

**“BUT I’M NOT DANGEROUS, JUDGE, I
PROMISE!”: EVALUATING THE
IMPLICATIONS OF INVOLUNTARY CIVIL
COMMITMENT CRITERIA AND
OUTPATIENT TREATMENT METHODS ON
THE ELDERLY**

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In the United States, mental illness amongst elders is continuously increasing. Some elders lose their independence due to the severe symptoms associated with these growing mental illnesses. This often leads to family members, unspecialized doctors, and judges controlling the liberty of many elders and deeming those elders a threat to themselves and others. Often times, this results in their involuntary inpatient confinement.

Where the ultimate goal is to treat elders that pose a threat to themselves and others, outpatient treatment rather than inpatient commitment should be the first resort. This will negate the possibility of “revolving door syndrome” and will result in less elders requiring mandatory inpatient hospitalization and treatment in the future. However, where inpatient confinement is a consideration, gerontologists should be present during commitment hearings and their opinions should be highly regarded. This will lead to consistent outcomes regarding inpatient commitment across the states. Reforming involuntary civil commitment standards and taking the power out of family members’ hands will preserve and protect the liberty and autonomy of many elders.

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I. Introduction

Bob is an eighty-one-year-old man with depression and Alzheimer's disease. Although Bob's story is fictional, it mirrors the story of an elder, who is suffering from a cognitive or psychological disorder, and who is thrown into the involuntary civil commitment process based upon psychological evaluations and family petitioning.

Bob has not experienced the severe side effects of his depression until now. Bob often lies awake at night wondering what causes him to keep himself alive. His sleeping and eating patterns have also deteriorated. In addition to depression, Bob has suffered from Alzheimer's disease for quite some time. Bob does not want to accept his disorders and does not believe he truly needs any treatment or help with making decisions about his life. Bob's depression began years ago when he found out he had Alzheimer's disease, but the side effects of his disorder have never affected him as severely as they have today. He has felt "down" before, but has never felt helpless, worthless, or suicidal. This is the way Bob feels now because of his increasingly severe physical and psychological symptoms.

Prior to civil commitment, Bob never underwent any type of electroconvulsive therapy (ECT)¹ in an attempt to treat any of his disorders, nor any other form of treatment with medical doctors. Bob was automatically removed from the community upon meeting his state's civil commitment criteria, which implemented a "dangerousness" standard following the infamous *O'Connor v. Donaldson* decision.² He tried to convince his family, doctors, and psychiatrists that he did not pose any danger, but they did not believe him. The court gave significant deference to Bob's medical professionals during his commitment hearing, and Bob felt that rebutting their opinions would

1. See *ECT, TMS And Other Brain Stimulation Therapies*, NAT'L ALL. ON MENTAL ILLNESS, <https://www.nami.org/Learn-More/Treatment/ECT-TMS-and-Other-Brain-Stimulation-Therapies> (last visited Nov. 23, 2015) [hereinafter *ECT, TMS And Other Brain Stimulation*] ("ECT is a procedure where controlled electric currents are passed through the brain while the person is under general anesthesia . . . It is most often used to treat severe depression and depression with psychosis that has not responded to medications.").

2. See *O'Connor v. Donaldson*, 422 U.S. 563, 576 (1975) (indicating that a state cannot confine a nondangerous person who can survive by himself or with the help of family members or friends).

do him no good.³ Medical professionals saw Bob as lacking the mental capacity to understand what his disorders were doing to him and how they may affect him in the future if he is not treated. The judge trusted and deemed these opinions apt to support inpatient civil commitment.

Despite the fact that his depression and Alzheimer's disease cause him to experience symptoms that vary in severity and frequency, Bob is involuntarily institutionalized in a psychiatric hospital as a result of the *future* "danger" he may pose to himself, his family, and to his community. While civilly committed, Bob is lonely. Bob did not receive his own bed or specialized treatment right away because the institution lacked the resources and space to provide him with the adequate care he needed. Eventually, Bob was forced into treatment for his disorders through modes of heavy antibiotics and sedatives. Since his institutionalization, Bob now has extreme limitations on his daily activities, daily interactions, and on his overall quality of life. He is consistently monitored and observed by doctors and mental health specialists who believe he is suicidal and may cause harm to himself or others at any time, especially if he is released back into the community. Bob does not understand the basis for these opinions. Despite his requests to be released from involuntary in-patient confinement, doctors keep telling him he is undergoing "treatment." Bob does not know what type of treatment, if any, is being rendered to him.

Bob's doctors, psychiatrists, and family members brought Bob's civil rights into play when they decided it was time to seek court intervention surrounding his perceived "dangerousness."⁴ The legal system intervenes in such cases where the doctor, psychiatrist, or family members of the mentally ill individual are "asking authorities to override the mentally ill person's constitutional liberty interests, by detaining him against his will for evaluation and/or treatment."⁵

Involuntary civil commitment in this situation is "commitment of a person who is ill, incompetent, drug-addicted, or the like, as con-

3. Christyne E. Ferris, Note, *The Search for Due Process in Civil Commitment Hearings: How Procedural Realities Have Altered Substantive Standards*, 61 VAND. L. REV. 959, 964 (2008).

4. See *Mental Health Commitment Laws: A Survey of the States*, TREATMENT ADVOC. CTR. 2, 5 (2014), <http://www.tacreports.org/storage/documents/2014-state-survey-abridged.pdf> [hereinafter *Survey of the States*].

5. *Id.*

trusted with a criminal sentence.”⁶ Does such court intervention protect an elder prior to civil commitment, or does it do more harm than good?

In the United States, the term “elder” typically refers to a person age sixty-five and older.⁷ Coincidentally, in the United States, the elderly population is increasing exponentially.⁸ It has been predicted that “by 2030, one in five persons in the United States will be elderly, and by the middle of this century, there will be more than eighty million older adults.”⁹ In 2012, 20.4% of elders seemed to have some form of mental illness.¹⁰ As the elder population continues to grow, the likelihood of mental illness will increase.

Both cognitive and psychological disorders can cause an elder to experience not only a diminished quality of life, but also a loss of independence in severe circumstances.¹¹ One of the main contributing factors to the onset of mental distress is when an individual remains untreated, especially if they suffer from depression or substance abuse.¹² Some of the most prominent mental illnesses in elders age sixty-five and older are anxiety, depression, Alzheimer’s disease, and dementia.¹³ Mental illness is identified more often in the elderly than in other age groups, which means they are more likely to fall victim to state statutes permitting involuntary civil commitment.¹⁴ Involuntary civil commitment is generally defined as “the legal process—operating at the confluence of the public safety, justice, and social service systems—whereby an individual found to pose a harm to self or others as a result of mental or physical impairment or disability is

6. Svetlana Walker, Comment, *The Failure of the Federal Courts to Incorporate O’Connor’s Dangerousness Requirement Into The Standards Utilized in Actions Challenging Wrongful Civil Commitments*, 31 *TOURO L. REV.* 149 (2014).

7. See *The State of Aging and Health in America 2013*, CTRS. FOR DISEASE CONTROL & PREVENTION 1 (2013), <http://www.cdc.gov/aging/pdf/state-aging-health-in-america-2013.pdf> [hereinafter *State of Aging 2013*].

8. Monique M. Williams, *Invisible, Unequal, and Forgotten: Health Disparities in the Elderly*, 21 *NOTRE DAME J.L. ETHICS & PUB. POL’Y* 441, 442 (2007).

9. *Id.*

10. Michele J. Karel, *Aging and Mental Health in the Decade Ahead: What Psychologists Need to Know*, 67 *AM. PSYCHOL.* 184, 185-86 (2012).

11. See *State of Aging 2013*, *supra* note 7, at 4.

12. See *id.* at 17.

13. See *Mental and Behavioral Health and Older Americans*, *AM. PSYCHOL. ASS’N* (2014), <http://www.apa.org/about/gr/issues/aging/mental-health.aspx> [hereinafter *Mental and Behavioral Health*].

14. Elizabeth A. McGuan, Note, *New Standards for the Involuntary Commitment of the Mentally Ill: “Danger” Redefined*, 11 *MARQ. ELDER’S ADVISOR* 181, 185 (2009).

forced to undergo treatment”¹⁵ Quite often, severe symptoms of the above illnesses may result in loss of independence, leading to involuntary civil commitment.¹⁶ Yet, is necessary treatment really provided when a patient is involuntarily committed to an inpatient facility?

Part II of this Note addresses the different types of mental disorders most often seen in the elderly population, reveals the history of civil commitment both in the United States and inter-nationally, and provides background on the seminal *O'Connor v. Donaldson* decision. Part III of this Note will analyze and critique: 1) the prevalence of the different forms of “dangerousness” criteria from state to state; 2) who has the power to petition for involuntary civil commitment; 3) evidence of professional evaluations during commitment hearings and their given weight in court; and 4) assisted outpatient treatment methods. Part IV proposes recommendations regarding civil commitment proceedings and treatment methods specifically pertaining to the elderly. These recommendations advocate for universal adoption of “need-for-treatment” commitment criteria when the candidate is elderly, presence of a gerontologist specializing in mental illness during the commitment proceeding to rebut expert testimony from medical doctors and psychiatrists if needed, mandatory outpatient treatment as a first resort upon a finding that an elder meets the state’s commitment criteria, and elimination of any current laws allowing the elderly individual’s guardian or family member the power to admit the elder to a mental health facility without court intervention. Part V of this Note concludes with Bob’s story and how it would be different given the aforementioned recommendations.

15. M. Susan Ridgely et al., *The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States*, RAND INST. FOR CIVIL JUSTICE 1, 12 (2001), http://www.rand.org/content/dam/rand/pubs/monograph_reports/2007/MR1340.pdf.

16. See *State of Aging 2013*, *supra* note 7, at 4.

II. Background

A. Anxiety, Depression, and Alzheimer's Disease: Identifying the Warning Signs and Treatment Options Available to the Elderly

Anxiety, depression, Alzheimer's disease, and dementia are among the most prominent cognitive mental disorders seen in elders.¹⁷ Specifically, anxiety is one of the most common psychological disorders among older adults as it affects ten to twenty percent of the elderly population.¹⁸ Quite often, guardians, doctors, and close family members of the elder do not recognize that he or she is struggling with anxiety, as the disorder commonly goes undiagnosed.¹⁹ Because of this, many elders are never treated for it.²⁰ Generally, when an elder is experiencing an anxiety disorder, he or she may experience: excessive worry or fear; refusal to do routine activities; avoidance of social situations; racing heart; poor sleep; depression; or even self-medicate themselves with alcohol.²¹ Anxiety can also cause an elder to suffer from "amnesia or flashbacks of a traumatic event."²²

Many different types of anxiety exist amongst the elderly population.²³ Anxiety generally encompasses specific phobias, social phobias, generalized anxiety disorder (GAD), post-traumatic stress disorder (PTSD), obsessive-compulsive disorder (OCD), and panic disorder.²⁴ Family members, guardians, and doctors often confuse anxiety for depression.²⁵ Due to similar stressors, anxiety and depression often occur simultaneously.²⁶ Additionally, anxiety sometimes goes undiagnosed because elders have lived with these problems for so long that they have become accustomed to dealing with them.²⁷

Despite going undiagnosed at times, anxiety disorders are treatable because their effects may be eliminated or lessened through pre-

17. See *Mental and Behavioral Health*, *supra* note 13.

18. *Anxiety and Older Adults: Overcoming Worry and Fear*, GERIATRIC MENTAL HEALTH FOUND., <http://www.aagponline.org/index.php?src=gendocs&ref=anxiety&category=Foundation> (last visited Nov. 23, 2015) [hereinafter *Anxiety and Older Adults*].

19. *Id.*

20. *Id.*

21. *Id.*

22. *Id.*

23. *Id.*

24. *Id.* (listing the various types of anxiety disorders with explanations).

25. See generally *id.*

26. *Id.*

27. *Id.*

scriptions and/or psychotherapy;²⁸ yet, the elder will still be encouraged to periodically see their mental health physician for the anxiety disorder.²⁹ The choice between psychotherapy and pre-scription medicine involves several factors, including: what the elder prefers; what other conditions coexist at the same time as the elder's anxiety; and the severity of the disorder itself.³⁰

Prescription medications, such as antidepressants, anti-anxiety drugs, and beta-blockers, are likely to keep anxiety under control for elders, as long as they are diagnosed properly.³¹ Antidepressants also work to balance brain chemistry; however, they take a while to take effect and may cause the elder to experience headaches, nausea, lack of sleep, and/or restlessness, which may result in behavior changes.³² Anti-anxiety drugs, on the other hand, can lead to serious addiction.³³ Since these prescriptions can lead to addiction with increasing dosages, elders usually only take them temporarily and then slowly wean themselves off of the drugs.³⁴

Psychotherapy is another form of treatment used to treat anxiety.³⁵ Generally, an elder will see "a trained mental health professional, such as psychiatrist, psychologist, social worker, or counselor" to discuss their anxiety and to identify potential solutions to improve their struggles with the disorder.³⁶ One very useful type of psychotherapy is cognitive-behavioral therapy (CBT).³⁷ CBT is tailored to each elder

28. *Anxiety Disorders*, NAT'L INST. OF MENTAL HEALTH, <http://www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml> (last visited Nov. 23, 2015) (discussing treatment for anxiety disorders universally, not specific to the type of disorder).

29. See *Anxiety and Older Adults*, *supra* note 18 ("Untreated anxiety can lead to cognitive impairment, disability, poor physical health, and a poor quality of life. Fortunately, anxiety is treatable with prescription drugs and therapy.").

30. See *Anxiety Disorders*, *supra* note 28 (noting some of the considerations in choosing between prescription medication and psychotherapy and how co-existing conditions may affect those considerations).

31. *Id.*

32. *Antidepressants*, U.S. NAT'L LIBR. OF MED., MEDLINEPLUS, <http://www.nlm.nih.gov/medlineplus/antidepressants.html> (last visited Nov. 23, 2015).

33. *Anxiety Disorders*, *supra* note 28 ("Because people can get used to them [high-potency benzodiazepines] and may need higher and higher doses to get the same effect, benzodiazepines are generally prescribed for short periods of time, especially for people who have abused drugs or alcohol and who become dependent on medication easily.").

34. *Id.*

35. See *generally id.* (discussing the various kinds of psychotherapy useful in treating anxiety).

36. *Id.*

37. *Id.*

to fit his or her needs and struggles with a specific disorder.³⁸ CBT or psychotherapy usually runs in a twelve-week program and requires true dedication from the individual inside and outside of each therapy session.³⁹

Although anxiety and depression are similar disorders, they have some major differences.⁴⁰ In the United States, depression affects approximately fifteen out of every one hundred elderly Americans.⁴¹ Elders who live in nursing homes and hospitals have a much higher risk of depression than those who live in their own home.⁴² Depression, unlike anxiety, is an emotionally-driven disorder.⁴³ Depression symptoms prominent in the elderly include, but are not limited to: persistent sadness; weight changes; difficulty concentrating; pacing and fidgeting; and withdrawal from daily activities.⁴⁴

Due to advancements in medicine and technology, elderly Americans can be successfully treated for depression.⁴⁵ Similarly, treatments for depression include, but are not limited to: psychotherapy; antidepressant medications; and ECT.⁴⁶ One treatment unique to depression is ECT.⁴⁷ ECT is very common among the elderly population and is the preferred method of treatment for those who are depressed or suicidal.⁴⁸ ECT is most commonly used for elderly

38. *See id.* (providing an in-depth description of CBT and giving examples of specific anxiety disorders, such as OCD, and how CBT works to help those who struggle with the disorder).

39. *See id.* (stating that often individuals have to complete exercises outside of therapy).

40. Harold Cohen, *Depression Versus Anxiety*, PSYCHCENTRAL (2013), <http://psychcentral.com/lib/depression-versus-anxiety/0001295>.

41. *Depression in Late Life: Not A Natural Part Of Aging*, GERIATRIC MENTAL HEALTH FOUND., <http://www.aagponline.org/index.php?src=gendocs&ref=depression&category=Foundation> (last visited Nov. 23, 2015) [hereinafter *Depression in Late Life*].

42. *Id.*

43. *See* Cohen, *supra* note 40 (identifying common emotions associated with depression to be "hopelessness, despair and anger").

44. *Depression in Late Life*, *supra* note 41.

45. *See generally id.* ("Most depressed elderly people can improve dramatically from treatment. In fact, there are highly effective treatments for depression in late life.")

46. Cohen, *supra* note 40; *Depression in Late Life*, *supra* note 41.

47. *See ECT, TMS And Other Brain Stimulation*, *supra* note 1 (stating that ECT is not used to treat anxiety disorders, but instead individuals with severe depression).

48. HAROLD A. SACKEIM, DIAGNOSIS AND TREATMENT OF DEPRESSION IN LATE LIFE 259 (Lon Schneider ed., 1994); *see* Bonnie S. Wiese, *Geriatric Depression: The Use of Antidepressants in the Elderly*, 53 BC MED. J. 341, 345-46 (2011), http://www.bcmj.org/sites/default/files/BCMj_53_Vol7_depression.pdf (mentioning a survey taken in 1987 by the National Institute of Mental Health which concluded

patients with severe depression and is over eighty percent effective in helping eliminate severe depression symptoms.⁴⁹ ECT pushes electrical currents through the brain and essentially instills chemical changes in parts of the brain that control “mood, appetite, and sleep.”⁵⁰ Patients undergo anesthesia and are injected with a muscle relaxant during the procedure.⁵¹ However, there may be a few concerns as to the safety of using ECT to treat elderly Americans.⁵² Heart rhythm problems, memory loss, attention problems, general confusion, nausea, and headaches are some of the common side effects of using ECT to treat the elderly.⁵³ Additionally, relapse after ECT treatment is extremely common, especially if the elderly individual does not maintain their ECT treatments either once a month or two to three times during a six-week period.⁵⁴ Thus, it is extremely important—especially for elders dealing with severe depression—to maintain and follow through with treatment in order to successfully mitigate their symptoms.⁵⁵

Alzheimer’s disease is a direct cause of deteriorating memory in elderly Americans.⁵⁶ By 2050, sixteen million elders may be affected by Alzheimer’s disease in the United States.⁵⁷ Currently, ten percent of elderly Americans over age sixty-five and fifty percent over age

elderly individuals, ages sixty-one and older, were the largest group taking advantage of ECT treatment).

49. Wiese, *supra* note 48; see *ECT, TMS And Other Brain Stimulation*, *supra* note 1.

50. Charles Kellner, *Patient Information: Electroconvulsive Therapy (ECT) (Beyond the Basics)*, UPTODATE, <http://www.uptodate.com/contents/electroconvulsive-therapy-ect-beyond-the-basics> (last updated Nov. 14, 2015).

51. *Id.*

52. See generally David T. Manly & Stanley P. Oakley, *Is ECT Appropriate in Old-Old Patients?*, PSYCHIATRIC TIMES (Jan. 1, 2001), <http://www.psychiatristimes.com/articles/ect-appropriate-old-old-patients> (discussing risks and concerns surrounding the use of ECT to treat elderly individuals).

53. John Hauser, *Risks of Electroconvulsive Therapy (ECT)*, PSYCHCENTRAL, <http://psychcentral.com/lib/risks-of-electroconvulsive-therapy-ect/0004063> (last updated Jan. 30, 2013).

54. Irving M. Reti, *Electroconvulsive Therapy Today*, JOHN HOPKINS SCH. OF MED. 22, 31, http://www.hopkinsmedicine.org/psychiatry/specialty_areas/brain_stimulation/docs/DepBulletin407_ECT_extract.pdf (last visited Nov. 23, 2015).

55. See generally *id.*

56. *Understanding the Most Common Dementing Disorder: Initiative on Alzheimer’s Disease and Related Disorders*, GERIATRIC MENTAL HEALTH FOUND., http://www.aagponline.org/index.php?src=gendocs&ref=Alzheimers_Disease&category=Foundation (last visited Nov. 23, 2015) [hereinafter *Common Dementing Disorder*].

57. Williams, *supra* note 8, at 467.

eighty-five are believed to have Alzheimer's disease.⁵⁸ Essentially, as people age, their chances of Alzheimer's disease and its severity increase.⁵⁹ Common symptoms of Alzheimer's disease include: trouble with short-term and long-term memory; drastic mood changes; loss of judgment; and loss of physical coordination.⁶⁰

Interestingly enough, Alzheimer's disease is never diagnosed with complete certainty until a person dies and an autopsy is performed to examine their brain tissue; thus, doctors are constantly using different procedures to diagnose Alzheimer's disease as accurately as possible while the elder is still alive.⁶¹ When a doctor believes the elder may have Alzheimer's disease, the doctor may decide to "conduct tests of memory, problem solving, attention, counting, and language [or] carry out standard medical tests, such as blood and urine tests, to identify other possible causes of the problem."⁶² Additionally, in order to check that the elder's symptoms are not related to another cause, doctors may choose to perform brain scans such as a computed tomography (CT) or magnetic resonance imaging (MRI).⁶³ Elders can also pursue other options to ensure that their diagnosis is as accurate as possible.⁶⁴ The elder may seek the advice of geriatricians, geriatric psychiatrists, neurologists, neuropsychologists, and/or Alzheimer's Disease Research Centers to speed up the entire diagnosis process instead of relying solely on a primary doctor and test performance by other health experts not specialized in diagnosing Alzheimer's disease.⁶⁵ Treatment for Alzheimer's disease focuses on different aspects of the disease, such as managing behavioral symptoms of "sleeplessness, agitation, wandering, anxiety, anger, and depression."⁶⁶ Some of the medications that help treat Alzheimer's disease include Aricept, Exelon, Razadyne, Namenda, or a combination of these upon doctors' advice.⁶⁷

58. *Common Dementing Disorder*, *supra* note 56.

59. *Id.*

60. *Id.*

61. *About Alzheimer's Disease: Diagnosis*, NAT'L INST. ON AGING, <http://www.nia.nih.gov/alzheimers/topics/diagnosis> (last visited Nov. 23, 2015) [hereinafter *About Alzheimer's Disease*].

62. *Id.*

63. *Id.*

64. *Id.*

65. *Id.*

66. *Alzheimer's Disease: Treatments*, NIHSeniorHealth, <http://nihseniorhealth.gov/alzheimersdisease/treatments/01.html> (last updated May 2015).

67. *Alzheimer's Disease Medications: Fact Sheet*, NAT'L INST. ON AGING (June 2015), <https://www.nia.nih.gov/alzheimers/publication/alzheimers-disease-fact>

B. Past and Present: The History and Evolution of Involuntary Civil Commitment in the United States

Involuntary civil commitment has been present in the United States for centuries and does not seem to be disappearing anytime soon.⁶⁸ Civil commitment reflects Ancient Greek ideals that have taken root and remain etched in American legal history today.⁶⁹ These include the Greek “formulation of the so-called ‘insanity defense,’ the use of the ‘asylum’ as a place of serenity and recuperation for the mentally ill, and the definitions of basic principles of ‘informed consent,’ democracy, and the essential powers of the state.”⁷⁰ Before Americans created asylums for the mentally ill, the mentally ill were typically sent to prisons or shelters for the poor.⁷¹ Confinement of the mentally ill ensured that they would not harm the community.⁷² Yet, interestingly enough, mentally ill persons were not given treatment of any kind upon confinement.⁷³

Eventually, around 1817, asylums for the mentally ill were established in Connecticut, New York, Massachusetts, and Pennsylvania, but they did not receive any state funding.⁷⁴ Years later, states stepped in and publicly funded these asylums.⁷⁵ Eventually, asylums for the mentally ill were seen in both northern and southern states.⁷⁶ Over time, these asylums were eventually transformed into state-run mental institutions.⁷⁷ Individuals were committed to these institutions when they appeared to fall victim to psychological and cognitive disorders, such as dementia, and were not able to be cured or treated for

sheet (listing medication names for those with mild to moderate and moderate to severe forms of Alzheimer’s Disease).

68. See generally Megan Testa & Sara G. West, *Civil Commitment in the United States*, 7 *PSYCHIATRY* 30, 32 (Oct. 2010), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3392176/pdf/PE_7_10_30.pdf.

69. See generally Paul F. Stavis, An Address by Paul F. Stavis at the Nat’l Conference of Nat’l Alliance for the Mentally Ill, Washington, D.C., July 21, 1995, reprinted in *Civil Commitment: Past, Present, and Future Treatment Advocacy Center, TREATMENT ADVOC. CTR.*, <http://www.treatmentadvocacycenter.org/component/content/article/360> (last visited Nov. 23, 2015) [hereinafter Address by Paul F. Stavis].

70. *Id.*

71. Testa & West, *supra* note 68.

72. *Id.*

73. *Id.*

74. *Id.*

75. *Id.*

76. *Id.*

77. *Id.*

their symptoms by the treatments available during that time period.⁷⁸ During the 1950s, these asylums contained more than 500,000 committed individuals with psychological disorders.⁷⁹

The prevailing view during the 1860s was that those with severe psychological disorders also “lacked the capacity to make decisions,” which ultimately allowed for anyone to be involuntarily committed by their family members or doctors.⁸⁰ Additionally, during this same time period, arbitrary standards governing institutionalization resulted in the loss of many rights and responsibilities of the committed individual.⁸¹ The legal standards for involuntary civil commitment in the 1860s “required only that the presence of mental illness and a recommendation for treatment be established to prove that admission of a person to a psychiatric hospital against his or her will was necessary,” and this standard carried with it an automatic presumption that commitment would improve and cure mental illness regardless of the kind.⁸²

Beginning in the 1900s, states decided it was time to institute legal protections for individuals subject to the civil commitment process, such as: rights to a trial and to an attorney; stricter civil commitment standards; and shifting the commitment power from physicians to judges.⁸³ While these new protections seemed to allow those considered for commitment to retain their legal rights, the legal system and due process challenges still took significant time to sort out during which the considered person could be confined to jail.⁸⁴

Decades later, in the 1960s, the civil rights movement spurred the deinstitutionalization movement.⁸⁵ This movement advocated for greater rights and freedoms from civil commitment hospitals, for

78. *Id.*

79. *See id.* at 33 (“Populations in America’s asylums swelled to more than 500,000 during the 1950s, with an all time high of 559,000 United States psychiatric inpatients in 1953.”).

80. *Id.* at 32.

81. *See id.* (discussing the case of Elizabeth Packard, who ultimately was committed for “moral insanity” for exploring traditions outside of her religion, to which her husband civilly committed her and then subsequently took away her child custody and property).

82. *Id.*

83. Testa & West, *supra* note 68; *see* Ferris, *supra* note 3.

84. Testa & West, *supra* note 68, at 32-33.

85. *See* Chris Koyanagi & Judge David L. Bazelon, *Learning From History: Deinstitutionalization of People with Mental Illness As Precursor to Long-Term Care Reform*, KAISER FAM. FOUND. 1 (Aug. 2007), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7684.pdf>.

available prescription treatment methods, patient rights, and for the elimination of involuntary civil commitment in state hospitals.⁸⁶ During the 1980s and 1990s, care and treatment for the mentally ill was reaching the point of diminishing returns: families of mentally ill individuals could not meet statutory minimums for involuntary commitment, and thus their mentally ill family members were not receiving the care they needed.⁸⁷ Even if statutory requirements were met and the individuals received the treatment they needed, once released back into the community, their mental health deteriorated once again since they were not given any resources to maintain their stable condition.⁸⁸ This became known as the “revolving door syn-drome.”⁸⁹ Over the past couple of decades, many states have decided to reform their statutes to grant courts greater discretion in involuntarily committing mentally ill patients and in providing for outpatient treatment in order to help prevent the “revolving door syndrome” problem.⁹⁰ Outpatient treatment helped those patients maintain their condition after release from the hospital and allowed them to learn how to continue living within their society while also properly treating themselves.⁹¹

C. Comparative Views on Involuntary Civil Commitment

Outside of the United States, other countries have also had a history of evolving standards and views surrounding involuntary civil commitment.⁹² Consequently, there are similarities as well as differences between the reforms and evolving standards in the United States and those of other countries.⁹³ For instance, most countries are similar to the United States in that their reforms and legislation possess strong concerns surrounding the restrictions of personal liberties

86. See Testa & West, *supra* note 68, at 33.

87. See McGuan, *supra* note 14, at 189.

88. See *id.*

89. *Id.*

90. McGuan, *supra* note 14, at 189; see also *Outpatient Commitment for “Revolving Door” Patients: Compliance and Treatment*, TREATMENT ADVOC. CTR., <http://www.treatmentadvocacycenter.org/resources/assisted-outpatient-treatment/about-aot/1396> (last visited Nov. 23, 2015) [hereinafter “*Revolving Door*” Patients].

91. See generally Rachel A. Scherer, *Toward a Twenty-First Century Civil Commitment Statute: A Legal, Medical, and Policy Analysis of Preventative Outpatient Treatment*, 4 IND. HEALTH L. REV. 361, 362-63 (2007); see “*Revolving Door*” Patients, *supra* note 90.

92. See generally Paul S. Appelbaum, *Almost a Revolution: An International Perspective on the Law of Involuntary Commitment*, 25 J. AM. ACAD. PSYCHIATRY L. 135, 137 (1997) (discussing civil commitment reform in other countries).

93. See generally *id.*

and rights of the individual considered for civil commitment.⁹⁴ Some countries, like Austria, have tried to mimic the United States by writing their laws to incorporate “dangerousness” criteria in addition to a finding of mental illness.⁹⁵ Countries that have similar policy concerns over individual liberty and those which have mimicked the “dangerousness” model for involuntary civil commitment include: Belgium, Germany, Israel, the Netherlands, Northern Ireland, Russia, Taiwan, and parts of Canada.⁹⁶

Yet, some countries have decided not to follow the United States’ position on involuntary civil commitment and have instead tailored their involuntary civil commitment statutes and standards to fit their own preferences and concerns with commitment.⁹⁷ For example, in New South Wales, Australia, their 1983 Mental Health Act expanded the “dangerousness” standard to include financial harm risks—that is, to prevent a manic person from going on extensive spending sprees (which they likely would not intend had they not fallen victim to their manic disorders), physical harm to oneself and others, and severe harassment.⁹⁸ Statutes like the 1983 Mental Health Act in New South Wales place special emphasis and importance on protecting others in the community who may fall victim to severe mistreatment or danger when around the mentally ill individual.⁹⁹

With regard to reviewing procedures for civil commitment and due process, many countries stray from the United States’ view of due process and defer to their own legal standards.¹⁰⁰ For example, British statutes do not defer to physician recommendations to civilly commit a person until after that person is already institutionalized, and then will defer only if that person explicitly requests review of his institu-

94. Appelbaum, *supra* note 92; see Testa & West, *supra* note 68 (discussing United States concerns on individual rights restrictions).

95. Appelbaum, *supra* note 92; see *O’Connor v. Donaldson*, 422 U.S. 563 (1975) (adding a second requirement of a finding of dangerousness in addition to mental illness).

96. Appelbaum, *supra* note 92.

97. *Id.* at 138.

98. *Id.* at 137 (“I [Paul S. Appelbaum] asked an Australian colleague, who told me that the advocacy group for persons with bipolar disorders had lobbied for its [1983 Mental Health Act] adoption, seeking to prevent families of manic patients from being left destitute by patients’ spending sprees.”).

99. See *id.* at 138 (mentioning an additional statute in Israel allowing for a mentally ill individual to be civilly committed for endangering and harming others in the community).

100. See *id.* (mentioning that some countries do not immediately review decisions to involuntarily civilly commit someone, but instead review these decisions after the person is already committed).

tionalization in a hearing.¹⁰¹ Surprisingly, only about one-fourth of those civilly committed under the British statute actually request review of their institutionalization.¹⁰² Even if they do request review, the actual process does not begin for at least six months.¹⁰³ Further, the review takes place in front of a “mental health tribunal (typically composed of a lawyer, a doctor, and a lay member) and not a court.”¹⁰⁴ In the United States, if a person considered for civil commitment requests review, they will appear in front of a judge for a formal hearing in a courtroom.¹⁰⁵

D. Due Process, the Seminal *O'Connor v. Donaldson* Decision, and Its Progeny

When drafting the Due Process Clauses within the United States Constitution, the Framers had in mind the country’s present and future when they sought “to reduce the power of the state to a comprehensible, rational, and principled order, and to ensure that citizens are not deprived of life, liberty, or property except for good reason.”¹⁰⁶ The Fourteenth Amendment states that no state shall “deprive any person of life, liberty, or property, without due process of law.”¹⁰⁷ The Fifth Amendment reads similarly, but applies to the federal government instead of state governments.¹⁰⁸ Federal and state governments have a difficult time infringing on fundamental rights unless they have justification for the infringement by showing that it furthers a compelling state interest.¹⁰⁹ For centuries, the concern with involuntary civil commitment has been voiced and addressed by the United States and by international countries through various types of reform; however, the problem of states and other countries infringing on per-

101. *Id.*

102. *Id.* (stating that about twenty-five percent of those civilly committed actually request post commitment review).

103. *Id.*

104. *Id.*

105. See generally *Civil Commitment: Information About the Process for People Alleged to be Mentally Ill*, DISABILITY RIGHTS OHIO (2003), <http://www.disabilityrightsOhio.org/civil-commitment#involuntary> [hereinafter *Information About the Process*] (discussing speedy commitment proceedings usually occurring prior to commitment, if possible).

106. Timothy Sandefur, *In Defense of Substantive Due Process, or the Promise of Lawful Rule*, 35 HARV. J. L. & PUB. POL’Y 283, 285 (2012).

107. U.S. CONST. amend. XIV.

108. U.S. CONST. amend. V.

109. McGuan, *supra* note 14, at 191.

sonal liberties has constantly presented itself.¹¹⁰ In 1975, the Supreme Court in *O'Connor v. Donaldson* addressed the constitutionality of involuntary civil commitment head on.¹¹¹

In 1975, the Supreme Court in *O'Connor* considered the interplay between an individual's due process rights and a state's power to involuntarily commit an individual.¹¹² In *O'Connor*, Kenneth Donaldson (Donaldson) was involuntarily committed for fifteen years in a Florida state hospital as a result of his father's original belief that Donaldson "suffer[ed] from 'delusions.'"¹¹³ When Donaldson's father initiated his son's civil commitment proceeding, "Donaldson was found to be suffering from 'paranoid schizophrenia' and was committed [involuntarily] for 'care, maintenance, and treatment' pursuant to Florida statutory provisions that ha[d] since been repealed."¹¹⁴ Neither prior to nor during his commitment proceeding did Donaldson receive advice of counsel, nor was he ever determined to be a danger to himself or others.¹¹⁵ Despite Donaldson's repeated requests for release to O'Connor, the hospital's superintendent, over the fifteen-year period he was committed, O'Connor blatantly refused each request.¹¹⁶

As a result of O'Connor's extended confinement of Donaldson absent real justification, the Supreme Court decided to make a change in the state's power to civilly commit an individual that it believed fit within their very loose definition of danger so that people like Donaldson would finally be afforded the protections guaranteed to them under the Due Process Clause.¹¹⁷ The Supreme Court ultimately held that states cannot constitutionally confine nondangerous individuals that are capable of surviving safely "with the help of willing and responsible family members or friends."¹¹⁸ States, physicians, and the media have interpreted *O'Connor* as affording committed individuals vast protections against indefinite institutionalization through the

110. See generally Appelbaum, *supra* note 92, at 138.

111. *O'Connor v. Donaldson*, 422 U.S. 563 (1975) ("In short, a State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.").

112. See generally *O'Connor*, 422 U.S. at 563; see also Address by Paul F. Stavis, *supra* note 69.

113. *O'Connor*, 422 U.S. at 565.

114. *Id.* at 565-66.

115. See generally *id.* at 563.

116. *Id.* at 567.

117. See generally *id.* at 563.

118. See generally *O'Connor*, 422 U.S. at 563; see also Address by Paul F. Stavis, *supra* note 69.

right to treatment and consideration of the ability of the patient to live among the community with the help and availability of nuclear family or friends.¹¹⁹ The *O'Connor* decision led to a major increase in deinstitutionalization in the United States and still serves as one of the most poignant cases for constitutional protections of the mentally ill.¹²⁰

Several cases following *O'Connor* questioned various state statutes that allowed for civil commitment of nondangerous individuals.¹²¹ Part of Hawaii's civil commitment statute allowed for commitment of an individual when they posed danger to property of value, which the court in *Suzuki v. Yuen* ultimately struck down as "not sufficiently compelling to warrant the curtailment of liberty brought about by involuntary commitment."¹²² Although *O'Connor's* additional dangerousness criteria, after a finding of mental illness, has been adopted by all fifty states, some states increasingly overlook dangerousness and focus more on their own subjective opinion of dangerousness or those opinions of the medical professionals evaluating the considered individual.¹²³

Aside from the new dangerousness requirement, the *O'Connor* Court left open an interesting question to which it has never returned: whether "the provision of treatment, standing alone, can ever constitutionally justify involuntary confinement or, if it can, how much and what kind of treatment would suffice for that purpose?"¹²⁴

119. See THOMAS S. SZASZ, *PSYCHIATRIC SLAVERY* 100 (1977) (discussing varying interpretations by states, physicians, etc. on the vague *O'Connor v. Donaldson* decision).

120. See generally Address by Paul F. Stavis, *supra* note 69.

121. Walker, *supra* note 6, at 159. See *Suzuki v. Yuen*, 617 F.2d 173 (9th Cir. 1980); *Doremus v. Farrell*, 407 F. Supp. 509 (D. Neb. 1975).

122. *Suzuki*, 617 F.2d at 176.

123. Walker, *supra* note 6, at 159-60.

124. *O'Connor*, 422 U.S. at 589 n.10; see Mary Ann Bernard, *Supreme Court Mental Health Precedent and Its Implications* (9/09), MENTAL ILLNESS POLICY ORG., <http://mentalillnesspolicy.org/legal/mental-illness-supreme-court.html> (last visited Nov. 23, 2015).

III. Analysis

A. Implications and Flaws within *O'Connor's* Ambiguous "Dangerousness" Requirement and the Subsequent "Gravely Disabled" and "Need-for-Treatment" Standards

Currently, states have the ability to write and implement their own laws and standards regarding the processes and criteria for involuntary civil commitment.¹²⁵ Thus, considered individuals with varying degrees of mental illnesses remain at the mercy of state authority when fighting against involuntary civil commitment.¹²⁶ Virtually every state uses some sort of "dangerousness" requirement; thus, dangerousness must be present to civilly commit someone against his or her will.¹²⁷ A 2014 survey performed by the Treatment Advocacy Center examined involuntary civil commitment laws across the United States, and its findings highlight the extremely poor quality and poor usage of these involuntary treatment and civil commitment laws.¹²⁸ For instance, the survey notes that roughly fourteen states had mere average quality standards surrounding their involuntary civil commitment laws.¹²⁹ The problem with many states' civil commitment statutes was that some base their standards off of probability.¹³⁰ For instance, West Virginia operates under a standard similar to "grave disability," discussed in greater detail below, which requires the petitioner to state that "the individual is *likely* to cause serious harm to self or others due to what the application believes are symptoms of mental illness or addiction."¹³¹ This allows the petitioner to seek commitment based on mere probability and assumptions regarding the individual's mental illness, which then essentially fulfills the requirements of the statute.¹³²

The definition of "dangerousness" does vary state to state, with some states deciding to forgo the vague "dangerousness" standard set forth by *O'Connor* in order to enact "more progressive commitment

125. See generally *Survey of the States*, *supra* note 4, at 2.

126. See *id.* at 3.

127. See *id.* at 7.

128. See *id.* at 3.

129. See *id.* at 3.

130. See *id.* at 7.

131. W. VA. CODE § 27-5-4(c)(2) (2012) (emphasis added); see *Survey of the States*, *supra* note 4, at 18.

132. *Survey of the States*, *supra* note 4, at 7.

standards.”¹³³ In the majority of states, there are two prevailing types of standards which a patient must meet in order to be involuntarily committed: the “gravely disabled” standard and the “need-for-treatment” standard.¹³⁴ Each standard will be explained and critiqued in relation to their implications on the elderly population.

1. O’CONNOR’S VAGUE “DANGEROUSNESS” STANDARD

Currently, all fifty states have a “dangerousness” requirement set forth in their criteria for involuntary civil commitment in accordance with *O’Connor*.¹³⁵ The dangerousness standard has evolved within the states to incorporate different interpretations of what constitutes ‘danger,’ sometimes even beyond requiring an “imminent physical danger to self or others evidenced by overt acts.”¹³⁶ Few states have decided to follow the “dangerousness” definition set forth by *O’Connor*: someone who is dangerous and incapable of surviving on his own or with the help of family and friends.¹³⁷ The current general “dangerousness” requirement does not allow courts to order involuntary civil commitment until it is proven that the considered individual suffers from a severe mental illness and is “an immediate, physical danger to self or others.”¹³⁸ The “dangerousness” standard itself still poses problems due to its tendency to allow courts broad authority when making the decision on whether or not to civilly commit an individual.¹³⁹ However, the few states that still utilize the “dangerousness” standard very loosely use it for different treatment commitment methods, both inpatient and outpatient.¹⁴⁰ One example of a

133. *Id.*

134. *Id.*

135. John Snook & Kathryn Cohen, *Civil Commitment Laws: A Survey of the States*, TREATMENT ADVOC. CTR. 1, 4 (Jul. 21, 2014), <http://dls.virginia.gov/GROUPS/MHS/Treatment%20Advocacy%20Ctr.pdf>.

136. *Id.*

137. *O’Connor v. Donaldson*, 422 U.S. 563, 565 (1975); see *Better Treatment Standards*, TREATMENT ADVOC. CTR., <http://webcache.googleusercontent.com/search?q=cache:p8RM8I4htmUJ:www.treatmentadvocacycenter.org/solution/better-treatment-standards+&cd=1&hl=en&ct=clnk&gl=us> (last visited Nov. 23, 2015) [hereinafter *Better Treatment Standards*].

138. *Better Treatment Standards*, *supra* note 137.

139. Donald H. Stone, *Confine Is Fine: Have the Non-Dangerous Mentally Ill Lost Their Right To Liberty? An Empirical Study to Unravel the Psychiatrist’s Crystal Ball*, 20 VA. J. SOC. POL’Y & L. 323, 325 (2012).

140. *Better Treatment Standards*, *supra* note 137 (“In Maryland, dangerousness is a requirement for inpatient commitment. In New York it is required for court-ordered inpatient treatment, but broader criteria are provided for assisted patient treatment (AOT).”).

state that still utilizes the “dangerousness” standard in close accordance with *O’Connor* is Iowa.¹⁴¹ Specifically, Iowa defines “dangerousness” as a likelihood of “inflict[ing] 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.”¹⁴² One flaw of *O’Connor’s* “dangerousness” requirement is that the *O’Connor* Court did not precisely define “danger,” thus allowing states to define it on their own (*i.e.*, more or less stringently).¹⁴³

Since states have the ability to define danger differently, there is great likelihood that similar cases will produce different commitment outcomes, especially amongst elders.¹⁴⁴ The varying definitions of “dangerousness” among different states are: “substantial risk, clear and present threat, substantial physical harm, substantial likelihood of harm, substantial likelihood of physical harm, substantial likelihood of serious harm, likelihood of serious harm, demonstrated danger, likely to cause harm, and reasonable expectation of harm.”¹⁴⁵ Since elders may become more reserved and quiet as they age or deteriorate health-wise, such vague definitions of “dangerousness” can be prejudicial and over-inclusive of elders who do not pose real danger, especially if they are evaluated by a medical professional untrained in gerontology.¹⁴⁶

2. “GRAVELY DISABLED” STANDARDS

A majority of states using the “gravely disabled” standard to define danger base their definitions on the “premise that a person may pose a physical threat to himself through inability. . . to provide for the basic necessities of human survival, just as surely as if he were actively trying to harm himself.”¹⁴⁷ States such as Alaska, California, Connecticut, Georgia, and Washington follow this standard and provide explicit definitions of the term “gravely disabled.”¹⁴⁸ California

141. IOWA CODE § 229.1(17) (2012); see Snook & Cohen, *supra* note 135, at 44.

142. IOWA CODE § 229.1(17)(b) (2012); see Snook & Cohen, *supra* note 135.

143. See Walker, *supra* note 6, at 160-61.

144. See generally McGuan, *supra* note 14, at 203-05.

145. Walker, *supra* note 6, at 160-61.

146. See generally *id.* at 162-63.

147. *Survey of the States*, *supra* note 4, at 7; see also Snook & Cohen, *supra* note 135, at 6.

148. See CAL. WELF. & INST. CODE § 5008(h)(1)-(2) (2012) (defining “gravely disabled” in California); ALASKA STAT. § 47.30.915(9) (2012) (defining “gravely disabled” in Alaska).

excludes individuals with delusions, psychosis, hallucinations, and similar symptoms from fitting within the definition of “gravely disabled” if that person can care for and provide himself or herself with the basic necessities of life outside of their disorder.¹⁴⁹ This definition of “gravely disabled” allows California to more accurately commit those in need of treatment rather than infringing upon the Due Process rights of those who do not require commitment.¹⁵⁰ Alaska defines “gravely disabled” as a “condition in which a person as a result of mental illness . . . is in danger of physical harm arising from such complete neglect of basic needs for food, clothing, shelter, or personal safety as to render serious accident, illness, or death highly probable if care by another is not taken.”¹⁵¹

Georgia, on the other hand, has put a twist on its “gravely disabled” standard.¹⁵² Georgia added a requirement of imminence within its standard that requires the concerned individual petitioning intervention for the mentally ill person to wait until the danger to the mentally ill person’s self or others is an “imminently life-endangering crisis.”¹⁵³ In Washington, the individual must be “in danger of serious physical harm from failure to provide for essential human needs of health or safety” or must “manifest[s] severe deterioration in routine functioning” which can be “evidenced by repeated and escalating loss of cognitive or volitional control over his . . . actions and is not receiving such care as is essential for his . . . safety.”¹⁵⁴

The “gravely disabled” standard, similar to the other standards, has been subject to criticism.¹⁵⁵ In *In re Detention of LaBelle*, the “gravely disabled” standard was challenged for its vagueness, but it ultimately survived.¹⁵⁶ Yet, the Court did not refrain from expressing its concerns about the standard despite its survival.¹⁵⁷ The Court acknowledged that the state maintains a legitimate interest in “pro-

149. *California Civil Jury Instructions (CACI): 4002. “Gravely Disabled” Explained*, JUSTIA, <https://www.justia.com/trials-litigation/docs/caci/4000/4002.html> (last visited Nov. 23, 2015).

150. See generally *Survey of the States*, *supra* note 4, at 7.

151. ALASKA STAT. § 47.30.915(9) (2012); see also *Survey of the States*, *supra* note 4, at 7.

152. See *Survey of the States*, *supra* note 4, at 8.

153. *Id.*

154. WASH. REV. CODE § 71.05.020(17) (2012); see Snook & Cohen, *supra* note 135, at 5 (identifying Washington statute as gravely disabled standard).

155. See generally *In re Detention of LaBelle*, 728 P.2d 138, 144-45 (Wash. 1986).

156. *Id.*

157. *Id.* at 144.

tecting the community from the dangerously mentally ill and in providing care to those that are unable to care for themselves.”¹⁵⁸ Especially with regard to elders who may neglect caring for themselves as they get older, this standard may be over-inclusive by collapsing definitions of danger and neglecting to care for one’s self. Most of the time, neglecting to care for one’s self will not pose any danger to the community.¹⁵⁹ Yet, danger to the community triggers involuntary civil commitment as an option to protect the public from the mentally ill individual.¹⁶⁰ It is questionable whether self-neglect due to mental illness is a cognizable danger to society warranting involuntary institutionalization. Self-neglect, in some cases, could be easily remedied by simply acquiring a caretaker or a medical professional to care for the elder in an outpatient capacity prior to institutionalizing them.¹⁶¹

3. THE OVER-INCLUSIVE “NEED-FOR-TREATMENT” STANDARD

Aside from a majority of the states currently incorporating a “gravely disabled” standard into their involuntary civil commitment laws, roughly half of the states also allow for court intervention through a “need-for-treatment” standard.¹⁶² When people, especially elders, are diagnosed with mental illnesses, they may not accept their disorders or truly understand the effects the disorders may have on their minds and bodies.¹⁶³ Some elders may feel terrified when thinking of the potential ways in which their disorder will change them mentally and physically.¹⁶⁴ Yet, “need-for-treatment” standards may be able to prevent deterioration and alleviate ignorance and fear of one’s disorder.

“Need-for-treatment” standards are commonly seen in a majority of states, including Wisconsin, Idaho, and Arizona.¹⁶⁵ Wisconsin’s statute requires that a person “[is] substantially unable to make informed treatment choice, needs care or treatment to prevent deterioration” and that it is “substantially probable that if untreated will lack

158. *Id.* at 143.

159. See generally Testa & West, *supra* note 68, at 34.

160. See generally *id.* at 30-31.

161. Lawrence Robinson et al., *Elder Abuse and Neglect*, HELPGUIDE (Sept. 2015), <http://www.helpguide.org/articles/abuse/elder-abuse-and-neglect.htm>.

162. Snook & Cohen, *supra* note 135, at 9; *Better Treatment Standards*, *supra* note 137.

163. *Mental and Behavioral Health*, *supra* note 13.

164. See generally Robinson et al., *supra* note 161.

165. *Better Treatment Standards*, *supra* note 137.

services for health or safety and suffer severe mental, emotional or physical harm that will result in the loss of ability to function in the community or loss of cognitive or volitional control over thoughts or actions.”¹⁶⁶ Essentially, “need-for-treatment” standards generally “require a finding that the person’s mental illness prevents him from seeking help on a voluntary basis and, if not treated, will cause him severe suffering and harm his health.”¹⁶⁷ In *State of Wisconsin v. Dennis H*, the Court relentlessly supported the idea behind the “need-for-treatment” standard in identifying that there is in fact a rational basis to differentiate between an individual who is able to make an informed decision and one who lacks the capacity to do so, so that courts can help those who are unable to make these informed decisions to avoid any harms that may occur as a result of their mental illnesses.¹⁶⁸

Arizona, uniquely, has a statute that essentially reaches mentally ill individuals regardless of whether they are able to survive on their own or with the help of others or whether they are nonviolent.¹⁶⁹ Arizona’s statute terms those that are “persistently or acutely disabled” to need treatment.¹⁷⁰ To be “persistently or acutely disabled,” the statute requires a substantial probability of the individual suffering severe harm without treatment, lack of capacity to make informed decisions about treatment and their disorder, and requires a “reasonable prospect of being treatable.”¹⁷¹ Although this will make institutionalization widely available to and ordered to those who may not pose any imminent danger, it will have a prevention mechanism that saves the person prior to their illness taking control over their life and endangering them and those around them.¹⁷²

Moreover, “need-for-treatment” standards, if continuously implemented by states, will be over-inclusive of elderly patients and may be a great contributing factor to the scarce resources in institu-

166. WIS. STAT. § 51.20(1)(a)(2)(e) (2012); see Snook & Cohen, *supra* note 135, at 8.

167. *Survey of the States*, *supra* note 4, at 7.

168. *In re Commitment of Dennis H.*, 647 N.W.2d 851, 862 (Wis. 2002).

169. ARIZ. REV. STAT. ANN. § 36-501(31)(a)-(c) (2012); see *Survey of the States*, *supra* note 4, at 7.

170. ARIZ. REV. STAT. ANN. § 36-501(31)(a)-(c) (2012).

171. *Id.*

172. See *Survey of the States*, *supra* note 4, at 7 (“Need-for-treatment laws make commitment available to the person who suffers greatly in the grip of severe mental illness, even if he manages to meet his basic survival needs and exhibits not violent or suicidal tendencies.”).

tions and hospitals.¹⁷³ With regard to elders meeting the criteria under “need-for-treatment” standards, they could ultimately enjoy the benefits of being treated prior to their illness becoming dangerous.¹⁷⁴ However, it is important that states do not involuntarily commit elders at the outset because most elders captured under this standard will likely not be dangerous to themselves or others at that point.¹⁷⁵ This would in turn provide more inpatient beds for those who really need them in comparison to those who do not yet pose overt danger to themselves or others.¹⁷⁶

B. Admission of the Elderly into a Mental Health Facility: Who Has the Requisite Power of Involuntary Commitment?

In all fifty states, there is a mandatory requirement that an individual undergoes a civil commitment hearing for involuntary placement into a mental health facility,¹⁷⁷ but, the commitment process itself can be confusing. Is it the judge, a guardian, or a family member who may ultimately petition for commitment of the elder into a mental health facility? Some states have guardianship statutes that address this issue.¹⁷⁸ Currently, thirty states follow the Uniform Guardianship & Protective Proceedings Act (UGPPA), which allows a guardian to initiate involuntary civil commitment proceedings, but only in accordance with the state’s law on involuntary civil commitment.¹⁷⁹ However, four out of the thirty states that follow the UGPPA allow

173. *Id.*

174. *Id.*

175. *Id.* at 8.

176. *Obstacles to Use of Involuntary Treatment*, TREATMENT ADVOC. CTR. 4, <http://webcache.googleusercontent.com/search?q=cache:tyHZbpnW8dQJ:tacreports.org/state-survey/use-of-laws/obstacles-to-use+&cd=2&hl=en&ct=clnk&gl=us> (“Given the decimation of the public hospital bed supply over the last half-century at the same time the country nearly doubled its population, it should come as no surprise that there are not enough public inpatient beds for all the individuals in acute psychiatric crisis.”).

177. Karna Sandler, *A Guardian’s Health Care Decision-Making Authority: Statutory Restrictions*, 35 BIFOCAL: A J. OF THE ABA COMM’N ON LAW & AGING 98, 107 (2014), http://webcache.googleusercontent.com/search?q=cache:c_N2f11lhQJ:www.americanbar.org/publications/bifocal/vol_35/issue_4_april2014/guardianship_health_care_decisions_statutory_restrictions.html+&cd=1&hl=en&ct=clnk&gl=us.

178. *See id.* (“Thirty state guardianship statutes follow the UGPPA, which states ‘a guardian may not initiate the commitment of a ward to a mental health-care institution except in accordance with the State’s procedure for involuntary civil commitment.’”).

179. UNIF. GUARDIANSHIP & PROTECTIVE PROC. ACT § 316 (NAT’L CONFERENCE OF COMM’R ON UNIF. STATE LAWS) (1997); *see* Sandler, *supra* note 177.

guardians to place the mentally ill elder into a mental health facility without court order for a time period ranging from two to forty-eight days.¹⁸⁰ Missouri and North Dakota are two states that allow a guardian to civilly commit an elder to a mental health facility for thirty to forty-eight days without court order.¹⁸¹ Although a few states allow for involuntary commitment without court intervention for a limited time period, states like Missouri and North Dakota may struggle with the problem of guardians who civilly commit an elder solely based upon their own personal assumption and opinion that the elder is “dangerous” or becoming “gravely disabled.”¹⁸² By requiring a court order for involuntary civil commitment, the elder enjoys greater protection of his or her civil rights along with greater accuracy and objectivity when it comes to involuntary civil commitment decision-making.¹⁸³ When a guardian is able to civilly commit an elder, he or she will likely use a greater degree of subjectivity within their decision-making, as compared to a court.¹⁸⁴ Additionally, the guardian may not be able to identify the signs or symptoms of mental illness and weigh them properly in determining whether the elder is “dangerous.”¹⁸⁵

C. Mental Health Professionals’ Opinions in Civil Commitment Hearings: How Much Deference Is Too Much?

Because states define danger so differently and often, vaguely, psychiatrists and clinical evaluators may base their evaluations of the individual on their own subjective definitions of danger that ultimately fit within the state’s vague definition.¹⁸⁶ Since psychiatrists and

180. Sandler, *supra* note 177 (identifying Arizona, New Hampshire, Missouri, and North Dakota as the states which allow for civil commitment without court order for a limited time period); *see also* ARIZ. REV. STAT. ANN. § 14-5312.01 (2012); MO. REV. STAT. § 475.120 (2012); N.H. REV. STAT. ANN. § 464-A:25 (2012); N.D. CENT. CODE § 30.1-28-12 (2012).

181. *See* MO. REV. STAT. § 475.120 (2012) (allowing a guardian to commit an elderly individual into a mental health facility for up to 30 days without court order); N.D. CENT. CODE § 30.1-28-12 (2012) (allowing a guardian to commit an elderly individual into a mental health facility for up to 45 days without court order). *See also* Sandler, *supra* note 177, at 107 n.9.

182. *See* Sandler, *supra* note 177, at 107 (suggesting court approval in involuntary civil commitment proceedings is a protective measure).

183. *See generally id.* (suggesting court approval in involuntary civil commitment proceedings is a protective measure).

184. *See id.*

185. *See id.*

186. Walker, *supra* note 6, at 161.

evaluators may assess patients in accordance with their professional judgment and own definitions of dangerousness, patients may be wrongly committed.¹⁸⁷ When judges hear psychiatrist testimony about their evaluations during commitment hearings, some judges give complete deference to the evaluation, especially when the patient is elderly and incompetent.¹⁸⁸ More serious implications may arise when elders are evaluated using these subjective standards.¹⁸⁹ Thus, if states are able to continue defining “dangerousness” on their own, psychiatrists and clinical evaluators’ recommendations should be subject to greater scrutiny during commitment hearings as there is potential their recommendations may be too subjective or unfairly prejudicial to the elder.¹⁹⁰

Additionally, although elders may be unable to care for themselves, this inability may not always be attributable to their mental illness.¹⁹¹ Elders, during the course of their life and outside of their disorders, may have physical problems that prevent them from being able to care for themselves that are not in any way related to psychological disorders.¹⁹² These physical conditions include arthritis, osteoporosis, diabetes, and more.¹⁹³ Additionally, even when elders are evaluated by physicians, courts, or family members, many of them are ignored and often treated based upon the belief that they lack the capacity to make decisions for themselves regardless of whether they have any mental incapacity.¹⁹⁴ When determining whether an elder is in fact “an immediate physical danger to self or others,” psychiatric professionals will usually perform testing and evaluations on the considered individual to assess the degree to which their disorder is causing danger to themselves or others by asking them various questions

187. *Id.* at 164.

188. *Id.* at 165.

189. See generally Tamara Hill, *History of the “Dangerousness” Criteria of Involuntary Commitment*, PSYCHCENTRAL (May 26, 2013), <http://webcache.googleusercontent.com/search?q=cache:4hk8NyaReakJ:blogs.psychcentral.com/caregivers/2013/06/history-of-the-dangerousness-criteria-of-involuntary-commitment/+&cd=1&hl=en&ct=clnk&gl=us>.

190. See Walker, *supra* note 6, at 164.

191. See generally Hill, *supra* note 189.

192. Jim Crossett, *The Most Common Health Issues Seniors Face and Why Elderly Care Matters in Redding, CT*, SYNERGY HOMECARE (July 24, 2014), <http://www.synergyhomecare.com/agencies/ct/danbury/ct03/blog/posts/2014/7/24/the-most-common-health-issues-seniors-face-and-why-elderly-care-matters-in-redding-ct/#.VG-qDJNhsag>.

193. *Id.*

194. See Jan Ellen Rein, *Preserving Dignity and Self-Determination of the Elderly in the Face of Competing Interests*, 60 GEO. WASH. L. REV. 1818, 1822 (1992).

to determine the severity and imminence of their mental illness.¹⁹⁵ Because elders may be at a greater risk for being wrongly committed due to misunderstandings of their mental illnesses or simply aging itself, states should require evaluations to also be done by gerontologists, or, at least, require courts to hear psychiatrists' evaluations with greater scrutiny absent specialization in implications of aging.¹⁹⁶

D. Assisted Outpatient Treatment: An Overall Better Option For Elders?

Assisted Outpatient Treatment, often referred to as "AOT," broadly consists of court-ordered treatment that puts a condition on a mentally-ill individual's stay within the community by ordering them to complete treatment, typically in the form of medication.¹⁹⁷ Most commonly, individuals who are involved with AOT are those that have been noncompliant with treatment options in the past and who now have been mandated to take treatment as recommended in order to stay within their communities.¹⁹⁸ Currently, there are forty-five states that allow various forms of AOT for a mentally ill individual; yet, unfortunately, these states do not utilize this treatment as often as they should.¹⁹⁹ AOT methods are usually low-cost alternatives that reduce hospitalizations and violence.²⁰⁰ This form of involuntary treatment is one which allows the mentally ill individual "increased autonomy in a less restrictive treatment environment (i.e., less restrictive than a hospital), while permitting the provider to monitor compliance and detect early signs of relapse or decompensation."²⁰¹

Originally, involuntary outpatient treatment was seen as an alternative to the historic involuntary civil commitment via hospitaliza-

195. See generally Hill, *supra* note 189.

196. See generally Walker, *supra* note 6, at 180-81.

197. See Snook & Cohen, *supra* note 135, at 14; *Assisted Outpatient Treatment Could Be Key Component in Crisis Solutions Initiative*, CIVITAS INST. (Dec. 11, 2013, 12:21 PM), <http://www.nccivitas.org/2013/assisted-outpatient-treatment-key-component-crisis-solutions-initiative/> [hereinafter *Assisted Outpatient Treatment Could Be Key*].

198. Snook & Cohen, *supra* note 135, at 11 (discussing AOT as useful with "outpatient commitment of a person who is at the time . . . under treatment and not dangerous but has a documentable history of treatment non-adherence with bad outcomes").

199. *Id.*

200. DJ Jaffe, *Involuntary Treatment and Involuntary Commitment Laws: Basis in Law and History*, MENTAL ILLNESS POLICY ORG. (2011), <http://mentalillnesspolicy.org/ivc/involuntary-commitment-concepts.html> (last visited Nov. 23, 2015).

201. Ridgely et al., *supra* note 15, at 13.

tion.²⁰² Since the 1980s, laws have been enacted to capture a greater range of mentally ill individuals who qualify for this form of outpatient commitment.²⁰³ By broadening the scope of these out-patient commitment standards, states are effectively increasing the likelihood of the individual's long-term success while simultaneously decreasing any risks of deterioration before the individual becomes gravely disabled or dangerous in the sense that hospitalization is warranted.²⁰⁴ Some states may still use the "gravely disabled" or "need-for-treatment" standards to define "dangerousness" in the outpatient treatment setting prior to institutionalization.²⁰⁵ One way states may do so is by giving the mentally ill individual the opportunity to comply with treatment before being removed to a more restrictive environment, such as involuntary hospitalization, in which they will lose most of their autonomy to make decisions.²⁰⁶ Another way states may use inpatient standards to permit outpatient treatment is by granting the mentally ill individual conditional release from the hospital in order to allow them the opportunity to attempt outpatient treatment.²⁰⁷ However, upon deterioration or resistance to outpatient treatment, conditional release from the hospital may be revoked without a new court order because the original court order for involuntary inpatient commitment may remain valid.²⁰⁸

The two aforementioned ways that AOT methods may be implemented within the community are not the only options.²⁰⁹ Some states, such as North Carolina and West Virginia, may elect to order AOT by ordering mentally ill individuals, who are *likely* to become gravely disabled or meet the requisite civil commitment standard in the near future, to comply with court-ordered treatment within the community.²¹⁰ Usually, this form of AOT does not result in forced medication or forced psychosocial intervention; thus, the individual still retains the ability to have control over his or her own treatment methods.²¹¹

202. *Id.*

203. *Id.*

204. *Id.*

205. *See id.* at 14 (discussing inpatient commitment criteria as one sufficient legal test for triggering involuntary outpatient commitment).

206. *Id.*

207. *Id.*

208. *Id.*

209. *Id.*

210. Ridgely et al., *supra* note 15, at 14; *see* N.C. GEN. STAT. § 122C-3(27) (2012).

211. Ridgely et al., *supra* note 15, at 14.

If the mentally ill individual fails to comply with AOT, “the mental health provider can usually request that a law enforcement officer transport the patient to the treatment center for examination, but the patient cannot be automatically admitted (or readmitted) involuntarily to the hospital.”²¹² For readmission, the court must give the mentally ill individual a hearing on whether involuntary civil commitment via hospitalization is warranted.²¹³

Currently, states seem to be adopting these various AOT methods when the individual meets the involuntary commitment standard; however, the actual utilization of AOT is questionable and concerning given the increased autonomy and less restriction that outpatient treatment could provide a mentally ill individual.²¹⁴ Some states have reported using AOT rather infrequently, although they did have the means and authority to utilize it.²¹⁵ States that are hesitant to utilize AOT prior to involuntary hospitalization have identified reasons for doing so, stating that “extend[ing] coercive social control into the community and . . . the aversion to coercion [could] deter people with mental illness from seeking treatment.”²¹⁶

One potential benefit of mandatory AOT, however, is that it alleviates the strain on psychiatric hospitals that automatically admit individuals the court deems to satisfy commitment criteria and also saves the hospital’s resources.²¹⁷ For instance, in North Carolina, inpatient commitment resources are very scarce due to the high amount of patients that are civilly committed.²¹⁸ However, North Carolina’s outpatient treatment system is also strained in the sense that after an individual is released from a psychiatric hospital, he or she often fails to comply with treatment and is thus re-admitted into the psychiatric

212. *Id.*

213. *Id.*

214. *See id.* at 15 (“Although it appears that many states are adopting or considering outpatient commitment statutes, in practice these laws have been inconsistently utilized.”).

215. *See id.* (“More recent survey data reported that respondents in 13 states and the District of Columbia estimated the use of outpatient commitment in their jurisdiction to be common or very common, whereas in 21 states the use of outpatient commitment was reported to be rare or very rare.”).

216. *Id.*

217. *Assisted Outpatient Treatment Could Be Key*, *supra* note 197.

218. *See id.* (“Inpatient resources for people in crisis are so scarce that it takes an average of three-and-a-half days to get admitted to a psychiatric facility.”).

hospital.²¹⁹ This cycle of admission, discharge, and re-admission is the same “revolving door” problem discussed earlier.²²⁰ It is crucial that states put an end to this cycle by providing resources for the individual to maintain his or her stability after release from the hospital or by simply providing the individual the opportunity to strive within the community from the start, prior to ordering inpatient institutionalization.

IV. Recommendation

Given that the elderly population composes the largest age group suffering from mental illness,²²¹ involuntary civil commitment standards should be reformed and tailored specifically to the elderly in four distinct ways. Primarily, all states should adopt the “need-for-treatment” standard as incorporated into civil commitment laws by nearly half of the states to prevent or minimize the chance of individuals needing hospitalization in the future and of their mental illness worsening before treatment is obtained.²²² Thus, a positive finding for “dangerousness” under a “need-for-treatment” standard should not lead directly to involuntary inpatient commitment.

Secondly, during the civil commitment hearing, states should universally require gerontologists to be available to rebut professional opinions of psychiatrists or medical doctors who lack experience in elder health and in the implications of aging. This would prevent the elder’s “danger” from improperly being attributed to their mental illness when the “danger” is instead a result of a physical problem or a general aspect of aging.

Third, upon finding that a mentally ill elder meets the state’s civil commitment criteria and poses a “danger” to society, all states should adopt and require a form of mandatory AOT as the first meth-

219. *See id.* (“Few patients follow through with treatment after they are discharged from psychiatric hospitals. The result is a system that is constantly in a state of crisis.”).

220. *See* Katherine B. Cook, *Revising Assisted Outpatient Treatment Statutes in Indiana: Providing Mental Health Treatment for Those in Need*, 9 IND. HEALTH L. REV. 661, 668 (2012) (discussing the general revolving door problem, specifically to mentally ill individuals who are released from inpatient commitment and then commit crimes); *see also* *Assisted Outpatient Treatment Could Be Key*, *supra* note 197 (“Scarce resources are wasted as people with severe mental illnesses are trapped in a destructive “revolving door” of hospitalization, discharge, regression, and hospitalization.”).

221. McGuan, *supra* note 14, at 183.

222. *See* Snook & Cohen, *supra* note 135, at 14.

od of treatment ordered by the court instead of inpatient hospitalization. This would set the elder up for greater success and likely prevent the “revolving door” problem by giving the elder the opportunity to succeed and obtain treatment resources within the community.

Lastly, the few states that allow for a guardian to involuntarily commit a mentally ill elder to a mental health facility for a limited-time and without court order should be eliminated. This would allow for greater protection of the elder’s civil liberties and eliminate any potential bias on behalf of the guardian.²²³ Each recommendation will be discussed in sequence.

A. Adopt a “Need-for-Treatment” Standard

“Need-for-treatment” standards are becoming more popular in the United States.²²⁴ Earlier treatment can reduce the chances of potential deterioration and ultimately prevent an elder’s cognitive disorder from spinning out of control, leading to involuntary inpatient commitment.²²⁵ States should also universally tailor these “need-for-treatment” standards specifically to the elderly to prevent them from becoming a grave danger to themselves, their caretakers, and society.²²⁶ However, implementation of these “need-for-treatment” standards on elders would be contingent on courts first ordering the elder to mandatory AOT prior to mandatory inpatient commitment. If involuntary inpatient, instead of outpatient, commitment was first ordered upon the elder meeting commitment criteria, hospital resources would continue to become increasingly scarce and unavailable for those who are in grave need since the state is operating under a universal need-for-treatment model, which is likely over-inclusive and committing nondangerous individuals to inpatient facilities that do not have the room.²²⁷ Although “need-for-treatment” standards may be over-inclusive, with AOT as a first resort, elders will get proper

223. See Sandler, *supra* note 177 (discussing the few states that allow guardians to commit elderly individuals to a mental health facility for a limited time).

224. See generally Snook & Cohen, *supra* note 135, at 22.

225. See generally *id.* at 13 (“Broader commitment standards can . . . reduc[e] the likelihood of unnecessary deterioration and decompensation, limiting the need for lengthy hospitalization or contact with law enforcement.”).

226. *Survey of the States*, *supra* note 4, at 27.

227. See *id.* (recommending more beds for patients if the need-for-treatment standard is implemented universally). In reality, if this standard was implemented with the first outcome after meeting the criteria being court-ordered mandatory outpatient treatment, there would be no need for more beds.

care while still retaining their personal liberties. Thus, mandatory AOT as a first resort is a must under the “need-for-treatment” standard, as advocated for within this recommendation.

B. Make Gerontologists Readily Available to Support or Rebut Professional Opinions and to Discuss the Implications of Aging

During the civil commitment hearing or re-hearing, the elder’s doctors, nurses, psychiatrists, and other medical professionals will be able to testify as to what went wrong, what they observed about the elder’s mental health, and why they have evaluated the elderly individual as needing inpatient commitment.²²⁸ The courts should weigh the testimony of different medical and mental health professionals and give the elder an opportunity to rebut the testimony with another expert opinion.²²⁹ Unless the elder prefers to bring in another expert, states should universally require gerontologists to be present to support or rebut professional opinions of psychiatrists or medical doctors who lack experience in geropsychology.²³⁰ These gerontologists should also be able to discuss the interplay between symptoms of psychological disorders and the implications of aging. It has been found that only 4.2% of psychologists specialize in geropsychology.²³¹ By having gerontologists educate more psychologists through consistent trainings or simply requiring their presence during commitment hearings, there may be more consistency and accuracy in outcomes that occur within commitment hearings. This would protect the elder from improper conclusions and subjective bias based on misinformation about the elder’s mental illness. By bringing forth or requiring more psychologists to learn or focus on geropsychology, this may also help assist medical doctors and other medical professionals

228. See Walker, *supra* note 6, at 165.

229. *Id.* (recommending that courts should utilize independent expert testimony to give the patient an opportunity to contest professional findings and psychological and health assessments).

230. See *Mental and Behavioral Health*, *supra* note 13 (discussing the need for more geropsychologists to understand the aging process and perform psychological tests on the elderly).

231. *Id.* (“Data indicate that although only 4.2 percent of practicing psychologists identify geropsychology as their primary focus of work, 39 percent of all psychologists report delivering services to adults over the age of 65 each week.”).

handling the elder's AOT to better understand his needs and effective treatment methods for his illness.²³²

Although critics have argued that courts should not give an immense amount of deference to expert opinions during hearings,²³³ more deference should be given to the opinions of medical professionals who have dealt exclusively with the elder's outpatient treatment prior to the commitment hearing in contrast to evaluators who the elder has seen on occasion prior to outpatient treatment.

C. Adopt Mandatory Assisted Outpatient Treatment

In cases specifically dealing with elderly patients, all states should require AOT²³⁴ as the first court-ordered treatment if an elder meets commitment criteria set forth by the states. Thus, involuntary civil commitment should be a court-ordered last resort, absent exceptional circumstances warranting emergency treatment.²³⁵ Inpatient commitment may also be implemented if the elder fails to comply with outpatient treatment and is found, during a re-commitment hearing, to pose danger to society. By requiring outpatient treatment from the start, there would be a decrease in the probability of relapse and re-admission into a facility²³⁶ as elders are set up for success by first being treated within their community. Individuals who are first introduced to mandatory AOT are less likely to become hospitalized in the future.²³⁷

Yet, despite these recommendations, critics may dispute that an elder, who is not dangerous now, but who may pose danger in the near future, should still have to comply with mandated inpatient

232. See generally *id.*

233. See Walker, *supra* note 6, at 165 ("Courts are urged not to give extensive deference to committing psychiatrists' expert opinions during commitment hearings."); see Bruce J. Winick, *Therapeutic Jurisprudence and the Civil Commitment Hearing*, 10 J. CONTEMP. LEGAL ISSUES 37, 41-42 (1999).

234. Christian E. Piccolo, *Falling Through the Cracks: The Need for Enhanced Supervision in the Involuntary Outpatient Civil Commitment Setting*, 54 VILL. L. REV. 309, 314 (2009) (giving an overview of outpatient commitment and its pros and cons).

235. See *Survey of the States*, *supra* note 4, at 27 (generally recommending emergency hospitalization standards, but only for individuals who may not meet criteria for civil commitment).

236. See *Assisted Outpatient Treatment Could Be Key*, *supra* note 197 (discussing ways in which AOT can interject and increasingly destroy the "revolving door" problem).

237. *Id.* ("Studies from Duke University and Columbia University have shown conclusively that assisted outpatient treatment is an evidence-based practice that improves outcomes, both for participants and for the public at large.").

treatment.²³⁸ However, this problem rests within the state's commitment criteria, not within the treatment method. It is important to acknowledge that AOT has significant implications on the civil commitment system as a whole as it has been proven to "reduce the strain on families, law enforcement, and the public health system," which is important in states like North Carolina, where resources are becoming more and more scarce.²³⁹

D. Eliminate Commitment Power by Guardians

Although the majority of states do not have statutes allowing guardians or family members to admit an elder into a mental health facility without court order for a limited time, the few states that do have this statute should eliminate it once and for all.²⁴⁰ By allowing these statutes in the United States, the door is left open for potential abusive decision-making over the interests, liberties, and life of the elder. There is potential that the family member may be using statutes such as these to rid of the elder for a while if they are overwhelmed taking care of them or are simply frustrated. These statutes allow the legal system to put a ton of trust in guardians and family members to evaluate the need for civil commitment without any standards or psychological or mental health training, and go forward with their decision temporarily, absent court intervention. By not allowing these statutes, the potential for abusive decision-making by family members or guardians will be minimized, and decisions to civilly commit an individual will be more accurate and protective of the elder subject to professional judgment and court intervention. Eliminating a guardian's power to commit an elder is crucial because involuntary civil commitment can significantly curtail the elder's liberty and significantly harm the elder in the future.²⁴¹

238. *See id.*

239. *See id.*

240. *See Sandler, supra* note 177 (discussing the current state of the law surrounding involuntary civil commitment by a guardian for a limited period of time).

241. Paul F. Stavis, *Involuntary Hospitalization in the Modern Era: Is "Dangerousness" Ambiguous or Obsolete?*, TREATMENT ADVOC. CTR. (1989), <http://treatmentadvocacycenter.org/component/content/article/359>.

V. Conclusion

As an American citizen, Bob was entitled to an attorney, a civil commitment hearing, and his due process rights. Even though Bob is elderly and may not have been able to fully understand his rights and the civil commitment process itself, he was never properly afforded the opportunity to contest or rebut opinions within his civil commitment proceeding. In Bob's situation, he lived in a state in which "dangerousness" was vaguely defined, vesting the court with broad decision-making power over whether Bob posed a danger to himself and to his community, warranting involuntary inpatient commitment. Upon meeting his state's vague "dangerousness" criteria, Bob would be committed to an inpatient facility where he may not have a room right away or the resources that he needs for treatment.

Although Bob may eventually receive the treatment and resources he needs, upon discharge, Bob is at greater risk of falling victim to "revolving door syndrome."²⁴² During his commitment, Bob may be locked away and kept quiet until he is eventually discharged. Bob may then be released with no assistance in maintaining his stable condition within his community, causing him to relapse and be readmitted to an inpatient facility.

Following the recommendations in Part IV, a "need-for-treatment" standard in Bob's state would seek to treat Bob before he poses a danger to himself and his community and could potentially help Bob cope with his mental disorder before it puts him or the rest of society in grave danger.²⁴³ Additionally, upon finding that treatment was needed due to Bob's mental illness likely causing danger in the future, Bob would be subject to mandatory AOT as the first court-ordered treatment. This would provide Bob greater protection as an elderly patient wanting to stay within his community during the last phase of his life. Involuntary inpatient commitment would not be court-ordered unless Bob fails to comply with his AOT or emergency circumstances warrant inpatient treatment right away. By being ordered to outpatient treatment instead of inpatient treatment, Bob is permitted to stay within his community and maintain greater auton-

242. See "Revolving Door" Patients, *supra* note 90.

243. See generally Alison Pfeffer, "Imminent Danger" and Inconsistency: The Need for National Reform of the "Imminent Danger" Standard for Involuntary Civil Commitment in the Wake of the Virginia Tech Tragedy, 30 *CARDOZO L. REV.* 277, 289-90 (2008) (describing need for treatment standards in various states as encompassing individuals with deteriorating conditions, not danger).

omy to make basic decisions about his daily life than he would have had were he confined to a locked hospital room.²⁴⁴ Bob will not be as restricted during AOT as he would be when committed for involuntary inpatient treatment.²⁴⁵ Additionally, if Bob's state did away with any such law allowing for Bob's guardian or family member to civilly commit him for a limited time to a mental health facility without court order, Bob would be afforded more protection with court intervention than without it, as his family members would not be entrusted with decision-making power over Bob's mental health based on their own subjective and often unfounded assumptions. In turn, this extra protection by the court system would ensure more accurate decision-making along with fair and more objective treatment of the elder and their liberty.

If Bob fails to comply with his mandatory AOT, Bob will return to court for a commitment re-hearing. During this commitment re-hearing, the medical professionals handling Bob's outpatient treatment will likely testify as to their experience with Bob during outpatient treatment. Bob may rebut their opinions through his own expert witnesses or gerontologists, who have greater knowledge on the implications of aging. Overall, with these elder-specific involuntary civil commitment recommendations, Bob will be afforded more protection against the curtailment of his liberty if he were ultimately considered for inpatient commitment.

244. See McGuan, *supra* note 14, at 183 (discussing the various implications and circumstances surrounding involuntary [inpatient] civil commitment and the restraints and loss of autonomy associated with such).

245. See Snook & Cohen, *supra* note 135, at 22.