala. § 22-52-1.2. Petition; generally.	Code of Ala. § 22-52-91. Generally.
Alaska			Alaska Stat. § 47.30.700. Initial involuntary commitment procedures.	Alaska Stat. § 47.30.730. Petition for 30-day commitment.
Arizona				A.R.S. § 36-533. Petition for treatment.
Arkansas	A.C.A. § 20-47-210. Immediate confinement — Initial evaluation and treatment.		A.C.A. § 20-47-207. Involuntary admission — Original petition.	See column C.
California		Cal Wel & Inst Code § 5200. Persons subject to court-ordered evaluation.		
Colorado	Colo. Rev. Stat. § 27-65-105. Emergency procedure.	Colo. Rev. Stat. § 27-65-106. Court-ordered evaluation for persons with mental health disorders.		
Connecticut	Conn. Gen. Stat. § 17a-503. Detention by police officer prior to commitment. Issuance of emergency certificates by psychologist and certain clinical social workers and advanced practice registered nurses.		Conn. Gen. Stat. § 17a-497. Commitment jurisdiction. Application. Appointment of three-judge court.	See column C.
Delaware				16 Del. C. § 5008. Probable cause complaint.
DC			D.C. Code § 21-541. Petition to Commission; copy to person affected.	See column C.

	A	B	C	D
State	**Emergency Detention**	**"Court-ordered evaluation"**	**Involuntary commitment**	**Longer-term commitment**
Florida	Fla. Stat. § 394.463. Involuntary examination.			Fla. Stat. § 394.467. Involuntary inpatient placement.
Georgia	O.C.G.A. § 37-3-41. Emergency admission based on physician's certification or court order; report by apprehending officer; entry of treatment order into patient's clinical record; authority of other personnel to act under statute; annual reporting.	O.C.G.A. § 37-3-61. Initiation of proceedings for court ordered evaluation.		O.C.G.A. § 37-3-81. Procedure for detention of patient beyond evaluation period; final disposition.
Hawaii	HRS § 334-59. Emergency examination and hospitalization.		HRS § 334-60.3. Initiation of proceeding for involuntary hospitalization.	See column C.
Idaho			Idaho Code § 66-329. Commitment to department director upon court order -- Judicial procedure.	See column C.
Illinois	405 ILCS 5/3-607 Court ordered temporary detention and examination.		405 ILCS 5/3-701. Petition for involuntary admission.	405 ILCS 5/3-611. [Filing petition, first certificate and proof of service].
Indiana			Ind. Code Ann. § 12-26-6-2. Methods of commencing commitment proceedings.	Ind. Code Ann. § 12-26-5-9. Orders of court for release or hearings — Time for hearing.
Iowa	Iowa Code § 229.11. Judge may order immediate custody.		Iowa Code § 229.6. Application for order of involuntary hospitalization.	See column C.
Kansas	K.S.A. § 59-2957. Petition for determination of mental illness; request for ex parte emergency custody order; content.		K.S.A. § 59-2957. Petition for determination of mental illness; request for ex parte emergency custody order; content.	See column C.
Kentucky			KRS § 202A.051. Proceedings for 60-day and 360-day involuntary hospitalizations — Petition contents.	See column C.
Louisiana	La. R.S. § 28:53.2. Order for custody; grounds; civil liability;		La. R.S. § 28:54. Judicial commitment; procedure.	See column C.

	A	B	C	D
State	**Emergency Detention**	**"Court-ordered evaluation"**	**Involuntary commitment**	**Longer-term commitment**
	criminal penalty for making a false statement.			
Maine				34-B M.R.S. § 3864. Judicial procedure and commitment.
Maryland	Md. Health-General Code Ann. § 10-622. Petition for emergency evaluation.		Md. Health-General Code Ann. § 10-614. Applicants.	Md. Health-General Code Ann. § 10-632. Notice and time of hearing; hearing officer; decision.
Massachusetts	ALM GL ch. 123, § 12. Commitment by physicians or police officers for limited period; notices; extension of term of commitment.			ALM GL ch. 123, § 7. Retention at Facilities, etc., of Persons Whose Discharge Would Create Likelihood of Serious Harm; Requirements, etc.
Michigan			MCLS § § 330.1434. Petition; filing; contents; clinical certificates; confidential record; assisted outpatient treatment; petition not seeking hospitalization.	MCLS § § 330.1452. Court hearing; date; receipt of certain documents.
Minnesota			Minn. Stat. § 253B.07. Judicial commitment; preliminary procedures.	See column C.
Mississippi			Miss. Code Ann. § 41-21-65. Affidavit for commitment; simplified affidavit form; use of Uniform Civil Commitment Affidavit to commence civil commitment proceedings; development of written Uniform Civil Commitment Guide outlining steps in commitment process.	Miss. Code Ann. § 41-21-71. Procedure after examination; release or confinement pending hearing.
Missouri	R.S.Mo. § 632.305. Detention for evaluation and treatment, who may request — procedure — duration — disposition after application.			R.S.Mo. § 632.330. Additional detention and treatment may be requested—contents of petition.

	A	B	C	D
State	**Emergency Detention**	**"Court-ordered evaluation"**	**Involuntary commitment**	**Longer-term commitment**
Montana			MCA § 53-21-121. Petition for commitment — contents of — notice of.	See column C.
Nebraska				
Nevada			Nev. Rev. Stat. Ann. § 433A.200. Filing of petition; certificate or statement of alleged mental health crisis; statement of parent consenting to treatment of minor; proceeding for admission of defendant in criminal action upon motion.	See column C.
New Hampshire	RSA § 135-C:28. Involuntary Emergency Admission Examination.		RSA § 135-C:35. Petition of responsible person.	RSA § 135-C:31. Involuntary Emergency Admission Hearing; Rules.
New Jersey			N.J. Stat. § 30:4-27.10. Court proceedings.	See column C.
New Mexico			N.M. Stat. Ann. § 43-1-11. Commitment of adults for thirty-day period.	See column C.
New York	NY CLS Men Hyg § 9.43. Emergency assessment for immediate observation, care, and treatment; powers of courts.			
North Carolina			N.C. Gen. Stat. § 122C-261. Affidavit and petition before clerk or magistrate when immediate hospitalization is not necessary; custody order.	N.C. Gen. Stat. § 122C-268. Inpatient commitment; district court hearing.
North Dakota	N.D. Cent. Code § 25-03.1-25. Detention or hospitalization — Emergency procedure.		N.D. Cent. Code § 25-03.1-08. Application to state's attorney or retained attorney — Petition for involuntary treatment — Investigation by mental health professional.	N.D. Cent. Code § 25-03.1-26. Emergency procedure — Acceptance of petition and individual — Notice — Court hearing set.

	A	B	C	D
State	**Emergency Detention**	**"Court-ordered evaluation"**	**Involuntary commitment**	**Longer-term commitment**
Ohio			ORC Ann. § 5122.11. Judicial hospitalization; temporary detention order.	See column C.
Oklahoma			43A Okl. St. § 5-410. Petition to the District Court.	See column C.
Oregon			ORS § 426.070. Initiation; notification required; recommendation to court; citation.	ORS § 426.237. Prehearing detention; duties of community mental health program director; certification for treatment; court proceedings.
Pennsylvania			50 P.S. § 7304. Court-ordered involuntary treatment not to exceed ninety days.	50 P.S. § 7303. Extended involuntary emergency treatment certified by a judge or mental health review officer—not to exceed twenty days.
Rhode Island	R.I. Gen. Laws § 40.1-5-7. Emergency certification.		R.I. Gen. Laws § 40.1-5-8. Civil court certification.	See column C.
South Carolina			S.C. Code Ann. § 44-17-510. Petition for judicial commitment; certificate of designated examiner.	See column C.
South Dakota				
Tennessee			Tenn. Code Ann. § 33-6-502. Prerequisites to judicial commitment for involuntary care and treatment.	Tenn. Code Ann. 33-6-413. Notice of admission to general sessions court — Notice of defendant's rights and status.
Texas	Tex. Health & Safety Code § 573.011. Application for Emergency Detention.		Tex. Health & Safety Code § 574.001. Application for court-ordered mental health services.	Tex. Health & Safety Code § 574.021. Motion for Order of Protective Custody.
Utah			Utah Code Ann. § 62A-15-631. Involuntary commitment under court order — Examination — Hearing — Power of court — Findings required — Costs.	See column C.

	A	B	C	D
State	**Emergency Detention**	**"Court-ordered evaluation"**	**Involuntary commitment**	**Longer-term commitment**
Vermont	18 V.S.A. § 7505. Warrant and certificate for emergency examination.		18 V.S.A. § 7612. Application for involuntary treatment.	18 V.S.A. § 7510. Preliminary hearing.
Virginia	Va. Code Ann. § 37.2-808. Emergency custody; issuance and execution of order.			Va. Code Ann. § 37.2-814. Commitment hearing for involuntary admission; written explanation; right to counsel; rights of petitioner.
Washington			Rev. Code Wash. (ARCW) § 71.05.150. Petition for initial detention of persons with behavioral health disorders — Evaluation and treatment period — Procedure — Tribal jurisdiction.	Rev. Code Wash. (ARCW) 71.05.240. Petition for fourteen day involuntary treatment or ninety days of less restrictive alternative treatment -- Probable cause hearing.
West Virginia			W. Va. Code § 27-5-2. Institution of proceedings for involuntary custody for examination; custody; probable cause hearing; examination of individual.	See column C.
Wisconsin			Wis. Stat. § 51.20. Involuntary commitment for treatment.	See column C.
Wyoming	Wyo. Stat. § 25-10-109. Emergency detention.			Wyo. Stat. § 25-10-110. Involuntary hospitalization proceedings.

Appendix C

Correlations Between all Variables Included in the Analysis (N = 36 States)

Variable	1	2	3	4	5
1. Number of admissions to inpatient psychiatric facilities	--	--	--	--	--
2. Statutory timing of hearing	-0.26	--	--	--	--
3. Number of inpatient psychiatric facilities per 100,000 people	-0.25	-0.11	--	--	--
4. Number of adults served in community mental health programs per 100,000 adults	0.28	0.01	0.05	--	--
5. Number of inpatient psychiatric beds per 100,000 people	-0.28	0.07	0.47*	0.05	--

*$p < 0.01$

Appendix D

Results of Multivariable Poisson Regression Analysis (N = 36 States)

Model 1	Coefficient	95% CI	*p*
Statutory timing of hearings	-0.059	-0.06, -0.058	<0.001*
Number of adults served in community mental health programs per 100,000 adults	0.00043	0.00042, 0.00043	<0.001*
Number of inpatient psychiatric beds per 100,000 people	-0.012	-0.012, -0.011	<0.001*
Model 2			
Statutory timing of hearings	-0.063	-0.064, -0.062	<0.001*
Number of adults served in community mental health programs per 100,000 adults	0.00044	.00043, .00044	<0.001*
Number of inpatient psychiatric facilities per 100,000 people	-0.38	-0.41, -0.36	<0.001*

*$p < 0.001$

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