CENTRE COUNTY DISTRICT ATTORNEY'S OFFICE

IN RE: OSAZE OSAGIE

REPORT OF INVESTIGATION

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I. BACKGROUND

On March 19, 2019, a warrant was issued pursuant to the Pennsylvania Mental Health Procedures Act Section 302 for Involuntary Emergency Examination and Treatment[1] for Osaze Osagie (hereinafter "Mr. Osagie"). That warrant was based on information received from Mr. Osagie's father. Mr. Osagie's father reported that Mr. Osagie was missing, had a history of anxiety and schizophrenia, and that he was probably off of his medications. A text message from Mr. Osagie indicated there would be trouble with the police "in a little bit;" that his "fast approaching deep sleep will result from a struggle between God and evil. . . and a battle between citizens of the US and the American government;" and "any poor soul whose life I take today, if any poor soul at all, may God forgive his sins if he has any."

Mr. Osagie told his father in a telephone conversation he was going to die. He also sent a text message to a caseworker indicating he would die very soon.

On March 20, 2019, Mr. Osagie was spotted at the local Weis Market walking in the direction of his apartment. An on-duty patrol officer (hereinafter

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[1] 50 P.S. § 7302 ("Section 302") provides for Involuntary Emergency Examination and Treatment not to exceed 120 hours. Written applications, warrants and written statements made under section 302 of the act (50 P.S. 7302), shall be made on Form MH-783 issued by the Department.

"Officer #1")[2] was dispatched to respond and check on Mr. Osagie. When he arrived at the apartment, two other officers met him there (hereinafter "Officer #2 and Officer #3"). Officer #1 knocked on Mr. Osagie's apartment door. When Mr. Osagie opened the door, his right hand was on the interior wall of the apartment so it could not be seen by the officers. Shortly after opening the door, Mr. Osagie stepped back, and a steak knife with a serrated blade became visible in his right hand. Officer #1 gave several commands to Mr. Osagie to drop the knife, to which Mr. Osagie responded with words to the effect of shoot me. Officer #1 began to retreat backward, and repeatedly told Mr. Osagie to drop the knife.

Officer #3 told Officer #2 to deploy his Taser on Mr. Osagie. When Mr. Osagie heard that statement, he stepped out of view into his apartment and concealed himself from the Officers to avoid being "tased." Seconds later, Mr. Osagie reappeared, running toward Officer #1 with the knife out. He was described as running as fast as a person could run. At that time, Officer #2 deployed his Taser which had no visible effects on Mr. Osagie. As Mr. Osagie turned toward Officer #2, Officer #1 discharged his weapon, fearing for his life and the life of Officer #2.

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[2] Three officers with the State College Police Department responded to Mr. Osagie's apartment. These officers will be referred to throughout this report as Officer #1, Officer #2, and Officer #3, respectively.

II. PENNSYLVANIA STATUTORY AUTHORITY ON USE OF FORCE

Law enforcement officers are authorized to use reasonable force when necessary in the performance of their duties, after considering the totality of the circumstances to successfully obtain lawful objectives. Pennsylvania Crimes Code § 508 provides police officers with the legal authority to use force while in the performance of specific duties, to include force which a person believes is necessary to defend himself or another from bodily harm while making an arrest. 18 Pa.C.S. § 508.

An officer is justified in using deadly force only when he or she believes that such force is necessary to prevent death or serious bodily injury to himself or another person. Pennsylvania law defines serious bodily injury as: "injury which creates a substantial risk of death or which causes serious permanent disfigurement or protracted loss or impairment of the function of any bodily member." 18 Pa.C.S. § 2602. A reasonable belief is one that is based on the circumstances known to an officer. Accordingly, police officers are justified to use deadly force to protect themselves or another from what they reasonably believe to be an imminent danger of death or serious bodily injury.

Police officers are directed to consider several factors when determining whether a reasonable belief of death or serious bodily injury to themselves or another exists. These factors include:

- whether the subject possesses the ability or means to carry out a threat of death or serious bodily injury upon another person;

- whether the subject possesses the opportunity to inflict serious bodily injury or cause the death of another person;

- whether the subject poses an imminent or immediate threat of death or serious harm to another person; and

- whether issues related to preclusion have been considered and deemed unwarranted.

For the reasons described below, the officer's use of deadly force was justified given the circumstances of this incident. At the time the officer discharged his weapon, he reasonably believed that both he and his fellow officer were in a life or death situation that posed both the threat of serious bodily injury and death. This report will address the reasons for reaching this conclusion. Additionally, the report will raise questions to be considered by the community and its policy makers regarding the process of serving 302 warrants.

III. DETAILS OF INVESTIGATION

A. THE FOLLOWING ITEMS WERE REVIEWED IN RELATION TO THIS INVESTIGATION:

- Pennsylvania State Police Reports prepared by the investigating officer, Corporal Thomas M. Stock
    - The police reports include witness interviews, the 302 warrant and photographs of the scene
- Recordings and records from Centre County 911 Center

- Autopsy findings and Pathologist's review
- Pennsylvania State Police Use of Force Training and Report
- Prior Police Reports regarding Mr. Osagie from the Pennsylvania State Police, State College Police, Ferguson Township Police, and Patton Township Police
- Medical records obtained from Strawberry Fields of State College, Pennsylvania[3]
- Medical and treatment records from Community Service Group, Opportunity Centre Clubhouse, Penn State University Psychology Clinic, Interfaith Human Services and The Meadows

B. INFORMATION RELATED TO THE 302 WARRANT FOR OSAZE OSAGIE

Police took a missing person report from Mr. Osagie's father on March 19, 2019 at approximately 9:55 p.m. Mr. Osagie's father reported that his son was missing from his apartment and that he had last spoken to him around 8:00 p.m. that same evening. His father also reported that Mr. Osagie had a history of anxiety and schizophrenia and was probably not taking his medication. Mr. Osagie's father was concerned that Mr. Osagie would harm himself.

Mr. Osagie's father reported that his son's behavior began to change approximately two weeks ago. Mr. Osagie sent a long text message at

[3] Strawberry Fields, Inc. provides community-based and residential services to children and adults with disabilities.

approximately 4:00 p.m. In the text message, Mr. Osagie reported the following, in part:

> Tell him I will not be able to attend any more of our appointments . . . although the police hid the secret reason, I have run into trouble with them before for the very reason I am about to run into trouble with them again in a little bit. The detective's hidden reason for getting me in trouble in the past was because of my love for God and my love for his creation. . .
>
> God is dead in this country, and soon I hopefully will be dead also. My fast – approaching deep sleep will result from a struggle between God and evil. . . and a battle between the citizens of the US and the American government.
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> [I]f my mission is successful, if I die for my God today. . . Any poor soul whose life I take today, if any poor soul at all, may God forgive his sins if he has any. And I pray there is no friendly fire. Lets see how much time I have left before finding out what life after death is really about.

Mr. Osagie's father indicated that he had a telephone call with his son and Mr. Osagie ended the call by saying he was going to die. Based on that information, a 302 warrant was authorized, signed and entered into the National Crime Information Center[4] system. Attempts were made in person and via telephone to contact Mr. Osagie and his roommate on March 19, 2019. Attempts to make contact with Mr. Osagie were not successful.

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[4] National Crime and Information Center is a system in which crime data is entered and accessible to criminal justice systems nationwide. This system assists law enforcement in apprehending fugitives, locating missing persons, recovering stolen property, and several other functions necessary to protect the public. www.fbi.gov/services/cjis/ncic

C. STRAWBERRY FIELDS RECORDS

Mr. Osagie resided in a Community Residential Rehabilitation Program through Strawberry Fields from March 2016 to December 2018. This period of time was the second time he had been admitted to the program. Mr. Osagie graduated in December 2018 in a planned discharge and moved into the apartment where the shooting occurred.

Mr. Osagie's medical records revealed that his diagnoses were: Axis 1 - Paranoid Schizophrenia; Axis II – Asperger's Disorder by history; Axis III – history of brain hemangioma; Axis IV – non-adherence with medications; and outpatient psychological treatment, chronic mental illness, and legal/housing/social/primary support. Mr. Osagie saw a doctor for his psychiatric needs. He participated in a peer support program from May 15, 2018 until January 16, 2019, when he requested discharge from the program.

On February 11, 2019 Mr. Osagie's caseworker from Community Services Group (hereinafter "CSG")[5] reported that Mr. Osagie was not doing well mentally. His caseworker indicated that Mr. Osagie's blended case manager[6] was going to attempt to reach out to offer support. Mr. Osagie's caseworker saw him at the

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[5] Community Services Group is a community-based, Pennsylvania mental health facility offering intellectual and developmental disability and mental health services. http://csgonline.org

[6] A blended case manager is someone who assists individuals with mental illness in gaining access to needed medical, social, educational and other services.

apartment for a scheduled meeting, but Mr. Osagie indicated he needed to go to the bank. Mr. Osagie reported not feeling well physically and indicated he might have to see a doctor or go to the hospital. Mr. Osagie indicated he was not going to a meeting with his caseworker from CSG.

On February 27, 2019 Mr. Osagie voluntarily stopped seeking services with CSG and Mobile Psych Rehab due to there being "too many doctor appointments" to continue. At the time, Mr. Osagie was unsure when his next psychiatrist appointment was scheduled. Mr. Osagie complained of not sleeping and having headaches. Mr. Osagie reported that his symptoms were not psychological. He denied having schizophrenia, instead claiming that his condition was "permanent anxiousness." His next visit was scheduled for March 21, 2019.

On March 19, 2019 Mr. Osagie's father reported him missing. On March 20, 2019. Mr. Osagie's caseworker reported the following events:

- 8:08 a.m. – attempted to call Osaze – voicemail full. Will attempt to call other places.

- His caseworker from CSG Mobile received the following text message last night:

> "Please please tell [redacted] I'm sorry for not being able to reply to her and to [redacted]. Tell her I'm sorry about her lost relative. Also tell her that I'm sorry but I don't have time to see any of you guys in the near future

because I myself may be uh, hurt very soon. Very soon - - - maybe even no longer alive. I am so sorry."

- Advised CSG caseworker to 302 him to "hopefully intensify the urgency of the police to try and find him." Checked hospital to see if he had been admitted. Hospital has a 302 and hopefully he will be found and admitted.

- 8:44 a.m. – Called Osaze's father – he reports Osaze is not coherent. Refused to come to dinner. BCM updates Osaze is pulling back from services.

- 8:59 a.m. – Called Centre Clubhouse who has not seen or heard from Osaze.

- 10:52 a.m. – Called Osaze's phone.

- 1:44 p.m. –Osaze's previous peer support specialist from Strawberry Fields saw him at Weis – headed to his apartment. Will notify Can Help so they can alert police.

- 1:48 p.m. – Updated Can Help re: Osaze sighting.

D. Interview of Strawberry Fields Caseworker

Mr. Osagie's caseworker from Strawberry Fields was interviewed. The caseworker indicated he is not a counselor. His job is to link clients with services. The caseworker reported that he typically went to Mr. Osagie's residence every three to four weeks. He indicated Mr. Osagie had been pulling back from services and was regressing. He last saw Mr. Osagie in February when Mr. Osagie turned

him away. He indicated that he tried to convince him to see a doctor, but Mr. Osagie declined.

The caseworker began noticing Mr. Osagie's regression when he moved from Community Residential Rehabilitation Services (hereinafter "CRR")[7] to his current apartment. Mr. Osagie's caseworker believed Mr. Osagie was off his medication. The caseworker saw a definite downward slide in Mr. Osagie's behavior and reported that Mr. Osagie was not seeing a therapist. When Mr. Osagie's caseworker became aware of the 302 warrant, he started making calls to people who knew him.

E. Interview of Mr. Osagie's Roommate

Mr. Osagie's roommate met Mr. Osagie in December 2016 and they became roommates in December 2018. Mr. Osagie's roommate said that Mr. Osagie's behavior started changing over the last month. He thought Mr. Osagie was depressed and did not talk much during this time period. The week before the shooting, Mr. Osagie's roommate reported that Mr. Osagie would not talk to him in passing.

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[7] Community Residential Rehabilitation Services are designed and operated to assist persons with chronic psychiatric disability to live as independently as possible through the training and assistant in the skills of community living and by serving as an integrating focus for the person's rehabilitation. Pennsylvania Code § 5310.2.

The roommate reported that on March 17, 2019, he saw Mr. Osagie at 3:00 a.m. reading his Bible, which was unusual because he was usually asleep at that time. On March 19, 2019, police advised the roommate that Mr. Osagie was missing; so, he attempted to call Mr. Osagie's cellphone multiple times only to discover that his cellphone was turned off. The last time the roommate heard Mr. Osagie in the apartment was on March 19, 2019 at 2:20 p.m. when he heard and saw that the bathroom light and fan were on. When the roommate returned to the apartment at 4:15 p.m., Mr. Osagie was not there.

The roommate reported that he went to bed on March 20, 2019 at 1:00 p.m. and was awoken by the sounds of gun shots. The roommate stated that Mr. Osagie had not been attending his community support group meetings with his counselor for the last three or four weeks.

F. Police Statements Regarding the Incident

On March 19, 2019, Mr. Osagie's father contacted the State College Police Department regarding text messages and statements that Mr. Osagie made regarding killing himself and potentially others. Mr. Osagie's father met with two officers at the State College Police Department. Mr. Osagie's father reported that he was unable to locate his son and provided information he had regarding threats that had been made by Mr. Osagie.

Both officers went to Mr. Osagie's apartment with his father. The officers eventually made contact with Mr. Osagie's roommate, who indicated he had not seen Mr. Osagie since approximately 2:00 p.m. Multiple attempts were made to call Mr. Osagie at that time, but his phone was turned off.

An officer and Mr. Osagie's father then proceeded to contact Can Help[8] to obtain a 302 warrant. A State College police officer canvassed the area of Mr. Osagie's apartment, as well as checking the Weis Market. He interviewed staff from Weis Market to determine whether anyone had seen Mr. Osagie. No information was developed on Mr. Osagie's location.

At 6:45 a.m. on March 20, 2019, officers of the State College Police Department on the morning shift were briefed that there was a 302 warrant for Mr. Osagie and that he was reported missing. That morning detectives made attempts to contact Mr. Osagie via telephone, but it appeared that his cellphone was still turned off. An officer checked the vicinity of the Hamilton Plaza shopping center, with no contact being made with Mr. Osagie.

At approximately 1:44 p.m., Mr. Osagie's previous peer support specialist from Strawberry Fields saw him at the Weis Market heading toward his apartment.

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[8] Can Help is a hotline that provides dual diagnosis clients with mental health services.

Strawberry Fields was notified, and they notified Can Help. Can Help then notified the State College Police Department. Radio calls confirmed that at 1:48 p.m., Mr. Osagie was spotted near the Weis Market. Officer #1 was the first officer to respond. He was on routine patrol after finishing lunch at the police station. He received a call from dispatch indicating Mr. Osagie had been seen at the Weis Market. Officer #1 asked dispatch to call the person back to obtain information on how Mr. Osagie was dressed and where he was headed. Dispatch advised Officer #1 that Mr. Osagie was walking from the Weis Market with bags in his hands toward his apartment. Officer #1 was directed to respond to the call.

Officer #2 was working the morning shift and was at roll call at 6:45 a.m. where he was made aware of the 302 warrant for Mr. Osagie. Officer #2 was briefed on some of the details of the 302 warrant during the morning briefing. Officer #2 did not believe he had ever dealt personally with Mr. Osagie, but he was aware of previous incidents similar in nature to what was being reported in the 302 warrant. Officer #2 radioed dispatch indicating that he was in the vicinity and would assist.

The third officer to respond had checked the daily briefing and saw there was a missing person report and a 302 warrant for Mr. Osagie. He recognized the name from prior mental health calls and was aware there had been a case in 2009

where Mr. Osagie had gone missing. Officer #3 knew that Mr. Osagie had a mental illness, but did not believe he had previously dealt directly with Mr. Osagie.

Officer #3 checked the laundromat at Hamilton Plaza shopping center that morning to see if Mr. Osagie was in the area. When he heard Officer #1 being dispatched to the Weis Market sighting, Officer #3 proceeded to the area to assist. Officer #3 was in plain clothes at the time, and Officers #1 and #2 were in full uniform. All officers had crisis intervention training, and Officer #3 received training from the FBI as a crisis negotiator.[9] Officer #1 circled the area of Mr. Osagie's apartment until the other officers arrived. Radio traffic confirmed that Officer #1 reported they were on scene at 1023 Old Boalsburg Road at 13:59:20 (1:59 p.m.). Both officers parked their vehicles down the street so the police cruisers could not be seen from the apartment. At approximately the same time, Officer #3 arrived and parked behind the two police cruisers.

At approximately 14:00 (2:00 p.m.), Officer #3 contacted the detective assigned to the case to confirm both that the 302 warrant was still active and the number of Mr. Osagie's apartment. After verifying that information, all three

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[9] Crisis intervention training involves a 40-hour training that is designed to educate first responders about mental illness, understanding the symptoms that people with mental illness experience, and developing the skills to de-escalate a crisis situation. (See Appendix F)

officers proceeded to attempt to make contact with Mr. Osagie. The three responding officers were familiar with the general layout of the apartment complex from previous calls not related to Mr. Osagie.

The three responding officers proceeded down a half flight of stairs to a narrow hallway with two apartments accessible at the bottom of the stairs. The hallway measured approximately three feet wide and seven feet long with apartment doors on either end of the hallway. Officer #1 positioned himself in front of Mr. Osagie's apartment door. Officer #2 was on the first stair going up from the landing with a view of Mr. Osagie's apartment door to his left. Officer #3 was approximately half way up the stairs. As Officer #3 stood on the flight of stairs, he could see the lights on top of the other officers' radios, situated on the shoulder area of their uniforms, blinking, indicating they were having trouble receiving reception at the bottom of the stairs. Officer #3 advised the officers of the blinking lights.

Officer #1 knocked on the door and waited. Officer #1 did not announce police presence and knocked a second time. Officer #1 covered the peep hole as he knocked because he did not want to provoke a response by Mr. Osagie to police being at his door. It took longer than it should have for someone to answer the door for an apartment of that size. Officer #1 knocked multiple times and could hear someone moving inside the apartment. An individual from inside the

apartment was heard saying he was coming to the door, and all officers could hear the sound of the door being unlocked.

Mr. Osagie's apartment door opened out and measured approximately two feet seven inches. Officer #1 asked whether the person answering the door was Mr. Osagie, who answered "yes." When Mr. Osagie opened the door, his right hand was out of view, up against the interior wall of the apartment at approximately shoulder height. Officer #1 asked Mr. Osagie if they could come in and talk, to which Mr. Osagie responded "no." Officer #1 then asked Mr. Osagie if he would come out and talk to them. Mr. Osagie responded "no." From his position on the stairs, Officer #2 could see Mr. Osagie's entire body except for his right hand, which was slightly outside his frame of view. Officer #3 could only hear the exchange and see the top of Mr. Osagie's head. He was not able to see Mr. Osagie's face or body.

At the time that Officer #1 asked Mr. Osagie if he would come outside to talk, Mr. Osagie stepped back, and a serrated steak knife was visible in his right hand. Mr. Osagie was holding out the knife at shoulder level with the blade pointed at Officer #1. At that time, Officer #1 drew his duty weapon with his right hand. Officer #1 ordered Mr. Osagie to drop the knife multiple times. At that point in time, Mr. Osagie backed up to the point where Officer #2 had a full view of Mr. Osagie and could see a knife in his right hand.

Officer #3 was not able to see the knife, but could hear Officer #1 scream "drop the knife, drop the knife" and assumed by the officer's reaction and voice that Mr. Osagie had a knife in his hand. In response to being told to drop the knife, Mr. Osagie said "shoot me," to which the officer responded, "no, drop the knife." Officer #1 began moving backward to put distance between himself and Mr. Osagie.

At approximately the same time, Officer #3 told Officer #2 to get his Taser ready. Officer #3 is not sure of the exact words that he said, but simultaneously with that command Officer #2 was taking his Taser out. Upon hearing the word Taser or seeing the Taser being activated, Mr. Osagie ran to his right, inside the apartment so that he was out of sight of Officers #1 and #2. At the same time that Mr. Osagie moved to his right, he said, "no, I want to die."

At the time that Mr. Osagie disappeared from view, Officer #1 attempted to make a radio call, a 10-33 (an emergency call), advising that Mr. Osagie had a knife. All three officers described Mr. Osagie as not being visible for seconds. As Officer #1 was backing up to the rear wall of the hallway, Mr. Osagie came back into sight. He was running out of the apartment with a knife in his right hand, brandishing it with the blade extended. At the time that Mr. Osagie came into view in the doorway, Officer #2 discharged his Taser. Officer #2 heard Officer #1 yell "stop" and described Mr. Osagie as running as fast as a person can run, through the

door with the knife up in his hand. Officer #2 presumed that the Taser missed because Mr. Osagie kept coming at them.

Officer #2 reported that Officer #1 backed up behind his position as Mr. Osagie was running. Officer #2 estimated that Mr. Osagie was approximately three feet from him and closing when he shot the Taser. Subsequent forensic examination confirmed that Mr. Osagie was shot by the Taser. The spread between the two electronic probes was approximately six inches.

All three officers confirmed that the Taser was shot first, that Officer #1 retreated past Officer #2's position, and then there were gunshots. Officer #2 estimated that Officer #1 was "at best" two feet away from Mr. Osagie when he began shooting his duty weapon. After shooting the Taser, Officer #2 dropped the Taser and was attempting to transition to his gun when shots were fired. Officer #2 described the shots as being so close to him that initially he thought he had been shot in the arm because he could feel the muzzle blast and concussion from the gun.

As Officer #1 was backing up, he saw Officer #2 discharge his Taser, which did not stop Mr. Osagie. As Officer #1 backed up, he tripped on the stairs and fell backward. At that time, Officer #1 saw Mr. Osagie "cant" or turn to the right toward Officer #2. At that point, Officer #1 began to fire his pistol. Officer #1 believed he shot three times, but physical evidence confirmed he shot four rounds.

Officer #1 ceased firing when he saw that Mr. Osagie was falling and the attack had been stopped. Officer #1 reported that he saw a shot strike Mr. Osagie's left side torso. At the time that he discharged his weapon, Officer #1 estimated that his feet were approximately one foot or less from Mr. Osagie. Officer #1 described leaning and falling backward onto the wall, with his torso being approximately two feet from Mr. Osagie. Officer #1 described shooting as he was falling and that he did not have time to aim.

Mr. Osagie fell at Officer #1's feet with his head up against the opposite door that faced Mr. Osagie's apartment. The knife was still in Mr. Osagie's hand. Officer #2 described Officer #1's weapon as being out and extended in full draw at the beginning of the incident and shooting from his hip at the end. Officer #1 called in shots fired. Officer #2 looked down at Officer #1 who had already holstered his weapon. Officer #1 appeared momentarily "locked up;" so, Officer #2 grabbed him by the vest saying, "you did what you had to do, you saved us – are you good?" Officer #1 threw his keys to Officer #3 telling him to retrieve his first aid kit from his vehicle.

Officer #2 saw the knife laying in Mr. Osagie's hands and kicked it back into Mr. Osagie's apartment. Officer #2 advised Officer #1 that he "had it from here," and Officer #1 left the scene, having no further involvement in events. Officer #3 made calls for assistance and medics and then contacted the State Police

to advise them of an officer involved shooting. Upon the arrival of medics and Pennsylvania State Police, Officer #2 vacated the scene.

Officer #1 reported that at the time he was charged by Mr. Osagie, the knife was raised up and pointed at both him and Officer #2. Officer #1 believed that had he not fired his weapon, he and Officer #2 would have been seriously injured or dead. Officer #1 estimated that the time from knocking on the door to rendering aid was at most twenty seconds. When Officer #1 first saw the knife, Mr. Osagie stepped back, and he estimated the distance at approximately six feet between him and Mr. Osagie. Officer #1 extended the distance between him and Mr. Osagie by retreating to the rear door while telling Mr. Osagie to drop the knife. Officer #1 reported that when he fired, he felt he had no alternative, and he thought he was going to be stabbed in the neck by Mr. Osagie.

Officer #2 indicated that but for Officer #1's quick actions, it was his opinion that one or both of them would have been seriously injured or dead. He estimated the time from the first knock on the door to the shooting would have been approximately twenty-five to thirty seconds, ten of those seconds were spent waiting for Mr. Osagie to answer the door.

Officer #3 advised that the landing allowed very little space to retreat and that at the time Officer #1 fired, he had nowhere else to go. When Officer #1 was rushed, he had to shoot. Officer #3 advised that Officers #1 and #2 were nearly

falling down, leaning against each other immediately after the shooting. He witnessed Mr. Osagie falling forward onto the floor.

G. Radio Calls

At 1:48:51 p.m., radio calls confirmed that Mr. Osagie was spotted near Weis Market. At 1:55:49 p.m., 911 gave a description of Mr. Osagie to Officer #1. At 1:56:32 p.m., the caseworker who had seen Mr. Osagie at Weis Market was identified to Officer #1. At 1:57:20 p.m., radio traffic confirmed that Officers #1, #2 and #3 were parking their vehicles near Mr. Osagie's apartment. At 1:59:20 p.m., Officers #1, #2 and #3 reported they were at the scene. At 2:02:56 p.m., Officer #1 indicated he needed other units, and at 2:03:00 p.m., Officer #1 gave the call sign for an emergency (10-33). Five seconds later at 2:03:05 p.m., the officer at the scene made a call of shots fired.

H. Forensic Service Unit (F.S.U.) Reports

The Pennsylvania State Police Forensic Service Unit (hereinafter "F.S.U.") secured, documented and collected evidence from the scene. The evidence relevant to this report is as follows: guns, magazines, bullets, bullet fragments, Taser, knife, green Taser blast door, Taser AFIDs, Taser cartridge, scene photos, and officers' duty belts. A suspected bullet strike was observed on the front door of the apartment, above the door knob on the interior side of the door. Pictures from the scene document marks in the paint of the stairwell going up and out of the

apartment. The duty belt worn by Officer #1 had similar paint on the belt, consistent with the paint from the apartment stairwell. Two rounds were collected at the scene, and two rounds were removed from the chest of Mr. Osagie.

I. Taser Download

The download from Officer #2's Taser indicated that the Taser was armed for ten seconds and then fired. Once a trigger is activated, the duration of the charge is five seconds, unless the trigger is activated again. Five seconds after being fired, the Taser was placed on safety. A six inch probe spread was measured. This is consistent with a Taser being 3.56 feet from Mr. Osagie at the time the trigger was activated.

J. Crime Lab

Officer #1's pistol and two extra magazines were taken into evidence and sent to the crime lab for testing by the Forensic Service Unit. Each of the unused magazines recovered had seventeen bullets. Officer #1's pistol recovered at the scene had thirteen unused rounds, with four casings recovered at the scene. Ballistic testing confirmed that Officer #1's weapon was utilized in this incident.

Mr. Osagie's clothing was collected by the F.S.U. and sent to the crime lab for gunshot residue and distance determination testing. The results of that testing are as follows:

- The area around the hole in the left shoulder area was examined and processed for the presence of gunshot residue, and a pattern of residue was found. Testing showed that the pattern was created at an approximate muzzle to garment distance of greater than 12 inches and less than 36 inches.

- The area around the hole in the left side rear panel of Mr. Osagie's shirt was examined and processed for the presence of gunshot residue, and a pattern of residue was found. Testing showed that the pattern was created at an approximate muzzle to garment distance of greater than 6 inches and less than 24 inches.

- The area around the hole in the right side rear panel of Mr. Osagie's shirt was examined and processed for the presence of gunshot residue, and a pattern of residue was found. Testing showed that the pattern was created at an approximate muzzle to garment distance of greater than 12 inches and less than 30 inches.[10]

K. Autopsy and Pathologist Results

The autopsy confirmed there were two Taser probe wounds approximately six inches apart. The pathologist confirmed that a six inch spread would probably not have disabled Mr. Osagie. The shock from a Taser, if it has an effect, might cause a person to turn away from the shock, or in Mr. Osagie's case, to turn to the right.

At the direction of the Centre County Coroner, a pathologist performed an autopsy of Mr. Osagie. Toxicology results confirmed that Mr. Osagie was not on

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[10] See April 26, 2019 Firearm and Tool Mark report from Pennsylvania State Police Bureau of Forensic Services. (Appendix B)

any medication or drugs, other than caffeine, at the time of the incident. The autopsy documented that Mr. Osagie was shot three times. The pathologist reviewed his forensic findings, together with the crime scene photos, officer statements and crime lab results with the purpose of confirming whether the responding officers' statements were consistent with the physical forensic evidence.

The pathologist concluded that the probable first shot struck Mr. Osagie in the left shoulder, exiting the front center of Mr. Osagie's chest. This bullet was recovered at the scene. The primary trajectory of that bullet was from left to right, back to front, and slightly down to up. The distance of the left shoulder wound was 67.5 inches from the bottom of his left foot. The pathologist concluded that the first shot was consistent with the officer's description of Mr. Osagie canting or turning to his right facing toward Officer #2, who was on the first step of the stairway leading up.

The second shot was documented as being on the left side of Mr. Osagie's mid-back, 63 inches up from the bottom of his left foot. The primary trajectory of the second shot was down to up, slightly left to right, and back to front. The pathologist's opinion was that the trajectory of this bullet was consistent with the officer's description of falling backward and shooting as he was falling.

The third and final shot was on Mr. Osagie's right mid-back, 60.5 inches from the bottom of his right foot, which is consistent with the officer's description of firing as he fell, and Mr. Osagie falling after being shot. The primary trajectory of this shot was right to left, slightly back to front, and parallel to the ground. This third shot was fatal. It was the pathologist's opinion that the first shot to the left shoulder would have caused Mr. Osagie to move away and turn, exposing the mid left to right back and that the trajectories confirm that Mr. Osagie was turning to his right as the officer was firing.

The pathologist concluded that the anatomical forensic physical evidence is consistent with Officer #1's description of what occurred, physical evidence recovered at the scene, and his medical examination.

IV. ANALYSIS AND CONCLUSION

At approximately 1:49 p.m., radio calls confirmed that Mr. Osagie was seen at the Weis Market. Approximately six minutes later, a description was given of Mr. Osagie that he was headed toward his apartment. At 2:00 p.m., Officers #1, #2 and #3 were on scene, confirming the active 302 warrant and Mr. Osagie's address. Three minutes later, officers were radioing in that there was an emergency. Seconds later, a call of shots fired was made over radio communication.

The above-described incident took less than thirty seconds from the responding officers knocking on Mr. Osagie's door to the call that shots had been

fired. Officer #1 had no other option than to shoot in self-defense and in defense of Officer #2 at the time that Mr. Osagie charged the officers with a knife. Radio traffic, Taser downloads, and forensic evidence are all consistent with the events as described by the officers on scene.

Mr. Osagie had expressed an intent and plan to kill himself and others that was specific to the events described by the officers. The Taser download and radio traffic calls confirmed that the time period from when the officers saw the knife to the time that Mr. Osagie charged through the doorway was less than ten seconds, with shots being fired immediately after the trigger of the Taser being activated. 911 dispatch time logs indicated that at 2:02:56 p.m., Officer #1 radioed that he "needs other units, needs other units." His second transaction called out a "10-33," an emergency, and the transmission ended at 2:03:02 p.m. Three seconds later, the officer transmitted "shots fired."

Police are trained in the use of force, and scientific research tells us the following in regards to general assaults[11]:

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[11] (1) Lewinski, William J. et al. (2015). Ambushes leading cause of officer fatalities – when every second counts: analysis of officer movement from trained ready tactical positions. *Law Enforcement Executive Forum*, 15(1), 1-15.; (2) Lewinski, William J. et al. (June 2014). Law Enforcement Executive Forum. Vol 14, No. 2; (3) Dysterheft, Jennifer L. et al. The influence of start position, initial step type, and usage of a focal point on sprinting performance. 320-328. and (4) Lewinski, William J. (2008). A survey of the research on human factors related to lethal force encounters: implications for law enforcement training, tactics, and testimony. *Law Enforcement Executive Forum*, 8(4) 129-152.

Type of Encounter	Speed of Assault (averages)
Handgun	.25 - .50
Physical Charge	.37 (3 feet) - .73 (6 feet)

Edged weapon assault research shows the following[12]:

Type of Encounter	Speed of Assault (averages)
Five (5) feet and slash	1/3 of a second
Nine (9) feet and slash	2/3 of a second
Twelve (12) to Fifteen (15) feet and slash	1 second

Scientific testing shows, on average, how long it takes an officer to deploy a service weapon and fire it as follows[13]:

Handgun Position	Aver. Time (Seconds)	Maximum Time	Minimum Time
Weapon on target, indexed finger	0.51	1.36	0.25
Weapon in snapped holster	1.82	2.93	1.29
Weapon in holster to interview hip	1.44	2.77	0.73
Weapon at low-ready, indexed finger and aimed shot	0.97	1.71	0.50

[12] April 25, 2019 report of Corporal Kevin E. Selverian; pg. 18-19. (Appendix A)
[13] April 25, 2019 Report of Corporal Kevin E. Selverian, pg. 19-20. (Appendix A)

Weapon at low-ready, indexed finger and point shot	0.64	1.02	0.42
Weapon at high-ready, indexed finger and aimed shot	0.83	1.46	0.44

At the time officers became aware Mr. Osagie had a knife in his right hand, it was objectively reasonable to believe that they were at risk of death or serious bodily injury due to an assault with a knife. The evidence supporting this conclusion is as follows:

- Mr. Osagie brandished a knife in his right hand.
- Mr. Osagie ran in the direction of the responding officers.
- Mr. Osagie was described as "running as fast as a human can run."
- Mr. Osagie pointed the referenced knife at Officer #1 as he moved toward the officer's location.

Mr. Osagie possessed both the ability and the means to seriously injure and kill both officers. It would be expected that Mr. Osagie would have been able to close the six feet distance between him and Officer #1 and assault the officer in approximately .73 seconds. It would have taken Officer #2 on average 1.82 seconds to draw his weapon from his holster. At the time that he was attacked by Mr. Osagie, Officer #2 had thrown down his Taser and was attempting to draw his pistol. He was unarmed at the time that Officer #1 shot.

Officers are trained and research shows that when moving backward with a subject charging, an individual will reach the officer in two-thirds of a second from a distance of seven feet while the officer is moving four feet backward. Officers are trained to retreat and move left or right to attempt to avoid an assault. Officer #1 retreating and moving left is consistent with police training and explains why the officer acted as he did.[14]

As found by Corporal Selverian of the Pennsylvania State Police, and as stated in the report[15], the "combination of facts and circumstances demonstrate that Mr. Osagie posed an immediate threat of death or serious bodily injury as follows:

- Mr. Osagie had a history of anxiety and schizophrenia.
- Mr. Osagie was probably not taking his prescribed medication.
- Mr. Osagie had sent a text message stating that he would have trouble with the police, that he would die, and that he might kill others in the process.
- The reported encounter between Mr. Osagie and the responding police officers occurred at close range and in a confined environment.
- Mr. Osagie brandished a knife in his right hand.
- Mr. Osagie failed to comply with repeated verbal commands to drop the knife.
- Mr. Osagie uttered words to the effect of "shoot me."

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[14] April 25, 2019 Report of Corporal Kevin E. Selverian, pg. 9-11. (Appendix A)
[15] Corporal Kevin Selverian authored a report dated April 25, 2019, analyzing the events at issue involving the death of Mr. Osagie. (Appendix A)

- Mr. Osagie ran toward Officer #1 with the knife pointed in the officer's direction."[16]

When a deadly force situation occurs, officers are trained to shoot to stop the threat. To do so, police must act quickly and efficiently or face the risk of serious bodily injury and/or death. Law enforcement officers are commonly taught the following tactical principals regarding the application of deadly force with a firearm:

- Police officers are taught to shoot and assess when discharging a firearm during a life-threatening encounter.
- Police officers are advised that their goal during a deadly confrontation should be to stop the threatening action of the subject.
- Police officers are instructed that the threatening behaviors of an assailant are generally not stopped by a single round fired by an officer.
- Police officers are cautioned that the threatening actions of a subject are not necessarily stopped when an involved assailant demonstrates movement to the ground.
- Police officers are taught that the immediate recognition of effective gunfire is often difficult to discern.
- Police officers are directed to target the center of a subject's available body mass when firing upon an assailant.[17]

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[16] April 25, 2019 Report of Corporal Kevin E. Selverian, pg. 16-17. (Appendix A)
[17] April 25, 2019 Report of Corporal Kevin E. Selverian, pg. 24. (Appendix A)

In split-second-decision-making-scenarios, officers are trained that it is not realistic to shoot at a hand or leg to neutralize a deadly threat. Medical research has found that "64% of gunshot victims with wounds to the chest and abdomen. . . can survive more than five minutes; some being able to perform strenuous activity and continue to physically fight."[18] Accordingly, for the safety of officers and others, police are trained to rapidly shoot until the threat is stopped. Officers are trained that an individual is most likely no longer a deadly threat when they fall to the ground or drop their weapon. In this case, Officer #1 stopped shooting when he saw Mr. Osagie falling.

Given the distance between Mr. Osagie and the officers and the speed at which Mr. Osagie was moving, Mr. Osagie had ample opportunity to inflict serious bodily injury and/or death to both officers. In particular, Officer #2 was exposed and unarmed at the time that Mr. Osagie turned toward Officer #2 with a knife up and out. The actions by Mr. Osagie posed an imminent and immediate threat of death or serious bodily injury to Officer #1 and Officer #2, and there was no time to use any other alternate means to stop the potentially deadly attack by Mr. Osagie.

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[18] April 25, 2019 Report of Corporal Kevin E. Selverian, pg. 25. (Appendix A)

At the time of this incident, the officers acted consistent with their training and were justified in the use of force, both in the deployment of the Taser and shooting of Mr. Osagie.

V. MENTAL HEALTH COMMITMENT PROCEDURES RELATIVE TO MR. OSAGIE

A. MENTAL HEALTH BACKGROUND REGARDING MR. OSAGIE

Some background on Mr. Osagie is necessary if one intends to review how the mental health process functioned in this case and whether it can be improved. Relevant to that inquiry, the following records were reviewed: prior police reports, Mount Nittany Medical Center records, Strawberry Fields records, Opportunity Center Clubhouse records, Penn State University Psychology Clinic records, The Meadows records, and records from Community Service Group.

These records established that Mr. Osagie had repeated contact with the legal and medical field dating back to 2009. Mount Nittany Medical Center records indicated that Mr. Osagie had been hospitalized for mental health issues on at least six occasions. He had a history of auditory hallucinations and paranoid delusions. In particular, Mr. Osagie thought that evil spirits were targeting him, and he had acted in the past in response to those delusions. These symptoms resulted in a number of incidents where threats and acts of violence to others occurred, which resulted in police and mental health intervention. Two of the

incidents involved Mr. Osagie brandishing a knife at members of the public when in a mental health crisis.

The above-referenced records also established a pattern of conduct where Mr. Osagie was non-compliant with his treatment and medication. When on medication, Mr. Osagie's symptoms appeared to be reduced and the risk of harm to others and himself minimized. From March 2016 until December 2018, Mr. Osagie lived in the Community Residential Rehabilitation Program and received a variety of services and support. These services appeared to be effective, as there were no records reviewed that reported threats or acts of violence from 2016 to 2018.

In December of 2018 when Mr. Osagie began to transition from the residential rehabilitation program to living independently, he became non-compliant with his treatment and medication. On January 16, 2019, he requested discharge from his peer support program. On February 11, 2019 Mr. Osagie's caseworker reported that Mr. Osagie was not doing well mentally. On February 27, 2019, Mr. Osagie ended services with CSG and Mobile Psych Rehab. At the time of the incident, Mr. Osagie was off his medication, not seeing a therapist, refusing to meet with his caseworker, refused to attend peer support programs, ended services with CSG and Mobile Psych Rehab, and was decompensating. It

was predictable that off his medication, Mr. Osagie's psychosis would return, and he would pose a threat to himself and others.

B. PENNSYLVANIA MENTAL HEALTH PROCEDURES ACT

The Pennsylvania Mental Health Procedures act was enacted on July 9, 1976. The act establishes procedures for the treatment of mentally ill persons. The procedures are to be applied consistently with the principles of due process to make voluntary and involuntary treatment available where the need is great and where the absence of treatment could result in serious harm to the mentally ill person or to others. 55 PA Code § 5100.3. The act applies to all involuntary treatment of mentally ill persons, whether inpatient or outpatient, and for all voluntary inpatient treatment of mentally ill persons. 55 PA Code § 5100.4.

1. Involuntary Commitment Statutes

Pennsylvania Statutes provide for involuntary commitment and treatment when a person is severely mentally ill and in need of immediate treatment. A person is severely mentally disabled when, as a result of mental illness, he poses a clear and present danger of harm to others or himself. 50 P.S. § 7301(a).

To establish a clear and present danger to another, the Statute requires that within the past thirty days the person has inflicted or attempted to inflict harm on another, and there is a reasonable probability it will happen again. Clear and

present danger to oneself is shown when in the last thirty days a person has made threats of suicide and taken action in furtherance of those threats.

Section 302 provides that an emergency examination may be conducted upon the certification of a physician or the issuance of a warrant. The warrant authorizes the police or any other authorized individual to transport the person to a designated facility. Once taken to a hospital, the individual must be examined, typically by an emergency room doctor, within two hours to determine whether he or she meets the criteria for involuntary commitment.

Section 303 provides for extended involuntary emergency treatment of an additional twenty days. Section 304 provides a period of involuntary commitment not to exceed an additional ninety days. The original conduct of danger to others or oneself must be proved, and it must be shown that the condition continues to present a clear and present danger. Under Section 305, one hundred and eighty days of additional involuntary commitment may be ordered if the condition still persists.

2. Assisted Outpatient Treatment (Effective Date 2/22/2019 – Not Available at Time of Incident)

A court may order assisted outpatient treatment when it is shown that: (a) a person is unlikely to survive safely in the community without supervision; (b) the person has a history of lack of voluntary adherence to treatment for mental illness

and one of the following applies: (i) within the last 12 months, the person's failure to adhere to treatment has resulted in involuntary inpatient hospitalization; or (ii) within the last 48 months the person's failure to adhere to treatment resulted in one or more acts of serious violent behavior toward others or himself, or threats of, or attempts at serious physical harm to others or himself.

C. APPLICATION OF MENTAL HEALTH PROCEDURES ACT TO MR. OSAGIE'S CASE

Mr. Osagie began to withdraw from treatment once he started living on his own. Over the course of two and a half months, his mental health deteriorated to the point where he was threatening to kill himself and others. Under Pennsylvania law, before action could be taken, Mr. Osagie's health had to deteriorate to the point where he posed a threat of imminent harm. Although Mr. Osagie had a history of previous hospitalizations, there needed to be an incident within the last thirty days in order to take action.

A concerned parent and professional described our legal structure as follows:

> "The laws in Pennsylvania are one of the strictest in the country to mandate a person to receive involuntary treatment. In Pennsylvania, the person must be an imminent threat to themselves or others. The threat must be in "crisis mode". Waiting this long for help has many unintended consequences. Other states and countries allow a doctor to determine the deterioration as justification for involuntary medical

treatment. Waiting for the crisis is often too late to actually receive help. The damage is done- to the person or others."[19]

In Mr. Osagie's case, had he been required to resume his medication, it is likely he would not have reached a point where he posed an immediate risk of danger to himself or others. Under Pennsylvania law, there was no mechanism for early intervention other than the 302 process. The 302 warrant in this case was granted on the grounds that Mr. Osagie posed a threat to himself, as evidenced by the text where he threatened to kill himself. The petition for the 302 warrant contained a copy of that text message. No other information regarding Mr. Osagie's previous legal or health issues were made available to police executing the warrant.[20] In previous contacts with police, Mr. Osagie had not threatened law enforcement or health providers.

Currently law enforcement is being called on to serve the majority of 302 warrants in Centre County. There has been a marked increase in 302 warrants over the last three years as follows:

7/2018 – 3/17/2019	163
Fiscal Year 2018	304
Fiscal Year 2017	57

[19] April 10, 2019 Email to Bernie Cantorna (Appendix J)

[20] While police can access criminal history information, previous mental health commitments are confidential. *50 P.S. § 711 Confidentiality of Records.*

The increase in warrants, and law enforcement being asked to serve these warrants, justifies a review of the 302 process from the protocol that Can Help uses, the information delivered to law enforcement and the process used to serve these warrants. In addition, Pennsylvania's Mental Health Statutes are restrictive in defining when a person can be involuntarily committed. Other jurisdictions allow for earlier intervention under different standards of proving dangerousness to oneself and others.[21]

In Pennsylvania, dangerousness required must be proved through acts that occurred within the last thirty days where a person has attempted to harm another or threatened suicide and taken action on those threats. At one time, most states required evidence of recent and overt acts or actions to establish that an individual posed a danger. Many states now allow prediction of future dangerousness based on recent behavior.[22] For example, Arizona allows a finding of dangerousness based on a doctor's opinion that the patient's continued behavior can be expected to result in serious physical harm.[23] South Dakota allows proof that a person is

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[21] See State Standards for Civil Commitments, *Treatment Advocacy Center* (Update July 2018). (Appendix G)
[22] Gordon, Sara G., "The Danger Zone: How the Dangerousness Standard in Civil Commitment Proceedings Harms People with Serious Mental Illness" (2016). *Scholarly Works*. Paper 911. http://scholars.law.unlv.edu/facpub/911. (Appendix H)
[23] See State Standards for Civil Commitments, *Treatment Advocacy Center* (Update July 2018) for a review of civil commitment statutes, CA, CT, ID, IL, IN. (Appendix G)

dangerous to himself or others based on treatment history and the person's recent acts or omissions. Some states like Alabama do not define dangerousness or include a timeframe; instead, the person must pose a threat of harm to himself or others.

There is an ongoing debate between civil libertarians and healthcare advocacy groups regarding the dangerousness standard of civil commitments.[24][25] The Osagie tragedy unfortunately thrusts Centre County into this debate and illustrates the challenges families face as a result of mental illness and Pennsylvania's legal structure.

It is beyond the scope of this report and the expertise of the District Attorney's Office to recommend improvements to local and state mental health procedures. It is our recommendation that a task force be created to address the question of how best to process 302 warrants and whether changes in the Pennsylvania Mental Health Commitment laws should be made. Such a task force should include representatives of the county mental health system, mental health

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[24] Gordon, Sara G., "The Danger Zone: How the Dangerousness Standard in Civil Commitment Proceedings Harms People with Serious Mental Illness" (2016). *Scholarly Works*. Paper 911. http://scholars.law.unlv.edu/facpub/911. (Appendix H)

[25] April 10, 2019 Email to Bernie Cantorna (Appendix J)

advocates and professionals, law enforcement, local government, and community members.

Bernie Cantorna
District Attorney

Megan A. McGoron
Integrity Officer

DATE: May 8, 2019

APPENDIX

A	April 25, 2019 Pennsylvania State Police Corporal Kevin E. Selverian Use of Force Report
B	April 26, 2019 Firearm and Tool Mark report from Pennsylvania State Police Bureau of Forensic Services.
C	302 Warrant
D	Text Message from Mr. Osagie to his father
E	Photographs
F	Information re: Crisis Intervention Team Program
G	"State Standards for Civil Commitment." *Treatment Advocacy Center. (July 2018.)*
H	Gordon, Sara G. "The Danger Zone: How the Dangerousness Standard in Civil Commitment Proceedings Harms People with Serious Mental Illness." *Scholarly Works. Paper 911. (2016.)*
I	Mental Health Procedures Act of July 9, 1976, P.L. 817, No. 143
J	April 10, 2019 Email to Bernie Cantorna

APPENDIX

A

PENNSYLVANIA STATE POLICE
Bureau of Training and Education
175 East Hersheypark Drive
Hershey, Pennsylvania 17033

Tel: (717) 533-9111
Fax: (717) 533-1201

April 25th, 2019

Bernie Cantorna
District Attorney
Centre County District Attorney's Office
Courthouse Annex – Room 302
106 East High Street
Bellefonte, PA 16823

Re: Officer-Involved Shooting of Osaze Osagie

Dear Mr. Cantorna,

In response to your request I have reviewed an abridged narrative of the referenced case and identified law enforcement training principals that are generally applicable to circumstances of this nature.

This correspondence shall serve as my expert report and expression of pertinent law enforcement teachings related to this incident.

Introduction

The following statements apply to this entire report and any related attachments:

Legal Advice or the Practice of Law: The expert services rendered in this case and this document do not constitute legal advice, and are not to be construed, in any way, as the practice of law. This expert report was developed by a law enforcement expert.

Report Focus: This report is focused solely on the captioned incident and associated concerns.

Case Specific Limitation: Any actions, statements, writings, reports, information, and testimony are specifically limited to this case.

Expert Capacity: This report and any subsequent reports, testimony, and opinions are provided within my capacity as an independent law enforcement defensive tactics instructor and use of force analyst.

Right to Amend: The opinions in this report are living opinions. Should additional discovery material be received, or additional research be completed and reviewed, these opinions may be altered or reinforced.

Further Development: The opinions expressed in this report are not necessarily final. Rather, they are documented to comply with current report requests. Each opinion may be further developed through research, investigation, during deposition or trial testimony.

Specific References: Some of the opinions in this report may cite specific materials reviewed or considered. These citations are not intended to be all inclusive. I specifically reserve the right to supplement the support for each of the opinions contained in this report.

Identified Issues: If new issues are identified, or developed after the submission of this report, I reserve the right to supplement this report.

Degree of Certainty: All opinions articulated in this report are in direct regard to the captioned case and are expressed to a reasonable degree of professional certainty.

Discussions and Explanations of Underlying Issues: Any discussion or explanation of the underlying issues are intended to assist the reader with his or her understanding of the concepts that inform my opinions in this matter. They reflect my applicable skills and knowledge, as gained through my experience, education, and training.

Credibility Determinations: Credibility determinations are solely and exclusively within the province of the trier of fact.

Expert Qualifications

The opinions expressed in this report are based upon my personal and professional knowledge, skill, experience, education, and training garnered over the past thirty (30) years. The following represents a summation of my personal and professional training and experience.

Formal Education: I have been awarded a Bachelor of Arts Degree in Criminal Justice from Moravian College. I have also earned several credit hours associated with a master's level Criminal Justice Administration program provided by West Chester University.

I successfully completed the Pennsylvania State Police Basic Training program. This program comprised approximately twelve hundred hours of law enforcement training.

Professional Experience: I am currently a full-time law enforcement officer and have been employed by the Pennsylvania State Police for a period of twenty-four (24) years. During my employment with the Pennsylvania State Police I have served in a variety of capacities in relation to several professional assignments.

I have held a position as a Patrol Section member within the Pennsylvania State Police. This assignment included service as a first responder and the provision of proactive patrol duties. I responded to over one thousand calls for service and was responsible for the investigation of incidents; such as, traffic accidents, assaults, public disturbances, thefts, property crimes, missing persons, and drug related offenses. I also effectuated hundreds of arrests associated with unlawful activities while serving in this capacity.

I have served as a Criminal Investigation Section member within the Pennsylvania State Police. During this assignment I investigated hundreds of significant criminal incidents. These included the investigation of incidents; such as, criminal homicides, physical assaults, sexual assaults, child abuse cases, kidnappings, officer-involved shootings, thefts, property crimes, drug offenses, and fraud related cases. I effectuated numerous arrests for misdemeanor and felony grade offenses. The responsibilities of this position required a practical understanding of criminal law and procedure, as well as, the competent application of recognized investigative measures.

I have held several positions within the Pennsylvania State Police Bureau of Training and Education. I have served as a defensive tactics instructor within the Basic Training Section at the Pennsylvania State Police Academy, as an in-service instructor at the Pennsylvania State Police Southeast Regional Training Center, and I am currently assigned as a Use of Force Specialist within the department's Use of Force Unit.

While assigned to the Basic Training Section I trained hundreds of Pennsylvania State Police cadets. Topics of instruction included defensive tactics, the appropriate application of force, physical conditioning, and first aid. The defensive tactics taught addressed areas such as hands-on control techniques, the application of deadly and less-lethal force options, proper handcuff / restraint procedures, vehicle removal techniques, weapon retention / disarming, and edged weapon defense.

During my assignment within the Advanced Regional Training Section and Use of Force Unit I have trained thousands of municipal, state, and federal law enforcement officers regarding a wide array of topics and continue to provide instruction to Pennsylvania State Police cadets in both classroom and tactical settings. The focus of much of this training surrounds the instruction of recognized defensive tactics related to deadly and less-lethal force options, the lawful application of force, and the proper implementation of criminal investigative techniques.

My duties within the Bureau of Training and Education have allowed me to contribute to the development of numerous department use of force training programs. I have authored multiple use of force related lesson plans, consulted during the formation and revision of department policies, and contributed to an inter-department use of force publication.

During my assignment within the Bureau of Training and Education I have conducted over one-hundred comprehensive analyses related to a variety of application of force cases. These examinations have addressed officer-involved shootings, conducted electrical weapon (TASER) deployments, oleoresin capsicum deployments, ASP baton deployments, legal interventions, and the application of hands-on control techniques.

In this capacity, I have provided analysis and consultation to agencies such as the Pennsylvania State Police, municipal police departments, the Pennsylvania Attorney General's Office, and several Pennsylvania District Attorneys' Offices.

I have given testimony and expert opinion related to police use of force matters in the Pennsylvania Court of Common Pleas, Coroner's Inquest, and Pennsylvania State Police Arbitration Hearings.

Throughout my career I have also been attached to various details outside the scope of my regularly assigned duties. These included the participation in fugitive apprehension details, aggressive patrol assignments, security force, and wiretap / surveillance details. I have also performed protection duties for visiting dignitaries to the Commonwealth of Pennsylvania.

Professional Training and Certifications: I have attended more than five thousand hours of law enforcement training during my career with the Pennsylvania State Police. The majority of this training addressed matters related to recognized defensive tactics, the lawful application of force, and the proper investigation and analysis of significant use of force events.

I currently hold instructor-level certifications related to the implementation of a variety of deadly and less-lethal force options, to include: firearm, conducted electrical weapon, oleoresin capsicum, ASP baton, handcuff, and hands-on control tactic certifications. I am also currently certified as an advanced specialist in the behavioral analysis of force encounters.

Incident Circumstances

The following represents the abridged narrative of the referenced incident that was provided by the Centre County District Attorney's Office:

On March 19, 2019 a 302 warrant was issued for Osaze Osagie. That warrant was based on information received from Mr. Osagie's father. Mr. Osagie was reported missing and had a history of anxiety and schizophrenia. It was also reported that he was probably off his medication. The text message stated that Mr. Osagie would have trouble with the police, that he would die and that he might kill others in the process.

Mr. Osagie told his father in a telephone conversation that he was going to die. He also sent a text message to a case worker indicating that he would die very soon.

On March 20, 2019, Osaze Osagie was spotted at the local Weis grocery store, walking in the direction of his apartment. Officer #1 was dispatched to respond and check on Mr. Osagie. Officers #2 and #3 arrived at the scene to assist. All officers had CIT (Crisis Intervention Training). I have attached photos of the stairway leading down to Mr. Osagie's apartment and the hallway in front of his door. The hallway is approximately 3' wide and 7' long. Mr. Osagie's door opens out and measures 2' 7" wide.

Officer #1 positioned himself in front of the apartment door. Officer #2 was on the first step of the stairs leading down to the landing and Officer #3 was approximately half way up the stairs. Officer #1 knocked on the door and waited. He did not announce any police presence and knocked a second time. Eventually someone said, "I'm coming". Officer #1 had covered the peep hole, so Mr. Osagie would not be alerted to the police presence.

Officers heard the tumbler of the lock being opened and the door slowly opened into the hallway. Officer #1 asked whether the person answering the door was Mr. Osagie, who answered "yes". At the time he opened the door, his right hand was out of view, up against the interior wall and not visible. His arm was at approximately shoulder height. Officer #1 asked if he could come in and talk and Mr. Osagie responded "no". The Officer then asked, "do you want to come out and talk to us". Mr. Osagie responded "no".

At that point in time, Mr. Osagie stepped back, and a knife was visible in his right hand. The knife was being held out at shoulder level, with the blade pointing out at Officer #1. Officer #1 drew his weapon with his right hand and told Mr. Osagie to drop the knife. Mr. Osagie said words to the effect of "shoot me" while the Officer repeatedly told him to drop the knife and began moving backwards to put distance between himself and Mr. Osagie.

At approximately the same time, Officer #3 told Officer #2 to Taser Mr. Osagie. As Officer #2 activated his Taser and brought it to bear, Mr. Osagie ran to his right, the Officer's left, so he was out of the line of fire of the Taser. As Mr. Osagie stepped to the right, he stated he wanted to die. Seconds later Mr. Osagie became visible, running forward with a knife out towards Officer #1. He was described as running as fast as a human can run. As soon as Mr. Osagie was visible to Officer #2, he attempted to shoot him with his Taser, believing he had missed.

Officer #1 retreated past Officer #2's position on the stairs. He shot four times. As he was shooting, he was leaning and falling backwards, having tripped on the steps to his left. Officer #1 estimates that when he first saw the knife, Mr. Osagie stepped back and was approximately six feet from the officer's position.

Officer #2 estimates he shot his Taser approximately three feet from Mr. Osagie.

Materials Reviewed

The opinions in this case are based upon an examination of the following materials:

- An abridged narrative of the captioned case provided by the Centre County District Attorney's Office.
- Tennessee v. Garner, 471 U.S. 1, 11 (1985)
- Graham v. Connor, 490 U.S. 386, 396-97 (1989)
- *Plakas v. Drinski*, 19 F.3d 1143 (7th Cir. 1994)
- *Scott v. Edinburg*, 346 F. 3d 752 (7th Cir. 2003)
- *Menuel v. City of Atlanta*, 25 F. 3d 990 (11th Cir. 1994)
- Bumgarner, J., Lewinski, W., Hudson, W., & Stapp, C. (2006). An examination of police officer mental chronometry: "I swear… I don't know how I shot him in the back." *Journal of The Association for Crime Scene Reconstruction*, 12, 11-26.
- Dysterheft, J.L., Lewinski, W.J., Seefeldt, D.A., & Pettitt, R.W. (2013) The influence of start position, initial step type, and usage of a focal point on sprinting performance *International Journal of Exercise Science,* 6, 320-327.
- Honig, A., Lewinski, W.J. (2008). A survey of the research on human factors related to lethal force encounters: Implications for law enforcement training, tactics, and testimony. *Law Enforcement Executive Forum*, 8(4), 129-152.
- Lewinski, W.J., Redmann, C. (2009). New developments in understanding the behavioral science factors in the "stop shooting" response. *Law Enforcement Executive Forum*, 9(4), 35-54.
- Lewinski, W.J., Hudson, W.B. (2003). Time to start shooting? Time to stop shooting? The Tempe Study. *The Police Marksman*, 5, 26-29.
- Lewinski, W.J., Hudson, W.B., & Dysterheft, J.L. (2014). Police officer reaction time to start and stop shooting: The influence of decision-making and pattern recognition. *Law Enforcement Executive Forum*, 14(2), 1-16.
- Lewinski, W.J., Dysterheft, J.L., Bushey, J.M., & Dicks, N.D. (2015). Ambushes leading cause of officer fatalities – when every second counts: analysis of officer movement from trained ready tactical positions. *Law Enforcement Executive Forum*, 15(1), 1-15.

- Remsberg, C. (2006). Why Shooting to Wound Doesn't Make Sense Scientifically, Legally or Tactically. *FSI News*, 3, 1-6.

Incident Analysis

The analysis of this incident was based upon a request to address the following relevant issues:

- Law enforcement training protocols common to the instruction of Pennsylvania Criminal Justification Statute.
- Law enforcement training protocols common to the instruction of the Objective Reasonableness Standard set forth by constitutional requirement.
- Law enforcement training protocols related to the dynamics and threats posed by an edged weapon attack.

All opinions and related information expressed in this report are predicated upon the facts and circumstances contained in the previously referenced narrative provided by the Centre County District Attorney's Office.

Pennsylvania Criminal Justification Statute

Law enforcement officers are generally provided with the subsequent direction in relation to Pennsylvania Criminal Justification Statute:

Section 508 of the Pennsylvania Crimes Code (Title 18 PaCS) provides peace officers with the legal justification to apply that force which is necessary to achieve an enumerated purpose. The content of this statute outlines a peace officer's authority to utilize necessary force in the following circumstances:

- 508 (a) Peace Officer's Use of Force in Making Arrest
- 508 (c) Use of Force Regarding Escape
- 508 (d) Use of Force to Prevent Suicide or the Commission of Crime

In the present case Officer #1 reportedly utilized deadly force upon Mr. Osagie in an apparent attempt to protect himself and / or others from significant harm.

Section 508 (a) of the Pennsylvania Crimes Code reads as follows:

§ 508. Use of force in law enforcement.

(a) Peace officer's use of force in making arrest.

(1) A peace officer, or any person whom he has summoned or directed to assist him, need not retreat or desist from efforts to make a lawful arrest because of resistance or threatened resistance to the arrest. He is justified in the use of any force which he believes to be necessary to effect the arrest and of any force which he believes to be necessary to defend himself or another from bodily harm while making the arrest.

However, he is justified in using deadly force only when he believes that such force is necessary to prevent death or serious bodily injury to himself or such other person, or when he believes both that:

(i) such force is necessary to prevent the arrest from being defeated by resistance or escape; and

(ii) the person to be arrested has committed or attempted a forcible felony or is attempting to escape and possesses a deadly weapon, or otherwise indicates that he will endanger human life or inflict serious bodily injury unless arrested without delay.

The above standards authorize police officers to use deadly force to protect themselves or another from what they reasonably believe to be an imminent danger of death or serious bodily injury.

These standards also allow police officers to use deadly force in their efforts to effect an arrest or prevent a subject's escape when there is probable cause to believe that the person to be arrested poses a threat of death or serious bodily injury to themselves or another person.

Police officers are routinely directed to consider several factors when determining whether a reasonable belief or the probable cause to believe a threat of death or serious bodily injury to themselves or another exists. These factors include:

- Whether the subject possesses the ability or means to carry out a threat of death or serious bodily injury upon another person;
- Whether the subject possesses the opportunity to inflict serious bodily injury or cause the death of another person;
- Whether the subject poses an imminent or immediate threat of death or serious harm to another person; and
- Whether issues related to preclusion have been considered and deemed unwarranted.

Whether the subject possesses the ability or means to carry out a threat of death or serious bodily injury upon another person:

Police officers are directed to evaluate whether a subject possesses the weapon(s) and / or physical ability necessary to carry out a threat of death or serious bodily injury upon another person.

The evidence in the present case revealed:

- Mr. Osagie brandished a knife in his right hand.
- Mr. Osagie ran in the direction of the responding officers.
- Mr. Osagie was described as, "running as fast as a human can run."
- Mr. Osage pointed the referenced knife at Officer #1 as he moved toward the officer's location.

Law enforcement officers are routinely instructed that knives represent a type or category of lethal weapon. The Pennsylvania State Police defines a lethal weapon as any firearm, whether loaded or unloaded, or any device designed as a weapon and capable of producing death or serious bodily injury, or any other device or instrumentality which, in the manner in which it is used or intended to be used, is calculated or likely to produce death or serious bodily injury.

The circumstances of the present case demonstrated that Mr. Osagie was in possession of an item commonly regarded as a lethal weapon.

Mr. Osagie also exhibited behaviors that would lead a reasonable police officer to believe that he was physically capable of causing the death or serious bodily injury to another person with the referenced weapon.

Whether the subject possesses the opportunity to inflict serious bodily injury or cause the death of another person:

Police officers are instructed to identify whether a subject, in possession of the ability to cause harm, is within striking distance to inflict serious bodily injury or cause the death of another person.

The evidence in the instant case revealed that the reported encounter between Mr. Osagie and the responding police officers occurred at close range and in a confined environment.

- Officer #1 estimated that he and Mr. Osagie were separated by approximately six (6) feet when he initially observed a knife in Mr. Osagie's hand.

- The hallway in which this incident occurred measured approximately seven (7) feet in length and three (3) feet in width.

Police officers are taught that resistant subjects can often traverse significant distances in relatively short periods of time. In an effort to emphasize this principal, in relation to edged weapon assaults, law enforcement officers are advised that an armed and motivated assailant may be capable of:

- Traversing a distance of five (5) feet, while initiating a slashing motion with an outstretched arm, in approximately 1/3 of a second.

- Traversing a distance of nine (9) feet, while initiating a slashing motion with an outstretched arm, in approximately 2/3 of a second.

- Traversing a distance of twelve (12) to fifteen (15) feet, while initiating a slashing motion with an outstretched arm, in approximately one (1) second.

The above teachings are supported by peer-reviewed research and will be addressed further at a later point in this report.

The results of the referenced research combined with the factual and environmental circumstances of the present event established that Mr. Osagie was afforded the opportunity to cause substantial harm to the responding police officers.

Whether the subject poses an imminent or immediate threat of death or serious harm to another person:

Police officers are taught to consider whether a subject has taken a significant step toward initiating a threat of death or serious bodily injury to another person.

The evidence in the present case disclosed:

- Mr. Osagie brandished a knife in his right hand.

- Mr. Osagie failed to comply with repeated verbal commands to drop the knife.

- Mr. Osagie uttered words to the effect of "shoot me."

- Mr. Osagie ran toward Officer #1 with the knife pointed in the officer's direction.

Law enforcement officers are instructed that a subject's rapid movement toward themselves or another person while brandishing an edge weapon commonly represents a significant step toward the initiation of a substantial threat.

The nature of a comparable threat posed to a police officer becomes particularly dangerous when the circumstances of the event fail to afford the officer with sufficient time, distance, and / or opportunity to engage in necessary tactical response behaviors including, but not limited to:

- The execution of lateral and / or rearward movement practices intended to maintain or increase the distance between himself and a subject in possession of an edged weapon.

- The acquisition of sufficient cover or concealment that would otherwise place an object between himself and a subject wielding an edged weapon.

The environmental conditions and reported speed of the assault in the present case appeared to make it difficult for the responding officers to efficiently incorporate the referenced tactical response behaviors.

The reported actions of Mr. Osagie during the present incident would lead a reasonable police officer to believe that a significant step toward a threat of death or serious bodily injury had been initiated.

Whether issues related to preclusion have been considered and deemed unwarranted:

Police officers must determine if the use of deadly force is necessary based upon the facts and circumstances known to them at the time of application.

Law enforcement officers are taught to consider the legal and tactical applicability of less-lethal force options and exclude them as viable alternatives before resorting to lethal measures.

The evidence in the present case revealed:

- Officer #1 discharged his firearm four times in an apparent effort to stop Mr. Osagie's threatening and assaultive actions.

- Officer #2 deployed his TASER (conducted electrical weapon) on one occasion in an apparent effort to stop Mr. Osagie's threatening and assaultive actions.

Law enforcement officers are routinely directed to utilize less-lethal force options to protect themselves and others from a threat of bodily injury and to employ deadly force when necessary to protect themselves and others from a reasonably perceived threat of death or serious bodily injury. This instruction is provided to ensure officer adherence to current legal and tactical protocols associated with the appropriate application of force.

The circumstances of the current incident demonstrated that Mr. Osagie took a significant step toward causing the death or infliction of serious bodily injury upon another in a manner that required the use of deadly force by Officer #1 in an effort to stop the referenced action.

It should be noted that Officer #2 implemented a TASER deployment in an attempt to control Mr. Osagie, despite no legal obligation to utilize a less-lethal force option. The apparent ineffectiveness of this option highlighted tactical concerns and deficiencies associated with the application of less-lethal force in circumstances similar to those encountered by the responding officers during the present event.

Federal Circuit Courts of Appeal have repeatedly supported the law enforcement direction that police officers are not required to employ less-lethal means of control when the use of deadly force would otherwise be justified.

In *Plakas v. Drinski*, the 7th Circuit Court of Appeals held:

- If the actions of the suspect justify the use of deadly force, a police officer is not required to use less-lethal force before employing deadly force.

- "There is no precedent in this Circuit (or any other) which says that the Constitution requires law enforcement officers to use all feasible alternatives to avoid a situation where deadly force can justifiably be used."

- "There are, however, cases which support the assertion that, where deadly force is otherwise justified under the Constitution, there is no constitutional duty to use non-deadly alternatives first."

In Scott v. Edinburg, the 7th Circuit Court of Appeals held:

- "We have rejected that position and stated, '[w]e do not believe that the Fourth Amendment requires the use of the least or even a less deadly alternative so long as the use of deadly force is reasonable under Tennessee v. Garner and Graham v. Connor...." Edinburg, 346 F. 3d at page 760.

In Menuel v. City of Atlanta, the 11th Circuit Court of Appeals held:

- "... 'where deadly force is otherwise justified under the Constitution, there is no constitutional duty to use non-deadly alternatives first..."

- "The Fourth Amendment does not require officers to use the least or even less intrusive alternatives in search and seizure cases.' ..."

Objective Reasonableness Standard

Police officers are routinely taught that every manner of force utilized by an officer in relation to the seizure of a citizen must be objectively reasonable.

This standard is derived from court interpretation of constitutional restrictions contained in the 4th Amendment of the U.S. Constitution and Article 1 Section 8 of the Pennsylvania Constitution

Tennessee v. Garner:

In the case of Tennessee v. Garner, the U.S. Supreme Court provided the following guidance:

- Apprehension by the use of deadly force is a seizure subject to the Fourth Amendment's reasonableness requirement.
- To determine whether such a seizure is reasonable, the extent of the intrusion on the suspect's rights under that Amendment must be balanced against the governmental interests in effective law enforcement.
- This balancing process demonstrates that, notwithstanding probable cause to seize a suspect, an officer may not always do so by killing him.

The related points of emphasis common to law enforcement training include:

- Applications of deadly force must be objectively reasonable based upon the totality of circumstances surrounding its use.
- Objective Reasonableness in relation to the application of deadly force is generally satisfied when:
    - The suspect poses an imminent threat of serious bodily harm or death to an officer or some other person who is present; or
    - An officer has probable cause to believe that the suspect has committed a violent felony involving the infliction or threatened infliction of serious bodily harm or death and by his or her escape poses a danger of serious bodily harm or death to others; and.
    - A warning should be given when feasible.

Graham v. Connor:

In the case of Graham v. Connor, the U.S. Supreme Court provided the following guidance:

- All claims that law enforcement officials have used excessive force -- deadly or not -- in the course of an arrest, investigatory stop, or other "seizure" of a free citizen are properly analyzed under the Fourth Amendment's "objective reasonableness" standard, rather than under a substantive due process standard.

- The Fourth Amendment "reasonableness" inquiry is whether the officers' actions are "objectively reasonable" in light of the facts and circumstances confronting them, without regard to their underlying intent or motivation.

- The "reasonableness" of a particular use of force must be judged from the perspective of a reasonable officer on the scene, and its calculus must embody an allowance for the fact that police officers are often forced to make split-second decisions about the amount of force necessary in a particular situation.

- The "reasonableness" of a particular use of force must be judged from the perspective of a reasonable officer on the scene, rather than with the 20/20 vision of hindsight.

- The test of reasonableness under the Fourth Amendment is not capable of precise definition or mechanical application.

- However, its proper application requires careful attention to the facts and circumstances of each particular case. Including the severity of the crime at issue, whether the suspect poses an immediate threat to the safety of the officers or others, and whether he is actively resisting arrest or attempting to evade arrest by flight.

- As in other Fourth Amendment contexts, however, the "reasonableness" inquiry in an excessive force case is an objective one:

- The question is whether the officers' actions are "objectively reasonable" in light of the facts and circumstances confronting them, without regard to their underlying intent or motivation.

- An officer's evil intentions will not make a Fourth Amendment violation out of an objectively reasonable use of force; nor will an officer's good intentions make an objectively unreasonable use of force constitutional.

Police officers are routinely taught that a determination regarding the appropriateness of force requires that careful attention be paid to the entirety of facts and circumstances known to the involved officer(s) at the time of application, to include:

- An assessment of the severity of crime at issue;
- Whether the subject poses an immediate threat to the safety of the officers or others; and
- Whether the subject is actively resisting arrest or attempting to evade arrest by flight.

Severity of Crime at Issue:

Police officers are directed to consider the classification and inherent nature of the relevant offense(s) or interaction related to an incident involving the use of force.

Law enforcement officers are taught that the severity of an offense or interaction is best distinguished by the actual or probable degree of violence, danger, and / or injury associated with the incident.

In the present case the involved officers reportedly responded to the scene based upon the following information:

- On 03/19/19, a mental health warrant was issued for Mr. Osagie.
- The mental health warrant was based on information received from Mr. Osagie's father.
- Mr. Osagie was reported missing and had a history of anxiety and schizophrenia.
- It was also reported that Mr. Osagie was probably not taking his prescribed medication.
- Mr. Osagie had sent a text message stating that he would have trouble with the police, that he would die, and that he might kill others in the process.
- Mr. Osagie told his father in a telephone conversation that he was going to die.
- Mr. Osagie also sent a text message to a case worker indicating that he would die very soon.
- On 03/20/19, Mr. Osagie was seen in the area of a local Weis grocery store and was walking in the direction of his apartment.

- Officer #1 was dispatched to respond and check on Mr. Osagie.

- Officers #2 and #3 arrived at the scene to assist.

The above information would likely cause a reasonable officer to conclude that Mr. Osagie was in a state of crisis at the time of this incident. Crisis situations generally comprise interactions with non-rational subjects and / or those experiencing a heightened state of emotion.

Law enforcement officers are routinely advised that the proper care of an individual in crisis often hinges upon a timely intervention. Police officers are also commonly cautioned that the circumstances of a crisis situation can be unpredictable, and they should be prepared to properly contend with any threat or danger that may arise.

At the outset of their encounter with Mr. Osagie, the responding officers did not appear to have knowledge of an overt act committed by the subject that would constitute a serious offense or interaction in the context of the referenced standard.

However, as the circumstances of this event unfolded the severity of the interaction substantially escalated. Mr. Osagie's act of charging Officer #1 with a knife in hand, would certainly provide a reasonable officer with the probable cause to believe that the subject had engaged in a violent felony involving the infliction or threatened infliction of serious bodily harm or death.

Immediate Threat to the Safety of Officers or Others:

Police officers are instructed to identify and consider the probable threats and dangers posed to them and / or others during an event.

Law enforcement officers are prompted to evaluate relevant factors, such as: officer - offender size and ability, the presence of pre-assault indicators, the possession and availability of weapons, the number of officers and subjects, pertinent environmental conditions, and officer - offender disabilities.

The facts and circumstances pertinent to an analysis of the nature of the threat posed to the responding police officers by Mr. Osagie included, but were not necessarily limited to:

- Mr. Osagie had a history of anxiety and schizophrenia.

- Mr. Osagie was probably not taking his prescribed medication.

- Mr. Osagie had sent a text message stating that he would have trouble with the police, that he would die, and that he might kill others in the process.

- The reported encounter between Mr. Osagie and the responding police officers occurred at close range and in a confined environment.

- Mr. Osagie brandished a knife in his right hand.
- Mr. Osagie failed to comply with repeated verbal commands to drop the knife.
- Mr. Osagie uttered words to the effect of "shoot me."
- Mr. Osagie ran toward Officer #1 with the knife pointed in the officer's direction.

As previously stated within this report, the combination of the above facts and circumstances demonstrated that Mr. Osagie posed an immediate threat of death or serious bodily injury to the responding police officers at the time of the referenced shooting.

Active Resistance or Attempted Flight:

Police officers are instructed to consider the manner and degree of any resistance or attempted flight exhibited by a subject.

The points of emphasis commonly presented during law enforcement instruction include; recognition of resistance and flight considerations, the legal authority to overcome resistance or prevent flight, and the probable danger or injury resulting from various manners of resistance and flight.

Police officers are taught to recognize the level of a subject's resistance and the probable dangers associated with the related behaviors. The various levels of subject resistance include:

- Psychological Intimidation
- Verbal Non-compliance
- Passive Resistance
- Active Resistance
- Active Aggression
- Aggravated Active Aggression

The subject's conduct during this incident would best be categorized as aggravated active aggression. This level of resistance is often defined as physical force exhibited by a subject which, under the circumstances in which it is used, is readily capable of causing death or serious bodily injury to another person.

It should be noted, that the officers involved in the present case possessed the legal authority to seize Mr. Osagie in relation to the referenced mental health warrant. The officers also possessed the authority to use deadly force once it became necessary to overcome resistance that was readily capable of causing death or serious bodily to themselves and their fellow officers.

Edged Weapon Attack

The following sections of this report address the requested law enforcement teachings related to the dynamics of an edged weapon assault. The information contained in these sections appear to be relevant to the present incident and may have influenced the performance of the involved officers.

Nature and Speed of Assault:

As previously discussed within this report, police officers are taught that resistant subjects can often traverse significant distances and initiate an edged weapon assault in relatively short time frames.

Law enforcement officers are frequently advised that an armed and motivated assailant may be capable of:

- Traversing a distance of five (5) feet, while initiating a slashing motion with an outstretched arm, in approximately 1/3 of a second.

- Traversing a distance of nine (9) feet, while initiating a slashing motion with an outstretched arm, in approximately 2/3 of a second.

- Traversing a distance of twelve (12) to fifteen (15) feet, while initiating a slashing motion with an outstretched arm, in approximately one (1) second.

The above information represents a combination of the results of a research study designed to identify average assailant sprint speeds (Lewinski, Dysterheft, Seefeldt, & Pettitt, 2013) and the average distance spanned by a subject when standing with an outstretched arm.

Police officers are routinely encouraged to engage in lateral and / or rearward movement practices, intended to maintain or increase the distance between themselves and a subject in possession of a weapon, when confronted by an edged weapon attack. However, they are reminded that an assailant's forward movement will often far outpace an officer's lateral or rearward movement.

In an effort to emphasize the above tactical principal, police officers are commonly exposed to the results of the previously referenced research study which revealed:

- In approximately 2/3 of a second the average participant was able to sprint approximately seven (7) feet in forward direction versus four feet in a rearward direction.

- In approximately one (1) second the average participant was able to sprint approximately fifteen (15) feet in forward direction versus nine (9) feet in a rearward direction.

- In approximately 1 ½ (1.5) seconds the average participant was able to sprint approximately twenty-five (25) feet in forward direction versus fourteen (14) feet in a rearward direction.

Speed of Response:

Law enforcement officers are regularly provided with the following points of instruction regarding officer response time to a threat of death or serious bodily injury.

- The threatening and assaultive action(s) of an armed assailant are often faster than the response time of an involved officer.

- It takes time for a law enforcement officer to start and stop firing a weapon in response to the initiation and subsequent cessation of a perceived threat.

    - A period of more than 1/2 second will often elapse from the time an officer recognizes a threat of death or serious bodily injury until he or she is able to fire one round from a pistol.

    - A police officer will frequently fire two or more rounds from a pistol following his or her recognition of a change in a subject's threatening or assaultive behavior.

- A police officer's response time relative to a deadly threat tends to increase as the movements required of the officer become more complex.

- A police officer will often be capable of firing multiple rounds from a pistol at a rate of one round per 1/4 of a second.

The scientific study of how quickly the human mind and body can and do react to stimuli, known as mental chronometry, goes back at least to the middle part of the 19th Century (Bumgarner, Lewinski, Hudson, & Stapp, 2006). Based upon human behavior and performance research it has long been known that action is generally faster than reaction and it takes time for a human being to start and stop a behavior in response to relevant circumstances.

The analysis of the human components of reaction time, indicates that several well-studied principles are in operation in every officer-involved shooting. These principles are connected to perception (the act of seeing and understanding a stimulus), processing (the act of making sense of what is seen and making decisions based upon these observations) and reaction (the act of responding to what is seen and processed) (Lewinski & Hudson, 2003).

The below described research study examined the above principles:

In this study, issues surrounding the time to start and stop shooting were examined. (Bumgarner, Lewinski, Hudson, & Stapp, 2006). The present study was a compilation of experiments conducted with over one-hundred police officers from a large department in the southwestern United States. The experiments sought to measure, amongst other things:

- The reaction time to a visual stimulus.
- The time it takes to stop pulling a trigger.
- Simple decision-making.

Reaction Time to a Visual Stimulus: The first experiment involved the use of a stimulus board that was placed in front of each participating officer. The stimulus board was a 10"x 10" square and displayed a pattern of clusters of light on the face of it. There were 9 clusters of lights on the square board (3 rows containing 3 clusters each) and each cluster contained 3 LED indicators.

While viewing the board, officers were asked to grip a modified Glock training pistol (with a trigger pull weight of 4.5 kg / 9.9 lbs.). The pistol was fitted with an electronic device to capture trigger pull data and record it in a computer. Officers were instructed to observe the light clusters in the upper left quadrant of the stimulus board. They were told to pull the trigger once, as quickly as possible, when a particular green light was illuminated.

The average trigger pull reaction for the participating officers, upon viewing the green light, was 0.31 seconds. Broken down further, it took an average of 0.25 seconds to mentally process that the light was on and decide to pull the trigger; it took 0.06 seconds to mechanically pull the trigger.

The Time it Takes to Stop Pulling the Trigger: During the second phase of the study the officers were instructed that the researchers were measuring the officer's ability to pull the trigger rapidly. The officers were asked to repeatedly pull the trigger as quickly as possible when the light on the stimulus board came on. However, they were also instructed to stop pulling the trigger immediately upon the light going off. In fact, they were misinformed that any extra trigger pulls after the light stopped illuminating would count against their overall score. As such, this experiment modestly added the elements of on-going attention and motivation.

On average, participating officers stopped pulling the trigger within 0.35 seconds from when the light went off. Approximately 68% of the officers (one standard deviation) fell within the range of 0.10 and 0.60 seconds to cease pulling the trigger and many officers did pull the trigger more than once after the light went off. On average, officers completed a minimum of one trigger pull and were starting a second after the stop signal occurred.

Another result of the second experiment revealed that the participants, when performing the directed continuous action, demonstrated an average of 0.28 seconds between consecutive trigger pulls.

Simple Decision-Making: The third experiment was an attempt to understand the impact of simple decision-making and visual complexity on reaction time. This experiment was an extension of the first in that this experiment added confounding elements to the simple determination of whether a light was illuminated. The element of a "go / no-go" decision requirement was one such addition.

In the first experiment, the illumination of the green light in the upper left corner (the only light to be illuminated) was all one needed to pull the trigger. In the third experiment, officers were instructed that a cluster of lights may be illuminated anywhere on the top line of the board. Further, they were only to pull the trigger when all three lights in a cluster were illuminated. They were not to pull the trigger if only two lights of a cluster came on.

The requirement of go / no-go decision-making in this experiment essentially doubled the reaction times observed in the first experiment. This is consistent with other reaction time literature.

The average time for the participating officers to identify the illumination of 3-light clusters, react to it, and actually pull the trigger was 0.56 seconds. If you remove the 0.06 seconds to mechanically pull the trigger, then the average time to perceive the light cluster, mentally process it, and decide to pull the trigger was 0.50 seconds (as compared to 0.25 seconds in the first experiment).

The primary purpose of the referenced research study was to examine the basic reaction, movement time, and decisions of police officers in response to simple stimuli to better understand the limitations of human performance in trained professionals in the cleanest, simplest laboratory situation (Lewinski, Hudson, & Dysterheft, 2014).

As previously mentioned, the study discovered that the average time in which an officer could stop shooting in response to a simple change in external circumstances, when he or she was actively engaged in the process of starting to shoot or actually shooting until the threat stops, was 0.35 seconds, with most of the officers (68%) taking up to 0.60 seconds (Lewinski & Redmann, 2009).

Because the average time for the average officer to cycle through trigger pulls on a Glock while firing multiple rounds was approximately a quarter of a second per trigger pull, this data means that the average officer can react to the simplest external stimulus to shoot serially and back off the trigger pull after firing two rounds when the stimulus is extinguished. This, of course, varies with at what point in the trigger pull sequence the officer detects the change (Lewinski & Redmann, 2009).

This study informs us that when the average officer stops shooting based solely on a perception of change in the outside world, the fastest the officer is able to do this is 0.35 seconds or the completion of one full trigger pull cycle and the completion of the second shot by pulling the trigger to the back of the trigger stop, resulting in two shots being fired (Lewinski & Redmann, 2009).

Due to the simplicity of the stimulus in this study (a single light going on or off), the researchers were able to obtain the fastest reaction time possible for the average officer to respond to anything and that includes both starting and stopping shooting. Any other type of reaction or response in any other circumstance is going to take the officer longer. This is generally due to the following:

- The laboratory test was the simplest challenge the officer could face, and it doesn't get any simpler than light on and light off.
- Actual shooting situations on the street often demand much more complex decision-making to both starting and stopping shooting than tested in the lab.
- These sometimes profoundly complex perceptual and decision-making processes can also be significantly emotionally laden and that can profoundly complicate and subsequently increase the time for the perception of a change in the threat and the resulting decision and reaction to stop shooting (Lewinski & Redmann, 2009).

The results of a separate study revealed increased officer response times when more complex movements were required of the participating officers (Lewinski, Dysterheft, Bushey, & Dicks, 2015). The study demonstrated that the average officer was able to fire a single round from the referenced trained ready tactical positions (in response to a start signal) in the following time periods:

- Weapon on target, indexed finger: 0.51 seconds
- Weapon in snapped holster: 1.82 seconds
- Weapon in holster to interview hip position: 1.44 seconds
- Weapon at low ready, indexed finger and aimed shot: 0.97 seconds
- Weapon at low ready, indexed finger and point shot: 0.64 seconds

- Weapon at high ready, indexed finger and aimed shot: 0.83 seconds

Street encounters are more visually and auditorily complex than the test conditions in the laboratory and often require the officer to see and hear many things simultaneously. This requires the officer to select the most important thing to focus on and hopefully this also turns out to be the most important factor(s) for the officer's safety and ultimate survival on the street and in the legal aftermath. For instance, an officer who is focused on a front sight placement will not be able to immediately see a change in the assailant's threat action and therefore will sometimes shoot many more rounds after the threat has changed or stopped (Lewinski & Redmann, 2009).

On the other hand, an officer who is focused on the subject and not their own gun sights will also be unable to stop immediately, but because of his or her focus, he or she may be able to stop sooner to a change in the behavior of the subject he or she is shooting at than an officer who is not focused on the subject. Unfortunately, this officer may also be very inaccurate with his or her shots. Simply stated, an officer must be focused on the behavior of the subject that changes if he or she is going to be able to react to that change as quickly as possible (Lewinski & Redmann, 2009).

In the laboratory, it was very clear that the light would go off and the officer would then be required to stop pulling the trigger. Most officers in an actual firefight do not know if or when the threat they are facing will cease or whether they will die before the threat stops. This primes their reaction to continue until a "noticeable" change occurs in "their perception" of the threat. If the "noticeable" change is different than what the officer expects or what occurs at a different location than the one the officer is focused on—that in and of itself will lengthen the officer's reaction time to stop shooting (Lewinski & Redmann, 2009).

One might logically conclude that if an officer cannot accurately see something that he or she needs to, the officer might have to first "focus" on it (visual and attentional focus takes time) to "clarify" that the officer is seeing what he or she believes he or she is seeing (this takes time); "make a decision" about it (this takes time); and, then, "stop" doing what he or she is doing. This simple illustration of the components of a stop shooting reaction informs us that the act of putting on the brakes on a motor activity like shooting takes time, particularly under conditions of intense focus as might occur when an officer is shooting to save his or her own life (Lewinski & Redmann, 2009).

Some officers might skip some or all of these steps, but for those who engage in all of them, the total time to stop shooting in a visually complex, dynamic, rapidly unfolding circumstance as most officer-involved shootings are, could be a total of the following approximate time factors: shift and focus (1/4 of a second), clarify (1/4 of a second), decision (1/4 to 1/2 of a second or more) and stop shooting (1/4 to 1/3 of a second). If one totals up the numbers, he or she can see that an officer who engages sequentially in all the proceeding steps can take a second to a second and a half or more to stop shooting. Measured in trigger pulls, which are occurring at a quarter of a second each, this is an extra four to six rounds after the threat stops (Lewinski & Redmann, 2009).

In summary, scientific and practical limitations governing human performance must be considered when evaluating an officer's performance. Reaction time includes both the processing of information as well as the time it takes to physically respond. In a shooting scenario, processing takes about four times longer than the actual response phase. This applies to both the initial processing of information that ultimately drives the officer's actions as well as the processing of any change in information intended to cease the officer's current course of action (Honig & Lewinski 2008).

To react, an officer must first perceive a threat, which will typically result from processing the actions of the suspect and then determining the appropriate response. The suspect, however, will by then already have moved in to the shorter response phase (e.g., pulling the trigger or charging with a knife), resulting in action always being faster than reaction. The greater the intensity of focus on a prior stimulus at the time of stimulus change, the longer it will take the officer to notice and respond to the change, including ceasing fire. Increasing the complexity of the scenario further increases the response lag. In practical terms, this will frequently result in it being physically impossible for an officer to immediately cease fire upon cessation of a threat (Honig & Lewinski 2008).

Tactical Response

Law enforcement officers are commonly taught the following tactical principals regarding the application of deadly force with a firearm.

- Police officers are taught to shoot and assess when discharging a firearm during a life-threatening encounter.
- Police officers are advised that their goal during a deadly confrontation should be to stop the threatening action of the subject.
- Police officers are instructed that the threatening behaviors of an assailant are generally not stopped by a single round fired by an officer.
- Police officers are cautioned that the threatening actions of a subject are not necessarily stopped when an involved assailant demonstrates movement to the ground.
- Police officers are taught that the immediate recognition of effective gunfire is often difficult to discern.
- Police officers are directed to target the center of a subject's available body mass when firing upon an assailant.

Shoot and Assess: Law enforcement officers are taught to shoot and assess during pertinent events and their goal should be to stop the threatening action of the subject. Officers are advised that once a subject's threatening actions have been halted, they are required to de-escalate or cease their application of force.

The training method of shoot and assess evolved and became more popular as more was understood in the law enforcement community regarding the actual stopping power of a bullet and the kind of circumstances officers confront when attempting to save their lives or the lives of others by means of lethal force (Lewinski & Redmann, 2009).

Generally, suspects are not stopped by a single round fired by an officer. Medical research has determined that 64% of gunshot victims with wounds to the chest and abdomen and 36% of those with wounds to the head and neck can survive more than five minutes, some even able to perform strenuous activity and to continue to physically fight (Lewinski, Hudson, & Dysterheft, 2014).

Recent research has also revealed that even novice shooters can fire at least three rounds in 1.5 seconds and, as previously discussed, an assailant with an edged weapon can often traverse significant distances in brief periods of time Therefore, the safest way for an officer to respond in a firefight is to shoot and continue to shoot accurate shots on target until the threat stops (Lewinski & Redmann, 2009).

Movement to the Ground: A subject's movement to the ground following an officer's discharge of a weapon will often be viewed as significant change in behavior. However, analysis of the manner in which people fall has revealed that it frequently takes 2/3 of a second to a full second or more for a person to fall to the ground from a standing position. It should be noted that this data is only applicable to those circumstances in which a subject has been struck in a motor center and the resulting effect is the instant loss of muscle tension (Remsberg, 2006). If a subject is struck elsewhere incapacitation may not occur or take significantly longer.

Generally, while an officer is noticing the referenced change, he is going to continue to fire if he is shooting as fast as he can under the stress of trying to save his own life or that of another. On average, from the time an officer perceives a change in stimulus to the time he is able to process that information and actually stop firing, two (2) to three (3) additional rounds will be expended. Therefore, shooting beyond the moment a threat is neutralized tends not to be a willful or malicious act; rather, in most cases, it is an involuntary consequence related to human dynamics (Remsberg, 2006).

Police officers are also instructed that the threatening actions of a subject are not necessarily stopped when an involved assailant demonstrates movement to the ground. Officers are cautioned that an assailant may remain a significant threat while falling to or on the ground, and this movement may be the result of a subject's attempt to gain a tactical advantage in relation to a deadly assault.

Effective Gunfire: Law enforcement officers are advised that the immediate recognition of effective gunfire is often difficult to discern. In other words, officers involved in shooting events routinely have difficulty determining whether their rounds are striking their intended target and causing the desired effect of incapacitation. This perceptual reality can certainly influence an officer's performance, particularly in relation to the time it takes an officer to stop shooting during a related incident.

Targeting Center Mass: Police officers are directed to target the center of a subject's available body mass when firing upon an assailant. This is due to the fact that center mass, most commonly denoted by a subject's torso, tends to represent the largest and most stable target for an officer attempting to stop an assailant's threatening and / or assaultive actions during a deadly force encounter.

Some members of society have taken issue with the above direction and asked questions; such as, "Do police officers really have to kill people when they shoot them?" and "Couldn't they be more humane and just aim for arms or legs?" Many experts in the field of law enforcement feel that there are several practical problems to a shoot to wound requirement, and this standard would encourage practices contrary to the realities of human behavior and performance.

The following information is drawn from a respected professional periodical and provides an illustration of some of the issues associated with a shoot to wound requirement (Remsberg, 2006).

Human Dynamics and Anatomy: The hands and arms can be the fastest moving parts of the body. For example, an average suspect can move his hand and forearm across his body to a 90-degree angle in 12/100 of a second and move his hand from his hip to shoulder height in 18/100 of a second. Conversely, the average officer pulling the trigger of a Glock semi-automatic pistol, one of the fastest cycling semiautomatic pistols manufactured, as fast as possible, requires approximately 1/4 of a second to discharge each round. Therefore, it would be unrealistic to expect an officer to react, track, shoot, and reliably hit a threatening suspect's forearm or a weapon in a suspect's hand in the time spans involved.

Even if the suspect were to hold his weapon arm steady for half a second or more, an accurate hit would be highly unlikely and in police shootings the suspect and his weapon are seldom stationary. In addition, the officer himself may be moving as he discharges his weapon, thus further reducing the expected accuracy of fire.

The upper arms of the body tend to move more slowly than the forearms and hands. However, when shooting at the upper arms of an assailant an officer runs a greater chance of striking the subject's brachial artery or torso. Wounds to these areas are associated with a high probability of fatality, so then, virtually eliminating the proposed benefits of a shoot to wound requirement.

The legs of the body tend to move slower than arms and to maintain more static positions. However, areas of the lower trunk and upper thigh are rich with vascularity. A suspect who is struck by a round in this area can "bleed out" in seconds if one of the major arteries is severed, so again, shooting to wound may not result in just wounding the suspect.

On the other hand, if an officer manages to incapacitate a suspect's legs in a non-fatal manner, that still leaves the offender's hands free to shoot or initiate some other manner of assault. The suspect's ability to threaten lives has not necessarily been stopped.

Legal Concerns: A shoot to wound mandate would not be legally valid because it sets a standard far beyond that established by Graham v. Connor, the benchmark U.S. Supreme Court decision regarding police use of force. Recognizing that violent encounters are tense, uncertain and rapidly evolving, the court does not require officers to use the least intrusive method of forcefully controlling a threatening suspect, but only what is reasonable. When an officer's life or that of a third party appears in jeopardy, shooting can be justified as reasonable.

By legal definition, the possible consequences of deadly force include both death and great bodily harm. The law has never broken these two consequences apart. Any time you fire a firearm, there's a substantial risk of great bodily harm or death. The law doesn't even so much as suggest that deadly force should be "just enough" to wound but with no probability of death. That's plain wrong legally and tactically and sends the wrong message.

Tactical Issues: Modern training teaches that when an officer uses deadly force, the intent should be to stop the suspect's threatening behavior as fast as possible. Like it or not, this is most reliably done by disrupting the central nervous system, by inducing severe hemorrhaging and / or by destroying skeletal integrity or bone structure.

Shooting for an assailant's center mass is usually considered the most effective first option, because the upper torso combines a concentration of vital areas and major blood vessels within the body's largest target area. When the risk of failure is death, an officer needs the highest percentage chance of success he can get.

A requirement to instead shoot for a smaller and faster-moving arm or leg with the intent to wound rather than to incapacitate invites a myriad of tactical dilemmas, such as:

- An officer's survival instinct may exert an overpowering influence on target selection causing him to aim at center mass rather than an arm or leg.
- Poor shot placement is bound to increase due to the increased probability of inaccurate rounds being fired.
- The use of an otherwise appropriate weapon, such as shotguns with a wide spread pattern, might be discouraged.
- Shots to the arms and legs could be dangerous to people besides the suspect because of a greater likely hood of through-and-through penetration.
- Shots to the arms and legs that don't persuade an offender to quit and leave the officer or others in peril.

- Shooting to wound reflects a misapplication of police equipment.

TASER Deployment:

A Conducted Electrical Weapon (TASER) is generally defined as a less-lethal weapon, which uses propelled wires and probes or direct contact to conduct energy through a subject, thereby affecting the subject's sensory and motor nervous system.

The effectiveness of a TASER deployment is directly linked to its' ability to stimulate the normal electrical impulses of a subject's sensory and motor nervous systems. The sensory nervous system consists of the nerves that connect the sensors of the body (eyes, ears, skin, etc.) to the brain. The motor nervous system consists of the nerves that go out from the spinal cord and connect to the muscles controlling muscle movements.

The adequate stimulation of these motor nerves will cause involuntary and uncontrollable muscle contractions that inhibit a subject from being able to perform coordinated physical movements. This restriction of movement is referred to as neuro-muscular incapacitation.

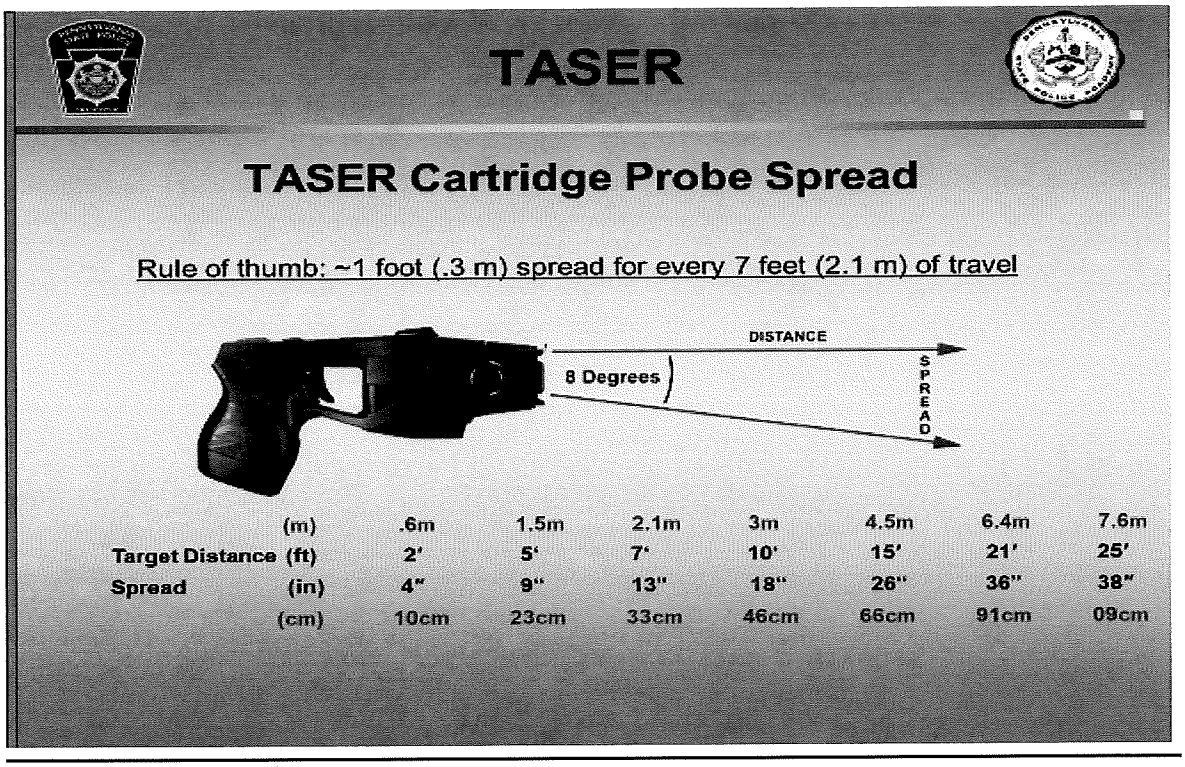
Law enforcement officers are provided with the following instruction regarding neuro-muscular incapacitation:

- There are different levels of neuro-muscular incapacitation ranging from limited area effects to significant body lockup.
- The greater the probe spread, the higher likelihood of creating sufficient neuro-muscular incapacitation
- A Conducted Electrical Weapon deployment may not foster total neuro-muscular incapacitation.
- A subject may maintain muscle control during a deployment, particularly in the arms and legs, depending on many factors including probe location and spread.

In the present case, Officer #2 estimated that he deployed his TASER upon Mr. Osagie from a distance of approximately three (3) feet. The abridged narrative relied upon for this report appeared to contain an implication that the referenced deployment proved to be ineffective in halting the actions of Mr. Osagie. Based upon these case facts and the information documented below, one would estimate that a deployment from the cited distance would result in a probe spread of just under six (6) inches.

Police officers are granted the following direction and guidance concerning the tactical deployment of a Conducted Electrical Weapon.

- The effectiveness of a Conducted Electrical Weapon deployment is directly related to probe spread and probe location
    - Greater probe spreads typically increase the effectiveness of a deployment.
    - A minimum twelve (12) inch probe spread is optimal.
    - A probe spread of less than twelve (12) inches will often result in limited or no neuro-muscular incapacitation.
    - Probe spreads under four (4) inches typically create a pain-only effect.
    - Probe spreads tend to be more effective if one probe is above and the other probe is below the beltline.
    - A deployment, utilizing a TASER X26P equipped with a standard 25' foot cartridge, will result in approximately one (1) foot of spread between probes for every seven (7) feet of travel from the device. (Reference below diagram)



- The following circumstances are commonly cited causes of an ineffective Conducted Electrical Weapon deployment.

    - Miss or single dart hit
    - Incomplete, broken, or intermittent circuit
    - Loose or thick clothing worn by the subject
    - Low nerve or muscle mass hit
    - Obese subject
    - Limited probe spread
    - Wires break
    - Operator error

This represents the conclusion of the requested report, if you have any concerns that require further attention please contact me at your convenience.

Respectfully,

CPL KL

Corporal Kevin E. Selverian
Use of Force Specialist
Pennsylvania State Police
Bureau of Training and Education

APPENDIX

B

PENNSYLVANIA STATE POLICE
BUREAU OF FORENSIC SERVICES

Harrisburg Regional Laboratory
1800 Elmerton Avenue
Harrisburg, PA 17110-9718
717-783-5554

Firearm and Tool Mark

CASE: HOMICIDE
LAB REPORT: H19-03374-3
DATE: March 20, 2019
REPORT DATE: April 26, 2019
PLACE: State College Borough, Centre County, Pennsylvania
INCIDENT NO.: PA2019-354397
FROM: PSP Rockview
SUBJECT: Osagie, Osaze O. (Victim)

SUBMISSION: Items 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16 and 17 were submitted by Timothy Guenot on March 22, 2019.
Item 18 was submitted by Timothy Guenot on March 29, 2019.

Items 16.1.1 and 18.1.2 were submitted by Nicholas L. Scianna of Harrisburg Regional Laboratory on April 23, 2019.

ITEMS:

1	**One (1) sealed envelope**
1.1	One (1) discharged FC headstamped (Federal) cartridge case, caliber: 9mm Luger, marked: S-1.
1.2	One (1) discharged and mutilated metal-jacketed bullet, marked: N-1.
2	**One (1) sealed envelope**
2.1	One (1) mutilated metal bullet jacket fragment, designated: N-2.
2.2	One (1) discharged FC headstamped (Federal) cartridge case, caliber: 9mm Luger, marked: S-2.
2.3	One (1) discharged and mutilated metal-jacketed bullet, marked: N-3.
4	**One (1) sealed envelope**
4.1	One (1) discharged FC headstamped (Federal) cartridge case, caliber: 9mm Luger, marked: S-3.
4.2	One (1) discharged FC headstamped (Federal) cartridge case, caliber: 9mm Luger, marked: S-4.
4.3	One (1) discharged and mutilated metal bullet jacket fragment, marked: N-4.
5	**One (1) sealed envelope**
5.1	One (1) mutilated lead fragment, marked: N-5.
6	**One (1) sealed envelope**
6.1	One (1) magazine for use with Item 14.1, marked: NLS-1.
6.2	Thirteen (13) undischarged FC headstamped (Federal) cartridges, caliber: 9mm Luger, marked: L-1 through L-13 respectively. NOTE: L-1 and L-2 were test fired during examinations of Item 14.1.
7	**One (1) sealed envelope**
7.1	One (1) magazine for use with Item 14.1, marked: NLS-2.
7.2	Fifteen (15) undischarged FC headstamped (Federal) cartridges, caliber: 9mm

Luger, marked: L-14 through L-28 respectively.

8	**One (1) sealed envelope**
8.1	One (1) magazine for use with Item 16.1, marked: NLS-3.
8.2	Seventeen (17) undischarged FC headstamped (Federal) cartridges, caliber: 9mm Luger, marked: L-29 through L-45 respectively. NOTE: L-29 through 31 were test fired during examinations of Item 16.1. L-32 was disassembled for comparison purposes. L-33 through L-45 were test fired using Item 16.1 during the creation of known distance test patterns.
9	**One (1) sealed envelope**
9.1	One (1) magazine for use with Item 16.1, marked: NLS-4.
9.2	Seventeen (17) undischarged FC headstamped (Federal) cartridges, caliber: 9mm Luger, marked: L-46 through L-62 respectively. NOTE: L-46 through L-49 were test fired using Item 16.1 during the creation of known distance test patterns.
10	**One (1) sealed envelope**
10.1	One (1) magazine for use with Item 16.1, marked: NLS-5.
10.2	Thirteen (13) undischarged FC headstamped (Federal) cartridges, caliber: 9mm Luger, marked: L-63 through L-75 respectively.
11	**One (1) sealed envelope**
11.1	One (1) magazine for use with Item 15.1, marked: NLS-6.
11.2	Eighteen (18) undischarged FC headstamped (Federal) cartridges, caliber: 9mm Luger, marked: L-76 through L-93 respectively. NOTE: L-76 and L-77 were test fired during examinations of Item 15.1.
12	**One (1) sealed envelope**
12.1	One (1) magazine for use with Item 15.1, marked: NLS-7.
12.2	Seventeen (17) undischarged FC headstamped (Federal) cartridges, caliber: 9mm Luger, marked: L-94 through L-110 respectively.
13	**One (1) sealed envelope**
13.1	One (1) magazine for use with Item 15.1, marked: NLS-8.
13.2	Seventeen (17) undischarged FC headstamped (Federal) cartridges, caliber: 9mm Luger, marked: L-111 through L-127 respectively.
14	**One (1) sealed box**
14.1	One (1) Glock semiautomatic pistol, model: 17 Gen4, caliber: 9x19, serial number: ZTZ871, marked: NLS. NOTE: As received, Item 14.1 was equipped with night sights.
15	**One (1) sealed box**
15.1	One (1) Glock semiautomatic pistol, model: 17 Gen4, caliber: 9x19, serial number: ZTZ908, marked: NLS. NOTE: As received, Item 15.1 was equipped with night sights.
16	**One (1) sealed box**
16.1	One (1) Glock semiautomatic pistol, model: 17 Gen4, caliber: 9x19, serial number: ZTZ880, marked: NLS. NOTE: As received, Item 16.1 was equipped with night sights.

ITEMS:

16.1.1 **One (1) sealed envelope**
16.1.1 Chemical test results of gunshot residue test patterns created using Item 16.1 and L-33 through L-49 of Items 8.2 and 9.2 respectively.

17 **One (1) sealed envelope**
17.1 One (1) discharged and mutilated metal-jacketed bullet, marked: N-6.
17.2 One (1) discharged and mutilated metal-jacketed bullet, marked: N-7.

18 **One (1) sealed paper bag**
18.1 One (1) Champs Sports Gear (CSG), grey thermal long-sleeve shirt, size: Large, marked: NLS-9. NOTE: As received, Item 18.1 was covered with dried blood.
18.1.1 Debris removed from Item 18.1, designated: X1 through X4 respectively.

18.1.2 **One (1) sealed envelope**
18.1.2 Chemical test results of gunshot residue examinations conducted on Item 18.1 (NLS-9).

CONCLUSIONS:

1 Examinations showed Items 14.1, 15.1 and 16.1 to be functional and capable of discharging the type of ammunition for which each was manufactured.

2 Examinations showed the weights of trigger pull to be approximately as follows: Item 14.1 - 5.8 pounds; Item 15.1 - 5.6 pounds; Item 16.1 - 5.6 pounds.

3 Examinations showed Items 1.1 (S-1), 2.2 (S-2), 4.1 (S-3) and 4.2 (S-4) were discharged within Item 16.1.

4 Examinations showed Items 1.2 (N-1), 2.3 (N-3), 4.3 (N-4), 17.1 (N-6) and 17.2 (N-7) were discharged from Item 16.1.

5 Examinations showed Item 2.1 (N-2) to be a mutilated metal bullet jacket fragment of no value for comparison purposes.

6 Examinations showed Item 5.1 (N-5) to be a mutilated lead fragment of no value for comparison purposes.

7 The area around the hole in the left side of the rear panel of Item 18.1 (NLS-9) was microscopically examined and chemically processed for the presence of gunshot residue and a pattern of residue was found. Using Item 16.1 and ammunition contained in Items 8.2 and 9.2, test patterns of gunshot residue were created at known distances for comparison purposes. Examinations showed the pattern of residue at this area of Item 18.1 (NLS-9) was created at an approximate muzzle-to-garment distance of greater than six (6) inches and less than twenty-four (24) inches.

8 The area around the hole in the right side of the rear panel of Item 18.1 (NLS-9) was microscopically examined and chemically processed for the presence of gunshot residue and a pattern of residue was found. Using Item 16.1 and ammunition contained in Items 8.2 and 9.2, test patterns of gunshot residue were created at known distances for comparison purposes. Examinations showed the pattern of residue at this area of Item 18.1 (NLS-9) was created at an approximate muzzle-to-garment distance of greater than twelve (12) inches and less than thirty

(30) inches.

9 The area around the hole in the left shoulder area of the rear panel of Item 18.1 (NLS-9) was microscopically examined and chemically processed for the presence of gunshot residue and a pattern of residue was found. Using Item 16.1 and ammunition contained in Items 8.2 and 9.2, test patterns of gunshot residue were created at known distances for comparison purposes. Examinations showed the pattern of residue at this area of Item 18.1 (NLS-9) was created at an approximate muzzle-to-garment distance of greater than twelve (12) inches and less than thirty-six (36) inches.

10 The area around the hole below the collar of the front panel of Item 18.1 (NLS-9) was microscopically examined and chemically processed for the presence of gunshot residue. Examinations showed the physical effects at this area to be consistent with the passage of a bullet.

11 The test fired bullets and cartridge cases from L-1 and L-2 of Item 6.2, L-29 through L-31 of Item 8.2, and L-76 and L-77 of Item 11.2 should be retained by the submitting agency for possible future examinations.

12 The disassembled components from L-32 of Item 8.2 should be retained by the submitting agency for possible future examinations.

13 The test fired cartridge cases from L-33 through L-45 of Item 8.2, and L-46 through L-49 of Item 9.2 should be retained by the submitting agency for possible future examinations.

14 Items 16.1.1 and 18.1.2 should be retained by the submitting agency for possible future examinations.

PLEASE ARRANGE FOR DISPOSITION OF THE EVIDENCE WITHIN THIRTY (30) DAYS.

Cpl. N[illegible]

Nicholas L. Scianna, III, Corporal
Firearm & Tool Mark Examiner
Harrisburg Regional Laboratory

ATTN: Thomas M. Stock

APPENDIX

C

19560 4228

APPLICATION FOR INVOLUNTARY EMERGENCY EXAMINATION AND TREATMENT

Mental Health Procedures Act of 1976
Section 302

(THE BLANKS BELOW MAY BE COMPLETED FOLLOWING ADMISSION.)

NAME Last	First	Middle	AGE	SEX
OSAGIE	OSAZE		30	MALE
ADDRESS [redacted]				
CENTRE	NAME OF BSU MHID		BSU NUMBER [redacted]	
NAME OF FACILITY	ADMISSION DATE		ADMISSION NUMBER	

INSTRUCTIONS

1. Part I must be completed by the person who believes the patient is in need of treatment If this person is not a physician, police officer, the County Administrator or his delegate, he or she must request authorization or a warrant through the County Administrator.

2. If the authorization or a warrant through the County Administrator is required, call or visit the Office of the County Administrator. Authorization to take a patient for examination without a warrant is to be documented in Part II. If a warrant is required, Part III must be completed by the County Administrator or a person designated by the Administrator to sign the warrants.

3. When the patient is taken to the examination facility, the rights described in Form MH 783-A must be explained. Part IV should be signed by the person who explains these rights to the patient.

4. Part V is to be completed by the County Administrator (or representative) or by the Director of the Facility (or representative) upon arrival of the patient at the facility.

5. Part VI is to be completed by the examining physician.

6. If additional sheets are required at any point in completing this form, note on this form the number of additional sheets which are attached.

7. If the patient is subject to criminal proceedings/detention, briefly describe below.

IMPORTANT NOTICE

ANY PERSON WHO PROVIDES ANY FALSE INFORMATION ON PURPOSE WHEN HE COMPLETES THIS FORM MAY BE SUBJECT TO CRIMINAL PROSECUTION AND MAY FACE CRIMINAL PENALTIES INCLUDING CONVICTION OF A MISDEMEANOR.

Part I
APPLICATION

I believe that OSAZE OSAGIE
(PERSON'S NAME)

is severely mentally disabled: (Check and complete all applicable for this patient)

A person is severely mentally disabled when, as a result of mental illness, his/her capacity to exercise self-control, judgment and discretion in the conduct of his/her affairs and social relations or to care for his/her own personal needs is so lessened that he/she poses a clear and present danger of harm to others or to himself or herself.

☐ Clear and present danger to others shall be shown by establishing that within the past 30 days the person has inflicted or attempted to inflict serious bodily harm on another and that there is reasonable probability that such conduct will be repeated. A clear and present danger of harm to others may be demonstrated by proof that the person has made threats of harm and has committed acts in furtherance of the threat to commit harm; or

Clear and present danger to himself shall be shown by establishing that within the past 30 days;

☐ (i) the person has acted in such manner as to evidence that he/she would be unable, without care, supervision and the continued assistance of others, to satisfy his/her need for nourishment, personal or medical care, shelter, or self-protection and safety, and that there is reasonable probability that death, serious bodily injury or serious physical debilitation would ensue within 30 days unless adequate treatment were afforded under the act; or

☒ (ii) the person has attempted suicide and that there is reasonable probability of suicide unless adequate treatment is afforded under this act. For the purpose of this subsection, a clear and present danger may be demonstrated by the proof that the person has made threats to commit suicide and has committed acts which are in furtherance of the threat to commit suicide; or

☐ (iii) the person has substantially mutilated himself/herself or attempted to mutilate himself/herself substantially and that there is the reasonable probability or mutilation unless adequate treatment is afforded under this act. For the purposes of this subsection, a clear and present danger shall be established by proof that the person has made threats to commit mutilation and has committed acts which are in furtherance of the threat to commit mutilation.

Describe in detail the specific behavior within the last 30 days which supports your belief (include location, date and time whenever possible, and state who observed the behavior):

Osaze has been acting erratically for about two weeks; the way he typically acts when he is off his medication. Today he sent me a very long incoherent text threatening to kill himself and hurt others. He cut off the call I had with him, ended the call by saying that he was going to die

I understand that I may be required to testify at a court hearing concerning the information I gave.

On the basis of the information I gave above, I believe that OSAZE OSAGIE
(PERSON'S NAME)

is in need of involuntary examination and treatment. I request that: (Check A or B - Notice that B can only be checked by a physician, a police officer, the County Administrator or his/her delegate).

A. ☒ The County Administrator issues a warrant authorizing a policeman or someone representing the County Administrator to take the patient to a facility for examination and treatment.

[redacted] Osagie — 3/17/19
SIGNATURE OF APPLICANT — DATE

[redacted] OSAGIE [redacted]
PRINT NAME AND ADDRESS OF APPLICANT — TELEPHONE NO.

B. ☐ That this facility examine the patient to determine his/her need for treatment.

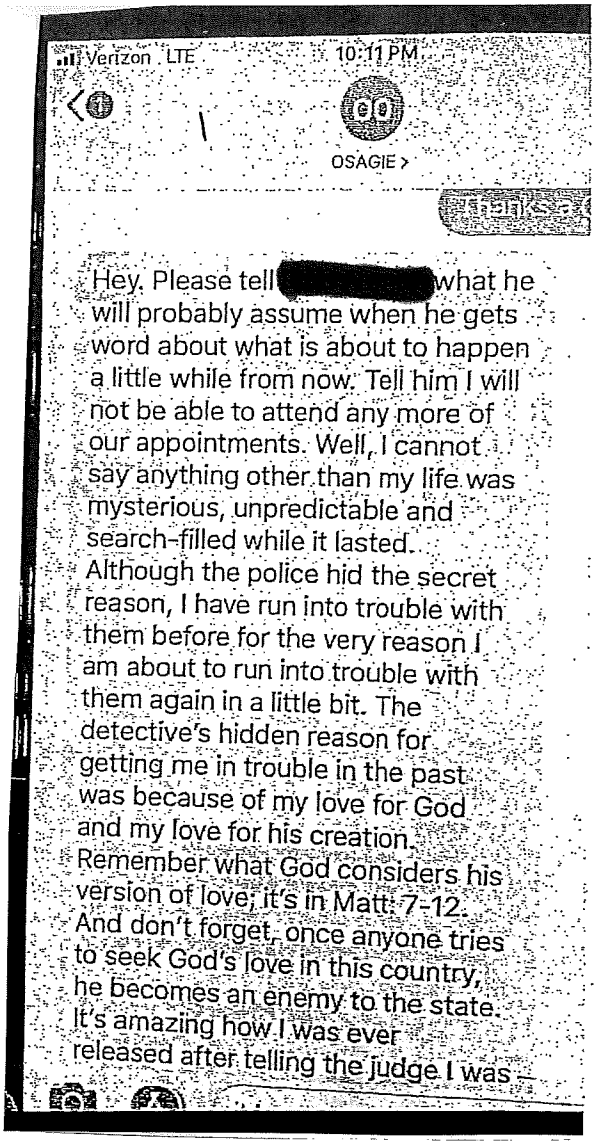
SIGNATURE OF PHYSICIAN, POLICE OFFICER COUNTY ADMINISTRATOR, OR REPRESENTATIVE — DATE

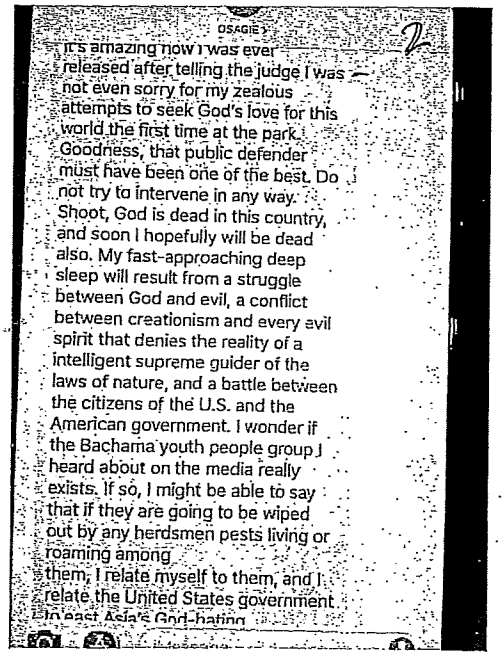
PRINT NAME AND TILE OF PHYSICIAN, POLICE OFFICER COUNTY ADMINISTRATOR, OR REPRESENTATIVE — TELEPHONE NO.

ADDRESS

APPENDIX

D

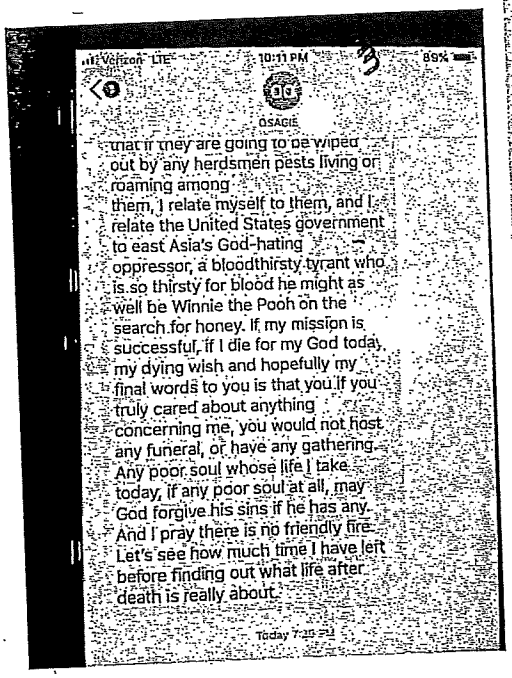




(No subject)

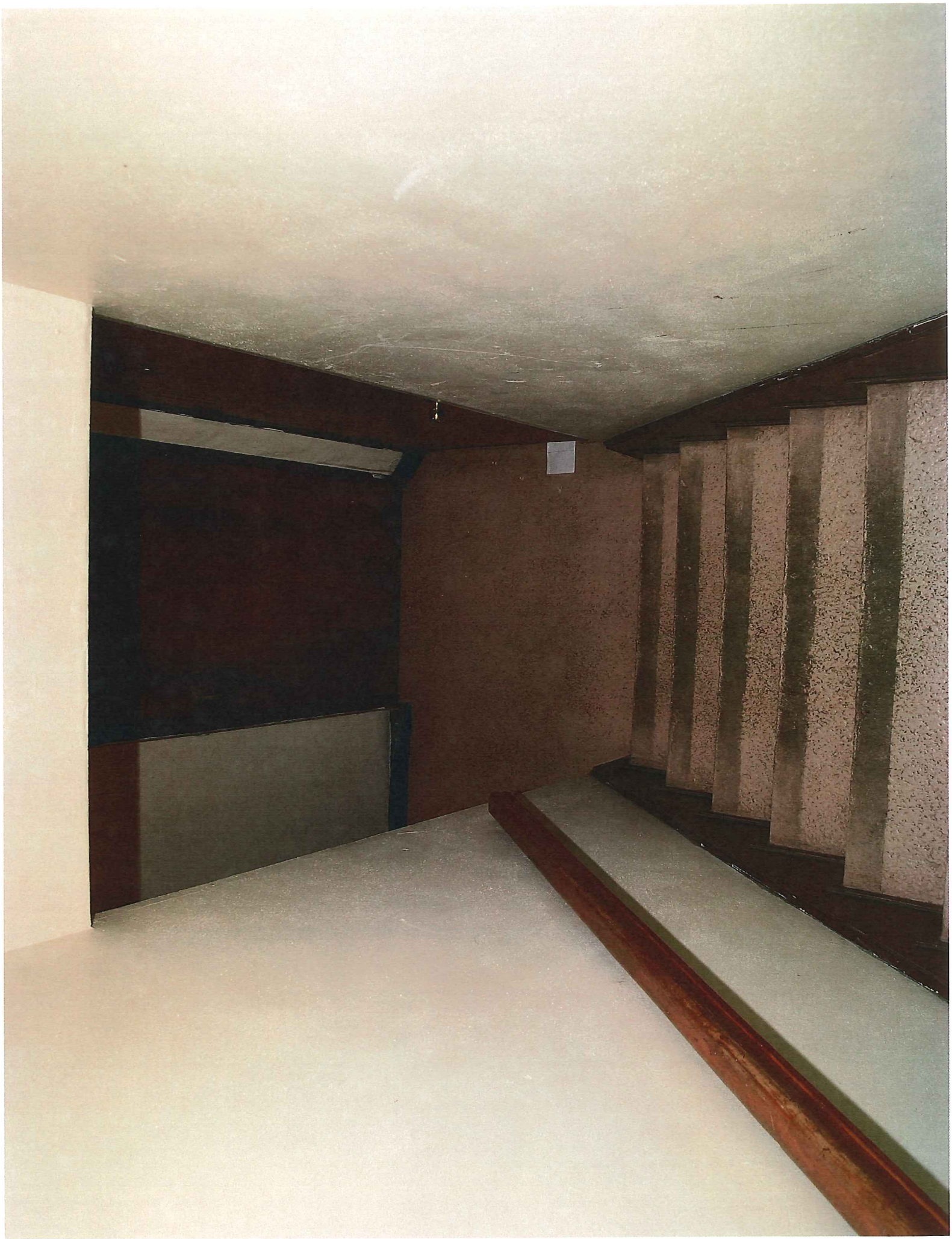
[redacted]

Today, 6:13 AM



APPENDIX

E

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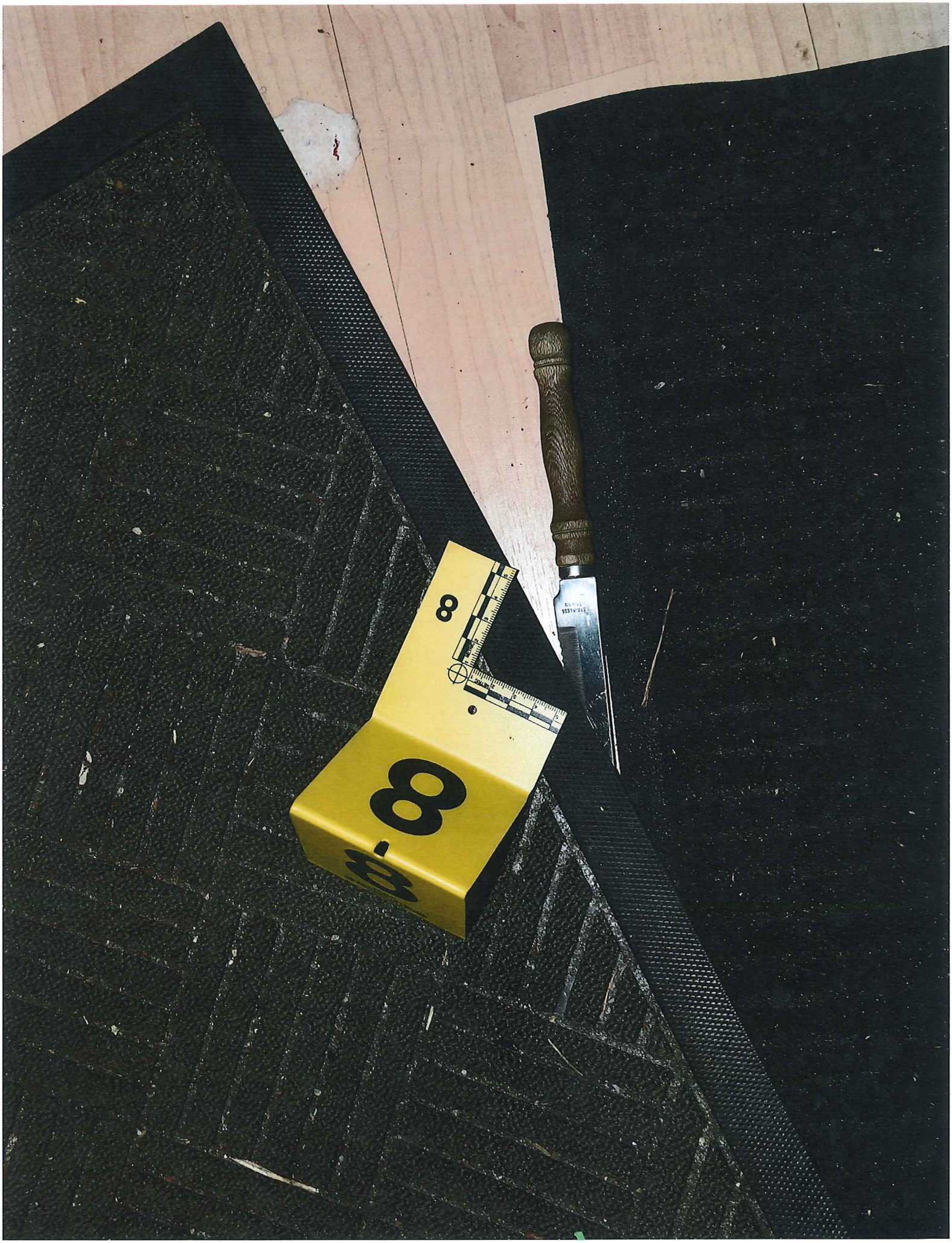
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MOTOROLA

APPENDIX

F

Crisis Intervention Team (CIT) Program

CIT involves a 40-hour training that is designed to educate first responders about mental illness, understanding the symptoms that people with mental illness experience, and developing the skills to de-escalate a crisis situation. Upon completion of the CIT training, first responders will be able to handle crisis calls to assist and help de-escalate an individual in need.

First responders must show a level of compassion, understanding, and a willingness to better understand mental illness and help break down the stigmas related to having a mental illness. Part of the CIT training will provide first responders the tools for responding more safely and compassionately to people with mental illness. CIT gives first responders options other than arrest and incarceration when they encounter people with mental illness by educating them on community resources that are available in our area. CIT has been shown to improve public safety and reduce injuries to officers and individuals in the community, while reducing the amount of time officers spend handling a mental health disturbance call. Upon completion of the 40-hour training, CIT officers report that they are more satisfied with CIT than with other jail diversion programs.

Upon completion of the training, first responders will be asked to maintain a level of commitment to the CIT program. This may include attending events such as the Out of the Darkness Walk for suicide prevention, attending CIT steering committee meetings, attending CIT refresher courses, and being involved with future CIT trainings. CIT is not just about the training. CIT is about being willing to make a commitment to a program that continues to evolve, and being part of a team which believes in building stronger relationships between law enforcement and the community.

The training is a full 40 hours, and we ask that you plan to be at the Ferguson Township Building (3147 Research Drive, State College) by 8am and plan to stay until 5pm each day. We ask that you please dress business-casual as we will be visiting different facilities in the community during the week. We also ask that you please limit your cell phone use. If you must respond to a call, please remove yourself from the training room out of consideration to the presenters and other trainees. We will be having working lunches every day, so please plan to remain with us for the entire day. We will also be providing snacks throughout the week. On Friday afternoon, we will be having a formal graduation ceremony and ask that everyone plan to ***bring*** your uniform with you so you can change prior to the ceremony.

Centre County CIT Training Agenda:

- Clinical Issues Related To Mental Illness (3hrs)
- Psychopharmacology (1hr)
- Substance Abuse and Co-occurring Disorders (2hrs)
- Adolescent Population (2hrs)
- Senior Citizen Population (1hr)
- Developmental and Intellectual Disabilities (1hr)
- Hearing Voices Exercise (2.5hrs)
- Advocacy Perspective (3hrs)
- Suicide Prevention (2hrs)
- Rights and Civil Commitment (1hr)
- CIT Policies and Procedures (0.5hrs)
- Basic Verbal Interventions (3hrs)
- Military Culture and Post-traumatic Stress Disorder (2hrs)
- Veteran's Panel and Veteran's Services (3hrs)
- Autism Spectrum Disorder (2hrs)
- Suicide By Cop and Officer Suicide (2hrs)
- Critical Incident Stress Management (1hr)
- Community Resources (2hrs)
- Site Visits (2hrs)
- Scenario-Based Skill Training (4hrs)

APPENDIX

G

STATE STANDARDS FOR CIVIL COMMITMENT

UPDATED: JULY 2018

200 NORTH GLEBE ROAD, SUITE 801
ARLINGTON, VIRGINIA 22203
(703) 294-6001

TreatmentAdvocacyCenter.org

Alabama

INPATIENT COMMITMENT

ALA. CODE § 22-52-10.4(a). A respondent may be committed to inpatient treatment if the probate court finds, based upon clear and convincing evidence that:

> (i) the respondent is mentally ill;
>
> (ii) as a result of the mental illness the respondent poses a real and present threat of substantial harm to self and/or others;
>
> (iii) the respondent will, if not treated, continue to suffer mental distress and will continue to experience deterioration of the ability to function independently; and
>
> (iv) the respondent is unable to make a rational and informed decision as to whether or not treatment for mental illness would be desirable.

OUTPATIENT COMMITMENT

ALA. CODE § 22-52-10.2. A respondent may be committed to outpatient treatment if the probate court finds, based upon clear and convincing evidence that:

> (i) the respondent is mentally ill;
>
> (ii) as a result of the mental illness the respondent will, if not treated, continue to suffer mental distress and will continue to experience deterioration of the ability to function independently; and
>
> (iii) the respondent is unable to make a rational and informed decision as to whether or not treatment for mental illness would be desirable.

Alaska

INPATIENT COMMITMENT

ALASKA STAT. § 47.30.735(c). [T]he court may commit the respondent to a treatment facility ... if it finds, by clear and convincing evidence, that the respondent is mentally ill and as a result is likely to cause harm to the respondent or others or is gravely disabled.

ALASKA STAT. § 47.30.915(12). "likely to cause serious harm" means a person who

> (A) poses a substantial risk of bodily harm to that person's self, as manifested by recent behavior causing, attempting, or threatening that harm;
>
> (B) poses a substantial risk of harm to others as manifested by recent behavior causing, attempting, or threatening harm, and is likely in the near future to cause physical injury, physical abuse, or substantial property damage to another person; or
>
> (C) manifests a current intent to carry out plans of serious harm to that person's self or another.

ED. NOTE: There is a discrepancy in Alaska law. The commitment standard includes the term "likely to cause harm," while the term defined is "likely to cause **serious** harm." [Emph. Added.]

ALASKA STAT. § 47.30.915(9). "gravely disabled" means a condition in which a person as a result of mental illness:

> (A) is in danger of physical harm arising from such complete neglect of basic needs for food, clothing, shelter, or personal safety as to render serious accident, illness, or death highly probable if care by another is not taken; or
>
> (B) will, if not treated, suffer or continue to suffer severe and abnormal mental, emotional, or physical distress, and this distress is associated with significant impairment of judgment, reason, or behavior causing a substantial deterioration of the person's previous ability to function independently.

OUTPATIENT COMMITMENT

ALASKA STAT. § 47.30.735(d). If the court finds that there is a viable less restrictive alternative [to inpatient commitment] available [to a person who meets the inpatient commitment criteria] and that the respondent has been advised of and refused voluntary treatment through the alternative, the court may order the less restrictive alternative treatment ... if the program accepts the respondent.

Arizona

INPATIENT OR OUTPATIENT COMMITMENT

ARIZ. REV. STAT. § 36-540(A). If the court finds by clear and convincing evidence that the proposed patient, as a result of mental disorder, is a danger to self, is a danger to others, has a persistent or acute disability or a grave disability and is in need of treatment, and is either unwilling or unable to accept voluntary treatment, the court shall order the patient to undergo [inpatient and/or outpatient treatment].

ARIZ. REV. STAT. § 36-501(7). "Danger to others" means that the judgment of a person who has a mental disorder is so impaired that the person is unable to understand the person's need for treatment and as a result of the person's mental disorder the person's continued behavior can reasonably be expected, on the basis of competent medical opinion, to result in serious physical harm.

ARIZ. REV. STAT. § 36-501(8). "Danger to self" means:

> (a) Behavior that, as a result of a mental disorder:
>
> > (i) Constitutes a danger of inflicting serious physical harm on oneself, including attempted suicide or the serious threat thereof, if the threat is such that, when considered in the light of its context and in light of the individual's previous acts, it is substantially supportive of an expectation that the threat will be carried out.
> >
> > (ii) Without hospitalization will result in serious physical harm or serious illness to the person.
>
> (b) Does not include behavior that establishes only the condition of having a grave disability.

ARIZ. REV. STAT. § 36-501(15). "Grave disability" means a condition evidenced by behavior in which a person, as a result of a mental disorder, is likely to come to serious physical harm or serious illness because the person is unable to provide for the person's own basic physical needs.

ARIZ. REV. STAT. § 36-501(32). "Persistent or acute disability" means a severe mental disorder that meets all the following criteria:

(a) If not treated has a substantial probability of causing the person to suffer or continue to suffer severe and abnormal mental, emotional or physical harm that significantly impairs judgment, reason, behavior or capacity to recognize reality.

(b) Substantially impairs the person's capacity to make an informed decision regarding treatment and this impairment causes the person to be incapable of understanding and expressing an understanding of the advantages and disadvantages of accepting treatment and understanding and expressing an understanding of the alternatives to the particular treatment offered after the advantages, disadvantages and alternatives are explained to that person.

(c) Has a reasonable prospect of being treatable by outpatient, inpatient or combined inpatient and outpatient treatment.

Arkansas

INPATIENT OR OUTPATIENT COMMITMENT

ARK. CODE ANN. § 20-47-207(c)(1). A person shall be eligible for involuntary admission if he or she is in such a mental condition as a result of mental illness, disease, or disorder that he or she poses a clear and present danger to himself or herself or others;

ARK. CODE ANN. § 20-47-207(c)(2). As used in this subsection, "a clear and present danger to himself or herself" is established by demonstrating that:

(A) The person has inflicted serious bodily injury on himself or herself or has attempted suicide or serious self-injury, and there is a reasonable probability that the conduct will be repeated if admission is not ordered;

(B) The person has threatened to inflict serious bodily injury on himself or herself, and there is a reasonable probability that the conduct will occur if admission is not ordered;

(C) The person's recent behavior or behavior history demonstrates that he or she so lacks the capacity to care for his or her own welfare that there is a reasonable probability of death, serious bodily injury, or serious physical or mental debilitation if admission is not ordered; or

(D) (i) The person's understanding of the need for treatment is impaired to the point that he or she is unlikely to participate in treatment voluntarily;

(ii) The person needs mental health treatment on a continuing basis to prevent a relapse or harmful deterioration of his or her condition; and

(iii) The person's noncompliance with treatment has been a factor in the individual's placement in a psychiatric hospital, prison, or jail at least two times within the last forty-eight months or has been a factor in the individual's committing one or more acts, attempts, or threats of serious violent behavior within the last forty-eight months.

ARK. CODE ANN. § 20-47-207(c)(3). As used in this subsection, "a clear and present danger to others" is established by demonstrating that the person has inflicted, attempted to inflict, or threatened to inflict serious bodily harm on another, and there is a reasonable probability that such conduct will occur if admission is not ordered.

California

INPATIENT COMMITMENT (OR OUTPATIENT COMMITMENT VIA CONSERVATORSHIP)

CALIF. WELF. & INST. CODE § 5250. [A person who has been detained and evaluated] may be certified for not more than 14 days of intensive treatment related to the mental disorder ... under the following conditions:

> (a) The professional staff of the agency or facility providing evaluation services has analyzed the person's condition and has found the person is, as a result of mental disorder or impairment by chronic alcoholism, a danger to others, or to himself or herself, or gravely disabled.
>
> (b) The facility providing intensive treatment ... agrees to admit the person.
>
> (c) The person has been advised of the need for, but has not been willing or able to accept, treatment on a voluntary basis.

CALIF. WELF. & INST. CODE § 5008(h)(1). "gravely disabled" means either of the following:

> (A) A condition in which a person, as a result of a mental disorder, is unable to provide for his or her basic personal needs for food, clothing, or shelter.
>
> (B) A condition in which a person has been found mentally incompetent [to stand trial on criminal charges] and all of the following facts exist:
>
> > (i) The indictment or information pending against the defendant at the time of commitment charges a felony involving death, great bodily harm, or a serious threat to the physical well-being of another person.
> >
> > (ii) The indictment or information has not been dismissed.
> >
> > (iii) As a result of mental disorder, the person is unable to understand the nature and purpose of the proceedings taken against him or her and to assist counsel in the conduct of his or her defense in a rational manner.

CALIF. WELF. & INST. CODE § 5250(d). Notwithstanding [other provision of law],, a person is not "gravely disabled" if that person can survive safely without involuntary detention with the help of responsible family, friends, or others who are both willing and able to help provide for the person's basic personal needs for food, clothing, or shelter. However, unless they specifically indicate in writing their willingness and ability to help, family, friends, or others shall not be considered willing or able to provide this help. The purpose of this subdivision is to avoid the necessity for, and the harmful effects of, requiring family, friends, and others to publicly state, and requiring the certification review officer to publicly find, that no one is willing or able to assist the mentally disordered person in providing for the person's basic needs for food, clothing, or shelter.

OUTPATIENT COMMITMENT ("ASSISTED OUTPATIENT TREATMENT")*

** Available only in counties that have "opted in" by Board of Supervisors action; otherwise outpatient commitment only permitted via conservatorship process.*

Criteria:

CALIF. WELF. & INST. CODE § 5346(a). In any county in which services are available ..., a court may order a person who is the subject of a petition filed pursuant to this section to obtain assisted outpatient treatment if the court finds, by clear and convincing evidence, that the facts stated in the verified petition filed in accordance with this section are true and establish that all of the requisite criteria set forth in this section are met, including, but not limited to, each of the following:

(1) The person is 18 years of age or older.

(2) The person is suffering from a mental illness[.]

(3) There has been a clinical determination that the person is unlikely to survive safely in the community without supervision.

(4) The person has a history of lack of compliance with treatment for his or her mental illness, in that at least one of the following is true:

(A) The person's mental illness has, at least twice within the last 36 months, been a substantial factor in necessitating hospitalization, or receipt of services in a forensic or other mental health unit of a state correctional facility or local correctional facility, not including any period during which the person was hospitalized or incarcerated immediately preceding the filing of the petition.

(B) The person's mental illness has resulted in one or more acts of serious and violent behavior toward himself or herself or another, or threats, or attempts to cause serious physical harm to himself or herself or another within the last 48 months, not including any period in which the person was hospitalized or incarcerated immediately preceding the filing of the petition.

(5) The person has been offered an opportunity to participate in a treatment plan by the director of the local mental health department, or his or her designee, provided the treatment plan includes [comprehensive services], and the person continues to fail to engage in treatment.

(6) The person's condition is substantially deteriorating.

(7) Participation in the assisted outpatient treatment program would be the least restrictive placement necessary to ensure the person's recovery and stability.

(8) In view of the person's treatment history and current behavior, the person is in need of assisted outpatient treatment in order to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to himself or herself, or to others[.]

(9) It is likely that the person will benefit from assisted outpatient treatment.

Colorado

INPATIENT OR OUTPATIENT COMMITMENT

COLO. REV. STAT. § 27-65-111(1). The court or jury shall determine that the respondent is in need of care and treatment only if the court or jury finds by clear and convincing evidence that the person has a

mental illness and, as a result of such mental illness, is a danger to others or to himself or herself or is gravely disabled.

COLO. REV. STAT. § 27-65-102(4.5). "Danger to self or others" means:

> (a) With respect to an individual, that the individual poses a substantial risk of physical harm to himself or herself as manifested by evidence of recent threats of or attempts at suicide or serious bodily harm to himself or herself; or
>
> (b) With respect to other persons, that the individual poses a substantial risk of physical harm to another person or persons, as manifested by evidence of recent homicidal or other violent behavior by the person in question, or by evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them, as evidenced by a recent overt act, attempt, or threat to do serious physical harm by the person in question.

COLO. REV. STAT. § 27-65-102(9). "Gravely disabled" means a condition in which a person, as a result of a mental health disorder, is incapable of making informed decisions about or providing for his or her essential needs without significant supervision and assistance from other people. As a result of being incapable of making these informed decisions, a person who is gravely disabled is at risk of substantial bodily harm, dangerous worsening of any concomitant serious physical illness, significant psychiatric deterioration, or mismanagement of his or her essential needs that could result in substantial bodily harm. A person of any age may be "gravely disabled", but such term does not include a person whose decision-making capabilities are limited solely by his or her developmental disability.

Connecticut*

**** Connecticut does not have an outpatient commitment law.***

INPATIENT COMMITMENT

CONN. GEN. STAT. ANN. § 17a-498(c)(3). If the court finds by clear and convincing evidence that the respondent has psychiatric disabilities and is dangerous to himself or herself or others or gravely disabled, the court shall make an order for his or her commitment, considering whether or not a less restrictive placement is available, to a hospital for psychiatric disabilities[.]

CONN. GEN. STAT. ANN. § 17a-495(a). "dangerous to himself or herself or others" means there is a substantial risk that physical harm will be inflicted by an individual upon his or her own person or upon another person, and "gravely disabled" means that a person, as a result of mental or emotional impairment, is in danger of serious harm as a result of an inability or failure to provide for his or her own basic human needs such as essential food, clothing, shelter or safety and that hospital treatment is necessary and available and that such person is mentally incapable of determining whether or not to accept such treatment because his judgment is impaired by his psychiatric disabilities.

Delaware

INPATIENT COMMITMENT

DEL CODE ANN. tit. 16 § 5011(a). An individual shall be involuntarily committed for inpatient treatment only if all of the following criteria are met by clear and convincing evidence:

> (1) The individual is a person with a mental condition;

(2) Based upon manifest indications, the individual is: (i) dangerous to self; or (ii) dangerous to others;

(3) All less restrictive alternatives have been considered and determined to be clinically inappropriate at the time of the hearing; and

(4) The individual has declined voluntarily inpatient treatment, or lacks the capacity to knowingly and voluntarily consent to inpatient treatment. When evaluating capacity, the court shall consider an individual's ability to understand the significant consequences, benefits, risks, and alternatives that result from the individual's decision to voluntarily request or decline inpatient treatment.

DEL CODE ANN. tit. 16 § 5001(3). "Dangerous to others" means that by reason of mental condition there is a substantial likelihood that the person will inflict serious bodily harm upon another person within the immediate future. This determination shall take into account a person's history, recent behavior and any recent act or threat.

DEL CODE ANN. tit. 16 § 5001(4) "Dangerous to self" means that by reason of mental condition there is a substantial likelihood that the person will imminently sustain serious bodily harm to oneself. This determination shall take into account a person's history, recent behavior, and any recent act or threat.

OUTPATIENT COMMITMENT

DEL CODE ANN. tit. 16 § 5013(a). A person shall be involuntarily committed by the court for outpatient treatment over objection only if all of the following criteria are satisfied by clear and convincing evidence:

(1) The person is 18 years of age or older.

(2) The person has a documented mental condition.

(3) The person is reasonably expected to become dangerous to self or dangerous to others or otherwise unlikely to survive safely in the community without treatment for the person's mental condition.

(4) The person is currently refusing to voluntarily participate in the treatment plan recommended by the person's mental health treatment provider or lacks the capacity to determine whether such treatment is necessary.

(5) The person has a documented history of lack of adherence with recommended treatment for the mental condition, or poses an extreme threat of danger to self or danger to others based upon recent actions, that has either:

(i) Resulted in a deterioration of functioning that was observed to be dangerous to the individual's personal health and safety; or

(ii) Resulted in a deterioration of functioning that was observed to be imminently dangerous to self or dangerous to others, including but not limited to suicidal ideation, violent threats, or violence towards others.

(6) All less restrictive treatment options have been considered and have either been determined to be clinically inappropriate at this time or evidence is offered to show that the person is not likely to adhere to such options.

District of Columbia

INPATIENT OR OUTPATIENT COMMITMENT

D.C. CODE ANN. § 21-545(b)(2). If the Court or jury finds that the person is mentally ill and, because of that mental illness, is likely to injure himself or others if not committed, the Court may order the person's commitment to the Department or to any other facility, hospital, or mental health provider that the Court believes is the least restrictive alternative consistent with the best interests of the person and the public.

Florida

INPATIENT COMMITMENT

FLA. STAT. § 394.467(1). A person may be ordered for involuntary inpatient placement for treatment upon a finding of the court by clear and convincing evidence that:

(a) He or she has a mental illness and because of his or her mental illness:

1. a. He or she has refused voluntary inpatient placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of inpatient placement for treatment; or

   b. He or she is unable to determine for himself or herself whether inpatient placement is necessary; AND

2. a. He or she is incapable of surviving alone or with the help of willing and responsible family or friends, including available alternative services, and, without treatment, is likely to suffer from neglect or refuse to care for himself or herself, and such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; or

   b. There is substantial likelihood that in the near future he or she will inflict serious bodily harm on self or others, as evidenced by recent behavior causing, attempting, or threatening such harm; and

(b) All available less restrictive treatment alternatives that would offer an opportunity for improvement of his or her condition have been judged to be inappropriate.

OUTPATIENT COMMITMENT ("INVOLUNTARY OUTPATIENT SERVICES")

FLA. STAT. § 394.4655(2). A person may be ordered to involuntary outpatient services upon a finding of the court, by clear and convincing evidence, that the person meets all of the following criteria:

(a) The person is 18 years of age or older;

(b) The person has a mental illness;

(c) The person is unlikely to survive safely in the community without supervision, based on a clinical determination;

(d) The person has a history of lack of compliance with treatment for mental illness;

(e) The person has:

1. At least twice within the immediately preceding 36 months been involuntarily admitted to a receiving facility or treatment facility ..., or has received mental health services in a forensic or correctional facility. The 36-month period does not include any period during which the person was admitted or incarcerated; or

2. Engaged in one or more acts of serious violent behavior toward self or others, or attempts at serious bodily harm to himself or herself or others, within the preceding 36 months;

(f) The person is, as a result of his or her mental illness, unlikely to voluntarily participate in the recommended treatment plan and has refused voluntary services for treatment after sufficient and conscientious explanation and disclosure of why the services are necessary or is unable to determine for himself or herself whether services are necessary;

(g) In view of the person's treatment history and current behavior, the person is in need of involuntary outpatient services in order to prevent a relapse or deterioration that would be likely to result in serious bodily harm to himself or herself or others, or a substantial harm to his or her well-being[;]

(h) It is likely that the person will benefit from involuntary outpatient services; and

(i) All available less restrictive alternatives that would offer an opportunity for improvement of his or her condition have been judged to be inappropriate or unavailable.

Georgia

INPATIENT COMMITMENT

GA. CODE ANN. § 37-3-1(12). "Mentally ill person requiring involuntary treatment" means a mentally ill person who is an inpatient or an outpatient.

GA. CODE ANN. § 37-3-1(9.1). "Inpatient" means a person who is mentally ill and:

(A) (i) Who presents a substantial risk of imminent harm to that person or others, as manifested by either recent overt acts or recent expressed threats of violence which present a probability of physical injury to that person or other persons; or

(ii) Who is so unable to care for that person's own physical health and safety as to create an imminently life-endangering crisis; and

(B) Who is in need of involuntary inpatient treatment.

OUTPATIENT COMMITMENT

GA. CODE ANN. § 37-3-1(12). "Mentally ill person requiring involuntary treatment" means a mentally ill person who is an inpatient or an outpatient.

GA. CODE ANN. § 37-3-1(12.1). "Outpatient" means a person who is mentally ill and:

(A) Who is not an inpatient but who, based on the person's treatment history or current mental status, will require outpatient treatment in order to avoid predictably and imminently becoming an inpatient;

(B) Who because of the person's current mental status, mental history, or nature of the person's mental illness is unable voluntarily to seek or comply with outpatient treatment; and

(C) Who is in need of involuntary treatment.

Hawaii

INPATIENT COMMITMENT

HAW. REV. STAT. § 334-60.2. A person may be committed to a psychiatric facility for involuntary hospitalization, if the court finds:

(1) That the person is mentally ill or suffering from substance abuse.

(2) That the person is imminently dangerous to self or others,; and

(3) That the person is in need of care or treatment, or both, and there is no suitable alternative available through existing facilities and programs which would be less restrictive than hospitalization.

HAW. REV. STAT. § 334-1. "Dangerous to others" means likely to do substantial physical or emotional injury on another, as evidenced by a recent act, attempt or threat.

HAW. REV. STAT. § 334-1. "Dangerous to property" means inflicting, attempting or threatening imminently to inflict damage to any property in a manner which constitutes a crime, as evidenced by a recent act, attempt or threat.

HAW. REV. STAT. § 334-1. "Dangerous to self" means the person recently has:

(1) Threatened or attempted suicide or serious bodily harm; or

(2) Behaved in such a manner as to indicate that the person is unable, without supervision and the assistance of others, to satisfy the need for nourishment, essential medical care, shelter or self-protection, so that it is probable that death, substantial bodily injury, or serious physical debilitation or disease will result unless adequate treatment is afforded.

HAW. REV. STAT. § 334-1. "Imminently dangerous to self or others" means that, without intervention, the person will likely become dangerous to self or dangerous to others within the next forty-five days.

OUTPATIENT COMMITMENT ("ASSISTED COMMUNITY TREATMENT")

HAW. REV. STAT. § 334-121. A person may be ordered to obtain assisted community treatment if the family court finds that:

(1) The person is mentally ill or suffering from substance abuse;

(2) The person is unlikely to live safely in the community without available supervision based on the professional opinion of the psychiatrist or advanced practice registered nurse with prescriptive authority and who holds an accredited national certification in an advanced practice registered nurse psychiatric specialization;

(3) The person, at some time in the past:

(A) has received inpatient hospital treatment for a mental illness or substance abuse or

(B) has been found to be imminently dangerous to self or others, as a result of mental illness or substance abuse;

(4) The person, based on the person's treatment history and current condition, is now in need of treatment in order to prevent a relapse or deterioration which would predictably result in the person becoming imminently dangerous to self or others;

(5) The person has a history of lack of adherence to treatment for mental illness or substance abuse, and the person's current mental status or the nature of the person's disorder limits or negates the person's ability to make an informed decision to voluntarily seek or comply with recommended treatment;

(6) The assisted community treatment is medically appropriate, and in the person's medical interests; and

(7) Considering less intrusive alternatives, assisted community treatment is essential to prevent the danger posed by the person.

Idaho

INPATIENT OR OUTPATIENT COMMITMENT

IDAHO CODE § 66-329(11). If, upon completion of the hearing and consideration of the record, and after consideration of reasonable alternatives ... the court finds by clear and convincing evidence that the proposed patient:

(a) is mentally ill; and

(b) is, because of such condition, likely to injure himself or others, or is gravely disabled due to mental illness;

the court shall order the proposed patient committed[.]

IDAHO CODE § 66-317(12). "Mentally ill" means a person, who as a result of a substantial disorder of thought, mood, perception, orientation, or memory, which grossly impairs judgment, behavior, capacity to recognize and adapt to reality, requires care and treatment at a facility or through outpatient treatment.

IDAHO CODE § 66-317(11). "Likely to injure himself or others" means either:

(a) A substantial risk that physical harm will be inflicted by the proposed patient upon his own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on himself; or

(b) A substantial risk that physical harm will be inflicted by the proposed patient upon another as evidenced by behavior which has cause such harm or which places another person or persons in reasonable fear of sustaining such harm; or

(c) The proposed patient lacks insight into his need for treatment and is unable or unwilling to comply with treatment and, based on his psychiatric history, clinical observation or other clinical evidence, if he does not receive and comply with treatment, there is a substantial risk he will continue to physically, emotionally or mentally deteriorate to the point that the person will, in the reasonably near future, inflict physical harm on himself or another person.

IDAHO CODE § 66-317(13). "Gravely disabled" means a person who, as the result of mental illness, is:

(a) In danger of serious physical harm due to the person's inability to provide for any of his own basic personal needs, such as nourishment, or essential clothing, medical care, shelter or safety; or

(b) Lacking insight into his need for treatment and is unable or unwilling to comply with treatment and, based on his psychiatric history, clinical observation or other clinical evidence, if he does not receive and comply with treatment, there is a substantial risk he will continue to physically, emotionally or mentally deteriorate to the point that the person will, in the reasonably near future, be in danger of serious physical harm due to the person's inability to provide for any of his own basic personal needs such as nourishment, essential clothing, medical care, shelter or safety.

Illinois

INPATIENT COMMITMENT

405 ILL. COMP. STAT. 5/1-119. "Person subject to involuntary admission on an inpatient basis" means:

(1) A person with mental illness who because of his or her illness is reasonably expected, unless treated on an inpatient basis, to engage in conduct placing such person or another in physical harm or in reasonable expectation of being physically harmed;

(2) A person with mental illness who because of his or her illness is unable to provide for his or her basic physical needs so as to guard himself or herself from serious harm without the assistance of family or others, unless treated on an inpatient basis; or

(3) A person with mental illness who

(i) refuses treatment or is not adhering adequately to prescribed treatment;

(ii) because of the nature of his or her illness, is unable to understand his or her need for treatment; and

(iii) if not treated on an inpatient basis, is reasonably expected, based on his or her behavioral history, to suffer mental or emotional deterioration and is reasonably expected, after such deterioration, to meet the criteria of either paragraph (1) or paragraph (2) of this Section.

In determining whether a person meets the criteria specified in paragraph (1) or (2), or (3), the court may consider evidence of the person's repeated past pattern of specific behavior and actions related to the person's illness.

OUTPATIENT COMMITMENT

405 ILL. COMP. STAT. 5/1-119.1. "Person subject to involuntary admission on an outpatient basis" means:

> (1) A person who would meet the criteria for admission on an inpatient basis as specified in Section 1119 in the absence of treatment on an outpatient basis and for whom treatment on an outpatient basis can only be reasonably ensured by a court order mandating such treatment; or
>
> (2) A person with a mental illness which, if left untreated, is reasonably expected to result in an increase in the symptoms caused by the illness to the point that the person would meet the criteria for commitment under Section 1119, and whose mental illness has, on more than one occasion in the past, caused that person to refuse needed and appropriate mental health services in the community.

Indiana

INPATIENT OR OUTPATIENT COMMITMENT*

**** See below for additional criteria required for outpatient commitment.***

IND. CODE ANN. § 12-26-6-8(a) [*"temporary commitment"*] and IND. CODE ANN. § 12-26-7-5(a) [*"regular commitment"*]. If at the completion of the hearing ... the court finds that the individual is mentally ill and either dangerous or gravely disabled, the court may order the individual to [inpatient or outpatient commitment].

IND. CODE ANN. § 12-7-2-53. "Dangerous," ... means a condition in which an individual as a result of mental illness, presents a substantial risk that the individual will harm the individual or others.

IND. CODE ANN. § 12-7-2-96. "Gravely disabled", ... means a condition in which an individual, as a result of mental illness, is in danger of coming to harm because the individual:

> (1) is unable to provide for that individual's food, clothing, shelter, or other essential human needs; or
>
> (2) has a substantial impairment or an obvious deterioration of that individual's judgment, reasoning, or behavior that results in the individual's inability to function independently.

OUTPATIENT COMMITMENT *(in addition to the criteria above)*

IND. CODE ANN. § 12-26-14-1. If a hearing has been held ... and the court finds that the individual is:

> (1) Mentally ill and either dangerous or gravely disabled;
>
> (2) Likely to benefit from an outpatient therapy program that is designed to decrease the individual's dangerousness or disability;
>
> (3) Not likely to be either dangerous or gravely disabled if the individual complies with the therapy program; and
>
> (4) Recommended for an outpatient therapy program by the individual's examining physician;

the court may order the individual to enter a therapy program as an outpatient.

Iowa

INPATIENT OR OUTPATIENT COMMITMENT

IOWA CODE § 229.13(1). If upon completion of the hospitalization hearing the court finds by clear and convincing evidence that the respondent has a serious mental impairment, the court shall order the respondent committed as expeditiously as possible for a complete psychiatric evaluation and appropriate treatment[.]

IOWA CODE § 229.1(20). "Seriously mentally impaired" or "serious mental impairment" describes the condition of a person with mental illness and because of that illness lacks sufficient judgment to make responsible decisions with respect to the person's hospitalization or treatment, and who because of that illness meets any of the following criteria:

> a. Is likely to physically injure the person's self or others if allowed to remain at liberty without treatment.
>
> b. Is likely to inflict serious emotional injury on members of the person's family or others who lack reasonable opportunity to avoid contact with the person with mental illness if the person with mental illness is allowed to remain at liberty without treatment.
>
> c. Is unable to satisfy the person's needs for nourishment, clothing, essential medical care, or shelter so that it is likely that the person will suffer physical injury, physical debilitation, or death.

IOWA CODE § 229.1(19). "Serious emotional injury" is an injury which does not necessarily exhibit any physical characteristics, but which can be recognized and diagnosed by a licensed physician or other mental health professional and which can be causally connected with the act or omission of a person who is, or is alleged to be, mentally ill.

Kansas

INPATIENT OR OUTPATIENT COMMITMENT*

**** See below for additional criteria required for outpatient commitment.***

KAN. STAT. ANN. § 59-2966(a). Upon the completion of the trial, if the court or jury finds by clear and convincing evidence that the proposed patient is a mentally ill person subject to involuntary commitment for care and treatment under this act, the court shall order treatment for such person[.].

KAN. STAT. ANN. § 59-2946(e). "Mentally ill person" means any person who is suffering from a mental disorder which is manifested by a clinically significant behavioral or psychological syndrome or pattern and associated with either a painful symptom or an impairment in one or more important areas of functioning, and involving substantial behavioral, psychological or biological dysfunction, to the extent that the person is in need of treatment.

KAN. STAT. ANN. § 59-2946(f)(1). "Mentally ill person subject to involuntary commitment for care and treatment" means a mentally ill person ... who also lacks capacity to make an informed decision concerning treatment, is likely to cause harm to self or others, and whose diagnosis is not solely one of the following mental disorders: Alcohol or chemical substance abuse; antisocial personality disorder;

mental retardation; organic personality syndrome; or an organic mental disorder. No person who is being treated by prayer in the practice of the religion of any church which teaches reliance on spiritual means alone through prayer for healing shall be determined to be a mentally ill person subject to involuntary commitment for care and treatment under this act unless substantial evidence is produced upon which the district court finds that the proposed patient is likely in the reasonably foreseeable future to cause substantial physical injury or physical abuse to self or others or substantial damage to another's property, as evidenced by behavior threatening, attempting or causing such injury, abuse or damage; except that if the harm threatened, attempted or caused is only harm to the property of another, the harm must be of such a value and extent that the state's interest in protecting the property from such harm outweighs the person's interest in personal liberty.

KAN. STAT. ANN. § 59-2946(f)(2). "Lacks capacity to make an informed decision concerning treatment" means that the person, by reason of the person's mental disorder, is unable, despite conscientious efforts at explanation, to understand basically the nature and effects of hospitalization or treatment or is unable to engage in a rational decision-making process regarding hospitalization or treatment, as evidenced by an inability to weigh the possible risks and benefits.

KAN. STAT. ANN. § 59-2946(f)(3). "Likely to cause harm to self or others" means that the person, by reason of the person's mental disorder:

> (a) Is likely, in the reasonably foreseeable future, to cause substantial physical injury or physical abuse to self or others or substantial damage to another's property, as evidenced by behavior threatening, attempting or causing such injury, abuse or damage; except that if the harm threatened, attempted or caused is only harm to the property of another, the harm must be of such a value and extent that the state's interest in protecting the property from such harm outweighs the person's interest in personal liberty; or
>
> (b) is substantially unable, except for reason of indigency, to provide for any of the person's basic needs, such as food, clothing, shelter, health or safety, causing a substantial deterioration of the person's ability to function on the person's own.

OUTPATIENT COMMITMENT *(in addition to the criteria above)*

KAN. STAT. ANN. § 59-2967(a). An order for outpatient treatment may be entered by the court at any time in lieu of any type of order which would have required inpatient care and treatment if the court finds that the patient is likely to comply with an outpatient treatment order and that the patient will not likely be a danger to the community or be likely to cause harm to self or others while subject to an outpatient treatment order.

Kentucky

INPATIENT COMMITMENT

KY. REV. STAT. ANN. § 202A.026. No person shall be involuntarily hospitalized unless such person is a mentally ill person:

> (1) Who presents a danger or threat of danger to self, family or others as a result of the mental illness;
>
> (2) Who can reasonably benefit from treatment; and

(3) For whom hospitalization is the least restrictive alternative mode of treatment presently available.

KY. REV. STAT. ANN. § 202A.011(2). "Danger" or "threat of danger to self, family or others" means substantial physical harm or threat of substantial physical harm upon self, family, or others, including actions which deprive self, family, or others of the basic means of survival including provision for reasonable shelter, food or clothing;

OUTPATIENT COMMITMENT

KY REV. STAT. ANN. § 202A.0815. No person shall be court-ordered to assisted outpatient mental health treatment unless the person:

(1) Has been involuntary hospitalized [by court order] at least two times in the past twelve months;

(2) Is diagnosed with a serious mental illness;

(3) Is unlikely to adequately adhere to outpatient treatment on a voluntary basis based on a qualified mental health professional's:

(a) Clinical observations;

(b) Review of treatment history, including the person's prior history of repeated treatment nonadherence; and

(c) Identification of specific characteristics of the person's clinical condition described as anosognosia, or failure to recognize his or her diagnosis of serious mental illness; and

(4) Is in need of court-ordered assisted outpatient treatment as the least restrictive alternative mode of treatment presently available and appropriate.

Louisiana

INPATIENT COMMITMENT

LA. REV. STAT. ANN. § 28:55(E)(1). If the court finds by clear and convincing evidence that the respondent is dangerous to self or others or is gravely disabled, as a result of substance-related or addictive disorder or mental illness, it shall render a judgment for his commitment.

LA. REV. STAT. ANN. § 28:2(3). "Dangerous to others" means the condition of a person whose behavior or significant threats support a reasonable expectation that there is a substantial risk that he will inflict physical harm upon another person in the near future.

LA. REV. STAT. ANN. § 28:2(4). "Dangerous to self" means the condition of a person whose behavior, significant threats or inaction supports a reasonable expectation that there is a substantial risk that he will inflict physical or severe emotional harm upon his own person.

LA. REV. STAT. ANN. § 28:2(10). "Gravely disabled" means the condition of a person who is unable to provide for his own basic physical needs, such as essential food, clothing, medical care, and shelter, as a result of serious mental illness or a substance-related or addictive disorder and is unable to survive safely

in freedom or protect himself from serious harm; the term also includes incapacitation by alcohol, which means the condition of a person who, as a result of the use of alcohol, is unconscious or whose judgment is otherwise so impaired that he is incapable of realizing and making a rational decision with respect to his need for treatment.

OUTPATIENT COMMITMENT

LA. REV. STAT. ANN. § 28:66 (A) A patient may be ordered to obtain civil involuntary outpatient treatment if the court finds that all of the following conditions apply:

(1) The patient is 18 years of age or older.

(2) The patient is suffering from a mental illness.

(3) The patient is unlikely to survive safely in the community without supervision, based on a clinical determination.

(4) The patient has a history of lack of compliance with treatment for mental illness that has resulted in either of the following:

(a) At least twice within the last thirty-six months, the lack of compliance with treatment for mental illness has been a significant factor resulting in an emergency certificate for hospitalization, or receipt of services in a forensic or other mental health unit of a correctional facility or a local correctional facility, not including any period during which the person was hospitalized or incarcerated immediately preceding the filing of the petition.

(b) One or more acts of serious violent behavior toward self or others or threats of, or attempts of, serious physical harm to self or others within the last thirty-six months as a result of mental illness, not including any period in which the person was hospitalized or incarcerated immediately preceding the filing of the petition.

(5) The patient is, as a result of his mental illness, unlikely to voluntarily participate in the recommended treatment pursuant to the treatment plan.

(6) In view of the treatment history and current behavior of the patient, the patient is in need of involuntary outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in the patient becoming dangerous to self or others or gravely disabled as defined in R.S. 28:2.

(7) It is likely that the patient will benefit from involuntary outpatient treatment.

Maine

INPATIENT COMMITMENT

ME. REV. STAT. ANN. tit. 34-B, § 3864(6)(A). The District Court shall so state in the record, if it finds upon completion of the hearing and consideration of the record:

(1) Clear and convincing evidence that the person is mentally ill and that the person's recent actions and behavior demonstrate that the person's illness poses a likelihood of serious harm;

(1-A) That adequate community resources for care and treatment of the person's mental illness are unavailable;

(2) That inpatient hospitalization is the best available means for treatment of the patient; and

(3) That it is satisfied with the individual treatment plan offered by the psychiatric hospital to which the applicant seeks the patient's involuntary commitment.

ME. REV. STAT. ANN. tit. 34B, § 3801(4-A). "Likelihood of serious harm" means:

A. A substantial risk of physical harm to the person as manifested by recent threats of, or attempts at, suicide or serious self-inflicted harm;

B. A substantial risk of physical harm to other persons as manifested by recent homicidal or violent behavior or recent conduct placing others in reasonable fear of serious physical harm;

C. A reasonable certainty that the person will suffer severe physical or mental harm as manifested by recent behavior demonstrating an inability to avoid risk or to protect the person adequately from impairment or injury

OUTPATIENT COMMITMENT ("PROGRESSIVE TREATMENT PROGRAM")

ME. REV. STAT. ANN. tit. 34B, § 3873-A(1). [A]n order from the District Court to admit a patient to a progressive treatment program [may be obtained] upon the following conditions:

A. The patient suffers from a severe and persistent mental illness;

B. The patient poses a likelihood of serious harm;

C. The patient has the benefit of a suitable individualized treatment plan;

D. Licensed and qualified community providers are available to support the treatment plan;

E. The patient is unlikely to follow the treatment plan voluntarily;

F. Court-ordered compliance will help to protect the patient from interruptions in treatment, relapses or deterioration of mental health; and

G. Compliance will enable the patient to survive more safely in a community setting without posing a likelihood of serious harm.

ME. REV. STAT. ANN. tit. 34B, § 3801(4)(D). "Likelihood of serious harm" means ... [f]or the purposes of [determining eligibility for a progressive treatment program], in view of the person's treatment history, current behavior and inability to make an informed decision, a reasonable likelihood that the person's mental health will deteriorate and that the person will in the foreseeable future pose a likelihood of serious harm as defined [for purposes of inpatient commitment].

Maryland*

Maryland does not have an outpatient commitment law.

INPATIENT COMMITMENT

MD. CODE ANN., HEALTH-GEN. § 10-632(e)(2). The hearing officer shall [o]rder the release of the individual from the facility unless the record demonstrates by clear and convincing evidence that at the time of the hearing each of the following elements exist as to the individual whose involuntary admission is sought:

(i) The individual has a mental disorder;

(ii) The individual needs in-patient care or treatment;

(iii) The individual presents a danger to the life or safety of the individual or of others;

(iv) The individual is unable or unwilling to be voluntarily admitted to the facility;

(v) There is no available less restrictive form of intervention that is consistent with the welfare and safety of the individual; and

(vi) If the individual is 65 years old or older and is to be admitted to a State facility, the individual has been evaluated by a geriatric evaluation team and no less restrictive form of care or treatment was determined by the team to be appropriate.

Massachusetts*

Massachusetts does not have an outpatient commitment law.

INPATIENT COMMITMENT

MASS. GEN. LAWS ANN. ch. 123, § 8(a). [T]he district court ... shall not order the commitment of a person at a facility or shall not renew such order unless it finds after a hearing that:

(1) such person is mentally ill, and

(2) the discharge of such person from a facility would create a likelihood of serious harm.

MASS. GEN. LAWS ANN. ch. 123, § 1. "Likelihood of serious harm" [means:]

(1) a substantial risk of physical harm to the person himself as manifested by evidence of, threats of, or attempts at, suicide or serious bodily harm;

(2) a substantial risk of physical harm to other persons as manifested by evidence of homicidal or other violent behavior or evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them; or

(3) a very substantial risk of physical impairment or injury to the person himself as manifested by evidence that such person's judgment is so affected that he is unable to protect himself in the community and that reasonable provision for his protection is not available in the community.

Michigan

INPATIENT OR OUTPATIENT COMMITMENT (ASSISTED OUTPATIENT TREATMENT)*

**** If the court relies exclusively on definition under § 330.1401(1)(d), only outpatient commitment may be ordered.***

MICH. COMP. LAWS § 330.1401(1). As used in this chapter, "person requiring treatment" means (a), (b), (c), or (d):

> (a) An individual who has mental illness, and who as a result of that mental illness can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure himself, herself, or another individual, and who has engaged in an act or acts or made significant threats that are substantially supportive of the expectation.
>
> (b) An individual who has mental illness, and who as a result of that mental illness is unable to attend to those of his or her basic physical needs such as food, clothing, or shelter that must be attended to in order for the individual to avoid serious harm in the near future, and who has demonstrated that inability by failing to attend to those basic physical needs.
>
> (c) An individual who has mental illness, whose judgment is so impaired by that mental illness that he or she is unable to understand his or her need for treatment, and whose impaired judgment, on the basis of competent clinical opinion, presents a substantial risk of significant physical or mental harm to the individual in the near future or presents a substantial risk of physical harm to others in the near future.
>
> (d) An individual who has mental illness, whose understanding of the need for treatment is impaired to the point that he or she is unlikely to voluntarily participate in or adhere to treatment that has been determined necessary to prevent a relapse or harmful deterioration of his or her condition, and whose noncompliance with treatment has been a factor in the individual's placement in a psychiatric hospital, prison, or jail at least 2 times within the last 48 months or whose noncompliance with treatment has been a factor in the individual's committing 1 or more acts, attempts, or threats of serious violent behavior within the last 48 months. An individual under this subdivision is only eligible to receive assisted outpatient treatment.

Minnesota

INPATIENT COMMITMENT

MINN. STAT. § 253B.09(1). If the court finds by clear and convincing evidence that the proposed patient is a person who is mentally ill, ... and after careful consideration of reasonable alternative dispositions, including but not limited to, dismissal of petition, voluntary outpatient care, voluntary admission to a treatment facility, appointment of a guardian or conservator, or release before commitment ..., it finds that there is no suitable alternative to judicial commitment, the court shall commit the patient to the least restrictive treatment program or alternative programs which can meet the patient's treatment needs[.]

MINN. STAT. § 253B.02(13). Person who is mentally ill.

> (a) A "person who is mentally ill" means any person who has an organic disorder of the brain or a substantial psychiatric disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality, or to reason or understand, which is manifested by instances of grossly disturbed behavior or faulty perceptions and poses a substantial likelihood of physical harm to self or others as demonstrated by:
>
> > (1) a failure to obtain necessary food, clothing, shelter, or medical care as a result of the impairment;
> >
> > (2) an inability for reasons other than indigence to obtain necessary food, clothing,

shelter, or medical care as a result of the impairment and it is more probable than not that the person will suffer substantial harm, significant psychiatric deterioration or debilitation, or serious illness, unless appropriate treatment and services are provided;

(3) a recent attempt or threat to physically harm self or others; or

(4) recent and volitional conduct involving significant damage to substantial property.

(b) A person is not mentally ill under this section if the impairment is solely due to:

(1) epilepsy;

(2) developmental disability;

(3) brief periods of intoxication caused by alcohol, drugs, or other mind-altering substances; or

(4) dependence upon or addiction to any alcohol, drugs, or other mind-altering substances.

MINN. STAT. § 253B.18(1)(a). If the court finds by clear and convincing evidence that the proposed patient is a person who is mentally ill and dangerous to the public, it shall commit the person to a secure treatment facility or to a treatment facility willing to accept the patient under commitment. The court shall commit the patient to a secure treatment facility unless the patient establishes by clear and convincing evidence that a less restrictive treatment program is available that is consistent with the patient's treatment needs and the requirements of public safety.

MINN. STAT. § 253B.02(17)(a). A "person who is mentally ill and dangerous to the public" is a person

(1) who is mentally ill; and

(2) who as a result of that mental illness presents a clear danger to the safety of others as demonstrated by the facts that (i) the person has engaged in an overt act causing or attempting to cause serious physical harm to another and (ii) there is a substantial likelihood that the person will engage in acts capable of inflicting serious physical harm on another.

Ed. Note: The critical distinction between a patient committed as a "person who is mentally ill" and one committed as a "person who is mentally ill and dangerous to the public" is that the latter is not permitted to transfer to voluntary status per MINN. STAT. § 253B.10(5).

OUTPATIENT COMMITMENT ("EARLY INTERVENTION TREATMENT")

MINN. STAT. § 253B.065(5)(b). The court shall order early intervention treatment if the court finds all of the elements of the following factors by clear and convincing evidence:

(1) the proposed patient is mentally ill;

(2) the proposed patient refuses to accept appropriate mental health treatment; and

(3) the proposed patient's mental illness is manifested by instances of grossly disturbed behavior or faulty perceptions and either:

(i) the grossly disturbed behavior or faulty perceptions significantly interfere with the proposed patient's ability to care for self and the proposed patient, when competent, would have chosen substantially similar treatment under the same circumstances; or

(ii) due to the mental illness, the proposed patient received court-ordered inpatient treatment ... at least two times in the previous three years; the patient is exhibiting symptoms or behavior substantially similar to those that precipitated one or more of the court-ordered treatments; and the patient is reasonably expected to physically or mentally deteriorate to the point of meeting the criteria for [inpatient] commitment ... unless treated.

For purposes of this paragraph, a proposed patient who was released [prior to commitment] and whose release was not revoked is not considered to have received court-ordered inpatient treatment[.]

MINN. STAT. § 253B.065(5)(d). For purposes of [determining eligibility for outpatient commitment], none of the following constitute a refusal to accept appropriate mental health treatment:

(1) a willingness to take medication but a reasonable disagreement about type or dosage;

(2) a good faith effort to follow a reasonable alternative treatment plan, including treatment as specified in a valid advance directive[;]

(3) an inability to obtain access to appropriate treatment because of inadequate health care coverage or an insurer's refusal or delay in providing coverage for the treatment; or

(4) an inability to obtain access to needed mental health services because the provider will only accept patients who are under a court order or because the provider gives persons under a court order a priority over voluntary patients in obtaining treatment and services.

Mississippi

INPATIENT OR OUTPATIENT COMMITMENT

MISS. CODE ANN. § 41-21-73(4). "If the court finds by clear and convincing evidence that the proposed patient is a person with mental illness .... and, if after careful consideration of reasonable alternative dispositions .... the court finds that there is no suitable alternative to judicial commitment, the court shall commit the patient for treatment in the least restrictive treatment facility that can meet the patient's treatment needs.

MISS. CODE ANN. § 41-21-61(e). "Person with mental illness" means any person who has a substantial psychiatric disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality, or to reason or understand, which

(i) is manifested by instances of grossly disturbed behavior or faulty perceptions; and

(ii) poses a substantial likelihood of physical harm to himself or others as demonstrated by

(A) a recent attempt or threat to physically harm himself or others, or

(B) a failure to provide necessary food, clothing, shelter or medical care for himself, as a result of the impairment.

"Person with mental illness" includes a person who, based on treatment history and other applicable psychiatric indicia, is in need of treatment in order to prevent further disability or deterioration which would predictably result in dangerousness to himself or others when his current mental illness limits or negates his ability to make an informed decision to seek or comply with recommended treatment.

MISS. CODE ANN. § 41-21-61(j). "Substantial likelihood of bodily harm" means that:

(i) The person has threatened or attempted suicide or to inflict serious bodily harm to himself; or

(ii) The person has threatened or attempted homicide or other violent behavior; or

(iii) The person has placed others in reasonable fear of violent behavior and serious physical harm to them; or

(iv) The person is unable to avoid severe impairment or injury from specific risks; and

(v) There is substantial likelihood that serious harm will occur unless the person is placed under emergency treatment.

Missouri

INPATIENT OR OUTPATIENT COMMITMENT

MO. ANN. STAT. 632.350(5). At the conclusion of the hearing, if the court or jury finds that the respondent, as the result of mental illness, presents a likelihood of serious harm to himself or to others, and the court finds that a program appropriate to handle the respondent's condition has agreed to accept him, the court shall order the respondent to be detained for involuntary treatment in the least restrictive environment for a period not to exceed ninety days or for outpatient detention and treatment under the supervision of a mental health program in the least restrictive environment for a period not to exceed one hundred eighty days.

MO. ANN. STAT. § 632.005(10). "Likelihood of serious harm" means any one or more of the following but does not require actual physical injury to have occurred:

(a) A substantial risk that serious physical harm will be inflicted by a person upon his own person, as evidenced by recent threats, including verbal threats, or attempts to commit suicide or inflict physical harm on himself. Evidence of substantial risk may also include information about patterns of behavior that historically have resulted in serious harm previously being inflicted by a person upon himself;

(b) A substantial risk that serious physical harm to a person will result or is occurring because of an impairment in his capacity to make decisions with respect to his hospitalization and need for treatment as evidenced by his current mental disorder or mental illness which results in an inability to provide for his own basic necessities of food, clothing, shelter, safety or medical care or his inability to provide for his own mental health care which may result in a substantial risk of serious physical harm. Evidence of that substantial risk may also include information about patterns of behavior that historically have resulted in serious harm to the person previously taking place because of a mental disorder or mental illness which resulted in his inability to provide for his basic necessities of food, clothing, shelter, safety or medical or mental health care; or

(c) A substantial risk that serious physical harm will be inflicted by a person upon another as evidenced by recent overt acts, behavior or threats, including verbal threats, which have caused

such harm or which would place a reasonable person in reasonable fear of sustaining such harm. Evidence of that substantial risk may also include information about patterns of behavior that historically have resulted in physical harm previously being inflicted by a person upon another person.

Montana

INPATIENT OR OUTPATIENT COMMITMENT*

**** If the court relies exclusively on finding under § 53-21-126(1)(d), only outpatient commitment may be ordered.***

MONT. CODE ANN. § 53-21-126(1). If the court determines that the respondent is suffering from a mental disorder, the court shall then determine whether the respondent requires commitment. In determining whether the respondent requires commitment ... the court shall consider the following:

(a) whether the respondent, because of a mental disorder, is substantially unable to provide for the respondent's own basic needs of food, clothing, shelter, health, or safety;

(b) whether the respondent has recently, because of a mental disorder and through an act or an omission, caused self-injury or injury to others;

(c) whether, because of a mental disorder, there is an imminent threat of injury to the respondent or to others because of the respondent's acts or omissions; and

(d) whether the respondent's mental disorder, as demonstrated by the respondent's recent acts or omissions, will, if untreated, predictably result in deterioration of the respondent's mental condition to the point at which the respondent will become a danger to self or to others or will be unable to provide for the respondent's own basic needs of food, clothing, shelter, health, or safety. Predictability may be established by the respondent's relevant medical history.

MONT. CODE ANN. § 53-21-127(7). Satisfaction of any one of the criteria listed in 53-21-126(1) justifies commitment pursuant to this chapter. However, if the court relies solely upon the criterion provided in 53-21-126(1)(d), the court may require commitment only to a community facility ... and may not require commitment at the state hospital, a behavioral health inpatient facility, or the Montana mental health nursing care center.

MONT. CODE ANN. § 53-21-102(9)(a). "Mental disorder" means any organic, mental, or emotional impairment that has substantial adverse effects on an individual's cognitive or volitional functions.

Nebraska

INPATIENT OR OUTPATIENT COMMITMENT

NEB. REV. STAT. § 71-925(1). The state has the burden to prove by clear and convincing evidence that (a) the subject is mentally ill and dangerous and (b) neither voluntary hospitalization nor other treatment alternatives less restrictive of the subject's liberty than inpatient or outpatient treatment ordered by the mental health board are available or would suffice to prevent the harm described in section 71-908.

NEB. REV. STAT. § 71-908. Mentally ill and dangerous person means a person who is mentally ill ... and because of such mental illness... presents:

(1) A substantial risk of serious harm to another person or persons within the near future as manifested by evidence of recent violent acts or threats of violence or by placing others in reasonable fear of such harm; or

(2) A substantial risk of serious harm to himself or herself within the near future as manifested by evidence of recent attempts at, or threats of, suicide or serious bodily harm or evidence of inability to provide for his or her basic human needs, including food, clothing, shelter, essential medical care, or personal safety.

Nevada

INPATIENT OR OUTPATIENT COMMITMENT*

**** See below for additional criteria required for outpatient commitment.***

NEV. REV. STAT. § 433A.310(1). [I]f the district court finds ... clear and convincing evidence that the person ... has a mental illness and, because of that illness, is likely to harm himself or herself or others if allowed his or her liberty or if not required to participate in a program of community-based or outpatient services, the court may order the involuntary admission of the person for the most appropriate course of treatment[.]

NEV. REV. STAT. § 433A.115(1). "[P]erson with mental illness" means any person whose capacity to exercise self-control, judgment and discretion in the conduct of the person's affairs and social relations or to care for his or her personal needs is diminished, as a result of a mental illness, to the extent that the person presents a clear and present danger of harm to himself or herself or others, but does not include any person in whom that capacity is diminished by epilepsy, mental retardation, Alzheimer's disease, brief periods of intoxication caused by alcohol or drugs, or dependence upon or addiction to alcohol or drugs, unless a mental illness that can be diagnosed is also present which contributes to the diminished capacity of the person.

NEV. REV. STAT. § 433A.115(2). A person presents a clear and present danger of harm to himself or herself if, within the immediately preceding 30 days, the person has, as a result of a mental illness:

(a) Acted in a manner from which it may reasonably be inferred that, without the care, supervision or continued assistance of others, the person will be unable to satisfy his or her need for nourishment, personal or medical care, shelter, self-protection or safety, and if there exists a reasonable probability that the person's death, serious bodily injury or physical debilitation will occur within the next following 30 days unless he or she is admitted to a mental health facility... and adequate treatment is provided to the person;

(b) Attempted or threatened to commit suicide or committed acts in furtherance of a threat to commit suicide, and if there exists a reasonable probability that the person will commit suicide unless he or she is admitted to a mental health facility... and adequate treatment is provided to the person; or

(c) Mutilated himself or herself, attempted or threatened to mutilate himself or herself or committed acts in furtherance of a threat to mutilate himself, or herself reasonable probability that he or she will mutilate himself or herself unless the person is admitted to a mental health facility... and adequate treatment is provided to the person.

NEV. REV. STAT. § 433A.115(3). A person presents a clear and present danger of harm to others if, within the immediately preceding 30 days, the person has, as a result of a mental illness, inflicted or attempted to inflict serious bodily harm on any other person, or made threats to inflict harm and

committed acts in furtherance of those threats, and if there exists a reasonable probability that he or she will do so again unless the person is admitted to a mental health facility ... and adequate treatment is provided to him or her.

OUTPATIENT COMMITMENT *(in addition to the criteria above)*

NEV. REV. STAT §433A.310(2). A court shall not admit a person to a program of community-based or outpatient treatment unless:

> (a) A program of community-based or outpatient services is available in the community in which the person resides or is otherwise made available to the person;
>
> (b) The person is 18 years or older;
>
> (c) The person has a history of noncompliance with treatment for mental illness;
>
> (d) The person is capable of surviving safely in the community in which he or she resides with available supervision;
>
> (e) The court determines that, based on the person's history of treatment for mental illness, the person needs to be admitted to a program of community-based or outpatient services to prevent further disability or deterioration of the person which is likely to result in harm to himself or herself or others;
>
> (f) The current mental status of the person or the nature of the person's mental illness limits or negates his or her ability to make an informed decision to seek treatment for mental illness voluntarily or to comply with recommended treatment for mental illness;
>
> (g) The program of community-based or outpatient services is the least restrictive treatment which is in the best interest of the person; and
>
> (h) The court has approved a plan of treatment developed for the person[.]

New Hampshire

INPATIENT OR OUTPATIENT COMMITMENT

N.H. REV. STAT. ANN. § 135-C:34. The standard to be used by a court, physician, or psychiatrist in determining whether a person should be admitted to a receiving facility for treatment on an involuntary basis shall be whether the person is in such mental condition as a result of mental illness as to create a potentially serious likelihood of danger to himself or to others.

N.H. REV. STAT. ANN. § 135-C:2(X). "Mental illness" means a substantial impairment of emotional processes, or of the ability to exercise conscious control of one's actions, or of the ability to perceive reality or to reason, when the impairment is manifested by instances of extremely abnormal behavior or extremely faulty perceptions. It does not include impairment primarily caused by: (a) epilepsy; (b) intellectual disability; (c) continuous or noncontinuous periods of intoxication caused by substances such as alcohol or drugs; or (d) dependence upon or addiction to any substance such as alcohol or drugs.

N.H. REV. STAT. ANN. § 135-C:27(II). As used in this section "danger to others" is established by demonstrating that within 40 days of the completion of the petition, the person has inflicted, attempted to inflict, or threatened to inflict serious bodily harm on another.

New Jersey

New Jersey

INPATIENT OR OUTPATIENT COMMITMENT

N.J. STAT. ANN. § 30:4-27.2(m). "In need of involuntary commitment" or "in need of involuntary commitment to treatment" means that an adult with mental illness, whose mental illness causes the person to be dangerous to self or dangerous to others or property and who is unwilling to accept appropriate treatment voluntarily after it has been offered, needs outpatient treatment or inpatient care at a short-term care or psychiatric facility or special psychiatric hospital because other services are not appropriate or available to meet the person's mental health care needs.

N.J. STAT. ANN. § 30:4-27.2(r). "Mental illness" means a current, substantial disturbance of thought, mood, perception or orientation which significantly impairs judgment, capacity to control behavior or capacity to recognize reality, but does not include simple alcohol intoxication, transitory reaction to drug ingestion, organic brain syndrome or developmental disability unless it results in the severity of impairment described herein. The term mental illness is not limited to "psychosis" or "active psychosis," but shall include all conditions that result in the severity of impairment described herein.

N.J. STAT. ANN. § 30:4-27.2(h). "Dangerous to self" means that by reason of mental illness the person has threatened or attempted suicide or serious bodily harm, or has behaved in such a manner as to indicate that the person is unable to satisfy his need for nourishment, essential medical care or shelter, so that it is probable that substantial bodily injury, serious physical harm or death will result within the reasonably foreseeable future; however, no person shall be deemed to be unable to satisfy his need for nourishment, essential medical care or shelter if he is able to satisfy such needs with the supervision and assistance of others who are willing and available. This determination shall take into account a person's history, recent behavior and any recent act, threat or serious psychiatric deterioration.

N.J. STAT. ANN. § 30:4-27.2(i) "Dangerous to others or property" means that by reason of mental illness there is a substantial likelihood that the person will inflict serious bodily harm upon another person or cause serious property damage within the reasonably foreseeable future. This determination shall take into account a person's history, recent behavior and any recent act, threat, or serious psychiatric deterioration.

New Mexico

INPATIENT COMMITMENT

N.M. STAT. ANN. § 43-1-11(E). Upon completion of the hearing, the court may order a commitment for evaluation and treatment not to exceed thirty days if the court finds by clear and convincing evidence that:

> (1) as a result of a mental disorder, the client presents a likelihood of serious harm to himself or others;
>
> (2) the client needs and is likely to benefit from the proposed treatment; and
>
> (3) the proposed commitment is consistent with the treatment needs of the client and with the least drastic means principle.

N.M. STAT. ANN. § 43-1-3(M). "likelihood of serious harm to oneself" means that it is more likely than not that in the near future the person will attempt to commit suicide or will cause serious bodily harm to the person's self by violent or other self-destructive means, including but not limited to grave passive neglect.

N.M. STAT. ANN. § 43-1-3(N). "likelihood of serious harm to others" means that it is more likely than not that in the near future a person will inflict serious, unjustified bodily harm on another person or commit a criminal sexual offense, as evidenced by behavior causing, attempting or threatening such harm, which behavior gives rise to a reasonable fear of such harm from the person.

OUTPATIENT COMMITMENT ("ASSISTED OUTPATIENT TREATMENT")*:

** Available only in jurisdictions that have "opted in" with a memorandum of understanding between the jurisdiction and the local district court.*

N.M. STAT. ANN. § 43-1B-3. A person may be ordered to participate in assisted outpatient treatment if the court finds by clear and convincing evidence that the person:

A. is eighteen years of age or older and is a resident of a participating municipality or county;

B. has a primary diagnosis of a mental disorder;

C. has demonstrated a history of lack of compliance with treatment for a mental disorder that has:

(1) at least twice within the last forty-eight months, been a significant factor in necessitating hospitalization or necessitating receipt of services in a forensic or other mental health unit or a jail, prison or detention center; provided that the forty-eight-month period shall be extended by the length of any hospitalization, incarceration or detention of the person that occurred within the forty-eight-month period;

(2) resulted in one or more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others within the last forty-eight months; provided that the forty-eight-month period shall be extended by the length of any hospitalization, incarceration or detention of the person that occurred within the forty-eight-month period; or

(3) resulted in the person being hospitalized, incarcerated or detained for six months or more and the person is to be discharged or released within the next thirty days or was discharged or released within the past sixty days;

D. is unwilling or unlikely, as a result of a mental disorder, to participate voluntarily in outpatient treatment that would enable the person to live safely in the community without court supervision;

E. is in need of assisted outpatient treatment as the least restrictive appropriate alternative to prevent a relapse or deterioration likely to result in serious harm to self or likely to result in serious harm to others; and

F. will likely benefit from, and the person's best interests will be served by, receiving assisted outpatient treatment.

New York

INPATIENT COMMITMENT

N.Y. MENTAL HYG. LAW § 9.37(a). The director of a hospital, upon application by a director of community services or an examining physician duly designated by him or her, may receive and care for in such hospital as a patient any person who, in the opinion of the director of community services or the director's designee, has a mental illness for which immediate inpatient care and treatment in a hospital is appropriate and which is likely to result in serious harm to himself or herself or others.

N.Y. MENTAL HYG. LAW § 9.31(c). If it be determined [by the court] that the patient is in need of retention, the court shall deny the application for the patient's release. If it be determined that the patient is not mentally ill or not in need of retention, the court shall order the release of the patient.

N.Y. MENTAL HYG. LAW § 9.01. As used in this article:

"in need of involuntary care and treatment" means that a person has a mental illness for which care and treatment as a patient in a hospital is essential to such person's welfare and whose judgment is so impaired that he is unable to understand the need for such care and treatment.

"need for retention" means that a person who has been admitted to a hospital pursuant to this article is in need of involuntary care and treatment in a hospital for a further period.

"likelihood to result in serious harm" or "likely to result in serious harm" means

> (a) a substantial risk of physical harm to the person as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that the person is dangerous to himself or herself, or
>
> (b) a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm.

OUTPATIENT COMMITMENT ("ASSISTED OUTPATIENT TREATMENT")

N.Y. MENTAL HYG. LAW § 9.60(c). A person may be ordered to receive assisted outpatient treatment if the court finds that such person:

> (1) is eighteen years of age or older; and
>
> (2) is suffering from a mental illness; and
>
> (3) is unlikely to survive safely in the community without supervision, based on a clinical determination; and
>
> (4) has a history of lack of compliance with treatment for mental illness that has:
>
> > (i) prior to the filing of the petition, at least twice within the last thirty-six months been a significant factor in necessitating hospitalization in a hospital, or receipt of services in a forensic or other mental health unit of a correctional facility, not including any current period, or period ending within the last six months, in which the person was or is hospitalized or incarcerated ; or
> >
> > (ii) prior to the filing of the petition, resulted in one or more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others within the last forty-eight months, not including any period, or period ending within the last six months, in which the person was or is hospitalized or incarcerated; and

(5) is, as a result of his or her mental illness, unlikely to voluntarily participate in the outpatient treatment that would enable him or her to live safely in the community; and

(6) in view of his or her treatment history and current behavior, is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to the person or others as defined in section 9.01 of this article; and

(7) is likely to benefit from assisted outpatient treatment.

North Carolina

INPATIENT COMMITMENT

N.C. GEN. STAT. § 122C-268(j). To support an inpatient commitment order, the court shall find by clear, cogent, and convincing evidence that the respondent is mentally ill and dangerous to self... or dangerous to others[.]

N.C. GEN. STAT. § 122C-3(11). "Dangerous to himself or others" means:

a. "Dangerous to himself" means that within the relevant past:

1. The individual has acted in such a way as to show:

I. That he would be unable, without care, supervision, and the continued assistance of others not otherwise available, to exercise self-control, judgment, and discretion in the conduct of his daily responsibilities and social relations, or to satisfy his need for nourishment, personal or medical care, shelter, or self-protection and safety; and

II. That there is a reasonable probability of his suffering serious physical debilitation within the near future unless adequate treatment is given pursuant to this Chapter. A showing of behavior that is grossly irrational, of actions that the individual is unable to control, of behavior that is grossly inappropriate to the situation, or of other evidence of severely impaired insight and judgment shall create a prima facie inference that the individual is unable to care for himself; or

2. The individual has attempted suicide or threatened suicide and that there is a reasonable probability of suicide unless adequate treatment is given pursuant to this Chapter; or

3. The individual has mutilated himself or attempted to mutilate himself and that there is a reasonable probability of serious self-mutilation unless adequate treatment is given pursuant to this Chapter.

Previous episodes of dangerousness to self, when applicable, may be considered when determining reasonable probability of physical debilitation, suicide, or self-mutilation.

b. "Dangerous to others" means that within the relevant past, the individual has inflicted or attempted to inflict or threatened to inflict serious bodily harm on another, or has acted in such a way as to create a substantial risk of serious bodily harm to another, or has engaged in extreme destruction of property; and that there is a reasonable probability that this conduct will be repeated. Previous episodes of dangerousness to others, when applicable, may be considered

when determining reasonable probability of future dangerous conduct. Clear, cogent, and convincing evidence that an individual has committed a homicide in the relevant past is prima facie evidence of dangerousness to others.

OUTPATIENT COMMITMENT

N.C. GEN. STAT. § 122C-271(a)(1). If the court finds by clear, cogent, and convincing evidence that the respondent is mentally ill; that he is capable of surviving safely in the community with available supervision from family, friends, or others; that based on respondent's treatment history, the respondent is in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness [to self or others]; and that the respondent's current mental status or the nature of his illness limits or negates his ability to make an informed decision to seek voluntarily or comply with recommended treatment, it may order outpatient commitment for a period not in excess of 90 days.

N.C GEN. STAT. § 122C-267(h). To support an outpatient commitment order, the court is required to find by clear, cogent, and convincing evidence that the respondent meets the criteria specified in *G.S. 122C-263(d)(1)*.

N.C GEN. STAT. § 122C-263(d)(1). If the physician or eligible psychologist finds that:

a. The respondent is mentally ill;

b. The respondent is capable of surviving safely in the community with available supervision from family, friends, or others;

c. Based on the respondent's psychiatric history, the respondent is in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness as defined by G.S. 122C-3(11); and

d. The respondent's current mental status or the nature of the respondent's illness limits or negates the respondent's ability to make an informed decision to seek voluntarily or comply with recommended treatment.

The physician or eligible psychologist shall so show on the examination report and shall recommend outpatient commitment.

North Dakota

INPATIENT OR OUTPATIENT COMMITMENT

N.D. CENT. CODE § 25-03.1-07. An individual may be involuntarily admitted under this chapter to the state hospital or another treatment facility only if it is determined that the individual is a person requiring treatment.

N.D. CENT. CODE § 25-03.1-02(13). "Person requiring treatment" means a person who is mentally ill or a person who is chemically dependent, and there is a reasonable expectation that if the individual is not treated for the mental illness or chemical dependency there exists a serious risk of harm to that individual, others, or property.

N.D. CENT. CODE § 25-03.1-02(12). "[P]erson who is mentally ill" means a person with an organic, mental, or emotional disorder that substantially impairs the capacity to use self-control, judgment and discretion in the conduct of personal affairs and social relations. The term does not include an individual with an intellectual disability of significantly subaverage general intellectual functioning that orgiginates

during the developmental period and is associated with impairment in adaptive behavior, although an individual who is intellectually disabled may also be a person who is mentally ill. Chemical dependency does not per se constitute mental illness, although a person who is chemically dependent may also be a person who is mentally ill.

N.D. CENT. CODE § 25-03.1-02(20). "Serious risk of harm" means a substantial likelihood of:

a. Suicide, as manifested by suicidal threats, attempts, or significant depression relevant to suicidal potential;

b. Killing or inflicting serious bodily harm on another individual or inflicting significant property damage, as manifested by acts or threats;

c. Substantial deterioration in physical health or substantial injury, disease, or death based upon recent poor self-control or judgment in providing one's shelter, nutrition, or personal care; or

d. Substantial deterioration in mental health which would predictably result in dangerousness to that individual, others, or property, based upon evidence of objective facts to establish the loss of cognitive or volitional control over the individual's thoughts or actions or based upon acts, threats, or patterns in the individual's treatment history, current condition, and other relevant factors, including the effect of the individual's mental condition on the individual's ability to consent.

Ohio

INPATIENT OR OUTPATIENT COMMITMENT*

**** If the court relies exclusively on definition under § 5122.01(B)(5), only outpatient commitment may be ordered.***

OHIO REV. CODE ANN. § 5122.15(C). If, upon completion of the hearing, the court finds by clear and convincing evidence that the respondent is a mentally ill person subject to court order, the court shall order the respondent for a period not to exceed ninety days to [a period of inpatient or outpatient commitment].

OHIO REV. CODE ANN. § 5122.01(B). "Mentally ill person subject to court order" means a mentally ill person who, because of the person's illness:

(1) Represents a substantial risk of physical harm to self as manifested by evidence of threats of, or attempts at, suicide or serious self-inflicted bodily harm;

(2) Represents a substantial risk of physical harm to others as manifested by evidence of recent homicidal or other violent behavior, evidence of recent threats that place another in reasonable fear of violent behavior and serious physical harm, or other evidence of present dangerousness;

(3) Represents a substantial and immediate risk of serious physical impairment or injury to self as manifested by evidence that the person is unable to provide for and is not providing for the person's basic physical needs because of the person's mental illness and that appropriate provision for those needs cannot be made immediately available in the community;

(4) Would benefit from treatment in a hospital for his mental illness and is in need of such treatment as manifested by evidence of behavior that creates a grave and imminent risk to substantial rights of others or the person; or

(5) (a) Would benefit from treatment as manifested by evidence of behavior that indicates all of the following:

(i) The person is unlikely to survive safely in the community without supervision, based on a clinical determination.

(ii) The person has a history of lack of compliance with treatment for mental illness and one of the following applies:

(I) At least twice within the thirty-six months prior to the filing of an affidavit seeking court-ordered treatment of the person... he lack of compliance has been a significant factor in necessitating hospitalization in a hospital or receipt of services in a forensic or other mental health unit of a correctional facility, provided that the thirty-six-month period shall be extended by the length of any hospitalization or incarceration of the person that occurred within the thirty-six-month period.

(II) Within the forty-eight months prior to the filing of an affidavit seeking court-ordered treatment of the person ..., the lack of compliance resulted in one or more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others, provided that the forty-eight-month period shall be extended by the length of any hospitalization or incarceration of the person that occurred within the forty-eight-month period.

(iii) The person, as a result of the person's mental illness, is unlikely to voluntarily participate in necessary treatment.

(iv) In view of the person's treatment history and current behavior, the person is in need of treatment in order to prevent a relapse or deterioration that would be likely to result in substantial risk of serious harm to the person or others.

(b) An individual who meets only the criteria described in division (B)(5)(a) of this section is not subject to hospitalization.

Oklahoma

INPATIENT COMMITMENT

43A OKL. ST. § 1-103(13)(a). "Person requiring treatment" means a person who because of his or her mental illness or drug or alcohol dependency:

(1) poses a substantial risk of immediate physical harm to self as manifested by evidence or serious threats of or attempts at suicide or other significant self-inflicted bodily harm,

(2) poses a substantial risk of immediate physical harm to another person or persons as manifested by evidence of violent behavior directed toward another person or persons,

(3) has placed another person or persons in a reasonable fear of violent behavior directed towards such person or persons or serious physical harm to them as manifested by serious and immediate threats,

(4) is in a condition of severe deterioration such that, without immediate intervention, there exists a substantial risk that severe impairment or injury will result to the person, or

(5) poses a substantial risk of immediate serious physical injury to self or death as manifested by evidence that the person is unable to provide for and is not providing for his or her basic physical needs.

OUTPATIENT COMMITMENT ("ASSISTED OUTPATIENT TREATMENT")

43A OKL. ST. § 1-103(20). "Assisted outpatient" means a person who:

(a) is eighteen (18) years of age or older,

(b) is either currently under the care of a facility certified by the Department of Mental Health and Substance Abuse Services as a Community Mental Health Center, or is being discharged from the custody of the Oklahoma Department of Corrections,

(c) is suffering from a mental illness,

(d) is unlikely to survive safely in the community without supervision, based on a clinical determination,

(e) has a history of lack of compliance with treatment for mental illness that has:

(1) prior to the filing of a petition, at least twice within the last thirty-six (36) months been a significant factor in necessitating hospitalization or treatment in a hospital or residential facility, or receipt of services in a forensic or other mental health unit of a correctional facility, or

(2) prior to the filing of the petition, resulted in one or more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others within the last twenty-four (24) months,

(f) is, as a result of his or her mental illness, unlikely to voluntarily participate in outpatient treatment that would enable him or her to live safely in the community,

(g) in view of his or her treatment history and current behavior, is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to the person or persons as defined in this section, and

(h) is likely to benefit from assisted outpatient treatment.

Oregon

INPATIENT OR OUTPATIENT COMMITMENT

OR. REV. STAT. § 426.005(1)(f). "Person with mental illness" means a person who, because of a mental disorder, is one or more of the following:

(A) Dangerous to self or others.

(B) Unable to provide for basic personal needs that are necessary to avoid serious physical harm in the near future, and is not receiving such care as is necessary to avoid such harm.

(C) A person:

(i) With a chronic mental illness[;]

(ii) Who, within the previous three years, has twice been placed in a hospital or approved inpatient facility by the [Oregon Health Authority] or the Department of Human Services[;]

(iii) Who is exhibiting symptoms or behavior substantially similar to those that preceded and led to one or more of the hospitalizations or inpatient placements referred to in sub-subparagraph (ii) of this subparagraph; and

(iv) Who, unless treated, will continue, to a reasonable medical probability, to physically or mentally deteriorate so that the person will become a person described under either or both subparagraph (A) or (B) of this paragraph or both.

OUTPATIENT COMMITMENT: ALTERNATIVE FORM ("ASSISTED OUTPATIENT TREATMENT")

OR. REV. STAT. § 426.133(2). A court may issue an order requiring a person to participate in assisted outpatient treatment if the court finds that the person:

(a) (A) Is 18 years of age or older;

(B) Has a mental disorder;

(C) Will not obtain treatment in the community voluntarily; and

(D) Is unable to make an informed decision to seek or to comply with voluntary treatment; and

(b) As a result of being a person described in paragraph (a) of this subsection:

(A) Is incapable of surviving safely in the community without treatment; and

(B) Requires treatment to prevent a deterioration in the person's condition that will predictably result in the person becoming a person with mental illness.

OR. REV. STAT. § 426.133(3). In determining whether to issue the order under subsection (2) of this section, the court shall consider, but is not limited to considering, the following factors:

(a) The person's ability to access finances in order to get food or medicine.

(b) The person's ability to obtain treatment for the person's medical condition.

(c) The person's ability to access necessary resources in the community without assistance.

(d) The degree to which there are risks to the person's safety.

(e) The likelihood that the person will decompensate without immediate care or treatment.

(f) The person's previous attempts to inflict physical injury on self or others.

(g) The person's history of mental health treatment in the community.

(h) The person's patterns of decompensation in the past.

(i) The person's risk of being victimized or harmed by others.

(j) The person's access to the means to inflict harm on self or others.

Pennsylvania

INPATIENT OR OUTPATIENT COMMITMENT

50 PA CONS. STAT. ANN. § 7304(a)(1). A person who is severely mentally disabled and in need of treatment... may be made subject to court-ordered involuntary treatment upon a determination of clear and present danger under section 301(b)(1) (serious bodily harm to others), or section 301(b)(2)(i) (inability to care for himself, creating a danger of death or serious harm to himself), or 301(b)(2)(ii) (attempted suicide), or 301(b)(2)(iii) (self-mutilation).

50 PA. CONS. STAT. ANN. § 7301(b)(1). Clear and present danger to others shall be shown by establishing that within the past 30 days the person has inflicted or attempted to inflict serious bodily harm on another and that there is a reasonable probability that such conduct will be repeated. If, however, the person has been found incompetent to be tried or has been acquitted by reason of lack of criminal responsibility on charges arising from conduct involving infliction of or attempt to inflict substantial bodily harm on another, such 30-day limitation shall not apply so long as an application for examination and treatment is filed within 30 days after the date of such determination or verdict. In such case, a clear and present danger to others may be shown by establishing that the conduct charged in the criminal proceeding did occur, and that there is a reasonable probability that such conduct will be repeated. For the purpose of this section, a clear and present danger of harm to others may be demonstrated by proof that the person has made threats of harm and has committed acts in furtherance of the threat to commit harm.

50 PA. CONS. STAT. ANN. § 7301(b)(2). Clear and present danger to himself shall be shown by establishing that within the past 30 days:

> (i) the person has acted in such manner as to evidence that he would be unable, without care, supervision and the continued assistance of others, to satisfy his need for nourishment, personal or medical care, shelter, or self-protection and safety, and that there is a reasonable probability that death, serious bodily injury or serious physical debilitation would ensue within 30 days unless adequate treatment were afforded under this act; or
>
> (ii) the person has attempted suicide and that there is the reasonable probability of suicide unless adequate treatment is afforded under this act. For the purposes of this subsection, a clear and present danger may be demonstrated by the proof that the person has made threats to commit suicide and has committed acts which are in furtherance of the threat to commit suicide; or
>
> (iii) the person has substantially mutilated himself or attempted to mutilate himself substantially and that there is the reasonable probability of mutilation unless adequate treatment is afforded under this act. For the purposes of this subsection, a clear and present danger shall be established by proof that the person has made threats to commit mutilation and has committed acts which are in furtherance of the threat to commit mutilation.

Rhode Island

INPATIENT OR OUTPATIENT COMMITMENT

R.I. GEN. LAWS § 40.1-5-8(j). If the court at a final hearing finds by clear and convincing evidence that the subject of the hearing is in need of care and treatment in a facility, and is one whose continued unsupervised presence in the community would, by reason of mental disability, create a likelihood of serious harm, and that all alternatives to certification have been investigated and deemed unsuitable, it shall issue an order committing the person to the custody of the director for care and treatment or to an appropriate facility.

R.I. GEN. LAWS § 40.1-5-2(7). "Likelihood of serious harm" means:

> (i) A substantial risk of physical harm to the person himself or herself as manifested by behavior evidencing serious threats of, or attempts at, suicide;
>
> (ii) A substantial risk of physical harm to other persons as manifested by behavior or threats evidencing homicidal or other violent behavior, or
>
> (iii) A substantial risk of physical harm to the mentally disabled person as manifested by behavior which has created a grave, clear, and present risk to his or her physical health and safety.
>
> (iv) In determining whether there exists a likelihood of serious harm the physician and the court may consider previous acts, diagnosis, words or thoughts of the patient. If a patient has been incarcerated, or institutionalized, or in a controlled environment of any kind, the court may give great weight to such prior acts, diagnosis, words, or thoughts.
>
> R.I. GEN. LAWS § 40.1-5-2(8). "Mental disability" means a mental disorder in which the capacity of a person to exercise self control or judgment in the conduct of his or her affairs and social relations, or to care for his or her own personal needs, is significantly impaired.

South Carolina

INPATIENT OR OUTPATIENT COMMITMENT

S.C. CODE ANN. § 44-17-580(A). If, upon completion of the hearing and consideration of the record, the court finds upon clear and convincing evidence that the person is mentally ill, needs treatment and because of his condition:

> (1) lacks sufficient insight or capacity to make responsible decisions with respect to his treatment; or
>
> (2) there is a likelihood of serious harm to himself or others,

the court shall order in-patient or out-patient treatment at a mental health facility ... and may order out-patient treatment following in-patient treatment.

S.C. CODE ANN. § 44-23-10(13). "Likelihood of serious harm" means because of mental illness there is:

> (a) a substantial risk of physical harm to the person himself as manifested by evidence of threats of, or attempts at, suicide or serious bodily harm;
>
> (b) a substantial risk of physical harm to other persons as manifested by evidence of homicidal or other violent behavior and serious harm to them; or

(c) a very substantial risk of physical impairment or injury to the person himself as manifested by evidence that the person is gravely disabled and that reasonable provision for his protection is not available in the community.

S.C. CODE ANN. § 44-23-10(7) "Gravely disabled" means a person who, due to mental illness, lacks sufficient insight or capacity to make responsible decisions with respect to his treatment and because of this condition is likely to cause harm to himself through neglect, inability to care for himself, personal injury, or otherwise.

S.C. CODE ANN. § 44-23-10(21). "Person with a mental illness" means a person with a mental disease to such an extent that, for the person's own welfare or the welfare of others or of the community, the person requires care, treatment or hospitalization.

South Dakota

INPATIENT OR OUTPATIENT COMMITMENT

S.D. CODIFIED LAWS § 27A-1-2. A person is subject to involuntary commitment if:

(1) The person has a severe mental illness;

(2) Due to the severe mental illness, the person is a danger to self or others or has a chronic disability; and

(3) The individual needs and is likely to benefit from treatment.

S.D. CODIFIED LAWS § 27A-1-1(6). "Danger to others," a reasonable expectation that the person will inflict serious physical injury upon another person in the near future, due to a severe mental illness, as evidenced by the person's treatment history and the person's recent acts or omissions which constitute a danger of serious physical injury for another individual. Such acts may include a recently expressed threat if the threat is such that, if considered in the light of its context or in light of the person's recent previous acts or omissions, it is substantially supportive of an expectation that the threat will be carried out;

S.D. CODIFIED LAWS § 27A-1-1(7). "Danger to self,"

(a) A reasonable expectation that the person will inflict serious physical injury upon himself or herself in the near future, due to a severe mental illness, as evidenced by the person's treatment history and the person's recent acts or omissions which constitute a danger of suicide or self-inflicted serious physical injury. Such acts may include a recently expressed threat if the threat is such that, if considered in the light of its context or in light of the person's recent previous acts or omissions, it is substantially supportive of an expectation that the threat will be carried out; or

(b) A reasonable expectation of danger of serious personal harm in the near future, due to a severe mental illness, as evidenced by the person's treatment history and the person's recent acts or omissions which demonstrate an inability to provide for some basic human needs such as food, clothing, shelter, essential medical care, or personal safety, or by arrests for criminal behavior which occur as a result of the worsening of the person's severe mental illness.

Tennessee*

Tennessee does not have an outpatient commitment law.

INPATIENT COMMITMENT

TENN. CODE ANN. § 33-6-502. IF AND ONLY IF

(1) a person has a mental illness or serious emotional disturbance, AND

(2) the person poses a substantial likelihood of serious harm because of the mental illness or serious emotional disturbance, AND

(3) the person needs care, training, or treatment because of the mental illness or serious emotional disturbance, AND

(4) all available less drastic alternatives to placement in a hospital or treatment resource are unsuitable to meet the needs of the person, THEN

(5) the person may be judicially committed to involuntary care and treatment in a hospital or treatment resource[.]

TENN. CODE ANN. § 33-6-501. IF AND ONLY IF

(1) (A) a person has threatened or attempted suicide or to inflict serious bodily harm on the person, OR

(B) the person has threatened or attempted homicide or other violent behavior, OR

(C) the person has placed others in reasonable fear of violent behavior and serious physical harm to them, OR

(D) the person is unable to avoid severe impairment or injury from specific risks, AND

(2) there is a substantial likelihood that such harm will occur unless the person is placed under involuntary treatment, THEN

(3) the person poses a "substantial likelihood of serious harm" for purposes of this title.

Texas

INPATIENT COMMITMENT

TEX. HEALTH & SAFETY CODE § 574.034(a). The judge may order a proposed patient to receive court-ordered temporary inpatient mental health services only if the judge or jury finds, from clear and convincing evidence, that:

(1) the proposed patient is a person with mental illness; and

(2) as a result of that mental illness the proposed patient:

(A) is likely to cause serious harm to the proposed patient;

(B) is likely to cause serious harm to others; or

(C) is:

(i) suffering severe and abnormal mental, emotional, or physical distress;

(ii) experiencing substantial mental or physical deterioration of the proposed patient's ability to function independently, which is exhibited by the proposed patient's inability, except for reasons of indigence, to provide for the proposed patient's basic needs, including food, clothing, health, or safety; and

(iii) unable to make a rational and informed decision as to whether or not to submit to treatment.

TEX. HEALTH & SAFETY CODE § 574.035(a). The judge may order a proposed patient to receive court-ordered extended inpatient mental health services only if the jury, or the judge if the right to a jury is waived, finds, from clear and convincing evidence, that:

(1) the proposed patient is a person with mental illness;

(2) as a result of that mental illness the proposed patient:

(A) is likely to cause serious harm to the proposed patient;

(B) is likely to cause serious harm to others; or

(C) is:

(i) suffering severe and abnormal mental, emotional, or physical distress;

(ii) experiencing substantial mental or physical deterioration of the proposed patient's ability to function independently, which is exhibited by the proposed patient's inability, except for reasons of indigence, to provide for the proposed patient's basic needs, including food, clothing, health, or safety; and

(iii) unable to make a rational and informed decision as to whether or not to submit to treatment;

(3) the proposed patient's condition is expected to continue for more than 90 days; and

(4) the proposed patient has received court-ordered inpatient mental health services under this subtitle or under Article 46.02, Code of Criminal Procedure, for at least 60 consecutive days during the preceding 12 months.

OUTPATIENT COMMITMENT

TEX. HEALTH & SAFETY CODE § 574.034(b). The judge may order a proposed patient to receive court-ordered temporary outpatient mental health services only if:

(1) the judge finds that appropriate mental health services are available to the proposed patient; and

(2) the judge or jury finds, from clear and convincing evidence, that:

(A) the proposed patient is a person with mental illness;

(B) the nature of the mental illness is severe and persistent;

(C) as a result of the mental illness, the proposed patient will, if not treated, continue to:

(i) suffer severe and abnormal mental, emotional, or physical distress; and

(ii) experience deterioration of the ability to function independently to the extent that the proposed patient will be unable to live safely in the community without court-ordered outpatient mental health services; and

(D) the proposed patient has an inability to participate in outpatient treatment services effectively and voluntarily, demonstrated by:

(i) any of the proposed patient's actions occurring within the two-year period which immediately precedes the hearing; or

(ii) specific characteristics of the proposed patient's clinical condition that make impossible a rational and informed decision whether to submit to voluntary outpatient treatment.

TEX. HEALTH & SAFETY CODE § 574.035(b). The judge may order a proposed patient to receive court-ordered extended outpatient mental health services only if:

(1) the judge finds that appropriate mental health services are available to the proposed patient; and

(2) the jury, or the judge if the right to a jury is waived, finds from clear and convincing evidence that:

(A) the proposed patient is a person with mental illness;

(B) the nature of the mental illness is severe and persistent;

(C) as a result of the mental illness, the proposed patient will, if not treated, continue to:

(i) suffer severe and abnormal mental, emotional, or physical distress; and

(ii) experience deterioration of the ability to function independently to the extent that the proposed patient will be unable to live safely in the community without court-ordered outpatient mental health services;

(D) the proposed patient has an inability to participate in outpatient treatment services effectively or voluntarily, demonstrated by:

(i) any of the proposed patient's actions occurring within the two-year period which immediately precedes the hearing; or

(ii) specific characteristics of the proposed patient's clinical condition that make impossible a rational and informed decision whether to submit to voluntary outpatient treatment;

(E) the proposed patient's condition is expected to continue for more than 90 days; and

(F) the proposed patient has received;

(i) court-ordered inpatient mental health services under this subtitle or under Subchapter D or E, Chapter 46B, Code of Criminal Procedure for a total of at least 60 days during the preceding 12 months; or

(ii) court-ordered outpatient mental health services under this subtitle or under Subchapter D or E, Chapter 46B, Code of Criminal Procedure, during the preceding 60 days.

Utah

INPATIENT OR OUTPATIENT COMMITMENT

UTAH CODE ANN. § 62A-15-631(16). The court shall order commitment of an individual who is 18 years of age or older to a local mental health authority if, upon completion of the hearing and consideration of the information presented ..., the court finds by clear and convincing evidence that:

(a) the proposed patient has a mental illness;

(b) because of the proposed patient's mental illness the proposed patient poses a substantial danger ... to self or others;

(c) the proposed patient lacks the ability to engage in a rational decision-making process regarding the acceptance of mental treatment as demonstrated by evidence of inability to weigh the possible risks of accepting or rejecting treatment;

(d) there is no appropriate less-restrictive alternative to a court order of commitment; and

(e) the local mental health authority can provide the individual with treatment that is adequate and appropriate to the individual's conditions and needs. In the absence of the required findings of the court after the hearing, the court shall forthwith dismiss the proceedings.

UTAH CODE ANN. § 62A-15-602(17). "Substantial danger" means that due to mental illness, an individual is at serious risk of:

(a) suicide;

(b) serious bodily self-injury;

(c) serious bodily injury because the individual is incapable of providing the basic necessities of life, including food, clothing, or shelter;

(d) causing or attempting to cause serious bodily injury to another individual; or

(e) engaging in harmful sexual conduct.

UTAH CODE ANN. § 62A-15-602(16). "Serious bodily injury" means bodily injury which involves a substantial risk of death, unconsciousness, extreme physical pain, protracted and obvious disfigurement, or protracted loss or impairment of the function of a bodily member, organ, or mental faculty.

Vermont

INPATIENT OR OUTPATIENT COMMITMENT

VT. STAT. ANN. tit. 18, § 7611. No person may be made subject to involuntary treatment unless he is found to be a person in need of treatment or a patient in need of further treatment.

VT. STAT. ANN. tit. 18, § 7101(17). "A person in need of treatment" means a person who has a mental illness and, as a result of that mental illness, his or her capacity to exercise self-control, judgment, or discretion in the conduct of his or her affairs and social relations is so lessened that he or she poses a danger of harm to himself, to herself, or to others:

(A) A danger of harm to others may be shown by establishing that:

(i) he or she has inflicted or attempted to inflict bodily harm on another; or

(ii) by his or her threats or actions he or she has placed others in reasonable fear of physical harm to themselves; or

(iii) by his or her actions or inactions he or she has presented a danger to persons in his or her care.

(B) A danger of harm to himself or herself may be shown by establishing that:

(i) he or she has threatened or attempted suicide or serious bodily harm; or

(ii) he or she has behaved in such a manner as to indicate that he or she is unable, without supervision and the assistance of others, to satisfy his or her need for nourishment, personal or medical care, shelter, or self-protection and safety, so that it is probable that death, substantial physical bodily injury, serious mental deterioration, or serious physical debilitation or disease will ensue unless adequate treatment is afforded.

VT. STAT. ANN. tit. 18, § 7101(16) "A patient in need of further treatment" means:

(A) A person in need of treatment; or

(B) A patient who is receiving adequate treatment, and who, if such treatment is discontinued, presents a substantial probability that in the near future his or her condition will deteriorate and he or she will become a person in need of treatment.

Virginia

INPATIENT COMMITMENT

VA. CODE ANN. § 37.2-817(C). [A] judge or special justice [shall order involuntary admission if he or she] finds by clear and convincing evidence that:

(a) the person has a mental illness and there is a substantial likelihood that, as a result of mental illness, the person will, in the near future,

(1) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or

(2) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs, and

(b) ["mandatory outpatient treatment" has] been investigated and determined to be inappropriate[.]

OUTPATIENT COMMITMENT ("MANDATORY OUTPATIENT TREATMENT") (3 TYPES)

Criteria for "mandatory outpatient treatment" in lieu of inpatient commitment:

VA. CODE ANN. § 37.2-817(D). [I]f the judge or special justice finds by clear and convincing evidence that (a) the person has a mental illness and ... there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future, (1) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or (2) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs; (b) less restrictive alternatives to involuntary inpatient treatment that would offer an opportunity for improvement of his condition have been investigated and are determined to be appropriate; (c) the person has agreed to abide by his treatment plan and has the ability to do so; and (d) the ordered treatment will be delivered on an outpatient basis by the community services board or designated provider to the person, the judge or special justice shall ... order that the person be admitted involuntarily to mandatory outpatient treatment. Less restrictive alternatives shall not be determined to be appropriate unless the services are actually available in the community.

Criteria for "mandatory outpatient treatment" to follow simultaneously-obtained inpatient commitment order:

VA. CODE ANN. § 37.2-817(C1). In the order for involuntary admission, the judge or special justice may authorize the treating physician to discharge the person to mandatory outpatient treatment ...if the judge or special justice further finds by clear and convincing evidence that (i) the person has a history of lack of compliance with treatment for mental illness that at least twice within the past 36 months has resulted in the person being subject to an order for involuntary admission pursuant to subsection C; (ii) in view of the person's treatment history and current behavior, the person is in need of mandatory outpatient treatment following inpatient treatment in order to prevent a relapse or deterioration that would be likely to result in the person meeting the criteria for involuntary inpatient treatment; (iii) as a result of mental illness, the person is unlikely to voluntarily participate in outpatient treatment unless the court enters an order authorizing discharge to mandatory outpatient treatment following inpatient treatment; and (iv) the person is likely to benefit from mandatory outpatient treatment.

Criteria for "mandatory outpatient treatment" ordered upon discharge from currently pending inpatient commitment order:

VA CODE ANN. § 37.2-817(C). Upon motion ... a hearing shall be held prior to the release date of any involuntarily admitted person to determine whether such person should be ordered to mandatory outpatient treatment pursuant to subsection D upon his release if such person, on at least two previous occasions within 36 months preceding the date of the hearing, has been (A) involuntarily admitted pursuant to this section or (B) the subject of a temporary detention order and voluntarily admitted himself[.]

Washington

INPATIENT OR OUTPATIENT COMMITMENT

REV. CODE WASH. § 71.05.240(3). [I]f the court finds by a preponderance of the evidence that such person, as the result of mental disorder, presents a likelihood of serious harm, or is gravely disabled, and, after considering less restrictive alternatives to involuntary detention and treatment, finds that no such alternatives are in the best interests of such person or others, the court shall order that such person be detained for involuntary treatment not to exceed fourteen days in a facility certified to provide treatment by the department.

REV. CODE. WASH. § 71.05.280. At the expiration of the fourteen-day period of intensive treatment, a person may be committed for further treatment ... if:

> (1) Such person after having been taken into custody for evaluation and treatment has threatened, attempted, or inflicted: (a) Physical harm upon the person of another or himself or herself, or substantial damage upon the property of others, and (b) as a result of mental disorder presents a likelihood of serious harm; or
>
> (2) Such person was taken into custody as a result of conduct in which he or she attempted or inflicted physical harm upon the person of another or himself or herself, or substantial damage upon the property of others, and continues to present, as a result of mental disorder, a likelihood of serious harm; or
>
> (3) Such person has been determined to be incompetent and criminal charges have been dismissed ..., and has committed acts constituting a felony, and as a result of a mental disorder, presents a substantial likelihood of repeating similar acts... or
>
> (4) Such person is gravely disabled.

REV. CODE WASH. § 71.05.020(34). "Likelihood of serious harm" means:

> (a) A substantial risk that:
>
> > (i) Physical harm will be inflicted by a person upon his or her own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on oneself;
> >
> > (ii) physical harm will be inflicted by a person upon another, as evidenced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm; or
> >
> > (iii) physical harm will be inflicted by a person upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others; or
>
> (b) The person has threatened the physical safety of another and has a history of one or more violent acts.

REV. CODE WASH. § 71.05.020(22). "Gravely disabled" means a condition in which a person, as a result of a mental disorder, or as a result of the use of alcohol or other psychoactive chemicals:

> (a) is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety; or

(b) manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety.

REV. CODE WASH. § 71.05.020(24). "History of one or more violent acts" refers to the period of time ten years prior to the filing of a petition under this chapter, excluding any time spent, but not any violent acts committed, in a mental health facility, a long-term alcoholism or drug treatment facility, or in confinement as a result of a criminal conviction;

REV. CODE WASH. § 71.05.020(57). "Violent act" means behavior that resulted in homicide, attempted suicide, nonfatal injuries, or substantial damage to property.

OUTPATIENT COMMITMENT: ALTERNATIVE FORM ("ASSISTED OUTPATIENT BEHAVIORAL HEALTH TREATMENT")

REV. CODE WASH. § 71.05.240(3)(d). If the court finds by a preponderance of the evidence that such person, as the result of a mental disorder or substance use disorder, is in need of assisted outpatient behavioral health treatment, and that the person does not present a likelihood of serious harm or grave disability, the court shall order an appropriate less restrictive course of treatment for not to exceed ninety days.

REV. CODE WASH. § 71.05.020(29). "In need of assisted outpatient behavioral health treatment" means that a person, as a result of a mental disorder or substance use disorder:

(a) Has been committed by a court to detention for involuntary behavioral health treatment during the preceding thirty-six months;

(b) is unlikely to voluntarily participate in outpatient treatment without an order for less restrictive alternative treatment, based on a history of nonadherence with treatment or in view of the person's current behavior;

(c) is likely to benefit from less restrictive alternative treatment; and

(d) requires less restrictive alternative treatment to prevent a relapse, decompensation, or deterioration that is likely to result in the person presenting a likelihood of serious harm or the person becoming gravely disabled within a reasonably short period of time.

West Virginia

INPATIENT OR OUTPATIENT COMMITMENT

W. VA. CODE § 27-1-12. Likely to cause serious harm

(a) "Likely to cause serious harm" means an individual is exhibiting behaviors consistent with a medically recognized mental disorder , excluding, however, disorders that are manifested only through antisocial or illegal behavior, and as a result of the mental disorder... :

(1) The individual has inflicted or attempted to inflict bodily harm on another;

(2) The individual, by threat or action, has placed others in reasonable fear of physical harm to themselves;

(3) The individual, by action or inaction, presents a danger to himself, herself or others in his or her care;

(4) The individual has threatened or attempted suicide or serious bodily harm to himself or herself; or

(5) The individual is behaving in a manner as to indicate that he or she is unable, without supervision and the assistance of others, to satisfy his or her need for nourishment, medical care, shelter or self-protection and safety so that there is a substantial likelihood that death, serious bodily injury, serious physical debilitation, serious mental debilitation or life-threatening disease will ensue unless adequate treatment is afforded.

(b) In making the "likely to cause serious harm" determination, judicial, medical, psychological and other evaluators and decision makers should utilize all available information, including psychosocial, medical, hospitalization and psychiatric information and including the circumstances of any previous commitments or convalescent or conditional releases that are relevant to a current situation, in addition to the individual's current overt behavior.

Wisconsin

INPATIENT OR OUTPATIENT COMMITMENT

WIS. STAT. ANN. § 51.20(1)(a). [A] written petition for examination shall allege that all of the following apply to the subject individual to be examined:

1. The individual is mentally ill, or ... drug dependent or developmentally disabled and is a proper subject for treatment.

2. The individual is dangerous because he or she does any of the following:

a. Evidences a substantial probability of physical harm to himself or herself as manifested by evidence of recent threats of or attempts at suicide or serious bodily harm.

b. Evidences a substantial probability of physical harm to other individuals as manifested by evidence of recent homicidal or other violent behavior, or by evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them, as evidenced by a recent overt act, attempt or threat to do serious physical harm.

c. Evidences such impaired judgment, manifested by evidence of a pattern of recent acts or omissions, that there is a substantial probability of physical impairment or injury to himself or herself. The probability of physical impairment or injury is not substantial ... if reasonable provision for the subject individual's protection is available in the community and there is a reasonable probability that the individual will avail himself or herself of these services[.] ... Food, shelter or other care provided to an individual who is substantially incapable of obtaining the care for himself or herself, by a person other than a treatment facility, does not constitute e reasonable provision for the subject individual's protection available in the community[.]

d. Evidences behavior manifested by recent acts or omissions that, due to mental illness, he or she is unable to satisfy basic needs for nourishment, medical care, shelter or safety without prompt and adequate treatment so that a substantial probability exists that death, serious physical injury, serious physical debilitation or serious physical disease will

imminently ensue unless the individual receives prompt and adequate treatment for this mental illness. No substantial probability of harm ... exists if reasonable provision for the individual's treatment and protection is available in the community and there is a reasonable probability that the individual will avail himself or herself of these services[.] ... Food, shelter or other care provided to an individual who is substantially incapable of obtaining the care for himself or herself, by any person other than a treatment facility, does not constitute reasonable provision for the individual's treatment or protection available in the community[.]

e. For an individual, other than an individual who is alleged to be drug dependent or developmentally disabled, after the advantages and disadvantages of and alternatives to accepting a particular medication or treatment have been explained to him or her and because of mental illness, evidences either incapability of expressing an understanding of the advantages and disadvantages of accepting medication or treatment and the alternatives, or substantial incapability of applying an understanding of the advantages, disadvantages and alternatives to his or her mental illness in order to make an informed choice as to whether to accept or refuse medication or treatment; and evidences a substantial probability, as demonstrated by both the individual's treatment history and his or her recent acts or omissions, that the individual needs care or treatment to prevent further disability or deterioration and a substantial probability that he or she will, if left untreated, lack services necessary for his or her health or safety and suffer severe mental, emotional or physical harm that will result in the loss of the individual's ability to function independently in the community or the loss of cognitive or volitional control over his or her thoughts or actions. The probability of suffering severe mental, emotional or physical harm is not substantial ... if reasonable provision for the individual's care or treatment is available in the community and there is a reasonable probability that the individual will avail himself or herself of these services[.] ... Food, shelter or other care that is provided to an individual who is substantially incapable of obtaining food, shelter or other care for himself or herself by any person other than a treatment facility does not constitute reasonable provision for the individual's care or treatment in the community[.]

Wyoming

INPATIENT OR OUTPATIENT COMMITMENT*

**** See below for <u>additional</u> criteria required for outpatient commitment.***

WYO. STAT. ANN. § 25-10-110(j). If, upon completion of the hearing and consideration of the record, the court or the jury finds by clear and convincing evidence that the proposed patient is mentally ill the court shall consider the least restrictive and most therapeutic alternatives[.]

WYO. STAT. ANN. § 25-10-101(a)(ix). "[M]entally ill" mean a physical, emotional, mental or behavioral disorder which causes a person to be dangerous to himself or others and which requires treatment, but do not include addiction to drugs or alcohol, drug or alcohol intoxication or developmental disabilities, except when one (1) or more of those conditions co-occurs as a secondary diagnosis with a mental illness.

WYO. STAT. ANN. § 25-10-101(a)(ii). "Dangerous to himself or others" means that, as a result of mental illness, a person:

(A) Evidences a substantial probability of physical harm to himself as manifested by evidence of recent threats of or attempts at suicide or serious bodily harm; or

(B) Evidences a substantial probability of physical harm to other individuals as manifested by a recent overt homicidal act, attempt or threat or other violent act, attempt or threat which places others in reasonable fear of serious physical harm to them; or

(C) Evidences behavior manifested by recent acts or omissions that, due to mental illness, he is unable to satisfy basic needs for nourishment, essential medical care, shelter or safety so that a substantial probability exists that death, serious physical injury, serious physical debilitation, serious mental debilitation, destabilization from lack of or refusal to take prescribed psychotropic medications for a diagnosed condition or serious physical disease will imminently ensue, unless the individual receives prompt and adequate treatment for this mental illness. No person, however, shall be deemed to be unable to satisfy his need for nourishment, essential medical care, shelter or safety if he is able to satisfy those needs with the supervision and assistance of others who are willing and available.

(D) While this definition requires evidence of recent acts or omissions of endangerment, either to self or others, a court may consider a person's mental health history in determining whether directed outpatient commitment or involuntary hospitalization is warranted.

OUTPATIENT COMMITMENT *(in addition to the criteria above)*

WYO. STAT. ANN. § 25-10-110.1. Directed outpatient commitment proceedings.

(a) If the court finds based upon the recommendation of an examiner or on its own determination that the proposed patient is mentally ill but does not require inpatient hospitalization, the court shall consider issuing a directed outpatient commitment order.

(b) In considering whether directed outpatient commitment is appropriate, the court may consider one (1) or more of the following:

(i) The proposed patient is diagnosed as having a mental illness;

(ii) Without directed outpatient treatment, the proposed patient is likely to be dangerous to himself or others based upon noncompliance with prior medical directives;

(iii) The proposed patient is likely to suffer substantial medical or mental deterioration or become seriously disabled;

(iv) The proposed patient lacks present ability to make an informed decision concerning his need for treatment; or

(v) Any other information concerning the proposed patient's need for outpatient care.

APPENDIX

H

2016

The Danger Zone: How the Dangerousness Standard in Civil Commitment Proceedings Harms People with Serious Mental Illness

Sara G. Gordon
University of Nevada, Las Vegas -- William S. Boyd School of Law

THE DANGER ZONE: HOW THE DANGEROUSNESS STANDARD IN CIVIL COMMITMENT PROCEEDINGS HARMS PEOPLE WITH SERIOUS MENTAL ILLNESS

Sara Gordon†

"It must be remembered that for the person with severe mental illness who has no treatment the most dreaded of confinements can be the imprisonment inflicted by his own mind, which shuts reality out and subjects him to the torment of voices and images beyond our own powers to describe."[1]

"Civil libertarians say no—that it is our right to commit crimes that land us in prison, that it is our choice to be so ill that we prefer to forage through garbage and live on the streets, that it is our prerogative to let voices in our heads torment us into sleepless nights. But something tells me that the people locked up in San

† Associate Professor of Law, William S. Boyd School of Law, University of Nevada, Las Vegas. Thank you to Linda Edwards, Michael Higdon, Ngai Pindell, and the participants in the 2014 University of Utah Legal Borders and Mental Disorders Law Review Symposium for their helpful comments and suggestions. Thanks also to the editors of the *Case Western Reserve Law Review* for valuable editorial suggestions and to Dawn Nielsen, Gil Kahn, and Chad Schatzle for excellent research assistance.

1. Olmstead v. L.C. *ex rel.* Zimring, 527 U.S. 581, 609–10 (1999) (Kennedy, J., concurring). In Olmstead, the Court held that under the ADA,

> States are required to provide community-based treatment for persons with mental disabilities when the State's treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities.

Id. at 607 (majority opinion). Justice Kennedy's concurrence, however, warned that this holding should be applied with "caution and circumspection" so as not to pressure states with "some incentive, for fear of litigation, to drive those in need of medical care and treatment out of appropriate care and into settings with too little assistance and supervision." *Id.* at 610 (Kennedy, J., concurring). Since *Olmstead*, "[twelve] states and the District of Columbia have completely eliminated large state-run [psychiatric facilities]." Liz Robbins, *For Special-Care Residents, State Policy Means Leaving Home*, N.Y. TIMES (Jan. 29, 2015), http://www.nytimes.com/2015/02/01/nyregion/as-new-york-moves-people-with-developmental-disabilities-to-group-homes-some-families-struggle.html [http://perma.cc/KJF4-FF42].

Quentin with a mental illness, and the people roving the back alleys of skid row, are not singing "God Bless America."[2]

ABSTRACT

Almost every American state allows civil commitment upon a finding that a person, as a result of mental illness, is gravely disabled and unable to meet their basic needs for food and shelter. Yet in spite of these statutes, most psychiatrists and courts will not commit an individual until they are found to pose a danger to themselves or others. All people have certain rights to be free from unwanted medical treatment, but for people with serious mental illness, those civil liberties are an abstraction, safeguarded for them by a system that is not otherwise ensuring access to shelter and basic medical care.

States' continued and primary use of dangerousness standard in civil commitment proceedings does not meet our obligations to people with serious mental illness. Continued perceptions of the link between mental illness and violence, coupled with the strict interpretation of commitment statutes based on states' *parens patriae* authority, have resulted in commitment standards that effectively commit people only when they are dangerous, which is often far past the point that they are in need of help. Courts and psychiatrists should recognize states' obligations to provide health care to people with mental illness by interpreting gravely disabled statutes to allow for commitment when an individual is unable to provide for her basic needs but does not pose a danger to herself.

CONTENTS

2. Jim Randall, *Helping Those Who Don't Know They Want It*, L.A. TIMES (Mar. 12, 2006), http://articles.latimes.com/2006/mar/12/opinion/oe-randall12 [http://perma.cc/7F9U-S42F].

INTRODUCTION

Serious mental illness affects approximately 9.6 million people in the United States, or about 4.1% of the population.[3] In addition to the many debilitating symptoms of serious mental illness, many people also lack insight into the extent and effects of their symptoms; lack of insight is neurologically based and is often a hallmark of serious mental illness.[4] This lack of insight coupled with the complexities of serious mental

3. U.S. Dep't OF HEALTH & HUM. SERVS., *Results from the 2012 National Survey on Drug Use and Health: Mental Health Findings* (Dec. 2013), http://www.samhsa.gov/data/sites/default/files/2k12MH_Findings/2k12MH_Findings/NSDUHmhfr2012.htm [http://perma.cc/6HQ2-V3SN] ("SAMHSA defined SMI as persons aged 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within DSM-IV (APA, 1994) that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities. . . . In 2012, there were an estimated 9.6 million adults aged 18 or older in the United States with SMI in the past year. This represented 4.1 percent of all adults in this country in 2012 . . . . The percentage of adults with past year SMI in 2012 was similar to that in 2008 (3.7 percent).).

4. Between 57 and 98% of people with schizophrenia have some lack of insight into their illness and over 84% of bipolar patients experience lack of insight during pure manic phases. Frederick Cassidy, *Insight in Bipolar Disorder: Relationship to Episode Subtypes and Symptom Dimensions*, 6 NEUROPSYCHIATRIC DISEASE AND TREATMENT 627, 629 (2010); *see also* E. FULLER TORREY, THE INSANITY OFFENSE: HOW AMERICA'S FAILURE TO TREAT THE SERIOUSLY MENTALLY ILL ENDANGERS ITS CITIZENS 116 (2012). "The term anosognosia . . . refers to a neurologically based denial of illness and unawareness of disability." Douglas S. Lehrer & Jennifer Lorenz, *Anosognosia in Schizophrenia: Hidden in Plain Sight*, 11 INNOVATIONS IN CLINICAL NEUROSCIENCE 10, 13 (2014). The authors break down the origin of the term anosognosia further, "[A]=without, noso=disease, gnosia=knowledge." *Id.* at 12–13. Although the exact anatomical basis is still unclear, it appears that the frontal and parietal lobes are most affected in people with anosognosia. TORREY, *supra*, at 116 ("The anatomical basis of anosognosia, however, should not be oversimplified. Most brain functions utilize circuits involving multiple brain areas, and this is certainly true for anosognosia. Thus there is no single 'anosognosia center'; rather, self-awareness is a product of a complex circuit prominently involving areas in the frontal and parietal lobes, the connections between them, and other brain areas."). Although this lack of insight has been noted in people with serious mental illness throughout history, the term was first used to describe people suffering from paralysis after a stroke who denied that they were paralyzed. Supreme Court Justice William Douglas suffered from anosognosia following a stroke; when he became paralyzed on his left side "he initially dismissed the paralysis as a myth, and weeks later he was still inviting reporters to go on hiking expeditions with him." James Shreeve, *The Brain That Misplaced Its Body*, DISCOVER MAG. (1995) *available at* http://discovermagazine.com/1995/may/thebrainthatmisp502 [http://perma.cc/35K2-GXR8].

illness means that people with chronic and long-term illnesses like schizophrenia and bipolar disorder often need some assistance in order to obtain mental health treatment and services.[5] Without assistance, whether from family members, communities, or the state, many are otherwise largely unable to care for themselves or access appropriate mental health care. This lack of access to treatment and resources has led to the marginalization of many people with mental illness—to the streets, to prisons, and to a variety of situations where they are at higher risk of becoming victims of crimes.[6]

Before the 1950s, many people with serious mental illness in the United States lived for most or all of their lives in state-run institutions.[7] But as states began to "deinstitutionalize" inpatient psychiatric patients and heighten civil commitment standards, more patients who would have previously been treated in a long-term inpatient facility were left to find treatment on their own in the community. Well-intentioned civil rights and community mental health advocates believed that most people suffering from serious mental illness would be better served in their own communities.[8] Of course, along with this belief was a corresponding expectation that those individuals would voluntarily seek that treatment and that treatment would be available to them in those communities.

For some patients with chronic and serious mental illness, however, especially those without the resources to obtain care in the community, neither of these things happened. Instead, many of these people have become "revolving-door patients"; they have a serious mental disorder, do not voluntarily comply with treatment, and are unable to live successfully in the community without treatment. They often cycle in and out of hospital emergency rooms, where they receive the minimum amount of care necessary to stabilize them, and are discharged. Long-term treatment in the community is often unavailable, and without that care, many people with serious mental illness live on the streets,

5. People without such insight into the nature of their illnesses are often unaware they have an illness, have difficulty recognizing the symptoms and deficits of the illness, and do not understand the need for treatment of the illness. Lehrer & Lorenz, *supra* note 4, at 11. Impaired insight in patients with serious mental illness is associated with lower treatment adherence, impaired social skills and work performance, higher rates of relapse, and increased violence and suicidal behavior. Peter F. Buckley et al., *Lack of Insight in Schizophrenia: Impact on Treatment Adherence*, 21 CNS DRUGS 129, 130 (2007).

6. Virginia Aldigé Hiday, *Criminal Victimization of Persons with Severe Mental Illness*, 50 PSYCHIATRIC SERVS. 62, 66 (1999) ("The rate of violent criminal victimization in the sample was more than two and a half times the rate in the general population.").

7. Megan Testa & Sara G. West, *Civil Commitment in the United States*, 7 PSYCHIATRY 30, 32 (2010).

8. TORREY, *supra* note 4, at 3–5.

commit crimes for which they are sent to prison, or become victims of crime themselves.

Access to appropriate mental health care is a problem with tremendous scope in this country and there is no easy solution. Issues ranging from funding, to delivery, to quality of care have led many to conclude that the "mental health care system is 'in shambles.'"[9] For some people with serious mental illness, however, it is not just a question of the delivery or quality of the care they receive; it is that they receive almost no mental health services at all. Civil commitment is one way to ensure that people who are otherwise not receiving treatment for mental illness receive those services. Although most states have statutes that ostensibly allow for commitment when a person is not dangerous to herself or others but is nevertheless unable meet her basic needs for food and shelter, these standards are often interpreted strictly to require dangerousness. In these cases, the individual's lack of ability to meet her basic needs must be so grave that death is likely to result. For this reason, some people with untreated serious mental illness do eventually harm themselves or another person, further increasing public perceptions of a link between mental illness and violence, and stigmatizing those with mental illness. Meanwhile, people with serious mental illness who are not dangerous often do not have access to appropriate mental health care, or the resources to obtain available care.

This Article proposes that courts and psychiatrists go beyond a finding of dangerousness as a predicate for civil commitment, and instead interpret gravely disabled statutes to allow for commitment when an individual is unable to provide for her basic needs but does not pose a danger to herself. An expansion of civil commitment is far from an ideal solution, but it is one that could potentially provide access to mental health care and treatment to individuals who will not otherwise receive it.

Part I of this Article traces the history of civil commitment in the United States, as well as shifts in attitudes about the role of the state in providing mental health care to people with serious mental illness. Part II reviews current state statutes and trends relating to civil commitment, including dangerousness and gravely disabled grounds. Part III examines the role of psychiatrists and courts in civil commitment proceedings and the tendency of both to read a dangerousness requirement into gravely disabled grounds for commitment. Part IV considers the public perception of the link between mental illness and violence and argues that this perception has been perpetuated by civil commitment statutes that incorporate connections between mental illness and dangerousness. This Part also examines the current research on the lack of a direct connection between mental illness and violence. Part V exam-

9. RICHARD G. FRANK & SHERRY A. GLIED, BETTER BUT NOT WELL: MENTAL HEALTH POLICY IN THE UNITED STATES SINCE 1950 2 (2006).

ines the effect of deinstitutionalization and heighted commitment standards on access to mental health treatment for people with serious mental illness. Part VI concludes and recommends that courts and psychiatrists recognize states' obligations to provide health care to people with serious mental illness by interpreting gravely disabled statutes to allow for commitment when an individual is unable to provide for her basic needs but does not pose a danger to herself.

I. THE HISTORY OF CIVIL COMMITMENT IN THE UNITED STATES

The United States has undergone enormous shifts in its treatment of people with mental illness, which has taken various forms from a more paternalistic model—one that sought to commit people whenever they might benefit from intervention—to a more libertarian model, or one that seeks to limit any form of commitment to people who might harm themselves or other members of society.[10] In this way, mental health differs markedly from physical health; patients must give informed consent to medical treatment for any physical disorder and any person "of adult years and sound mind has a right to determine what shall be done with his own body."[11] When an illness is mental rather than physical, however, the state is empowered by civil commitment statutes to impose its decision-making and requirements on that treatment. The scope of that power, however, has long been a subject of controversy.

State intervention in the mental health treatment of citizens in the form of civil commitment statutes is a fairly recent development in this country. In Colonial America, family members were the source of most care for the mentally ill, and those without familial support often formed groups of itinerant "drifters" who moved from town to town.[12] If a mentally ill person became violent or otherwise posed a threat to the community, he was imprisoned.[13] Because the family was responsible for supporting its members, early examples of community action appear limited to attempts to help impoverished families care for their mentally

10. Testa & West, *supra* note 7, at 32–33.

11. Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914). As the Supreme Court noted when citing *Schloendorff*, the informed consent doctrine "has become firmly entrenched in American tort law." Cruzan v. Dir., Missouri Dep't of Health, 497 U.S. 261, 269 (1990). Furthermore, the Court has found this right to be a constitutionally protected liberty. Riggins v. Nevada, 504 U.S. 127, 133–34 (1992).

12. SAMUEL J. BRAKEL ET AL., THE MENTALLY DISABLED AND THE LAW 12 (1985).

13. *Id.* at 12–13.

ill members. In this way, the treatment of the very poor and the mentally ill seem quite similar, and were often seen as examples of charity to the family, rather than any attempt to help the mentally ill person. For example, in 1655, Providence, Rhode Island, gave a man 15 shillings "for helpe in this his sad condition of his wife's distraction."[14]

In 1771, the first mental hospital was established in Pennsylvania and communities began to take a more active role in treating the mentally ill; soon state legislatures began passing laws that allowed for the involuntary commitment of citizens to state institutions.[15] These early statutes primarily allowed for the mentally ill to be confined when they were violent and posed a danger to themselves or their community, and when they did not have relatives who could properly care for them.[16] One of the first cases of commitment of a nonviolent mentally ill person was in 1845 in Massachusetts.[17] A man named Josiah Oakes was detained not because he was violent, but because his family believed that following the death of his wife, his hallucinations caused him to become engaged to a much younger woman of "bad character."[18] The court found that his detention was appropriate, both because his illness might cause him to take actions harmful to himself, but also because the restraint itself might "be conducive" to his restoration.[19]

For much of the next two hundred years, civil commitment statutes and the ability of the state to confine the mentally ill continued to expand. Many scholars attribute this expansion to two primary causes. First, as local governments expanded, the view that the family was solely obligated to care for its members changed and communities began to take a larger role in assuming responsibility for this care. Second, as the psychiatric field gained greater prominence, techniques were developed to help "treat" the mentally ill, and detention began to be seen as part of the therapeutic process.[20] As treatment for mental illness—and

14. ALBERT DEUTSCH, THE MENTALLY ILL IN AMERICA 49 (1937).

15. CHRISTOPHER SLOBOGIN ET AL., LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS 804 (5th ed. 2013).

16. BRAKEL ET AL., *supra* note 12, at 14 (citing a 1788 New York statute that noted that "there are sometimes persons, who by lunacy or otherwise are furiously madd, or are so far disordered in their senses that they may be dangerous to be permitted to go abroad").

17. In re Oakes, 8 Law Rep. 122 (Mass. 1845).

18. *Id.* at 127 ("The fact of an old man, a widower, wishing to marry a young wife, is not of itself evidence of insanity. But the circumstances, and the conduct of Mr. Oakes, attending the proposed marriage, are evidence that lie was laboring under a hallucination of mind.").

19. *Id.* at 129.

20. SLOBOGIN ET AL., *supra* note 15 at 805–06. As Slobogin notes, one well-known exception to this general expansion of commitment authority was a woman named Mrs. Packard, who was committed to the Illinois State Hospital in

optimism about that treatment—continued to develop, mental hospitals opened throughout the country.[21] Meanwhile, the standard for civil commitment continued to loosen and, by 1970, thirty-one states had statutes that allowed commitment upon a finding by a physician that the person was mentally ill and was in need of treatment.[22]

As state commitment standards evolved, courts began to articulate two primary legal principles that give states an interest in the civil commitment of people with mental illness. The first is the *parens patriae* authority, which gives the state the power—and the responsibility—to intervene on behalf of citizens who cannot act in their own best interests.[23] The *parens patriae* authority obligates the state to care for people whose mental illness renders them unable to make appropriate medical decisions for themselves.[24] The second principle is the police power, which obligates states to protect the interest of citizens.[25] The state, therefore, owes a duty to people other than the mentally ill individual. Statutes that allow for civil commitment when a person is believed to be dangerous to others are one example of the state's exercise of this police power to implement laws that may benefit society at large, though at the cost of the individual liberties of the mentally ill patient.[26]

1860 under a statute that allowed for "[m]arried women and infants, who in the judgment of the medical superintendent are evidently insane or distracted, may be received and detained in the hospital at the request of the husband . . . without the evidence of insanity or distraction required in other cases." Her commitment was based primarily on the testimony of two doctors, one of whom said she was rational, but was a "religious bigot," and the other who said she had "novel" ideas. Mrs. Packer was released three years later and vigorously campaigned against laws that allowed people to be committed based solely on their opinions. The Illinois legislature subsequently enacted a statute that required a jury trial before a person can be committed to a mental institution. *See also* BRAKEL ET EL., *supra* note 12, at 15.

21. SLOBOGIN ET AL., *supra* note 15, at 806.

22. *Id.*

23. For a general overview of the state's *parens patriae* authority as a basis for civil commitment, see BRUCE J. WINICK, CIVIL COMMITMENT: A THERAPEUTIC JURISPRUDENCE MODEL 66–68 (2005).

24. *See* Addington v. Texas, 441 U.S. 418, 426 (1978) (holding that "[t]he state has a legitimate interest under its *parens patriae* powers in providing care to its citizens who are unable because of emotional disorders to care for themselves").

25. Jacobson v. Massachusetts, 197 U.S. 11, 27 (1905). For a general overview of the state's police power as a basis for civil commitment, see WINICK, *supra* note 23, at 59–66.

26. Eric S. Janus, *Toward a Conceptual Framework for Assessing Police Power Commitment Legislation: A Critique of Schopp's and Winick's Explications of Legal Mental Illness*, 76 NEB. L. REV. 1, 2–4 (1997).

Notwithstanding the development of controlling legal standards, it was fairly simple to hospitalize a person against her will throughout the first half of the twentieth century: one simply had to establish the presence of mental illness and provide a physician's recommendation that treatment at a psychiatric hospital was necessary.[27] Inpatient treatment was considered beneficial and there were few procedural barriers to admission.[28] Because commitment statutes were overwhelmingly based on the states *parens patriae* authority, and because the government was ostensibly meeting its obligation to provide patients with necessary treatment during commitment, few were concerned with the coercive nature of requiring patients to comply with the prescribed treatment.[29]

Beginning in the 1950s, however, the country began experiencing another shift in its treatment of the mentally ill, this time away from the more paternalistic *parens patriae* approach and towards a libertarian approach—one where the state began to intervene less, commitment requirements became stricter, and mental hospitals began to rapidly diminish. This period of deinstitutionalization can be traced to a number of factors, including a series of exposés about the treatment of the mentally ill in state-run institutions,[30] and the concurrent efforts of civil rights lawyers and mental health professionals who pushed for mental health care reform.[31] At the same time, advances in modern psychiatric treatment and pharmacology contributed to the change. Chlorpromazine, or Thorazine, first became available in 1954 and was the first antipsychotic medication that controlled the symptoms of schizophrenia for some patients, thus allowing them to live outside the constraints of a psychiatric facility.[32] Mental health professionals began to

27. WINICK, *supra* note 23, at 4.

28. Testa & West, *supra* note 7, at 32.

29. *Id.*

30. *See, e.g.*, Mike Gorman, *Misery Rules in State Shadowland*, THE DAILY OKLAHOMAN 3 (1946), *available at* http://profiles.nlm.nih.gov/ps/access/TGBBGW.pdf [http://perma.cc/ZNK9-7YCY] (describing "the frightful squalor these unfortunates live in—beds jammed against one another, holes in the floor, gaping cracks in the wall, long rows of hard, unpainted benches, dirty toilets, dining halls where the food is slopped out by unkempt patient attendants and, above all, the terrifying atmosphere of hopelessness in institutions where thousands of patients are penned in day after day and night after night endlessly staring at blank walls"); ALBERT DEUTSCH, THE SHAME OF THE STATES 42 (1948) (describing mental hospitals as "buildings swarming with naked humans herded like cattle and treated with less concern, pervaded by a fetid odor so heavy, so nauseating, that the stench seemed to have almost a physical existence of its own").

31. TORREY, *supra* note 4, at 3–5.

32. E. FULLER TORREY ET AL., THE SHORTAGE OF PUBLIC HOSPITAL BEDS FOR MENTALLY ILL PERSONS: A REPORT OF THE TREATMENT ADVOCACY CENTER 3 (2008); Testa & West, *supra* note 7, at 33.

see psychotic patients as more manageable, and also more able to manage their own lives outside of institutions.[33]

At the same time, deinstitutionalization became judicially sanctioned when federal and state courts began changing standards for commitments.[34] Civil commitment laws were rewritten to provide greater protections to the mentally ill, and included provisions meant to protect the right to liberty of patients. Among these protections were the patient's right to a trial with an attorney present and increased oversight by courts throughout the duration of confinement.[35] Patients were also given rights to litigate before and after admission and to refuse treatment. The process effectively shifted from one overseen and administered by physicians to a more adversarial process subject to judicial review.

States also began to adopt stricter civil commitment standards, shifting away from the traditional need for treatment model to narrower "dangerousness to self or others" standards. Unlike traditional commitment standards, which relied on states' *parens patriae* authority, this heightened standard was an exercise further justified by the state's police power. Because the state has an interest in protecting citizens from the dangerous acts of people with mental illness, many states amended civil commitment statutes to allow for commitment only when the mentally ill person was found to pose a danger to themselves or others.[36] This standard continues to invoke the state's *parens patriae* authority to protect an individual who is dangerous to herself, but also uses the police power to protect communities from individuals who are dangerous to others.

Another related and significant explanation for the shift towards the closing of psychiatric facilities and the movement of the mentally ill into communities is the creation in the 1960s of federal programs and federal funding of the treatment of the mentally ill. For instance, in

33. Lisa Davis et al., *Deinstitutionalization? Where Have All the People Gone?*, 14 CURRENT PSYCHIATRY REP. 259, 260 (2012).

34. Gerald N. Grob, *The Paradox of Deinstitutionalization*, SOC'Y 51, 53 (July/August 1995). As Grob notes,

> [t]he traditional preoccupation with professional needs was supplemented by a new concern with patient rights. Courts defined a right to treatment in a least-restrictive environment, shorted the duration of all forms of commitment and placed restraints on its application, undermined the sole right of psychiatrists to make purely medical judgments about the necessity of commitment, accepted the right of patients to litigate both before and after admission to a mental institution, and even defined a right of a patient to refuse treatment under certain circumstances.

Id.

35. Testa & West, *supra* note 7, at 32.

36. WINICK, *supra* note 23, at 58–59.

1963 Congress passed the Community Mental Health Act,[37] providing funding for the creation of community-based outpatient treatment centers. The Act was meant to move treatment of individuals out of isolated hospitals and into the community, where they would have access to support groups and employment opportunities.[38] In 1965, Medicare and Medicaid were introduced, which provided federal funds to states for the treatment of mentally ill individuals, but only if those individuals lived in the community.[39]

These federal programs, therefore, created an incentive for states, which had traditionally financed mental hospitals with state funds, to discharge patients into the community and defer the cost of treatment to the federal government.[40] Outpatient treatment was expanded and states began moving mentally ill patients out of state hospitals and into federally subsidized facilities like nursing homes and group homes.[41] Other social welfare programs were also becoming more common during this time, including Social Security Income (SSI) and Social Security Disability Income (SSDI), which allowed people with mental illness who were living in the community to receive benefits from the federal government for housing and food stamps.[42]

While states may have originally been financially incentivized to shift the care of people with mental illness into communities, federal funding of community-based mental health services was significantly curtailed with the passage of the Omnibus Budget Reconciliation Act of 1981.[43] This act consolidated federal funding and shifted treatment costs for the mentally ill back to individual states, and provided a single block grant that allowed each state to administer its funds to mentally ill individuals.[44] Appropriations for the block grant were significantly

37. Pub. L. No. 88-164, 77 Stat. 282.

38. SLOBOGIN ET AL., *supra* note 15, at 810.

39. Davis et al., *supra* note 33, at 260.

40. TORREY ET AL., *supra* note 32, at 3 (2008); *see also* Robert A. Brooks, *Psychiatrists' Opinions About Involuntary Civil Commitment: Results of a National Survey*, 35 J. AM. ACAD. PSYCHIATRY L. 219, 219 (2007) (noting that, following California's lead from the 1960s, states increasingly "tighten[ed] criteria for civil commitment"); AM. PSYCHIATRIC ASS'N, MANDATORY OUTPATIENT TREATMENT RESOURCE 2 (1999). For an excellent description of the development of the role of Medicaid, Medicare and SSI in the coverage of mental health care, see FRANK & GLIED, *supra* note 9, at 93–96.

41. Davis et al., *supra* note 33, at 260.

42. *Id.*

43. *Id.*

44. *Id. See also* Nat'l Inst. of Mental Health, *Important Events in Mental Health History*, http://www.nih.gov/about-nih/what-we-do/nih-almanac/national-institute-mental-health-nimh [https://perma.cc/YV7E-DPGS]

lower than previous federal expenditures on community-based mental health programs, and the mental health system also had to compete with other governmental programs to receive its share of the funds.[45] As a result, state mental health spending has declined; Medicaid is now the largest funder of mental health services in the United States and contributes more money to mental health than any other public or private provider.[46] But this decentralization of services and entitlements is largely uncoordinated; "[t]he resources flow from a dizzying range of federal, state, and private organizations."[47]

These shifts in state approaches to treatment of the mentally ill have benefited many people with mental illness. Institutions in the middle of the twentieth century were often used to warehouse the mentally ill; many people lived in hospitals for most or all of their lives without receiving care. But, as discussed in the next Part, for people with serious mental illness who are not dangerous to either themselves or other people, but who are nevertheless unable to provide for their basic needs in the community, heightened standards for civil commitment have meant that not all individuals with serious mental illness living in their communities are receiving appropriate mental health care and services.

II. CURRENT TRENDS IN CIVIL COMMITMENT

A. Danger to Self or Others

Civil commitment laws in the United States are primarily the responsibility of individual states.[48] And while commitment statutes vary tremendously among states, every state first requires a finding that the person subject to commitment is mentally ill, and that as a result of that mental illness, the person meets one or more of the additional grounds for commitment.[49] Historically, the additional ground needed

(last updated Feb. 19, 2016) (depicting critical events in mental health treatment history).

45. FRANK & GLIED, *supra* note 9, at 60–61.

46. Cynthia Shirk, *Medicaid and Mental Health Services*, 66 NAT'L HEALTH POL'Y F. 3 (2008) ("In 2003, Medicaid spent over $26 billion on mental health services—about 26 percent of total national mental health expenditures.").

47. FRANK & GLIED, *supra* note 9, at 5.

48. Stuart A. Anfang & Paul S. Appelbaum, *Civil Commitment—The American Experience*, 43 ISR. J. PSYCHIATRY & RELATED SCI. 209, 211 (2006).

49. *See, e.g.*, ALA. CODE § 22-52-10.4 (2016) ("(a) A respondent may be committed to inpatient treatment if the probate court finds, based upon clear and convincing evidence that: (i) the respondent is mentally ill; (ii) as a result of the mental illness the respondent poses a real and present threat of substantial harm to self and/or others; (iii) the respondent will, if not treated, continue to suffer mental distress and will continue to experience deterioration of the ability to function independently; and (iv) the respondent is unable to make

for commitment was a simple finding of "need for treatment."[50] The need for treatment model was justified by the states' *parens patriae* authority and allowed the government to substitute its decision-making for that of an incompetent individual.[51] But beginning in the 1950s, states began to modify civil commitment standards, shifting away from the traditional need for treatment models to narrower "dangerousness to self or others" standards. The state's interest in protecting citizens from the dangerous acts of others is a fundamental part of its police power, and forms the basis for civil commitments based upon a finding of dangerousness to others.[52] In 1964, the District of Columbia adopted the first civil commitment statute with dangerousness as the only allowable grounds for commitment,[53] and in 1967 California adopted the Lanterman-Petris-Short Act, allowing for civil commitment only when a person was an imminent danger to themselves or others, or was so "gravely disabled" that he would be unable to meet his basic needs for survival.[54] Other states began adopting stricter dangerousness standards and rejecting previous "need for treatment" standards as vague and unconstitutional.[55]

Every state now allows that an individual may be committed upon a finding that she poses a danger to herself or others.[56] There are significant differences among states, however, as to the definition of danger

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a rational and informed decision as to whether or not treatment for mental illness would be desirable."). Most states also require that a decision in civil commitment adjudications represent the "least restrictive alternative." JOHN PARRY, CIVIL MENTAL DISABILITY LAW, EVIDENCE AND TESTIMONY 475 (2010) ("Often, this requirement affects if, where, and under what conditions commitment will take place, and not whether a person meets the commitment standards.").

50. *See supra* text accompanying notes 18–20.

51. WINICK, *supra* note 23, at 66.

52. *Id.* at 59.

53. Anfang & Appelbaum, *supra* note 48, at 211.

54. Carol A.B. Warren, *Involuntary Commitment for Mental Disorder: The Application of California's Lanterman-Petris-Short Act*, 11 L. & SOC'Y REV. 629, 630 (1977).

55. Anfang & Appelbaum, *supra* note 48, at 211.

56. Testa & West, *supra* note 7, at 33. Although Testa and West note that a minority of states, including Delaware and Iowa, did not allow for a commitment upon a finding of danger to self or others, both states have since updated their laws. *Id.* Delaware amended its statute in 2014 to allow for commitment when, "[b]ased upon manifest indications, the individual is: a. dangerous to self; or b. dangerous to others." DEL. CODE ANN. tit. 16, § 5011(a) (2014). Similarly, in 2013, Iowa amended its statute to allow for a commitment of a "person who presents a danger to self or others and lacks judgmental capacity due to . . . serious mental impairment." IOWA CODE ANN. § 229.6(2) (West 2016). A person with a "serious mental impairment" is one who "[i]s likely to

to self or others. Dangerousness is usually interpreted to mean physical harm to self, including attempted suicide, or to others, including overt acts and threats of violence.[57] At one time, most states required evidence of recent and overt threats or actions to establish that the individual posed a danger to others,[58] but many states now allow predictions of future dangerousness to be established based on recent behavior.[59] Some states require that the danger be imminent, or likely to occur immediately or in the near future,[60] while others have eliminated the imminence requirement, as long as the danger is substantial.[61] Other

physically injure the person's self or others if allowed to remain at liberty without treatment." IOWA CODE ANN. § 229.1(20) (West 2016). Neither statute allows for commitment upon a finding of grave disability.

57. PARRY, *supra* note 49, at 476.

58. *Id. See, e.g.*, Nev. Rev. Stat. § 433A.115(3) (2013) ("A person presents a clear and present danger of harm to others if, within the immediately preceding 30 days, the person has, as a result of a mental illness, inflicted or attempted to inflict serious bodily harm on any other person, or made threats to inflict harm and committed acts in furtherance of those threats, and if there exists a reasonable probability that he or she will do so again unless the person is admitted to a mental health facility . . . and adequate treatment is provided to him or her.").

59. *See, e.g.*, S.D. CODIFIED LAWS § 27A-1-1(6) (2013) ("'Danger to others,' a reasonable expectation that the person will inflict serious physical injury upon another person in the near future, due to a severe mental illness, as evidenced by the person's treatment history and the person's recent acts or omissions which constitute a danger of serious physical injury for another individual.").

60. *See, e.g.*, GA. CODE ANN. § 37-3-1(9.1)(A)(i) (2012) ("'Inpatient' means a person who is mentally ill and . . . [w]ho presents a substantial risk of imminent harm to that person or others, as manifested by either recent overt acts or recent expressed threats of violence which present a probability of physical injury to that person or other persons.").

61. *See, e.g.*, UTAH CODE ANN. § 62A-15-631(10)(b) (LexisNexis 2015) ("[B]ecause of the proposed patient's mental illness the proposed patient poses a substantial danger . . . ."). *See also* Robert I. Simon, *The Myth of "Imminent" Violence in Psychiatry and the Law*, 75 U. CIN. L. REV. 631, 632 (2006) (discussing the somewhat arbitrary timeframes clinicians use to determine "imminence"). In assessing imminent dangerousness to others, Simon notes that clinicians have used standards ranging from "[seven] days following assessment," to "the near future (i.e., days or a week or so)." *Id.* at 633. And while he observes that "[t]hese time limits seemed to be pulled out of thin air," he concedes that "in prediction research it is appropriate to use the term 'imminent,' so long as the time frame is specified . . . ." *Id.* at 634. In assessing imminent dangerousness to others, Simon notes that "[c]linicians ascribe arbitrary time limits for 'imminent' suicide, although most time frames are vague, usually given as a range such as 12–24 hours, 24–48 hours, 1–3 weeks, 1 month or 1 year." *Id.* at 632.

statutes do not define dangerousness or include a timeframe, but simply require that the person pose a threat of harm to herself or others.[62]

In *O'Connor v. Donaldson*,[63] the only Supreme Court case to speak directly to civil commitment criteria, the Court held that Kenneth Donaldson—a Florida man who had been held for fifteen years in a state hospital with no treatment—could not be held "without more" if he were not dangerous and "capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends."[64] The Court's use of the term "without more" has caused some to question whether the absence of treatment or the dangerousness criterion was more critical to the Court's analysis.[65] In other words, the opinion could be read to mean "if treatment is provided *or* if the patient is dangerous, commitment can continue."[66] Nevertheless, most courts have interpreted the case to endorse the dangerousness standard in civil commitment cases.[67]

62. *See, e.g.*, ALA. CODE § 22-52-10.4(a)(ii) (2016) ("[A]s a result of the mental illness the respondent poses a real and present threat of substantial harm to self and/or others . . . .").

63. 422 U.S. 563 (1975).

64. *Id.* at 576.

65. As Anfang and Appelbaum note, "the Court's comments . . . were so ambiguous that they could be interpreted to support either position." Anfang & Appelbaum, *supra* note 48, at 211.

66. *Id.* Interestingly, in a later case finding that patients must be mentally competent to sign consent forms for a voluntary inpatient commitment, the Court cited a different portion of the *O'Connor* decision, which seems to endorse the dangerousness standard Zinermon v. Burch, 494 U.S. 113, 134 (1989) (citing O'Connor, 422 U.S. at 575) ("[T]here is no constitutional basis for confining mentally ill persons involuntarily 'if they are dangerous to no one and can live safely in freedom'"). The Court did not cite the portion of the prior opinion that referred to "without more." *Compare* O'Connor, 422 U.S. at 575, *with* Zinermon, 494 U.S. at 134.

67. The Court also defined the burden of proof for a civil commitment in *Addington v. Texas*, where it rejected the beyond-a-reasonable-doubt standard and established the clear-and-convincing standard as providing the minimum procedural threshold for issuing an involuntary commitment order. Addington v. Texas, 441 U.S. 418, 432–33 (1979) ("We have concluded that the reasonable-doubt standard is inappropriate in civil commitment proceedings because, given the uncertainties of psychiatric diagnosis, it may impose a burden the state cannot meet and thereby erect an unreasonable barrier to needed medical treatment. . . . To meet due process demands, the standard has to inform the factfinder that the proof must be greater than the preponderance-of-the-evidence standard applicable to other categories of civil cases."); *see also* Alexander Tsesis, *Due Process in Civil Commitments*, 68 WASH. & LEE L. REV. 253 (2011) (arguing that the clear-and-convincing standard did not adequately protect patients' due process rights); PARRY, *supra* note 49, at 483 ("Forty-seven jurisdictions have statutory language that requires clear and convincing evidence or something that includes that

As states began adopting statutes that required a finding of dangerousness as grounds for commitment, this necessitated a means of assessing future dangerousness. As one author put it, the need for a reliable method of predicting future dangerousness

> did not arise as a result of clinical experience or wisdom, or of empirical evidence, or even of the quest for testable hypotheses about human behavior and its antecedents. It arose out of pragmatic needs for criteria to make distinctions between patients appropriate for inpatient or outpatient treatment, or for voluntary or involuntary treatment, when those became real choices in the 1960s and 1970s.[68]

Predicting the likelihood of future dangerousness required by civil commitment statutes, however, is a difficult task and has long posed unique challenges to clinicians. Early studies examining the accuracy of future risk assessment found that "clinicians had little expertise in predicting violent outcomes."[69] These critiques of clinical predictions of violence based on informal impressions and individual judgment led to the development of standardized psychological tests—actuarial risk assessment instruments—that help clinicians evaluate the likelihood that an individual will become violent.[70] And while these instruments have improved clinicians' ability to forecast future violence, they are not foolproof and many consider the field of risk assessment to continue to be largely unreliable.[71]

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standard plus something a little more, such as 'clear, cogent, and convincing' in North Carolina, Washington, and West Virginia.").

68. Michael A. Norko & Madelon V. Baranoski, *The Prediction of Violence; Detection of Dangerousness*, 8 BRIEF TREATMENT & CRISIS INTERVENTION 73, 73 (2008).

69. *See* Mairead Dolan & Michael Doyle, *Violence Risk Prediction*, 177 BRIT. J. OF PSYCHIATRY 303, 303 (2000) (citing various studies); *see also* Stephen D. Hart et al., *Precision of Actuarial Risk Assessment Instruments*, 190 BRIT. J. OF PSYCHIATRY (SUPP. 49) s60, s60 (2007) ("Research indicates that predictions of violence made using unaided (i.e., informal, impressionistic or intuitive) judgement are seriously limited with respect to both inter-clinician agreement and accuracy.").

70. Jennifer L. Skeem & John Monahan, *Current Directions in Violence Risk Assessment*, 20 CURRENT DIRECTIONS IN PSYCHOL. SCI. 38, 38 (2011); *see also* Hart et al., *supra* note 69, at s60 (discussing the development and use of actuarial risk assessment instruments (ARAIs)). Some states even require that specific risk assessment tools be used when assessing likelihood of future risk. Skeem & Monahan, *supra*, at 38 (noting that "Virginia's Sexually Violent Predator statute not only mandates the use of a specific instrument but also specifies the cutoff score on that instrument that must be achieved to proceed further in the commitment process").

71. *See, e.g.*, Norko & Baranoski, *supra* note 68, at 79–80 (noting that "[d]espite clear progress in the empirical understanding of the correlates of violence,

Furthermore, even with improved assessment techniques, dangerousness is a concept that is difficult to define and subject to individual interpretation. One study found that some psychiatrists interpreted a dangerousness standard to require that a patient pose an immediate, clear, or imminent danger to self or others, while others thought the statute required that the patient's condition present a probable, possible, or potential danger.[72] Others thought emergency hospitalization was permitted only for homicidal or suicidal patients, while some believed commitment was permissible when a patient exhibited self-destructive impulses.[73] Because many state statutes do not define "danger," the statutes themselves put the burden on clinicians to substitute their own judgment for what a finding of dangerousness should encompass.[74] Finally, a determination of dangerousness is distinct from most factual determinations because it requires clinicians to predict the likelihood of an event occurring in the future, as opposed to determining whether a particular event has already occurred.[75] Without clear statutory guidance on the definition of danger, many psychiatrists are necessarily forced to use "discretion to rule in a manner consistent with his or her value system, as opposed to applying fact and law in a neutral manner."[76]

B. Grave Disability

A finding of danger to self or others has therefore become the primary grounds for civil commitment since deinstitutionalization, and one

there are substantial limitations of the science, especially in application to individual patients or evaluees"); Dolan & Doyle, *supra* note 69, at 303 ("Violence risk prediction is an inexact science and as such will continue to provoke debate.").

72. Glenn G. Affleck et al., *Psychiatrists' Familiarity with Legal Statutes Governing Emergency Involuntary Hospitalization*, 135 AM. J. PSYCHIATRY 205, 208 (1978).

73. *Id.*

74. William M. Brooks, *The Tail Still Wags The Dog: The Pervasive And Inappropriate Influence By The Psychiatric Profession On The Civil Commitment Process*, 86 N.D. L. REV. 259, 293 (2010) [hereinafter Brooks]. *See, e.g.*, HAW. REV. STAT. ANN. § 334-1 (West 2008) ("'Dangerous to others' means likely to do substantial physical or emotional injury on another, as evidenced by a recent act, attempt or threat . . . 'Dangerous to self' means the person recently has: (1) Threatened or attempted suicide or serious bodily harm; or (2) Behaved in such a manner as to indicate that the person is unable, without supervision and the assistance of others, to satisfy the need for nourishment, essential medical care, shelter or self-protection, so that it is probable that death, substantial bodily injury, or serious physical debilitation or disease will result unless adequate treatment is afforded.").

75. Brooks, *supra* note 74, at 294.

76. *Id.* at 295.

that is justified under the state's police power and its *parens patriae* authority. More recently, however, many states have begun to recognize the value of commitment for individuals who are seriously mentally ill but not dangerous to themselves or others.[77] These additional grounds for commitment, including grave disability, are premised solely on states' *parens patriae* authority, in that the state is substituting its judgment for that of the mentally ill person and providing treatment that the individual might have chosen for herself had she been competent.[78] For the state to commit an individual using its *parens patriae* authority, hospitalization must be more than beneficial to the person; it must also be necessary because the person's ability to make decisions for herself is so impaired that she is unable to understand that treatment is in her own best interest.[79]

In the 1970s, states began including grounds for commitment based on "grave disability." Although grave disability can implicate states' police power when based upon a finding that the individual is dangerous to herself, it can also implicate the *parens patriae* authority when based upon a finding that the individual is unable to provide for her basic needs as a result of mental illness.[80] Although almost every state has a

77. Anfang & Appelbaum, *supra* note 48, at 212.

78. WINICK, *supra* note 23, at 66. Some states have allowed for even greater expansion of the *parens patriae* authority in civil commitments by again including explicit "need for treatment" standards in commitment statutes. *See, e.g.*, HAW. REV. STAT. ANN. § 334-60.2 ("A person may be committed to a psychiatric facility for involuntary hospitalization, if the court finds: (1) That the person is mentally ill or suffering from substance abuse; (2) That the person is imminently dangerous to self or others; and (3) That the person is in need of care or treatment, or both, and there is no suitable alternative available through existing facilities and programs which would be less restrictive than hospitalization.").

79. WINICK, *supra* note 23, at 42–43.

80. PARRY, *supra* note 49, at 478. At least forty-two states now incorporate a gravely disabled standard into civil commitment statutes. These include Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming. *See* TREATMENT ADVOCACY CENTER, STATE STANDARDS FOR ASSISTED TREATMENT: CIVIL COMMITMENT CRITERIA FOR INPATIENT OR OUTPATIENT PSYCHIATRIC TREATMENT (2014). A few states do not follow this trend. For example, Delaware allows for civil commitment when the person is unable to make reasonable decisions about hospitalization. DEL CODE ANN. tit. 16, § 5005(a) (Supp. 2014). Other states expand standards for gravely disabled. Iowa, for example, allows for commitment if the person has a mental illness and "[i]s likely to inflict serious emotional injury on members of the person's family or others who lack reasonable opportunity to avoid contact with the person with mental illness if the person with mental

ground for commitment based on an individual's inability to provide for her own basic needs, many state statutes do not clearly distinguish between grave disability based on dangerousness to self, and grave disability based on an inability to provide for basic needs like food, clothing, shelter, and medical care.[81] When grave disability is based on an inability to provide for one's basic needs, most states require that the resultant harm be "serious."[82] Other states simply require that as a result of mental illness, the person is unable to provide for basic needs.[83]

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illness is allowed to remain at liberty without treatment." IOWA CODE § 229.1(17)(b) (West 2016).

81. Parry, *supra* note 49, at 478 ("The requirement that proposed patients be unable to provide for their basic needs is found both as an independent criterion and also as part of the grave disability provisions. Like grave disability, the most common formulation is one in which the inability to care for oneself causes substantial personal harm."). Some states also include the inability to make rational decisions within gravely disabled grounds for commitment. *See, e.g.*, COLO. REV. STAT. § 27-65-102(9) (2015) ("'Gravely disabled' means a condition in which a person, as a result of a mental health disorder, is incapable of making informed decisions about or providing for his or her essential needs without significant supervision and assistance from other people."); CONN. GEN. STAT. § 17a-495 (2016) ("'[G]ravely disabled' means that a person, as a result of mental or emotional impairment, is in danger of serious harm as a result of an inability or failure to provide for his or her own basic human needs such as essential food, clothing, shelter or safety and that hospital treatment is necessary and available and that such person is mentally incapable of determining whether or not to accept such treatment because his judgment is impaired by his psychiatric disabilities.").

82. *See, e.g.*, WASH. REV. CODE § 71.05.020 ("Gravely disabled' means a condition in which a person, as a result of a mental disorder: (a) Is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety."). COLO. REV. STAT. § 27-65-102(9) (2015) ("'Gravely disabled' means a condition in which a person, as a result of a mental health disorder, is incapable of making informed decisions about or providing for his or her essential needs without significant supervision and assistance from other people. As a result of being incapable of making these informed decisions, a person who is gravely disabled is at risk of substantial bodily harm, dangerous worsening of any concomitant serious physical illness, significant psychiatric deterioration, or mismanagement of his or her essential needs that could result in substantial bodily harm.").

83. *See, e.g.*, OR. REV. STAT. § 426.005(1)(f) (2015) ("'Person with a mental illness' means a person who, because of a mental disorder, is . . . [u]nable to provide for basic personal needs that are necessary to avoid serious physical harm in the near future, and is not receiving such care as is necessary to avoid such harm."); CAL. WELF. & INST. CODE § 5008(h)(1)(A) (West Supp. 2016) ("'[G]ravely disabled' means . . . [a] condition in which a person, as a result of a mental health disorder, is unable to provide for his or her basic personal needs for food, clothing, or shelter.").

A minority of states explicitly tie a finding of grave disability to imminent danger.[84]

Many states have civil commitment statutes that allow for commitment on grounds of both danger to self and grave disability. Arizona's statute, for example provides the following:

> "Danger to self" (a) means behavior that, as a result of a mental disorder: (i) Constitutes a danger of inflicting serious physical harm on oneself, including attempted suicide or the serious threat thereof, if the threat is such that, when considered in the light of its context and in light of the individual's previous acts, it is substantially supportive of an expectation that the threat will be carried out (ii) Without hospitalization will result in serious physical harm or serious illness to the person (b) Does not include behavior that establishes only the condition of persons with grave disabilities.
>
> "Persons with grave disabilities" means a condition evidenced by behavior in which a person, as a result of a mental disorder, is likely to come to serious physical harm or serious illness because the person is unable to provide for the person's own basic physical needs.[85]

Some states have tried to make their *parens patriae* authority more explicit in gravely disabled commitment grounds by adding "deterioration" language to their civil commitment statutes, which allow for commitment when a person is not in imminent harm due grave disability, but is likely to become so in the near future without further treatment.[86] These broadened commitment standards are intended to provide treatment to people with serious mental illness, and also reduce the numbers of people with serious mental illness who become homeless or are incarcerated.[87] For example, Idaho defines gravely disabled to include an individual who, without treatment is substantially likely to "physically,

84. GA. CODE ANN. § 37-3-1(9.1) (2012) (allowing for inpatient commitment of a person "[w]ho is so unable to care for that person's own physical health and safety as to create an imminently life-endangering crisis").

85. ARIZ. REV. STAT. § 36-501.

86. John Kip Cornwell, *Understanding the Role of the Police and* Parens Patriae *Powers in Involuntary Civil Commitment Before and After* Hendricks, 4 PSYCHOL., PUB. POL'Y, & L. 377, 385 (1998). *See also* MISS. CODE ANN. § 41-21-61(e) (2016) (defining "person with mental illness" as "a person who, based on treatment history and other applicable psychiatric indicia, is in need of treatment in order to prevent further disability or deterioration which would predictably result in dangerousness to himself or others when his current mental illness limits or negates his ability to make an informed decision to seek or comply with recommended treatment").

87. Cornwell, *supra* note 86, at 385–86.

emotionally or mentally deteriorate to the point that the person will, in the reasonably near future, be in danger of serious physical harm due to the person's inability to provide for any of his own basic personal needs such as nourishment, essential clothing, medical care, shelter or safety."[88] Under these standards, the *parens patriae* authority explicitly allows for commitment before an individual is dangerous to herself.

Notwithstanding available *parens patriae* grounds for civil commitment, including grave disability, many courts and psychiatrists continue to read a dangerousness requirement into *parens patriae* grounds for commitment.[89] After the predicate finding of mental illness, "dangerous to self or others" is the most commonly used grounds for civil commitment orders.[90] And as discussed in the next Part, in civil commitment proceedings, "dangerousness determinations predominate whichever standard is used."[91]

III. THE ROLE OF PSYCHIATRISTS AND COURTS IN CIVIL COMMITMENT PROCEEDINGS

In the United States, mental health professionals typically testify in civil commitment hearings, and courts rely heavily on that testimony when deciding if an individual meets the state's standards for civil commitment.[92] Psychiatrists are "perceived as holding the most power in the commitment process—in fact, some observers see courts as 'rubber stamps' of psychiatrists' testimony."[93] Studies suggest that there is a high correlation between psychiatrist's recommendations and judges'

88. IDAHO CODE ANN. § 66-317(13) (West 2016).

89. *See infra* text accompanying notes 158–170.

90. PARRY, *supra* note 49, at 476.

91. *Id.* at 474.

92. Brooks, *supra* note 40, at 219 ("Psychiatrists make decisions on admissions and discharges, and also frequently provide expert testimony in civil commitment cases."). *See also* WINICK, supra note 23, at 63 (noting that "[c]ivil commitment courts typically rely upon the testimony of clinical expert witnesses who have evaluated the individual and who present their clinical conclusions concerning the degree of risk he or she is thought to present"); Grant H. Morris, *"Let's Do the Time Warp Again": Assessing the Competence of Counsel in Mental Health Conservatorship Proceedings*, 46 SAN DIEGO L. REV. 283, 314–15 (2009) ("[D]espite the fallibility of psychiatric testimony, judges and juries, serving as fact finders in civil commitment and conservatorship proceedings, typically defer to psychiatric judgments that the person has a mental disorder and that the mental disorder meets the statutory standard for commitment or a conservatorship.").

93. Brooks, *supra* note 74, at 285 ("When judges defer to psychiatrists at a rate between 90 and 100 percent of the time the psychiatrist experts actually become the decision-makers in the civil commitment process.").

decisions in civil commitment proceedings, often as high as 90%.[94] Most judges have little training in mental health law or psychiatric diagnosis, so this deference to psychiatric forensic testimony in civil commitment proceedings is not surprising.[95] Furthermore, civil commitment proceedings may not be given priority by judges with busy caseloads, who may therefore lack an incentive to carefully scrutinize psychiatrists' recommendations.[96] Civil commitment proceedings tend to be short and perfunctory; as one author put it, "It seems safe to conclude that civil commitment is a disfavored stepchild in the large family of concerns that must be addressed by the justice system."[97]

Like judges, lawyers are also deferential to psychiatrists in commitment adjudications. One study of North Carolina lawyers found that lawyers felt conflicted by their dual roles in commitment proceedings.[98] They viewed mental illness and treatment as medical problems, and tended to defer to psychiatrists' opinions and recommendations regarding civil commitment.[99] At the same time, they felt obligated to advocate for their clients and prevent the client's loss of freedom that would result from commitment.[100] Many lawyers in the study noted that "if they fought commitment under these circumstances, they could obtain release for anyone, even for the dangerously mentally ill; but release of the dangerous would be a Pyrrhic victory that would endanger the respondent or society and eliminate the chance for help."[101] Perhaps as a result of these conflicting goals, most lawyers prepared much less for civil commitment cases than for other cases, many did not speak to clients before the hearing, and "rarely took an adversary role to obtain release of their clients whom psychiatrists had recommended for commitment."[102]

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94. *Id.*

95. Paul S. Applebaum, *Civil Commitment from a Systems Perspective*, 16 L. & HUM. BEHAV. 61, 66 (1992); *see also* Brooks, *supra* note 74, at 286 ("[J]udges defer to psychiatric opinion because they feel they lack the requisite expertise to independently assess whether patients meet the statutory criteria for commitment.").

96. Applebaum, *supra* note 95, at 66–67.

97. *Id.* at 66.

98. Virginia Aldigé Hiday, *Are Lawyers Enemies of Psychiatrists? A Survey of Civil Commitment Counsel and Judges*, 140 AM. J. PSYCHIATRY 323, 326 (1983).

99. *Id.*

100. *Id.*

101. *Id.*

102. *Id.* (noting that "they almost never challenged the medical affidavit or argued that the respondent was not mentally ill" and that "[o]nly infrequently did they argue that the dangerousness criterion was not met").

Civil commitment proceedings necessarily involve the interaction of two distinct systems: the mental health system and the justice system.[103] When testifying in civil commitment proceedings, psychiatrists therefore rely on both state commitment statutes and on the criteria in the Diagnostic and Statistical Manual of Mental Disorders (DSM). Typically, the DSM is used to diagnose the requisite mental condition, and it refers to its use in civil commitment proceedings by noting

> [w]hen used appropriately, diagnoses and diagnostic information can assist legal decision makers in their determinations. For example, when the presence of a mental disorder is the predicate for a subsequent legal determination (e.g., involuntary civil commitment), the use of an established system of diagnosis enhances the value and reliability of the determination.[104]

In the context of civil commitment statutes, however, the DSM-5 is not determinative with respect to the outcome of a civil commitment proceeding. The finding of a "mental illness" is a predicate to other legal determinations, such as whether a person is dangerous or gravely disabled. Psychiatrists in commitment proceedings are therefore asked to make both clinical and legal determinations, and those legal determinations require knowledge of the relevant statutes and case law. For instance, how a psychiatrist believes the law requires her to interpret "gravely disabled" can have a large impact on whether a person is found to satisfy commitment statutes.

Several studies of psychiatrists and other clinicians "have documented a remarkable degree of ignorance of commitment criteria."[105] Specifically, some psychiatrists are not aware of available grounds for civil commitment apart from grounds based upon a finding of danger to self or others. For instance, one study surveyed 1,500 members of the American Psychiatric Association (APA), including 1,000 APA general members and 250 members from each of two APA membership sections (Emergency Psychiatry and Suicide/Self-Injury) whose members were thought to have had more experience with civil commitment.[106] The study found many psychiatrists were not accurate when asked about grounds for civil commitment in their state. Only 70.7% of respondents correctly believed that grave disability was a ground for commitment

103. Applebaum, *supra* note 95, at 64–66.

104. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL ON MENTAL DISORDERS 25 (5th ed. 2013).

105. Applebaum, *supra* note 95, at 65.

106. Brooks, *supra* note 40, at 220.

in their state when it was a ground.[107] In contrast, 61.5% of respondents thought grave disability was a ground when it was not.[108]

Furthermore, some scholars have suggested that mental illness and dangerousness are so intertwined that psychiatrists and judges are in fact unable to separate them.[109] This conflation is reflected in the Supreme Court's decision in *O'Connor v. Donaldson*[110] and in states' responses to that decision, namely that the majority of states now have a dangerousness criterion in their civil commitment statutes.[111] Several studies have found that changes in civil commitment standards do not affect court practices or rates of commitment.[112] This discrepancy between civil commitment laws and their application has led some authors to "conclude that the actors' socially embedded agency—their perspectives, motivations and interests, as influenced by broader social representations—is the most determinant factor in civil commitment decisions."[113]

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107. *Id.* at 223.

108. *Id.*

109. *E.g.*, Bernadette Dallaire et al., *Civil Commitment Due To Mental Illness And Dangerousness: The Union Of Law And Psychiatry Within A Treatment-Control System*, 22 SOC'Y OF HEALTH & ILLNESS 679, 691 (2000) (noting that "the widely shared tendency to equate mental illness with dangerousness is manifested in the rationale for, and operationalisation of, civil commitment laws").

110. 422 U.S. 563 (1975).

111. PARRY, *supra* note 49, at 476 (noting that "'dangerous to self or others,' or similar criteria based on harm to self or others, is the most commonly used statutory element for extended involuntary inpatient commitment; it is incorporated in some manner into the statutes of 36 jurisdictions and is an absolute requirement in most of them").

112. *See, e.g.*, Jonathan J. Marz & Richard M. Levinson, *Statutory Change And 'Street-Level' Implementation Of Psychiatric Commitment*, 27 SOC'Y SCI. & MED. 1247, 1253–54 (1988) ("Thus, rather than being passive objects of statutory changes, participants in the mental health system may actively adapt to the changes and look for ways to cope within the framework to obtain desired outcomes . . . the ambiguity of statutory criteria combined with the interests of participants dilute the impact of changes in the law."); Paul S. Appelbaum, *Almost A Revolution: An International Perspective On The Law Of Involuntary Commitment*, 25 J. AM. ACAD. OF PSYCHIATRY & L. 135, 142 (1997) (discussing the "relative lack of impact of commitment law changes in the United States").

113. Dallaire et al., *supra* note 109, at 690; *see also id.* at 689 ("[W]e observed that the pertinent legal provisions appeared less as rules uniformly applied than as rhetorical instruments where the actual citation of the entire article of the law served as sole argument for the law to be applied."). Of course, it is also possible that judges and psychiatrists do not apply standards with which they disagree. As one author put it, "laws are enforced by people; they do not enforce themselves. Unless a law is generally accepted as being worthy

While many states therefore include grave disability as an additional ground for commitment, courts and psychiatrists often conflate the two provisions, perhaps because some state statutes require that the grave disability due to an inability to provide for basic needs put the individual in danger of serious harm. Yet even in states that require serious harm, this requirement of harm should not be interpreted to rise to the level of danger or imminent danger to self as required by other dangerousness grounds for commitment. A common canon of statutory construction provides that if a statute includes a specific provision targeting a particular issue, that provision should apply instead of provisions more generally covering the issue.[114] Gravely disabled provisions premised on an inability to provide for one's basic needs are included in almost every state civil commitment statute. This ground for commitment is included as an additional ground to provisions that allow for commitment when a person poses a danger to herself. For that reason, gravely disabled grounds that require a person's inability to meet her basic needs to require serious harm should not also be read to require a heightened finding of danger to self.

Moreover, the legislative intent of the gravely disabled standard seems to have been to broaden commitment statutes to allow for commitment before an individual was found to be dangerous. The Alaska Supreme Court, for example, in reviewing the legislative history of Alaska's addition of gravely disabled to its statutes in 1984, noted that the law before the amendment only allowed the state "to hold people with violent tendencies and the addition of the 'gravely disabled' language would allow [the state psychiatric facility] 'to hold people that need to [be held], but haven't shown a violent tendency.'"[115] The intent of the gravely disabled grounds for commitment was to allow "a person [to] be committed before it's too late."[116] Similarly, proponents of a bill to include a separate ground of "gravely disabled" in Hawaii statutes governing emergency commitment noted that

> the courts have been reluctant to enforce Hawaii's civil commitment laws absent a finding that the individual is imminently dangerous, thereby forcing the individual to live on the streets or left in the care of family and friends who must watch the individuals

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of respect, it will be widely ignored." PAUL S. APPLEBAUM, ALMOST A REVOLUTION: MENTAL HEALTH LAW AND THE LIMITS OF CHANGE 41 (1994).

114. *E.g.*, Green v. Bock Laundry Mach. Co., 490 U.S. 504, 524 (1989) (stating that "[a] general statutory rule usually does not govern unless there is no more specific rule").

115. Wetherhorn v. Alaska Psychiatric Inst., 156 P.3d 371, 377 (Alaska 2007).

116. *Id.*

> decompensate to the point of becoming dangerous to themselves or others before obtaining treatment.[117]

Yet despite the availability of a finding of grave disability due to a person's inability to meet her basic needs, dangerousness determinations predominate commitment adjudications and many courts interpret "gravely disabled" to mean that a person is unable to care for her own basic needs and therefore poses an imminent danger to herself.[118] For example, in *In re M.M.*,[119] a Louisiana court found that an individual was not gravely disabled because the hospital

> did not prove clearly and convincingly that she is unable to provide for her own basic physical needs as a result of her illness *and* that she is unable to survive safely in freedom or protect herself from serious harm, the statutory requirements for a finding that she was gravely disabled. There is no evidence in the record indicating that she was dangerous to herself or dangerous to others.[120]

The Louisiana statute defines "grave disability" as "the condition of a person who is unable to provide for his own basic physical needs, such as essential food, clothing, medical care, and shelter, as a result of serious mental illness or substance abuse and is unable to survive safely in freedom or protect himself from serious harm."[121] Louisiana's code has a separate provision that defines "[d]angerous to self" as "the condition of a person whose behavior, significant threats or inaction supports a reasonable expectation that there is a substantial risk that he will inflict physical or severe emotional harm upon his own person."[122] Louisiana's definition of grave disability does not require a finding of "danger to self," only that the person cannot survive safely in freedom. Moreover, the inclusion of a separate definition of "danger to self," which does encompass situations where an individual is likely to inflict physical harm on herself, suggests that the legislature intended to create a gravely disabled grounds for commitment that was broader than the strict "danger to self" grounds, namely one that allowed for the commitment of an individual when she cannot "survive safely in freedom" but does not necessarily pose a danger to herself. Notwithstanding this additional ground for commitment, the Louisiana court seems to have inter-

117. S. 16-2650, Reg. Sess., at 1180 (Haw. 1992).

118. PARRY, *supra* note 49, at 474.

119. 552 So. 2d 528 (La. Ct. App. 1989).

120. *Id.* at 530.

121. LA. REV. STAT. ANN. § 28:2(10) (2015).

122. *Id.* at § 28:2(4).

preted the gravely disabled requirement of serious harm to mean imminent danger to self, thus conflating the two separate commitment grounds.

Similarly, in *In re C.K.*,[123] a Washington court found that C.K. was gravely disabled because he refused to take medication and if he were not ordered to take his medication, there would be a "very high probability that his behavior will once again become dangerous to himself and others."[124] Yet the Washington statute governing civil commitment defines "gravely disabled" as "a condition in which a person, as a result of a mental disorder is . . . in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety."[125] Like Louisiana, the Washington statute distinguishes between harm to others and harm to self, and provides that a person presents a "likelihood of serious harm" to herself when there is a substantial risk that "[p]hysical harm will be inflicted by a person upon his or her own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on oneself."[126] While the court in this case did find that the person satisfied the commitment standard, the language of the decision again reflects a misunderstanding of the separate grounds for commitment, as well as the likely legislative intent behind the inclusion of two separate grounds.

While some state legislatures have therefore recognized that many people with serious mental illness might benefit from civil commitment before they have deteriorated to the point that they might pose a danger to themselves or others, the research suggests that some psychiatrists and courts have not fully embraced standards other than a dangerousness standard in civil commitment proceedings. And while a heightened standard of civil commitment is appropriate and protective of the civil liberties of people with mental illness, it has also had unintended effects. Many people with serious mental illness are unable to perceive a need for treatment, and many of those people also lack the financial resources or support systems to help them obtain treatment. For these individuals, a heightened commitment standard coupled with a lack of available community-based resources has led to a near-complete absence of

123. *In re* C.K., 29 P.3d 69.

124. *Id.* at 75 (finding that "the court below properly considered C.K.'s past patterns of behavior, taking into consideration C.K.'s prior decompensation when not under treatment and discontinuing his medication, his dangerous behavior as a result of his serious mental disorder while not medicated, his lack of appreciation for the necessity of taking his medication, his stated intent to discontinue medication unless ordered by the court, and the very high probability that his behavior will once again become dangerous to himself and others if not under court order to take his medication").

125. WASH. REV. CODE ANN. § 71.05.020(17) (West 2016).

126. *Id.* § 71.05.020(27(a)).

mental health care. As explained in the next Part, moreover, the interpretation of commitment standards to require a finding of dangerousness may be further perpetuating perceptions about the link between mental illness and violence, and the associated stigma experienced by people with untreated mental illness.

IV. PUBLIC PERCEPTIONS ABOUT MENTAL ILLNESS & DANGEROUSNESS

When civil commitment standards began changing from a need-for-treatment standard to a dangerousness standard, so too did public perceptions of the dangerousness of people with mental illness. In one study, researchers compared perceptions of the link between mental illness and dangerousness in 1950 and in 1996. For both time periods, respondents were asked: "When you hear someone say that a person is 'mentally-ill,' what does that mean to you?"[127] During both time periods, people who described mental illness as including psychosis were more likely to mention violence in their description of mental illness.[128] But the number of people who described mental illness as including psychosis and violence more than doubled between 1950 and 1996, from 12.7% in 1950 to 31% in 1996.[129] In other words, people in 1996 were more than twice as likely to think of people with mental illness as both psychotic and violent than they were in 1950.

Another recent study examined these attitudes slightly differently. Respondents were given descriptions of a man named "John" and asked how likely they thought it was that John would be violent towards other people.[130] In the first scenario, John was described as someone who was "troubled," but otherwise not suffering from any mental illness.[131] In this scenario, John was sometimes a little worried or a little sad, but otherwise "getting along pretty well."[132] In response to this

127. Jo Phelan et al., *Public Conceptions of Mental Illness in 1950 and 1996: What Is Mental Illness and Is It to be Feared?*, 41 J. HEALTH & SOC. BEHAV. 188, 191 (2000).

128. "[T]his association between descriptions of psychosis and mentions of dangerousness increased substantially over the period under study. Among respondents who did not mention psychosis in their description of a mentally ill person, the percentage who mentioned violence decreased from 3 percent in 1950 to 2 percent in 1996." *Id.* at 197.

129. *Id.*

130. Bernice A. Pescosolido, *The Public's View of the Competence, Dangerousness, and Need for Legal Coercion of Persons With Mental Health Problems*, 89 AM. J. PUB. HEALTH 1339, 1340 (1999).

131. *Id.*

132. The full scenario is as follows:

description, 16.8% of respondents said that John was likely or very likely to do something violent to another person.[133] In the second scenario, John was given characteristics of a person suffering from major depression.[134] He was described as "feeling really down. . . . Even when good things happen, they don't seem to make John happy. He pushes on through his days, but it is really hard."[135] In response to this description, 33.3% of respondents felt that John was likely or very likely to do something violent to another person.[136] In the last scenario, John was described as a person with characteristics of schizophrenia.[137] John was

> John is a [ETHNICITY] man with an [EDUCATION LEVEL] education. Up until a year ago, life was pretty okay for John. While nothing much was going wrong in John's life he sometimes feels worried, a little sad, or has trouble sleeping at night. John feels that at times things bother him more than they bother other people and that when things go wrong, he sometimes gets nervous or annoyed. Otherwise John is getting along pretty well. He enjoys being with other people and although John sometimes argues with his family, John has been getting along pretty well with his family.

The full description of the vignettes is taken from Bruce G. Link et al., *Public Conceptions of Mental Illness: Labels, Causes, Dangerousness, and Social Distance*, 89 Am. J. Pub. Health 1328, 1329 (1999).

133. Pescosolido, *supra* note 130, at 1341 (noting that the other respondents answered as follows: Very likely: 4.3%; Somewhat likely: 12.5%; Not very likely: 45.9%; Not likely at all: 37.4%).

134. The full scenario is as follows:

> John is a [ETHNICITY] man with an [EDUCATION LEVEL] education. For the past two weeks John has been feeling really down. He wakes up in the morning with a flat heavy feeling that sticks with him all day long. He isn't enjoying things the way he normally would. In fact nothing gives him pleasure. Even when good things happen, they don't seem to make John happy. He pushes on through his days, but it is really hard. The smallest tasks are difficult to accomplish. He finds it hard to concentrate on anything. He feels out of energy and out of steam. And even though John feels tired, when night comes he can't go to sleep. John feels pretty worthless and very discouraged. John's family has noticed that he hasn't been himself for about the last month and that he has pulled away from them. John just doesn't feel like talking.

Link et al., *supra* note 132, at 1329.

135. *Id.*

136. Pescosolido, *supra* note 130, at 1341 (noting that the other respondents answered as follows: very likely: 9.2%; somewhat likely: 24.1%; not very likely: 49.3%; not likely at all: 17.4%).

137. *Id.* at 1340. The full scenario is as follows:

> John is a [ETHNICITY] man with an [EDUCATION LEVEL] education. Up until a year ago, life was pretty okay for John. But then, things started to change. He thought that people around him were making disapproving comments and talking behind his back. John

"hearing voices even though no one else was around. These voices told him what to do and what to think."[138] When given this description, 60.9% of respondents thought that John was likely or very likely to do something violent to another person.[139] As the authors concluded, respondents had "increased expectations of violence if they labeled the vignette person as having a mental illness."[140]

There are many reasons for this increase in the public perception that people with mental illness are more likely to be violent or dangerous to others. One possible explanation is that many people acquire much of their knowledge of mental illness from television and the news; one study found that 74% of Americans cited newspapers as their source of information about psychiatric disorders.[141] Television and movies about mental illness often feature "plots and characters that connect mental illness with violence or depict people with mental illness primarily as caricatures or stereotypes-subjects of humor or derision."[142] In newspapers, stories involving homicide committed by a person with mental illness are more likely to receive front-page coverage, and more likely to receive a follow-up story.[143] When stories are told about people with mental illness, moreover, they are most likely to involve a violent act,[144]

> was convinced that people were spying on him and that they could hear what he was thinking. John lost his drive to participle in his usual work and family activities and retreated to his home, eventually spending most of his day in his room. John was hearing voices even though no one else was around. These voices told him what to do and what to think. He has been living this way for six months.

Link et al., *supra* note 132, at 1329.

138. Link et al., *supra* note 132, at 1329.

139. Pescosolido, *supra* note 130, at 1341 (noting that the other respondents answered as follows: Very likely: 12.8%; Somewhat likely: 48.1%; Not very likely: 30.8%; Not likely at all: 8.3%).

140. *Id.* at 1343.

141. Otto Wahl, *News Media Portrayal of Mental Illness: Implications for Public Policy*, 46 AM. BEHAV. SCIENTIST 1594, 1594 (2003).

142. NAMI, *Wonderland Premiere Brings Call on White House to Fight Stigma in Entertainment Industry*, (March 20, 2000), https://www.nami.org/Press-Media/Press-Releases/2000/Wonderland-Premiere-Brings-Call-on-White-House-to [http://perma.cc/PL4P-FZ8F]. *See also, e.g.*, PSYCHO (Paramount Pictures 1960); AMERICAN PSYCHO (Lions Gate Films 2000); FRIDAY THE 13TH (Paramount Pictures 1980); THE SHINING (Warner Bros. 1980).

143. Otto Wahl et al., *Newspaper Coverage of Mental Illness: Is It Changing?*, 6 PSYCHIATRIC REHABILITATION SKILLS 9, 10–12 (2002) (reviewing various studies).

144. GREG PHILO ET AL., MEDIA AND MENTAL DISTRESS 50 (1996) (concluding that "this is a media world populated by 'psychopaths,' 'maniacs,' and 'frenzied knife men'"). This trend is not unique to the United States. *See, e.g.*, Raymond Nairn et al., *From Source Material To News Story In New*

and the most common theme of stories about mental illness is the dangerousness of the mentally ill person.[145]

Furthermore, when a person with a mental illness does commit a violent act, state legislatures often react by passing laws like New York's Secure Ammunition and Firearms Enforcement Act.[146] New York's law created a database of New Yorkers who are considered "too mentally unstable to carry firearms," and contains approximately 34,500 names.[147] While defending the law, which was enacted in response to the Newtown Connecticut shooting in 2012, Mayor Cuomo noted, "God bless you, be a sportsman, be a hunter. We're not against guns. But not guns for criminals and for the mentally ill."[148] It is difficult to miss the implicit link between criminality and mental illness in this statement, and many have criticized the law as further stigmatizing people with mental illness and reinforcing perceptions that people with mental illness are invariably violent. As one commentator noted, "[t]hat

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Zealand Print Media: A Prospective Study Of The Stigmatizing Processes In Depicting Mental Illness, 35 AUSTL. & N.Z. J. PSYCHIATRY 654, 658 (2001) ("Throughout the corpus of material, the themes and production practices we have described mutually reinforced and nuanced each other, consistently linking mental illness with violence and unpredictability.").

145. Wahl, *supra* note 143, at 14. Wahl selected 300 articles discussing mental illness from six U.S. newspapers, including the *New York Times*, the *Washington Post*, the *Los Angeles Times*, the *St. Louis Post-Dispatch*, the *Boston Globe*, and the *St. Petersburg Times*. He found that in 77 of the 300 articles (or 23%) that discussed mental illness, the most common theme was that "people who have mental illness may be dangerous." *But see* Phelan et al., *supra* note 127, at 203 (noting that "mentions of dangerousness were not significantly related to the frequency of reading the newspaper or of watching television").

146. *See* NY MENTAL HYG. 9.46 Reporting Requirements for Mental Health Professionals (2013) ("Amendments to the Mental Hygiene Law will help ensure that persons who are mentally ill and dangerous cannot retain or obtain a firearm. First, mental health records that are currently sent to NIDCS for a federal background check will also be housed in a New York State database. A new Section 9.46 of the Mental Hygiene Law will require mental health professionals, in the exercise of reasonable professional judgment, to report if an individual they are treating is likely to engage in conduct that will cause serious harm to him- or herself or others.") NY A02388 MEMO, http://assembly.state.ny.us/leg/?default_fld=&bn=A02388&term=2013&Summary=Y&Memo=Y [https://perma.cc/7VCZ-8KF5].

147. Anemona Hartocollis, *Mental Health Issues Put 34,500 on New York's No-Guns List*, N.Y. TIMES (Oct. 19, 2014), http://assembly.state.ny.us/leg/?default_fld=&bn=A02388&term=2013&Summary=Y&Memo=Y [https://perma.cc/7VCZ-8KF5].

148. Anemona Hartocollis & Thomas Kaplan, *Cuomo Defends Law Denying Guns to Mentally Ill People*, N.Y. TIMES (Oct. 19, 2014), http://www.nytimes.com/2014/10/20/nyregion/cuomo-defends-law-denying-guns-to-mentally-ill-people.html [https://perma.cc/Z2PT-M9JU].

[number] seems extraordinarily high to me. Assumed dangerousness is a far cry from actual dangerousness."[149]

Finally, some authors have theorized that the change in the language of commitment standards themselves and the widespread inclusion of language referring to dangerousness has actually increased stigma and the perception that mentally ill people are violent.[150] One study found that when respondents were asked in 1950 to describe a person with mental illness, 24 out of 335 people (or 7.2%) mentioned violence, but only one of those people used the term "dangerous to self or others."[151] When asked the same question in 1996, 75 out of 622 people (or 12.1%) mentioned violence, but 33 people used the term "dangerousness to self or others."[152] In other words, people who used the phrase "dangerous to self or others" to describe mental illness increased "from 4.2% of respondents in 1950 to 44% of respondents in 1996."[153] The authors concluded that these results suggest "widespread public knowledge of the dangerousness criterion for involuntary commitment might indeed have fueled the stereotype that people with mental illnesses are dangerous."[154] The dangerousness standard itself may therefore reinforce the idea of a link between mental illness and dangerousness and "reproduce stereotypes depicting as threats to public safety persons who experience severe psychological distress or disturbances."[155]

There is some disagreement in the psychiatric community about the actual link between violence and mental illness, although most mental health professionals and the APA generally caution against a direct

149. Hartocollis, *supra* note 147.

150. J.C. Phelan & B.G. Link, *The Growing Belief that People with Mental Illnesses are Violent: The Role of the Dangerousness Criterion for Civil Commitment*, 33 SOC. PSYCHIATRY PSYCHIATR. EPIDEMIOL. S7, S8 (1998).

151. *Id.* at S9.

152. *Id.*

153. *Id.* at S7.

154. *Id.* at S10. The authors note however, that "we cannot draw such a conclusion without reservation. In particular, it is possible that more people would have mentioned violence in 1996 than in 1950 for other reasons, and that they simply used 'dangerous to self or others' as a familiar phrase with which to express their beliefs." *Id.*

155. Dallaire et al., *supra* note 109, at 693; *see also id.* at 692–93 ("Because the widely shared tendency to equate mental illness with dangerousness is manifested in the rationale for, and operationalization of, civil commitment laws, however they are written, a civil commitment system which couples mental illness with dangerousness has little or no effect on restraining commitals that would otherwise be made on the basis of need for treatment. The net result of a dangerousness criterion, then, may be to manifest, reinforce, and reproduce stereotypes depicting as threats to public safety persons who experience severe psychological distress or disturbances.").

link between mental illness and violence or dangerousness.[156] But some researchers have concluded that there is a link, and that major mental disorders, like schizophrenia and bipolar disorders are "associated with significantly higher risks for physical violence against others."[157] Other authors have argued that this correlation is so strong that "[t]he mental health community has to start by accepting that violent and antisocial behaviours are among the potential complications of having a schizophrenic syndrome" and should respond accordingly by creating structured programs to manage "the active symptoms of the disorder [and] prevent the progress to violence."[158]

Other researchers have reached different results and present persuasive evidence that there is no causal link between mental illness and

156. J. Arboleda-Florez, et al., *Understanding Causal Paths Between Mental Illness and Violence*, 33 SOC. PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY S38, S38 (1998); *see also* AM. PSYCHOL. ASS'N (Apr. 21, 2014), http://www.apa.org/news/press/releases/2014/04/mental-illness-crime.aspx [http://perma.cc/BT98-NFC8] (citing Jillian K. Peterson et al., *How Often and How Consistently Do Symptoms Directly Precede Criminal Behavior Among Offenders With Mental Illness?*, 38 L. & HUM. BEHAV. 439 (2014)). As Peterson et al. note, however,

> the study sample was relatively small . . . and excluded offenders with a violent index offense (like the mental health court pool from which it was drawn). Therefore the results may not generalize to 'violent offenders.' This concern is only partly mitigated by the fact that nearly one fifth (17%) of the crimes analyzed in this study were violent or potentially violent because participants reported crimes other than their index offense. It is possible that the rate of direct crimes would differ in a sample with more violent offenses.

Jillian K. Peterson et al., *How Often and How Consistently Do Symptoms Directly Precede Criminal Behavior Among Offenders With Mental Illness?*, 38 L. & HUM. BEHAV. 439, 446 (2014).

157. Christian C. Joyal et al., *Mental Disorders and Violence: A Critical Update*, 3 CURRENT PSYCHIATRY REVS. 33, 34 (2007) (noting that "[o]nce gender, age, socio-demographic and socio-economic status are taken into account, the overall risk for physical assault is generally estimated to be 3 to 5 times higher than that of the general population").

158. Paul Mullen, *Schizophrenia and Violence: From Correlations to Preventive Strategies*, 12 ADVANCES IN PSYCHIATRIC TREATMENT 239, 239, 243 (2006).

> There is a correlation between having a schizophrenic syndrome and increased rates of antisocial behavior in general and violence in particular. The evidence that such associations are not just statistically but clinically and socially significant is now overwhelming. Why, if the connection is so clear, has it not been widely recognized by clinicians and service planners?

Id. at 239 (citations omitted). The author feels so strongly about this connection that the opening line of the abstract notes that "[p]eople with schizophrenia make a significant contribution to violence in our communities and, in so doing, often lay waste to their own lives." *Id.*

violence in the general population.[159] Violence is not predicted by mental illness alone, and "[t]he predicted probability of violence for severe mental illness alone is approximately the same as for subjects with no severe mental illness."[160] Instead, people with mental illness who also had some other risk factor, especially substance abuse or a history of violence were at higher risk of violence. People with a severe mental illness and both substance abuse and a history of violence "showed nearly 10 times higher risk of violence compared with subjects with severe mental illness only."[161] But as the authors concluded, "If a person has severe mental illness without substance abuse and history of violence, he or she has the same chances of being violent during the next 3 years as any other person in the general population."[162]

Furthermore, multiple studies have shown that people with serious mental illness are most likely to be violent during an initial psychotic episode before they have been diagnosed or treated,[163] or when they

159. *See, e.g.*, Eric B. Elbogen & Sally C. Johnson, *The Intricate Link Between Violence and Mental Disorder: Results From the National Epidemiologic Survey on Alcohol and Related Conditions*, 66 ARCHIVES GEN. PSYCHIATRY 152 (2009).

160. *Id.* at 155.

161. *Id.* Other risk factors associated with a higher risk of violence included reporting parental physical abuse, witnessing parents physically fighting, parental criminal history, juvenile detention, perceiving threats, being unemployed in the past year, being recently divorced, and being recently victimized. *Id.* at 154–155; *see also* Seena Fazel et al., *Schizophrenia, Substance Abuse, and Violent Crime*, 301 J. AM. MED. ASSOC. 2016, 2021 (2009) (finding that "the association between schizophrenia and violent crime is minimal unless the patient is also diagnosed as having substance abuse comorbidity"). The authors found that, among patients without such comorbidity, the risk of increased violence, as compared to the general population or siblings without mental illness, was 1.2 to 1.3. *Id.*

162. Elbogen & Johnson, *supra* note 159, at 157.

163. Matthew M. Large & Olav Nielssen, *Violence in First-Episode Psychosis: A Systematic Review and Meta-Analysis*, 125 SCHIZOPHRENIA RES. 209, 214 (2011) ("The finding of high rates of violence among first-episode psychosis patients is consistent with the finding of a disproportionate number of homicides, violent suicide attempts and serious harms such as cases of major self mutilation in first-episode psychosis compared to later in the course of the illness.") (citations omitted); *see also* Olav Nielssen & Matthew Large, *Rates of Homicide During the First Episode of Psychosis and After Treatment: A Systematic Review and Meta-analysis*, 36 SCHIZOPHRENIA BULL. 702, 708 (2010) ("The main findings of this study can be summarized as (i) approximately 4 in 10 of the homicides committed by people with a psychotic illness occur before treatment, (ii) approximately 1 in 700 people with psychosis commit a homicide before treatment, (iii) approximately 1 in 10,000 patients with psychosis who have received treatment will commit a homicide each year, and (iv) the rate of homicide in psychosis before treatment is approximately 15 times higher than the annual rate after treatment.").

have discontinued treatment.[164] But because many people with serious mental illness are unable to recognize the severity of their illness or their need for treatment—and because the state typically does not intervene until people are dangerous—a small number of these people go without treatment until, paradoxically, they become violent. These violent acts and the defendant's mental illness are then heavily publicized, further reinforcing the perception between mental illness and violence.[165] The pervasiveness of perceptions about the connection between mental illness and violence or dangerousness, coupled with the interpretation of gravely disabled grounds for commitment to require dangerousness may be further perpetuating this connection.

V. THE AFTERMATH: EFFECTS OF DEINSTITUTIONALIZATION AND THE DANGEROUSNESS STANDARD

As commitment laws became stricter, more patients who would have previously been treated in a long-term inpatient facility were returned to their communities. Civil rights and community mental health advocates believed that most people suffering from serious mental illness would be better served in their own communities.[166] At the same time, well-meaning lawyers and mental health professions expected that people with mental illness would voluntarily seek that treatment and that treatment would be available to them in their communities.

Deinstitutionalization and heighted commitment standards have made improvements in the lives of many people with mental illness.[167]

164. E. Fuller Torrey, *Stigma and Violence: Isn't It Time to Connect the Dots?*, 37 SCHIZOPHRENIA BULL. 892, 893 (2011) (citing various studies).

165. *E.g.*, Hipolito Corella, *Tucson Shooting: No Mental Health Treatment for Loughner Before Giffords Rampage*, ARIZONA DAILY STAR (Mar. 27, 2013), http://tucson.com/news/local/crime/tucson-shooting-no-mental-health-treatment-for-loughner-before-giffords/article_70b5b03c-96f4-11e2-b7dc-0019bb2963f4.html [http://perma.cc/H6B5-HQU6]; *James Holmes Saw Three Mental Health Professionals Before Shooting*, CBS NEWS (Sept. 19, 2012), http://www.cbsnews.com/news/james-holmes-saw-three-mental-health-professionals-before-shooting/ [http://perma.cc/7JGD-DS59].

166. *See, e.g.*, David L. Chambers, *Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives*, 70 MICH. L. REV. 1107, 1109 (1972) ("[E]ven if we concede that governments may hospitalize an ill person to protect him from himself, or to protect others from him, or simply to treat or care for him, these goals can generally be better served by keeping him in the community than by removing him.").

167. Davis et al., *supra* note 33, at 263; *see also* FRANK & GLIED, *supra* note 9, at 1 ("Almost all severely ill patients receive some treatment. That treatment, although not always entirely effective, is unlikely to be dangerous or inhumane. The living conditions of people with severe illnesses have generally improved at least as much as have conditions for the rest of society over the past five decades.").

Access to mental health care has continued to improve and the quality of care is better than it was when deinstitutionalization began, especially in regards to medications available to treat chronic mental illness.[168] Social welfare programs like Medicaid and Medicare, and SSI and SSDI have helped people with mental illness to obtain better housing and improved income status.[169] Many of these improvements, however, are largely seen in people who are in the middle class, and in those who have less serious disorders.[170]

For people with serious mental illness who are dependent on the state to provide mental health care and treatment, improvements in access to care and the quality of that care since deinstitutionalization have been more modest. Most communities have not developed appropriate structures to provide appropriate care to people with chronic and serious mental illness and psychiatric beds that were once available in state hospitals have not been recreated in the community. In order to live in communities, these individuals need community-based resources in place that assist them in obtaining appropriate mental health treatment. Because these systems have not been sufficiently developed, people suffering from serious mental illness continue to be overrepresented among the homeless, among the incarcerated, and among victims of violent crime.[171] Furthermore, when people with serious mental illness or their families attempt to obtain care within communities, they often encounter "a fragmented array of public programs that are run out of a large number of distinct federal, state, and local government bureaucracies."[172]

Instead of receiving appropriate long-term care in their communities, many of these people have become "revolving-door patients," those who have a serious mental disorder, do not voluntarily comply with treatment, and are unable to live successfully without treatment in the community.[173] They often live on the fringes of their communities, where they deteriorate to the point that they meet emergency commitment standards and are hospitalized, often in hospital emergency rooms.[174] Long-term treatment is often not available, so patients are

168. Davis et al., *supra* note 33, at 263.

169. *Id.*

170. FRANK & GLIED, *supra* note 9, at 1.

171. *Id.* at 143.

172. *Id.* at 144.

173. Mark R. Munetz et al., *The Ethics of Mandatory Community Treatment*, 31 J. AM. ACAD. PSYCHIATRY & L. 173, 173 (2003).

174. One can find examples of this phenomenon in most major cities around the country. *See, e.g.*, Brian M. Rosenthal, *'Boarding' Mentally Ill Becoming Epidemic In State*, SEATTLE TIMES (Oct. 5, 2013), http://seattletimes.com/html/localnews/2021968893_psychiatricboardingxml.html [http://perma.cc/

held just long enough to stabilize on medication and regain competency, where they are again released into the community. Once there, they discontinue treatment, decompensate, and the cycle begins again.[175]

One reason for unavailability of long-term psychiatric treatment following deinstitutionalization is the rapid decrease of psychiatric inpatient hospital beds in the United States; beds that were not recreated in communities after state facilities were closed.[176] Residents in state hospitals numbered almost 559,000 people in 1955; by 2003 that number had fallen to 47,000.[177] And while we know that most people with serious mental illness no longer live in state institutions, it is harder to say where they are living now. Many live with family members, who have once again been tasked with the primary responsibilities of caring for loved ones with mental illness when those individuals are too ill to care for themselves, but do not meet a civil determination of dangerousness. One study interviewed mothers of adult children with serious mental illness, and described the difficulty family members face waiting "for the inevitable point at which their children would meet criteria to be

53U9-DQ52]; Yesenia Amaro, *Inundated By The Mentally Ill, Valley Emergency Rooms Close To Ambulances*, LAS VEGAS REVIEW-JOURNAL (Feb. 26, 2014), http://www.reviewjournal.com/news/inundated-mentally-ill-valley-emergency-rooms-close-ambulances [http://perma.cc/CCP4-AX62].

175. *See* Munetz et al., *supra* note 173, at 174 (noting that this particularly affects patients "who do not believe they are ill or need treatment").

176. This Article does not address in detail, but does not mean to ignore, the profound impact that a lack of available beds might have on psychiatrists' decisions to recommend civil commitment. Faced with a shortage of inpatient psychiatric beds:

> [A] clinician might rightly engage in a sort of a triage. The patients who are thought to be most in need of hospitalization are committed, while patients who constitute somewhat less urgent cases, although still meeting commitment standards, are turned away. This low-visibility decision depends not on judges' enforcing the state's commitment laws, but on emergency room and admitting office clinicians' attempting to protect their institutions from being overwhelmed.

APPLEBAUM, *supra* note 113, at 52.

177. Testa & West, *supra* note 7, at 33; *see also* Davis et al., *supra* note 33, at 259; *No Room at the Inn: Trends and Consequences of Closing Public Psychiatric Hospitals 2005-2010*, TREATMENT ADVOCACY CTR. (July 19, 2012) (noting that in 2010, the number of state psychiatric beds per capita in the United States was nearly the same as the number of state psychiatric beds per capita in 1850 (14 beds per 100,000 individuals)); TORREY ET AL., *supra* note 32, at 5 (finding that the state with the most available public psychiatric beds per 100,000 population in 2005 was Mississippi (49.7), while the states with the fewest beds were Nevada (5.1) and Arizona (5.9)).

hospitalized involuntarily."[178] As one woman described it, "It's like you wait till something horrible happens before something can be done."[179]

For those without family to help, the situation is worse. While the numbers of people with mental illness receiving SSI has risen, those people are still about 60% more likely than people without mental illness to report incomes below $20,000 a year.[180] "For this group, living circumstances depend critically on access to publicly funded benefits, but benefits are meager and leave most people with severe illnesses in poverty."[181] Moreover, as the price of housing has increased, available subsidized housing has not increased enough to keep housing affordable for people with mental illness who rely on public benefits.[182]

Another commonly referenced result of deinstitutionalization and heightened commitment standards is increased rates of homelessness among people with serious mental illness. Recent estimates suggest that more than 25% of the homeless population in the United States has a serious mental illness,[183] while only 4.1% of the general population suffers from serious mental illness.[184] One study in Ohio found that 36% of study participants were homeless six months after discharge from a

178. Darcy Ann Copeland & MarySue V. Heilemann, *Getting "to the Point": The Experience of Mothers Getting Assistance for Their Adult Children Who Are Violent and Mentally Ill*, 57 NURSING RES. 136, 139 (2008).

179. *Id.* The sampled mothers noted a desire for their children to have earlier access to mental health treatment:

> The mothers felt that their desire for early intervention was in their children's best interests. Also, they did not want to be victimized violently. These mothers repeatedly voiced their frustration at having to wait until violence occurred before being able to access mental health treatment for their children. This situation resulted in worse outcomes for both mothers and their children.

Id. at 142.

180. Sherry A. Glied & Richard G. Frank, *Better but Not Best: Recent Trends in the Well-Being of The Mentally Ill*, 28 HEALTH AFF. 637, 645 (2009).

181. *Id.*

182. *Id.* ("Improvements in living conditions that might have been generated by increases in receipt of public benefits were offset by the increase in housing prices in many areas.").

183. SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., CURRENT STATISTICS ON THE PREVALENCE AND CHARACTERISTICS OF PEOPLE EXPERIENCING HOMELESSNESS IN THE UNITED STATES (2011); *see also* Laurence Roy et al., *Criminal Behavior and Victimization Among Homeless Individuals with Severe Mental Illness: A Systematic Review*, 65 PSYCHIATRIC SERVS. 739, 739 (2014) (noting that "between 20% and 50% of homeless adults also have a severe mental illness").

184. NAT'L INST. OF MENTAL HEALTH, SERIOUS MENTAL ILLNESS AMONG ADULTS (2012), http://www.nimh.nih.gov/statistics/SMI_AASR.shtml [http://perma.cc/U66H-BNL4].

psychiatric facility.[185] Another study in Massachusetts found among 187 patients with serious mental illness, 17% were "predominantly homeless" and 10% were "occasionally homeless" in the six months after discharge from a state psychiatric hospital.[186]

The effects of deinstitutionalization and heighted commitment standards can also be seen in the increase in rates of mentally ill people in jails and prisons.[187] Among state prison inmates, approximately 24% have a recent history of a mental health problem.[188] Another recent study reviewed the prevalence of serious mental illness in jail inmates in New York and Maryland.[189] The researchers found that rates of serious mental illness in women were 31%, while comparable rates among men were 14.5%.[190] If we generalize these findings to the 13 million

185. John R. Belcher, *Rights Versus Needs of Homeless Mentally Ill Persons*, 33 SOC. WORK 398, 399–400 (2001) ("[N]arrow interpretation of commitment criteria by service providers and other mental health professionals contributed to mental deterioration and homelessness for some respondents.").

186. Robert E. Drake et al., *Housing Instability and Homelessness Among Aftercare Patients of an Urban State Hospital*, 40 PSYCHIATRIC SERVS. 46, 49 (1989). *See also* Roy et al., *supra* note 183, at 743 (noting that homeless people with mental illness are also significantly more likely to be arrested for crimes).

187. TORREY, *supra* note 4, at 128–29.

188. DEP'T OF JUST., MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES (2006). The study used the following methodology:

> A recent history of mental health problems was measured by several questions in the BJS' inmate surveys. Offenders were asked about whether in the past 12 months they had been told by a mental health professional that they had a mental disorder or because of a mental health problem had stayed overnight in a hospital, used prescribed medication, or received professional mental health therapy.

Id. Jail inmates had slightly lower rates of recent mental health problems (21%) and federal prisoners had the lowest rate (14%). When asked about mental health problems that were not recent, that is those that had not required treatment in the past twelve months, the numbers jumped to 56% for state prisoners, 64% for jail inmates, and 45% for federal prisoners. *Id.* *See also* Christine M. Sarteschi, *Mentally Ill Offenders Involved with the U.S. Criminal Justice System: A Synthesis*, SAGE OPEN 1, 8 (2013) ("The most common types of psychological disorders found among inmates, according to government and congressional surveys and data collected from studies in the literature, include anxiety, affective, thought, and substance abuse disorders.").

189. Henry J. Steadman et al., *Prevalence of Serious Mental Illness Among Jail Inmates*, 60 PSYCHIATRIC SERVS. 761, 761 (2009) (including schizophrenia, schizophrenia spectrum disorder, schizoaffective disorder, bipolar disorder, brief psychotic disorder, delusional disorder, and psychotic disorder not otherwise specified).

190. *Id.* at 764.

annual jail admissions in the United States, there were about two million annual bookings of people with serious mental illness in 2007.[191] People with serious mental illness are also more likely than people without mental illness to be arrested. For instance, one study in Massachusetts found that among people with serious mental illness, 28% of them had been arrested in the past ten years.[192]

Although several studies have shown that people with mental illness are overrepresented in the prison population, these studies should not be read to suggest a link between mental illness and criminal behavior.[193] Instead, some authors have suggested that the large numbers of people with mental illness who are incarcerated might reflect a lack of access to appropriate mental health care: because people with mental illness regularly encounter obstacles to treatment and inadequate treatment, this "results in patients being arrested for both violent and nonviolent crimes. Often such charges are based on behaviors that are direct manifestations of the patients' then untreated symptoms, such as paranoia leading to trespassing or grandiosity resulting in breaking and entering."[194]

Furthermore, while heightened commitment standards were meant to reduce coercion of people with mental illness, many people with mental illness are already experiencing some type of state involvement in their receipt of the mental health services they do receive, and often these services involve conditions. People with mental illness regularly come into contact with various state agencies, including mental health agencies, social service agencies, and the criminal justice system, all of

191. *Id.*

192. William H. Fisher et al., *Patterns and Prevalence of Arrest in a Statewide Cohort of Mental Health Care Consumers*, 57 PSYCHIATRIC SERVS. 1623, 1625 (2005). Of the total arrests, 13.6% were for crimes including violence against other people; the remaining arrests were for crimes against public order, property crimes, motor vehicle offenses, less serious crimes against persons, drug offenses, public decency offenses, assault and battery on a police officer, firearm violations, and miscellaneous offenses. *Id.* Men were more likely to be arrested than women (36.1% of men with serious mental illness had experienced an arrest, while only 17.5% of women had been arrested in the previous ten years), and non-whites were more likely to be arrested than whites (26.5% of white individuals with serious mental illness had been arrested in the past ten years, while 33.3% of non-whites with serious mental illness had been arrested). *Id.* at 1326.

193. *See* Hiday, *supra* note 6, at 62 (finding that people with serious mental illness are about two-and-a-half times more likely to be the victim of a violent crime).

194. Marie E. Rueve, *Violence and Mental Illness*, 5 PSYCHIATRY 34, 36 (2008).

which apply some leverage to the individual in an attempt to improve treatment compliance.[195]

One recent study found that between 12 and 20% of people who are receiving treatment for mental illness have received either outpatient or inpatient commitment orders at some point during their lives, and nearly three-quarters "reported experiencing other kinds of leverage applied through the legal or social welfare system to improve their treatment adherence."[196] People who had a history of civil commitment were also more likely to have been ordered to seek treatment as a result of a criminal offense, or ordered to participate in treatment as a condition of receiving social security benefits.[197] They were more likely to have lived in some type of subsidized housing where treatment was mandated as a condition of occupancy.[198] Furthermore, people with some history of civil commitment often reported pressure from medical personnel and family members to comply with prescribed medication and treatment recommendations.[199]

Most people with serious mental illness therefore do not just experience coercion if they are civilly committed—instead they experience coercion at all levels of their involvement with the mental health system, in their receipt of social benefits, and through their involvement with the criminal justice system.[200] The small numbers of mentally ill people whose only experience with mandated mental health treatment is civil commitment or a related civil court treatment order report low

195. Marvin S. Swartz et al., *Use of Outpatient Commitment or Related Civil Court Treatment Orders in Five U.S. Communities*, 57 PSYCHIATRIC SERVS. 343, 349 (2006).

196. *Id.* at 346–47.

197. *Id.* at 346. This study sampled:

> A total of 1,011 adult outpatients recruited from sites that provide public psychiatric services in five cities across the United States, including Chicago; Durham, North Carolina; San Francisco; Tampa; and Worcester, Massachusetts. . . . Recruitment criteria specified that participants had to be aged 18 to 65 years, English or Spanish speaking, and in treatment during the past six months for a mental disorder, excluding those with only a substance use disorder.

Id. at 344.

198. *Id.* at 346.

199. *See id.* ("[A] history of outpatient commitment or similar civil court-ordered treatment was not significantly associated with satisfaction with mental health treatment or perceived sense of autonomy in everyday affairs.").

200. The groups of people with mental illness most likely to be subject to a civil commitment order are those who have poor social support, a history of violence, and a history of involvement with the police. The orders are also more common for people who live in group facilities and have co-occurring substance abuse problems. Swartz et al., *supra* note 195, at 347.

perceived coercion and high treatment satisfaction, "perhaps because their singular experiences with civil court treatment orders alone, without other types of leverage, identifies a group with a more benign course and a successful return to treatment adherence."[201] In contrast, people who have felt coerced by several different forms of leverage in their receipt of mental health services "likely had a more tumultuous course in which multiple agencies and actors attempted to ensure treatment adherence."[202]

VI. RECOMMENDATIONS: THE NEED FOR A BROADER INTERPRETATION OF GRAVELY DISABLED COMMITMENT STANDARDS

While deinstitutionalization and heighted commitment standards have therefore helped many individuals, some authors have noted that for others, it has been "one of the great social disasters of recent American history."[203] For many people with serious mental illness, especially the poor and people with chronic illnesses, the complexities of access to psychiatric care and the decentralization of services have created new and sometimes insurmountable obstacles to receiving care and services.[204] Furthermore, while heighted commitment standards were intended to reduce coercion, protect patient's civil liberties and ensure they receive the best possible treatment in the least restrictive setting, the requirement that the patient pose a danger to herself or others often means the person's health must deteriorate significantly before she will meet the commitment standard.[205] In many cases, this heightened standard has resulted in the marginalization of people with serious mental illness into poverty and homelessness, into prisons, and into a variety of situations where they are at higher risk of becoming victims of crimes.[206]

This is not a simple problem, nor one with an elegant solution. Improving access to mental health care will require reforms at all levels of government. Improving access to mental health care for individuals

201. *Id.* at 348.

202. *Id.*

203. TORREY, *supra* note 4, at 1 (noting that "[t]here are two major origins of the disaster—deinstitutionalization and the legal profession.)

204. Davis et al., *supra* note 33, at 263. These complexities are further exacerbated by the rise of health maintenance organizations (HMOs), private psychiatric hospitals, and Managed Behavioral Health Organizations (MBHOs), all of which have impacted access to treatment for people with severe mental illness. *Id.* at 260; *see also* Glied & Frank, *supra* note 180, at 637 ("[N]ot all people with mental health problems have shared in these improvements.").

205. Testa & West, *supra* note 7, at 34.

206. Hiday, *supra* note 6, at 62.

with serious mental illness is made more difficult by the complexities of serious mental illness and by the fact that many individuals are so ill they do not recognize a need for treatment. Creating systems that meaningfully improve access to mental health care, however, takes time. This Article does not propose that we abandon those efforts, but that in the meantime, courts and psychiatrists use systems that are already in place to provide care to individuals with serious mental illness who are otherwise living in deplorable conditions, on the streets, in poverty, or in the criminal justice system. One existing system is civil commitment and gravely disabled grounds for commitment. While all people have certain rights to be free from unwanted medical treatment, for people with serious mental illness who are homeless or in prison, those civil liberties are an abstraction, safeguarded for them by a system that is not otherwise allowing them access to shelter and basic medical care. As one psychiatrist famously noted, these patients are "dying with their rights on."[207]

States have an obligation to provide citizens with appropriate mental health care and a more robust civil commitment standard, one that more fully embraces the state's *parens patriae* authority and allows for commitment on gravely disabled grounds absent a finding of dangerousness could help provide that care. Although the police power has become the primary justification for civil commitment in the United States since deinstitutionalization, a requirement that a person be found dangerous to themselves or others before the state takes responsibility for providing mental health care is harming people with serious mental illness. Moreover, because many of these individuals lack insight into their need for treatment, they often do not voluntarily seek treatment, which can cause their illnesses to manifest "disturbed and disturbing behavior that can result in incarceration from stable housing arrangements, limited access to housing, and increased vulnerability to crime and abuse."[208]

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207. Darold A. Treffert, *Dying With Their Rights On*, 130 AM. J. PSYCHIATRY 1041 (1937). Treffert described Wisconsin's dangerousness standard for civil commitment:

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

Id.

208. *See supra* text accompanying notes 4–5.

Civil commitment and the dangerousness standard have become almost synonymous in the minds of the public, the mental health community, and the legal system. But the primary use of a dangerousness standard grounded in states' police powers is still failing a small but vulnerable population—individuals with untreated serious and chronic mental illness. Until we can create a better system—one that effectively provides community-based resources and treatment to individuals suffering from serious mental illness—courts and psychiatrists should more readily base commitment adjudications on states' *parens patriae* authority, including gravely disabled standards that allow for commitment when an individual is unable to meet her basic needs but is not dangerous to herself. This ground for commitment is already available in most state statutes, but the connection between mental illness, civil commitment, and dangerousness is so strong that many psychiatrists and courts are not interpreting these available standards to provide people with mental illness the care and treatment they need. The result is that many with serious mental illness are not receiving treatment at all.

CONCLUSION

States are empowered—and obligated—to provide appropriate mental health care to citizens under the *parens patriae* authority. Many states legislatures recognize this obligation and have amended civil commitment statutes to allow for the commitment and treatment of people with serious mental illness before they reach the point of dangerousness. Statutes that allow for commitment upon a finding of grave disability when a person is unable to meet her basic needs for survival are an appropriate exercise of states' *parens patriae* authority. However, continued perceptions of the link between mental illness and violence, coupled with a lack of awareness and underuse of those statutes have resulted in commitment standards that effectively commit people only when they are dangerous, which is often far past the point that they are in need of help, homeless, or imprisoned. In turn, many people who need treatment, but are not dangerous to themselves or others, receive little or no mental health care.

While all people have certain rights to be free from unwanted medical treatment, those civil liberties are perhaps less imperative than more immediate needs like shelter and basic medical and mental health care. States' continued and primary use of a dangerousness standard in civil commitment proceedings does not meet our obligations to people with serious mental illness. Courts and psychiatrists should recognize states' obligations to provide health care to citizens with serious mental illness by interpreting gravely disabled statutes to allow for commitment when an individual is unable to provide for her basic needs but does not pose a danger to herself.

APPENDIX

I

MENTAL HEALTH PROCEDURES ACT

Act of Jul. 9, 1976, P.L. 817, No. 143 **Cl. 50**

AN ACT

Relating to mental health procedures; providing for the treatment and rights of mentally disabled persons, for voluntary and involuntary examination and treatment and for determinations affecting those charged with crime or under sentence.

TABLE OF CONTENTS

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

ARTICLE I
General Provisions

Section 101. Short Title.--This act shall be known and may be cited as the "Mental Health Procedures Act."

Section 102. Statement of Policy.--It is the policy of the Commonwealth of Pennsylvania to seek to assure the availability of adequate treatment to persons who are mentally ill, and it is the purpose of this act to establish procedures whereby this policy can be effected. The provisions of this act shall be interpreted in conformity with the principles of due process to make voluntary and involuntary treatment available where the need is great and its absence could result in serious harm to the mentally ill person or to others. Treatment on a voluntary basis shall be preferred to involuntary treatment; and in every case, the least restrictions consistent with adequate treatment shall be employed. Persons who are mentally retarded, senile, alcoholic, or drug dependent shall receive mental health treatment only if they are also diagnosed as mentally ill, but these conditions of themselves shall not be deemed to constitute

mental illness: Provided, however, That nothing in this act shall prohibit underutilized State facilities for the mentally ill to be made available for the treatment of alcohol abuse or drug addiction pursuant to the act of April 14, 1972 (P.L.221, No.63), known as the "Pennsylvania Drug and Alcohol Abuse Control Act." Chronically disabled persons 70 years of age or older who have been continuously hospitalized in a State operated facility for at least ten years shall not be subject to the procedures of this act. Such a person's inability to give a rational, informed consent shall not prohibit the department from continuing to provide all necessary treatment to such a person. However, if such a person protests treatment or residence at a State operated facility he shall be subject to the provisions of Article III.

(102 amended Nov. 26, 1978, P.L.1362, No.324)

Section 103. Scope of Act.--This act establishes rights and procedures for all involuntary treatment of mentally ill persons, whether inpatient or outpatient, and for all voluntary inpatient treatment of mentally ill persons.

(103 amended Oct. 24, 2018, P.L.690, No.106)

Section 103.1. Definitions.--The following words and phrases when used in this act shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Assisted outpatient treatment." Community-based outpatient social, medical and behavioral health treatment services ordered by a court for a severely mentally disabled person, which may include one or more of the following services:

(1) Community psychiatric supportive treatment.

(2) Assertive community treatment.

(3) Medications.

(4) Individual or group therapy.

(5) Peer support services.

(6) Financial services.

(7) Housing or supervised living services.

(8) Alcohol or substance abuse treatments when the treatment is a co-occurring condition for a person with a primary diagnosis of mental health illness.

(9) Any other service prescribed to treat the person's mental illness that either assists the person in living and functioning in the community or helps to prevent a relapse or a deterioration of the person's condition that would be likely to result in a substantial risk of serious harm to the person or others.

"County local authority." The county commissioners of a county, or the city councils and the mayors of the first class cities, or two or more of these acting in concert.

"Department." The Department of Human Services of the Commonwealth.

"Facility." A mental health establishment, hospital, clinic, institution, center, day care center, base service unit, community mental health center, or part thereof, that provides for the diagnosis, treatment, care or rehabilitation of mentally ill persons, whether as outpatients or inpatients.

"Inpatient treatment." All treatment that requires full or part-time residence in a facility.

"Qualified professional." A mental health professional who:

(1) has a graduate degree, or the international equivalent, from an institution accredited or evaluated by an organization recognized by the department in a generally recognized clinical discipline that includes mental health clinical experience;

(2) has mental health clinical experience; and

(3) is licensed or certified by the Commonwealth.

"Secretary." The Secretary of Human Services of the Commonwealth.

(103.1 added Oct. 24, 2018, P.L.690, No.106)

Section 104. Provision for Treatment.--Adequate treatment means a course of treatment designed and administered to alleviate a person's pain and distress and to maximize the probability of his recovery from mental illness. It shall be provided to all persons in treatment who are subject to this act. It may include inpatient treatment, partial hospitalization, or outpatient treatment. Adequate inpatient treatment shall include such accommodations, diet, heat, light, sanitary facilities, clothing, recreation, education and medical care as are necessary to maintain decent, safe and healthful living conditions. Treatment shall include diagnosis, evaluation, therapy, or rehabilitation needed to alleviate pain and distress and to facilitate the recovery of a person from mental illness and shall also include care and other services that supplement treatment and aid or promote such recovery.

Section 105. Treatment Facilities.--Involuntary treatment and voluntary treatment funded in whole or in part by public moneys shall be available at a facility approved for such purposes by the county administrator (who shall be the County Mental Health and Mental Retardation Administrator of a county or counties, or his duly authorized delegate), or by the department. Approval of facilities shall be made by the appropriate authority which can be the department pursuant to regulations adopted by the department. Treatment may be ordered at the Veterans Administration or other agency of the United States upon receipt of a certificate that the person is eligible for such hospitalization or treatment and that there is available space for his care. Mental health facilities operated under the direct control of the Veterans Administration or other Federal agency are exempt from obtaining State approval. The department's standards for approval shall be at least as stringent as those of the joint commission for accreditation of hospitals and those of the Federal Government pursuant to Titles 18 and 19 of the Federal Social Security Act to the extent that the type of facility is one in which those standards are intended to apply. An exemption from the standards may be granted by the department for a period not in excess of one year and may be renewed. Notice of each exemption and the rationale for allowing the exemption must be published pursuant to the act of July 31, 1968 (P.L.769, No.240), known as the "Commonwealth Documents Law," and shall be prominently posted at the entrance to the main office and in the reception areas of the facility.

(105 amended Oct. 24, 2018, P.L.690, No.106)

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

Section 106. Persons Responsible for Formulation and Review of Treatment Plan.--(a) Pursuant to sections 107 and 108 of this act, a treatment team shall formulate and review an individualized treatment plan for every person who is in treatment under this act.

(b) A treatment team must be under the direction of either a physician or a licensed clinical psychologist and may include other mental health professionals.

(c) A treatment team must be under the direction of a physician when:

(1) failure to do so would jeopardize Federal payments made on behalf of a patient; or

(2) the director of a facility requires the treatment to be under the direction of a physician.

(d) All treatment teams must include a physician and the administration of all drugs shall be controlled by the act of April 14, 1972 (P.L.233, No.64), known as "The Controlled Substance, Drug, Device and Cosmetic Act."

Section 107. Individualized Treatment Plan.--(a) Individualized treatment plan means a plan of treatment formulated for a particular person in a program appropriate to his specific needs, including an assisted outpatient treatment plan under subsection (b). To the extent possible, the plan shall be made with the cooperation, understanding and consent of the person in treatment, and shall impose the least restrictive alternative consistent with affording the person adequate treatment for his condition.

(b) Assisted outpatient treatment plan means an individualized treatment plan developed by a qualified professional or the treatment team that is ordered by a court for involuntary outpatient civil commitment of a person. The treatment plan shall be reviewed and approved by a psychiatrist or a licensed clinical psychologist prior to submission to the court. The treatment plan shall contain the reasonable objectives and goals for a person determined to be in need of assisted outpatient treatment. In addition to the requirements of subsection (a), the treatment plan shall include:

(1) Delineation of specific assisted outpatient treatment services to be provided based on the person's specific needs.

(2) Delineation of the providers that agree to provide assisted outpatient treatment services to the person.

(3) Documentation of how the person was involved in the initial development of the treatment plan and the process for involving the person in ongoing evaluation and, if appropriate, modifications to the treatment plan.

(c) A treatment plan developed in accordance with this section shall meet all of the requirements of this act.

(d) In the development and approval of an individualized treatment plan, nothing in this subsection shall be construed to require a county to include in a person's individual treatment plan for assisted outpatient treatment a service that is not available in that county or for which no funding source or provider is available to pay for or render the service.

(107 amended Oct. 24, 2018, P.L.690, No.106)

Section 108. Periodic Reexamination, Review and Redisposition.--(a) Reexamination and Review.--Every person who is in treatment under this act shall be examined by a treatment team and his treatment plan reviewed not less than once in every 30 days.

(b) Redisposition.--On the basis of reexamination and review, the treatment team may either authorize continuation of the existing treatment plan if appropriate, formulate a new individualized treatment plan, or recommend to the director the discharge of the person. A person shall not remain in treatment or under any particular mode of treatment for longer than such treatment is necessary and appropriate to his needs.

(c) Record of Reexamination and Review.--The treatment team responsible for the treatment plan shall maintain a record of each reexamination and review under this section for each person in treatment to include:

(1) a report of the reexamination, including a diagnosis and prognosis;

(2) a brief description of the treatment provided to the person during the period preceding the reexamination and the results of that treatment;

(3) a statement of the reason for discharge or for continued treatment;

(4) an individualized treatment plan for the next period, if any;

(5) a statement of the reasons that such treatment plan imposes the least restrictive alternative consistent with adequate treatment of his condition; and

(6) a certification that the adequate treatment recommended is available and will be afforded in the treatment program.

Section 109. Mental Health Review Officer.--(a) Legal proceedings concerning extended involuntary emergency treatment under section 303(c), court-ordered involuntary treatment under section 304 or 305 or transfer hearings under section 306, may be conducted by a judge of the court of common pleas or by a mental health review officer authorized by the court to conduct the proceedings. ((a) repealed in part Oct. 5, 1980, P.L.693, No.142)

(b) In all cases in which the hearing is conducted by a mental health review officer, a person made subject to treatment shall have the right to petition the court of common pleas for review of the certification. A hearing shall be held within 72 hours after the petition is filed unless a continuance is requested by the person's counsel. The hearing shall include a review of the certification and such evidence as the court may receive or require. If the court determines that further involuntary treatment is necessary and that the procedures prescribed by this act have been followed, it shall deny the petition. Otherwise, the person shall be discharged.

(c) Notwithstanding any other provision of this act, no judge or mental health review officer shall specify to the treatment team the adoption of any treatment technique, modality, or drug therapy.

(d) Notwithstanding any statute to the contrary, judges of the courts of common pleas, mental health review officers and county mental health and mental retardation administrators shall notify the Pennsylvania State Police on a form developed by the Pennsylvania State Police of the identity of any individual who has been adjudicated incompetent or who has been involuntarily committed to a mental institution for inpatient care and treatment under this act or who has been involuntarily treated as described under 18 Pa.C.S § 6105(c)(4) (relating to persons not to possess, use, manufacture, control, sell or transfer firearms). The notification shall be transmitted by the judge, mental health review officer or county mental health and mental retardation administrator within seven days of the adjudication, commitment or treatment. Notwithstanding any statute to the contrary, county mental health and mental retardation administrators shall notify the Pennsylvania State Police on a form developed by the Pennsylvania State Police of the identity of any individual who before the effective date of this act had been adjudicated incompetent or had been involuntarily committed to a mental institution for inpatient care treatment under this act or had been involuntarily treated as described in 18 Pa.C.S. § 6105(c)(4). ((d) added July 2, 1996, P.L.481, No.77)

(109 repealed in part Apr. 28, 1978, P.L.202, No.53 and amended Nov. 26, 1978, P.L.1362, No.324)

Section 110. Written Applications, Petitions, Statements and Certifications.--(a) All written statements pursuant to section 302(a)(2), and all applications, petitions, and

certifications required under the provisions of this act shall be made subject to the penalties provided under 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities) and shall contain a notice to that effect.

(b) All such applications, petitions, statements and certifications shall be submitted to the county administrator in the county where the person was made subject to examination and treatment and such other county in the Commonwealth, if any, in which the person usually resides.

(c) Subsections (a) and (b) shall not apply to patients admitted pursuant to Article II when no part of the patient's care is provided with public funds provided that the department may require facilities to report clinical and statistical information so long as the data does not identify individual patients.

(d) ((d) repealed Oct. 5, 1980, P.L.693, No.142)

(110 amended Nov. 26, 1978, P.L.1362, No.324)

Section 111. Confidentiality of Records.--(a) All documents concerning persons in treatment shall be kept confidential and, without the person's written consent, may not be released or their contents disclosed to anyone except:

(1) those engaged in providing treatment for the person;

(2) the county administrator, pursuant to section 110;

(3) a court in the course of legal proceedings authorized by this act; and

(4) pursuant to Federal rules, statutes and regulations governing disclosure of patient information where treatment is undertaken in a Federal agency.

In no event, however, shall privileged communications, whether written or oral, be disclosed to anyone without such written consent. This shall not restrict the collection and analysis of clinical or statistical data by the department, the county administrator or the facility so long as the use and dissemination of such data does not identify individual patients. Nothing herein shall be construed to conflict with section 8 of the act of April 14, 1972 (P.L.221, No.63), known as the "Pennsylvania Drug and Alcohol Abuse Control Act."

(b) This section shall not restrict judges of the courts of common pleas, mental health review officers and county mental health and mental retardation administrators from disclosing information to the Pennsylvania State Police or the Pennsylvania State Police from disclosing information to any person, in accordance with the provisions of 18 Pa.C.S. § 6105(c)(4) (relating to persons not to possess, use, manufacture, control, sell or transfer firearms).

(111 amended July 2, 1996, P.L.481, No.77)

Compiler's Note: Section 111 was suspended by Pennsylvania Rule of Disciplinary Enforcement No.601, adopted February 2, 1984, insofar as it is inconsistent with the Rules of Disciplinary Enforcement.

Section 112. Rules, Regulations and Forms.--The department shall adopt such rules, regulations and forms as may be required to effectuate the provisions of this act. Rules and regulations adopted under the provisions of this act shall be adopted according to provisions of section 201 of the act of October 20, 1966 (3rd Sp.Sess., P.L.96, No.6), known as the "Mental Health and Mental Retardation Act of 1966," and the act of July 31, 1968 (P.L.769, No.240), known as the "Commonwealth Documents Law."

Section 113. Rights and Remedies of Persons in Treatment.--Every person who is in treatment shall be entitled

to all other rights now or hereafter provided under the laws of this Commonwealth, in addition to any rights provided for in this act. Actions requesting damages, declaratory judgment, injunction, mandamus, writs of prohibition, habeas corpus, including challenges to the legality of detention or degree of restraint, and any other remedies or relief granted by law may be maintained in order to protect and effectuate the rights granted under this act.

Section 114. Immunity from Civil and Criminal Liability.--(a) In the absence of willful misconduct or gross negligence, a county administrator, a director of a facility, a physician, a peace officer or any other authorized person who participates in a decision that a person be examined or treated under this act, or that a person be discharged, or placed under partial hospitalization, outpatient care or leave of absence, or that the restraint upon such person be otherwise reduced, or a county administrator or other authorized person who denies an application for voluntary treatment or for involuntary emergency examination and treatment, shall not be civilly or criminally liable for such decision or for any of its consequences.

(b) A judge or a mental health review officer shall not be civilly or criminally liable for any actions taken or decisions made by him pursuant to the authority conferred by this act.

(114 amended Nov. 26, 1978, P.L.1362, No.324)

Section 115. Venue and Location of Legal Proceedings.--(a) The jurisdiction of the courts of common pleas and juvenile courts conferred by Articles II and III shall be exercised initially by the court for the county in which the subject of the proceedings is or resides. Whenever involuntary treatment is ordered, jurisdiction over any subsequent proceeding shall be retained by the court in which the initial proceedings took place, but may be transferred to the county of the person's usual residence. In all cases, a judge of the court of common pleas or a mental health review officer of the county of venue may conduct legal proceedings at a facility where the person is in treatment whether or not its location is within the county.

(b) Venue for actions instituted to effectuate rights under this act shall be as now or hereafter provided by law.

Section 116. Continuity of Care.--(a) It shall be the responsibility of the facility administration to refer those voluntary and involuntary patients discharged from State institutional programs to the appropriate county mental health and mental retardation program.

(b) The county mental health and mental retardation program shall, pursuant to Article III of the "Mental Health and Mental Retardation Act of 1966," receive referrals from State-operated facilities and shall be responsible for the treatment needs of county residents discharged from institutions pursuant to Articles II and III of this act.

(116 added Nov. 26, 1978, P.L.1362, No.324)

Section 117. Assisted Outpatient Treatment Implementation by Counties.--(a) (1) The county administrator of any county may determine annually that the county mental health and intellectual disabilities program will not provide assisted outpatient treatment pursuant to section 301(c). The county administrator making the determination shall:

(i) provide notice to the secretary that the county program will not provide assisted outpatient treatment in accordance with section 301(c); and

(ii) notify the county local authority of the decision not to offer assisted outpatient treatment in accordance with section 301(c).

(2) The notification to the secretary under clause (1) shall be submitted annually in a form determined by the secretary.

(b) The secretary shall grant an annual waiver to any county that has notified the secretary under subsection (a) of the county's decision not to offer assisted outpatient services pursuant to section 301(c).

(c) Nothing in this section shall be construed as permitting a county or the secretary to waive existing obligations of a county to serve seriously mentally ill residents in accordance with all other applicable provisions of law and regulation.

(117 added Oct. 24, 2018, P.L.690, No.106)

Section 118. Assisted Outpatient Treatment Implementation by Department.--(a) The department shall modify the standard involuntary commitment petition forms and other relevant educational documents used in conjunction with the involuntary commitment process to describe, define and incorporate assisted outpatient treatment.

(b) The department shall develop a separate involuntary assisted outpatient treatment commitment petition form which shall include:

(1) The eligibility criteria for assisted outpatient treatment.

(2) After consultation with the Pennsylvania College of Emergency Physicians, appropriate guidance and instructions to the petitioner on use of hospital emergency departments in conjunction with the petition process for involuntary inpatient commitment or assisted outpatient treatment.

(118 added Oct. 24, 2018, P.L.690, No.106)

ARTICLE II
Voluntary Examination and Treatment

Section 201. Persons Who May Authorize Voluntary Treatment.--Any person 14 years of age or over who believes that he is in need of treatment and substantially understands the nature of voluntary treatment may submit himself to examination and treatment under this act, provided that the decision to do so is made voluntarily. A parent, guardian, or person standing in loco parentis to a child less than 14 years of age may subject such child to examination and treatment under this act, and in so doing shall be deemed to be acting for the child. Except as otherwise authorized in this act, all of the provisions of this act governing examination and treatment shall apply.

(201 amended Nov. 26, 1978, P.L.1362, No.324)

Section 202. To Whom Application May be Made.--Application for voluntary examination and treatment shall be made to an approved facility or to the county administrator, Veterans Administration or other agency of the United States operating a facility for the care and treatment of mental illness. When application is made to the county administrator, he shall designate the approved facility for examination and for such treatment as may be appropriate.

Section 203. Explanation and Consent.--Before a person is accepted for voluntary inpatient treatment, an explanation shall be made to him of such treatment, including the types of treatment in which he may be involved, and any restraints or restrictions to which he may be subject, together with a statement of his rights under this act. Consent shall be given

in writing upon a form adopted by the department. The consent shall include the following representations: That the person understands his treatment will involve inpatient status; that he is willing to be admitted to a designated facility for the purpose of such examination and treatment; and that he consents to such admission voluntarily, without coercion or duress; and, if applicable, that he has voluntarily agreed to remain in treatment for a specified period of no longer than 72 hours after having given written notice of his intent to withdraw from treatment. The consent shall be part of the person's record.

Section 204. Notice to Parents.--Upon the acceptance of an application for examination and treatment by a minor 14 years or over but less than 18 years of age, the director of the facility shall promptly notify the minor's parents, guardian, or person standing in loco parentis, and shall inform them of the right to be heard upon the filing of an objection. Whenever such objection is filed, a hearing shall be held within 72 hours by a judge or mental health review officer, who shall determine whether or not the voluntary treatment is in the best interest of the minor.

Section 205. Physical Examination and Formulation of Individualized Treatment Plan.--Upon acceptance of a person for voluntary examination and treatment he shall be given a physical examination. Within 72 hours after acceptance of a person an individualized treatment plan shall be formulated by a treatment team. The person shall be advised of the treatment plan, which shall become a part of his record. The treatment plan shall state whether inpatient treatment is considered necessary, and what restraints or restrictions, if any, will be administered, and shall set forth the bases for such conclusions.

Section 206. Withdrawal from Voluntary Inpatient Treatment.--(a) A person in voluntary inpatient treatment may withdraw at any time by giving written notice unless, as stated in section 203, he has agreed in writing at the time of his admission that his release can be delayed following such notice for a period to be specified in the agreement, provided that such period shall not exceed 72 hours. Any patient converted from involuntary treatment ordered pursuant to either section 304 or 305 to voluntary treatment status shall agree to remain in treatment for 72 hours after having given written notice of his intent to withdraw from treatment.

(b) If the person is under the age of 14, his parent, legal guardian, or person standing in loco parentis may effect his release. If any responsible party believes that it would be in the best interest of a person under 14 years of age in voluntary treatment to be withdrawn therefrom or afforded treatment constituting a less restrictive alternative, such party may file a petition in the Juvenile Division of the court of common pleas for the county in which the person under 14 years of age resides, requesting a withdrawal from or modification of treatment. The court shall promptly appoint an attorney for such minor person and schedule a hearing to determine what inpatient treatment, if any, is in the minor's best interest. The hearing shall be held within ten days of receipt of the petition, unless continued upon the request of the attorney for such minor. The hearing shall be conducted in accordance with the rules governing other Juvenile Court proceedings.

(c) Nothing in this act shall be construed to require a facility to continue inpatient treatment where the director of the facility determines such treatment is not medically indicated. Any dispute between a facility and a county

administrator as to the medical necessity for voluntary inpatient treatment of a person shall be decided by the Commissioner of Mental Health or his designate.

(206 amended Nov. 26, 1978, P.L.1362, No.324)

Section 207. Transfer of Person in Voluntary Treatment.--A person who is in voluntary treatment may not be transferred from one facility to another without his written consent.

ARTICLE III
Involuntary Examination and Treatment

Section 301. Persons Who May be Subject to Involuntary Emergency Examination and Treatment.--(a) Persons Subject.--Whenever a person is severely mentally disabled and in need of immediate treatment, he may be made subject to involuntary emergency examination and treatment. A person is severely mentally disabled when, as a result of mental illness, his capacity to exercise self-control, judgment and discretion in the conduct of his affairs and social relations or to care for his own personal needs is so lessened that he poses a clear and present danger of harm to others or to himself, as defined in subsection (b), or the person is determined to be in need of assisted outpatient treatment as defined in subsection (c). ((a) amended Oct. 24, 2018, P.L.690, No.106)

(b) Determination of Clear and Present Danger.--(1) Clear and present danger to others shall be shown by establishing that within the past 30 days the person has inflicted or attempted to inflict serious bodily harm on another and that there is a reasonable probability that such conduct will be repeated. If, however, the person has been found incompetent to be tried or has been acquitted by reason of lack of criminal responsibility on charges arising from conduct involving infliction of or attempt to inflict substantial bodily harm on another, such 30-day limitation shall not apply so long as an application for examination and treatment is filed within 30 days after the date of such determination or verdict. In such case, a clear and present danger to others may be shown by establishing that the conduct charged in the criminal proceeding did occur, and that there is a reasonable probability that such conduct will be repeated. For the purpose of this section, a clear and present danger of harm to others may be demonstrated by proof that the person has made threats of harm and has committed acts in furtherance of the threat to commit harm.

(2) Clear and present danger to himself shall be shown by establishing that within the past 30 days:

(i) the person has acted in such manner as to evidence that he would be unable, without care, supervision and the continued assistance of others, to satisfy his need for nourishment, personal or medical care, shelter, or self-protection and safety, and that there is a reasonable probability that death, serious bodily injury or serious physical debilitation would ensue within 30 days unless adequate treatment were afforded under this act; or

(ii) the person has attempted suicide and that there is the reasonable probability of suicide unless adequate treatment is afforded under this act. For the purposes of this subsection, a clear and present danger may be demonstrated by the proof that the person has made threats to commit suicide and has committed acts which are in furtherance of the threat to commit suicide; or

(iii) the person has substantially mutilated himself or attempted to mutilate himself substantially and that there is

the reasonable probability of mutilation unless adequate treatment is afforded under this act. For the purposes of this subsection, a clear and present danger shall be established by proof that the person has made threats to commit mutilation and has committed acts which are in furtherance of the threat to commit mutilation.

((b) amended Nov. 26, 1978, P.L.1362, No.324)

(c) Determination of Need for Assisted Outpatient Treatment.--(1) The need for assisted outpatient treatment shall be shown by establishing by clear and convincing evidence that the person would benefit from assisted outpatient treatment as manifested by evidence of behavior that indicates all of the following:

(i) The person is unlikely to survive safely in the community without supervision, based on a clinical determination.

(ii) The person has a history of lack of voluntary adherence to treatment for mental illness and one of the following applies:

(A) Within the 12 months prior to the filing of a petition seeking assisted outpatient treatment, the person's failure to adhere to treatment has been a significant factor in necessitating involuntary inpatient hospitalization or receipt of services in a forensic or other mental health unit of a correctional facility, provided that the 12-month period shall be extended by the length of any hospitalization or incarceration of the person in a correctional institution that occurred within the 12-month period.

(B) Within the 48 months prior to the filing of a petition seeking court-ordered assisted outpatient treatment, the person's failure to adhere to treatment resulted in one or more acts of serious violent behavior toward others or himself or threats of, or attempts at, serious physical harm to others or himself, provided that the 48-month period shall be extended by the length of any hospitalization or incarceration of the person in a correctional institution that occurred within the 48-month period.

(iii) The person, as a result of the person's mental illness, is unlikely to voluntarily participate in necessary treatment and the person previously has been offered voluntary treatment services but has not accepted or has refused to participate on a sustained basis in voluntary treatment, provided that voluntary agreement to enter into services by a person during the pendency of a petition for assisted outpatient treatment shall not preclude the court from ordering assisted outpatient treatment for that person if reasonable evidence exists to believe that the person is unlikely to make a voluntary sustained commitment to and remain in a treatment program.

(iv) Based on the person's treatment history and current behavior, the person is in need of treatment in order to prevent a relapse or deterioration that would be likely to result in substantial risk of serious harm to others or himself.

(2) An individual who meets only the criteria described in clause (1) shall not be subject to involuntary inpatient hospitalization unless a separate determination is made that the individual poses a clear and present danger in accordance with subsection (b).

((c) added Oct. 24, 2018, P.L.690, No.106)

Section 302. Involuntary Emergency Examination and Treatment Authorized by a Physician - Not to Exceed One Hundred Twenty Hours.--(Hdg. amended Nov. 26, 1978, P.L.1362, No.324) (a)

Application for Examination.--Emergency examination may be undertaken at a treatment facility upon the certification of a physician stating the need for such examination; or upon a warrant issued by the county administrator authorizing such examination; or without a warrant upon application by a physician or other authorized person who has personally observed conduct showing the need for such examination.

(1) Warrant for Emergency Examination.--Upon written application by a physician or other responsible party setting forth facts constituting reasonable grounds to believe a person is severely mentally disabled and in need of immediate treatment, the county administrator may issue a warrant requiring a person authorized by him, or any peace officer, to take such person to the facility specified in the warrant.

(2) Emergency Examination Without a Warrant.--Upon personal observation of the conduct of a person constituting reasonable grounds to believe that he is severely mentally disabled and in need of immediate treatment, any physician or peace officer, or anyone authorized by the county administrator may take such person to an approved facility for an emergency examination. Upon arrival, he shall make a written statement setting forth the grounds for believing the person to be in need of such examination.

(b) Examination and Determination of Need for Emergency Treatment.--A person taken to a facility shall be examined by a physician within two hours of arrival in order to determine if the person is severely mentally disabled within the meaning of section 301(b) and in need of immediate treatment. If it is determined that the person is severely mentally disabled and in need of emergency treatment, treatment shall be begun immediately. If the physician does not so find, or if at any time it appears there is no longer a need for immediate treatment, the person shall be discharged and returned to such place as he may reasonably direct. The physician shall make a record of the examination and his findings. In no event shall a person be accepted for involuntary emergency treatment if a previous application was granted for such treatment and the new application is not based on behavior occurring after the earlier application. ((b) amended Oct. 24, 2018, P.L.690, No.106)

(c) Notification of Rights at Emergency Examination.--Upon arrival at the facility, the person shall be informed of the reasons for emergency examination and of his right to communicate immediately with others. He shall be given reasonable use of the telephone. He shall be requested to furnish the names of parties whom he may want notified of his custody and kept informed of his status. The county administrator or the director of the facility shall:

(1) give notice to such parties of the whereabouts and status of the person, how and when he may be contacted and visited, and how they may obtain information concerning him while he is in inpatient treatment; and

(2) take reasonable steps to assure that while the person is detained, the health and safety needs of any of his dependents are met, and that his personal property and the premises he occupies are secure.

(d) Duration of Emergency Examination and Treatment.--A person who is in treatment pursuant to this section shall be discharged whenever it is determined that he no longer is in need of treatment and in any event within 120 hours, unless within such period:

(1) he is admitted to voluntary treatment pursuant to section 202 of this act; or

(2) a certification for extended involuntary emergency treatment is filed pursuant to section 303 of this act.

((d) amended Nov. 26, 1978, P.L.1362, No.324)

Section 303. Extended Involuntary Emergency Treatment Certified by a Judge or Mental Health Review Officer - Not to Exceed Twenty Days.--(a) Persons Subject to Extended Involuntary Emergency Treatment.--Application for extended involuntary emergency treatment may be made for any person who is being treated pursuant to section 302 whenever the facility determines that the need for emergency treatment is likely to extend beyond 120 hours. The application shall be filed forthwith in the court of common pleas, and shall state the grounds on which extended emergency treatment is believed to be necessary. The application shall state the name of any examining physician and the substance of his opinion regarding the mental condition of the person. ((a) amended Nov. 26, 1978, P.L.1362, No.324)

(b) Appointment of Counsel and Scheduling of Informal Hearing.--Upon receiving such application, the court of common pleas shall appoint an attorney who shall represent the person unless it shall appear that the person can afford, and desires to have, private representation. Within 24 hours after the application is filed, an informal hearing shall be conducted by a judge or by a mental health review officer and, if practicable, shall be held at the facility.

(c) Informal Conference on Extended Emergency Treatment Application.--(1) At the commencement of the informal conference, the judge or the mental health review officer shall inform the person of the nature of the proceedings. Information relevant to whether the person is severely mentally disabled and in need of treatment shall be reviewed, including the reasons that continued involuntary treatment is considered necessary. Such explanation shall be made by a physician who examined the person and shall be in terms understandable to a layman. The judge or mental health review officer may review any relevant information even if it would be normally excluded under rules of evidence if he believes that such information is reliable. The person or his representative shall have the right to ask questions of the physician and of any other witnesses and to present any relevant information. At the conclusion of the review, if the judge or the review officer finds that the person is severely mentally disabled and in need of continued involuntary treatment, either as an inpatient or through less restrictive assisted outpatient treatment, he shall so certify. Otherwise, he shall direct that the facility director or his designee discharge the person. ((1) amended Oct. 24, 2018, P.L.690, No.106)

(2) A record of the proceedings which need not be a stenographic record shall be made. Such record shall be kept by the court or mental health review officer for at least one year.

((c) amended Nov. 26, 1978, P.L.1362, No.324)

(d) Contents of Certification.--A certification for extended involuntary treatment shall be made in writing upon a form adopted by the department and shall include:

(1) findings by the judge or mental health review officer as to the reasons that extended involuntary emergency treatment is necessary;

(2) a description of the treatment to be provided together with an explanation of the adequacy and appropriateness of such treatment, based upon the information received at the hearing;

(3) any documents required by the provisions of section 302;

(4) the application as filed pursuant to section 303(a);

(5) a statement that the person is represented by counsel; and

(6) an explanation of the effect of the certification, the person's right to petition the court for release under subsection (g), and the continuing right to be represented by counsel.

(e) Filing and Service.--The certification shall be filed with the director of the facility and a copy served on the person, such other parties as the person requested to be notified pursuant to section 302(c), and on counsel.

(f) Effect of Certification.--Upon the filing and service of a certification for extended involuntary emergency treatment, the person may be given treatment in an approved facility for a period not to exceed 20 days.

(g) Petition to Common Pleas Court.--In all cases in which the hearing was conducted by a mental health review officer, a person made subject to treatment pursuant to this section shall have the right to petition the court of common pleas for review of the certification. A hearing shall be held within 72 hours after the petition is filed unless a continuance is requested by the person's counsel. The hearing shall include a review of the certification and such evidence as the court may receive or require. If the court determines that further involuntary treatment is necessary and that the procedures prescribed by this act have been followed, it shall deny the petition. Otherwise, the person shall be discharged.

(h) Duration of Extended Involuntary Emergency Treatment.--Whenever a person is no longer severely mentally disabled or in need of immediate treatment and, in any event, within 20 days after the filing of the certification, he shall be discharged, unless within such period:

(1) he is admitted to voluntary treatment pursuant to section 202; or

(2) the court orders involuntary treatment pursuant to section 304.

Section 304. Court-ordered Involuntary Treatment Not to Exceed Ninety Days.--(a) Persons for Whom Application May be Made.--(1) A person who is severely mentally disabled and in need of treatment, as defined in section 301(a), may be made subject to court-ordered involuntary treatment upon a determination of clear and present danger under section 301(b)(1) (serious bodily harm to others), or section 301(b)(2)(i) (inability to care for himself, creating a danger of death or serious harm to himself), or 301(b)(2)(ii) (attempted suicide), or 301(b)(2)(iii) (self-mutilation), or upon determination that a person meets the requirements under section 301(c) (determination of need for assisted outpatient treatment).

(2) Where a petition is filed for a person already subject to involuntary treatment, it shall be sufficient to represent, and upon hearing to reestablish, that the conduct originally required by section 301(b) in fact occurred, and that his condition continues to evidence a clear and present danger to himself or others, or that the conduct originally required by section 301(c) in fact occurred and that his condition continues to evidence a need for assisted outpatient treatment. In such event, it shall not be necessary to show the reoccurrence of dangerous conduct, either harmful or debilitating, within the past 30 days.

((a) amended Oct. 24, 2018, P.L.690, No.106)

(b) Procedures for Initiating Court-ordered Involuntary Treatment for Persons Already Subject to Involuntary Treatment.--(1) Petition for court-ordered involuntary treatment for persons already subject to treatment under sections 303, 304 and 305 may be made by the county administrator or the director of the facility to the court of common pleas.

(2) The petition shall be in writing upon a form adopted by the department and shall include a statement of the facts constituting reasonable grounds to believe that the person is severely mentally disabled and in need of treatment. The petition shall state the name of any examining physician and the substance of his opinion regarding the mental condition of the person. It shall also state that the person has been given the information required by subsection (b)(3).

(3) Upon the filing of the petition the county administrator shall serve a copy on the person, his attorney, and those designated to be kept informed, as provided in section 302(c), including an explanation of the nature of the proceedings, the person's right to an attorney and the services of an expert in the field of mental health, as provided by subsection (d).

(4) A hearing on the petition shall be held in all cases, not more than five days after the filing of the petition.

(5) Treatment shall be permitted to be maintained pending the determination of the petition.

(c) Procedures for Initiating Court-ordered Involuntary Treatment for Persons not in Involuntary Treatment.--(1) Any responsible party may file a petition in the court of common pleas requesting court-ordered involuntary treatment for any person not already in involuntary treatment for whom application could be made under subsection (a).

(2) The petition shall be in writing upon a form adopted by the department and shall set forth facts constituting reasonable grounds to believe that the person is within the criteria for court-ordered treatment set forth in subsection (a). The petition shall state the name of any examining physician and the substance of his opinion regarding the mental condition of the person.

(3) Upon a determination that the petition sets forth such reasonable cause, the court shall appoint an attorney to represent the person and set a date for the hearing as soon as practicable. The attorney shall represent the person unless it shall appear that he can afford, and desires to have, private representation.

(4) The court, by summons, shall direct the person to appear for a hearing. The court may issue a warrant directing a person authorized by the county administrator or a peace officer to bring such person before the court at the time of the hearing if there are reasonable grounds to believe that the person will not appear voluntarily. A copy of the petition shall be served on such person at least three days before the hearing together with a notice advising him that an attorney has been appointed who shall represent him unless he obtains an attorney himself, that he has a right to be assisted in the proceedings by an expert in the field of mental health, and that he may request or be made subject to psychiatric examination under subsection (c)(5).

(5) Upon motion of either the petitioner or the person, or upon its own motion, the court may order the person to be examined by a psychiatrist appointed by the court. Such examination shall be conducted on an outpatient basis, and the

person shall have the right to have counsel present. A report of the examination shall be given to the court and counsel at least 48 hours prior to the hearing.

(6) Involuntary treatment shall not be authorized during the pendency of a petition except in accordance with section 302 or section 303.

(c.1) Procedures for Initiating Assisted Outpatient Treatment for Persons Already Subject to Involuntary Treatment.--(1) Petition for assisted outpatient treatment for persons already subject to involuntary treatment under section 301(b)(1) or (2), or persons with mental illness subject to treatment in a forensic facility or a correctional institution who are ready for release, may be made by the county administrator or the director of the facility to the court of common pleas.

(2) The petition shall be in writing upon a form adopted by the department and shall include a statement of the facts constituting reasonable grounds to believe that the person is:

(i) No longer determined to be in need of involuntary inpatient treatment under section 301(b)(1) or (2) or no longer subject to treatment in a forensic facility or correctional institution.

(ii) Determined to be in need of assisted outpatient treatment under section 301(c).

(3) The petition shall state the name of any examining psychiatrist or licensed clinical psychologist and the substance of his opinion regarding the mental condition of the person. It shall also state that the person has been given the information required by subsection (b)(3).

(4) Upon the filing of the petition, the county administrator shall serve a copy on the person, his attorney and those designated to be kept informed, as provided in section 302(c), including an explanation of the nature of the proceedings, the person's right to an attorney and the services of an expert in the field of mental health, as provided by subsection (d).

(5) A hearing on the petition shall be held in all cases not more than five days after the filing of the petition.

(6) Treatment shall be permitted to be maintained pending the determination of the petition.

((c.1) added Oct. 24, 2018, P.L.690, No.106)

(c.2) Procedures for Initiating Assisted Outpatient Treatment for Persons Not in Involuntary Treatment.--(1) Any responsible party may file a petition in the court of common pleas requesting assisted outpatient treatment for any person determined under section 301(c) to be in need of assisted outpatient treatment, who is not already in involuntary treatment and who is not already in assisted outpatient treatment for whom application could be made under subsection (a).

(2) The petition shall be in writing upon a form adopted by the department and shall set forth facts constituting reasonable grounds to believe that the person is within the criteria as defined under section 301(c) for a person in need of assisted outpatient treatment. The petition shall be accompanied by a statement of a psychiatrist, or a statement signed by a clinical licensed psychologist stating that the clinician who issued the statement has examined the person and is of the opinion that the person is in need of assisted outpatient treatment, or shall be accompanied by a written statement by the applicant, under oath, that the person has

refused to submit to an examination by a psychiatrist or by a clinical licensed psychologist.

(3) Upon a determination that the petition sets forth reasonable cause, the court shall appoint an attorney to represent the person and set a date for the hearing as soon as practicable. The attorney shall represent the person unless it shall appear that he can afford, and desires to have, private representation.

(4) The court, by summons, shall direct the person to appear for a hearing. The court may issue a warrant directing an individual authorized by the county administrator or a peace officer to bring such person before the court at the time of the hearing if there are reasonable grounds to believe that the person will not appear voluntarily. A copy of the petition shall be served on such person at least three days before the hearing together with a notice advising him that an attorney has been appointed who shall represent him unless he obtains an attorney himself, that he has a right to be assisted in the proceedings by an expert in the field of mental health and that he may request or be made subject to psychiatric examination under clause (5).

(5) Upon motion of either the petitioner or the person, or upon its own motion, the court may order the person to be examined by a psychiatrist or other qualified professional appointed by the court, provided that:

(i) a qualified professional who is appointed by the court and is not a psychiatrist or licensed clinical psychologist shall be selected from a panel of qualified professionals specifically designated by the county administrator for the qualified professional's demonstrated expertise and ability to conduct court-ordered examinations for assisted outpatient treatment consistent with the qualified professional's scope of practice;

(ii) the examination shall be conducted on an outpatient basis and the person shall have the right to have counsel present;

(iii) the written report prepared by the qualified professional under subclause (i) shall be reviewed and approved by a psychiatrist or a licensed clinical psychologist prior to submission to the court; and

(iv) the written report on the results of the examination shall be given to the court and counsel at least 48 hours prior to the hearing.

(6) Involuntary treatment shall not be authorized during the pendency of a petition except in accordance with sections 302 and 303.

((c.2) added Oct. 24, 2018, P.L.690, No.106)

(d) Professional Assistance.--A person with respect to whom a hearing has been ordered under this section shall have and be informed of a right to employ a physician, clinical psychologist or other expert in mental health of his choice to assist him in connection with the hearing and to testify on his behalf. If the person cannot afford to engage such a professional, the court shall, on application, allow a reasonable fee for such purpose. The fee shall be a charge against the mental health and mental retardation program of the locality.

(e) Hearings on Petition for Court-ordered Involuntary Treatment.--A hearing on a petition for court-ordered involuntary treatment shall be conducted according to the following:

(1) The person shall have the right to counsel and to the assistance of an expert in mental health.

(2) The person shall not be called as a witness without his consent.

(3) The person shall have the right to confront and cross-examine all witnesses and to present evidence in his own behalf.

(4) The hearing shall be public unless it is requested to be private by the person or his counsel.

(5) A stenographic or other sufficient record shall be made, which shall be impounded by the court and may be obtained or examined only upon the request of the person or his counsel or by order of the court on good cause shown.

(6) The hearing shall be conducted by a judge or by a mental health review officer and may be held at a location other than a courthouse when doing so appears to be in the best interest of the person.

(7) A decision shall be rendered within 48 hours after the close of evidence.

(8) If the person is believed to be in need of assisted outpatient treatment in accordance with section 301(c), a hearing on the petition shall be conducted in accordance with the following additional requirements:

(i) No later than the date of the hearing, a treatment team shall provide a written proposed assisted outpatient treatment plan to the court. The plan shall state all treatment services recommended for the person and, for each service, shall specify a provider that has agreed to provide the service.

(ii) In developing a written proposed assisted outpatient treatment plan, the treatment team shall take into account, if existing, an advance directive for mental health treatment and provide the following persons with an opportunity to participate:

(A) the person believed to be in need of court-ordered assistant outpatient treatment;

(B) all current treating providers;

(C) upon the request of the person believed to be in need of court-ordered assistant outpatient treatment, an individual significant to the person, including any relative, close friend or individual otherwise concerned with the welfare of the person; and

(D) any authorized guardian or other surrogate decision-maker.

(iii) The written proposed assisted outpatient treatment plan shall include case management services or an assertive community treatment team to provide care coordination and assisted outpatient treatment services recommended by the treatment team. If the plan includes medication, the prescribing physician's order shall state whether such medication should be self-administered or administered by a specified provider. In no event shall the plan recommend the use of physical force or restraints to administer medication to the person.

(iv) A qualified professional, who has personally examined the person within ten days of the filing of the petition, shall provide testimony in support of the finding that the person meets all of the criteria for assisted outpatient treatment and in support of a written proposed treatment plan developed pursuant to this section, including:

(A) the recommended assisted outpatient treatment, the rationale for the recommended assisted outpatient treatment and the facts that establish that such treatment is the least restrictive appropriate alternative;

(B) information regarding the person's access to, and the availability of, recommended assisted outpatient treatment in the community or elsewhere; and

(C) if the recommended assisted outpatient treatment includes medication, the types or classes of medication that should be authorized, the beneficial and detrimental physical and mental effects of such medication and whether such medication should be self-administered or administered by a specified provider and the ongoing process for management of such medications in response to changes in the person's medical condition.

(9) A decision shall be rendered within 48 hours after the close of evidence.

((e) amended Oct. 24, 2018, P.L.690, No.106)

(f) Determination and Order.--(1) Upon a finding by clear and convincing evidence that the person is severely mentally disabled and in need of treatment and subject to subsection (a), an order shall be entered directing treatment of the person in an approved facility as an inpatient or an outpatient, or a combination of such treatment as the director of the facility shall from time to time determine. Inpatient treatment shall be deemed appropriate only after full consideration has been given to less restrictive alternatives, including assisted outpatient treatment. Investigation of treatment alternatives shall include consideration of the person's relationship to his community and family, his employment possibilities, all available community resources, and guardianship services. An order for inpatient treatment shall include findings on this issue.

(2) If the person is found to be in need of assisted outpatient treatment in accordance with section 301(c) or as a result of consideration of less restrictive settings under clause (1), the court shall order the person to receive assisted outpatient treatment for a period not to exceed 90 days from any provider or facility approved by the department or the county administrator for purposes of providing assisted outpatient treatment, provided that a jail or any other State or county correctional institution shall not be an authorized facility.

(3) The facility or provider shall examine and treat the person in accordance with the assisted outpatient treatment plan. If the person is receiving assisted outpatient treatment, or receives treatment in an outpatient setting during a subsequent period of continued commitment under section 305, the facility or provider to whom the person is ordered shall determine the appropriate assisted outpatient treatment plan for the person.

(4) If the approved court-ordered assisted outpatient treatment plan includes medications, the court order shall authorize the treatment team, in accordance with their professional judgment and under supervision of the prescribing physician, to perform routine medication management, including adjustment of specific medications and doses, in consultation with the person and as warranted by changes in the person's medical condition.

(5) The provider or facility responsible for the assisted outpatient treatment plan shall inform the court if the person fails materially to adhere to the treatment plan and comply with the court order. If the court receives information that a patient is not complying with the court's order, the court may take any of the following actions:

(i) set a modification hearing to assess the person's failure to adhere to the assisted outpatient treatment plan;

(ii) amend the assisted outpatient treatment plan to foster adherence to necessary treatment by the person; or

(iii) issue an order for the person to be examined in accordance with section 302 for purposes of evaluation and, if appropriate, file a petition that the person poses a clear and present danger under section 301(b), provided that a State or county correctional institution may not be considered an authorized treatment facility.

(6) If the court determines under clause (5) that the person has failed to adhere to the assisted outpatient treatment plan, the court may not hold that person in contempt or otherwise sanction the person solely based on the failure to comply with the assisted outpatient treatment plan.

(7) The person subject to assisted outpatient treatment may petition the court for enforcement of a service specifically contained in that person's individualized treatment plan, provided that the petition must include clear and convincing evidence demonstrating that the service is not being provided in accordance with that plan.

(8) A copy of the person's individualized treatment plan and related documents shall be made available to the court for purposes of proceedings under clause (5) or (7).

((f) amended Oct. 24, 2018, P.L.690, No.106)

(g) Duration of Court-ordered Involuntary Treatment.--(1) A person may be made subject to court-ordered involuntary treatment under this section for a period not to exceed 90 days, excepting only that: Persons may be made subject to court-ordered involuntary treatment under this section for a period not to exceed one year if:

(i) the person meets the criteria established by clause (2); and

(ii) the person may be subject to assisted outpatient treatment for a period not to exceed 180 days if the person meets the criteria established by clause (5).

(2) A person may be subject to court-ordered involuntary treatment for a period not to exceed one year if:

(i) severe mental disability is based on acts giving rise to the following charges under the Pennsylvania Crimes Code: murder (§ 2502); voluntary manslaughter (§ 2503); aggravated assault (§ 2702); kidnapping (§ 2901); rape (§ 3121(1) and (2)); involuntary deviate sexual intercourse (§ 3123(1) and (2)); arson (§ 3301); and

(ii) a finding of incompetency to be tried or a verdict of acquittal because of lack of criminal responsibility has been entered.

(3) If at any time the director of a facility concludes that the person is not severely mentally disabled or in need of treatment pursuant to subsection (a), he shall discharge the person provided that no person subjected to involuntary treatment pursuant to clause (2) may be discharged without a hearing conducted pursuant to clause (4).

(4) In cases involving involuntary treatment pursuant to clause (2), whenever the period of court-ordered involuntary treatment is about to expire and neither the director nor the county administrator intends to apply for an additional period of court-ordered involuntary treatment pursuant to section 305 or at any time the director concludes that the person is not severely mentally disabled or in need of treatment, the director shall petition the court which ordered the involuntary treatment for the unconditional or conditional release of the person.

Notice of such petition shall be given to the person, the county administrator and the district attorney. Within 15 days after the petition has been filed, the court shall hold a hearing to determine if the person is severely mentally disabled and in need of treatment. Petitions which must be filed simply because the period of involuntary treatment will expire shall be filed at least ten days prior to the expiration of the court-ordered period of involuntary treatment. If the court determines after hearing that the person is severely mentally disabled and in need of treatment, it may order additional involuntary treatment not to exceed one year; if the court does not so determine, it shall order the discharge of the person.

(5) A person may be subject to assisted outpatient treatment for a period of up to 180 days if the person continues to meet the requirements of section 301(c) or is being discharged from involuntary inpatient treatment under this article.

((g) amended Oct. 24, 2018, P.L.690, No.106)

(304 amended Nov. 26, 1978, P.L.1362, No.324)

Section 305. Additional Periods of Court-ordered Involuntary Treatment.--(a) At the expiration of a period of court-ordered involuntary treatment under section 304(g) or this section, the court may order treatment for an additional period upon the application of the county administrator or the director of the facility in which the person is receiving treatment. Such order shall be entered upon hearing on findings as required by sections 304(a) and (b), and the further finding of a need for continuing involuntary treatment as shown by conduct during the person's most recent period of court-ordered treatment. The additional period of involuntary treatment shall not exceed 180 days; provided that persons meeting the criteria of section 304(g)(2) may be subject to an additional period of up to one year of involuntary treatment. A person found dangerous to himself under section 301(b)(2)(i), (ii) or (iii) shall be subject to an additional period of involuntary full-time inpatient treatment only if he has first been released to a less restrictive alternative. This limitation shall not apply where, upon application made by the county administrator or facility director, it is determined by a judge or mental health review officer that such release would not be in the person's best interest.

(b) The director of the facility in which the person is receiving treatment shall notify the county administrator at least ten days prior to the expiration of a period of involuntary commitment ordered under section 304 or this section.

(c) At the expiration of a period of assisted outpatient treatment under section 304(g) or this section, the court may order treatment for an additional period upon the application of the county administrator or the treatment team. Such order shall be entered upon hearing on findings as required by sections 304(a) and (b) and the further finding of a need for continuing assisted outpatient treatment. The additional period of involuntary treatment shall not exceed 180 days. ((c) added Oct. 24, 2018, P.L.690, No.106)

(305 amended Nov. 26, 1978, P.L.1362, No.324)

Section 306. Transfer of Persons in Involuntary Treatment.--(a) Subject to the provisions of subsections (b) and (c), persons in involuntary treatment pursuant to this act may be transferred to any approved facility.

(b) In the absence of an emergency, persons committed pursuant to section 304(g)(2) may not be transferred unless written notice is given to the committing judge and the district

attorney in the committing county and no objection is noted from either within 20 days of receipt of said notice. If the court or the district attorney objects to said transfer, a hearing shall be held by the court within 20 days to review the commitment order. A decision shall be rendered within 48 hours after the close of evidence.

(c) Whenever such transfer will constitute a greater restraint, it shall not take place unless, upon hearing, a judge or mental health review officer finds it to be necessary and appropriate.

(306 amended Nov. 26, 1978, P.L.1362, No.324)

ARTICLE IV
Determinations Affecting Those Charged With Crime, or Under Sentence

Section 401. Examination and Treatment of a Person Charged with Crime or Serving Sentence.--(a) Examination and Treatment to be Pursuant to Civil Provisions.--Whenever a person who is charged with crime, or who is undergoing sentence, is or becomes severely mentally disabled, proceedings may be instituted for examination and treatment under the civil provisions of this act in the same manner as if he were not so charged or sentenced. Proceedings under this section shall not be initiated for examination and treatment at Veterans Administration facilities if such examination and treatment requires the preparation of competency reports and/or the facility is required to maintain custody and control over the person. Such proceedings, however, shall not affect the conditions of security required by his criminal detention or incarceration.

(b) Status in Voluntary and Involuntary Treatment.--Whenever a person who is detained on criminal charges or is incarcerated is made subject to inpatient examination or treatment, he shall be transferred, for this purpose, to a mental health facility. Transfer may be made to a Veterans Administration facility provided that neither custody nor control are required in addition to examination and treatment. Such individuals transferred to the Veterans Administration are not subject to return by the Federal agency to the authority entitled to have them in custody. During such period, provisions for his security shall continue to be enforced, unless in the interim a pretrial release is effected, or the term of imprisonment expires or is terminated, or it is otherwise ordered by the court having jurisdiction over his criminal status. In those instances where a person is charged with offenses listed in section 304(g)(2) and where the court, after hearing, deems it desirable, security equivalent to the institution to which he is incarcerated must be provided. Upon discharge from treatment, a person who is or remains subject to a detainer or sentence shall be returned to the authority entitled to have him in custody. The period of involuntary treatment shall be credited as time served on account of any sentence to be imposed on pending charges or any unexpired term of imprisonment. ((b) amended Nov. 26, 1978, P.L.1362, No.324)

(c) Persons Subject to the Juvenile Act.--As to any person who is subject to a petition or who has been committed under the Juvenile Act, the civil provisions of this act applicable to children of his age shall apply to all proceedings for his examination and treatment. If such a person is in detention or is committed, the court having jurisdiction under the Juvenile Act shall determine whether such security conditions shall

continue to be enforced during any period of involuntary treatment and to whom the person should be released thereafter.

Section 402. Incompetence to Proceed on Criminal Charges and Lack of Criminal Responsibility as Defense.--(a) Definition of Incompetency.--Whenever a person who has been charged with a crime is found to be substantially unable to understand the nature or object of the proceedings against him or to participate and assist in his defense, he shall be deemed incompetent to be tried, convicted or sentenced so long as such incapacity continues.

(b) Involuntary Treatment of Persons Found Incompetent to Stand Trial Who are Not Mentally Disabled.--Notwithstanding the provisions of Article III of this act, a court may order involuntary treatment of a person found incompetent to stand trial but who is not severely mentally disabled, such involuntary treatment not to exceed a specific period of 60 days. Involuntary treatment pursuant to this subsection may be ordered only if the court is reasonably certain that the involuntary treatment will provide the defendant with the capacity to stand trial. The court may order outpatient treatment, partial hospitalization or inpatient treatment. ((b) amended Nov. 26, 1978, P.L.1362, No.324)

(c) Application for Incompetency Examination.--Application to the court for an order directing an incompetency examination may be presented by an attorney for the Commonwealth, a person charged with a crime, his counsel, or the warden or other official in charge of the institution or place in which he is detained. A person charged with crime shall be represented either by counsel of his selection or by court-appointed counsel.

(d) Hearing; When Required.--The court, either on application or on its own motion, may order an incompetency examination at any stage in the proceedings and may do so without a hearing unless the examination is objected to by the person charged with a crime or by his counsel. In such event, an examination shall be ordered only after determination upon a hearing that there is a prima facie question of incompetency. Upon completion of the examination, a determination of incompetency shall be made by the court where incompetency is established by a preponderance of the evidence. ((d) amended July 2, 1996, P.L.481, No.77)

(e) Conduct of Examination; Report.--When ordered by the court, an incompetency examination shall take place under the following conditions:

(1) It shall be conducted as an outpatient examination unless an inpatient examination is, or has been, authorized under another provision of this act.

(2) It shall be conducted by at least one psychiatrist or licensed psychologist and may relate both to competency to proceed and to criminal responsibility for the crime charged.

(3) The person shall be entitled to have counsel present with him and shall not be required to answer any questions or to perform tests unless he has moved for or agreed to the examination. Nothing said or done by such person during the examination may be used as evidence against him in any criminal proceedings on any issue other than that of his mental condition.

(4) A report shall be submitted to the court and to counsel and shall contain a description of the examination, which shall include:

(i) diagnosis of the person's mental condition;

(ii) an opinion as to his capacity to understand the nature and object of the criminal proceedings against him and to assist in his defense;

(iii) when so requested, an opinion as to his mental condition in relation to the standards for criminal responsibility as then provided by law if it appears that the facts concerning his mental condition may also be relevant to the question of legal responsibility; and

(iv) when so requested, an opinion as to whether he had the capacity to have a particular state of mind, where such state of mind is a required element of the criminal charge.

((e) amended March 19, 2014, P.L.50, No.21)

(f) Experts.--The court may allow a psychiatrist or licensed psychologist retained by the defendant and a psychiatrist or licensed psychologist retained by the Commonwealth to witness and participate in the examination. Whenever a defendant who is financially unable to retain such expert has a substantial objection to the conclusions reached by the court-appointed psychiatrist or licensed psychologist, the court shall allow reasonable compensation for the employment of a psychiatrist or licensed psychologist of his selection, which amount shall be chargeable against the mental health and mental retardation program of the locality. ((f) amended March 19, 2014, P.L.50, No.21)

(g) Time Limit on Determination.--The determination of the competency of a person who is detained under a criminal charge shall be rendered by the court within 20 days after the receipt of the report of examination unless the hearing was continued at the person's request.

(h) Definition.--As used in this section, the term "licensed psychologist" means an individual licensed under the act of March 23, 1972 (P.L.136, No.52), known as the "Professional Psychologists Practice Act." ((h) added March 19, 2014, P.L.50, No.21)

Compiler's Note: Section 3 of Act 21 of 2014, which amended subsecs. (e) and (f), provided that the amendment shall apply to actions initiated on or after the effective date of section 3.

Section 403. Hearing and Determination of Incompetency to Proceed; Stay of Proceedings; Dismissal of Charges.--(a) Competency Determination and Burden of Proof.--Except for an incompetency examination ordered by the court on its own motion as provided for in section 402(d), the individual making an application to the court for an order directing an incompetency examination shall have the burden of establishing incompetency to proceed by a preponderance of the evidence. The determination shall be made by the court. ((a) amended July 2, 1996, P.L.481, No.77)

(b) Effect as Stay - Exception.--A determination of incompetency to proceed shall effect a stay of the prosecution for so long as such incapacity persists, excepting that any legal objections suitable for determination prior to trial and without the personal participation of the person charged may be raised and decided in the interim.

(c) Defendant's Right to Counsel; Reexamination.--A person who is determined to be incompetent to proceed shall have a continuing right to counsel so long as the criminal charges are pending. Following such determination, the person charged shall be reexamined not less than every 90 days by a psychiatrist appointed by the court and a report of reexamination shall be

submitted to the court and to counsel. ((c) amended Nov. 26, 1978, P.L.1362, No.324)

(d) Effect on Criminal Detention.--Whenever a person who has been charged with a crime has been determined to be incompetent to proceed, he shall not for that reason alone be denied pretrial release. Nor shall he in any event be detained on the criminal charge longer than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future. If the court determines there is no such probability, it shall discharge the person. Otherwise, he may continue to be criminally detained so long as such probability exists but in no event longer than the period of time specified in subsection (f).

(e) Resumption of Proceedings or Dismissal.--When the court, on its own motion or upon the application of the attorney for the Commonwealth or counsel for the defendant, determines that such person has regained his competence to proceed, the proceedings shall be resumed. If the court is of the opinion that by reason of the passage of time and its effect upon the criminal proceedings it would be unjust to resume the prosecution, the court may dismiss the charge and order the person discharged.

(f) Stay of Proceedings.--In no instance, except in cases of first and second degree murder, shall the proceedings be stayed for a period in excess of the maximum sentence of confinement that may be imposed for the crime or crimes charged, or ten years, whichever is less. In cases of a charge of first or second degree murder, there shall be no limit on the period during which proceedings may be stayed. ((f) amended Nov. 26, 1978, P.L.1362, No.324)

(g) Procedure When Person Is Discharged.--If the person of the defendant is discharged pursuant to subsection (d), but the charges remain open pursuant to subsection (f), the court discharging the defendant shall, on its own motion or on the motion of the Commonwealth or on the motion of the defense, order the defendant to submit to a psychiatric examination every 12 months after said discharge of the person, to determine whether the defendant has become competent to proceed to trial. If such examination reveals that the defendant has regained competency to proceed, then a hearing shall be scheduled and the court shall determine, after a full and fair hearing, whether the defendant is competent to proceed. If the defendant is adjudged competent, then trial shall commence within 90 days of said adjudication. If such examination reveals that the defendant is incompetent to proceed, the court shall order the defendant to submit to a new competency examination in 12 months. ((g) added Nov. 26, 1978, P.L.1362, No.324)

Section 404. Hearing and Determination of Criminal Responsibility; Bifurcated Trial.--(a) Criminal Responsibility Determination by Court.--At a hearing under section 403 of this act the court may, in its discretion, also hear evidence on whether the person was criminally responsible for the commission of the crime charged. It shall do so in accordance with the rules governing the consideration and determination of the same issue at criminal trial. If the person is found to have lacked criminal responsibility, an acquittal shall be entered. If the person is not so acquitted, he may raise the defense at such time as he may be tried.

(b) Opinion Evidence on Mental Condition.--At a hearing under section 403 or upon trial, a psychiatrist or licensed psychologist appointed by the court may be called as a witness

by the attorney for the Commonwealth or by the defendant and each party may also summon any other psychiatrist or licensed psychologist or other expert to testify.

(c) Bifurcation of Issues or Trial.--Upon trial, the court, in the interest of justice, may direct that the issue of criminal responsibility be heard and determined separately from the other issues in the case and, in a trial by jury, that the issue of criminal responsibility be submitted to a separate jury. Upon a request for bifurcation, the court shall consider the substantiality of the defense of lack of responsibility and its effect upon other defenses, and the probability of a fair trial.

(d) Definition.--As used in this section, the term "licensed psychologist" means an individual licensed under the act of March 23, 1972 (P.L.136, No.52), known as the "Professional Psychologists Practice Act."

(404 amended March 19, 2014, P.L.50, No.21)

Compiler's Note: Section 3 of Act 21 of 2014, which amended section 404, provided that the amendment shall apply to actions initiated on or after the effective date of section 3.

Section 405. Examination of Person Charged with Crime as Aid in Sentencing.--Examination Before Imposition of Sentence. Whenever a person who has been criminally charged is to be sentenced, the court may defer sentence and order him to be examined for mental illness to aid it in the determination of disposition. This action may be taken on the court's initiative or on the application of the attorney for the Commonwealth, the person charged, his counsel, or any other person acting in his interest. If at the time of sentencing the person is not in detention, examination shall be on an outpatient basis unless inpatient examination for this purpose is ordered pursuant to the civil commitment provisions of Article III.

Section 406. Civil Procedure for Court-ordered Involuntary Treatment Following a Determination of Incompetency, or Acquittal by Reason of Lack of Criminal Responsibility or in Conjunction with Sentencing.--Upon a finding of incompetency to stand trial under section 403, after an acquittal by reason of lack of responsibility under section 404, or following an examination in aid of sentencing under section 405, the attorney for the Commonwealth, on his own or acting at the direction of the court, the defendant, his counsel, the county administrator, or any other interested party may petition the same court for an order directing involuntary treatment under section 304.

Section 407. Voluntary Treatment of a Person Charged with Crime or Serving Sentence.--(a) Whenever a person in criminal detention, whether in lieu of bail or serving a sentence, believes that he is in need of treatment and substantially understands the nature of voluntary treatment he may submit himself to examination and treatment under this act, provided that at least one physician certifies the necessity of such treatment and certifies further that such treatment cannot be adequately provided at the prison or correctional facility where the person then is detained. Such certificate shall set forth the specific grounds which make transfer to a mental health facility necessary. The correctional facility shall secure a written acceptance of the person for inpatient treatment from the mental health facility and shall forward such acceptance to the court.

(b) Before any inmate of a prison or correctional facility may be transferred to a mental health facility for the purpose

of examination and treatment the district attorney shall be notified by the correctional facility and shall be given up to 14 days after receipt of notification to conduct an independent examination of the defendant. The court shall review the certification of the physician that such transfer is necessary and the recommendation of the physician for the Commonwealth and may request any other information concerning the necessity of such transfer. Upon the motion of the district attorney, a hearing shall be held on the question of the voluntary treatment of a person charged with a crime or serving a sentence. Upon such review the court shall either approve or disapprove the transfer.

(c) Where possible, the sentencing judge shall preside. ((c) repealed in part Oct. 5, 1980, P.L.693, No.142)

(d) A report of the person's mental condition shall be made by the mental health facility to the court within 30 days of the person's transfer to such facility. Such report shall also set forth the specific grounds which require continued treatment at a mental health facility. After the initial report the facility shall thereafter report to the court every 180 days.

(e) If at any time the person gives notice of his intent to withdraw from treatment at the mental health facility he shall be returned to the authority entitled to have him in custody, or proceedings may be initiated under section 304 of this act. During the pendency of any petition filed under section 304 concerning a person in treatment under this section the mental health facility shall have authority to detain the person regardless of the provisions of section 203, provided that the hearing under section 304 is conducted within seven days of the time the person gives notice of his intent to withdraw from treatment.

(f) The period of voluntary treatment under this section shall be credited as time served on account of any sentence to be imposed on pending charges or any unexpired term of imprisonment.

(407 added Nov. 26, 1978, P.L.1362, No.324)

Section 408. Costs of Treatment.--(408 repealed June 18, 1997, P.L.179, No.18)

ARTICLE V
Effective Date, Applicability, Repeals and Severability

Section 501. Effective Date and Applicability.--This act shall take effect 60 days after its enactment and shall thereupon apply immediately to all persons receiving voluntary treatment. As to all persons who were made subject to involuntary treatment prior to the effective date, it shall become applicable 180 days thereafter.

Section 502. Repeals.--(a) The definition of "mental disability" in section 102, and sections 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 416, 418, 419, 420 and 426, act of October 20, 1966 (3rd Sp.Sess., P.L.96, No.6), known as the "Mental Health and Mental Retardation Act of 1966," are hereby repealed, except in so far as they relate to mental retardation or to persons who are mentally retarded.

Section 29 of the act of December 6, 1972 (P.L.1464, No.333), known as the "Juvenile Act," except so far as it relates to mental retardation or to persons who are mentally retarded, is hereby repealed.

(b) All acts and parts of acts are repealed in so far as they are inconsistent herewith.

Section 503. Severability.--If any provision of this act including, but not limited to, any provision relating to children or the application thereof including but not limited to an application thereof to a child is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provisions or application and to this end the provisions of this act are declared severable.

APPENDIX

J

Bernie Cantorna

From: [redacted]
Sent: Wednesday, April 10, 2019 5:14 AM
To: Bernie Cantorna
Subject: Help for people with mental illness

Good morning Mr. Cantorna,

I wrote the PA ACLU to get help for my son in 2016.
PA ACLU was not able to help me because of lack of resources- but as you proceed with the shooting death of Mr. Osagie I was hoping you can challenge the involuntary hospitalization laws in Pennsylvania.
Your investigation focuses on the first responders, in Mr. Osagie's case it was police who responded. Typically, the I CAN HELP- call center is called and a person with very little training comes out to determine if the person is a risk to them selves or others.
I am begging you- the **modifiable** injustice is the criteria for a 503 (involuntary hospitalization).

I have spoken to people who know the police who responded to Osaze Osagie. I don't believe he was shot because he was black, but he definitely was shot because he suffered from an untreated mental illness. Research has shown, people with mental illness across all racial groups faced heightened dangers when interacting with law enforcement.
http://chicagopolicyreview.org/2019/01/11/mental-health-crises-significant-factor-in-police-shootings/?fbclid=IwAR13InIO3ZvOW3rkQlHp71ykkrZ89xgyNVDnz0fDvYh5u0jhTf2Ar6nf5sU
The only information I know about Osaze was that he suffered for weeks where his mental health condition deteriorated. Did his family ask for help earlier? Or was the first time they asked for help that fateful day where instead of receiving help, their beautiful son was shot and killed. The national crisis for the lack of medical treatment for those with mental illness has finally reached our small town. Please don't lose sight that this tragedy could have been prevented if he received proper medical care before he was in crisis.

PREVENTION

The laws in Pennsylvania are one of the strictest in the country to mandate a person to receive involuntary treatment. In Pennsylvania, the person must be an imminent threat to themselves or others. The threat must be in "crisis mode". Waiting this long for help has many unintended consequences. Other states and countries allow a doctor to determine the deterioration as justification for involuntary medical treatment. Waiting for the crisis is often too late to actually receive help. The damage is done- to the person or others. We need to demand the laws to change in PA. This is a law you can request help change.
Emergency rooms need to be able to admit people and find inpatient hospital beds. I don't blame average citizens for their lack of awareness of the injustice people with a mental illness receive. Talk to families- we are the ones left caring for an unstable person, and have no medical training to do so.

CRISIS INTERVENTION

The police were delivering a warrant that would involuntarily require him/ her to involuntary inpatient hospitalization treatment (probably a very short stay- because well the system is broken despite health parity laws that require insurance to treat mental illness as the same as physical illness). I am speculating that the victim was suffering from paranoid delusions, and that others were coming to kill him (I read the family said it was consequences of Autism- but the

deterioration of mental health due to not taking his medicine, and the knife- I think he may have had a co-morbid condition). And well, the police did show up with guns and probably validated his fear- most likely using the knife to protect himself. Most of the police in the State College community receive Crisis Intervention Training (CIT). It is special training in how to respond to a person suffering from a mental illness. I have heard all the officers that delivered the warrant were trained. Where a typical arrest demeanor escalates a situation, CIT officers are trained in ways to de-escalate the situation. Can you ensure CIT training needs to include: de-escalation, personal anxiety management, argument avoidance strategies, engagement and rapport strategies, room placement, non-lethal disarmament? Of course- at all possible the medical community should demand intervention is in place before the situation is in crisis mode. Waiting 2 weeks to respond to a "crisis" is a terrible plan for handling a medical disease. We need to support families by providing the medical treatment earlier.

TREATMENT

Assisted outpatient treatment is an effective model to help citizens who suffer from a mental illness. Unfortunately, this model waits until a citizen breaks the law to receive this support. Non-compliance with medicine should prompt that type of service (as was in the case of Osaze Osagie). The lack of adequate housing with trained staff that ensures medication is dispersed daily (or monthly injectables), and counseling are all effective treatments for those suffering from mental illness. There are models for Early Psychosis Prevention clinics in PA (and internationally) that have been shown to be effective. But the availability of these clinics are limited. They are only in Philadelphia and Pittsburgh. I tried to get my son there but they really want local people so they can set you up to use local resources. We even drove to Johns Hopkins Early Psychosis clinic, but they only offered a second opinion, we lived too far away to receive services.

These resources are severely limited in State College community. Helping a person who is unaware of their mental illness (Anosognosia) learn it is more effective to take the medicine to achieve their goals (see Dr. Amador- I'm not sick and I don't need help). When we know better- we can do better. We need to stand and demand better medical services for those suffering.

And pray for the family of those who are still fighting or lost their battle with the illness.

I know the family is grieving right now, but if they are ever ready- please tell them they are not alone. People are praying for them, and their family. I attend local NAMI meetings (2nd Tuesday of each month at 7pm- South Hills School of Business). They are always welcome to come and share their story and support others who have a family members who suffer or have lost their battle with mental illness.

This tragic event of Mr. Osagie can prompt change in Centre County, and Pennsylvania as a whole. There will only be more cases similar to his story. Involuntary commitment finally worked in my son's case, and now that he is coherent he thanks me for fighting for him and getting him the help he needed. There is hope for treatment, and recovery. Due to this fight, and my doctoral training of program evaluation, I can see places where the system can be improved and it starts with changing the involuntary commitment laws in Pennsylvania.If there is anything I can do to help please contact me.

Thanks,

[redacted]