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REVOLVING DOORS OF HOSPITALIZATION AND INCARCERATION: HOW PERCEPTIONS OF PROCEDURAL JUSTICE AFFECT TREATMENT OUTCOMES

MARIA SLATER*

ABSTRACT

This Article compares the levels of procedural justice afforded to persons with severe mental illness in the civil and criminal systems, either via involuntary commitment in state psychiatric hospitals in the civil system or via mental health court as an alternative to incarceration in the criminal system. Using Virginia's mental health courts and civil commitment systems as case studies, this Article compares the procedures by which a person can be involuntarily committed in the civil system with those afforded to persons who are funneled into mental health treatment courts in the criminal system, analyzing how levels of procedural justice—both actual and perceived—affect treatment outcomes. The underlying premise of this Article is that the higher the level of perceived procedural fairness, the higher the likelihood that a person with acute mental illness will comply with treatment. This Article ultimately suggests that certain aspects of procedural due process in the mental health court model should be utilized in the civil commitment system in order to effect positive treatment outcomes by increasing perceived levels of procedural fairness and resultant buy-in to treatment.

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VI. RECOMMENDATIONS

I. REVOLVING DOORS OF HOSPITALIZATION AND INCARCERATION

Mental health treatment for persons with acute mental illness in the United States has experienced a major shift in the past half century, from exclusive focus on institutionalized care in state mental hospitals to deinstitutionalization and a move to the provision of community-based treatment and support.¹ As a result, the number of persons in state and county mental hospitals has dropped dramatically.² However, at the same time, the number of individuals with severe mental illness in prisons and jails has risen drastically.³ Many individuals with severe mental illness rotate in and out of the criminal justice system, arrested and charged for minor offenses—offenses symptomatic of an underlying illness—and sentenced to short periods in jail for low-level misdemeanors.⁴ All too often, these individuals are back before the court shortly after their release, their symptoms “undetectable during the cursory court process.”⁵ Instead

1. COUNCIL OF STATE GOV'TS, No. 197103, CRIMINAL JUSTICE/MENTAL HEALTH CONSENSUS PROJECT 7 (2002), <https://www.ncjrs.gov/pdffiles1/nij/grants/197103.pdf> [<https://perma.cc/PTC4-TC8R>].

2. *See id.* (stating that the number of persons has dropped from 559,000 people in 1955 to less than 80,000 in 1999).

3. *See* John Monahan, Marvin Swartz & Richard J. Bonnie, *Mandated Treatment in the Community for People with Mental Disorders*, 22 HEALTH AFFAIRS 28, 28 (2003) (stating that a person with serious mental illness is almost five times more likely to be incarcerated than admitted to a hospital or emergency medical center); *see also* Joseph A. Miglione, Jr., *An Effective Model for Misdemeanor Courts and the Mentally Ill Defendant*, VA. LAW., Dec. 2013, at 64, 64 (“Our jails have, effectively, become the new state institutions for the mentally ill.”); COUNCIL OF STATE GOV'TS, *supra* note 1, at xii, 4 (stating that according to studies, the prevalence of mental illness is three to four times higher among inmates in jail and prison than in the general population, and almost half of inmates with mental illness are incarcerated for non-violent crimes); MARGARET CAMARENA, SOC. SCI. RSCH. CTR. AT OLD DOMINION UNIV., NORFOLK MENTAL HEALTH COURT EVALUATION STUDY 7 (2007) (“By the end of 2000, there were nearly one million people with mental illness in the criminal justice system.”).

4. BUREAU OF JUST. ASSISTANCE, A GUIDE TO MENTAL HEALTH COURT DESIGN AND IMPLEMENTATION xi (2005), <https://bja.ojp.gov/sites/g/files/xyckuh186/files/Programs/Guide-MHC-Design.pdf> [<https://perma.cc/ZCC7-KGAY>]; *see* E. FULLER TORREY, AARON D. KENNARD, DON ESLINGER, RICHARD LAMB & JAMES PAYLE, MORE MENTALLY ILL PERSONS ARE IN JAILS AND PRISONS THAN HOSPITALS: A SURVEY OF THE STATES 3–5, 9 (2010); *see also* CAMARENA, *supra* note 3, at 6–7, 22 (noting the high rates of incarceration and recidivism for those with mental illnesses).

5. BUREAU OF JUST. ASSISTANCE, *supra* note 4, at xi. Inmates with a mental illness are often released with little to no “supply of medications and enough money to take a one-way trip on public transportation[,] [w]ithout housing, linkage to a community-based mental health treatment program, or other much needed services.” COUNCIL OF STATE GOV'TS, *supra* note 1, at 9.

of deinstitutionalization, there has been a marked “re-institutionalization” of persons with acute mental illness, from state psychiatric hospitals to correctional institutions.⁶ In turn, stress, overcrowding, and threats of violence in jail and prison often cause individuals with acute mental illness to further deteriorate, interrupting what treatment options may have been available and creating a vicious cycle of repeated incarcerations.⁷ Aside from evaluations for legal competency, “most people with mental illnesses cycle through the [criminal justice system] with little attention paid to their [underlying] conditions.”⁸ For a fortunate few, mental health treatment court is offered as an alternative to incarceration, allowing individuals to address underlying mental illnesses causing this vicious cycle.⁹

Individuals who do not enter the criminal justice system often enter a different set of revolving doors, admitted to hospitals and emergency medical centers for short stays, medicated, and then released, only to be admitted again a short period later.¹⁰ In response, many states have implemented involuntary commitment statutes, using hospitalization as leverage to compel treatment as a means of reducing relapse.¹¹ Many persons involuntarily committed in the civil system experience some form of leveraging by the state, whereby deprivation is avoided and rewards are contingent on adherence to mandated treatment.¹² This treatment compelled by the state has become an increasingly hot-button topic in mental health, as the state’s interest in public safety and welfare clashes with individual liberty interests.¹³

6. See Institute of L., Psyc. & Pub. Pol’y at U. Va., *Three Virginia Jurisdictions Establish Specialized Mental Health Dockets*, 31 DEVS. IN MENTAL HEALTH L., Feb. 2012, at 5, 6 (2012) [hereinafter ILPPP] (“In Virginia, the Department of Behavioral Health and Developmental Services (“DBHDS”) surveyed its jail population in 2005 and . . . determined that . . . 16% of its jail population, suffer from serious mental illness . . . defined as schizophrenia, schizoaffective disorder, bipolar disorder, and depressive or other mood disorders.”).

7. BUREAU OF JUST. ASSISTANCE, *supra* note 4, at xi; see COUNCIL OF STATE GOV’TS, *supra* note 1, at 5, 8–9, 102 (“Once incarcerated, people with mental illness become especially vulnerable to assault or . . . intimidation by predatory inmates.”).

8. BUREAU OF JUST. ASSISTANCE, *supra* note 4, at xi.

9. See ILPPP, *supra* note 6, at 6–7 (noting the limited number of jurisdictions in which a mental health court or docket exists in Virginia).

10. Monahan et al., *supra* note 3, at 29–31 (referring to such individuals as “revolving-door patients”); see also BRETT M. MERFISH, VIRGINIA CIVIL COMMITMENT PROCEDURE AND PRACTICE: POLICY ANALYSIS AND RECOMMENDATIONS TO INCREASE VOLUNTARY ADMISSION 29 (2010) (referring to such individuals as “frequent flyers”).

11. See, e.g., Richard J. Bonnie & John Monahan, *From Coercion to Contract: Reframing the Debate on Mandated Community Treatment for People with Mental Disorders*, 29 LAW & HUM. BEHAV. 485, 485–86, 498 (2005).

12. *Id.* at 485–86.

13. See *id.* at 499.

This Article seeks to compare the procedure afforded to individuals via involuntary commitment in the civil system and that afforded to them via mental health treatment courts in the criminal system, analyzing the legal mechanisms by which leveraging is applied in each system to gain adherence to treatment. This Article then examines how levels of procedural protections afforded in each system affect perceptions of procedural fairness and impact treatment outcomes.¹⁴ Part II lays out the processes by which a person can end up in mandated treatment via involuntary commitment in the civil system versus mental health court in the criminal system. Part III uses Virginia's mental health court and civil commitment systems as case studies, comparing the procedures by which a person can be involuntarily committed with the procedures by which a person can be funneled into mental health treatment court. Part IV then analyzes how levels of procedural justice—both actual and perceived—affect treatment outcomes. Part V suggests utilizing certain aspects of procedural due process afforded in the mental health court model in the civil commitment system in order to effect positive treatment outcomes in the civil system by increasing perceived levels of procedural fairness and resultant buy-in to treatment.

The underlying premise of this Article is that the higher the level of perceived procedural fairness, the higher the likelihood that a person with acute mental illness will comply with treatment.¹⁵ Mandated treatment in the civil system and mandated treatment in the criminal system are, in reality, simply varying points of interception along the continuum at which individuals with mental illness are diverted into treatment. While not disregarding the obvious differences between mental health treatment compelled via involuntary commitment in the civil system versus treatment offered as an alternative to incarceration in the criminal justice system, this Article posits that these processes can be compared side-by-side instead of analyzed in a vacuum. In so doing, this Article seeks to analyze how levels of perceived procedural due process afforded in each can be used to inform the treatment models of both and ultimately effect positive outcomes.¹⁶

14. See *id.* at 498–99; see also Monahan et al., *supra* note 3, at 28, 34 (“[P]resumably, some practices are likely to work better than others do—because they are more effective or because they are more respectful of patients’ values and wishes, or both.”).

15. See, e.g., Norman G. Poythress, John Petrila, Annette McGaha & Roger Boothroyd, *Perceived Coercion and Procedural Justice in the Broward Mental Health Court*, 25 INT’L J.L. & PSYCHIATRY 517, 521 (2002) (“[E]nhanced perceptions of procedural justice would be ‘... likely to facilitate the subsequent therapeutic process.’”).

16. See COUNCIL OF STATE GOV’TS, *supra* note 1, at 25 (depicting a flowchart of “select events” that can lead a person with mental illness into the criminal justice system).

II. MANDATED TREATMENT IN THE CIVIL V. CRIMINAL SYSTEMS

At the outset, it is important to note that there are obvious differences between mandated treatment in a mental health court and mandated treatment in the civil system via civil commitment. The mental health court treatment model utilizes the alternative of incarceration as leverage to gain compliance in treatment, whereas the civil commitment system uses the threat of hospitalization as leverage to gain compliance in treatment.¹⁷ Yet, the same actions on an individual's part can lead to either form of state-compelled treatment. For instance, a person urinating on a street corner in public or making lewd gestures to passersby could be taken by an officer to the nearest hospital for psychiatric evaluation, hospitalized, involuntarily committed, and then offered outpatient treatment in the civil system. Alternatively, that person could be arrested, charged with public indecency, incarcerated, and subsequently offered the option of participation in a mental health treatment court. In either scenario, that individual's actions may be symptomatic of an underlying, untreated mental illness, yet those same actions can result in widely disparate outcomes.¹⁸ A host of variables affect how law enforcement responds to an individual with acute mental illness during that individual's initial interaction with the state, including the level of crisis intervention training of the individual officer, the availability of mental health resources in that community or jurisdiction, and the ability of the officer to obtain an on-scene mental health assessment.¹⁹ If the person is not diverted into the civil system prior to entry into the criminal justice system, an even wider array of variables come into play, such as the availability of mental health clinicians to conduct immediate on-site assessments after arrest, the ability to arrange for treatment as a condition of pretrial release, and the amount of revenue available for administration and delivery of mental health services in that jurisdiction.²⁰

The many factors that determine when and whether an individual with serious mental illness is diverted into mental health treatment are outside the scope of this Article. Instead, this Article addresses the levels of procedural protections afforded in the civil and criminal systems once the state uses its police power to compel treatment, analyzing how differences in the two systems can be used to inform treatment outcomes.²¹

17. See Bonnie & Monahan, *supra* note 11, at 485–86.

18. See COUNCIL OF STATE GOV'TS, *supra* note 1, at 6.

19. See *id.* at 4–5, 25.

20. See *id.* at 16–17, 25, 54.

21. See *id.* at 16, 19, 48–49.

A. An Overview of the Civil Commitment Process

Many states have attempted to implement community-based treatment programs, targeting individuals who repeatedly circulate through local hospitals, emergency medical centers, and social welfare systems.²² However, even where treatment options are available, noncompliance with treatment often leads to repeated involuntary hospitalizations for those with acute mental illness.²³ Individuals with mental illness often lack insight into their sickness and, as a result, do not comply with taking medication or adhering to treatment.²⁴ This lack of insight is known as “anosognosia,” a neurological deficit “affect[ing] the prefrontal cortex of the brain . . . used for insight and understanding of one’s needs.”²⁵ Because of this lack of insight, a state may deem involuntary commitment necessary.²⁶ Involuntary civil commitment is reserved for this group—those “‘severely and persistently mentally ill’ individuals . . . who suffer from a DSM-IV Axis I disorder[,] [which] includes schizophrenia, schizoaffective disorder, bipolar disorder, and major depression[,]” and who are noncompliant with adhering to treatment or taking medication.²⁷

Civil commitment laws vary by state, with most states authorizing three main forms of court-ordered involuntary treatment.²⁸ The first, and most immediate, involves individuals in acute mental health crisis and emergency hospitalization, in which persons undergoing an acute mental health crisis are admitted to a hospital emergency room or other treatment facility for psychiatric evaluation for a short, fixed period of time, often referred to as a “psychiatric hold.”²⁹ After the psychiatric hold period for evaluation, a judge can determine

22. Monahan et al., *supra* note 3, at 29.

23. *Id.* at 30, 33.

24. *See id.* at 36–37.

25. Christine Marie Sarteschi, *Assessing the Effectiveness of Mental Health Courts: A Meta-Analysis of Clinical and Recidivism Outcomes* 40 (2009) (Ph.D. dissertation, University of Pittsburgh) (ResearchGate).

26. Rachel A. Scherer, *Toward a Twenty-First Century Civil Commitment Statute: A Legal, Medical, and Policy Analysis of Preventive Outpatient Treatment*, 4 IND. HEALTH L. REV. 361, 375 (2007); *see also* MERFISH, *supra* note 10, at 4 (stating that “the most prevalent barrier to voluntary treatment may not be readily remedied: it is individuals’ inability to identify their own conditions as problematic due to a lack of insight”).

27. Scherer, *supra* note 26, at 371–72, 375, 380.

28. *Know the Laws in Your State*, TREATMENT ADVOC. CTR., <https://www.treatmentadvocacycenter.org/component/content/article/183-in-a-crisis/1596-know-the-laws-in-your-state> [https://perma.cc/GW62-WTA8] (“Three forms of involuntary treatment are authorized by civil commitment laws in 46 states and the District of Columbia. Two forms are available in Connecticut, Maryland, Massachusetts, and Tennessee, where court-ordered outpatient treatment has not yet been adopted.”).

29. *Id.*

whether a person continues to meet the state's civil commitment criteria after the emergency evaluation period and can order further hospital treatment for the individual.³⁰ This process, the second form of court-ordered involuntary treatment, is known as inpatient civil commitment—or involuntary commitment—and “is practiced in all states, but the standards that qualify an individual for it vary from state to state.”³¹ The third type of civil commitment, practiced in all but four states, is called outpatient civil commitment and “is a treatment option in which a judge orders a qualifying person with symptoms of mental illness to adhere to a mental health treatment plan while living in the community.”³²

Each state's civil commitment statute and process is slightly different. Twenty states incorporate some form of an understanding of psychiatric deterioration when determining whether a person should be civilly committed.³³ Some states' civil commitment statutes allow consideration of treatment history and the likelihood of future deterioration; seven states employ a standard requiring imminent harm to self or others to be eligible for civil commitment.³⁴ As one study put it, “[t]he United States is effectively running [fifty] different experiments, with no two states taking the same approach.”³⁵

While involuntary commitment can and often does require inpatient hospitalization, outpatient commitment statutes explicitly use avoidance of hospitalization as leverage to coerce compliance with treatment in the community.³⁶ Outpatient mandated treatment usually is offered as a less restrictive alternative to inpatient hospitalization in one of three scenarios: as a less restrictive alternative to inpatient hospitalization, through conditional release, or as a preventive measure.³⁷ A person who meets the statutory criteria for involuntary inpatient commitment may be offered outpatient commitment

30. *Id.*

31. *Id.*

32. *Id.*

33. TREATMENT ADVOC. CTR., GRADING THE STATES: AN ANALYSIS OF INVOLUNTARY PSYCHIATRIC TREATMENT LAWS 1 (2018), https://www.treatmentadvocacycenter.org/storage/documents/2018_Grading_the_States.pdf [<https://perma.cc/SK2D-MFES>].

34. *Id.* at 1, 16.

35. *Id.* at 1.

36. See COUNCIL OF STATE GOV'TS, *supra* note 1, at 48; TREATMENT ADVOC. CTR., STATE STANDARDS FOR ASSISTED TREATMENT: CIVIL COMMITMENT CRITERIA FOR INPATIENT OR OUTPATIENT PSYCHIATRIC TREATMENT 2 (2014), http://www.treatmentadvocacycenter.org/storage/documents/Standards_-_The_Text_-_June_2011.pdf [<https://perma.cc/JA5V-EK7J>] (stating that all states and the District of Columbia have statutes allowing court-ordered inpatient treatment and that 45 states plus D.C. also have statutes governing court-ordered outpatient treatment for those who meet the legal criteria); Bonnie & Monahan, *supra* note 11, at 485.

37. Bonnie & Monahan, *supra* note 11, at 497–98.

as a less restrictive alternative to hospitalization after an acute mental health crisis, without ever undergoing inpatient commitment.³⁸ In some states, outpatient commitment is available as a preventive procedure, whereby a court can order that a person be involuntarily committed before a psychiatric crisis has occurred if the court believes the person to be at such risk that involuntary commitment is deemed necessary, but can offer mandated outpatient treatment as a less restrictive option.³⁹ Alternatively, an individual already involuntarily committed to inpatient hospitalization may be offered a conditional release, under which discharge from the hospital is conditioned on continuing treatment in the community.⁴⁰

B. Mental Health Treatment Courts in the Criminal Justice System

Individuals who do not enter the revolving set of hospital doors via the civil commitment system may instead enter a different set of revolving doors, rotating in and out of jails and prisons in the criminal justice system as they incur repeated charges for behaviors actually symptomatic of their underlying mental illness.⁴¹ Many persons with serious mental illness are arrested for minor crimes related to their untreated mental illness and based on an underlying need for survival.⁴² If an individual is not intercepted and diverted into mental health treatment via the civil commitment system, that individual instead likely will be funneled by law enforcement into the criminal system.⁴³ Consider the hypothetical of a person with serious mental illness urinating on a street corner in public or making lewd gestures to passersby.⁴⁴ If that person is not diverted by law enforcement into hospitalization and treatment via the civil commitment system, that individual is likely instead to be arrested and charged with public indecency.⁴⁵ Though the behavior is the same in both scenarios, it can lead to widely divergent outcomes: either hospitalization and civil commitment or incarceration. For a fortunate few who do enter the criminal justice system, mental health court treatment is offered as an alternative to incarceration, belatedly diverting such persons into mandated treatment.⁴⁶

38. *Id.* at 498.

39. *See id.* at 499.

40. *Id.* at 497–98.

41. *See* Monahan et al., *supra* note 3, at 29; BUREAU OF JUST. ASSISTANCE, *supra* note 4, at xi.

42. COUNCIL OF STATE GOV'TS, *supra* note 1, at xii.

43. *Id.*

44. *Id.*

45. *Id.*

46. *See* BUREAU OF JUST. ASSISTANCE, *supra* note 4, at 2.

Mental health courts initially developed in response to the overrepresentation of people with mental illnesses in the criminal justice system, diverting select defendants with mental illness into judicially supervised, community-based treatment.⁴⁷ Part of the growing therapeutic jurisprudence movement,⁴⁸ mental health courts attempt to link persons with mental illness in the legal system with other social services, addressing the underlying problems that led to that individual's involvement with the criminal justice system in the first place.⁴⁹ Defendants offered the option of mental health court treatment work with a team of court and mental health professionals under a treatment plan tailored to that individual, appearing at regular status hearings in mental health court and given incentives and sanctions depending on that individual's adherence to treatment.⁵⁰ Over 470 mental health treatment courts currently operate in the United States in more than 45 states,⁵¹ with wide variation in the type of charge accepted in each court, the treatment options offered, the monitoring practices, and the adjudication model used.⁵² For instance, while some mental health courts offer pre-adjudication services, others are probation-based or only provide services after a person has pled guilty.⁵³

47. See, e.g., *id.* at 2–3.

48. *Id.* at 5 (stating that David Wexler, one of the founders of the movement in the United States, describes therapeutic jurisprudence as “the study of the role of the law as a therapeutic agent”).

49. See *id.*; see also Poythress et al., *supra* note 15, at 519 (stating that mental health courts “abandoned much of the ‘formal lawyering’ and other stylistic aspects of a traditional adversarial forum in favor of methods designed to” facilitate the individual’s recovery via treatment).

50. See ROBERT V. WOLF, BUREAU OF JUST. ASSISTANCE, PRINCIPLES OF PROBLEM-SOLVING JUSTICE 3–4, 8 (2007), <https://www.courtinnovation.org/sites/default/files/Principles.pdf> [<https://perma.cc/2PGU-XD3G>].

51. *Mental Health Treatment Court Locator*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (last visited Dec. 10, 2020), available at <https://samhsa.gov/gains-center/mental-health-treatment-court-locator>.

52. BUREAU OF JUST. ASSISTANCE, *supra* note 4, at v; Bonnie & Monahan, *supra* note 11, at 490 (“Mental health courts differ [in] . . . the type of charges accepted (felony or misdemeanor), the type of adjudication model employed (pre or post-plea), the type of sanctions used (jail or no-jail), and the type of supervision imposed (mental health or criminal justice personnel).”).

53. LAUREN ALMQUIST & ELIZABETH DODD, COUNCIL OF STATE GOV'TS JUST. CTR., MENTAL HEALTH COURTS: A GUIDE TO RESEARCH-INFORMED POLICY AND PRACTICE 12 (2009), https://bja.ojp.gov/sites/g/files/xyckuh186/files/Publications/CSG_MHC_Research.pdf [<https://perma.cc/NPW8-NKC5>]; see also MICHAEL THOMPSON, FRED OSHER & DENISE TOMASINI-JOSHI, COUNCIL OF STATE GOV'TS, IMPROVING RESPONSES TO PEOPLE WITH MENTAL ILLNESS: THE ESSENTIAL ELEMENTS OF A MENTAL HEALTH COURT 4 (2005) (outlining potential legal outcomes for participation in a mental health court program). In the pre-adjudication model, the prosecution of charges is suspended while participant is in Mental Health Court (MHC) treatment; in the post-plea model, sentencing is suspended

The likelihood of a person being funneled into a mental health treatment court in the criminal justice system is extremely low.⁵⁴ For a person to be offered the option of mental health court treatment as an alternative to criminal adjudication of their offense in a traditional court setting, two things must be true. First, a mental health court or specialty docket must exist in the jurisdiction where that person was charged (and/or convicted if in a mental health court that is post-plea or probation-based). Second, that person must be referred and accepted into the mental health court or docket once in the criminal system.⁵⁵ Even if a mental health court exists in that jurisdiction and a person is referred to that specialty court, the person must additionally agree to undergo treatment, the mental health treatment team in that court must deem the person a good candidate for treatment as an alternative to incarceration, and resources must exist in the community linking that individual to providers and services and thus making mental health court treatment a viable option.⁵⁶ Consequently, the likelihood of an individual being funneled into mental health court treatment once in the criminal justice system is low, though the number of mental health treatment courts in existence in the United States rises each year.⁵⁷

Under the criteria and benchmarks for mental health courts outlined by the Bureau of Justice Assistance, courts are to give defendants an informed choice in whether to participate in mental health

during treatment, and participation is taken into account in later sentencing. ALMQUIST & DODD, *supra* note 53, at 13. In the probation model, treatment via the MHC is offered in conjunction with probation. See Patricia A. Griffin, Henry J Steadman & John Petrila, *The Use of Criminal Charges and Sanctions in Mental Health Courts*, 53 PSYCHIATRIC SERVS. 1285, 1286 (2002).

54. See ALMQUIST & DODD, *supra* note 53, at 1. For instance, in Virginia, only seven out of thirty-two judicial districts have established mental health dockets, and only one out of thirty-one judicial circuits has an established mental health court. VA. DEP'T OF BEHAV. HEALTH & DEV. SERVS., THE ESSENTIAL ELEMENTS OF MENTAL HEALTH DOCKETS IN VIRGINIA 7, 9–12 (2016), <http://www.dbhds.virginia.gov/library/forensics/fofo%20%20mental%20health%20docket%20report%20final.pdf> [<https://perma.cc/4GQE-P2GA>] (noting the districts and circuit in Virginia in which mental health treatment dockets and court exist); Virginia Courts in Brief, VA.'S JUD. SYS., <http://www.courts.state.va.us/courts/cib.pdf> [<https://perma.cc/RGB6-W7YM>] (noting the number of judicial districts and circuits in Virginia); Judge Tina Snee Leads New Mental Health Efforts in Fairfax County Courts, FAIRFAX CNTY. VA. (May 7, 2019), <https://www.fairfaxcounty.gov/publicaffairs/snee-leads-mental-health-efforts-courts> [<https://perma.cc/5DAL-TQGN>]. Thus, an individual in the criminal justice system in Virginia is unlikely even to have this option available. See VA. DEP'T OF BEHAV. HEALTH & DEV. SERVS., *supra* note 54, at 2.

55. THOMPSON ET AL., *supra* note 53, at 3.

56. *Id.* at 3, 5.

57. See Carol Fisler, *When Research Challenges Policy and Practice: Toward a New Understanding of Mental Health Courts*, JUDGES' J., Sept. 2015, at 8, 8 ("A handful of mental health courts were launched in the late 1990s, a few dozen by 2003, and by 2010 approximately 300 . . ."); see also *Mental Health Treatment Court Locator*, *supra* note 51.

court or to opt for routine criminal court processing.⁵⁸ Mental health advocates have expressed concern over the extent to which defendants are actually informed of their choice in whether to participate in mental health court or to opt for routine case processing.⁵⁹ For instance, in an investigation of a Broward County mental health court, one study showed that 46.3% of respondents did not know that the decision to participate in the mental health court program was optional.⁶⁰ The same study revealed that twenty-nine percent of defendants did not realize participation was voluntary until after they had agreed to participate.⁶¹

Data on mental health courts is also extremely limited.⁶² The “supportive evidence base for [mental health courts] is sorely lacking[.]”⁶³ in part because few mental health courts exist, and in part because few studies have been completed on the operation and impact of those currently in operation. Moreover, the success or failure of a mental health treatment court depends on the availability of mental health services within that jurisdiction, and not solely on the mental health treatment model used in that court.⁶⁴ Thus, it is hard to pinpoint the extent to which failure in improving treatment outcomes or reducing recidivism rates is attributable to lack of mental health services in the area more generally versus the extent to which such failures can be attributed to the mental health court itself.⁶⁵

III. VIRGINIA AS A CASE STUDY

A. *The Civil Commitment Process in Virginia*

Virginia’s civil commitment process usually begins when an individual is brought to a hospital emergency department or mental health facility during a psychiatric crisis.⁶⁶ A person can voluntarily

58. THOMPSON ET AL., *supra* note 53, at 5.

59. See Sarteschi, *supra* note 25, at 44–45.

60. *Id.* at 46.

61. *Id.*

62. BUREAU OF JUST. ASSISTANCE, *supra* note 4, at v (“Program planners should also be aware of the limited evidence base . . .”).

63. Sarteschi, *supra* note 25, at 39; see also BUREAU OF JUST. ASSISTANCE, *supra* note 4, at v (noting lack of empirical studies on MHCs); Fidler, *supra* note 57, at 9 (“By 2010, only a few studies of individual courts had provided evidence regarding the effectiveness of the program model.”).

64. See, e.g., Sarteschi, *supra* note 25, at 76 (“[I]t can be argued that how well MHC participants fare within a program is largely dependent on the nature of mental health services facilitated by the MHC.”).

65. See *id.* at 42.

66. See NAT’L ALL. ON MENTAL ILLNESS, GUIDE TO PSYCHIATRIC CRISIS AND CIVIL COMMITMENT PROCESS IN VIRGINIA 3 (2016), <https://namivirginia.org/wp-content/uploads/sites>

seek help during a crisis, or if that individual is unwilling to undergo an evaluation voluntarily, a magistrate can issue an emergency custody order (ECO) permitting law enforcement to detain and transport that individual to the hospital for a mental health assessment.⁶⁷ A magistrate may order an ECO upon the request of relatives, law enforcement, or any other “responsible person.”⁶⁸ Once an ECO is ordered, a “pre-admission screener” is then obligated by statute to provide emergency mental health services within eight hours of the emergency custody order.⁶⁹ If he or she deems it appropriate, the pre-admission screener can then request a temporary detaining order from the local magistrate judge.⁷⁰ Once a temporary detaining order is ordered, Virginia law permits the individual to be detained for up to seventy-two hours for evaluation and emergency treatment.⁷¹ During this temporary detaining order period, an independent examiner conducts a more extensive clinical evaluation of the individual to determine whether he or she meets the statutory criteria for involuntary inpatient admission to the hospital.⁷² If the independent examiner independently finds that statutory commitment criteria are met, he or she must certify this to the court,⁷³ and a civil commitment hearing must follow within the seventy-two-hour temporary detaining order period.⁷⁴ If the independent examiner does not find that statutory commitment criteria are met, that individual is released, obviating any need for a civil commitment hearing.⁷⁵

Either a district court judge or special justice appointed by the circuit court presides over an individual’s civil commitment proceeding, which usually takes place at the hospital where the person has

/127/2016/03/GuidetoPsychiatricCrisisandCivilCommitmentProcessforWebsite-justlawscriteria2016.pdf [https://perma.cc/X7H2-33H5].

67. VA. CODE ANN. § 37.2-808(A)–(C) (2020) (“[A] magistrate shall issue, upon the sworn petition of any responsible person, treating physician, or upon his own motion, an emergency custody order [upon] . . . probable cause . . .”).

68. *See id.* § 37.2-808(A) (stating that any “responsible person” can petition the court for an ECO).

69. *Id.* §§ 37.2-808(K), 37.2-809(A)–(B). This person is employed by the local community services board. § 37.2-809(A).

70. *Id.* § 37.2-809(B) (“A magistrate shall issue, upon the sworn petition of any responsible person, treating physician, or upon his own motion and only after an evaluation conducted in-person or by means of a two-way electronic video and audio communication system as authorized in § 37.2-804.1 by an employee or a designee of the local community services board to determine whether the person meets the criteria for temporary detention, a temporary detention order if it appears [warranted] from all evidence readily available . . .”).

71. *Id.* § 37.2-809(H).

72. *Id.* §§ 37.2-809(H), 37.2-815, 37.2-816.

73. VA. CODE ANN. §§ 37.2-815(C), 37.2-817(A).

74. *Id.* § 37.2-814(A) (2020).

75. *See id.* § 37.2-815(B) (listing the examination considerations).

been detained.⁷⁶ At this hearing, the special justice may question the petitioner, respondent, and any other family members or individuals testifying.⁷⁷ The civil commitment process varies depending on the jurisdiction in which it occurs.⁷⁸ For instance, some Virginia counties report utilizing the entire temporary detaining order period before having the hearing to give an individual more time to become open and receptive to the idea of treatment on an outpatient basis, allowing an individual multiple opportunities before and during the hearing to agree to voluntary commitment.⁷⁹ Where more time is given, a patient has more opportunity to stabilize after a psychiatric crisis and more time in which to gain cognitive insight, which increases that individual's ability to understand the need for treatment and agree to comply voluntarily.⁸⁰ Other counties initiate civil commitment hearings immediately after the temporary detaining order is issued, offering few opportunities and little time in which a patient can choose to voluntarily comply with treatment.⁸¹ Of the dispositions recorded in Virginia in 2007, almost half resulted in a court order for involuntary inpatient treatment, about six percent resulted in court-ordered involuntary outpatient treatment, and about thirty percent resulted in voluntary admission for inpatient treatment.⁸²

Virginia's civil commitment statute defines "mental illness" as "a disorder of thought, mood, emotion, perception, or orientation that significantly impairs judgment, behavior, capacity to recognize reality, or ability to address basic life necessities and requires care and treatment for the health, safety, or recovery of the individual or for the safety of others."⁸³ In Virginia, before a person can be involuntarily

76. *See id.* § 37.2-815(A), (C); MERFISH, *supra* note 10, at 8.

77. *See* UNIV. VA. SCHS. OF L. & MED., A STUDY OF CIVIL COMMITMENT HEARINGS HELD IN THE COMMONWEALTH OF VIRGINIA DURING MAY 2007: A REPORT TO THE COMMISSION ON MENTAL HEALTH LAW REFORM iii (2008), http://www.courts.state.va.us/programs/concluded/cmh/reports/2007_05_civil_commitment_hearings.pdf [<https://perma.cc/48YQ-Z5RA>].

78. *See* COMMONWEALTH VA. COMM'N ON MENTAL HEALTH L. REFORM, PROGRESS REPORT ON MENTAL HEALTH LAW REFORM (2009) 50 (2009) [hereinafter VA. COMM'N ON MENTAL HEALTH], http://www.courts.state.va.us/programs/concluded/cmh/reports/2009_progress_report.pdf [<https://perma.cc/UA9U-8U8G>] (report of Prince William County CSB).

79. *See id.* at 45.

80. *See id.*

81. *Contra id.*

82. UNIV. VA. SCHS. OF L. & MED., *supra* note 77, at 16–17.

83. VA. CODE ANN. § 37.2-100 (2020); *see also* BRUCE J. COHEN, RICARD J. BONNIE & JOHN MONAHAN, UNDERSTANDING AND APPLYING VIRGINIA'S NEW STATUTORY CIVIL COMMITMENT CRITERIA 4 (2008), <http://www.dbhds.virginia.gov/library/mental%20health%20services/omg-understanding-and-applying-virginias-new-statutory-civil-commitment.pdf> [<https://perma.cc/3UG3-SRTJ>] (interpreting 2008 amendments made to the statute's language).

committed, a judicial determination must be made by clear and convincing evidence that the person has a mental illness, and that this mental illness presents:

[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.⁸⁴

In addition, Virginia's involuntary commitment statute requires that a person be in need of hospitalization and treatment and unwilling to or incapable of volunteering for such treatment.⁸⁵ If all of these requirements are met and additionally "all available less restrictive treatment alternatives to involuntary inpatient treatment . . . have been . . . determined to be inappropriate,"⁸⁶ a judge or special justice can "order that the person be admitted involuntarily to a facility for a period of treatment not to exceed [thirty] days."⁸⁷

If an individual has already been involuntarily committed to inpatient treatment in a hospital setting, that individual may be offered mandatory outpatient treatment as a less restrictive alternative.⁸⁸ Under the outpatient treatment model, a court can order that an individual receive community-based treatment and that the person be hospitalized if found not in compliance with such treatment.⁸⁹ For outpatient treatment to be offered as a less restrictive alternative to an individual, the judge or special justice must find, in addition to the findings delineated above for involuntary inpatient treatment, 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

84. VA. CODE ANN. § 37.2-817(C) (2020) (emphasis added).

85. *See id.*

86. *Id.*

87. *Id.*

88. *Id.* § 37.2-817(C1).

89. *Id.* § 37.2-817.1.

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.⁹⁰

In other words, if the judge finds that the individual has a history of noncompliance but may benefit from outpatient commitment based on this history, the judge can offer outpatient treatment as an alternative.⁹¹ Typically, a special justice may recommend mandated outpatient treatment at a civil commitment hearing when an individual has had repeated involuntary hospitalizations and is deemed in need of “encouragement” to participate in outpatient treatment, when a person has shown noncompliance with outpatient services in the past but seems willing to make greater efforts to comply with mandated outpatient treatment, or when a person has been discharged from the hospital but has failed to follow up with mental health and psychiatric services after discharge, as an incentive to comply with treatment in order to avoid being hospitalized again.⁹² In this way, mandated outpatient treatment is used to provide “additional motivation for client[s] to attend services,”⁹³ offering outpatient treatment instead of hospitalizing a person every time that individual is found out of compliance with treatment.

In practice, mandated outpatient treatment is often difficult to implement due to lack of resources.⁹⁴ For instance, the Fairfax-Falls Church Community Services Board reported long waiting lists for many services that would be appropriate for a client on an outpatient basis, eliminating the ability to offer outpatient treatment to individuals as a less restrictive alternative.⁹⁵ Time constraints also impede the process by which mandated outpatient treatment can occur.⁹⁶ Treatment providers are “required to draft a comprehensive [mandatory outpatient] treatment plan within [five] days of the commitment hearing,”⁹⁷ an incredibly quick mandated turnaround that in practice is hard to meet, as the local service providers, the patient, and the magistrate judge must all agree on a treatment plan before it is drafted.⁹⁸ Mandated outpatient treatment is also

90. VA. CODE ANN. § 37.2-817(C1).

91. *Id.*

92. VA. COMM’N ON MENTAL HEALTH, *supra* note 78, at 44.

93. *Id.*

94. *See id.* at 45.

95. *Id.*

96. *Id.*

97. *Id.*

98. VA. COMM’N ON MENTAL HEALTH, *supra* note 78, at 45.

utilized less frequently than inpatient commitment because of the added burden on judges and community treatment providers.⁹⁹ For instance, some special justices do not order outpatient treatment because mandated outpatient treatment cases “keep them on the hook.”¹⁰⁰ In other words, “[s]pecial justices are required to approve of the comprehensive treatment plan . . . after the hearing occurs, and are also responsible for overseeing the compliance process if [an individual] is [found] noncompliant” during outpatient treatment, obligating the justice to bear additional burdens of oversight throughout the treatment process rather than solely during the commitment hearing itself.¹⁰¹ Community service provider representatives have also reported that special justices often do not order mandated outpatient treatment because of the complicated steps involved in such an order and because of fiscal restraints, as justices are not given additional compensation for ordering outpatient treatment rather than inpatient, though the outpatient process burdens that justice with additional responsibilities.¹⁰²

B. Virginia’s Mental Health Treatment Courts

In Virginia, the impetus to establish mental health courts began after a task force was formed in 2002 to study ways to provide for diversion and jail mental health services.¹⁰³ The task force recommended that Virginia establish mental health courts in selected localities,¹⁰⁴ and a planning committee established Virginia’s first mental health court in Norfolk in 2004.¹⁰⁵ General district courts in Petersburg, Richmond, and Norfolk later established specialty dockets for channeling defendants into mental health treatment in 2011.¹⁰⁶ Currently, thirteen operational mental health dockets exist in Virginia, the most recent approved by the Virginia Supreme Court for Fairfax County in 2019.¹⁰⁷ For a person in Virginia to have the

99. *Id.* at 44.

100. *Id.*

101. *Id.*

102. *Id.*

103. CAMARENA, *supra* note 3, at 7–8; see ILPPP, *supra* note 6, at 6–7; Migliozi, *supra* note 3, at 64.

104. CAMARENA, *supra* note 3, at 7–8; see also VA. CODE ANN. § 16.1-69.35(4) (2020) (“Subject to such rules as may be established pursuant to § 16.1-69.32, the chief judge may establish special divisions of any general district court when the work of the court may be more efficiently handled thereby . . .”).

105. CAMARENA, *supra* note 3, at 8; ILPPP, *supra* note 6, at 7.

106. ILPPP, *supra* note 6, at 6–7.

107. See *Virginia Behavioral/Mental Health Dockets*, VA.’S JUD. SYS., http://www.courts.state.va.us/courtadmin/aoc/djs/programs/sds/programs/bhd/advisory/bhd_direct

option of mental health treatment instead of criminal adjudication of their offense, a mental health court or docket must exist in that jurisdiction, and that individual must be referred to the court or docket by law enforcement, pretrial services staff, defense counsel, or the judge.¹⁰⁸ For instance, a judge may order a defendant be placed on a mental health court docket if he or she determines there is a “sufficient history of mental illness to warrant the community-based services,” and in some district courts, defendants “evaluated for competency or sanity [are] automatically referred to the [specialty mental health] docket.”¹⁰⁹

The Norfolk Mental Health Court (Norfolk MHC) follows a post-plea model, meaning that a “defendant must first be found guilty either after a plea or a trial” before being referred into mental health court treatment in the Norfolk MHC.¹¹⁰ Defendants are only eligible to participate if they have an Axis I diagnosis that is determined to have been a factor in their arrest.¹¹¹ Additionally, only those with non-violent felonies and non-violent misdemeanor appeals to the Circuit Court are eligible for the program, and individuals with a prior record of violent offenses or sex offenses are not eligible.¹¹²

If a person agrees to participate in the Norfolk MHC, that person is referred to the Commonwealth Attorney’s Office and the mental health court team.¹¹³ Once the team agrees that the person would likely be responsive to services, the person may then enter the program.¹¹⁴ “[A] presentence report is prepared and sentencing is set for a date one year after entry into the program.”¹¹⁵ Upon completion of the program, the defendant must still be sentenced based on his or her previous conviction.¹¹⁶ However, if a defendant successfully completes the mental health treatment program, the finding

tory.pdf [https://perma.cc/8BP9-A3AN]; *Reducing the Number of People with Mental Illness in Jail*, FAIRFAX CNTY. NEWS CTR. (May 9, 2019), <https://www.fairfaxcounty.gov/news2/fairfax-county-is-stepping-up-in-may/> [https://perma.cc/656M-GMY3].

108. See *Virginia Behavioral/Mental Health Dockets*, *supra* note 107; THOMPSON ET AL., *supra* note 53, at 3; see also Migliozi, *supra* note 3, at 65 (describing the management of the docket).

109. Migliozi, *supra* note 3, at 66 n.11.

110. ILPPP, *supra* note 6, at 7. The Norfolk Mental Health Court is a specialized docket that funnels mentally ill offenders into its program; it is not an independently operated or funded mental health court. See *id.*

111. CAMARENA, *supra* note 3, at 9; see also Migliozi, *supra* note 3, at 66 n.2 (defining Axis I).

112. CAMARENA, *supra* note 3, at 9.

113. *Id.*

114. *Id.* If a case does not satisfy admissibility criteria, it is then sent back to the circuit court. *Id.*

115. ILPPP, *supra* note 6, at 8; see CAMARENA, *supra* note 3, at 9.

116. See CAMARENA, *supra* note 3, at 10.

of guilt prior to program entry may be vacated and another disposition imposed instead, such as a dismissal of the charge or conviction of a lesser-included offense.¹¹⁷ The majority of defendants channeled into the Norfolk MHC were found to have committed minor property and drug crimes or minor assaults that were not premeditated and were manifestations of their underlying diagnosis.¹¹⁸

A hypothetical helps illustrate the process of entering mental health court. A defendant with paranoid schizophrenia may be arrested and jailed for ten misdemeanor fire code violations.¹¹⁹ His court-appointed attorney, recognizing his competence issues, requests a court-ordered evaluation, after which he is diagnosed as having paranoid schizophrenia and bipolar disorders but found competent to stand trial on anti-psychotic medications.¹²⁰ The court-appointed public defender and prosecutor meet to recommend his sentencing disposition.¹²¹ Taking into account the burden of providing incentives for the defendant to continue his prescribed medication, the need to assure stable housing for the defendant, and the need to find necessary outpatient services, the defendant and prosecutor jointly refer him to the mental health court or docket in that jurisdiction, assuming one exists.¹²² The mental health treatment team, after reviewing defendant's case and history, agrees that the defendant would be a good candidate for mental health court and forms a tentative treatment plan.

At the mental health court hearing, the defendant is given the option of continuing with regular trial in traditional court or of pleading guilty to all charges and deferring the final disposition during a twelve-month probationary period in mental health court treatment.¹²³ During this period, defendant would be released on bail and required to attend regular meetings with local community treatment providers, who would monitor his medication and psychiatric treatment.¹²⁴ After considering, the defendant opts to plead guilty and enter mental health court treatment, deferring sentencing for one year.¹²⁵ During this period, defendant returns to court

117. *Id.*; ILPPP, *supra* note 6, at 8. If a defendant does not comply with his or her treatment program, he or she is dropped from the program and sentenced in normal circuit court. CAMARENA, *supra* note 3, at 10.

118. *Id.* at 18.

119. Migliozi, *supra* note 3, at 64.

120. *Id.* at 64–65.

121. *See id.* at 65.

122. *See id.*

123. *See* ILPPP, *supra* note 6, at 7–8.

124. Migliozi, *supra* note 3, at 65.

125. *See* ILPPP, *supra* note 6, at 7–8.

periodically, at first weekly and eventually monthly, and his case manager reports to the mental health court judge on defendant's compliance with treatment.¹²⁶ Defendant is informed that violations of the treatment plan will result in an immediate violation hearing in the mental health court, potential revocation of his bond status, and conviction of the charges pending against him.¹²⁷ The case manager discusses with other members of the mental health treatment team defendant's compliance in taking prescribed medication and attending meetings with doctors, therapists and support groups; the team recommends changes throughout the course of the year to appropriately tailor the treatment plan.¹²⁸ The team also suggests appropriate actions to the judge to sanction and reward the defendant based on compliance, and the mental health court judge allots sanctions and incentives based on these suggestions and his or her own observation of the defendant's compliance with treatment.¹²⁹ At times, a short period of jail time—usually about a week—is sanctioned for noncompliance.¹³⁰

IV. COERCION AND PROCEDURAL JUSTICE

Engagement in treatment is “strongly related to the belief about the justice of the process by which the person was admitted.”¹³¹ This concept is often referred to as “procedural justice,” or “the perceived fairness of court procedure and [of] interpersonal treatment” as an individual interacts with the state in receiving coerced or compelled treatment.¹³² Carol Fisler, director of the Mental Health Court Programs at the Center for Court Innovation, describes this dynamic as:

126. *See id.* at 9.

127. Migliozi, *supra* note 3, at 65.

128. CAMARENA, *supra* note 3, at 15.

129. *See id.* at 12.

130. *Id.* at 4 (stating that over half of participants in the program for over nine months had been jailed at some point for noncompliance).

131. MERFISH, *supra* note 10, at 4; *see also* Sarah M. Manchak, Jennifer L. Skeem & Karen S. Rook, *Care, Control, or Both? Characterizing Major Dimensions of the Mandated Treatment*, 38 LAW & HUM. BEHAV. 47, 49 (2014) (discussing the potential for negative responses to feeling coerced into treatment); John Monahan, Charles W. Lidz, Steven K. Hoge, Edward P. Mulvey, Marlene M. Eisenberg, Loren H. Roth, William P. Gardner, & Nancy Bennett, *Coercion in the Provision of Mental Health Services: The MacArthur Studies*, in RESEARCH IN COMMUNITY AND MENTAL HEALTH: COERCION IN MENTAL HEALTH SERVICES—INTERNATIONAL PERSPECTIVES 13, 26–27 (Joseph P. Morrissey & John Monahan eds., 1999) (“[A] patient’s beliefs that others acted out of genuine concern, treated the patient respectfully and in good faith, and afforded the patient a chance to tell his or her side of the story, are associated with low levels of experienced coercion.”). “Procedural justice” is used here to refer to a participant’s subjective experience and perception of fairness in the case disposition process. Poythress et al., *supra* note 15, at 520.

132. Fisler, *supra* note 57, at 12.

[Q]uite different from distributive justice, or the perceived sense of the fairness of a final outcome (whether someone won or lost a case). . . researchers have demonstrated a strong connection between individuals' perceptions of procedural justice and their future attitudes and behavior . . . People who feel the legal system, and their own treatment within it, to be fair will internalize the values of the system, show greater compliance with court orders, and be less likely to re-offend.¹³³

Key factors affecting a person's perception of procedural justice in the civil or criminal system include: the level to which a person feels they have been treated with dignity by the authoritative decision-maker, the level to which a person feels they have a voice in the proceedings, whether that individual's express preferences are respected, the extent to which an individual is given decisional autonomy, and whether the proceedings feel neutral, unbiased, and consistent throughout treatment.¹³⁴ If an individual perceives the process through which a court mandates treatment as fair, that individual is more likely to engage within and comply in the subsequent therapeutic process.¹³⁵

State-compelled or coerced treatment can negatively affect treatment outcomes, undermining the client-provider relationship by "infusing an adversarial undercurrent into the process," thereby causing an individual to mistrust their treatment providers and the mental health system generally.¹³⁶ When an individual with a serious mental illness feels compelled or coerced to take part in treatment, that individual is more likely to resist treatment and less likely to engage in therapeutic goals.¹³⁷ Despite this, many states have authorized the use of incentives and disincentives to promote

133. *Id.* at 9, 12.

134. Monahan et al., *supra* note 131, at 26–27; Poythress et al., *supra* note 15, at 520; Fisler, *supra* note 57, at 12.

135. Poythress et al., *supra* note 15, at 521 ("[E]nhanced perceptions of procedural justice [are] . . . likely to facilitate the subsequent therapeutic process.").

136. MERFISH, *supra* note 10, at 3–4; Eric B. Elbogen, Jeffrey W. Swanson & Marvin S. Swartz, *Effects of Legal Mechanisms on Perceived Coercion and Treatment Adherence Among Persons with Severe Mental Illness*, 191 J. NERVOUS & MENTAL DISEASE 629, 635 (2003) (stating that studies indicate that some types of leveraging are "perceived as so coercive for some patients that they become mistrustful of the mental health system" and of treatment providers and drop out of services entirely).

137. Manchak et al., *supra* note 131, at 49; *see also* MERFISH, *supra* note 10, at 3–4 ("Mandated treatment has been linked to poorer clinical outcomes including non-adherence as well as an increased chance that mental health services consumers will be involuntarily committed in the future . . . There is some evidence that the disempowerment of individuals resulting from the coercive nature of the civil admission process prevents them from fully participating in any subsequent care rendered.").

adherence to treatment.¹³⁸ As Professors Bonnie and Monahan note, “[a]pproximately half the people receiving treatment in the public sector for mental disorder have experienced some form of ‘leverage’ in which deprivations such as jail or hospitalization have been avoided, or rewards such as money or housing have been obtained, contingent on treatment adherence.”¹³⁹ Though a more assertive approach may coerce treatment, treatment outcome is greatly affected by the way in which such treatment is mandated—*how* leverage is used and the effects of this on an individual’s perception of procedural justice in the treatment process.¹⁴⁰ Moreover, while early studies focused on the voluntary or involuntary nature of commitment as an indicator of subsequent treatment compliance, more recent studies demonstrate that “if anything, mandated treatment relationships are slightly more affiliative than voluntary ones.”¹⁴¹ In other words, some studies show mandated treatment relationships as having better treatment outcomes than those entered into voluntarily.¹⁴²

So how can this inform involuntary treatment in the civil and criminal contexts? Legal mechanisms determine the process afforded to an individual, as the state compels their treatment.¹⁴³ In turn, perceptions of the procedural fairness of these legal mechanisms can greatly affect compliance and resulting treatment outcomes.¹⁴⁴ Therefore, understanding what forms of leveraging are more likely to engender adherence in treatment and what forms of leveraging decrease compliance is crucial for informing treatment methods and outcomes.¹⁴⁵

Some amount of leveraging has actually been shown to improve treatment outcomes.¹⁴⁶ For instance, a meta-analysis of twenty-five studies of mental health courts found that treatment programs that were not entirely voluntary had higher rates of reduced recidivism

138. Bonnie & Monahan, *supra* note 11, at 485.

139. *Id.*

140. See Manchak et al., *supra* note 131, at 48–49.

141. *Id.* at 53 (showing that mandated treatment relationships scored slightly higher on pure affiliation with the therapist, affiliative autonomy felt, client pure affiliation, and affiliative submission to the treatment and therapy). *But see* MERFISH, *supra* note 10, at 3–4.

142. See *id.*

143. Elbogen et al., *supra* note 136, at 629.

144. See *id.* at 636.

145. See Monahan et al., *supra* note 3, at 37 (“It is unfortunate that instruments of therapeutic leverage, including incentives and disincentives as well as mandates, are not often mentioned in studies of interventions that aim to facilitate treatment adherence. Rectifying this omission is especially important in the context of mental health care.”).

146. See Michelle Edgely, *Why Do Mental Health Courts Work? A Confluence of Treatment, Support and Adroit Judicial Supervision*, 37 INT’L J. L. & PSYCHIATRY 572, 572 (2014).

than programs that were entirely voluntary.¹⁴⁷ Each study in the meta-analysis examined levels of voluntariness in rehabilitative programs for offenders with mental disorders, with programs designated as “voluntary, somewhat voluntary or involuntary.”¹⁴⁸ Programs designated as “somewhat voluntary” were found to have higher rates of reduced recidivism than completely voluntary and involuntary programs.¹⁴⁹ Thus, some amount of coercion positively correlated with adherence to treatment.¹⁵⁰ Because participation is leveraged with the alternative of incarceration in the mental health court model, the mental health court model falls into the category of “somewhat voluntary.” Offenders choose between participation in mental health court or mainstream case processing.¹⁵¹ While the leveraging involved in mandated treatment is often framed as coercive, for individuals with severe mental illness, whose choices are limited to begin with, offering the option of mental health court treatment often expands their already constrained range of choice.¹⁵² As researchers Scott and Stuntz explain, “[a] person with few and unpalatable choices may live in a coercive environment. An offer that exploits those circumstances is nevertheless value enhancing, and enforcement is appropriate. More choices are better, even—perhaps especially—if one has few to begin with.”¹⁵³ While coercive, mandated treatment can act to expand the range of choice for a person offered the option of mental health treatment court, rather than constricting that range.¹⁵⁴ Additionally, because social networks for incarcerated individuals are often very limited, service providers in mental health courts are more likely to be perceived as extremely “positive” individuals in that network.¹⁵⁵

In contrast, persons involuntarily committed in the civil system have access to a potentially wider social network; thus, outpatient treatment, though a less restrictive alternative to inpatient hospitalization, may not be perceived as expanding the range of choice for an individual who, if not at risk of being committed, would otherwise be free from the state’s influence in their medical decision-making.¹⁵⁶

147. *Id.* at 576.

148. *Id.*

149. *Id.*

150. *Id.*

151. *Id.*

152. See Bonnie & Monahan, *supra* note 11, at 487.

153. *Id.* (quoting R.E. Scott & W.J. Stuntz, *Plea Bargaining as Contract*, 101 YALE L.J. 1909, 1920 (1992)).

154. *Id.*

155. Manchak et al., *supra* note 131, at 54.

156. MERFISH, *supra* note 10, at 4.

Rather than feeling an expanded range of choice in the civil commitment system, patients often feel disempowered and voiceless in the process.¹⁵⁷ In part, this is because it is difficult for patients to appeal a commitment determination and “civil commitment law is not often subject to independent judicial review.”¹⁵⁸ Thus, appeals of decisions at a hearing are rare, often leaving participants feeling that they are without a voice in challenging any decisions made.¹⁵⁹

Ironically, adding more procedural requirements in efforts to enhance procedural fairness often does more harm than good.¹⁶⁰ Stricter civil commitment laws are correlated with higher rates of incarceration of mentally ill individuals.¹⁶¹ This is because the more steps involved in the civil commitment process, the less likely a person who is decompensating but refusing to be voluntarily admitted to a hospital will meet the criteria for involuntary commitment.¹⁶² As John Oliver points out in his article examining this, “Virginia’s requirement that there be probable cause for finding a ‘substantial likelihood’ of ‘harm’ before an ECO can be issued for a person [by a magistrate] . . . has been criticized” as too high of a bar in emergency situations, “preventing more timely intervention for someone . . . in crisis” who needs treatment but lacks awareness of their illness and refuses help.¹⁶³ Certain studies report mental health workers purposely re-incarcerating clients in order to get them to access mental health services, finding it “easier to access mental health treatment from the jail facility than to attempt involuntary commitment to a mental institution.”¹⁶⁴ Thus, adding procedural protections in the civil commitment process can have adverse effects, costing both time and resources, impeding access to needed mental health resources, and limiting the care available to individuals in emergency situations.¹⁶⁵ However, though adding procedural safeguards to the civil

157. *Id.*

158. *Id.* at 33.

159. *See id.*

160. *See* VA. COMM’N ON MENTAL HEALTH, *supra* note 78, at 44.

161. *See* Sarteschi, *supra* note 25, at 15–16.

162. *See id.*; *see also* VA. COMM’N ON MENTAL HEALTH, *supra* note 78, at 44 (pointing out that special justices “don’t want the headache” involved in ordering mandatory outpatient treatment (MOT)).

163. John E. Oliver, *Responding to Concerned Family Members During a Mental Health Crisis: Reflections on a Critical Incident*, 34 DEVS. IN MENTAL HEALTH L., Dec. 2015, at 1, 1–2, 5 (recounting a mother’s failed attempt to commit her daughter three days after her daughter was discharged from her fourteenth psychiatric hospitalization, the magistrate’s refusal to issue an ECO, and her daughter’s subsequent suicide).

164. Sarteschi, *supra* note 25, at 15–16.

165. *See* MERFISH, *supra* note 10, at 5; *see also* Samuel Jan Brakel, *Searching for the Therapy in Therapeutic Jurisprudence*, 33 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 455, 475 (2007) (“The U.S. Supreme Court, not known for endorsing the civil libertarian

commitment model may not result in better treatment outcomes, there are striking differences between the civil and criminal systems' compelled treatment models that can be used to inform procedural protections in the civil commitment process.

V. USING DIFFERENCES TO INFORM TREATMENT MODELS

Key factors differ in the criminal system versus the civil system that affect perceptions of procedural justice in each. These factors are: the range of choice and voice afforded to the participant in each system, the relationship of the participant with the judge in each model, and the expanded access to services in the mental health court model—services which are noticeably absent in the involuntary commitment model.¹⁶⁶ If incorporated into the civil commitment model, all three of these factors in the mental health court model could have positive effects on treatment outcomes in the civil commitment model.

A. *Relationship with the Judge*

The first and most important difference involves relationship development with a person in authority. Studies show that the relationship between the presiding judge and an individual can greatly affect treatment outcomes.¹⁶⁷ In a study of the progress of a cohort of program participants in Norfolk's Mental Health Treatment Court (Norfolk MHC), participants reported that the support they received from the presiding judge was crucial in helping them stabilize and that the close, ongoing supervision provided by case managers and regular meetings with the judge and probation officer were critical to compliance with conditional treatment plans.¹⁶⁸ This report is similar to findings in other therapeutic court models, with participants citing an ongoing relationship with the judge as critical to recovery.¹⁶⁹ For instance, the National Institute of Justice found in its study of therapeutic courts that "interactions with the drug court judge [was] one of the most important factors influencing participants' drug

agenda in mental health, has (unwittingly it would seem) contributed to discouraging access to psychiatric care by burdening even voluntary admissions with potentially heavy-handed procedural and/or substantive process requirements.").

166. See CAMARENA, *supra* note 3, at 28–29.

167. See *id.*

168. *Id.* at 3 (focusing on a cohort over a period of eighteen months in 2006 and 2007). This is affirmed by studies of participants in mental health treatment court in New York, who reported on the value to their overall treatment of direct conversations with the presiding judge in asking questions about their progress and problems. *Id.* at 29.

169. See, e.g., *id.* at 7, 29 (citing other such studies).

court experience.”¹⁷⁰ The Norfolk Mental Health Court study confirms the importance of this ongoing relationship with the judge, with Norfolk MHC participants citing as imperative to the process the support they received from the presiding judge and “the fact that [the judge] had continued to be supportive even when they had violated one of the conditions of their probation.”¹⁷¹

One of the most important features of the Norfolk MHC, reported as directly contributing to successful treatment outcomes, was that the judge gave people “second chances,” letting them remain in the program even if they were found out of compliance, so long as they maintained their commitment to their overall treatment plan.¹⁷² Comments by participants in the study indicated that the judge’s reputation for strict enforcement, combined with perceptions of fair treatment, gained their compliance with the program’s rules and regulations: participants knew that noncompliance would be sanctioned and knew that sanctions were applied consistently.¹⁷³ Comments also indicated that participants respected the judge’s decisions and felt personally accountable to the judge because of the ongoing relationship they had developed with that judge.¹⁷⁴ Having direct conversation with the judge, having the judge ask them about their progress, and having the judge care about the problems they were facing made participants feel respected and personally accountable to that judge.¹⁷⁵ Third-party observations of interactions between participants and the judge in the Norfolk MHC conducted over time confirm the significance of this relationship.¹⁷⁶ These observations found that initially, participants were often reserved, responding succinctly to the judge’s questions and seemingly not invested in treatment, but that over time, as the judge developed a relationship with participants, participants began to share more information with the judge in their mental health court, and consequently had more buy-in to the treatment program.¹⁷⁷

The relationship with a single judge rather than multiple authoritative figures also is key to whether such a relationship becomes a

170. *Id.* at 7.

171. *Id.* at 16.

172. CAMARENA, *supra* note 3, at 20.

173. *Id.* at 21.

174. *Id.*

175. *Id.* at 29.

176. *Id.*

177. *Id.* at 29 (“The change in the interaction between the male participants and the judge was particularly dramatic . . . regular interaction with a single judge also might be important because it promotes effective judicial supervision, continuity of monitoring, and consistency in practices and application of sanctions.”).

positive and influential factor in treatment outcomes.¹⁷⁸ Studies demonstrate that “the more judges [an] offender[] deal[s] with, the greater the likelihood of poor treatment attendance[]” and that, correspondingly, “[o]ffenders who participate in courts where there is only one judge are far less likely to be terminated early or to miss . . . treatment sessions than those exposed to multiple judges.”¹⁷⁹ Testimony of a mental health court judge in New York reinforces the importance of this personal connection, with the judge explaining that he interacted with participants as a way “‘to engage them human to human,’ and to compensate for the fact that they had been given short shrift all their lives and to give them hope.”¹⁸⁰

Judge Migliozi, a judge for the Norfolk General District Court mental health docket, noted that in the mental health court docket model in Virginia, the specialty docket procedure “provides an isolated and dignified opportunity for defendants’ family members to be present and to offer background information and suggestions to the court in an effort to determine an appropriate sentencing disposition.”¹⁸¹ It was this dignity and the privacy afforded to defendants in Virginia’s mental health court docket that the judge found most important in making the docket work.¹⁸² The judge went on to note “that family members in attendance provid[ed] the greatest service” to the mental health court docket and that the specialty docket allowed family members to do so in a way that avoided the embarrassment of personal issues being “paraded before a packed courtroom of less sensitive citizens.”¹⁸³

The civil commitment model lacks an equivalent ongoing relationship with the special justice involved in the hearing process.¹⁸⁴ It also lacks similar dignity-enhancing procedures.¹⁸⁵ This ongoing relationship with a single judge may be the single greatest difference affecting lower perceptions of procedural fairness in the civil commitment system. Although case managers and treatment teams provide ongoing, regular supervision in mandated outpatient treatment, there is no similar ongoing relationship with the judge mandating that treatment, and individuals often interact with a different special justice every time they are re-hospitalized and re-committed.¹⁸⁶ That

178. See CAMARENA, *supra* note 3, at 29.

179. *Id.*

180. *Id.*

181. Migliozi, *supra* note 3, at 65–66.

182. See *id.* at 65.

183. *Id.* at 65.

184. See MERFISH, *supra* note 10, at 27, 30.

185. *Id.* at ii, 11–12.

186. See CAMARENA, *supra* note 3, at 4; Scherer, *supra* note 26, at 428–29; Monahan et al., *supra* note 3, at 33.

there is not a comparable equivalent in the civil commitment model may play into the lowered perceptions of procedural justice reported in the civil commitment process, as participants do not have an ongoing relationship with an authoritative figure able to imbue the process with an attitude of impartiality and positive influence. Because there is no ongoing judge in the civil commitment model, it is also less likely that decisions regarding court-ordered treatment will be consistent over time for individuals compelled into treatment.

B. Access to Services

The second difference in treatment model between civil commitment and mental health treatment court involves access to services. Persons involved in mandated outpatient treatment often go through the same onerous process of hospitalization in order to receive emergency services every time they have a psychotic episode, stop taking medication, or are found out of compliance with treatment.¹⁸⁷ Moreover, individuals in the civil commitment system experience difficulty in gaining access to services each time they relapse.¹⁸⁸ In a survey of service providers in Virginia, many respondents reported that even if the civil commitment system worked more efficiently, their local community-based services would not be adequately prepared to handle additional cases if mandated outpatient treatment was ordered more frequently by the special justice in that jurisdiction.¹⁸⁹ For instance, respondents in the Norfolk Mental Health Court study reported difficulty in gaining access to more intensive residential treatment due to limited beds in public facilities and high costs at private facilities.¹⁹⁰ Lack of available resources in turn affected access to needed medications.¹⁹¹ Indeed, the study reported that for some participants, the only way to gain access to resources needed for treatment was through the local jail—and noticeably, not through the civil commitment process.¹⁹²

In contrast, once in the Norfolk Mental Health Court, participants had greater access to therapeutic and treatment services.¹⁹³ Greater access to services resulted in part because of connections of case managers, persons on the mental health court team, and the presiding judge with local treatment providers.¹⁹⁴ In other words,

187. See VA. COMM'N ON MENTAL HEALTH, *supra* note 78, at 44.

188. See Monahan et al., *supra* note 3, at 33.

189. VA. COMM'N ON MENTAL HEALTH, *supra* note 78, at 43.

190. CAMARENA, *supra* note 3, at 17.

191. *Id.* at 19.

192. *Id.* at 17.

193. *Id.* at 16.

194. *Id.* at 28.

participation in the Norfolk Mental Health Court allowed participants a better chance of accessing such services because of the collaboration between the circuit court and local community treatment providers—a much higher chance than trying to access such services on their own.¹⁹⁵ In some cases, the judge could “intervene to ensure that service providers responded to requests for assistance,” using his or her influence to ensure participants received treatment that, on their own, they would be unlikely to access.¹⁹⁶ When asked why they decided to participate in the Norfolk Mental Health Court, almost as many participants reported wanting access to services as those who reported not wanting to go to jail as their primary motivation.¹⁹⁷

While in the mental health court model, the presiding “judge’s interpersonal skills and ability to resolve legal problems expeditiously and to facilitate access to services”¹⁹⁸ enabled treatment to continue even when participants fell out of compliance, an equivalent figure with the capacity to expediate re-entry into treatment after non-adherence is noticeably lacking in the civil commitment model. Because of the lack of a figure that provides continuity in an individual’s treatment plan and monitoring over time, services are harder to access in the civil commitment model, efficiency impeded, and consistency lacking in each run-in with the civil commitment system.¹⁹⁹

It should be pointed out that lack of access to resources can provide reverse incentives. For instance, concerns have been raised over the channeling of individuals with serious mental illness into the criminal justice system due to lack of stable placement or services upon release.²⁰⁰ The Bazelon Center has noted “the potential of mental health courts to encourage arrest as a strategy for accessing mental health services that are not otherwise available”²⁰¹ and the temptation of sentencing a person with acute mental health issues to the maximum time when they otherwise would not have been in order to coerce participation in mental health court treatment over routine criminal processing.²⁰² While beyond the scope of this Article, this issue is noteworthy, as are the efforts that have been made to address these patterns.²⁰³ This Article focuses instead

195. *Id.*

196. CAMARENA, *supra* note 3, at 28.

197. *Id.* at 15 (reporting 8 and 10 out of 23, respectively).

198. *Id.* at 29.

199. *See id.* at 29 (discussing the importance of judicial interactions).

200. Bonnie & Monahan, *supra* note 11, at 492.

201. *Id.* at 492; see Susan Stefan & Bruce J. Winick, *A Dialogue on Mental Health Courts*, 11 PSYCH., PUB. POL’Y & L. 507, 519–20 (2005).

202. Bonnie & Monahan, *supra* note 11, at 493; see also Sarteschi, *supra* note 25, at 42 (noting that over half of the twenty MHCs studied required a guilty or no contest plea as a condition of participation in the MHC program).

203. *See* INST. OF L., PSYCH. & PUB. POL’Y AT UNIV. OF VA., *The SJ 47 Subcommittee to*

on what occurs after an individual has been funneled into the system via civil commitment or mental health court as an alternative to incarceration.

C. Choice Afforded in the Process

The third factor that differs between the models is the range of choice and voice afforded in each process. One factor adding to the disempowerment and voicelessness patients often feel in the civil commitment process is bias on the justice's part in civil commitment hearings.²⁰⁴ This concept, often referred to as the "attitudinal predilections" of special justices, may contribute to the lack of choice or voice felt by participants in the civil commitment process, reinforcing feelings of disempowerment and constriction.²⁰⁵ For instance, a study of special justices presiding over civil commitment hearings in Virginia revealed that many special justices entered into the hearings with a strong predilection that commitment would result, holding cursory hearings as a matter of procedure but interacting little with the individual or with treatment providers in reaching the decision.²⁰⁶ While some special justices required second evaluations of the patient and engaged in more extensive questioning of the community treatment providers and the patient, others reportedly entered the hearing process and performed no additional evaluations or mental health screenings of the individual; instead they proceeded with the hearing soon after the temporary detaining order was ordered and before the individual had a chance to stabilize and opt for voluntary treatment.²⁰⁷

Added to this, few special justices offered opportunities throughout the hearing for the patient to choose to commit him or herself voluntarily, although this legal mechanism is available and could operate to expand the range of choice for that individual.²⁰⁸ Instead,

Study Mental Health Services in the Commonwealth in the 21st Century, 34 DEVS. IN MENTAL HEALTH L., Dec. 2015, at 6, 8–9 (recounting challenges presented by the large number of individuals with serious mental illness in Virginia jails and prisons and experts' recommendations on ways to divert such persons from the criminal justice system into treatment).

204. See MERFISH, *supra* note 10, at 32.

205. See *id.*

206. *Id.* at 30 & n.140 (noting information gathered from surveys of fifteen special justices from areas with high rates of involuntary commitment).

207. See *id.* at 30 & n.141 (noting information gathered from surveys of thirteen justices from areas with low rates of involuntary commitment); see also VA. COMM'N ON MENTAL HEALTH, *supra* note 78, at 44 (describing how some justices find the statutes for mandated outpatient treatment to contain too many complicated steps).

208. See MERFISH, *supra* note 10, at 8, 30, 33. The counties in Virginia in which MOTs

many justices offered the option of voluntary commitment merely as a matter of procedure and only at the beginning of the hearing, which, if it occurred on the heels of the temporary detaining order, gave the individual little time to become receptive to the idea of voluntarily receiving treatment.²⁰⁹ Because of the attitudinal predilection of many justices at these hearings and the lack of procedure through which to appeal decisions once made, many patients viewed the commitment process as arbitrary and disempowering, completely dependent on the special justice in their jurisdiction, and without recourse if decided incorrectly.²¹⁰ These factors ultimately contribute to lowering levels of perceived procedural fairness in the civil commitment system.

In contrast, judges in mental health treatment courts often provided opportunities not only for participants themselves to have a voice in the process, but for their family members to also provide background information and suggestions to the court in an effort to determine the best course of treatment and sentencing disposition for each participant.²¹¹ Having direct conversations with the judge, having the judge ask them about their progress, and having the judge care about the problems they were facing made participants feel respected and personally accountable to that judge, and in turn made participants feel like they had a voice in their mental health treatment and progress.²¹²

It should be noted that although mandated treatment can act to expand the range of choice for a person who opts for mental health treatment court in the criminal justice system as an alternative to incarceration or other punishment, this is rarely true for a person involuntarily committed via the civil system, who, but for such commitment, would otherwise be free from the state's influence in their decision-making.²¹³ However, the extreme limitations, rather than expansions, put on a person's choice in the civil commitment process can at least be mitigated by ensuring that the judges presiding over their civil commitment hearings do not have a predilection towards one outcome, but instead come into the hearing with no "attitudinal predilection" towards commitment—or at least with a semblance of outward neutrality so that persons facing involuntary commitment do not believe that the outcome has been decided

are ordered more frequently report that "[w]ith few exceptions, clients who are under [Mandated Outpatient Treatment] orders . . . [are] very cooperative with treatment." VA. COMM'N ON MENTAL HEALTH, *supra* note 78, at 45.

209. See MERFISH, *supra* note 10, at ii, 8, 30.

210. See *id.* at 4, 32–33.

211. Migliozi, *supra* note 3, at 65.

212. CAMARENA, *supra* note 3, at 29.

213. See Bonnie & Monahan, *supra* note 11, at 487.

before they have had a chance to say a word.²¹⁴ At the very least, individuals facing involuntary civil commitment should be given the chance at their hearing to provide information on their own background, to have family members to speak on their behalf, and to be presented the option of voluntary buy-in to treatment at multiple points throughout the process.

VI. RECOMMENDATIONS

Borrowing from the successes of the mental health treatment court model, this Article recommends the following changes to the mandated outpatient treatment model:

(1) Make efforts to have the same special justice assigned to an individual who is frequently hospitalized under a temporary detaining order in order to provide continuity in commitment hearings over time. Make concerted efforts to have the same special justice preside at each civil commitment hearing for that individual so that the individual can establish an ongoing relationship with that special justice, enabling the individual to feel personal accountability to the judge in complying with treatment and shifting that individual's perceptions of procedural justice in the civil commitment process over time. Having the same special justice involved in each hearing can allow a patient to develop an ongoing relationship with a single special justice, making them more likely to view that authoritative figure as a positive influence, to engage in treatment, and to feel personal accountability for relapses in treatment compliance. Having the same special justice involved in each hearing also increases the likelihood of consistency in decision-making, and thus it may improve that individual's perception of procedural fairness in the civil commitment process, making them more likely to comply with mandated treatment.

(2) Allow an individual multiple opportunities throughout the temporary detaining order period and the civil commitment hearing process to choose to commit him or herself voluntarily. The opportunity should be afforded to an individual immediately before the hearing, at different points throughout the hearing, and immediately before a final order of involuntary commitment, thus giving an

214. See MERFISH, *supra* note 10, at 32–33.

individual multiple opportunities to become open to the possibility of voluntarily complying with treatment, expanding that individual's range of choice, and allowing him or her more of a voice throughout the process.

While the complexities of mandated mental health treatment in both the civil and criminal systems cannot be compounded into quick solutions or simple fixes, procedural mechanisms and treatment methods in the mental health court model can inform the civil commitment model. Allowing individuals a greater voice and expanding range of choice in the civil commitment process can lead to improved perceptions of procedural justice, thereby increasing engagement in treatment. Additionally, establishing mechanisms for an ongoing relationship with the special justice involved in each civil commitment hearing of an individual can allow for a more positive relationship to develop with the authoritative decision-maker, for more consistency in decision-making regarding treatment, and consequently, for higher levels of perceived procedural fairness and buy-in of that individual. The single, most critical factor shown in the mental health court treatment model that engenders compliance and effects positive treatment outcomes for persons with serious mental illness is the ongoing relationship with a single judicial figure.²¹⁵ Thus, having one special justice preside over all civil commitment hearings for that individual in the civil commitment process is likely to improve an individual's compliance with treatment over time. Enabling this ongoing relationship is the single greatest step that can be taken to improve the civil commitment process and effectuate more positive treatment outcomes, decreasing the number of individuals entering the revolving doors of the civil system over time.

215. CAMARENA, *supra* note 3, at 28–29.