

Legal Tools Throughout the Behavioral Health Care Continuum

Part of the *Refocus and Renew: Moving Towards Health*
FY2025 Technical Assistance Coalition Policy Paper Series

SAMHSA
Substance Abuse and Mental Health
Services Administration

2026

Legal Tools Throughout the Behavioral Health Care Continuum

Legal Tools Throughout the Behavioral Health Care Continuum was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) under Task 2.2 of NASMHPD's Technical Assistance Coalition contract/task order, HHSS283201700024I/75S20321F42001. Asha Stanly served as contracting officer representative.

PUBLIC DOMAIN NOTICE

All material appearing in this publication is in the public domain and may be reproduced or copied without permission from SAMHSA. Citation of the source is appreciated. However, this publication may not be reproduced or distributed for a fee without the specific, written authorization of the Office of Communications, SAMHSA, HHS.

ELECTRONIC ACCESS

This publication may be downloaded from <https://library.samhsa.gov>

ORIGINATING OFFICE

Substance Abuse and Mental Health Services Administration, 5600 Fishers Lane, Rockville, MD 20857, SAMHSA.

Publication No. PEP26-01-006.

Released 2026.

Table of Contents

Introduction	4
Civil Psychiatric-Legal Interventions	5
Psychiatric Advance Directives.....	5
Assisted Outpatient Treatment	7
Involuntary Psychiatric Hospitalization	11
Medication Over Objection, Emergency and Nonemergency	15
Guardianship	19
Criminal-Legal System Interface With Psychiatric Treatment	23
Competency Restoration Treatment.....	23
Criminal Justice Treatment Courts.....	27
<i>Mental health courts</i>	30
<i>Drug courts</i>	31
<i>Additional considerations and treatment courts</i>	31
Civil Commitment for Substance Use Disorders	33
Conclusion	36
References	37
Acknowledgments	48

Abstract¹

Awareness of the intersection between the law and mental health practice is imperative for those providing care and treatment for individuals with serious mental illness, serious emotional disorders, and substance use disorders in hospital, community, and forensic settings. The statutes, regulations, and policies that guide aspects of treatment delivery may vary at the national, state, and local levels, though common elements are often present. Opportunities to promote recovery exist in these settings when these interventions are used appropriately. This paper reviews several legal topics that are commonly encountered by mental health professionals. Civil legal interventions discussed in this paper include psychiatric advance directives, assisted outpatient treatment (AOT), involuntary inpatient hospitalization, and medication treatment over objection in hospital and carceral settings. Guardianship, which involves a significant curtailment of a person's civil rights, is also discussed, with identification of opportunities to optimize an individual's autonomy and preferences. The paper then addresses forensic programs encountered by justice-involved populations, including competency restoration and special criminal treatment courts, to provide an overview of interventions that exist in these settings. Civil commitment for substance use disorders (SUDs), an area of recent increased attention and debate, is also reviewed.

Highlights

- Psychiatric advance directives can be helpful tools to document an individual's treatment preferences and instructions prior to a psychiatric crisis.
- Psychiatric medication over a patient's objection is sometimes necessary in emergent and nonemergent situations. Some states require judicial hearings for such processes, whereas other states allow professional reviews to determine when patients can be medicated over their objection in nonemergent situations.
- AOT is one way in which courts order individuals with serious mental illness (SMI) who have a history of nonadherence to comply with treatment, with a goal of keeping them out of institutional settings and providing comprehensive care. In addition to an individual being required to adhere to their treatment plan, in AOT the treatment team has increased outward accountability to provide and coordinate the services.
- Types of guardianship orders differ based on the circumstances leading to the individual's deficits in decision-making, their needs, and state statutes. Alternatives to guardianship orders can help facilitate respect for a person's autonomy by assisting in the clear communication of their preferences.
- Competence to stand trial restoration traditionally involved psychiatric treatment in a state hospital, which allowed for a therapeutic environment, frequent contact with mental health providers, and intensive medication management. With the increase in requests for competency evaluations, state mental health systems have struggled to keep up with long waiting lists for restoration services, leading systems to turn to alternative treatment settings for competency restoration.

¹ This publication is not intended to constitute or provide legal advice; readers are urged to seek legal and other advice as appropriate.

- The impact of SUDs continues to represent a great public health risk. Given the relatively low percentage of individuals with SUDs who seek treatment, states have investigated alternatives, including compelled SUD treatment. Overall data on this approach is lacking, yet authorizing statutes have moved forward in several states.

Recommendations

1. **Promoting and respecting autonomy:** Policymakers, practitioners, and mental health services leaders should consider promoting the use of alternative strategies for decision-making that help an individual maintain autonomy, including psychiatric advance directives, medical advance directives, durable medical powers of attorney, and supported decision-making. Such strategies also enable alternate decision makers, including guardians, to make decisions consistent with the individual's wishes and best interests during periods in which the individual lacks decisional capacity.
2. **Familiarization with state statutes:** Each state or jurisdiction determines its own specific standards for civil commitment, including criteria for involuntary hospitalization and the procedures required for the pursuit of it. These standards additionally vary for children and adolescents, with different standards applied based on the age of the minor. Such variability is also found in regulations concerning overriding a person's right to refuse treatment in nonemergent situations, and this variability can potentially contribute to differences in length of hospitalization and course of treatment. Mental health providers and service leaders should familiarize themselves with the specific standards in the jurisdiction in which they practice in an effort to provide optimal treatment.
3. **Data-driven sustainability:** Despite challenges due to variability in state statutes, further research is needed to identify optimal models of AOT oversight; distinguish differences among populations participating in AOT, such as those with co-occurring SUD; and better understand the sustainability of an individual's improvement, if any, following the completion of an AOT order.
4. **Partnerships:** To address the overrepresentation of people with mental health conditions and SUDs in the criminal legal system, jurisdictions have specialty courts with separate dockets tailored to the specific needs of individuals in this system, with a focus on linkage to community-based treatment interventions. Policymakers, courts, and treatment providers can partner in developing and utilizing specialty treatment courts, such as mental health or drug courts, to improve outcomes, including increased engagement in treatment services and reduced recidivism rates.
5. **Opportunities for innovation:** With the increasing number of competency evaluation requests, the growing number of individuals requiring competency restoration services, and the limited availability and resources to provide these services in state hospital systems, alternative approaches, including community-based competency restoration programs, jail-based restoration programs, and diversion programs, should be further investigated and implemented by state leaders.
6. **SUD treatment challenges:** The practice of compelled SUD treatment is evolving, varies by state and by interpretation of state statute, and potentially poses ethical and clinical concerns. More data should be collected on the immediate and long-term outcomes of compelled treatment in the settings where this takes place, in order to better understand its use. This research could inform future policy related to this area.

Introduction

In all of health care, there are governing statutes, regulations, and policies that shape aspects of how treatment is delivered. The legal regulation of mental health practices represents an entire field of study in and of itself. Psychiatrists and other mental health professionals are trained about issues such as voluntary and involuntary psychiatric admission to a hospital early in their careers. The legal status of an inpatient is included in the doctor's admission orders, which is not true for other types of medical care. Thus, having an understanding of some of the areas in which law and mental health practices intersect is critical for those working to help individuals with serious mental illness (SMI), serious emotional disorders, and substance use disorders (SUD) in their recovery.

On July 24, 2025, President Trump issued the executive order "[Ending Crime and Disorder on America's Streets.](#)" The issues of homelessness, SUDs, SMI, and civil commitment have been debated in many cities and states in recent years, and this executive order has provided further direction in this area. Thus, mental health leaders should have a basic knowledge about what laws allow or prohibit regarding the treatment of people with mental illness.

Today, there are also key policy issues that require attention to legal processes that can impact the care of people with SMI. In this paper, several legal topics are reviewed, all with practical applications that may be different in each state but have common elements. As the state efforts evolves to provide an array of services that meet people where their needs are, it is important to understand these legal topics and the legal parameters that may be involved. These legal interventions can be tools that foster recovery, if used appropriately and with attention to the balance of over- and underuse, as many of them also have a risk of stifling recovery or doing harm if not used appropriately.

The civil legal interventions that are presented in this paper vary in the degree to which they restrict individuals' civil rights. When fundamental rights are curtailed in the United States, constitutional issues can be raised, and thus there must be due process and a substantive basis to restrict those rights. Every law that allows a restriction of rights has had a rich and robust history to get to where it is today. The appropriateness of each tool discussed below can vary depending on the individual, clinical requirements, resources available, and legal and regulatory restrictions such as eligibility under state statute. In most instances there is a balance, reflecting the idea that to intervene too aggressively with restrictions would be abuse of power, but to leave an individual uncared for when their symptoms impair their ability to care for themselves or create dangerous situations would be neglectful. Where and when to draw the line requires thoughtful awareness of the risks and benefits of intervening. While this publication is intended as a general guide, application of these principles may be subject to state or territorial legal requirements, ethics, institutional and professional guidelines, and other considerations. This publication is not intended to constitute or provide legal advice; readers are urged to seek legal and other advice as appropriate.

Civil Psychiatric-Legal Interventions

PSYCHIATRIC ADVANCE DIRECTIVES

When Nancy Cruzan's parents wanted to have their daughter's life support removed after she had been living unconscious with no hope of recovery, a legal battle ensued. At issue was whether the removal was allowable, considering that she could not openly express her preference. It was unclear what degree of evidence was needed to know whether she would have wanted to end life support if she had been competent to make her own decisions. After many grueling years for her parents, the United States Supreme Court recognized that competent individuals have a fundamental right to refuse life-sustaining treatment in *Cruzan v. Director, Missouri Department of Health* (1990). The court recognized Missouri's statute, which required clear and convincing evidence of an incompetent person's earlier competent wishes to withdraw life-sustaining treatment, as constitutionally permissible. This laid the groundwork for advance healthcare directives, which are also referred to as advance directives.¹ Following the *Cruzan* decision, the U.S. Congress passed the [Patient Self-Determination Act](#) in 1990. The act introduced federal requirements intended to implement advance directive policies at all healthcare facilities that receive federal funding through Medicaid and Medicare programs.² These policies included asking patients if they had or would like to have advance directives, giving patients information about creating advance directives, and honoring advance directives should the individuals become unable to make their own decisions later. Every state has enacted a statute authorizing advance directives.

Psychiatric advance directives developed in parallel with medical advance directives. Many states adopted [The Uniform Health-Care Decisions Act](#), which allowed mental health directives to be incorporated into general advance medical directives.³ However, at least 25 states enacted specific statutes for psychiatric advance directives.^{4,5} Where medical advance directives typically outline decisions about situations a person has not experienced (e.g., end-of-life care), psychiatric advance directives outline decisions mental health patients have likely experienced in the past, such as psychiatric decompensation, and are often based on past treatment experiences. In 2006, the Centers for Medicare & Medicaid Services (CMS), in its published final rules on seclusion and restraints, specified that psychiatric advance directives should be part of psychiatric care.⁶

Psychiatric advance directives allow individuals to put in writing in advance their wishes for treatment should they become incapacitated during an episode of greater symptoms.

Psychiatric advance directives are legal documents that allow an individual with mental illness to state their preferences for treatment in advance of a crisis in which they lose the capacity to give or withhold informed consent for treatment.⁷ Psychiatric advance directives can include advance instructions as well as a healthcare power of attorney. Instructions can include preferred medications and treatment modalities (or the choice to forgo treatment), advance consent for the contact of support persons, and information regarding practical matters such as childcare and contacting an employer.⁸ Healthcare powers of attorney designate proxy or surrogate decision makers who act in accordance with the incapacitated person's previously expressed wishes and known values, or in their best interest if the incapacitated person's preferences are unknown.

Psychiatric advance directives go into effect when an individual is found to lack decision-making capacity. A treating provider, such as psychiatrist or another physician, is typically the one to determine whether a patient has the capacity to make treatment decisions at the time when the individual is evaluated. The treating provider and other mental health professionals can then refer to the psychiatric advance directive for details regarding the patient's preferences for treatment. Once the patient regains decision-making capacity, the person can resume directly making determinations regarding their care. In many states, a "Ulysses" clause is attached to the psychiatric advance directives statute, which means that the expressed preferences on the psychiatric advance directive are not revocable until the patient regains decision-making capacity.⁹

Research has shown that psychiatric advance directives can honor an individual's autonomy, facilitate conversations about treatment, help prevent crises from occurring, and reduce coercive treatment.^{10,11} They can also enhance the therapeutic alliance between patients and their providers, as they require engagement and conversations about treatment preferences.

The issue of psychiatric advance directives in the setting of involuntarily hospitalized psychiatric patients was examined by the U.S. Court of Appeals for the Second Circuit in the case of *Hargrave v. Vermont* (2003).¹² In this case, Nancy Hargrave, a woman with schizophrenia and prior hospitalizations, had completed a durable power of attorney (DPOA) for health care, in which she designated a substitute decision maker and refused "any and all antipsychotic, neuroleptic, psychotropic, or psychoactive medications." In its ruling, the court struck down Vermont's law that allowed mental health professionals to override a person's advance refusal of psychotropic medications through a DPOA. The court determined that the law was discriminatory on the basis of disability and violated the Americans with Disabilities Act of 1990, as the law allowed only the advance directives of persons with mental illness who were civilly committed to be overridden. Although an influential federal case, the ruling has a limited jurisdiction, and similar rulings have not been made in other federal court jurisdictions. In other states, most laws that authorize psychiatric advance directives provide broad legal immunity to physicians who, based on their clinical judgment and standards of practice, decline to follow a patient's documented instructions.¹³ Additionally, states with psychiatric advance directive statutes allow for those directives to be superseded by an involuntary civil commitment order when a patient meets the criteria for involuntary hospitalization.

The case of *Hargrave* is partially influential in that it highlights the concern that many clinicians have about patients refusing treatment in their psychiatric advance directives. A systematic review in 2023 looked at the content of psychiatric advance directives in various countries, including the United States.¹⁴ The study identified six themes: signs of crisis, general treatment approach, preferences regarding the treatment setting, treatment preferences, coercion, and social instructions. Regarding treatment preferences, the study found that patients generally expressed clear, detailed, and clinically relevant preferences that were frequently based on previous personal experience with hospital admissions and adverse effects of medications. It noted that very few participants (0.3 percent) recorded a refusal of all medications in their psychiatric advance directives. The study concluded that psychiatric professionals' concerns that psychiatric advance directives would contain preferences incompatible with practice standards were not confirmed.

Although providers have legal obligations to implement psychiatric advance directives when patients have executed them, there are barriers that can limit their completion and implementation. As a result, they remain underutilized in many states and treatment settings.¹⁵ One study indicates that an initial barrier to psychiatric advance directives is treating providers' lack of familiarity, which can be overcome with brief education targeted to providers.¹⁶ Even if a patient has a psychiatric advance directive, it may not be followed due to practical issues concerning the storage and retrieval of the documents as well as a lack of communication of their presence to treatment providers.

Regardless, psychiatric advance directives can be helpful tools to document a patient's treatment preferences and instructions prior to a psychiatric crisis. They can help reduce the number of crises and the coercive treatment of patients. However, under particular circumstances, psychiatric advance directives can be overridden by civil commitment proceedings and clinical standards. Although there is a concern that psychiatric advance directives will be utilized to refuse all treatment, research suggests that this rarely happens. Still, psychiatric advance directives are underutilized as a result of a lack of understanding by providers as well as practical barriers. Therefore, policymakers, practitioners, and mental health services leaders could consider developing communication strategies for individuals and communities across state provider networks to promote the use of psychiatric advance directives.

“Policymakers, practitioners and mental health services leaders could consider developing communications strategies for individuals and communities across state provider networks to promote the use of psychiatric advance directives.”

Still, psychiatric advance directives are underutilized as a result of a lack of understanding by providers as well as practical barriers. Therefore, policymakers, practitioners, and mental health services leaders could consider developing communication strategies for individuals and communities across state provider networks to promote the use of psychiatric advance directives.

ASSISTED OUTPATIENT TREATMENT

In responding to individuals with SMI and complex treatment and human service needs, communities have looked for alternative strategies to hospitalization to promote treatment adherence and improve outcomes. All too often, the lives of individuals with SMI are complicated by frequent visits to emergency medical facilities, co-occurring SUDs, unstable housing, engagement with social welfare agencies, repeated psychiatric inpatient hospitalizations, and involvement in the criminal justice system, including detention in carceral settings. Although the goal of treatment is to engage individuals in voluntary, community-based services as a first step, for some individuals with SMI, this can present a real challenge.

Assisted outpatient treatment (AOT), which is also referred to as “outpatient civil commitment,” “involuntary outpatient commitment,” “mandatory outpatient treatment,” or “community treatment orders,” is one tool that state and local governments have used to attain adherence in outpatient care by individuals with SMI who have a history of nonadherence and/or have refused treatment and meet specific criteria that allow for a court order. AOT serves a unique role to facilitate ongoing psychiatric care in the community for individuals who are unable or unwilling to engage in such care voluntarily, do not pose an immediate threat to themselves or others requiring inpatient admission, and are unlikely to be able to live safely in the community without more coordination and oversight of their care. AOT is a civil court procedure whereby a judge orders the individual to adhere to an outpatient treatment plan and orders the service system to provide

that treatment, with the goal to prevent relapse, deterioration, involuntary hospitalization, and involvement in the criminal justice system.¹⁷

Individuals who might benefit from AOT often lack full awareness of their own mental health and substance use challenges and needs. Some have labeled this lack of awareness as “anosognosia,” a term that originated in stroke literature. In individuals with SMI, especially for those with co-occurring SUDs, there can be many factors that contribute to lack of awareness, nonadherence to treatment, and poor insight. More work and research are needed to understand this phenomenon of “insight” as policymakers develop strategies to help people remain in care.

Many states have had versions of outpatient commitment laws, or laws allowing patients civilly committed to a state hospital to live in the community on “conditional release,” for some time. However, more recently, the concept of “[AOT programs](#)” has emerged to convey that an array of processes and infrastructure need to come together, beyond just a state statute, to make AOT work. AOT laws themselves have been most extensively studied in North Carolina, New York, and Ohio, whose programs have served as models for other states. Often, the political impetus for the passage of AOT laws arises in response to violent acts, even though AOT is not a violence prevention program. Kendra’s Law in New York state and Kevin’s Law in Michigan are two examples of statutes named after the victims of violence by individuals with a history of mental illness.^{18,19} At present, 48 states and the District of Columbia have statutes authorizing AOT.²⁰

AOT: A court order commitment to a recommended plan of services in the community. Nonadherence will then result in several potential actions, including rehospitalization. Because this is a civil order, jail and punishment are not part of the remedy for nonadherence.

AOT programs: Infrastructure and collaborative processes developed to support individuals under AOT orders, often involving courts, the local behavioral health providers and authorities, law enforcement, hospitals, peers with lived experience, and others who may be involved.

Most commonly, AOT orders are considered part of an individual’s discharge planning following an involuntary hospitalization, as they “step down” and receive community-based treatment but continue to require close monitoring due to concerns regarding risk of harm to themselves or others in the context of nonadherence with treatment. AOT orders may also be used to “step up” engagement and treatment with nonadherent individuals in the community with SMI, to prevent further decompensation. The provisions outlining who is allowed to petition for commitment to start the process are delineated by state statute. Some states allow family members to initiate a process to petition the civil court for their loved one to receive care when that individual has been reluctant to engage in treatment. In addition to hospital and community settings, AOT orders may be obtained for individuals transitioning out of carceral environments, either in lieu of competency restoration or post-incarceration, if they meet the usual civil AOT criteria. In all instances, AOT orders provide a level of additional monitoring for the individual in the community.²¹

All states require the presence of a mental illness as one of the statutory criteria for AOT, and eligible individuals must also be considered to present some level of risk of harm to self or

others. States vary in terms of other criteria that may qualify an individual for AOT, including the inability to make decisions, grave disability, risk of relapse or deterioration, a history of noncompliance leading to threats to self or others or repeated hospitalizations or jail stays, an unwillingness or inability to voluntarily engage in treatment, or the opinion provided by a mental health professional that the individual's mental illness is reasonably treatable or will benefit from treatment under an AOT order.²¹

In addition to the criteria impacting eligibility for AOT, states also differ in their requirements for the development of treatment plans that individuals are expected to adhere to in the community. In some states, the AOT order contains a detailed treatment plan developed by clinical providers that identifies an individual's components of care, including case management services, types of medications, and housing. However, in other states, treatment plans are less clearly defined but remain deferential to providers.^{17,21} The length of treatment as outlined in an AOT order is also based upon state statute, with opportunities for modification or extension of such orders upon authority of the court. For example, New York state's initial AOT orders may not exceed 1 year in duration, with the opportunity to renew the order for a similar period of time if during each hearing the court finds, on the basis of clear and convincing evidence, that the individual continues to meet all criteria for AOT.¹⁸

The "black robe effect" is a colloquial term used to explain the impact of the court order and involvement of the judge in promoting treatment adherence. However, this is not to be confused with the importance of the quality of the treatment that is needed to improve the well being of the service recipient. Some scholars refer to the white coat effect to emphasize the importance of proper treatment and the role of clinicians working with the individuals in alignment with the court order.

State statutes vary in their requirements for community provider oversight of AOT orders, including the monitoring of participants and data tracking. Since an AOT order or program is usually locally driven, jurisdictional practices can differ between judges, courts, counties, and other levels of regionalization. State behavioral health leaders have a role to play in setting policies for entities, especially when the work is tied to state-authorized funding. This takes organization among state leaders to help shape practices downstream.

The role of the judge has been considered by some to be a component of a program's effectiveness, though research supporting that assertion is lacking.²² In some jurisdictions, the individual is ordered into treatment under an AOT order, and the behavioral health system then works with the individual, only further involving the court if needed, such as if orders to have the person reevaluated become necessary. More recently, some AOT programs have adopted a model in which individuals on AOT orders engage with a more active court that requires check-in between participants, their treatment teams, and the ordering judge as well as other AOT court personnel, similar to other specialty treatment courts, as described below. The data on this model is still being developed. However, the AOT order itself may impact treatment effectiveness for the individual, in that AOT orders hold participants, treatment providers, and treatment services all accountable for the services provided, while also uniformly working to help sustain the participant's engagement in those services. As a result, participants are less likely to "fall through the cracks" of the treatment system while participating under an active AOT order.²³

The research looking at outcomes associated with AOT has expanded over the last 30 years following the initial studies of programs created in North Carolina and New York, and there is good evidence for AOT program effectiveness as it relates to many outcomes.²⁴ Studies have indicated that participation in AOT is associated with a decrease in hospitalization, including lower rates of hospitalization compared with those engaged in voluntary services.²⁵⁻²⁷ Furthermore, it has been reported that individuals engaged in AOT have reductions in emergency department visits and length of hospitalization.^{26,28} AOT has also been noted to improve access to mental health treatment services, engagement with treatment services, and adherence to medications.²⁹⁻³¹ Beyond engagement with mental health treatment services, there may be other health benefits to participants, including the earlier identification of physical health conditions.³² Studies have also demonstrated that individuals under an AOT order have a decreased likelihood of being arrested, a reduced risk of criminal victimization, and a lower risk of harm to self or others.³³⁻³⁸ Some studies have demonstrated a decreased likelihood of homelessness, reduced engagement in harmful behaviors such as substance use, fewer barriers to treatment, and a higher quality of life.³⁹

Criticisms of the existing literature have focused on the fact that many studies were from one state, occurred outside the United States, or had methodological flaws. Given that most of the U.S. data collected is over a decade old and from New York state, critics have argued that it is difficult to determine whether results can be replicated in other states.²³ It has also been observed that randomized controlled trials in this population are not possible given the ethical, legal, and financial barriers to constructing such studies.⁴⁰ Recent articles have pointed out opportunities for future research, including studies that measure wellness and recovery-oriented outcomes such as quality-of-life measures and perceived coercion.²² It has also been suggested that there is a need for more research focused on varied geographic locations, identifying potential disparities among populations participating in AOT, and identifying optimal models of AOT oversight. Further research is needed to identify whether improvements in the individual's trajectory made while under an AOT order are sustained following the completion of the order.^{23,40}

Use of AOT raises the ethical tension between the principles of autonomy and beneficence. The American Psychiatric Association's (APA's) Position Statement on Involuntary Outpatient Commitment and Related Programs of Assisted Outpatient Treatment declares, "Psychiatrists must be aware of the conflict between the patient's interest in self-determination and promotion of the patient's medical best interest."⁴¹ The APA has also noted that efforts to engage the patient, and, when appropriate, their families, in the development of their treatment plan should be a "cornerstone of treatment" even when the treatment plan is court ordered.⁴¹

Notably, treatment providers working with individuals in their care who are under an AOT order cannot force treatment adherence, including forcing an individual to take their psychiatric (or other) medications. If a person is nonadherent with aspects of treatment, processes outlined in state statutes can include transport by law enforcement for a psychiatric evaluation, engagement with mental health crisis teams, and/or appearance in court with the ordering judge.^{17,18} Ethically, such processes could be considered efforts to maintain treatment adherence and reduce risk of further decompensation, including hospitalization, thus benefiting a person's autonomy and health. Or, they could be considered coercive and limiting to the ethical concept of autonomy. At least one study indicated an increased sense of coercion in the

context of case manager reminders and warnings regarding treatment nonadherence.⁴² In these scenarios, minimizing the coercive element of treatment whenever possible, in favor of a more collaborative approach, even when there is an overarching court order, may have the added benefit of promoting the ethical principles of autonomy and beneficence simultaneously. In a study of AOT participants in six counties in Ohio, participants reported high levels of satisfaction and feelings of empowerment regarding their treatment teams and the courts, with more than 75 percent indicating satisfaction with both stakeholders. Furthermore, participants reported benefiting from the court order and the program, indicating that opportunities can exist to provide individually focused treatment that is respectful of the ethical tensions present in such settings.⁴³

Weighing the ethical considerations and the social impact of implementing AOT laws in the context of AOT programs within local and state mental health system extends beyond the individuals engaging with AOT. For example, the allocation of resources toward those with a history of nonadherence may have an impact on the availability of resources for individuals voluntarily seeking treatment, thus affecting individuals actively attempting to engage in treatment to ameliorate symptoms. At least one study has indicated that several participants expressed such concerns regarding resource distribution, though at that point the program had been able to maintain service levels across all levels of care for both court-ordered and voluntary service recipients.

One example of a state working to educate partners and build AOT program coordination and effectiveness is Michigan, which works with the Wayne State University Center for Behavioral Health and Justice and has built an [AOT toolkit](#) to convey partner roles and ways to improve processes.

Given that some states designate funding specifically for the administration of the services required to create an AOT program in a community trying to build infrastructure to support individuals under AOT orders, appropriate allocation of resources is an ongoing challenge for healthcare systems engaged with individuals under AOT orders. Achieving a balance in resource distribution will remain an ongoing challenge within state systems, particularly if further funding is not provided while court-mandated treatment is still required. Either way, to successfully implement AOT laws, there is a tremendous need for collaboration among multiple stakeholders, including outpatient providers, agencies providing oversight, and the courts.²¹

INVOLUNTARY PSYCHIATRIC HOSPITALIZATION

In psychiatric treatment, ideally, an array of services are available with varying intensities of medically necessary intervention, ranging from prevention to outpatient treatment to admission to a psychiatric hospital. Although psychiatric hospitalization can provide more intensive psychotherapeutic and psychopharmacologic treatment coupled with close medical monitoring of safety, it also requires the individual to be away from home and separated from their natural supports. Psychiatric hospitalization also involves restriction of movement, typically to a locked psychiatric ward, although some open and unlocked wards do exist. The decision as to whether to hospitalize a person is a complex decision that is similar in some ways to what occurs in other areas of health care. In psychiatric practice, this decision has an added layer of complexity in that it necessitates balancing the individual's rights to liberty and freedom from confinement against maintaining the safety of the individual and others in the community. When the individual

wants to be hospitalized and recognizes how hospitalization can help address their psychiatric issues—a voluntary admission—there are fewer tensions.

Involuntary psychiatric hospitalization takes place when, under certain circumstances, hospitalization is pursued over an individual's objection. Involuntary hospitalization, also referred to as civil commitment, involves a legal process whereby a judge or judicial decision maker may order an individual with symptoms of SMI to be psychiatrically hospitalized and/or receive psychiatric treatment in a supervised setting for a defined period. In this section, the issue of the hospitalization order itself is discussed as separate from any order for medication over objection that may occur after such a court order, which will be discussed later.

The state's right to pursue civil commitment of an individual is rooted in two legal principles: *parens patriae* and police powers.⁴⁴ *Parens patriae*, translated to "parent of the nation," is the principle derived from English common law in which the government maintains the duty to act as a protector of individuals unable to protect themselves or act in their own best interests. Police powers afford the government the power to enforce order to protect the interests of its people, including to maintain public safety. It is important to note that while it is within a state's right to enact civil commitment statutes in accordance with these principles, each state has its own specific laws to guide the implementation of involuntary hospitalization.

In order to appreciate the standards behind the laws regulating voluntary and involuntary hospitalization, it is helpful to understand the history of psychiatric hospitals' landmark legal cases that have further shaped state statutory construction. In the 17th and 18th centuries, persons with mental illness were primarily cared for by their family members or left to the local community in the absence of specialty physicians and hospital settings. Thus, when someone needed care, they could be brought to the institution and be signed in by family and the physicians. Involuntary confinement was primarily reserved for when symptoms of mental illness threatened the security of the community. In 1752, Pennsylvania State Hospital opened a dedicated unit for the treatment of mental illness, [representing](#) one of the first organized efforts to provide targeted treatment of psychiatric conditions. The first dedicated institution for the care of people with mental illness followed in Virginia in 1773. By the early 19th century, there was increasing movement toward specialized institutions in the context of population growth and medical innovations arising in Europe. An increasing view of mental illness as a social issue led to heightened emphasis on governmental intervention for management, with a primary focus on helping those with mental illness by removing them from negative influences and stressors that disrupted their natural moral balance.⁴⁵ By the end of the Civil War (1865), nearly every state had at least one state-operated psychiatric institution.

As the 19th century progressed, psychiatric orientation changed, with mental health institutions increasingly viewed almost as prisons for individuals with mental illness. During this period, the legal standard for involuntary hospitalization required only the presence of a mental illness and the recommendation for treatment.⁴⁶ In the early to mid-20th century, the mental hygiene movement arose, with an increasing focus on research and development of institutional alternatives as novel therapeutic options emerged, including the introduction of psychotropic medications. In the 1960s, a number of governmental and political outcomes converged to transfer care from inpatient psychiatric settings to community-based treatment, including the

establishment of Medicare and Medicaid in 1960 and the passage of the Community Mental Health Centers Act in 1963.^{47,48}

As a result of the Civil Rights and deinstitutionalization movements, the standard for involuntary hospitalization moved toward requiring the risk of dangerousness resulting from mental illness, rather than a justification based on treatment needs.⁴⁶ In *Lake v. Cameron* (1966), the Washington, D.C., Court of Appeals established the consideration of the “least restrictive alternative” for treatment, recognizing that the deprivation of liberty associated with involuntary hospitalization should not go beyond what is necessary for protection of the ill person.⁴⁹ This language was subsequently incorporated into nearly two-thirds of state civil commitment laws.

As a state example, California passed the Lanterman-Petris-Short (LPS) Act in 1969, outlining criteria for involuntary hospitalization that included requiring that an individual be of imminent danger to themselves or others, or “gravely disabled” to the point of being unable to care for themselves.⁵⁰ Notably, the criteria did not include need for treatment as an indication for civil commitment. Recent shifts in California law have provided for more treatment-focused policy that includes court involvement, as opposed to the very rights-oriented statute that the LPS Act represented.⁵¹

The U.S. Supreme Court has reviewed a few cases pertaining to civil commitment, beginning with *O’Connor v. Donaldson* in 1975. In this case, Mr. Donaldson, considered non-dangerous, was held in a Florida state psychiatric hospital without receiving treatment. The court held that the government “cannot constitutionally confine, without more, a non-dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.”⁵² Although the “without more” in this decision is ambiguous, it is generally considered to mean more dangerousness that would warrant confinement, or more significant treatment of a mental health condition.

In 1972, the Federal District Court of Wisconsin decided *Lessard v. Schmidt*, a case in which the plaintiff, Ms. Lessard, alleged due process violations in the course of her civil commitment. The *Lessard* decision provided procedural safeguards for civil commitment, including the right to counsel, advance notice of a hearing, and the right to a jury. Furthermore, the decision set the standard of proof for involuntary hospitalization in Wisconsin as “beyond a reasonable doubt,” the same standard as for a criminal conviction, noting that the same liberty interests are at stake in civil commitment proceedings.⁵³ This standard is considered the high-water mark in commitment proceedings. In contrast, the U.S. Supreme Court set the minimum standard of proof in civil commitment proceedings as “clear and convincing evidence” in *Addington v. Texas* (1979).⁵⁴ Although *Lessard* was a case from Wisconsin, its influence swept the country, with states quickly adopting language that would allow involuntary hospitalization only where there was dangerousness (e.g., danger to self or others) or significant grave disability.

The question of someone’s ability to voluntarily sign themselves in to a psychiatric hospital has also been addressed with legal protections. Unlike medical hospitalization, where an individual is free to leave, in voluntary psychiatric hospitalization there are typically mechanisms to hold a person should they change their mind. Determining competence regarding treatment decisions, including psychiatric hospitalization and medication, requires a balance of respecting an

individual's autonomy, their ability to understand relevant information provided to them, and their reasoning through treatment options to make an informed decision.⁵⁵ In *Zinermon v. Burch* (1990), the U.S. Supreme Court specifically addressed the question of competence to voluntarily agree to hospitalization in a patient impaired by psychiatric symptoms; the court decided that procedural protections were not in place for Mr. Burch, though it could have been assumed that he would have had impairments in his capacity to make the decision to sign in voluntarily.⁵⁶

Although voluntary psychiatric admissions are based on an individual's willingness to pursue and engage in mental health treatment in the hospital, additional procedures in most state statutes include an attestation by the admitting psychiatrist that the individual is either "suitable" for psychiatric hospitalization or competent to agree to the hospitalization. There are also procedures should such a patient request discharge from the hospital after agreeing to be hospitalized. A study from 2014 found that a majority of jurisdictions employ a waiting and observation period after a patient on voluntary legal status requests discharge, often 72 hours.⁵⁷ At the end of this period, the individual must either be released or involuntary civil commitment should be sought if an authorized clinician determines that they meet the state's civil commitment standards.

With respect to civil commitment, each state or jurisdiction determines its own specific standards, including criteria for involuntary hospitalization and the procedures required for the pursuit of it. However, in most states, there are two processes for pursuing involuntary commitment.⁴⁴ All states have some provision for an emergency pickup or a temporary hold for the initial phases.⁵⁸ After that occurs, short-term or acute hospitalizations are authorized through emergency evaluations of limited duration, typically 2–5 days. This evaluation is completed by a physician or other qualified professional, although the types of providers who meet the criteria for this role vary by state or jurisdiction. This emergency period of time is not typically reviewed by a legal decision maker in the normal course of business, such as a court or magistrate, prior to the hospitalization or the legal hold. However, at the end of the specified duration of the hold, there are typically three options: release, voluntary admission, or pursuit of civil commitment. If commitment is pursued, the length of the commitment order can vary depending on several factors.

The process for hospitalization of a minor under age 18 is different and varies significantly depending on individual state standards. In nearly all states, a minor is admitted if a physician determines that psychiatric hospitalization is medically indicated and the parent or guardian consents to psychiatric hospitalization. In contrast to adults, there is more of a focus on medical appropriateness for admission over dangerousness or risk of harm to self, although the latter remains a consideration. Currently, nearly two-thirds of states allow minors over a certain age to consent to hospitalization absent parental involvement; others may require more than parental consent, such as a judicial review if either the parent or the minor objects, if a minor is older than a defined age.⁵⁹

In 1979, the U.S. Supreme Court addressed constitutional processes for hospitalization of minors in *Parham v. J.R. and J.L.* The Georgia statute in question allowed for admission to a psychiatric hospital via application by a guardian if the hospital superintendent found evidence of mental illness and determined the child to be suitable for treatment. The court articulated a need for a "neutral fact finder" to determine the need for psychiatric admission and continued

commitment but opined that a formal adversarial hearing was not necessary.⁶⁰ Further, there was a recognition that parents have important rights in the lives of their children, including the right to seek and consent to treatment in the hospital. In a position statement released in 2021, the APA held the position that where they exist, formal proceedings for civil commitment of minors should not differ significantly from adult procedures.⁶¹

MEDICATION OVER OBJECTION, EMERGENCY AND NONEMERGENCY

Prior to the 20th century, mental health patients had limited rights to refuse whatever treatment was offered in hospital settings. In general, psychiatrists had the authority to determine treatment for both involuntarily and voluntarily hospitalized patients. Several factors contributed to the development of patients' right to refuse treatment, including civil commitment case law as a distinct framework for hospitalization separate from medication administration, the evolution of informed consent, and public perception about the quality of care in psychiatric institutions.⁶² The doctrine of informed consent recognized that the presumption that committed patients were globally incompetent was erroneous and that a patient's treatment-specific decision-making capacity must be upheld unless after examination there was a justification to override it.^{63,64} Additionally, the public became aware of the quality of care at some psychiatric institutions as well as gained a greater understanding of the risks and limitations of psychiatric medications.⁶⁵ This led to a greater emphasis on patient autonomy and self-determination regarding medication treatment outside of emergency situations.

Two initial cases guided different legal approaches to determining a patient's right to refuse psychiatric medication treatment in nonemergency situations (**Table 1**). In *Rogers v. Commissioner of Mental Health* (1983), the Massachusetts Supreme Judicial Court adopted a "rights-driven" model to determine when medication over a patient's objection could be authorized.⁶⁶ In this model, individual liberty interests are emphasized, and patient objections can be overridden only for incompetent individuals, absent an emergency. A court decision is required to find a patient incompetent, and medication decisions are then made by "substituted judgment," in which the court attempts to approximate what the patient would have wanted if competent. Decisions based on substituted judgment may take into consideration a patient's and family's preferences, previously experienced side effects, the patient's prognosis, and religious considerations. Conversely, a "treatment-driven" model described in *Rennie v. Klein* (1983) was found to satisfy U.S. constitutional requirements by the Third Circuit Court of Appeals.⁶⁷ In this treatment-driven model, the patient's right to refuse treatment is limited to situations in which the patient is being prescribed inappropriate care. Thus, the authority to override a patient's refusal is determined by professionals such as psychiatrists, medical directors, or multidisciplinary boards. A judicial hearing is not required.

Table 1: Legal Approaches to Medication Over Objection

State-based legal approach	Landmark legal case	Key differences
Rights-driven model	<i>Rogers v. Commissioner of Mental Health</i> (1983)	<ul style="list-style-type: none"> • Liberty interests emphasized • Judicial decision required to medicate over objection • Decision made based on substituted judgment
Treatment-driven model	<i>Rennie v. Klein</i> (1983)	<ul style="list-style-type: none"> • Focus on inappropriate care • Professional judgment employed to medicate over objection • Judicial hearing not required

In the context of the changing landscape of the 1980s, one state, New York, shifted from a treatment-driven model based on administrative procedure to a more rights-driven model, which required a judicial hearing, after the decision in the New York Court of Appeals case *Rivers v. Katz* (1986).⁶⁸ A study examining the rates of refusals and time to resolution after the changes were instituted found significantly decreased numbers of patients formally refusing medications.⁶⁹ However, for patients who refused medications, the time to determine their capacity to refuse medications significantly increased. It was noted that some patients who had an increased wait time for a judicial hearing ended up with worsening symptoms and required the use of emergency medication, seclusion, or restraints. Therefore, the study authors questioned whether patients were truly benefiting from the more rights-driven model. Another study included more than 1,400 psychiatric patients admitted to acute inpatient units and examined them prospectively.⁷⁰ The results showed that patients who refused antipsychotic medications had longer hospitalizations and were more likely to require seclusion or restraints. Most episodes of treatment refusal ended with the voluntary acceptance of medications. Additionally, of the 18 percent of patients who had a judicial review hearing, involuntary treatment was ordered in every case. Overall, these cases reflect the wide state-to-state variations when determining a psychiatric inpatient's right to refuse medication treatment.

Turning to federal standards, the U.S. Supreme Court has not directly ruled on a federal constitutional right to refuse treatment. However, the court has typically supported a treatment-driven model. The court determined in *Youngberg v. Romeo* (1982) that an institutionalized individual had the right to be free from unnecessary restraints.⁷¹ A deference to professional judgment was given in this case.

The U.S. Supreme Court has weighed in on the right to refuse treatment for some specialized populations (**Table 2**). In *Washington v. Harper* (1990), the court set the minimum constitutional requirements to medicate a sentenced prisoner against their will for treatment in nonemergency circumstances.⁷² The court found the state of Washington's regulatory scheme sufficient, as it required treatment based on dangerousness and medical appropriateness, and it also established procedures for review, including the right to notice, lay representation, and a hearing

before a professional panel. A judicial hearing was not required in such instances. The Ninth Circuit Court of Appeals extended the standard in *Harper* to pretrial detainees in *U.S. v. Loughner* (2012).⁷³ In *Riggins v. Nevada* (1992), the U.S. Supreme Court did not set specific standards for the involuntary medication of pretrial detainees, although it called for medical appropriateness, assessment of dangerousness, and use of the least restrictive option.⁷⁴ Additionally, in *Sell v. U.S.* (2003), the U.S. Supreme Court established criteria that must be met to involuntarily medicate a pretrial detainee for the purpose of restoring their competence to stand trial.⁷⁵ The criteria include that important government interests are at stake, the treatment is medically appropriate, the treatment is likely to render the defendant competent, the treatment is unlikely to have side effects that will interfere significantly with the defendant’s ability to assist counsel, the treatment is the least intrusive option, and the treatment is necessary to further governmental trial-related interests. The court also made clear that in civil processes, states have other remedies available outside those discussed in *Sell* that should be considered to medicate individuals over their objection, such as through guardianship for those individuals who are incapable of making competent decisions.

Table 2: Legal Approaches to Medication Over Objection in Specialized Populations

Specialized population	Landmark legal case	Criteria to medicate over objection
Sentenced prisoners	<i>Washington v. Harper</i> (1990)	<ul style="list-style-type: none"> • Treatment is based on dangerousness and medical appropriateness. • Procedures for review included the right to notice, lay representation, and a hearing before a professional panel.
Pretrial detainees	<i>Riggins v. Nevada</i> (1992) <i>U.S. v. Loughner</i> (2012)	<ul style="list-style-type: none"> • The U.S. Supreme Court did not set a specific standard in <i>Riggins</i>. • The Ninth Circuit Court of Appeals extended the standard set in <i>Harper</i>.
Pretrial detainees who are incompetent to stand trial	<i>Sell v. U.S.</i> (2003)	<ul style="list-style-type: none"> • Important government interest is at stake. • Treatment is medically appropriate. • Treatment is likely to render the defendant competent. • Treatment is unlikely to have side effects that make the defendant unable to assist their counsel. • Treatment is the least intrusive option. • Treatment is necessary to further governmental trial-related interests.

Exceptions to the need for informed consent for medication exist in cases of emergencies. In medical emergencies, there is typically an understanding of implied or presumed consent for medical intervention. Criteria for medical emergencies typically rely on temporal immediacy and expected harm in the delay of treatment based upon the principle of *parens patriae*.⁷⁶ Regarding psychiatric emergencies, an individual may be unwilling to take medications when offered. What constitutes a psychiatric emergency may be less straightforward, but situations include when there are readily observable imminent risks of dangerous behaviors and there is a need to maintain the safety of the patient and the staff. In *Rogers*, the Massachusetts Supreme Judicial Court noted that a patient may be treated against their will to prevent the “immediate, substantial, and irreversible deterioration of a serious mental illness” in which “even the smallest of avoidable delays would be intolerable.” Nevertheless, such a circumstance may be difficult to define in practice,⁷⁷ and this criterion is rarely utilized. Scenarios in which a patient is not eating or drinking due to catatonia (a syndrome characterized by abnormal movements, behaviors, and withdrawal) may represent some of the gray-area situations in which an emergency may exist only at certain moments in the individual’s illness presentation. Cases are nuanced and must be considered on an individualized basis.

Rates of medication refusal in inpatient mental health populations can range from 2 percent to 44 percent, with higher rates of treatment refusal at times observed in forensic settings.⁷⁸ One study found that of those who refused medications in civil hospital settings, most ended their refusal in 2–4 days.⁷⁹ Individuals with schizophrenia spectrum disorders who refuse medications over prolonged periods have been found to have less insight, less satisfaction with their most recent psychiatrist and previous medication, and more negative beliefs about the harmful effects of medications.⁸⁰

Emergency involuntary medication administration is carried out based on knowledge of what medications can work safely and an assessment of the patient’s circumstances. When evaluating a patient in a nonemergency situation who is refusing medications, it is important to consider their reasons, the context, and the appropriateness of the proposed treatment. Patients may refuse medications for several reasons, including experienced or anticipated side effects, incomplete knowledge of the medication, and illness-related reasons, to name a few. The timing of a patient’s refusal of medication should also be considered, as different factors may influence patients who were recently admitted, patients who refuse later in the course of their hospitalization, or patients in outpatient settings. It is important to determine whether the context entails an emergency or not, which may influence medication selection and its administration. Finally, the appropriateness of the recommended medication should be considered. It is important to complete a thorough review of the patient’s history and collateral information to ensure that the recommended treatment fits the patient’s diagnosis and clinical presentation. An assessment of side effects should be undertaken as well as an exploration of a patient’s complaints.

In nonemergency situations, treatment refusal often provides an opportunity to engage and negotiate with a patient. Psychoeducation and motivational interviewing may be tools to use in these scenarios. Providers should consider reasonable alternatives to which the patient might agree. Using additional members of the treatment team, family members, and even peer support professionals may be helpful in facilitating agreement to take the recommended medication. Overall, the therapeutic relationship should be maximized with a person-centered perspective. When it is not possible to negotiate a reasonable course of treatment and a

psychiatrist decides to take formal steps to implement involuntary medication, the patient should be informed and provided with the reasons why medication is being pursued over their objection. Additionally, all patients should be educated on the process to treat patients over their objection and their rights, including the right to legal representation when required by law. Most patients who refuse medications in situations requiring an administrative or judicial review have their refusal overturned.^{70,79} One study found that most patients who received involuntary medications later came to accept medications voluntarily.⁸¹

Although the topic of seclusion and restraint is beyond the scope of this paper, the implementation of medication over objection, even in a nonemergency, may involve a manual hold that would constitute restraint. Therefore, even when there is legal authority to medicate the patient despite their objection, the decision to lay hands on a psychiatric inpatient should not be taken lightly and must also be legally justified, either as integral to a court order for medications or based on local restraint rules and CMS and Joint Commission guidelines if facilities are accredited. It is important to remember that involuntary administration of psychiatric medications is best done under a proper medical authority and ideally in a clinical and therapeutic hospital setting. Where these procedures are implemented in carceral settings, it is vital to have medical input on policies and practices. Civil commitment orders for AOT do not authorize the holding of a person for medications, so medication adherence may become an issue to be dealt with in an inpatient setting.

To summarize, when a patient declines recommended psychiatric medications, it is important to determine the best strategies to try to help the individual come to agreement themselves. It is also important to ensure that the patient's decisions are made competently, or to determine whether an alternative decision maker, such as a guardian, is in order. In nonemergent situations, it is important to attempt to work with the patient on an acceptable treatment plan that incorporates their wishes and preferences, their values, and their expectations for treatment. If a psychiatric inpatient continues to decline the recommended medications, alternative medication options have also been explored, and the patient continues to present serious risk concerns absent treatment, then formal steps should be taken to involuntarily medicate the patient when necessary. Depending on the jurisdiction, this step may necessitate a judicial hearing or a professional review. However, if a patient is a member of a specialized population, such as a prisoner, a pretrial detainee, or a pretrial detainee undergoing competency restoration, other specific criteria may need to be met for involuntary medication treatment.

GUARDIANSHIP

Guardianship refers to the process by which a court appoints an individual or entity to take over decision-making for an adult when the court determines that they are unable to make decisions for themselves. It is a transfer of decision-making ability from one individual (the incapacitated individual) to another (the guardian). Guardians have a duty to the person whom they serve, meaning that they must make decisions for the individual that are in the individual's best interest, regardless of the interests of the guardian.⁸² Guardianship orders are pursued in situations in which an individual with a physical, mental, or developmental disability lacks decision-making capacities in areas such as finances, safety, legal issues, and health care. Laws regarding guardianship of individuals with intellectual disabilities differ from guardianship laws that address other conditions that lead to decision-making incapacity.

Types of guardianship may vary depending on the needs of the individual as well as laws in the jurisdiction where the person resides. Guardians of the person are involved in all the individual's personal decisions, including those relating to place of residence, health care, and visitors. Guardians of the property, also referred to as conservators, are involved in the management of financial decisions, including those affecting money, investments, real estate, and gift giving.

Three types of guardianships are commonly utilized by the courts. In full guardianship, also called plenary guardianship, the guardian has the power to make decisions for an incapacitated individual regarding all aspects of their life, including financial, property, and medical care decisions.⁸³ It is the most restrictive form of guardianship, and the specific definitions of incompetence used in these scenarios are guided by state statute.⁸⁴ Limited guardianship, in contrast, functions to provide decision-making powers in a manner specified in the court order. For example, some individuals lack decision-making capacity in some areas, such as medical care, place of residence, property, or finances, but retain the capacity to make decisions in other areas. Limited guardianship enables an individual to maintain some autonomy, but implementing this type of guardianship is more complex.⁸⁵ Lastly, a temporary guardianship is created to perform one or more specific tasks, for example, to ensure that an individual receives necessary care and protection in the short term.⁸⁶ Once the temporary guardian's function, as outlined in the court order, is completed, the guardian is relieved of their duties to the individual. It is possible that a temporary guardian may transition to full guardianship or limited guardianship, depending on the evolving needs of the individual.

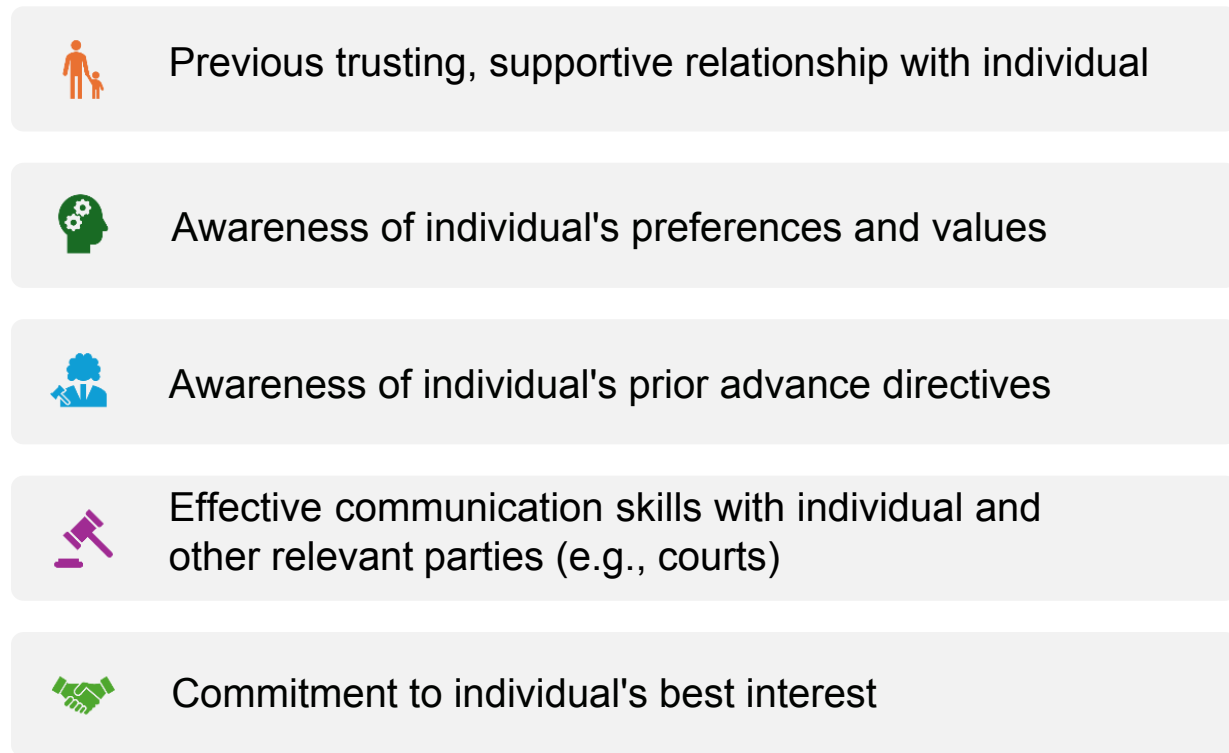
The process by which a guardian is appointed starts with a petition by an interested party, such as a family member or a healthcare professional. Petitions for guardianship typically contain information regarding the individual's reported incapacities. In jurisdictions that require a clinical assessment, further information would be provided by a qualified healthcare professional such as a physician or other mental health professional. Subsequent steps in the guardianship process can take several weeks or months to complete, due to the filing of court paperwork; the notification of all interested parties, including the alleged incapacitated person; and the hearing. The court is responsible for ensuring that the alleged incapacitated person's due process rights are protected while appropriately investigating the extent of the incapacity, if any. Such an investigation may include the appointment of an independent party or guardian *ad litem* to provide a report with recommendations to the court. If the standard of proof is met for a finding of incapacity, a guardian will be appointed. Guardians are often family members, but when one cannot be identified or there are concerns that preclude involvement of interested family members, the courts may appoint an unrelated person, such as a professional guardian or an attorney, to serve as the individual's guardian. It can be difficult at times to identify individuals to serve as guardians, and this challenge can create complexity and delays in receiving treatment.⁸⁷

Guardianship laws are different in every state and territory, and the differences include the criteria for eligibility to serve as a guardian and the process by which a guardian is appointed. Providers, family members, and others, including psychiatrists and other mental health professions, must be aware of such jurisdictional rules when guardianship is pursued for an individual under their care. State laws may also impact psychiatric treatment in these different settings, including the ability of a guardian to consent to an individual's psychiatric hospitalization without use of the involuntary commitment processes.

Given the variability of guardianship laws, challenges exist when individuals with guardianship orders in one state cross into another state for a specific purpose, such as for outpatient medical care, medical hospitalization, or psychiatric hospitalization. The National Conference of Commissioners on Uniform State Laws originally developed the Uniform Probate Code (UPC) in 1969 to create consistency among states in the decision-making processes on certain issues, including guardianship and durable powers of attorney.⁸⁸ The UPC was last amended in 2019, and at present, 18 states have adopted all or part of it, meaning that inconsistencies across states remain.⁸⁹ Other attempts have been made to manage jurisdictional differences regarding guardianship. For example, the Uniform Adult Guardianship and Protective Proceedings Jurisdiction Act, originally approved in 2007, addresses complexities relating to guardianship issues across state lines and encourages the facilitation of communication between jurisdictions on issues such as guardianship recognition among states and transfers of guardianship orders between states. As of the end of 2025, 47 states and the District of Columbia have adopted this act, with Florida, Michigan, and Texas the only states where this act has not been adopted as law.⁹⁰

For healthcare professionals, the guardianship process can create clinical, legal, and ethical dilemmas. The need to find a balance between protecting vulnerable individuals from safety concerns under the ethical principles of beneficence and nonmaleficence while also respecting an individual's autonomy remains present even after a guardian is appointed. Optimally, a guardian is a person the individual knows and with whom they have a trusting, supportive relationship, so that decisions can be made in a manner consistent with previously reported preferences and values expressed in conversations with loved ones or the use of advance directives, and the decisions will at the very least be in the individual's best interests (**Figure 1**). Such preferences and values are not always known, with literature suggesting that rates of completion of advance directives in the United States range between 20 percent and 37 percent.⁹¹⁻⁹³

Figure 1: Characteristics of Optimal Guardians



Although guardianship should function to protect a vulnerable individual, the nature of the system leaves guardianship at risk for misconduct, malfeasance, or the failure of a guardian to fulfill their obligations. Estimates regarding the total number of Americans under guardianship are difficult to obtain due to the system's decentralized nature, with one extrapolation of data indicating that approximately 1.3 million individuals were under guardianship in 2015 and assets under the control of guardians estimated at approximately \$50 million.⁹⁴ Abuses by guardians are well documented in the media, as there are several areas in which abuse can occur, including mismanagement of individuals' finances, excessive fees by attorneys appointed as guardians, and professional guardians being overwhelmed by large caseload numbers and unable to appropriately monitor individuals' well-being. Professional guardians making medical decisions for their own convenience rather than in the individual's best interests is just one example of inappropriate behavior driven by unmanageable caseloads.⁹⁵

As a result of such mismanagement, efforts have been made to provide more oversight of guardians by way of the courts and state legislatures. For example, states commonly require the guardian to file an annual accounting of the individual's finances. Other proposals to improve the accountability of guardians have included the implementation of a statewide data collection system, the standardization of forms for financial management plans, and the creation of additional training requirements for those interested in becoming guardians.^{96,97} Efforts on the state and national levels to improve this system to benefit those who require close monitoring and management of their lives remain ongoing.

Given the potential for abuse, and because guardianship is seen as a restriction of autonomy, some advocates have promoted the use of alternative strategies for decision-making that can

be facilitated or guided in a supportive way to help maintain the person's autonomy. Advance directives, which provide information about an individual's stated preferences, as described above, are one such way to document an individual's preferences if they become incapable of making care decisions at a later time. A durable medical power of attorney allows a person to maintain decision-making abilities but appoint an individual to make medical decisions at a later point in time if an alternate decision maker is needed in the future. Supported decision-making has been proposed as another alternative to optimize autonomy while offering care that is respectful and person-centered. Supported decision-making was originally developed in Canada and Australia for work with individuals with intellectual and developmental disabilities, and its use with people with mental illness continues to be studied.^{98,99} Use of such alternatives, when possible, promotes patient autonomy and respect for decisions and limits the use of guardianship orders to a last resort.

Criminal-Legal System Interface With Psychiatric Treatment

COMPETENCY RESTORATION TREATMENT

Competence to stand trial (CST), also called adjudicative competence, is a legal construct referring to a criminal defendant's ability to participate in criminal legal proceedings related to an alleged offense.¹⁰⁰ Criminal defendants may be referred for a CST evaluation if the prosecuting attorney, defense attorney, or judge has concerns regarding an individual's understanding of their legal case and legal proceedings or questions their ability to rationally assist in their defense. Individuals may be found incompetent to stand trial (IST, also referred to as unfit to stand trial, unable to aid and assist, or other terms particular to a jurisdiction), typically related to a mental condition. Most commonly, individuals are found IST due to symptoms of mental illness, intellectual disability, or a neurocognitive disorder that impedes their ability to proceed as a defendant. This could include an inability to understand the charges, an inability to assist in their own defense, or a rational or factual lack of understanding of the court process. Once a defendant is found by a judge to be IST, their case is effectively paused until their competence is restored. In almost all states and territories, they are court-ordered to receive competency restoration (CR) treatment, which includes psychiatric treatment with the goals of treating the condition that impeded their competence and returning the individual to court to proceed in the criminal process.¹⁰¹ Individuals found IST due to an underlying mental condition will likely need psychiatric treatment to address the symptoms originally causing their inability to proceed through the criminal justice system.¹⁰¹ Also, CR is prioritized especially when the government has a vested interest in ensuring that the criminal defendant's case can be prosecuted.¹⁰²

The general competency evaluation process includes an individual's undergoing a court-ordered forensic examination, after which most state statutes require the forensic evaluator to opine on whether an individual's competence is likely to be restored within a statutorily defined period.¹⁰⁰ These evaluations may be conducted under stressful or undesirable circumstances, such as within time constraints; in noisy and busy carceral settings; and sometimes without any collateral information, such as records, communication with jail or mental health staff, or knowledge of a defendant's prior psychiatric treatment.¹⁰²

There are three main outcomes following a CST evaluation. If the defendant is found competent, their criminal legal case will proceed. If the defendant is found IST but restorable, the individual will await the judge's decision on a treatment setting, whether it is hospital-based restoration, outpatient or community-based restoration, or jail-based restoration where available. If the defendant is found IST and not restorable, a determination must be made as to whether the individual meets criteria for civil commitment.¹⁰³ These processes can involve a significant amount of waiting for defendants: waiting for the competency evaluation, a hearing to determine competency, and state psychiatric bed availability; once opined as restored by forensic evaluators, a new hearing to determine competency; and finally, progression through the legal proceedings. These waiting periods pose ethical dilemmas, as individuals may go without necessary psychiatric treatment for long periods of time or be gratuitously detained pretrial for longer than if the competence issue had not been raised.¹⁰³

Information important in determining competency and restorability includes whether an individual's psychiatric symptoms impair their adjudicative capacities, the responsiveness of those symptoms to treatment, and the projected time required for treatment.¹⁰⁰ Most jurisdictions have placed limits on the time allocated for competency restoration, which typically has some relation to the potential penalty if the individual were to be found guilty.¹⁰² A history of psychiatric hospitalization and the presence of psychosis increase the chances that an individual will be found incompetent. Available studies indicate that rates of competency restoration are high, with 75–90 percent of individuals attaining competency within 6 months of inpatient restoration treatment.¹⁰⁴⁻¹⁰⁶ This data is complicated by terminology differences and time frames allowable by statute that often drive outcomes rather than vice versa. Unsurprisingly, those with severe cognitive impairment, such as intellectual disability or persistent psychosis, are most likely to be found unrestorable.^{100,106} If an individual is believed to be IST, they generally cannot be psychiatrically committed indefinitely for purposes of CR, as it would violate the individual's due process, equal protection, and the prohibition against cruel and unusual punishment.¹⁰⁷ Thus, after a period of restoration, there must be a disposition that would allow either release or continued commitment under other vehicles, such as civil commitment with charges dismissed. States vary in the degree to which this guidance is upheld and may have different statutory schemes that make the allowable time frame for restoration indefinite, especially for certain charges.

In order to meet the standard to be found competent, defendants must not only have a factual understanding of the legal proceedings against them, but they must also be able to consult with their attorney with a reasonable degree of rational understanding; therefore, the goal of CR treatment is to achieve a level of both factual and rational understanding of the criminal charges against them and the process to prosecute them.¹⁰⁸ At the end of treatment, an individual may still be experiencing symptoms; however, symptoms should not still be interfering significantly with CST capacities.¹⁰² Regarding factual and rational competence, factual deficits are easier to identify and address through education on key courtroom personnel and legal proceedings. A rational understanding or the ability to rationally assist in a defense is typically viewed as an advanced ability, as individuals should be able to not only understand but manipulate information and apply it to their legal case.

General knowledge about the court, including charges, potential penalties, and the roles of various courtroom personnel, as well as legal proceedings, including pleas, potential outcomes, the plea-bargaining process, and the processes of a trial, are important for defendants to

understand. It is equally important for a defendant to be able to apply this general knowledge to their specific case. A condition that affects a defendant's memory of an alleged offense, such as permanent, retrograde amnesia, does not necessarily render them IST. If a defendant can extrapolate details of the alleged offense from extrinsic information sufficient to rationally assist in their defense, then it is not a denial of the right to due process or the right to effective assistance of counsel.¹⁰⁹

It should be noted that a CST evaluation assesses the individual's adjudicative capacities in real time. Should a defendant's capacity change due to a change in their mental status at any time during legal proceedings, courts must reconsider whether a defendant is now incapable of meeting the standards of competence.¹¹⁰

Once an individual is ordered to CR treatment, they may be without psychiatric treatment for an extended period of time. An individual's clinical state may have changed significantly by the time they are admitted to a hospital or sent to an alternative site for competency restoration. It is prudent that treating psychiatrists and social workers review CST reports to gain an understanding of the rationale behind the IST opinion.

The most traditional CR treatment setting has been the state hospital, as it typically allows for more frequent interactions with psychiatrists, psychologists, and social workers to implement restoration techniques (e.g., individual and group therapies), in addition to close observation of psychiatric symptoms with intensive medication management. If medications are needed, they can be given voluntarily, or, if an individual refuses, processes will be followed that are either similar to civil processes or rely upon the *Sell* case, as described above. Hospital settings are more therapeutic than carceral settings; however, with the increase in requests for competency evaluations and the subsequent increase in those requiring CR treatment, state mental health authorities have been struggling with waiting lists for services and for state hospital admission for restoration treatment.

Prolonged wait times to complete the evaluation and/or for admission for CR treatment can leave defendants sitting in county jails for extended periods without appropriate psychiatric treatment. These prolonged wait times for individuals detained and waiting for evaluations or CR treatment have been determined to be a violation of due process in some jurisdictions. For example, in *Trueblood v. Washington State Department of Social and Health Services* (2016), a class action lawsuit on behalf of those awaiting evaluation or treatment, the federal courts emphasized individuals' constitutional right to timely services and treatment in a therapeutic environment.¹¹¹

There are many logistical challenges to rendering evaluations or CR treatment in a timely manner—notably, the limited number of evaluators or evaluation centers, increasing numbers of referrals in many states, limited hospital bed availability, and possible delays in court proceedings. A collaboration between six states in 2018 found that even though all of the states kept IST waiting lists, there was no organized, systematic approach in assessing the appropriate level of care needed or in the identification of appropriate diversion options. Due to this lack of triaging patients for IST placement, all individuals ordered for CR treatment were presumed to have the same risks and clinical needs, resulting in most being referred for placement in the state hospital system.¹¹² Since that initial collaborative, many other national conversations about this issue have resulted in reports and guidelines.^{113,114}

At the state level, there is a great deal of activity to try to minimize waiting times for competency services, at times catalyzed by litigation against the state. Judges and attorneys may feel compelled to raise a concern about a defendant’s competence to stand trial with the hope that restoration treatment will also fulfill their desperate need for mental health care. Unfortunately, this can lead to long wait times for individuals in jails and the community awaiting admission to a state hospital for restoration treatment.¹¹⁵ Initiatives in Florida and California aim to divert individuals with mental illnesses out of the criminal justice system and into community-based treatment programs, with a focus on recovery from their illness, not simply competency restoration and return to court. The Miami-Dade Forensic Alternative Center, which aims to provide alternative placements for defendants found IST without serious offenses or histories of violence, opened in 2009. The center’s goal is to restore defendants’ competence and work on their release to the community with mental health treatment.¹¹⁶

Texas has also taken steps to reduce wait times for CR services in the context of a 38 percent increase in people found IST in the past 20 years and lists of over 1,800 people in Texas jails awaiting restoration treatment. The Texas Judicial Commission on Mental Health (JCMH), created by joint order of the Supreme Court of Texas and the Court of Criminal Appeals of Texas, aims to work with the courts regarding individuals with mental illnesses and intellectual disabilities. JCMH partnered with the Texas Health and Human Services Commission to create a resource guide, *Eliminate the Wait: The Texas Toolkit for Rightsizing Competency Restoration Services*, for various disciplines at the front line of reducing the number of individuals with mental illnesses and SUDs entering the criminal justice system, including mental health providers, law enforcement, judges, and attorneys. The guide outlines each discipline’s role in diversion and providing mental health services and includes educational materials and checklists for each discipline involved.¹¹⁷ Currently, the initiative focuses on mental health providers, law enforcement, the courts, and county jails all playing a role in reducing the number of people waiting for inpatient CR services (**Table 3**).¹¹⁸

Table 3: Approaches to Reduce Wait Times for Inpatient Competency Restoration Services

Crisis and community services	Emergency services and law enforcement	Initial detention and legal proceedings	Jails and courts
<p>System leaders ensure available mental health services.</p> <p>Judges and providers consider outpatient competency restoration treatment.</p>	<p>Police engage in diversion strategies when called to psychiatric emergencies to minimize criminal justice involvement.</p>	<p>Jail staff and mental health professionals can screen and treat mental illness.</p> <p>Jail staff coordinate with courts and mental health services on restoration treatment.</p>	<p>Judges and attorneys aim for diversion and alternatives to hospital-based competency restoration.</p>

In an effort to pursue more prompt treatment, alternative treatment settings, including jail- and community-based programs, have been explored and developed.¹⁰² A comprehensive jail-based program described by Jennings and Bell in 2012 included forensic evaluation, medication management, and CR treatment and maintenance in a jail pod transformed into a mental health unit.¹¹⁹ The outlined program paralleled CR treatment typical of a hospital setting, where defendants would meet with their treatment team and engage in group programming targeted at mental health and adjudicative competencies. A 5-year review of the program detailed an overall competency restoration rate of 83 percent, with an average treatment length of 77 days.¹¹⁹ There are notable pros and cons to jail-based CR programs, including selection issues and the restoration treatment occurring in a nontherapeutic environment. In support of these alternative programs, there may be reduced waiting lists for hospital beds, reduced time to treatment, a decreased length of time to restore competence, judicious transition from competency restoration to adjudication, and use of staff with specialized knowledge and training for a forensic population. Disadvantages of jail-based CR programs include limited access to mental health professionals in some jurisdictions, lack of program structure, and concerns about providing mental health services in a jail when an individual might otherwise need a therapeutic setting.

Community-based programs or outpatient CR services are a second alternative to hospital-based restoration treatment and may be a suitable option for individuals without violent charges and also released from carceral settings prior to trial. This approach aligns with the goals of assertive community treatment teams in that close observation, tailored programming, transportation, medication management, and frequent contact with mental health professionals are vital. Community-based CR programs may have the added benefit of addressing various psychosocial stressors that may contribute to the individual's poor mental health, such as unemployment and unstable housing.¹⁰² Similar to Florida and Texas, the state of Washington has implemented the Forensic Navigator Program, which is designed to advocate for individuals undergoing court-ordered competency evaluations or CR treatment, and their transition to the community following a resolution of their case. Forensic navigators, with the support of case managers and community liaisons, also support the diversion of forensically involved criminal defendants away from jails and inpatient settings and into community-based CR services.¹²⁰

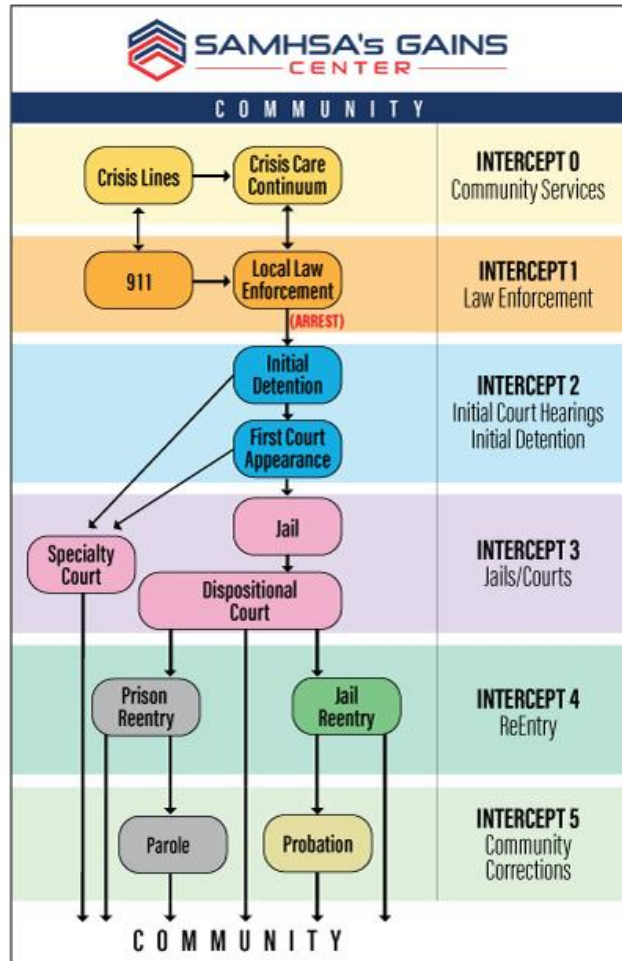
CR treatment is complex and varies by state and treatment setting. Unfortunately, there is no current uniform standard of practice for CR treatment, which further complicates the landscape. More research on models to divert individuals from the criminal system and into treatment services could help avoid the funneling of individuals into restoration services as a proxy for treatment as usual. Although there is much to learn about effective restoration methods, especially in outpatient settings, communities should continue to strive for appropriate diversion protocols or alternative pathways to care and treatment.

CRIMINAL JUSTICE TREATMENT COURTS

At the start of 2025, nearly 2 million people were incarcerated in the United States.¹²¹ Individuals with mental health concerns, including SMI and SUD, have higher rates of involvement in the criminal justice system. A recent meta-analysis assessing the prevalence of mental illness in incarcerated individuals across 43 countries estimated that nearly one in seven incarcerated persons meet criteria for SMI, such as a mood disorder or psychotic illness.¹²² Another study in adult prison populations found that nearly half of individuals with a psychotic disorder or major

depression had a comorbid SUD.¹²³ In the late 1990s and early 2000s, courts began to develop novel interventions to address the overrepresentation of mental illness and SUDs in criminal legal settings.

Figure 2: Sequential Intercept Model



In 2006, Munetz and Griffin published a framework for decriminalization of individuals with SMI, called the Sequential Intercept Model (SIM; **Figure 2**).¹²⁴ The SIM identified five intercepts along a continuum in which individuals with mental illness may encounter the legal system: law enforcement and emergency services; initial hearings and detention; jails and courts; reentry from jails, prisons, and hospitals; and community corrections and community support services. A sixth intercept, known as Intercept 0, has since been added to encapsulate community services prior to legal system involvement, including crisis lines, crisis care, and prevention efforts.¹²⁵ Intercept 3 identifies where SMI and SUD intersect with the legal system at the level of jails and courts, following initial hearing and detention but prior to reentry programming and community transition. One attempt to address the overrepresentation of people with these disorders in the criminal legal system developed at Intercept 3 with the rise of specialty courts with separate dockets tailored to the specific needs of individuals in this system, with a focus on linkage to community-based treatment

interventions. In these specialty courts, there is a team-based approach to court decisions involving the defendant, the judge, the prosecutor, the defense attorney, and treatment providers (including case management). According to the National Treatment Court Resource Center, there are more than 4,000 specialty treatment or criminal justice courts in the United States.¹²⁶ Two of the more common forms of specialty treatment courts are mental health courts and drug courts (**Table 4**).¹²⁷

Table 4: Common Forms of Specialty Treatment Courts (adapted from the National Treatment Court Resource Center)

Type of treatment court	Description	Number across U.S. ^a
Mental health court	Specialty criminal court with separate dockets to address mental health concerns, based on the concept of therapeutic jurisprudence	655
Drug treatment court	Specialty criminal court designed for individuals with substance use disorders, with close coordination between the legal and treatment systems to improve treatment outcomes and support abstinence	1,826 ^b
Juvenile mental health court	Specialty mental health court for juvenile offenders	60
Juvenile drug treatment court	Specialty drug/hybrid court for juvenile offenders	261
Safe Babies Court Team, or equivalent	Multidisciplinary treatment court for infants and toddlers from birth to age 3 and their families involved in the child welfare system, including judges and child welfare partners with training in infant mental health and trauma-informed care	150 ^c
Family treatment drug court, or equivalent	Multidisciplinary treatment court for children and families involved in the child welfare system due to custodial parent or caregiver substance use	383

^a Data from National Treatment Court Resource Center. *Treatment Courts Across the United States (2023)*. National Treatment Court Resource Center; 2024.

^b Number includes drug courts and hybrid court programs for cases involving drugs, driving while intoxicated, or driving under the influence.

^c Data from Zero to Three, based on participating counties across the United States.

MENTAL HEALTH COURTS

Mental health treatment courts were developed in the 1990s, with the first created in Broward County, Florida. These specialty treatment courts have since expanded across the United States and abroad. Also called “therapeutic jurisprudence,” the primary concept behind mental health courts is the belief that the law can serve in a therapeutic capacity.¹²⁸ Although mental health courts vary in their inclusion criteria and organization, Redlich and colleagues identified six characteristics of mental health courts,¹²⁹ and at their foundation, mental health courts remain criminal courts but with separate specialty dockets to address mental health concerns in select populations. As previously mentioned, inclusion criteria can vary, ranging from SMI to more general mental health problems. Some courts require the criminal conduct to have been related to mental health symptoms. In other mental health courts, the defendant need only have a history of mental illness to qualify, regardless of whether the mental illness contributed to the causation of the crime. Most mental health courts include eligibility criteria related to the individual’s criminal charges, often limited to misdemeanors or other low-level, nonviolent charges. Screening measures and referral to these specialty dockets may also vary and are not standard across jurisdictions. Mental health courts are intended to redirect individuals who meet certain criteria into treatment and out of the criminal legal system.

“ Involvement in mental health courts is always voluntary and generally chosen by the individual in lieu of jail time. The courts mandate participation in community-based mental health treatment programming, which may include adherence to psychotropic medications.

Participants engage in periodic status hearings and direct community “supervision.” This community supervision may take various forms; for example, community treatment providers or probation officers, or a combination of the two, may directly report to the court.¹³⁰ Finally, courts may offer incentives for compliance, such as graduation from the program after a period of stability and/or dropped charges, or sanctions for nonadherence, including increased supervision, return to jail, or dismissal from the program.

With any structured change to a system’s approach, attention is paid to outcomes and potential disadvantages. One specific outcome measure is reduction in recidivism and later return to the criminal justice system. Study results on outcomes for mental health courts have yielded variable findings. A recent meta-analysis of 30 peer-reviewed publications found a 74 percent reduction in recidivism in mental health court participants.¹³¹ Another study of the impact of these mental health courts on reoffending in Australia found a 43 percent higher rate of reoffending in individuals not granted the option to divert to the specialty court.¹³² Additionally, preliminary studies of cost-effectiveness have shown positive results in terms of payer savings and reduced use of crisis and emergency interventions.¹³³ However, critiques of the current system also exist, due to issues such as the potential for coercion despite involvement being formally voluntary, the use of reactionary over preventive approaches, and the risk of bias in referral to these courts.¹³³

DRUG COURTS

The most common type of specialty courts in the United States are drug courts, or courts designed for individuals with SUDs. First developed in Dade County, Florida in 1989, these specialty courts have rapidly expanded across the country.¹²⁶ The drug court model involves close coordination between systems, including the criminal legal system and the substance use treatment system, to improve treatment outcomes and support abstinence from substances.¹³⁴ Generally, there are two ways to access drug treatment courts, either prior to entering a plea (“pre-plea”), or following conviction but prior to sentencing.¹³⁵ Pathways to participation may vary but typically involve screening for program eligibility and an agreement to participate in programming. Engagement in drug court often involves intensive community-based substance use treatment, random urine testing, and stringent oversight with frequent hearings regarding status and compliance.¹³⁴ In 1997, the National Association of Drug Court Professionals identified 10 key components of drug courts.^{134,136} These components include but are not limited to early identification of eligibility, use of a collaborative and non-adversarial approach to balance public safety and individual due process rights, access to a variety of treatment services, drug testing, coordinated monitoring, and ongoing judicial engagement with regular status hearings.

Similar to mental health court outcomes, as discussed above, research has been conducted to assess drug court outcomes, including impact on abstinence duration and recidivism rates. A 2023 meta-analysis assessed the impact of punishment and treatment on substance use and recidivism.¹³⁷ The authors found that while punitive interventions and incarceration do not decrease recidivism (the latter actually increases risk of recurrence), engagement in specialized treatment programs decreases psychoactive substance use and criminal recidivism rates. An additional systematic review found an overall reduction in recidivism rates in individuals engaged in drug court compared to traditional probation, with a 26 percent overall reduction across all studies.¹³⁸ Sheeran and Varline looked more broadly at the impact of treatment courts compared to traditional court interventions on recidivism, including a comparison of individuals whose drug court eligibility was revoked.¹³⁹ In comparing those who did not complete drug court requirements (revoked) to those who were never referred, results have been variable. Some studies found a reduction in recidivism for revoked participants compared to the traditional group, although another study found a higher rate in the revoked group than among individuals involved in standard court proceedings—40 percent and 26 percent, respectively.^{139,140} These findings may speak to the reasons for revocation, namely violation of treatment court expectations, including ongoing substance use, which increased risk of recidivism more broadly.

ADDITIONAL CONSIDERATIONS AND TREATMENT COURTS

Drug courts and mental health courts are the oldest models of specialty courts. Additional types of specialty courts include domestic violence courts, Veterans’ treatment courts, homelessness courts, and human trafficking courts, to name a few. Each has a model that uses an alternative to traditional criminal case processing, in which a court “team” works with an individual to help them access resources and stay in treatment or resolve multiple social and systemic issues for which they need additional supports. In exchange for these services, the individual agrees to comply with treatment and other aspects of a judge’s order.

Although not considered a traditional “specialty court,” juvenile courts are designed generally with a specific focus on rehabilitation. First developed in Cook County, Illinois, in 1899 as a result of local advocacy efforts, juvenile courts developed with the focus of intervening on behalf of youth who needed assistance. In contrast to adult criminal proceedings, juvenile courts had a primary goal of rehabilitation and promoting the best interests of the child, with less emphasis on individual and community deterrence, incapacitation, and punishment. However, at the start, juvenile courts were generally informal, with broad discretion regarding legal decision-making and outcomes. In the 1960s and 1970s, there was a shift in focus from rehabilitation to deterrence and punishment with a series of landmark cases (*Kent v US*, 1966; *In re Gault*, 1967; *In re Winship*, 1970; *McKeiver v Pennsylvania*, 1976), known collectively as the criminalization of juvenile court.¹⁴¹⁻¹⁴⁴ Although these courts have changed with regard to the procedures and criminal protections afforded to juveniles, they are still considered courts with a focus on rehabilitation and access to treatment services.

Within the juvenile court system, there are also specialty mental health and drug courts that may be relevant, depending on the circumstances surrounding a juvenile’s court involvement and their individual needs. As with adult specialty courts, eligibility criteria and structure for these courts vary by jurisdiction.

Children and families may also intersect with the legal system due to child welfare system involvement, which arises as a result of an investigation into alleged maltreatment, including abuse or neglect. Children at young ages are especially vulnerable, with children under the age of 1 year comprising over 20 percent of maltreatment victims.¹⁴⁵ While a primary goal of the child welfare system is maintaining intact families and/or reunifying families, children may be removed from the home through the course of an investigation. This removal, intended for safety, may have unintended consequences related to attachment and development. In response, an intervention called the Safe Babies Court Team (SBCT), also called the Best for Babies court or infant-toddler court program in certain states, was developed. These programs are intended to serve children from birth to 3 years of age and their families to improve safety, well-being, and placement permanency. Developed by Zero to Three, SBCT programs are led by a partnership between a judge and a child welfare representative with training in infant mental health and trauma-informed care. A recent 2023 study found that short-term outcomes include reduced time to placement permanency and improvements in well-being for the child and the family.¹⁴⁶

Children and families may find themselves involved with the child welfare system due to substance use by a custodial parent or guardian. Involvement in child welfare as a result of parental substance use is associated with low family reunification rates and increased reentry of children into the foster care system following reunification, and there is limited coordination across legal and treatment systems.¹⁴⁷ As a result, family treatment drug courts (FTDCs), also known as family treatment courts and dependency treatment courts, were developed in the 1990s. Modeled after adult drug treatment courts, FTDCs focus on improving family functioning and providing other positive supports, including but not limited to assistance with substance use treatment, reunification, housing security, and employment. A 2019 meta-analysis found a statistically significant increase in reunification and a reduction in foster care reentry for families involved in FTDCs.¹⁴⁸

CIVIL COMMITMENT FOR SUBSTANCE USE DISORDERS

The legal definition of mental illness for the purpose of civil commitment varies by state but is typically a disorder of thought or mood, which may include schizophrenia, bipolar disorder, or severe major depression, that substantially impacts an individual's functioning, including their ability to maintain employment, manage relationships, or complete activities of daily living. This definition would not include impairment caused solely by a SUD. Generally, if there is a co-occurring mental illness that is creating risk of harm, then the individual would be committed under the mental illness commitment statute (as described above).

In some states, however, there are statutes that recognize SUDs as the primary basis for civil commitment, and the individual may or may not have a co-occurring mental illness. The process of civil commitment for SUDs is generally the same in that it is a legal proceeding that mandates that individuals with substance use issues enter into involuntary treatment, typically initiated by a concerned family member or healthcare professional, and is distinguished from criminal confinement or from other forms of civil commitment.^{103,149} The idea legally compelling treatment for SUDs dates back to the early 1800s, when many physicians began accepting the view of problematic substance use as a medical condition rather than a moral failure and began advocating for legislation to allow for compulsory SUD treatment. Even in the absence of formal legislation for involuntary treatment, individuals with SUDs often face some kind of coercion to seek treatment, whether by their family, regulatory bodies, or a social service agency.¹⁵⁰

SUDs are of great public health concern, with high rates of substance-related overdose deaths and low rates of treatment, in part prompting some states to consider legislation regarding civil commitment of individuals with SUDs. According to the Substance Abuse and Mental Health Services Administration (SAMHSA) National Survey on Drug Use and Health, in 2024, 48.4 million people age 12 or older (16.8 percent of the U.S. population), met criteria for a SUD in the past year, including 27.9 million with an alcohol use disorder, 28.2 million with a drug use disorder, and 7.7 million people with both use disorders.¹⁵² Among those who were classified as needing SUD treatment, approximately 19.3 percent (10.2 million people) actually received treatment. Among the 40.7 million adults who had a SUD and did not receive SUD treatment, 95.6 percent (38.1 million people) did not seek treatment or think they should receive it.¹⁵² The data leads to a similar consideration to civil commitment for individuals with mental illnesses: Are people so impaired by SUD that they fail to see the need for treatment? And if so, is there an obligation to compel these individuals to enter SUD treatment?^{151,152}

While some states do allow the involuntary treatment of individuals with SUDs, there are often stipulations, such as that the individual must have a comorbid psychiatric condition, or commitment may apply only to use of certain substances.¹⁵³ Additionally, civil commitment for SUDs may involve hospitalization, compulsory outpatient treatment, or a combination of the two. Unlike treatment mandated in drug courts, individuals need not have involvement in the criminal justice system to be court-ordered to receive treatment.¹⁵⁴ Although the treatment setting is discussed as part of compelled SUD treatment, there is little information on what compelled treatment entails, whether an individual undergoes a detoxification period, whether they receive specific therapies, whether they have access to peer and anonymous support groups, or whether they are prescribed medication, such as medications for alcohol or opioid use disorders. Limited guidance is available on what type of involuntary treatment for SUDs should be utilized.

Several concerns arise regarding the effectiveness of compulsory treatment for individuals with SUDs, including the individual's agreement or "buy in" to the treatment, violation of patient autonomy or civil liberties, financial strain on current systems and resources, and potentially life-threatening scenarios in which individuals compelled to treatment leave or finish the program and engage in a level of substance use that they are no longer physiologically accustomed to, which can carry great medical risks. Additionally, evidence of the effectiveness of compulsory treatment for individuals with SUDs is limited and highlights the need to further examine the success of these treatment programs.¹⁵³ Civil commitment of individuals with SUDs requires careful review of the legal, ethical, and practical implications, as there is little information regarding the success of these statutes, as well as the potential harms or benefits for this patient population.

A 2015 review of states that have statutory authority to civilly commit individuals with SUDs found wide variability in the criteria for commitment and in the utilization of this legislation.¹⁴⁹ Dangerousness to self or others was the most frequent justification for commitment; however, some states allowed commitment under other circumstances, using criteria that were set by individual states, including grave disability or loss of decision-making capacity.

“ There has been a renewed interest in the use of civil commitment in the treatment of individuals with SUDs due to the opioid epidemic and the desire to expand access to SUD treatment; however, this practice has proven to be controversial, considering the possible curtailment of individual liberties, potentially without achieving the desired outcome of abstinence from the substance.

The APA's current position includes the stipulation that all states should pledge adequate access to evidence-based treatment, including agreed-upon informed consent to medications for SUD and various psychosocial interventions.¹⁵⁵ The APA notes that the effectiveness of civil commitment for SUDs has not been demonstrated or generalized in research, in part due to variations in the ways the statutes are interpreted and implemented by each state, making comparisons between various treatment modalities challenging. Because of the absence of evidence demonstrating the effectiveness of civil commitment for SUDs, the APA does not recommend or oppose SUD commitment statutes but notes that commitment programs must meet the standard of care, be evidence-based, protect individuals' liberties, monitor specific outcomes (e.g., reduction of relapse and overdose deaths, improvement of functionality, etc.), and be administered through health systems as opposed to correctional systems, and should receive appropriate, dedicated funding separate from that of other mental health services.¹⁵⁵

As of 2021, 34 states and the District of Columbia have enacted civil commitment statutes for SUDs; however, each state has its own statutory criteria for the commitment of individuals with SUDs.¹⁵⁶ While these statutes may be appealing to family members of those with SUDs or for those healthcare professionals who primarily treat individuals with SUDs, there remain ethical concerns about the deprivation of individual liberties; the variability of state-level interpretation and implementation of these statutes; and the limited, nongeneralizable data on the effectiveness of these programs at present. For example, support for or opposition to compelled SUD treatment has often been derived from studies in other countries, from interventions in the

criminal justice system (e.g., drug courts), or from civil commitment of individuals with co-occurring psychiatric illness.

Whether civil commitment for SUD treatment improves or worsens outcomes for individuals with SUDs over the long term is uncertain. Civil commitment may mitigate the immediate threat of overdose; however, it is unclear whether this compelled SUD treatment will lead individuals to improved insight and continued recognition of the need for treatment, long-term engagement in their care, or improved judgment and decision-making. Additionally, it is unclear whether involuntary SUD treatment will lead to sociolegal improvements, such as reduced criminal justice involvement or improved occupational attainment and social functioning.¹⁵⁴ There may be other unintended consequences of involuntary treatment, such as increased risk of overdose once the individual has left treatment and is in a more physiologically vulnerable state if they relapse on substances. Additionally, much like involuntary treatment for mental illnesses, civil commitment for SUDs may become public information and impact an individual's future employment.¹⁵⁴ Cochran and colleagues analyzed the impact of states' civil commitment statutes for SUDs on opioid overdose death rates in the United States between 2010 and 2021, which was divided between pre-COVID (2010–2019) and post-COVID eras (2020–2021).¹⁵⁷ There was no difference in the annual mean age-adjusted opioid overdose death rates between states with and without civil commitment laws for SUDs, which was consistent in the pre-COVID era. However, in the post-COVID era, there was a significant increase in the number of opioid overdose death rates in the states with statutes for civil commitment of those with SUDs, compared with those without ($p = .0032$).¹⁵⁷ Many factors may have contributed to this finding, including recent laws being enacted in response to the worsening opioid crisis and physicians' prior opposition or unawareness of these laws. As a separate issue, when individuals are committed with comorbid psychiatric conditions and SUDs, treatment of the psychiatric condition is typically prioritized, and the SUD may not receive adequate or any formal SUD treatment. The data available regarding specific SUD treatment may be skewed if individuals are committed and treated under different statutes.¹⁴⁹

In the absence of data on the effectiveness of compelled SUD treatment, judges and medical providers make decisions on an individual basis to proceed with civil commitment for SUDs, which may or may not help, and without knowing whether the population as a whole that is subject to commitment is benefiting from or potentially being harmed by this intervention. There appears to be wide variability in the content and application of civil commitment statutes for SUDs in the United States, which reflects the lack of consensus on the utilization of involuntary treatment for such circumstances. Even in states that have statutes that are operational for substance use commitment, engagement in voluntary substance use services, engagement with peers, and helping families overall are all critical best practices.

Conclusion

This paper has described several approaches to help move people with mental illness toward recovery and recovery-oriented goals. Because many of these approaches are implemented in the context of commitment and court orders, they do not reflect the best first approaches, which involve screening, prevention, and intervention on a voluntary basis to help people stay in treatment when needed. In mental health services and other related fields, the nature of the conditions opens a window for some interventions to be implemented involuntarily. As noted in the Josiah Oakes case from the Massachusetts Supreme Judicial Court in 1845, however:

The right to restrain an insane person of his liberty, is found in that great law of humanity, which makes it necessary to confine those whose going at large would be dangerous to themselves or others. In the delirium of a fever, or in the case of a person seized with a fit, unless this were the law, no one could be restrained against his will. And the necessity which creates the law, creates the limitation of the law.¹⁵⁸

Today, as much as 175 years ago, it is important to continue to find the right balance and develop approaches that will maximize sustainable positive outcomes so individuals with SMI can live their best lives as full and valued members of society.

References

1. *Cruzan v Director, Missouri Department of Health*, 497 US 261 (1990).
2. Greco PJ, Schulman KA, Lavizzo-Mourey R, Hansen-Flaschen J. The Patient Self-Determination Act and the future of advance directives. *Ann Intern Med*. 1991;115(8):639-643. doi:10.7326/0003-4819-115-8-639
3. Fisher MS Jr. Psychiatric advance directives and the right to be presumed competent. *J Contemp Health Law Policy*. 2009;25(2):386-405.
4. National Resource Center on Psychiatric Advance Directives. State by state info. Updated January 2024. Accessed June 26, 2025. <https://nrc-pad.org/states/>
5. National Resource Center on Psychiatric Advance Directives. FAQs. Accessed July 29, 2025. <https://nrc-pad.org/faqs/>
6. Centers for Medicare & Medicaid Services. 42 CFR § 482 (2006).
7. Swanson JWS, Hannon MJ, Elbogen EB, Wagner HR, McCauley BJ, Butterfield MI. Psychiatric advanced directives: a survey of persons with schizophrenia, family members, and treatment providers. *Int J Forensic Ment Health*. 2003;2(1):73-86. doi:10.1080/14999013.2003.1047118
8. Substance Abuse and Mental Health Services Administration. *A Practical Guide to Psychiatric Advance Directives*. Substance Abuse and Mental Health Services Administration; 2019. Accessed March 19, 2026. <https://library.samhsa.gov/sites/default/files/psychiatric-advance-directives-pep19-pl-guide-4.pdf>
9. Fleischner RD. Advance directives for mental health care: an analysis of state statutes. *Psychol Public Policy Law*. 1998;4(3):788-804.
10. Swanson JW, Swartz MS, Elbogen EB, et al. Psychiatric advance directives and reduction of coercive crisis interventions. *J Ment Health*. 2008;17(3):255-267. doi:10.1080/09638230802052195
11. Swanson JW, Swartz MS, Elbogen EB, et al. Facilitated psychiatric advance directives: a randomized trial of an intervention to foster advance treatment planning among persons with severe mental illness. *Am J Psychiatry*. 2006;163(11):1943-1951. doi:10.1176/ajp.2006.163.11.1943
12. *Hargrave v Vermont*, 340 F3d 27 (2nd Cir 2003).
13. Swanson JW, McCrary SV, Swartz MS, Elbogen EB, Van Dorn RA. Superseding psychiatric advance directives: ethical and legal considerations. *J Am Acad Psychiatry Law*. 2006;34(3):385-394.
14. Gaillard AS, Braun E, Vollmann J, Gather J, Scholten M. The content of psychiatric advance directives: a systematic review. *Psychiatr Serv*. 2023;74(1):44-55. doi:10.1176/appi.ps.202200002
15. Swanson J, Swartz M, Ferron J, Elbogen E, Van Dorn R. Psychiatric advance directives among public mental health consumers in five U.S. cities: prevalence, demand, and correlates. *J Am Acad Psychiatry Law*. 2006;34(1):43-57.

16. Avila A, Leeper E. Assessment of barriers to effective use of psychiatric advance directives: providers' knowledge and attitudes. *Psychol Serv.* 2022;19(2):271-282. doi:10.1037/ser0000525
17. Swartz MS, Hoge SK, Pinals DA, et al. Resource document on involuntary outpatient commitment and related programs of assisted outpatient treatment. American Psychiatric Association; 2015. Accessed March 19, 2026. <https://www.psychiatry.org/getattachment/685f787b-f08f-4b2c-ac4b-35821d50e4fd/Resource-Document-2015-Involuntary-Outpatient-Commitment.pdf>
18. Mental Hygiene Law (2025), § 9.60. Accessed May 7, 2025. <https://www.nysenate.gov/legislation/laws/MHY/9.60>
19. Mental Health Code, Act 258 (1974, last amended 2022), § 330.1469a. Accessed March 19, 2026. <https://www.legislature.mi.gov/documents/mcl/pdf/MCL-330-1469A.pdf>
20. Miller D. Outpatient civil commitment: a look at Maryland's new legislation. *Psychiatr Times.* 2024;41(8):16-17. Accessed May 7, 2025. <https://www.psychiatristimes.com/view/outpatient-civil-commitment-a-look-at-marylands-new-legislation>
21. Meldrum ML, Kelly EL, Calderon R, Brekke JS, Braslow JT. Implementation status of assisted outpatient treatment programs: a national survey. *Psychiatr Serv.* 2016;67(6):630-635. doi:10.1176/appi.ps.201500073
22. Munetz MR, Ritter C, Teller JL, Bonfine N. Mental health court and assisted outpatient treatment: perceived coercion, procedural justice, and program impact. *Psychiatr Serv.* 2014;65(3):352-358. doi:10.1176/appi.ps.002642012
23. Hancq ES, Munetz M, Silver SC, Parker HA, Bonfine N. Critical gaps in assisted outpatient treatment research in the United States. *Adm Policy Ment Health.* 2024;51(6):839-842. doi:10.1007/s10488-024-01377-z
24. Swanson JW, Swartz MS. Why the evidence for outpatient commitment is good enough. *Psychiatr Serv.* 2014;65(6):808-811. doi:10.1176/appi.ps.201300424
25. Swartz MS, Swanson JW, Wagner HR, Burns BJ, Hiday VA, Borum R. Can involuntary outpatient commitment reduce hospital recidivism? findings from a randomized trial with severely mentally ill individuals. *Am J Psychiatry.* 1999;156(12):1968-1975. doi:10.1176/ajp.156.12.1968
26. Munetz MR, Grande T, Kleist J, Peterson GA. The effectiveness of outpatient civil commitment. *Psychiatr Serv.* 1996;47(11):1251-1253. doi:10.1176/ps.47.11.1251
27. Swartz MS, Wilder CM, Swanson JW, et al. Assessing outcomes for consumers in New York's assisted outpatient treatment program. *Psychiatr Serv.* 2010;61(10):976-981. doi:10.1176/ps.2010.61.10.976
28. Van Putten RA, Santiago JM, Berren MR. Involuntary outpatient commitment in Arizona: a retrospective study. *Hosp Community Psychiatry.* 1988;39(9):953-958. doi:10.1176/ps.39.9.953
29. Swartz MS, Swanson JW, Steadman HJ, Robbins PC, Monahan J. *New York State Assisted Outpatient Treatment Program Evaluation.* Duke University School of Medicine; 2009.
30. Busch AB, Wilder CM, Van Dorn RA, Swartz MS, Swanson JW. Changes in guideline-recommended medication possession after implementing Kendra's Law in New York. *Psychiatr Serv.* 2010;61(10):1000-1005. doi:10.1176/ps.2010.61.10.1000

31. Van Dorn RA, Swanson JW, Swartz MS, et al. Continuing medication and hospitalization outcomes after assisted outpatient treatment in New York. *Psychiatr Serv.* 2010;61(10):982-987. doi:10.1176/ps.2010.61.10.982
32. Segal SP, Hayes SL, Rimes L. The utility of outpatient commitment: acute medical care access and protecting health. *Soc Psychiatry Psychiatr Epidemiol.* 2018;53(6):597-606. doi:10.1007/s00127-018-1510-5
33. Gilbert AR, Moser LL, Van Dorn RA, et al. Reductions in arrest under assisted outpatient treatment in New York. *Psychiatr Serv.* 2010;61(10):996-999. doi:10.1176/ps.2010.61.10.996
34. Swanson JW, Borum R, Swartz MS, Hiday VA, Wagner HR, Burns BJ. Can involuntary outpatient commitment reduce arrests among persons with severe mental illness? *Crim Justice Behav.* 2001;28(2):156-189.
35. Hiday VA, Swartz MS, Swanson JW, Borum R, Wagner HR. Impact of outpatient commitment on victimization of people with severe mental illness. *Am J Psychiatry.* 2002;159(8):1403-1411. doi:10.1176/appi.ajp.159.8.1403
36. Kisely SR, Campbell LA, O'Reilly R. Compulsory community and involuntary outpatient treatment for people with severe mental disorders. *Cochrane Database Syst Rev.* 2017;3(3):CD004408. doi:10.1002/14651858.CD004408.pub5
37. Phelan JC, Sinkewicz M, Castille DM, Huz S, Muenzenmaier K, Link BG. Effectiveness and outcomes of assisted outpatient treatment in New York state. *Psychiatr Serv.* 2010;61(2):137-143. doi:10.1176/ps.2010.61.2.137
38. Swanson JW, Swartz MS, Borum R, Hiday VA, Wagner HR, Burns BJ. Involuntary out-patient commitment and reduction of violent behaviour in persons with severe mental illness. *Br J Psychiatry.* 2000;176:324-331. doi:10.1192/bjp.176.4.324
39. Swanson JW, Swartz MS, Elbogen EB, Wagner HR, Burns BJ. Effects of involuntary outpatient commitment on subjective quality of life in persons with severe mental illness. *Behav Sci Law.* 2003;21(4):473-491. doi:10.1002/bsl.548
40. Valasek CJ, Nelson KL, Fettes DL, Sommerfeld DH. Emerging trends in research on assisted outpatient treatment in the United States: a narrative review. *Psychiatr Serv.* 2025;76(5):469-478. doi:10.1176/appi.ps.20240190
41. Position statement on involuntary outpatient commitment and related programs of assisted outpatient treatment. American Psychiatric Association; 2020. Accessed March 19, 2026. <https://www.psychiatry.org/getattachment/d50db97b-59aa-4dd4-a0ec-d09b4e19112e/Position-Involuntary-Outpatient-Commitment.pdf>
42. Starks SL, Kelly EL, Castillo EG, Meldrum ML, Bourgois P, Braslow JT. Client outreach in Los Angeles County's assisted outpatient treatment program: strategies and barriers to engagement. *Res Soc Work Pract.* 2022;32(7):839-854. doi:10.1177/1049731520949918
43. Hancq ES, Silver S, South K. *Measuring Experiences: An Evaluation of AOT Participant Satisfaction.* Treatment Advocacy Center; 2023. Accessed March 19, 2026. https://www.tac.org/reports_publications/measuring-experiences-an-evaluation-of-aot-participant-satisfaction/
44. Simpson JR, Carannante V. Hospitalization: voluntary and involuntary. In: Rosner R, Scott CL, eds. *Principles and Practice of Forensic Psychiatry.* 3rd ed. CRC Press; 2017:125-130.
45. Wallace ER IV, Gach J, eds. *History of Psychiatry and Medical Psychology.* Springer; 2008.

-
46. Testa M, West SG. Civil commitment in the United States. *Psychiatry (Edgmont)*. 2010;7(10):30-40.
 47. Baillargeon J, Binswanger IA, Penn JV, Williams BA, Murray OJ. Psychiatric disorders and repeat incarcerations: the revolving prison door. *Am J Psychiatry*. 2009;166(1):103-109. doi:10.1176/appi.ajp.2008.08030416
 48. West S, Friedman SH, Shand JP. Civil commitment. In: Jamieson A, Moenssens A, eds. *Wiley Encyclopedia of Forensic Science*. John Wiley & Sons; 2012.
 49. *Lake v Cameron*, 364 F2d 657 (DC Cir 1966).
 50. Anfang SA, Appelbaum PS. Civil commitment: the American experience. *Isr J Psychiatry Relat Sci*. 2006;43(3):209-218.
 51. California Department of Healthcare Services. Community Assistance, Recovery, and Empowerment Act. Updated July 2025. Accessed July 28, 2025. <https://www.dhcs.ca.gov/Pages/CARE-ACT.aspx>
 52. *O'Connor v Donaldson*, 422 US 563 (1975).
 53. *Lessard v Schmidt*, 349 F Supp 1078 (ED Wis 1972).
 54. *Addington v Texas*, 441 US 418 (1979).
 55. Appelbaum PS. Clinical practice: assessment of patients' competence to consent to treatment. *N Engl J Med*. 2007;357(18):1834-1840. doi:10.1056/NEJMcp074045
 56. *Zinerman v Burch*, 494 US 113 (1990).
 57. Garakani A, Shalenberg E, Burstin SC, Weintraub Brendel R, Appel JM. Voluntary psychiatric hospitalization and patient-driven requests for discharge: a statutory review and analysis of implications for the capacity to consent to voluntary hospitalization. *Harv Rev Psychiatry*. 2014;22(4):241-249. doi:10.1097/hrp.0000000000000044
 58. Hedman LC, Petrila J, Fisher WH, Swanson JW, Dingman DA, Burris S. State laws on emergency holds for mental health stabilization. *Psychiatr Serv*. 2016;67(5):529-535. doi:10.1176/appi.ps.201500205
 59. Ash P, Bahekar P, Benedek E, et al. Resource document on consent for voluntary hospitalization of minors. American Psychiatric Association; 2022. Accessed March 19. <https://www.psychiatry.org/getattachment/6dd28cc3-fdf2-46a4-bb29-d2ce62bc5321/Resource-Document-Consent-for-Voluntary-Hospitalization-of-Minors.pdf>
 60. *Parham v J.R.*, 442 US 584 (1979).
 61. Position statement on the civil commitment of minors. American Psychiatric Association; 2021. Accessed June 25, 2025. <https://www.psychiatry.org/getattachment/5c61e4a5-4a42-46a5-9efc-aeacb0a76c25/Position-Civil-Commitment-of-Minors.pdf>
 62. Pinals DA, Nesbit A, Hoge SK. Treatment refusal in psychiatric practice. In: Rosner R, Scott CL, eds. *Principles and Practice of Forensic Psychiatry*. 3rd ed. CRC Press; 2017:155-164.
 63. Appelbaum PS. *Almost a Revolution: Mental Health Law and the Limits of Change*. Oxford University Press; 1994.
 64. Appelbaum PS, Gutheil TG. *Clinical Handbook of Psychiatry and the Law*. Lippincott Williams and Wilkins; 2007.

65. Hoge SK, Appelbaum PS, Geller JG. Involuntary treatment. In: Tasman A, Hales RE, Frances A, eds. *American Psychiatric Press Review of Psychiatry*. American Psychiatric Press; 1989:432-450.
66. *Rogers v Commissioner of Department of Mental Health*, 458 NE2d 308 (Mass. 1983).
67. *Rennie v Klein*, 720 F2d 266 (3rd Cir 1983).
68. *Rivers v Katz*, 67 NY2d 485 (N.Y. 1986).
69. Ciccone JR, Tokoli JF, Clements CD, Gift TE. Right to refuse treatment: impact of *Rivers v. Katz*. *Bull Am Acad Psychiatry Law*. 1990;18(2):203-215.
70. Hoge SK, Appelbaum PS, Lawlor T, et al. A prospective, multicenter study of patients' refusal of antipsychotic medication. *Arch Gen Psychiatry*. 1990;47(10):949-956. doi:10.1001/archpsyc.1990.01810220065008
71. *Youngberg v Romeo*, 457 US 307 (1982).
72. *Washington v Harper*, 494 US 210 (1990).
73. *U.S. v Loughner*, 672 F3d 731 (9th Cir 2012).
74. *Riggins v Nevada*, 504 US 127 (1992).
75. *Sell v U.S.*, 539 US 123 (2003).
76. Swartz MS. What constitutes a psychiatric emergency: clinical and legal dimensions. *Bull Am Acad Psychiatry Law*. 1987;15(1):57-68.
77. Becker SHD, Forman H. Implied consent in treating psychiatric emergencies. *Front Psychiatry*. 2020;11:127. doi:10.3389/fpsy.2020.00127
78. Owiti JA, Bowers L. A narrative review of studies of refusal of psychotropic medication in acute inpatient psychiatric care. *J Psychiatr Ment Health Nurs*. 2011;18(7):637-647. doi:10.1111/j.1365-2850.2011.01713.x
79. Kasper JA, Hoge SK, Feucht-Haviar T, Cortina J, Cohen B. Prospective study of patients' refusal of antipsychotic medication under a physician discretion review procedure. *Am J Psychiatry*. 1997;154(4):483-489. doi:10.1176/ajp.154.4.483
80. Lincoln TM, Jung E, Wiesjahn M, Wendt H, Bock T, Schlier B. The impact of negative treatment experiences on persistent refusal of antipsychotics. *Compr Psychiatry*. 2016;70:165-173. doi:10.1016/j.comppsy.2016.07.009
81. Schwartz HI, Vingiano W, Perez CB. Autonomy and the right to refuse treatment: patients' attitudes after involuntary medication. *Hosp Community Psychiatry*. 1988;39(10):1049-1054. doi:10.1176/ps.39.10.1049
82. U.S. Department of Justice. Guardianship overview. Updated September 30, 2024. Accessed March 30, 2025. <https://www.justice.gov/elderjustice/guardianship-overview>
83. Chamberlain S, Baik S, Estabrooks C. Going it alone: a scoping review of unbefriended older adults. *Can J Aging*. 2018;37(1):1-11. doi:10.1017/s0714980817000563
84. Moyer J, Naik AD. Preserving rights for individuals facing guardianship. *JAMA*. 2011;305(9):936-937. doi:10.1001/jama.2011.247
85. Moyer J, Wood S, Edelstein B, et al. Clinical evidence in guardianship of older adults is inadequate: findings from a tri-state study. *Gerontologist*. 2007;47(5):604-612. doi:10.1093/geront/47.5.604

86. American Bar Association Commission on Law and Aging. 2021 adult guardianship legislation summary. American Bar Association; 2022. Accessed April 30, 2025. https://www.americanbar.org/content/dam/aba/administrative/law_aging/2021-guardianship-leg-summrly.pdf
87. Catlin CC, Connors HL, Teaster PB, Wood E, Sager ZS, Moye J. Unrepresented adults face adverse healthcare consequences: the role of guardians, public guardianship reform, and alternative policy solutions. *J Aging Soc Policy*. 2022;34(3):418-437. doi:10.1080/08959420.2020.1851433
88. National Conference of Commissioners on Uniform State Laws. Uniform Probate Code (1969) (Last amended or revised in 2019). Accessed January 21, 2025. <https://www.uniformlaws.org/HigherLogic/System/DownloadDocumentFile.ashx?DocumentFileKey=fc93703d-9b36-2fe9-be86-6b2494c9dcc7&forceDialog=1>
89. Lowder JL, Buzney SJ, Montoni LM. Uniform Probate Code. In: Loue SJ, Sajatovic M, eds. *Encyclopedia of Aging and Public Health*. Springer; 2008:791-792.
90. Adult Guardianship and Protective Proceedings Jurisdiction Act. Updated April 10, 2025. Accessed May 1, 2025. <https://www.uniformlaws.org/committees/community-home?CommunityKey=0f25ccb8-43ce-4df5-a856-e6585698197a>
91. Larson EJ, Eaton TA. The limits of advance directives: a history and assessment of the Patient Self-Determination Act. *Wake Forest L Rev*. 1997;32:249.
92. Rao JK, Anderson LA, Lin FC, Laux JP. Completion of advance directives among U.S. consumers. *Am J Prev Med*. 2014;46(1):65-70. doi:10.1016/j.amepre.2013.09.008
93. Yadav KN, Gabler NB, Cooney E, et al. Approximately one in three US adults completes any type of advance directive for end-of-life care. *Health Aff (Millwood)*. 2017;36(7):1244-1251. doi:10.1377/hlthaff.2017.0175
94. Uekert BH, Genthon, K. Data quality undermines accountability in conservatorship cases. Brief no. 7. National Center for State Courts, 2018. <https://ncsc.contentdm.oclc.org/digital/collection/famct/id/1539/>
95. Appelbaum PS. Preventing abuses in guardianship cases. *Psychiatr Serv*. 2023;74(10):1108-1111. doi:10.1176/appi.ps.20230374
96. Fourth National Guardianship Summit: Maximizing Autonomy and Ensuring Accountability, May 2021: recommendations adopted by summit delegates. *Syracuse L Rev*. 2022;72:29.
97. Hurme SB, Robinson D. What's working in monitoring guardianships: challenges and best practices. *Syracuse L Rev*. 2022;72:289, 294.
98. Pinals DA. *Beyond the Borders: Lessons From the International Community to Improve Mental Health Outcomes*. National Association of State Mental Health Program Directors; 2019.
99. Browning M, Bigby C, Douglas J. A process of decision-making support: exploring supported decision-making practice in Canada. *J Intellect Dev Disabil*. 2021;46(2):138-149. doi:10.3109/13668250.2020.1789269
100. Mossman D, Noffsinger SG, Ash P, et al. AAPL Practice Guideline for the forensic psychiatric evaluation of competence to stand trial. *J Am Acad Psychiatry Law*. 2007;35(4 Suppl):S3-72.

101. Pinals DA, Callahan L. Evaluation and restoration of competence to stand trial: intercepting the forensic system using the Sequential Intercept Model. *Psychiatr Serv.* 2020;71(7):698-705. doi:10.1176/appi.ps.201900484
102. Goodness K, Felthous AR. Treatment for restoration of competence to stand trial. In: Rosner R, Scott CL, eds. *Principles and Practice of Forensic Psychiatry*. 3rd ed. CRC Press; 2017:257-266.
103. Substance Abuse and Mental Health Services Administration. *Foundation Work for Exploring Incompetence to Stand Trial Evaluations and Competence Restoration for People With Serious Mental Illness/Serious Emotional Disturbance*. Substance Abuse and Mental Health Services Administration; 2023. Accessed March 19, 2026. <https://library.samhsa.gov/product/foundation-work-exploring-incompetence-stand-trial-evaluations-competence-restoration/pep23-01-00-005>
104. Pirelli G, Gottdiener WH, Zapf PA. A meta-analytic review of competency to stand trial research. *Psychol Public Policy Law.* 2011;17(1):1.
105. Pinals DA. Where two roads meet: restoration of competence to stand trial from a clinical perspective. *New Eng J on Crim & Civ Confinement.* 2005;31:81.
106. Mossman D. Predicting restorability of incompetent criminal defendants. *J Am Acad Psychiatry Law.* 2007;35(1):34-43.
107. *Jackson v Indiana*, 406 US 715 (1972).
108. *Dusky v U.S.*, 362 US 402 (1960).
109. *Wilson v U.S.*, 391 F2d 460 (DC Cir 1968).
110. *Drope v Missouri*, 420 US 162 (1975).
111. *Trueblood v Washington State Department of Social and Health Services*, 822 F3d 1037 (9th Cir 2016).
112. Fader-Towe H, Pinals DA. Data on Evaluations as a Foundation for States Rethinking Competency to Stand Trial. *J Am Acad Psychiatry Law.* 2021;49(4):540-544. doi:10.29158/JAAPL.210108-21
113. Fader-Towe H, Kelly E. *Just and Well: Rethinking How States Approach Competency to Stand Trial*. Council of State Governments Justice Center; 2020. Accessed March 19, 2026. <https://csgjusticecenter.org/wp-content/uploads/2020/10/Just-and-Well27OCT2020.pdf>
114. Substance Abuse and Mental Health Services Administration. *Foundation Work for Exploring Incompetence to Stand Trial Evaluations and Competence Restoration for People With Serious Mental Illness/Serious Emotional Disturbance*. Substance Abuse and Mental Health Services Administration; 2023. Accessed March 19, 2026. <https://library.samhsa.gov/product/foundation-work-exploring-incompetence-stand-trial-evaluations-competence-restoration/pep23-01-00-005>
115. Leifman S, Fader-Towe H. Improving the courts' response to people with mental illnesses. *Criminal Justice* 2020;34(4):18-21.
116. Levin A. Program prepares defendants for return to the community. *Psychiatr News.* 2014;49(5):1. doi:10.1176/appi.pn.2014.2a16

117. Texas Judicial Commission on Mental Health, Texas Health and Human Services Commission *Eliminate the Wait: The Texas Toolkit for Rightsizing Competency Restoration Services*. Texas Judicial Commission on Mental Health and Texas Health and Human Services Commission; 2021.
118. Policy Research Associates. Texas initiative aims to reduce the wait for inpatient competency restoration services. June 22, 2022. Accessed July 28, 2025. <https://www.prainc.com/gains-texas-initiative/>
119. Jennings JL, Bell JD. The “ROC” model: psychiatric evaluation, stabilization and restoration of competency in a jail setting. In L’Abate L, ed. *Mental Illnesses: Evaluation, Treatments and Implications*. InTech; 2012.
120. Washington State Department of Social and Health Services. Forensic navigator program. Accessed July 28, 2025. <https://www.dshs.wa.gov/bha/office-forensic-mental-health-services/forensic-navigator-program>
121. Prison Policy Initiative. Mass incarceration: the whole pie. March 11, 2025. Accessed July 18, 2025. <https://www.prisonpolicy.org/reports/pie2025.html>
122. Emilian C, Al-Juffali N, Fazel S. Prevalence of severe mental illness among people in prison across 43 countries: a systematic review and meta-analysis. *Lancet Public Health*. 2025;10(2):e97-e110. doi:10.1016/s2468-2667(24)00280-9
123. Baranyi G, Fazel S, Langerfeldt SD, Mundt AP. The prevalence of comorbid serious mental illnesses and substance use disorders in prison populations: a systematic review and meta-analysis. *Lancet Public Health*. 2022;7(6):e557-e568. doi:10.1016/s2468-2667(22)00093-7
124. Munetz MR, Griffin PA. Use of the Sequential Intercept Model as an approach to decriminalization of people with serious mental illness. *Psychiatr Serv*. 2006;57(4):544-549. doi:10.1176/ps.2006.57.4.544
125. Abreu D, Parker TW, Noether CD, Steadman HJ, Case B. Revising the paradigm for jail diversion for people with mental and substance use disorders: Intercept 0. *Behav Sci Law*. 2017;35(5-6):380-395. doi:10.1002/bsl.2300
126. National Treatment Court Resource Center. What are drug courts? Updated 2025. Accessed July 18, 2025. <https://ntcrc.org/what-are-drug-courts/>
127. National Treatment Court Resource Center. Treatment courts across US states/territories (2023). 2024. Accessed March 19, 2026. https://ntcrc.org/wp-content/uploads/2024/06/2023_NTCRC_TreatmentCourt_Count_Table.pdf
128. Lim L, Day A. Mental health diversion courts: some directions for further development. *Psychiatr Psychol Law*. 2013;20(1):36-45. doi:10.1080/13218719.2011.619059
129. Redlich AD, Steadman HJ, Monahan J, Robbins PC, Petrla J. Patterns of practice in mental health courts: a national survey. *Law Hum Behav*. 2006;30(3):347-362.
130. Griffin PA, Steadman HJ, Petrla J. The use of criminal charges and sanctions in mental health courts. *Psychiatr Serv*. 2002;53(10):1285-1289. doi:10.1176/appi.ps.53.10.1285
131. Fox B, Miley LN, Kortright KE, Wetsman RJ. Assessing the effect of mental health courts on adult and juvenile recidivism: a meta-analysis. *Am J Crim Justice*. 2021;46(4):644-664.
132. Soon Y-L, Singh S, Greenberg D, et al. Impact of mental health court diversion on reoffending: a direct comparison of diverted and undiverted groups. *Int J Forensic Ment Health*. 2024;23(4):484-498.

133. Sarteschi CM, Vaughn MG, Kim K. Assessing the effectiveness of mental health courts: a quantitative review. *J Crim Justice*. 2011;39(1):12-20.
134. Delen D, Zolbanin HM, Crosby D, Wright D. To imprison or not to imprison: an analytics model for drug courts. *Ann Oper Res*. 2021;303(1):101-124.
135. Mitchell O, Wilson DB, Eggers A, MacKenzie DL. Assessing the effectiveness of drug courts on recidivism: a meta-analytic review of traditional and non-traditional drug courts. *J Crim Justice*. 2012;40(1):60-71.
136. National Association of Drug Court Professionals, Drug Court Standards Committee. *Defining Drug Courts: The Key Components*. U.S. Department of Justice, Office of Justice Programs, Drug Courts Program Office; 1997.
https://www.nycourts.gov/legacyPDFS/courts/problem_solving/drugcourts/Defining-Drug-Courts-The-Key-Components.pdf
137. Tomaz V, Moreira D, Souza Cruz O. Criminal reactions to drug-using offenders: a systematic review of the effect of treatment and/or punishment on reduction of drug use and/or criminal recidivism. *Front Psychiatry*. 2023;14:935755.
doi:10.3389/fpsy.2023.935755
138. Wilson DB, Mitchell O, MacKenzie DL. A systematic review of drug court effects on recidivism. *J Exp Criminol*. 2006;2(4):459-487.
139. Sheeran AM, Varline J. The effect of drug treatment court on recidivism: a comparison with traditional court intervention. *J Offender Rehabil*. 2024;63(6):367-386.
140. Spohn C, Piper R. *The Douglas County Drug Court: Characteristics of Participants, Case Outcomes and Recidivism*. University of Nebraska Omaha; 2004.
141. *Kent v United States*, 383 US 541 (1966).
142. *In re Gault*, 387 US 1 (1967).
143. *In re Winship*, 397 US 358 (1970).
144. *McKeiver v Pennsylvania*, 403 US 528 (1971).
145. U.S. Department of Health and Human Services. Child maltreatment. 2023.
<https://acf.gov/cb/report/child-maltreatment-2023> Accessed March 19, 2026.
146. Joseph J, DesAutels SJ, Gracey K, Kronenberg M, Kuhn T, Raman R. Child and family outcomes of the Safe Babies Court Team: a scoping review. *Child Youth Serv Rev*. 2023;149:106956. doi:10.1016/j.chilyouth.2023.106956
147. Brook J, McDonald T. The impact of parental substance abuse on the stability of family reunifications from foster care. *Child Youth Serv Rev*. 2009;31(2):193-198.
doi:10.1016/j.chilyouth.2008.07.010
148. Zhang S, Huang H, Wu Q, Li Y, Liu M. The impacts of family treatment drug court on child welfare core outcomes: a meta-analysis. *Child Abuse Negl*. 2019;88:1-14.
doi:10.1016/j.chiabu.2018.10.014
149. Christopher PP, Pinals DA, Stayton T, Sanders K, Blumberg L. Nature and utilization of civil commitment for substance abuse in the United States. *J Am Acad Psychiatry Law*. 2015;43(3):313-320.
150. Hall KT, Appelbaum PS. The origins of commitment for substance abuse in the United States. *J Am Acad Psychiatry Law*. 2002;30(1):33-45; discussion 46-48.

-
151. Christie C, Baker C, Cooper R, Kennedy PJ, Madras B, Bondi P. *The President's Commission on Combating Drug Addiction and the Opioid Crisis*. U.S. Government Printing Office; 2017.
 152. Substance Abuse and Mental Health Services Administration. *2023 Companion Infographic Report: Results from the 2021, 2022, and 2023 National Surveys on Drug Use and Health*. Substance Abuse and Mental Health Services Administration; 2024.
 153. Jain A, Christopher PP, Fisher CE, Choi CJ, Appelbaum PS. Civil commitment for substance use disorders: a national survey of addiction medicine physicians. *J Addict Med*. 2021;15(4):285-291. doi:10.1097/adm.0000000000000847
 154. Jain A, Christopher P, Appelbaum PS. Civil commitment for opioid and other substance use disorders: does it work? *Psychiatr Serv*. 2018;69(4):374-376. doi:10.1176/appi.ps.201800066
 155. Position statement on civil commitment for adults with substance use disorders. American Psychiatric Association; 2019. Accessed May 27, 2025. <https://www.psychiatry.org/getattachment/00976942-2f44-4f6d-9a19-edc9a344bd8e/Position-Civil-Commitment-for-Adults-with-SUD.pdf>
 156. Prescription Drug Abuse Policy System. Involuntary commitment for substance use. Updated May 1, 2021. Accessed May 28, 2025. <https://pdaps.org/datasets/civil-commitment-for-substance-users-1562936854>
 157. Cochran P, Chindavong PS, Edelenbos J, et al. The impact of civil commitment laws for substance use disorder on opioid overdose deaths. *Front Psychiatry*. 2024;15:1283169. doi:10.3389/fpsy.2024.1283169
 158. Authority to restrain the insane. *Am J Insanity*. 1846;3:225-234. Accessed April 3, 2026. <https://www.disabilitymuseum.org/dhm/lib/detail.html?id=1305&page=all>

Acknowledgments

Matthew W. Grover, M.D.

Director, Forensic Psychiatry Fellowship
Clinical Assistant Professor
Department of Psychiatry
University of Michigan Medical School

Hayley Getzen, M.D., M.P.H.

Adjunct Clinical Assistant Professor, Department of Psychiatry, University of Michigan
Medical School
Assistant Professor (Clinical), Department of Psychiatry and Behavioral Neurosciences, Wayne
State University School of Medicine

Kathleen L. Kruse, M.D.

Medical Director, Nyman Family Unit for Child and Adolescent Mental Health and Wellness
Michigan Medicine
Clinical Assistant Professor
Department of Psychiatry
University of Michigan Medical School

Debra A. Pinals, MD

Senior Medical and Forensic Advisor and Editor-in-Chief, National Association of State Mental
Health Program Directors
Adjunct Clinical Professor of Psychiatry and Director, Program in Psychiatry, Law and Ethics,
University of Michigan
Medical Director, Behavioral Health and Forensic Programs, Michigan Department of Health
and Human Services

Jessica Powlinski, M.D.

Adjunct Clinical Assistant Professor, Department of Psychiatry, University of Michigan
Medical School
Staff Psychiatrist and Consulting Forensic Examiner, Center for Forensic Psychiatry,
Saline, Michigan