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REPORT

I. Introduction

In 1972, the U.S. Supreme Court observed that involuntary civil commitment of people with mental disabilities entails a "massive curtailment of liberty."[1] To justify such an intrusion on a person's liberty, the Court, in *O'Connor v. Donaldson*,[2] required that the state must show that the person is dangerous to themselves or others and that commitment was the least restrictive means of achieving its goals. That ruling required amendment of those state civil commitment statutes that previously had authorized civil commitment based only on a finding that the person was mentally ill and in need of care and treatment. Although some states added the person's grave disability (essentially, an inability to care for oneself) as an additional commitment prong, dangerousness in many statutes was further defined to require a recent, overt act in order to address the difficulties of predicting potential dangerousness in this population. Furthermore, in *Addington v. Texas*,[3] the Court held that courts must find these elements by the heightened standard of clear and convincing evidence, once again recognizing the important liberty interests implicated.

Recently, states and localities across the country have taken steps to make it easier to civilly commit individuals against their will—also known as involuntary commitment, involuntary hospitalization, or civil commitment. This move is in response to perceived serious mental illness among the growing unhoused population, as well as public fear about the potential for violence by individuals with mental health disabilities. These actions also may reflect a concern on the part of elected officials that the presence of unhoused people on the streets has a negative effect on tourism and others' perception of the quality of urban life.

However, studies show that although there is a slightly elevated risk for violence by individuals with severe mental illness such as schizophrenia, serious violent acts are rare. In fact, these individuals are more frequently the victims of violence.[4] Furthermore, there is no evidence that court-ordered involuntary treatment in hospitals is more effective than quality community-based treatment. Although involuntary treatment has produced improved outcomes in some places, these outcomes appear to result from the fact that there was literally nowhere else for the person to go to receive services—in other words, involuntary treatment was the only option.[5] Safe, stable, and affordable housing, provided with voluntary supports, has been shown to help individuals with

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[1] Humphrey v. Cady, 404 U.S. 504, 509 (1972).
[2] 422 U.S. 563 (1975).
[3] 441 U.S. 418 (1979).
[4] *See* Bazelon Center for Mental Health Law, *Mayor Adams' Plan Will Not Help People With Mental Disabilities* 1, n.6 (Dec. 12, 2022), https://www.bazelon.org/wp-content/uploads/2022/12/NYC-statement-final-12-12-22.pdf (citing sources).
[5] *Id.* at 1.

mental health disabilities stabilize and avoid involuntary hospitalization and incarceration.[6]

Launched in 1965, the deinstitutionalization movement—shifting care from institutions to community-based settings with necessary services and supports—was fueled by the abuse and neglect of patients and the appalling inhumane conditions and human rights violations to which they were subjected in psychiatric facilities. A return to institutionalization is not the solution to unsheltered individuals with serious mental illness; there are other viable alternatives. Moreover, even on its own terms, the increased use of involuntary hospitalization to get allegedly mentally ill people off the streets is of questionable value, as there are often an insufficient number of available psychiatric hospital beds, the quality of treatment is often poor, patients are likely to be discharged after a short l stay, and discharge planning is often incomplete, resulting in a revolving door of hospitalizations.[7]

Accordingly, this Resolution calls on the American Bar Association ("ABA") to address the real needs of individuals who are unhoused and living with mental illness by urging state, local, territorial, and tribal governments not to broaden their statutory or regulatory criteria for involuntary civil commitment of people with mental health disabilities as a strategy to address homelessness. Instead, the ABA calls upon these governments to increase funding for and access to safe and affordable housing and non-coercive community-based supports and services for people with mental health disabilities.

This Resolution builds on prior ABA policy. In February 2023, the ABA House of Delegates adopted a policy affirming the importance of individuals' rights to direct their own medical course of treatment, in the context of their relationship with their treating health care provider. That policy opposes governmental actions and policies that would unreasonably deny or interfere with a person's ability to direct their own health care, including their right to refuse unwanted medical treatment and their legally authorized substitute decisionmakers' rights to refuse medical treatment on their behalf.[8] The patient's right to make decisions about their health care is grounded in the common law rights of bodily integrity and self-determination, as well as liberty interests protected by the Fourteenth Amendment.

II. Recent Expansion Efforts

Recent efforts to expand involuntary commitment take the form of proposed or enacted changes to state law. These efforts have in some cases been led by mayors of some of

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[6] *See, e.g.*, Sam Tsemberis & Ronda F. Eisenberg, "Pathways to Housing: Supported Housing for Street-Dwelling Homeless Individuals With Psychiatric Disabilities," *Psychiatric Servs.*, vol. 51, no. 4, pp. 487-93 (Apr. 1, 2000), https://ps.psychiatryonline.org/doi/10.1176/appi.ps.51.4.487.

[7] Jennifer Gerlach, "What We Don't Talk About With Involuntary Hospitalization," *Psychology Today* (Apr. 2, 2024), https://www.psychologytoday.com/us/blog/beyond-mental-health/202404/what-we-dont-talk-about-with-involuntary-hospitalization.

[8] 23MY512, https://www.americanbar.org/content/dam/aba/directories/policy/midyear-2023/512-midyear-2023.pdf.

our largest cities, like New York City.[9] The proposed changes take many forms. Some bills change the definition of "dangerousness" or "grave disability" so that more individuals will be found eligible for commitment.[10] For example, in November 2022, New York Mayor Eric Adams issued a directive clarifying that outreach workers, city-operated hospitals, and first responders have the authority to remove a person who appears to be mentally ill and displays an inability to meet basic living needs, even when no recent dangerous act has been observed.[11] No "overt act" demonstrating that the person is violent, suicidal, or engaging in outrageously dangerous behavior likely to result in imminent harm is required.[12] Serious untreated physical injury, unawareness or delusional misapprehension of surroundings, or unawareness or delusional misapprehension of physical condition or health may be reasonable indicia of an inability to support basic needs due to mental illness that poses harm to the individual.[13]

In 2023 California Governor Gavin Newsom signed Senate Bill 43, which expands the legal definition of "gravely disabled" to include a condition in which a person is unable to provide for their personal safety or necessary medical care because of a severe substance use disorder, a co-occurring mental health disorder and a severe substance use disorder, or chronic alcoholism.[14] In Oregon, Representatives Andersen, Diehl, and Mannix have introduced House Bill 4074, which defines "Person with mental illness" as a person who, because of a mental disorder, is unable to provide for basic personal

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[9] *See, e.g.*, Gabriel Poblete, "Adams Renews Push for Forced Psych Hospitalization as Albany Gets Back to Work," *The City* (Jan. 8, 2024) (New York City's mayor advocates with state legislature to change state involuntary commitment law, to expand pool of medical professionals who can initiate involuntary treatment, and allow hospitalization of those experiencing "substantial inability" to meet basic support needs), https://www.thecity.nyc/2024/01/08/city-hall-push-forced-hospitalization-albany-session/; NPR, *The Politics of Involuntary Commitment* (Mar. 29, 2023), https://www.npr.org/transcripts/1166782560 (Portland mayor announced support for loosening criteria for involuntary commitment, even though a lack of treatment capacity means "the system can barely handle the patients it has right now").

[10] *See, e.g.*, Poblete, *supra* note 9; Jocelyn Wiener, *Gavin Newsom signs law in 'overhaul' of mental health system. It changes decades of practice* (Oct. 10, 2023), https://calmatters.org/health/2023/10/california-mental-health-involuntary-treatment-law/ (California's governor signs bill expanding legal definition of who is "gravely disabled" and can be forcibly treated); Whitney Bryen, "Could New Law Change How Oklahoma Police Interact With Those Suffering From Mental Illness," *The Oklahoman* (Feb. 6, 2024), https://www.oklahoman.com/story/news/2024/02/06/oklahoma-legislature-mental-health-care-bill-aims-change-civil-commitment/72483232007/ (new bill expands definition of eligibility for involuntary commitment to include someone who has history of threatening or posing physical harm to themselves or others resulting from mental illness or substance use, and someone who commits "extreme destruction of property").

[11] NYC Office of the Mayor, *Mayor Adams Announces Plan to Provide Care for Individuals Suffering From Untreated Severe Mental Illness Across NYC* (Nov. 29, 2022), https://www.nyc.gov/office-of-the-mayor/news/870-22/mayor-adams-plan-provide-care-individuals-suffering-untreated-severe-mental#/0.

[12] *Id.*

[13] NYC Office of the Mayor, Mental Health Involuntary Removals (Nov. 28, 2022), https://www.nyc.gov/assets/home/downloads/pdf/press-releases/2022/Mental-Health-Involuntary-Removals.pdf.

[14] California Legislative Information, Senate Bill No. 43 (Oct. 12, 2023), https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB43.

needs that are necessary to avoid serious physical harm in the near future and is not receiving such care as is necessary to avoid such harm.[15]

State lawmakers in Ohio are considering a bill that would add a "psychiatric deterioration" standard for involuntary hospitalization. To qualify, the following criteria must be met: (1) the person's judgment is impaired by a lack of understanding of having an illness or a need for treatment, or both; (2) they have refused treatment or are not following a prescribed treatment; (3) they have been diagnosed with schizophrenia, schizoaffective disorder, bipolar disorder, delusional disorder, or major depressive disorder; and (4) they are "reasonably expected to suffer mental deterioration" if not treated and, because of that, would fall into another category outlined in existing law to involuntary commitment.[16]

Many efforts to expand involuntary commitment laws designate various stakeholders to make subjective determinations about whether a person with a disability poses a danger to themselves or others—now or in the future—or is otherwise gravely disabled. These stakeholders include bystanders and first responders, including police who set involuntary commitments in motion, and medical professionals and judges who sign orders allowing such commitments.

Recently, some laws, such as California's amended statute, have permitted not just individuals with mental illness, but also those with substance use conditions, including chronic alcoholism, to be committed.[17] Others provide for a larger group of persons who can authorize commitment. For example, on February 5, 2024, DC Council member Christina Henderson introduced Bill 25-0692, the "Enhancing Mental Health Crisis Support and Hospitalization Amendment Act of 2024,"[18] which would broaden the pool of qualified healthcare professionals authorized to initiate involuntary commitment processes, incorporating Psychiatric-Mental Health Nurse Practitioners with expertise in mental health assessments.[19]

Other proposals allow more days of detention before a judge decides whether commitment is justified.[20] In February 2024, the Utah House and Senate both

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[15] *See* Oregon Legislative Assembly, House Bill 4074 (Feb. 5, 2024), https://olis.oregonlegislature.gov/liz/2022R1/Downloads/MeasureDocument/HB4074/Introduced.

[16] Sarah Szilagy, *Disability rights groups worry about an Ohio bill to expand involuntary psychiatric commitment* (May 9, 2024), https://www.nbc4i.com/news/politics/disability-rights-groups-worry-about-an-ohio-bill-to-expand-involuntary-psychiatric-commitment/.

[17] *See, e.g.*, Weiner, *supra* at note 10 (California law expands population of persons who can be involuntarily committed to include individuals with substance use disorder and chronic alcoholism).

[18] DC B25-0692, 2023-2024, 25th Council (introduced Feb. 5, 2024), https://legiscan.com/DC/drafts/B25-0692/2023.

[19] *See, e.g.*, Nora Scully, *New Bill Would Expand Involuntary Commitment in DC* (Feb. 28, 2024) , https://streetsensemedia.org/article/new-bill-would-expand-involuntary-commitment-in-dc/ (bill supported by four DC Councilmembers would expand the types of mental health professionals who can initiate involuntary commitment)..

[20] *See, e.g.*, Scully, *supra* note 19 (newly introduced bill would extend timeframe for involuntary detention from seven to 15 days); Sammy Gibbons, *Mental Health Advocates Raise Alarm Over New NJ Involuntary Commitment Law*, NorthJersey.com (Aug. 22, 2023),

unanimously passed a bill to expand the time that an individual in "dangerous mental health crisis" can be committed to a hospital before being released.[21] Some proposals make the commitment process more expedient, including, as with Councilmember Henderson's bill, by permitting or even encouraging hearings in which petitions are adjudicated over video conference.[22]

In some states proposals for various forms of involuntary commitment expansion are regularly introduced in the state's legislature or through administrative regulation. For example, in 2022 Maryland proposed amendments to its emergency petition law that would expand the circumstances under which a person would be deemed "dangerous" and subjected to involuntary hospital admission.[23] Among other things, the revised regulation would permit an individual to be detained if their behavior places "others in reasonable fear of physical harm," a broader standard than in the current law—which requires that the individual presents a danger to the life or safety of the individual themselves or others at the time the involuntary commitment hearing is held—that could result in commitment orders issued based on the subjective perspective of a bystander.[24] This is particularly problematic for Black and brown people in Maryland, who are already disproportionately involuntarily committed and often may be perceived as more threatening by others due to the color of their skin, mode of communication, or other cultural factors.[25]

III. Constitutional and Other Concerns

These efforts to expand involuntary treatment constitute an infringement on individuals' Fourteenth Amendment due process rights involving the liberty interest of all persons to be free from confinement.[26] Further, the promise of disability rights laws, like the Americans with Disabilities Act and Section 504 of the Rehabilitation Act,[27] is that all people with disabilities, including those with mental health disabilities, have the right to live independently with freedom to make informed choices about where they live, what they do during the day, and what medical care they receive, and to live in their own homes and communities with the supports they want and need to participate in all the

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https://www.northjersey.com/story/news/health/2023/08/22/new-jersey-mental-health-crisis-law-alarms-social-service-groups-involuntary-confinement-hospitals/70623537007/ (new law permits hospitals to hold individuals for involuntary treatment for up to six days, if the hospital cannot place the individual in short-term care facility within three days, the maximum time allowed to hold individuals under old law).

[21] Brigham Tomco, *Utah Legislature Extends Involuntary Commitment for Mental Health Crises*, Deseret News (Feb. 29, 2024), https://www.deseret.com/2024/02/29/xgr-clancy-involuntary-commitment-bill/.

[22] Scully, *supra* note 199; *see also* Erin Beck, *Lawmakers want to speed up the process for committing West Virginians In mental health crises to hospitals* (Feb. 12, 2024), https://mountainstatespotlight.org/2024/02/12/virtual-hearings-mental-health-commitment/ (new bill would allow involuntary commitment hearings to be conducted over video conference).

[23] *See, e.g.*, Letter to Jourdan Green, Director, Office of Regulation and Policy Coordination, Maryland Dep't of Health (Dec. 5, 2022) (comments on proposed amendments to COMAR 10.21.01 – Involuntary Admission to Inpatient Mental Health Facilities) (on file).

[24] *Id.* at 3.

[25] *Id.*

[26] *See supra* notes 1-3 and accompanying text.

[27] 42 U.S.C. § 12101 et seq. (Americans with Disabilities Act); 29 U.S.C. § 794 (Section 504).

opportunities for daily living and community participation enjoyed by others.[28] As the U.S. Supreme Court ruled 25 years ago in the seminal case *Olmstead v. L.C.*,[29] unnecessary institutionalization of people with disabilities is discrimination actionable under the Americans with Disabilities Act because "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."[30] Involuntary commitment is an infringement on these rights, involving the loss of liberty and autonomy inherent in being unable to make one's own choices about medical and mental health care.

Expansion of involuntary commitment laws may also result in misdiagnosis or over-diagnosis of severe mental health conditions, particularly among Black, Indigenous, and other people of color. In New York, California, and elsewhere, Black and brown people with disabilities are overrepresented in the population of individuals experiencing homelessness, and therefore are more likely to be involuntarily hospitalized.[31]

Not only is involuntary commitment an infringement on human and civil rights, but it is often counterproductive. Institutionalization not only reinforces stigmatization and dehumanization—the sense that a person is inherently "less than" and that they represent a diagnosis rather than a human life—but also is a form of "othering."[32] Fear of being deprived autonomy discourages people from seeking care.[33] Coercion undermines therapeutic relationships, including in situations when providers may be required to testify as to whether an individual is "compliant" with a prescribed course of treatment, and long-term recovery.[34] When treatment plans are imposed, it is not

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[28] *See* 42 U.S.C. § 12101 (ADA findings and purpose); White House, Proclamation on the Anniversary of The Americans With Disabilities Act (July 25, 2022), https://www.whitehouse.gov/briefing-room/statements-releases/2022/07/25/proclamation-on-the-anniversary-of-the-americans-with-disabilities-act/.

[29] 527 U.S. 581 (1999).

[30] *Id.* at 601.

[31] *See, e.g.*, Stacy M. Brown, "Blacks Hit Hardest as NYC's Homeless Population Grows Amid Mental Health Crisis," *The Washington Informer* (Mar. 23, 2022), https://www.washingtoninformer.com/blacks-hit-hardest-as-nycs-homeless-population-grows-amid mental-health-crisis/
(citing Coalition for the Homeless report that 57% of heads of households in NYC shelters are Black and 32% are Hispanic/Latinx); cf. First Amended Complaint at ¶ 2, Disability Rights California v. County of Alameda, 2021 WL 212900 (N.D. Cal. Feb. 22, 2021) (No. 5:20-cv-05256-CRB), https://www.disabilityrightsca.org/system/files/file_attachments/Amended_Complaint.pdf ("During a recent two-year period, over 2,300 people were detained at the County's psychiatric facilities more than three times, the majority of whom were Black."); National Alliance to End Homelessness, *Homelessness and Racial Disparities* (Dec. 2023), https://endhomelessness.org/homelessness-in-america/what-causes-homelessness/inequality.

[32] Kim Samuel, "Bringing Back Institutionalization Would Be Inhumane—and Ineffective," *Psychology Today* (Nov. 21, 2023), https://www.psychologytoday.com/us/blog/the-power-of-belonging/202311/bringing-back-institutionalization-would-be-inhumane-and.

[33] *See, e.g.*, Ira Burnim, "Mental Health Treatment and the Myth of Legal Leverage?," *SJC Exchange* (Nov. 10, 2021), https://sjcexchange.org/communities/community-home/librarydocuments/viewdocument?DocumentKey=f0cdd4b4-1707-4563-ab16-5c3b227c236d.

[34] *See, e.g.*, Physicians for Human Rights, *Neither Justice nor Treatment: Drug Courts in the United States* 16 (June 2017), https://phr.org/wp-content/uploads/2017/06/phr_drugcourts_report_singlepages.pdf (quoting treatment provider: "It was very

surprising that the individual may not comply with the plan. Shared responsibility for the person's voluntary participation in services promotes "buy-in" and better treatment outcomes. In the long term the best way to secure treatment "compliance" is to respect the individual's informed choice.

Supporters of expanded involuntary commitment argue that many people with mental disabilities will not voluntarily consent to treatment because they "lack insight" into their condition, among other reasons.[35] Most people with mental health challenges have the capacity to make medical decisions for themselves.[36] Too often, any assumption to the contrary is based on stereotypes about people with serious mental health conditions, and reflects a failure to listen to and engage them in identifying what services they think would be of value in their lives and would meet their needs. Research indicates that effective engagement of people with mental health conditions, including by people with their own lived experience with mental health conditions or with homelessness, helps individuals see the value in and agree to participate in supportive services.[37]

Involuntary commitment relies on determinations that are subjective. Predictions of future behavior, especially dangerousness, are often notoriously unreliable.[38] Moreover, reliance on involuntary commitment may confirm false stereotypes about people with mental disabilities being inherently dangerous despite available evidence that people with mental health conditions are not more dangerous than people without mental health conditions.[39] And the experience of being forced to be treated—historically, an experience that involves some degree of physical restraint—is traumatizing and humiliating, often exacerbating a person's mental health condition. For far too many

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difficult to do true treatment and therapy with [drug court] clients because there was this sense that we were going to tell the team and judge, and they would be punished.").

[35] *See, e.g.*, Shanti Silver & Elizabeth Sinclair Hancq, "Anosognosia", *Treatment Advocacy Ctr.* 1 (Oct. 2023), https://www.treatmentadvocacycenter.org/wp-content/uploads/2023/12/TAC_ORPA_ResearchSummary_Anosognosia.pdf ("Anosognosia, also called lack of insight . . . is the most common reason for not seeking or maintaining treatment among people with [serious mental illness].").

[36] *See, e.g.*, A. Calcedo-Barba et al., "A meta-review of literature reviews assessing the capacity of patients with severe mental disorders to make decisions about their healthcare," *BMC Psychiatry*, vol. 20, no. 1, p. 339 (June 30, 2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7324958/ ("Whilst impairments in decision-making capacity may exist, most patients with a severe mental disorder, such as schizophrenia or bipolar disorder are able to make rational decisions about their healthcare.").

[37] *See, e.g.*, Tsemberis & Eisenberg, *supra* note 6, at pp. 487-93.

[38] *See, e.g.*, Robert T. M. Phillips, "Predicting the Risk of Future Dangerousness," *AMA Journal of Ethics* (June 2012), https://journalofethics.ama-assn.org/article/predicting-risk-future-dangerousness/2012-06 ("In reality, no one can predict future dangerousness precisely and with absolute certainty.").

[39] *See, e.g.*, Linda A. Teplin *et al.*, "Crime Victimization in Adults with Severe Mental Illness," *Arch. Gen. Psychiatry*, vol. 62, no. 8, pp. 911, 914 (Aug. 2005), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1389236/pdf/nihms5174.pdf ("Over one quarter of the SMI sample had been victims of a violent crime (attempted or completed) in the past year, 11.8 times higher than the [general population] rates . . . ."); Heather Stuart, "Violence and Mental Illness: An Overview," *World Psychiatry*, vol. 2, no. 2, pp. 121, 123 (June 2003), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1525086/pdf/wpa020121.pdf ("It is far more likely that people with a serious mental illness will be the victim of violence," rather than its perpetrator.).

people with mental health disabilities, especially Black and brown people, the use of force to compel treatment has resulted in physical injury or death.[40]

IV. Alternatives to Involuntary Commitment

Broadening civil commitment is not a solution to homelessness. We need to address the core underlying issues. For many people with mental health disabilities and their advocates, involuntary commitment is only appropriate in rare circumstances when there is a serious and immediate safety threat to the individual or other people. Even when a court may have ordered hospitalization or a course of treatment, force should be used to effectuate the order only as needed to prevent an imminent risk of serious harm. Efforts to de-escalate and stabilize the situation must be made before force is used.[41]

Safe, stable, and affordable housing, provided with voluntary supports, has been shown to help individuals with mental health disabilities stabilize and avoid involuntary hospitalization and incarceration.[42] Communities across the country are employing proven methods to meet the needs of individuals with serious mental health conditions who experience homelessness or housing instability and as a result cycle between the streets, the emergency room, and the jail.[43]

Housing

Providing safe, affordable, and permanent housing, along with the supports people with mental disabilities need to attain and maintain tenancy, has been shown to lead to housing stability, improve mental health symptoms, reduce hospitalization and law enforcement involvement, and increase satisfaction with one's quality of life.[44] Stable

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[40] *See generally* Legal Defense Fund & Bazelon Center for Mental Health Law, *Advancing an Alternative to Police: Community-Based Services for Black People with Mental Illness* (2022), https://www.bazelon.org/wp-content/uploads/2022/07/2022.07.06-LDF-Bazelon-Brief-reAlternative-to-Policing-Black-People-with-Mental-Illness.pdf.

[41] *See* Lessard v. Schmidt, 349 F. Supp. 1078,1096 (E.D. WI. 1972) (subsequent procedural history omitted) ("[T]he person recommending full-time involuntary hospitalization must bear the burden of proving (1) what alternatives are available; (2) what alternatives were investigated; and (3) why the investigated alternatives were not deemed suitable."); *cf.* SAMHSA, *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit* 20 (2020), https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf (goal of onsite de-escalation by responders "is not just to determine a needed level of care to which the individual should be referred, but to resolve the situation so a higher level of care is not necessary").

[42] *See generally* Bazelon Center for Mental Health Law, *Diversion to What? Evidence-Based Mental Health Services That Prevent Needless Incarceration* (2019), https://www.bazelon.org/wp-content/uploads/2019/09/Bazelon-Diversion-to-What-Essential-Services-Publication_September-2019.pdf (collecting studies).

[43] *Id.*

[44] *See* Dennis P. Culhane et al., "The Impact of Supportive Housing for Homeless People with Severe Mental Illness on the Utilization of the Public Health, Corrections, and Emergency Shelter Systems: The New York-New York Initiative," *Housing Policy Debate*, vol. 13, no. 1, pp. 107, 137-38 (2002), http://works.bepress.com/metraux/16; Corp. for Supportive Hous., *The New York/New York Agreement*

housing is a prerequisite for people with mental health disabilities to be able to focus on and engage in recovery, and is a powerful motivator for people to engage in treatment.[45] Having a roof over one's head is a near-foundational precondition for voluntary engagement in services that can foster recovery in the community. Scattered-site housing guards against individuals with mental health conditions being stigmatized and promotes integration into communities and access to will have access to the amenities and opportunities enjoyed by others.[46]

Housing with supports is often significantly less expensive than institutional care. Many states and localities have federally and locally funded rental subsidy programs that can be used to help provide housing to people with mental disabilities, including until the individual is able to secure a federal rental subsidy.[47] States may also obtain Medicaid funding for short-term (up to six months) of rent, pre-tenancy and post-tenancy services and supports, and other, one-time expenses like security deposits, moving expenses, and paying for furniture and establishing utilities.[48]

Voluntary Community-Based Services

Every state and locality should have the capacity to provide an array of services that have been shown to prevent hospitalization and incarceration, and help people avoid crises of the sort that prompt commitment proceedings. Voluntary community-based services, such as Assertive Community Treatment, mobile crisis services, supported employment, and peer support services—delivered not in the hospital, but in the person's own home and community—have been shown to break the cycle of institutionalization.[49]

Cost Study: The Impact of Supportive Housing on Services Use for Homeless Mentally Ill Individuals 5 (May 2001), https://shnny.org/uploads/NYNY_Agreement_Cost_Study_2001.pdf.

[45] *See, e.g.*, Yinan Peng et al., "Permanent Supportive Housing with Housing First to Reduce Homelessness and Promote Health among Homeless Populations with Disability: A Community Guide Systematic Review," *J. Pub. Health Manag. Pract.*, vol. 26, no. 5, pp. 404-11 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8513528/pdf/nihms-1743985.pdf; Ehren Dohler et al., "Supportive Housing Helps Vulnerable People Live and Thrive in the Community," *Center for Budget & Pol'y Priorities* (May 31, 2016), https://www.cbpp.org/research/supportive-housing-helps-vulnerable-people-live-and-thrive-in-the-community.

[46] *See, e.g.*, Leyla Gulcur, et al., *Community Integration of Adults with Psychiatric Disabilities and Histories of Homelessness*, *Community Mental Health J.*, vol. 43, pp. 211-28 (2007), https://link.springer.com/article/10.1007/s10597-006-9073-4.

[47] *See, e.g.*, U.S. Dep't of Hous. & Urb. Dev., *HUD Announces the Availability of $30.3 Billion for Housing Authorities to Provide Affordable Housing* (Apr. 13, 2023), https://www.hud.gov/press/press_releases_media_advisories/hud_no_23_076; Georgia Dep't of Behav. Health & Developmental Disabilities, *Get Help with Supportive Housing*, https://dbhdd.georgia.gov/be-dbhdd/be-supported/supportive-housing-services (describing state-funded Georgia Housing Voucher Program).

[48] *See, e.g.*, National Housing & Rehab. Ass'n, *New CMS Guidance Clarifies, Broadens Use of Medicaid Funds for Housing Supports* (Mar. 27, 2024), https://www.housingonline.com/2024/03/27/new-cms-guidance-clarifies-broadens-use-of-medicaid-funds-for-housing-supports/.

[49] *See, e.g.*, Letter from Disability Rights California to The Honorable Assembly Member Jim Wood (June 22, 2023), https://www.disabilityrightsca.org/latest-news/sb-43-eggman-as-amended-4-27-23-supplemental-opp (in "Supplemental Opposition Letter Providing Alternative Framework," stating that "we

A. Assertive Community Treatment

Assertive Community Treatment (ACT), which has been called "a hospital without walls,"[50] is a multi-disciplinary team approach to providing an individualized package of services and supports that have been proven effective in meeting the day-to-day needs of people with serious mental health conditions.[51] Team members provide counseling, peer supports, case management, psychiatric services, supported employment or supported education, and substance use services, among others.[52] The team is on call 24 hours a day to address the individual's needs.[53]

B. Mobile Crisis Services

Although ACT teams should be the first responders to their clients in times of crisis, for those not receiving ACT mobile crisis teams can come to wherever the person is in the community to help de-escalate mental health crises.[54] These teams should be available 24 hours per day, and should respond to calls for help as timely as do law enforcement responders.[55] They should be able to link an individual with ongoing voluntary services, such as ACT services, and have access to community-based crisis apartments where individuals can stay for a short period of time as an alternative to hospitalization.[56]

C. Supported Employment

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must invest in . . . community-based services instead of pursuing legislation to expand involuntary commitment").

[50] *See, e.g.*, Ross Ellenhorn, "Assertive Community Treatment: A "Living-Systems" Alternative to Hospital and Residential Care," *Psychiatric Annals*, vol. 45, no. 3, pp. 120-25 (2015), https://www.ellenhorn.com/pdf/assertive-community-treatment.pdf ("ACT programs are often described as a 'hospital without walls.'").

[51] *See generally*, SAMHSA, Assertive Community Treatment, The Evidence (2008), https://store.samhsa.gov/sites/default/files/sma08-4344-theevidence.pdf.

[52] *See, e.g.*, Susan D. Phillips et al., "Moving Assertive Community Treatment into Standard Practice," *Psychiatric Servs.* (June 1, 2001), https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.52.6.771.

[53] *Id.*

[54] *See, e.g.*, Hannah Weslowski, "Mobile Crisis Teams: Providing an Alternative to Law Enforcement for Mental Health Crises," *NAMI* (Jul. 13, 2022), https://www.nami.org/Blogs/NAMI-Blog/July-2022/Mobile-Crisis-Teams-Providing-an-Alternative-to-Law-Enforcement-for-Mental-Health-Crises.

[55] *See, e.g.*, Shenyang Guo et al., "Assessing the Impact of Community-Based Mobile Crisis Services on Preventing Hospitalization," *Psychiatric Servs.*, vol. 52, no. 2, pp. 223-28 (Feb. 2001), https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.52.2.223; Roger L. Scott, "Evaluation of a Mobile Crisis Program: Effectiveness, Efficiency, and Consumer Satisfaction," *Psychiatric Servs.*, vol. 51, no. 9, pp. 1153-156 (Sept. 2000), https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.51.9.1153.

[56] *See, e.g.*, NYC Health, *Crisis Services/Mental Health: Mobile Crisis Teams*, https://www.nyc.gov/site/doh/health/health-topics/crisis-emergency-services-mobile-crisis-teams.page ("Mobile Crisis Teams can provide mental health engagement, intervention and follow-up support to help people remain connected with treatment providers.").

Supported employment is a package of services and supports aimed at helping people with serious mental disabilities get and keep a job in the mainstream workforce.[57] Supports are not time-limited and are focused on the individual's vocational goals and preferences.[58] Supported employment services help connect individuals with jobs, provide on-the-job support and tailored trainings, and work with employers to identify necessary accommodations.[59]

D. Peer Support Services

People with lived experience with mental health conditions and mental health services providing peer supports can and should be involved with, if not leading, all of these services.[60] Peer workers serve on ACT teams, on mobile crisis teams, and as street outreach workers.[61] They can provide employment supports and operate community crisis apartments.[62] Peer workers help their clients stay connected to treatment providers, build confidence, maintain or develop social relationships, and participate in community activities.[63] Of all service providers, peer workers often are closest to the individual being served, and advocate for them with other staff. Peer work is fast becoming a primary component of the behavioral health service delivery system, and individuals receiving peer supports report increased social connectedness and ability to address stressors and crises.[64]

These are all evidence-based practices that can be provided in the quantity and intensity that makes sense for the individual and is commensurate with the level of risk that the individual might relapse. When delivered with fidelity and the empathy, alliance, and positive regard that comprise a robust therapeutic relationship, these services can make treatment more likely to be successful without resort to involuntary commitment. Delivery of these services should be trauma-informed, through practices that acknowledge traumas experienced by both the provider and the individual participating

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[57] *See generally* Substance Abuse & Mental Health Servs. Admin., U.S. Dep't of Health & Hum. Servs., *Building Your Program: Supported Employment* (2009), https://store.samhsa.gov/sites/default/files/sma08-4364-buildingyourprogram.pdf.
[58] *Id.*
[59] *Id.*
[60] *See, e.g.*, Mental Health America, *Peer Services*, https://www.mhanational.org/peer-services.
[61] *See, e.g.*, Bazelon Center for Mental Health Law, *When There's a Crisis, Call a Peer: How People with Lived Experience Make Mental Health Crisis Services More Effective* 48-49 (Jan. 2024), https://www.bazelon.org/wp-content/uploads/2024/01/Bazelon-When-Theres-a-Crisis-Call-A-Peer-full-01-03-24.pdf.
[62] *Id.*
[63] *See generally* New York State Office of Mental Health, *NYS OMH Mental Health Outpatient Treatment and Rehabilitative Services Guidance on Youth, Family, Adult, and Older Adult Peer Support Services* 6-8 (Nov. 23, 2022) [hereinafter NYS OMH Peer Support Guidance], https://omh.ny.gov/omhweb/clinic_restructuring/part599/mhotrs-peer-support-services-guidance.pdf (peer specialists connect individuals with appropriate services and supports, and "[h]elp[] the individuals identify and become involved in leisure and recreational activities in their community").
[64] *Id.*

in the service, and culturally responsive.[65] Increased cultural responsiveness that is fostered when trained peer support workers help others in the communities in which they work (and often live) is invaluable to delivery of behavioral support services in many of those communities, where historical oppression, violence, and discrimination present significant barriers to recovery for many people.[66]

States may seek federal funding through Medicaid for all these critical community-based mental health services, as well as others like intensive case management and outpatient substance use services. They are increasingly doing so through innovative methods like home and community-based service waivers, state plan amendments, and demonstration projects.[67]

Psychiatric Advance Directives

Psychiatric advance directives (PADs) provide a legal means for individuals to refuse or consent to future mental health treatment during periods of incapacity.[68] PADs may include advance instructions for mental health treatment decisions, or proxy decision-makers, or both.[69] More than just an instrument for crisis-planning, PADs are now considered part of a remedy for individuals with mental disabilities experiencing a sense of disempowerment and alienation from treatment. In this respect, PADs are consistent with the current movement toward "self-directed care," which in this circumstance may diminish actual as well as perceived coercion, improve service engagement and effectiveness, and thus promote long-term recovery.[70] Statutes permitting the use of some form of PAD exist in about half the states. States should consider enacting or strengthening these statutes so that they are clearly treated by behavioral health and

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[65] *See generally* SAMHSA, Trauma-Informed Care in Behavioral Health Services (2015), https://store.samhsa.gov/sites/default/files/sma15-4420.pdf.

[66] *See, e.g.*, Ruth White, *Why Mental Health Care Is Stigmatized in Black Communities* (Feb. 12, 2019), https://dworakpeck.usc.edu/news/why-mental-health-care-stigmatized-black-communities; NAMI, *African American Mental Health* , https://www.nami.org/find-support/diverse-communities/african-americans ("Conscious or unconscious bias from providers and lack of cultural competence result in misdiagnosis and poorer quality of care for African Americans.").

[67] *See generally* U.S. Dep't of Health & Hum. Servs., Centers for Medicare & Medicaid Servs. (CMS), *Coverage of Services and Supports to Address Health-Related Social Needs in Medicaid and the Children's Health Insurance Program* (Nov. 16, 2023), https://www.medicaid.gov/sites/default/files/2023-11/cib11162023.pdf (describing how states may seek Medicaid reimbursement for housing, employment, and peer supports); Heather Saunders, *A Look at State Take-Up of ARPA Mobile Crisis Services in Medicaid* (Nov. 30, 2023), https://www.kff.org/medicaid/issue-brief/a-look-at-state-take-up-of-arpa-mobile-crisis-services-in-medicaid/.

[68] *See, e.g.*, SAMHSA, A Practical Guide to Psychiatric Advance Directives 4 (2019), https://www.samhsa.gov/sites/default/files/practical-guide-psychiatric-advance-directives.pdf.

[69] *Id.* at 4-5.

[70] *See, e.g.*, Joint Commission, *Quick Safety 53: Improving Care With Psychiatric Advance Directives* , https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety-issue-53/quick-safety-53-improving-care-with-pads/ ("PADs can serve as beneficial tools for patients with mental illness, allowing them to exercise more autonomy over their mental health treatment and provide a forum for collaborative, coordinated treatment planning.").

public safety systems as legally relevant indications of a person's informed choice regarding treatment.[71]

V. Conclusion

By investing in housing and non-coercive community supports and services, states can restore the balance in their behavioral health and public safety systems so that they more appropriately value individual autonomy and liberty and help people with mental disabilities avoid the interactions with others that typically engender efforts to expand involuntary commitment. Broadening the nation's involuntary commitment laws is the wrong approach to our housing and mental health crises. Virtually all people with serious mental health conditions do not need to be treated involuntarily but can be served in their own homes and communities of choice if they are engaged in appropriate and voluntary services and supports. Through this Resolution, the American Bar Association calls on states and municipalities to reject efforts to expand these punitive laws, and instead invest in housing and voluntary community-based services.

Respectfully submitted,

Robert Dinerstein, Chair
Commission on Disability Rights

August 2024

[71] *See*, *e.g.*, National Resource Center on Psychiatric. Advance Directives. (Jan. 2024), https://nrc-pad.org/states/.

GENERAL INFORMATION FORM

Submitting Entity: Commission on Disability Rights

Submitted By: Robert Dinerstein

1. Summary of the Resolution(s). Urges state, local, territorial, and tribal governments not to expand their criteria for involuntary commitment of people with mental disabilities to address homelessness, but instead to provide funding for and access to safe and affordable housing and community-based supports and services.

2. Indicate which of the ABA's Four goals the resolution seeks to advance (1-Serve our Members; 2-Improve our Profession; 3-Eliminate Bias and Enhance Diversity; 4-Advance the Rule of Law) and provide an explanation on how it accomplishes this. Goal 3. This Resolution seeks to eliminate the increasing social stigma associated with unhoused individuals with mental disabilities, including that these individuals pose a high risk of violence, as well as the stigma that accompanies involuntary commitment. Further, expansion of involuntary commitment laws may result in misdiagnosis or over-diagnosis of severe mental health conditions, particularly among Black, Indigenous, and other people of color. Black and brown people with disabilities are overrepresented in the population of individuals experiencing homelessness, and therefore are more likely to be involuntarily hospitalized.

3. Approval by Submitting Entity. April 12, 2024 by ABA Commission on Disability Rights' volunteer members

4. Has this or a similar resolution been submitted to the House or Board previously? No

5. What existing Association policies are relevant to this Resolution and how would they be affected by its adoption? This Resolution builds on 23M512, affirming the importance of individuals' rights to direct their own medical course of treatment, and opposing governmental actions and policies that would unreasonably deny or interfere with a person's abilities to direct their own health care, including their right to refuse unwanted medical treatment and their legally authorized substitute decisionmakers' rights to refuse medical treatment on their behalf.

6. If this is a late report, what urgency exists which requires action at this meeting of the House?
N/A

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7. Status of Legislation. (If applicable) As outlined in the Introduction on pp. 2-5, various states and mayors have passed legislation broadening involuntary commitment, and other states are considering doing so.

8. Brief explanation regarding plans for implementation of the policy, if adopted by the House of Delegates. We would work with the ABA Governmental Affairs Office to oppose state legislation that expands the involuntary commitment criteria and support state efforts to fund safe, stable, and affordable housing with voluntary community-based services and supports.

9. Cost to the Association. (Both direct and indirect costs) None.

10. Disclosure of Interest. (If applicable) None.

11. Referrals. (List ABA entities and use proper names. For a list of all entities click here.)
Section of Civil Rights and Social Justice
Section of State and Local Government
Government and Public Sector Lawyers Division
Commission on Homelessness & Poverty
Forum on Affordable Housing and Community Development Law
Solo, Small Firm and General Practice Division
Judicial Division
Young Lawyers Division
Senior Lawyers Division
Criminal Justice Section
Real Property, Trust and Estate Law Section

12. Name and Contact Information (Prior to the Meeting. Please include name, telephone number and e-mail address). *Be aware that this information will be available to anyone who views the House of Delegates agenda online.*); Robert Dinerstein, rdiners@wcl.american.edu, 301.520.6096; Amy Allbright, amy.allbright@americanbar.org; 703.336.2501

13. Name and Contact Information. (Who will present the Resolution with Report to the House?) Please include best contact information to use when on-site at the meeting. *Be aware that this information will be available to anyone who views the House of Delegates agenda online.* Robert Dinerstein, rdiners@wcl.american.edu, 301.520.6096

EXECUTIVE SUMMARY

1. Summary of the Resolution.

   Urges state, local, territorial, and tribal governments not to expand their criteria for involuntary commitment of people with mental disabilities to address homelessness, but instead funding for and access to safe and affordable housing as well as community-based supports and services.

2. Summary of the issue that the resolution addresses.

   This Resolution addresses efforts by states across the country to make it easier to commit individuals against their will—also known as involuntary commitment, involuntary hospitalization, or civil commitment—to address serious mental illness among the growing unhoused population.

3. Please explain how the proposed policy position will address the issue.

   This policy will address the needs of unhoused individuals with serious mental health conditions by calling for the provision of safe, stable, and affordable housing with voluntary community-based services and supports.

4. Summary of any minority views or opposition internal and/or external to the ABA which have been identified.

   None.