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Adam G. Gerhardstein

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COMMENT

A FIRST EPISODE STANDARD FOR INVOLUNTARY TREATMENT

ADAM G. GERHARDSTEIN*

INTRODUCTION

When I was 21, my senior year of college was interrupted by a psychotic manic episode—my first and so far only manic episode while living with bipolar disorder. Like many people experiencing mania or psychosis for the first time, it had its way with me. Every aspect of my life was detrimentally affected by my episode—my relationships, education, and financial assets. But as my life imploded around me, I saw nothing wrong with my behavior or me. Everything made sense to my manic mind, but it did not make sense to others, no matter how much energy and passion I put into my explanations.

My manic episode came to an abrupt halt after I was involuntarily hospitalized and slammed onto a stark hospital bed, secured in four-point restraints. The silent room muffled my roars, and the restraints withstood my violent struggle against them. Hospital staff patiently but firmly challenged my scornful resolve until I kept the pills in my mouth and swallowed. Medicated and restrained, I fell asleep for the first time in 144 hours (six full days and nights). Twenty-four hours later, I woke up in a semi-conscious state and began the lifelong journey of living with a mental illness.

For a long time, being strapped to that bed was the most traumatic experience of my life. But time has a way of rewriting history. With eight years of perspective, that trauma has morphed into gratitude. Without that intervention, I may have never been able to accomplish what I have since—regain my health, build a successful career, marry a woman of gold, and make the dean's list in law school. Now, when I look back on my hospitali-

* Juris Doctor, University of St. Thomas School of Law, 2013. Acknowledgements: This article grew out of a conversation with Mindy Greiling. It was nurtured by the insights and support of George V. Babolia, Dr. S. Charles Schulz, Judge Jay M. Quam, Eric S. Janus, Julie Oseid, Valerie Aggerbeck, as well as my parents, Mimi Gingold and Al Gerhardstein, and my wife, Meredith S. Hicks. Contact: adam.gerhardstein@gmail.com.

zation, I am only haunted by what happened before I was involuntarily hospitalized.

My parents, sister, and girlfriend pled with me to go to the hospital, but I would not budge from my apartment. I was extremely manic, having not slept for four days and four nights. My family called the police, but when the police officers arrived at my apartment they knew little about mental illness and had no reason to think I was dangerous, so they left. In Ohio, and everywhere else in the United States, if a mentally ill person poses no risk of physical harm, then the state will not intervene. Soon after the police left, in a manic rage, I hit my mother in the face.

I still remember the sudden thud of my manic hand against her panicked face. That memory will forever haunt me.

I have since learned that becoming violent—hitting my mom—gave me a sure-fire ticket to treatment. I was dangerous. In every state in the nation, I met the standard for involuntary hospitalization. After my parents begged, bribed, and wrestled me to the hospital door, I was admitted and I got treatment. My life depended on that treatment and hitting my mom ensured that I got it.

My experience is not unique. Many parents, in the midst of their child's first episode, have taken blows, or worse, before they could get their child treatment.

This paper proposes a new standard for involuntary treatment,¹ one that does not include a requirement of physical harm. Instead, I am proposing a standard that allows for involuntary treatment when an individual is experiencing their first major episode² of a psychiatric disorder. Specifically, the first-episode standard would allow for the involuntary treatment of individuals who are (1) over 18; (2) mentally ill (the presence of a mental disorder that diminishes a person's ability to reason, resulting in an impairment of functioning³); and (3) have never received psychiatric treatment for the disorder.

The first-episode standard would have three major benefits. First, it would soften the trauma of a first episode, assisting families in their at-

1. "Involuntary treatment" is the term I use to encompass both involuntary commitment to an inpatient facility and court-ordered outpatient treatments.

2. "First episode" is the term I use to describe the initial manifestation of a mental illness; for example, bipolar disorder would first manifest through a manic or hypomanic episode, and schizophrenia through a psychotic episode. The most common age-of-onset for mental disorders is during an individual's teenage years or her twenties. Ronald C. Kessler et al., *Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication (NCSR)*, 62 GEN. PSYCHIATRY 593, 595 (2005).

3. The definition of "mental illness" in the involuntary treatment statutes of all fifty states contains those three basic elements: (1) the presence of a mental disorder that (2) diminishes a person's ability to reason, (3) resulting in an impairment of functioning. For statutory definitions from all fifty states and the District of Columbia, see BRUCE J. WINICK, *CIVIL COMMITMENT: A THERAPEUTIC JURISPRUDENCE MODEL*, 75–78 (Carolina Academic Press, 2005).

tempts to intervene before their loved ones' lives are in complete disarray and their episode escalates to the point of violence. Second, it would expand access to early, effective treatment, giving an individual experiencing their first major episode the best chance for a healthy long-term prognosis. Finally, it would reduce the number of future hospitalizations, the most expensive form of psychiatric treatment, consequently reducing the health care costs paid by government programs, which pay for the majority of psychiatric hospitalizations nationwide.

Psychiatry has identified first episodes as a major turning point in the lives of individuals with mental illnesses. A first episode marks the onset of a major psychiatric disorder. A first manic or depressive episode leads to a diagnosis of bipolar disorder or depression, and a first psychotic episode usually leads to a diagnosis of schizophrenia. Psychiatric literature is saturated with studies concerning first episodes.⁴ Advocacy groups for the mentally ill and their families conduct surveys about their experiences during first episodes.⁵ Hospitals set up psychiatric treatment programs to specifically treat first episodes.⁶ Books have been written to help patients and their families deal with first episodes.⁷ Despite these advances in other areas, the law and legal literature is nearly devoid of references to first episodes. In fact, after searching through hundreds of law review articles, statutes, and legal books, I have only seen first episodes discussed in one article⁸ and one book,⁹ both written by one legal scholar: Ms. Elyn R. Saks.

Like me, Saks has a mental illness and has received involuntary treatment.¹⁰ She is currently a renowned legal scholar at the University of Southern California Gould School of Law specializing in mental health law.

4. See, e.g., Katherine N. Thompson, Patrick D. McGorry & Susan M. Harrigan, *Reduced Awareness of Illness in First-Episode Psychosis*, 42 COMPREHENSIVE PSYCHIATRY 6, 498–503 (2001); see also Mauricio Tohen et al., *Baseline Characteristics and Outcomes in Patients With First Episode or Multiple Episodes of Acute Mania*, 71 J. CLIN. PSYCHIATRY 3, 255–61 (2010).

5. See, e.g., NATIONAL ALLIANCE ON MENTAL ILLNESS, FIRST EPISODE: PSYCHOSIS: RESULTS FROM A 2011 NAMI SURVEY (2011) [hereinafter NAMI, FIRST EPISODE], available at <http://www.nami.org/FirstEpisode/firstepisodesurvey.pdf>.

6. See, e.g., UNIVERSITY OF MINNESOTA MEDICAL CENTER, FAIRVIEW, FIRST EPISODE PSYCHOSIS PROGRAM, www.uofmmmedicalcenter.org/Specialties/Behavioralhealth/First-Episode-Psychosis/ (last visited Sept. 13, 2012).

7. See MICHAEL T. COMPTON & BETH BROUSSARD, *THE FIRST PSYCHOSIS: A GUIDE FOR PATIENTS AND THEIR FAMILIES* (2009).

8. See Elyn R. Saks, *Involuntary Outpatient Commitment*, 9 PSYCHOL. PUB. POL'Y & L. 94 (2003).

9. See ELYN R. SAKS, *REFUSING CARE: FORCED TREATMENT AND THE RIGHTS OF THE MENTALLY ILL* (2002).

10. After becoming a leading legal scholar, Saks published a memoir, *The Center Cannot Hold: My Journey Through Madness*, discussing her journey with schizophrenia. She struggled with the decision whether to expose her illness, but the memoir was warmly received, and it earned her a \$500,000 McArthur Foundation “genius” award, which she used to create the Saks Institute for Mental Health Law, Policy, and Ethics. See Benedict Carey, *Memoir About Schizophrenia Spurs Others to Come Forward*, N.Y. TIMES (Oct. 22, 2011), available at <http://www.nytimes.com/2011/10/23/health/23livesside.html>.

Buried in the middle of her book, *Refusing Care*, is a discussion of a standard allowing hospitalization on the first episode, regardless of whether the individual poses a threat of physical harm.¹¹ In a later article, she proposes a closely related “one-shot rule” to allow one course of involuntary outpatient treatment for individuals after multiple hospitalizations.¹² Her proposals are both premised on Alan Stone’s “thank you” theory of civil commitment, which proposes “that without treatment the patient will deteriorate and, never having realized the benefits of treatment, will never appreciate that he would really like it.”¹³ Her proposals would allow individuals to get inpatient involuntary treatment during their initial mental health crises, and if they later become non-compliant with treatment, to get one course of involuntary outpatient treatment to experience living in the community while being treated. Saks’s work was published in 2002 and 2003, but failed to trigger a larger discussion. In fact, I could not find a single notable scholarly response, and when I spoke with Saks, she was also unaware of any response to her work.¹⁴

Saks’s work theorizes why early intervention is warranted during a first episode. My Comment differs significantly in style and substance. I largely avoid the theoretical reasons for adopting a first-episode standard, focusing instead on the individual, social, medical, and political reasons. Most notably, I discuss a first-episode standard in practice—its language and application within the current mental health landscape. However, our work is complimentary, and given the paucity of legal discussion of this topic, would be most valuable if read in tandem.

Section I of this Comment briefly discusses the medical, legal, and systemic changes in the mental health field over the last fifty years. Section II discusses the unique characteristics of a first episode. Section III is the

11. SAKS, *supra* note 9, at 56–68.

12. Saks, *supra* note 8, at 95.

13. SAKS, *supra* note 9, at 59; *see also* Saks, *supra* note 8, at 100.

14. Saks’s proposal is so buried in the dominant debate that I only discovered it near the end of writing my first draft. As a result, I developed my own language describing our shared idea, and this article is not written as a response to her work or as an expansion upon it. Once I discovered her work, I called her on July 30, 2012, and she verified that as far as she knew her proposal had never sparked a larger discussion. The idea of a first episode standard came to me from Mindy Greiling, a Minnesota State Representative, who has worked to reform involuntary treatment laws since her son had his first psychotic episode in 1999. When I met with her on June 21, 2012, she knew of no one who had seriously discussed a first episode standard. Over the next three weeks, to further develop the idea, I spoke with professionals involved in almost every stage of the involuntary treatment process: George V. Babolia, the Director of Social Work Services at the University of St. Thomas Interprofessional Center and a clinical social worker who does assessments in a Minnesota emergency room for involuntary hospitalizations; Dr. S. Charles Schulz, Psychiatrist and Head of the University of Minnesota’s Department of Psychiatry; Judge Jay M. Quam, Minnesota District Court Presiding Judge of Hennepin County’s Mental Health Court; Eric S. Janus, former Managing Attorney of Minneapolis Legal Aid Society and currently Dean of William Mitchell School of Law specializing in civil commitment scholarship. Their insights were invaluable.

most important section as it defines the first-episode standard, and discusses how it could be integrated into most states' involuntary treatment delivery systems. Section IV addresses some therapeutic and legal concerns that may be raised by the first-episode standard. The conclusion calls for further discussion and, ultimately, the adoption of the first-episode standard.

I. INVOLUNTARY TREATMENT STANDARDS ARE CHANGING

The seismic shifts in mental health and involuntary treatment of the last fifty years were never clearer to me than when Minnesota State Representative Mindy Greiling told me her personal story.¹⁵ When Mindy was in fifth grade, in 1958, her grandmother was sent to Minnesota's Rochester State Hospital to be treated for schizophrenia. To this day, Mindy remembers dreaming of getting her grandmother out of that asylum. Forty-one years later, in 1999, Mindy's son had his first psychotic episode and she struggled to get him involuntarily committed. Instead of dreaming about getting a loved one out of a hospital, Mindy found herself fighting to get a loved one in. Having recently been elected to the state legislature, Mindy returned to her post, organized her colleagues, and effected a change in Minnesota's legal standards for involuntary treatment to hopefully make it easier for mentally ill individuals to get effective treatment.¹⁶

Medical, legal, and systemic treatment of mental illness has shifted dramatically over the last fifty years. Advances in medication and psychotherapy have allowed more and more people with mental disorders to live their lives relatively symptom-free and without dramatic side effects.¹⁷ The state-run mental hospitals of the 1950s and 60s have been largely emptied, dispersing many people into the community, re-institutionalizing many

15. Conversation with Mindy Greiling on June 21, 2012 (her story is shared here with her permission).

16. Greiling and her colleagues amended MINN. STAT. § 253B.02 in the first special session of 2001 as follows:

Subd. 13. [MENTALLY ILL PERSON.] (a) "Mentally ill person" 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 to substantial property.

Act effective July 1, 2002, 2001 Minn. Sess. Law Serv. 1st Sp. Sess. Ch. 9 (S.F. 4). Available in this form at: <https://www.revisor.leg.state.mn.us/laws/?doctype=Chapter&year=2001&type=1&id=9> (last visited Oct. 1, 2012).

17. RICHARD G. FRANK & SHERRY A. GLIED, *BETTER NOT WELL: MENTAL HEALTH POLICY IN THE UNITED STATES SINCE 1950*, 26-47 (2006).

others in nursing homes and prisons, and leaving some homeless.¹⁸ Coinciding with this shift was the rise of health insurance programs, particularly Medicare and Medicaid. These two factors shifted the entire mental health system from “a centralized planned activity run by the states to a pluralistic, market-oriented system of care.”¹⁹ This shift has not gone without criticism:

The consequence has been to exchange a set of bureaucratic failures and tight budgets that took responsibility for all care for a circumscribed population for a vastly richer, decentralized system of care that suffers from market failure and allows some people with significant impairments to fall through the cracks.²⁰

Among the forces driving these changes was a slew of class-action litigation resulting in a number of Supreme Court decisions regarding the civil commitment of people with mental illness.²¹ Responding to egregious cases of institutional abuse and mismanagement, the Court addressed due process protections for individuals involuntarily confined in mental health facilities,²² the nature and duration of civil commitments,²³ the standard of proof in civil commitment hearings,²⁴ and the confinement of non-dangerous individuals with mental illness.²⁵ As these decisions rippled through state legislatures and treatment facilities, civil commitment shifted from a medical model that allowed psychiatrists and physicians to “commit patients based upon an assessment of whether the best interests of the patient required care and treatment in hospitals,” to a legal model “that specified more restrictive standards for commitment and imposed procedural requirements for its involuntary application.”²⁶

As part of this trend, the fifty states reformed their standards for involuntary treatment. Generally accepted legal theory provides that civil commitment is justified by the government’s *parens patriae* and police powers.²⁷ Under its *parens patriae* powers, the state has a legitimate interest in providing care to individuals who cannot care for themselves; under its police powers, the state can protect the community from potential dangers.²⁸ Thus, the legal standards for civil commitment determine how

18. *Id.* at 1–5.

19. *Id.* at 69.

20. *Id.*

21. See Alison Pfeffer, Note, “Imminent Danger” and Inconsistency: The Need for National Reform of the “Imminent Danger” Standard for Involuntary Civil Commitment in the Wake of the Virginia Tech Tragedy, 30 *CARDOZO L. REV.* 277, 283–89 (2008), for a concise overview of these holdings.

22. See *O’Connor v. Donaldson*, 422 U.S. 563 (1975).

23. See *Jackson v. Indiana*, 406 U.S. 715 (1972).

24. See *Addington v. Texas*, 441 U.S. 418 (1979).

25. See *Zinermon v. Burch*, 494 U.S. 113 (1990).

26. WINICK, *supra* note 3, at 4.

27. 53 *AM. JUR.* 2d *Mentally Impaired Persons* § 7 (1996).

28. Eric S. Janus, *Hendricks and the Moral Terrain of Police Power Civil Commitment*, 4 *PSYCHOL. PUB. POL’Y & L.* 297, 303 (1998).

broadly the courts will interpret inability to care for oneself and danger to the community. In the wake of the class-action litigation of the 1970s, states drew tighter boundaries around their *parens patriae* and police powers. In many cases, this resulted in civil commitment standards requiring that a person pose an imminent danger to themselves or others before they could be involuntarily treated.²⁹

Almost all states have now broadened their standards beyond imminent danger.³⁰ Currently, “most state involuntary civil commitment laws regard a serious or substantial ‘risk’ or ‘likelihood’ of harm to self or others as sufficient.”³¹ Other states have significantly broadened the application of their *parens patriae* powers, allowing for involuntary treatment when individuals are “gravely disabled,” meaning they cannot care for their basic needs, or when they have a need for medical treatment (not including psychiatric treatment) and are not seeking it out.³² In still other states, individuals can be given involuntary treatment if they harm property.³³ The one thread that ties these various involuntary treatment standards together is that they all require courts to justify involuntary treatment by the potential of physical harm—whether that is bodily harm to another person, threats to the medical health of the person with the mental illness, or harm to physical property.

It is well known that mental illness can cause some individuals to seriously neglect their own physical health or, more rarely, become violent towards others.³⁴ There is no doubt that intervention is appropriate in those cases. But, even if an individual does not threaten any sort of physical harm, her mental illness can still unravel her life and destroy her future, especially if she does not see her illness coming. That is the problem a first-episode standard—requiring a need for treatment and not a likelihood of physical harm—could help address.

II. FIRST EPISODES OF MENTAL ILLNESS ARE LEGALLY RECOGNIZABLE AND CRITICAL TO AN INDIVIDUAL’S PSYCHIATRIC PROGNOSIS

In this section, I will first argue that the law has an episodic view of mental illness, giving it an inherent ability to recognize first episodes. Then, I will argue that if the law were to recognize first episodes it could play an

29. The legal evolution of civil commitment standards is discussed more below in section IV(B)(1), but an example of an “imminent danger” standard is still the law in Georgia, where a person must “present a substantial risk of imminent harm to that person or others” to be civilly committed. GA. CODE ANN. § 37-3-1(9.1) (2010).

30. Pfeffer, *supra* note 21, at 289–93.

31. *Id.* at 289.

32. WINICK, *supra* note 3, at 99–100.

33. See MINN. STAT. § 253B.02, subd. 13 (2010).

34. The vast majority of individuals having psychotic episodes do not become violent in any way. See Matthew M. Large & Olav Nielssen, *Violence in First-Episode Psychosis: A Systemic Review and Meta-Analysis*, 125 SCHIZOPHRENIA RES. 214 (2011).

important role in addressing the unique individual, social, medical, and political effects of first episodes.

A. *The Law Already Has an Episodic View of Mental Illness*

Today, in every state, a person must meet three general requirements to be given involuntary mental health treatment: (1) an age requirement, usually 18; (2) the person must be mentally ill; and (3) the person must be causing harm or likely to cause harm to themselves, someone else, or property.³⁵ Of these three requirements, the third gets the most attention from lawyers, scholars, physicians, legislators, and people personally affected by involuntary treatment, but for the vast majority of people the first two requirements are the most important. The age and mental illness requirements create a proportionally tiny class of people who could even conceivably be involuntarily committed—adults who are mentally ill. Minors are excluded from this definition because even if they refuse mental health treatment they can be “voluntarily” admitted to a psychiatric hospital by their parents or by the state when the child is a state ward. This is because “[m]ost children, even in adolescence, simply are not able to make sound judgments concerning many decisions, including their need for medical care or treatment. Parents can and must make those judgments.”³⁶ Of adults in the United States, ninety-seven to ninety-nine percent will never qualify for involuntary treatment because they will never fit the statutory definitions of people who are mentally ill.³⁷ Statutory definitions of mental illness are simple, yet profound, and it is within them that I discovered something no legal scholar has discussed before—the law’s episodic view of mental illness.

Statutory definitions of mental illness vary from state to state but the core elements are always (1) the presence of a mental disorder that (2) diminishes a person’s ability to reason, (3) resulting in an impairment of functioning.³⁸ For example, in Ohio, where I was involuntarily hospitalized, mental illness has a thirty-one word definition: “Mental illness means a substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life.”³⁹

35. For excerpts from all fifty state statutes, see TREATMENT ADVOCACY CENTER, STATE STANDARDS FOR ASSISTED TREATMENT: CIVIL COMMITMENT CRITERIA FOR INPATIENT OR OUTPATIENT PSYCHIATRIC TREATMENT, 1–85 (2011), available at www.treatmentadvocacycenter.org/storage/documents/Standards_-_The_Text_-_June_2011.pdf.

36. Parham v. J.R., 442 U.S. 584, 603 (1979).

37. Studies of prevalence of mental illness vary widely, but those that take into account individuals’ functioning, which is one component of statutory definitions and considered to be a differentiating element between mental illness and severe mental illness, indicate that somewhere between 1% and 2.8% of the population could potentially fit statutory definitions of mental illness. FRANK & GLIED, *supra* note 17, at 20.

38. See WINICK, *supra* note 3, at 75–78, for statutory definitions from all fifty states and the District of Columbia.

39. OHIO REV. CODE § 5122.01(A) (2012).

In clinical settings, much greater attention is given to the definition and description of mental illnesses. Clinicians—such as psychiatrists, psychologists, counselors, therapists, or nurses—do not look to state statutes to define and diagnose mental illness. Instead, they most commonly rely on the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) published by the American Psychiatric Association.⁴⁰ Its diagnoses are long and nuanced. For example, in order to make a diagnosis of Bipolar I Disorder, a clinician must be able to make sense of almost 14,000 words describing the various behavioral phenomena that the clinician may be observing from a patient.⁴¹ Bipolar I Disorder is only one of 297 disorders described within the DSM-IV. Although legal definitions of mental illness are substantially shorter and less nuanced than clinical definitions, the law’s understanding of mental illness is actually quite insightful.

For clinical purposes, I have been mentally ill since I was hospitalized in 2004. But according to Ohio law, 2004 was the last time I was mentally ill—it was only during my manic episode that I met the statutory definition of a person with a mental illness. This is why I say the law has an episodic view of mental illness.

According to the DSM-IV, “Bipolar I Disorder is characterized by the occurrence of one or more manic episodes or mixed episodes.”⁴² A manic episode is a “distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least one week (or any duration if hospitalization is necessary).”⁴³ A selection of symptoms (such as grandiosity, decreased need of sleep, pressured speech, or distractibility) must be observed in order for this distinct period to be characterized as a manic episode.⁴⁴ That distinct period of time—that episode—is the prerequisite for being diagnosed with bipolar disorder, and that diagnosis is a prerequisite to a lifetime of mental health treatment to prevent or extinguish future episodes. Clinically, I am always viewed as a person with a mental illness. With that label, I gain access to the medications I need to stay healthy and stay out of the hospital—at least when my psychiatrist is making his diagnosis based on the DSM-IV and not the Ohio Revised Code.

Like other states, the core components of Ohio’s definition of mental illness are (1) the presence of a mental disorder that (2) diminishes a person’s ability to reason, (3) resulting in an impairment of functioning.⁴⁵ Even

40. AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed. 2000). The fifth edition of the DSM was released in May 2013 during the revision phase of this article. Its changes to the portions discussed here were not expected to be significant.

41. See *generally id.* at ch. 6.

42. *Id.*

43. *Id.*

44. *Id.*

45. See WINICK, *supra* note 3, at 75–78, for statutory definitions from all fifty states and the District of Columbia.

if I have had a “mental disorder” since my diagnosis with bipolar disorder in 2004, it has not since diminished my ability to reason or impaired my functioning to the point where I would meet this statutory definition. As a result, the law would not label me as a person with a mental illness.

Consequently, as I write this, I meet the psychiatric diagnostic criteria for a person with a mental illness, but I do not meet the statutory criteria for a person with a mental illness. This contradiction signals the different interests of psychiatry and the law.

With treatment, most people diagnosed with schizophrenia, bipolar disorder, or major depression are not psychotic, manic, or depressed; they are at work or at school living healthy lives like everyone else. Psychiatry is concerned with these people, but the law is not. Psychiatrists and other clinicians want to make sure these people stay healthy, so they monitor little blips on the radar and make treatment adjustments as necessary. But occasionally, things go wrong. Individuals with mental illness may not adhere to their treatments or their illness is triggered by something they cannot control, and they have an episode. Episodes are the manifestations of severe mental illnesses and they come in many different varieties that clinicians have described thoroughly.⁴⁶ Usually it is psychotic, manic, and major depressive episodes that lead to involuntary treatment.

Psychosis, mania, and major depression are extreme mental states. They are incomprehensible to those who have never experienced them or witnessed someone else go through them. Most people who experience these states of mind do not stay there long and try not to go back often. These rare states of mind are both real and unusual. They should not be glossed over or brushed aside. Any discussion of the standards for involuntary treatment must address the fact that such standards only apply to a unique class of individuals who are momentarily unpredictable, irrational, and yes, insane.

The law, whether it knows it or not, has an unbiased view of those labeled elsewhere as mentally ill, a view that society as a whole should perhaps aspire to. The law could care less what an individual has been labeled; it only becomes concerned when an individual’s illness flares up, they lose their ability to reason, and their functioning becomes impaired. It is episodes that interest the law. Yet the law has struggled to figure out what to do during episodes. Currently, it segregates episodes based on whether the individual’s behavior during that time poses some sort of physical danger. The problem is that not all people become dangerous during an epi-

46. For example, in the DSM-IV, of the roughly 14,000 words describing Bipolar I Disorder, 4,000 describe major depressive episodes, 2,500 describe manic episodes, 1,100 describe mixed episodes, and 1,600 describe hypomanic episodes. And all of these episodes can come in varying levels of severity and frequency. A person’s bipolar diagnosis tracks these episodes and changes to reflect whatever the most recent episode was. So after a depressive episode, someone would be bipolar I, most recent episode depressed.

sode, but even when they do not, they almost always need some form of help. This is especially true during their first episode—when they are standing in their apartments, yelling in their mothers’ faces that nothing is wrong with them, and yet something so clearly is—even if it has yet to be diagnosed.

B. There Are Unique Individual, Social, Medical, and Political Effects of First Episodes that the Law Does Not Address

While the law does view mental illness episodically, it has failed to draw a crucial distinction between episodes. An individual’s first psychotic, manic, or severe depressive episode⁴⁷ has a profound impact on their life, their family, and society as a whole.

First episodes present unique individual and social challenges. When first episodes strike, people with mental illness and their families do not know where to turn or what they need. “The issues facing a first episode client are different from those facing a chronically ill patient and his/her relatives . . . they do not have prior experience with psychosis, the acuteness of the episode is more mystifying and there is often diagnostic ambiguity.”⁴⁸ The National Alliance on Mental Illness conducted a survey of 1,215 people who had experienced psychosis and 2,882 people who had witnessed someone in the early stages of psychosis, and when asked who was most helpful to them during the early stages of psychosis, 22.2% of individuals who experienced psychosis and 21% of their loved ones answered “no one.”⁴⁹ This was the greatest proportion among responses—suggesting a high level of isolation and desperation.⁵⁰ There are many resources about mental illness available on the Internet and in the community, but people

47. Most involuntary treatment is for psychotic, manic, or severe depressive episodes. However, most of the literature that I cite only deals with psychotic and manic episodes. This is because most of the behavior that would warrant first episode involuntary treatment would stem from mania or psychosis. Usually, depressive episodes only result in involuntary treatment when an individual becomes suicidal, at which point they are a danger to themselves and there would be no need for a first episode standard. Elyn R. Saks conceptualizes a first episode standard as applying to “First Psychotic Breaks,” SAKS, *supra* note 9, at 59. Most likely, people who would get treatment under the first episode standard would be psychotic. However, defining the standard by psychosis or limiting the standard to psychosis is impractical. Neither police officers in the field nor judges in the courtroom are positioned to make clinical diagnosis. “Psychosis” is a clinical term. It is only mentioned in legal definitions of mental illness in the District of Columbia and New Jersey, which specifically says, “The term mental illness is not limited to ‘psychosis’ or ‘active psychosis.’” N.J. STAT. ANN. § 30:4-27.2(r) (West 2010). Using new language, especially clinically loaded language could cause confusion among the many players who would work with the standard, potentially making it unworkable. A simple solution is to re-conceptualize current legal definitions of “mental illness” as “episodes.” Thus when I use the term “first episode” I am referring to the first time someone could meet the statutory definition of mentally ill.

48. Jean Addington, April Collins, Amanda McCleery & Donald Addington, *The Role of Family Work in Early Psychosis*, 79 SCHIZOPHRENIA RES. 77, 79 (2005).

49. NAMI, FIRST EPISODE, *supra* note 5, at 4.

50. *Id.*

first experiencing it are in the midst of a crisis, have rarely—if ever—given any thought to mental illness, and as a result, do not know where to look.

Furthermore, the individuals experiencing first episodes often have little or no insight into their illness. More plainly stated, the people who are psychotic or manic do not think anything is wrong with them. In the Segarra study out of Spain, only 52.2% of people with schizophrenia and 49.4% with schizoaffective disorder showed good insight after they had been initially admitted to an inpatient or outpatient psychiatric unit.⁵¹ You would think that being admitted to a hospital would give an indication that something is wrong, but this study suggests that for half of mentally ill people—myself included—it does not.

Lack of insight is a problem if the goal is to stay healthy. Insight into one's illness is layered and comes with different consequences. For example, some individuals may not believe they are mentally ill, but they do believe that taking medication helps them to function in society.⁵² Even that layer of insight can have profound impacts on their long-term prognosis. Studies have shown that people with greater awareness of the benefits of treatment have greater adherence to treatment and have shorter, less frequent hospitalizations—which means shorter, less frequent major episodes.⁵³ Most importantly, “insight is the biggest predictor of who will refuse to take medicine.”⁵⁴ What these studies show, and what common sense confirms, is that people who believe they have a mental illness are more likely to adhere to mental health treatment; as with other illnesses, adhering to treatment makes it much more likely you will stay healthy.

The good news is that people who have low insight during their first episode can develop insight over time. The Segarra study found that while only 50% of the participants had strong insight at onset, around 82% of them had good insight after a year of consistent treatment.⁵⁵ However, a few studies suggest that some people with serious mental illnesses may never develop insight and that their lack of insight has a biological origin.⁵⁶ Yet it is currently impossible to distinguish between individuals incapable of developing insight and those who eventually will before they are in treatment.

When serious mental illness goes untreated the consequences can be disastrous, both for the individuals with mental illness and for their communities. Dr. E. Fuller Torrey has linked untreated mental illness to the mass

51. R. Segarra et al., *Longitudinal Changes of Insight in First Episode Psychosis and its Relation to Clinical Symptoms, Treatment Adherence and Global Functioning: One-year Follow-up from the Eiffel Study*, 27 EUR. PSYCHIATRY 43, 44–47 (2012).

52. See XAVIER AMADOR, I AM NOT SICK, I DON'T NEED HELP!: HOW TO HELP SOMEONE WITH MENTAL ILLNESS ACCEPT TREATMENT 16 (2nd ed. 2007).

53. See *id.* at 17.

54. *Id.*

55. See Segarra, *supra* note 51, at 47.

56. See AMADOR, *supra* note 52, at 21–36, for a discussion of anosognosia.

incarceration and homelessness of people with serious mental illness, citing studies which report “that 40 percent of individuals with serious mental illnesses have been in jail or prison at some time in their lives.”⁵⁷ In addition, one-third of homeless men and two-thirds of homeless women have serious psychiatric disorders.⁵⁸ In addition to these alarming statistics, during the last thirty years, Dr. Torrey has compiled a database of news stories involving encounters between people with mental illness and the law—most ending with the untreated person in prison or dead.⁵⁹ Two universal truths can be gleaned from these statistics: (1) episodes of mental illness happen in public, not in the privacy of one’s mind; and (2) having a severe episode can disrupt an individual’s life in the most dramatic ways possible.

Fortunately, not all episodes have such tragic consequences. Many people can be psychotic or manic for some time without doing anything criminal or winding up homeless. But during that time, life becomes difficult. The National Alliance on Mental Illness survey asked individuals who had experienced a first psychotic episode to rate how difficult it was to manage various aspects of their daily lives during their psychosis. The respondents were asked to rate the aspects on a scale of 1 to 5, with 5 being very difficult. The respondents “rated social life as very difficult (51.1 percent) followed by work (47.5 percent), romantic relationships (47.4 percent), friendships (42.6 percent), and relationships with parents (39.2 percent).”⁶⁰ The same survey found that first episodes made family and friends’ social lives, work, and romantic relationships more difficult as well.⁶¹ Even when a first episode does not land an individual in prison or on the streets, it often makes it very difficult for the afflicted and their loved ones to manage the basic aspects of their everyday lives.

Fortunately, a first episode can be a last episode, or at least the last major episode. With proper treatment and the development of insight, people with schizophrenia, bipolar disorder, and depression can stay stable and healthy indefinitely. This ideal outcome is not experienced by most, but it is possible, and it should be the ultimate goal of treatment. Many steps must be taken in achieving this goal—some are large interventions, others occasional tweaks, and almost always daily doses. Long-term stability depends on a large number of factors—treatment adherence, the severity and type of

57. E. Fuller Torrey et al., *More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States*, 1 (2010), available at http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf.

58. See E. FULLER TORREY, *THE INSANITY OFFENSE: HOW AMERICA’S FAILURE TO TREAT THE SERIOUSLY MENTALLY ILL ENDANGERS ITS CITIZENS* 124 (2008).

59. See TREATMENT ADVOCACY CENTER, *Preventable Tragedies Database*, PREVENTABLE TRAGEDIES, <http://www.treatmentadvocacycenter.org/problem/preventable-tragedies-database> (last visited Sept. 13, 2012) (using the “Advanced Search” box, check the option for “Person with mental illness injured or killed in altercation with law enforcement,” and insert a date range for the last thirty years in the “Date or Date Range” search box).

60. NAMI, *FIRST EPISODE*, *supra* note 5, at 9.

61. See *id.* at 3.

the illness, social and familial support, quality and availability of care, and the holistic health of the individual to name a few. But, no matter what, the first step towards this ideal outcome is getting effective treatment early in the onset of the first episode.

Research has shown that early and consistent treatment has a positive effect on the long-term course of the illness.⁶² “[W]hen antipsychotic drugs are given shortly after the illness first emerges, and subsequent psychotic episodes are treated quickly to shorten their duration, future response to treatment and prognosis is greatly improved.”⁶³ Conversely, when there is a longer period between when the episode begins and when the person begins treatment, there is a greater chance that person will have more episodes.⁶⁴ One study followed 276 seriously mentally ill young people over seven-and-a-half years, and found that those who had less episodes and episodes that were treated early in their onset were higher functioning and less ill later in life.⁶⁵ Unfortunately, there can be long delays between when an individual first experiences symptoms and eventually receives treatment. In one survey of 250 people living with schizophrenia, the average period of time between onset and initial treatment was 8.5 years.⁶⁶

A delay in treatment is problematic for those with mental illnesses. Some researchers have suggested that when episodes go untreated they can have severe consequences. These scholars claim that psychotic episodes may be toxic to the brain, actually killing or altering brain cells.⁶⁷ For depression and mania, researchers have observed a “kindling effect,” as if each additional episode is a twig that helps build a larger fire, and when it dies down the coals still simmer and can flare up with little provocation. This “kindling effect” may lead to more frequent and easily-triggered manic or depressive episodes.⁶⁸

Frequent, prolonged episodes not only negatively impact the people who suffer them, they negatively impact every taxpayer. In 2001, total nationwide spending on mental health services equaled \$85.4 billion, of which, federal and state government spent 63.1%, or \$53.89 billion.⁶⁹ The most expensive way to provide mental health services is in an inpatient setting. One day of inpatient treatment for bipolar disorder in a community-

62. See AMADOR, *supra* note 52, at 13.

63. *Id.* at 14.

64. See A.C. Altamura et al., *Duration of Untreated Psychosis as a Predictor of Outcome in First-Episode Schizophrenia: A Retrospective Study*, 52 SCHIZOPHRENIA RES. 29, 32 (2001).

65. See AMADOR, *supra* note 52, at 14.

66. See NATIONAL ALLIANCE ON MENTAL ILLNESS, SCHIZOPHRENIA: PUBLIC ATTITUDES, PERSONAL NEEDS 4–5 (2008) [hereinafter NAMI, SCHIZOPHRENIA], available at www.nami.org/ssstemplate.cfm?section=HIZOPHRENIA%20SURVEY

67. See AMADOR, *supra* note 52, at 13.

68. See, e.g., Kenneth S. Kendler, Laura M. Thornton & Charles O. Gardner, *Genetic Risk, Number of Previous Depressive Episodes, and Stressful Life Events in Predicting Onset of Major Depression*, 158 AM. J. PSYCHIATRY 582 (2001).

69. See FRANK & GLIED, *supra* note 17, at 51.

based hospital costs an average of \$876 for privately insured patients and \$804 for patients on Medicaid.⁷⁰ Comparatively, my outpatient mental health expenses for last year cost \$8.62 per day.⁷¹ In addition to hospital costs, when a person with a mental illness has a major episode that leads to civil commitment, the general public also covers much of the litigation costs associated with that process.⁷²

Psychotic, manic, and major depressive episodes are expensive. Cost can seem trivial, however, when compared with other consequences, like when episodes land people on the streets or in jail. Even if that fate is avoided, episodes still make life very difficult for the individuals experiencing them and their loved ones, especially first episodes. But first episodes can be last episodes, and studies show that the best way to prevent multiple episodes from happening—and the personal difficulties and public expenses that accompany them—is to provide individuals mental health treatment soon after their first episode emerges. That is what the first-episode standard would help facilitate.

III. A FIRST-EPISODE STANDARD FOR INVOLUNTARY TREATMENT WOULD WORK

This paper proposes an alternative standard for involuntary treatment that could be used when individuals pose no physical danger, but are experiencing their first episode of a mental illness. It would use the state's pre-existing requirements for an individual's age and symptoms of mental illness, but eliminate the physical harm requirements. This proposed standard would encompass a small percentage of the general population—those who meet the statutory definition of a person who is mentally ill, but have never received mental health treatment for their condition. It is a narrow standard, but it would help a discrete group of people and their families during an unprecedented crisis point in their lives.

To meet the first-episode standard and qualify for involuntary treatment, individuals must be (1) over 18, (2) mentally ill (the presence of a mental disorder that diminishes a person's ability to reason, resulting in an

70. Michael Stensland et al., *An Examination of Costs, Charges, and Payments for Inpatient Psychiatric Treatment in Community Hospitals*, 63 *PSYCHIATRIC SERVICES* 666, 670 (2012).

71. The cost of my medications was \$2,402.65 and the cost of my outpatient psychiatrist visits was \$744, which totals \$3,146.65. My insurance paid \$2,638.50 of these costs.

72. See, e.g., MINN. STAT. § 253B.23 subd.1(a) (2012) (“In each proceeding under this chapter the court shall allow and order paid to each witness subpoenaed the fees and mileage prescribed by law; to each examiner a reasonable sum for services and for travel; to persons conveying the patient to the place of detention, disbursements for the travel, board, and lodging of the patient and of themselves and their authorized assistants; and to the patient's counsel, when appointed by the court, a reasonable sum for travel and for the time spent in court or in preparing for the hearing. Upon the court's order, the county auditor shall issue a warrant on the county treasurer for payment of the amounts allowed, excluding the costs of the examiner, which must be paid by the state courts.”).

impairment of functioning), and (3) have never received psychiatric treatment for the disorder. The first and second of these requirements already exist within the statutes of all fifty states and the District of Columbia.⁷³

This standard hinges on the belief that individuals deserve, and in a healthy state would want, an effective course of treatment for their mental illness. The first-episode standard is intended to assist individuals and families in times of crisis. The goal is to give individuals who are having their first episode an opportunity to get healthy, so that they can reflect on their first experience of mental illness and decide whether to pursue further treatment.⁷⁴ Having a severe episode and getting diagnosed are traumatic experiences, and there is nothing that the law or any form of treatment can do to prevent that. What first-episode involuntary treatment can do is get an individual treatment early in the development of their mental illness, so that they have the best chance to recover quickly, and are positioned for a positive long-term prognosis if they choose to pursue further treatment. After the first-episode involuntary treatment comes to an end, the standard reverts to the state's existing standards for involuntary treatment.

I call this a first-episode standard, but the statutory construction would more accurately be described as an initial-treatment standard. However, I chose to call it a first-episode standard for three reasons. First, the problem this standard seeks to address is primarily caused by the emergence of a mental illness during a first episode. Second, clinicians are familiar with first episodes and understand their importance in the course of a mental illness. Third, by calling it a first-episode standard, its name reflects the law's already-episodic view of mental illness.

More important than the standard's name is its elements, and with the third I considered two different constructions. My first draft of the third element was that the individual "is having a first episode" instead of "has never received psychiatric treatment for the disorder." I chose the latter because "first episode" is a clinical concept, and even though it would be statutorily defined, it would ultimately require non-clinicians to make clinical decisions. By simply requiring that the individual has not received treatment, the statute uses plain language that is more easily understood by everyone. In the end, this language should accomplish the same goal—helping people get treatment at the emergence of their mental illness. However, as written, the third requirement of the first-episode standard presents at least three issues that are best illustrated by hypotheticals.

First, does a first-episode standard apply to a young woman who was treated for anxiety or depression as a teenager and five years later has a psychotic episode? This hypothetical presents the problem of how this stan-

73. See WINICK, *supra* note 3, at 75–78 (listing statutory definitions from all fifty states and the District of Columbia).

74. See SAKS, *supra* note 9, at 59–60.

dard will account for the former treatment of a different, less-severe mental illness. The statute addresses this concern by specifying that the person has never received treatment for *the disorder*. Under the statute, *the disorder* is the one diminishing the person's ability to reason, resulting in an impairment of functioning. The natures of anxiety and depression are fundamentally different from psychosis or mania. Dealing with anxiety or depression will not likely prepare individuals or their loved ones to deal with a severe psychotic or manic episode, especially if the prior treatment did not include hospitalization. Since the purpose of the statute is to assist in such situations, and because *the disorder* causing the young woman's episode is not anxiety or depression, she meets the standard.

Second, does a first-episode standard apply to a man who has a major manic episode and voluntarily seeks out treatment, but then, after recovering, has a second major episode and does not seek out treatment? Here, the issue is whether a first-episode involuntary treatment standard covers a person dealing with a second episode of the same disorder. The standard is meant to help families and individuals during an unprecedented crisis. Because this man has already had a manic episode, presumably was diagnosed with bipolar disorder, and was treated, he and his loved ones should have some idea of the challenges he faces and the resources that are available. Under the statute, he already *received treatment* for *the disorder* diminishing his ability to reason, resulting in an impairment of functioning. Consequently, he would not meet the standard.

Third, does a first-episode standard apply to a woman who was involuntarily treated for her first manic episode and is diagnosed with bipolar disorder, but then, years later, has what appears to be a psychotic episode that is more typical of schizophrenia? The woman here is experiencing a first episode of *the disorder*, however she has already received one course of involuntary treatment for another disorder. The question is whether the first-episode standard could ever be used twice for the same person if she is experiencing an episode of a different disorder. The most important functional purpose of the first-episode standard is to get individuals admitted to an inpatient psychiatric hospital under an emergency hold. The woman above already received inpatient treatment for her manic episode. As a result, she and her family are aware of inpatient treatment and hopefully were educated on the legal standards one must meet for any further involuntary treatment beyond the first episode. While the language of the first-episode standard could be interpreted to allow for two courses of first-episode involuntary treatment for separate *disorders*, such a use is inconsistent with the purposes of the statute. As a result she would not meet the first-episode standard, nor would anyone who was previously hospitalized under it.

Also inherent in this statutory construction is the presumption that there is a form of treatment for the disorder causing the episode. If there is no psychiatric treatment for the disorder, then there is no way the third

requirement could be met. The concept of medical appropriateness is built into the standard.⁷⁵ This language protects against the involuntary treatment of people for whom available treatments will do no good. For example, all hospitals with inpatient psychiatric units are equipped to treat psychotic, manic, and major depressive episodes, so people likely to be diagnosed with the treatable conditions of schizophrenia, bipolar disorder, or major depression can be put on emergency holds.⁷⁶ However, if a hospital is not equipped to treat an episode, then the individual should not be hospitalized. For example, most hospitals would not be equipped to treat people who are expressing the symptoms of antisocial personality disorder, kleptomania, pyromania, or pathological gambling.⁷⁷ All of these are psychiatric diagnoses, but they are not treatable in most hospital settings.⁷⁸

To be workable, a first-episode standard must take into account the people who would be using it and the environments in which it would be used. While the standard is designed to benefit individuals having an episode, the primary users of the standard will be families, police officers, emergency room staff, and courts. Almost all involuntary treatment begins when police officers or family members bring an individual who is having an episode to the emergency room.⁷⁹ When police officers are called to help an individual having an episode, they make an initial determination upon encountering the individual as to whether the individual meets the state's legal standard for involuntary treatment.⁸⁰ If the officers make a good faith determination that the individual meets the standard, the police officers can transport the individual to an emergency room.⁸¹ When an individual is brought to the emergency room, hospital staff makes their own determination as to whether the individual meets the state's legal standards for involuntary treatment.⁸² If the required staff within a hospital determines the individual meets the involuntary treatment standard, then the individual can

75. See WINICK, *supra* note 3, at 52–59.

76. See *id.*

77. See *id.*

78. See *id.*

79. See NATIONAL ALLIANCE ON MENTAL ILLNESS OF MINNESOTA, UNDERSTANDING THE MINNESOTA CIVIL COMMITMENT PROCESS 7–8 (2006), available at <http://www.namihelps.org/assets/PDFs/civil-commitmentSinglePg102108.pdf> (providing an overview of one state's civil commitment process).

80. See, e.g., OHIO REV. CODE § 5122.10 (2012) “[A] police officer, or sheriff may take a person into custody . . . and may immediately transport the parolee, [that person] . . . to a hospital . . . if . . . the police officer, or sheriff has reason to believe that the person is a mentally ill person subject to hospitalization under court order . . . and represents a substantial risk of physical harm to self or others”)

81. *Id.*

82. See, e.g., *id.* (“A person transported or transferred to a hospital . . . shall be examined by the staff of the hospital . . . within twenty-four hours after arrival . . . [and] if the chief clinical officer of the hospital . . . believes that the person is not a mentally ill person subject to hospitalization by court order, the chief clinical officer shall release or discharge the person immediately”).

be placed on an emergency hold, usually lasting seventy-two hours. By the end of that emergency hold, the hospital must either convince the individual to become a voluntary patient, institute civil commitment proceedings, or release the individual from the hospital.⁸³ Usually patients become voluntary, are released during their emergency hold, or are released in the period between the hold and the full commitment hearing, so the courtroom would be the least common environment where this standard would be used.⁸⁴ Regardless, the first-episode standard must be workable at every possible step of its use, from transportation to the hospital, to the emergency room, to the courtroom.

A. *During First Episodes, Non-dangerous Individuals Should Be Transported to the Hospital Without the Use of Force*

Almost exclusively, either families or police officers bring mentally ill people to hospitals for involuntary treatment.⁸⁵ My family, as with most, did this through a combination of pleading, ingenuity, bribery, threats, and brute force. Unlike families, police officers are empowered by law to take people into custody they believe meet the standard for involuntary treatment.⁸⁶ They can restrain and transport the individual against their protestations.⁸⁷

Police have an intimate, yet troubled relationship with mental illness. Around 7% of police contacts involve individuals with mental illness,⁸⁸ but police “often feel inadequately trained to identify and intervene in cases involving mental illness, yet when called to respond, they are responsible to provide a disposition that both serves the needs of the individual and maintains order and safety in the community.”⁸⁹

To address this problem, many states and municipalities have specially trained mental health response teams, otherwise known as crisis intervention teams (CITs).⁹⁰ These teams vary widely in their composition, organization, policies, and procedures.⁹¹ They can be made up of police officers

83. See OHIO REV. CODE § 5122.11 (2012).

84. Statistics on this are hard to find, probably due to the unavailability of hospital data and the diversity of holding periods of the many states, but this is common knowledge among practitioners in the field and is stated plainly by Diane Greenley. See DIANE GREENLEY, *Civil Commitment and Voluntary Treatment*, WISCONSIN COALITION FOR ADVOCACY 358, available at <http://drwi.org/wp-content/uploads/2008/09/civil-commitment-voluntary-treatment.PDF>.

85. See NAMI, SCHIZOPHRENIA, *supra* note 66, at 3–4 (describing the various initiating circumstances).

86. See OHIO REV. CODE § 5122.10 (2012).

87. See *id.*

88. See Randy Borum, *Police Perspectives on Responding to Mentally Ill People in Crisis: Perceptions of Program Effectiveness*, 16 BEHAV. SCI. & L. 393, 393–405 (1998).

89. *Id.* at 394.

90. See, e.g., CIT CENTER, *CIT National Directory*, THE UNIVERSITY OF MEMPHIS, <http://cit.memphis.edu> (providing a national directory of all the locations with CITs).

91. See Borum, *supra* note 88, at 395.

and/or mental health professionals, but whatever their structure, they have special training to deal with mental health crises. This type of specialized response team would be vitally important to a first-episode standard.

When the police encounter individuals who meet the first-episode standard, by definition, these individuals would not present any physical danger to themselves or others. This complicates the use of force, even the use of handcuffs. Conceptually, it is hard to justify handcuffing someone who has not committed a crime when there is no indication that the person's hands, left uncuffed, will cause any harm. Being handcuffed by the police is traumatic, and thus should be avoided in such situations. Where the individual is not presenting a danger to himself or others, the use of force, in general, should be avoided.

The proper police response to an individual's first episode would need to be further studied and discussed. There is the possibility that a first-episode standard and the police are largely incompatible. Ideally, a crisis intervention team will exist in the jurisdiction where the individual is having a first episode and, using their training, can either convince the individual to get mental health treatment voluntarily or manage to get them to a hospital without using physical force. Such a team could be called in by officers already on the scene and 911 operators could be trained to inquire about the possibility of mental health issues.

In my situation, when my father called the police, he was hopeful that specially trained officers would respond. When young, untrained officers arrived, he quickly shifted from asking for their help to convincing them to leave. He knew their presence could cause more harm than good. In such situations, when untrained officers respond and they see no physical danger, maybe it is enough if they inform the individual and other people present of the first-episode standard for involuntary treatment, but that the officers will not use force to transport a non-dangerous individual to the hospital.

B. The First-Episode Standard Is Easily Applied in the Emergency Room

When family or police officers bring an individual to the emergency room, the hospital staff will do their own assessment of whether the individual meets the first-episode standard and consequently qualifies for an emergency hold. Hospital staffs are well suited for this task. A first episode is much more connected to medical diagnoses than physical harm standards, so it should be more workable for clinicians.

Upon arrival at the hospital, the individual will go through the regular assessment process that usually includes a clinical interview and blood tests to see if the episode is drug induced.⁹² The clinicians will usually speak

92. The information in this paragraph came from an interview on June 15, 2012 with George V. Babolia, the Director of Social Work Services at the University of St. Thomas Interprofessional

with the police or family who brought the individual in for treatment. They may also contact other family of the individual if they are able and it is appropriate. On the basis of the information they gather, clinicians will determine whether the individual is experiencing an episode of a treatable mental illness and whether it has ever been treated before. If they determine it is the individual's first episode, then they could place the individual on an emergency hold if they think it would be therapeutic to the individual.

Prior to placing individuals on emergency holds, hospital staff should make every effort to explain the situation to individuals and encourage them to voluntarily admit themselves. Voluntary admissions are preferable to involuntary admissions for a number of reasons: they avoid compulsion, the patient receives more rights in the hospital, and evidence has shown that "willing patients are *better* patients; they are more cooperative, more motivated to get better, and more successfully treated."⁹³ For all first-episode patients, hospitals should provide them and their families with a general education about their mental illness and possible treatments.

C. Current Involuntary Treatment Legal Procedures Can Easily Adapt to First-Episode Standards

While on an emergency hold, if the hospital or the individual's family members believe the individual would benefit from further treatment and the individual is unwilling to become a voluntary patient, then the hospital or family could petition the court for extended court-ordered treatment.

Introducing a new standard for involuntary treatment will only require one significant change to the legal process currently in place in most states. Respondents will still be given notice, appointed counsel, have the right to cross examine witnesses and present evidence, and be entitled to full hearings.⁹⁴ While the petitioner will need to prove the respondent meets the first-episode standard and not a physical harm standard, the petitioner will still need to prove it by clear and convincing evidence.⁹⁵ Courts considering first-episode cases should still consider the medical appropriateness of hospitalization and whether there is a less restrictive alternative available.⁹⁶ In states with court-ordered outpatient treatment programs, such alternatives to hospitalization should be considered.

The one substantive change to current legal procedure would be the process for termination of the involuntary treatment. Most state statutes currently provide for a ninety-day initial commitment. In practice, most commitments do not last the full ninety days. One survey showed that 61.5% of

Center, and a clinical social worker who does assessments in a Minnesota emergency room for involuntary hospitalizations.

93. SAKS, *supra* note 9, at 62.

94. See WINICK, *supra* note 3, at 141–42.

95. See *Addington v. Texas*, 441 U.S. 418, 433 (1979).

96. See WINICK, *supra* note 3, at 69–72.

patients were discharged after spending thirty days or less in the hospital and another 20.7% of patients were discharged between thirty-one and sixty days.⁹⁷ This indicates that most civilly committed patients are discharged by the hospital long before their ninety-day court-ordered commitment ends. Institutions that care for the civilly committed have the power to discharge patients to a less restrictive setting when the patients have stabilized.⁹⁸ Patients who still pose some form of physical harm will rarely be released to a less restrictive setting, and may be eligible for an extension of their ninety-day commitment by court order.⁹⁹ Hospitals and courts consider both the risk of physical harm and the treatment needs of a patient before releasing her. The physical harm element is a necessary element of that decision, and that element is not part of the first-episode standard. As a result, the first-episode standard needs its own method for determining when it is appropriate to release a patient committed under the first-episode standard.

The proper time to end the involuntary treatment of first-episode patients must “‘bear some reasonable relation’ to the espoused purpose of commitment.”¹⁰⁰ The purpose of first-episode involuntary treatment is to treat the acute first episode so the individual can make choices about their continued treatment in a healthier state of mind.¹⁰¹ This leaves two logical options for the termination of first-episode involuntary treatment. Either the individual is discharged when the first episode has been successfully treated and they are able to make decisions about their future treatment with a healthy state of mind, or a hard deadline is set on the length of first-episode involuntary treatments based on the length of time it usually takes for patients to respond to treatment after a first episode.

The first option mirrors physical harm standards more closely—an individual is hospitalized because X; therefore, when X is resolved, the individual should be released. This approach is treatment-oriented and flexible enough to meet the needs of a wide range of individual experiences. However, some episodes may be treatment adverse, making it difficult to find an effective treatment in a short period of time, if there are effective treatments at all. In those worst case scenarios, courts would be put in the awkward position of deciding when to discontinue ongoing treatment efforts because

97. *See id.* at 2–3 n. 9.

98. *See, e.g.*, OHIO REV. CODE § 5122.15(F) (2012) (“If, at any time prior to the expiration of the ninety-day period, it is determined by the hospital . . . that the respondent’s treatment needs could be equally well met in an available and appropriate less restrictive environment . . . (1) The respondent shall be released from the care of the hospital . . . ; and (2) [the hospital] . . . shall place the respondent in the least restrictive environment . . .”).

99. *See id.* § 5122.15(H).

100. Eric S. Janus & Wayne A. Logan, *Substantive Due Process and the Involuntary Confinement of Sexually Violent Predators*, 35 CONN. L. REV. 319, 338 (2003) (quoting *Jackson v. Indiana*, 406 U.S. 715, 738 (1972)).

101. *See supra* Part III.

the hospitalization does not appear to be medically appropriate. Without court intervention, the treatment efforts could continue indefinitely.

That concern would be addressed by the second option—a hard deadline based on the usual amount of time it takes to stabilize a severely mentally ill patient. Research indicates that psychotic episodes, the most severe type of episodes, have the greatest response rate to anti-psychotic medication within the first three weeks of treatment.¹⁰² Nonetheless, extended treatment—especially up to six weeks—continues to produce clinically significant improvements.¹⁰³ Since the most affected individuals should be relatively stable within six weeks and the general goal is to allow the individual to make decisions about future treatment in a healthy state of mind, then a time-limited first-episode standard lasting no longer than sixty days would be enough to restore most everyone experiencing a first episode to a healthier state of mind. The standard could have a sixty-day minimum involuntary treatment period, with most individuals requiring much less time in the hospital.

These two approaches to ending first-episode involuntary treatment are compatible and could be used in tandem. A state could allow for involuntary treatment up until the point of stabilization or a hard deadline, whichever comes first. Determining the hard deadline for a first-episode commitment is a serious policy choice that should be based on more scientific evidence than is presented here. It may also require the weighing of non-scientific factors raised by interested groups representing families and patients. But given the goals of the first-episode standard, the most important factor for states to consider is how long it will take to restore patients to a healthier state of mind so they can make decisions about their future treatment.

D. Legislatures Adopting First-Episode Standards Should Include Findings of Fact

Before a first-episode standard ever makes it into the field, it would need to pass through a state legislature. Legislatures drafting these standards should include substantial legislative findings of fact for the sake of both legal practitioners and people with mental illness. Being that the laws would be unprecedented, legal actors would benefit from understanding the evidence they are based upon and what purposes the laws seek to achieve. As a result, legislative findings of fact should touch upon the unique individual, social, medical, and political problems and opportunities presented by first episodes, and point to them as the reasons for the adoption of the laws.

102. Takefumi Suzuki et al., *Time Course of Improvement with Antipsychotic Medication in Treatment-Resistant Schizophrenia*, 199 *BRIT. J. PSYCHIATRY* 275, 275–79 (2011).

103. *Id.*

Not only would this be helpful to judges and lawyers, it would also be helpful to patients. A first-episode standard, as a law, has therapeutic potential within itself. "Legal rules, legal practices, and the way legal actors . . . play their roles impose consequences on the mental health and emotional well-being of those affected."¹⁰⁴ People who are involuntarily hospitalized are usually given a description of their rights by the hospital. This pamphlet usually includes the legal standard for commitment. For individuals hospitalized under a first-episode standard, the pamphlet could include not only the legal definition of a first episode, but also the reasons the legislature adopted a law allowing for involuntary treatment during first episodes. Reading the reasons why they are being involuntarily treated could further expand the ability of first-time patients to gain insight into their illnesses.

IV. THE CONCERNS RAISED BY A FIRST-EPIISODE STANDARD ARE LEGITIMATE, BUT ARE OUTWEIGHED BY ITS POTENTIAL BENEFITS

There are many questions about a first-episode standard that this paper does not address, but there are two urgent concerns that need to be addressed. First, would a first-episode standard be therapeutic? And second, is a first-episode standard constitutional?

A. *Would a First-Episode Standard be Therapeutic?*

Any form of involuntary treatment involves compulsion.¹⁰⁵ Individuals resistant to treatment are compelled to accept it. Given the mental state of the individuals, it is not clear whether this compulsion is against their will,¹⁰⁶ but it is certainly against their protestations. For obvious reasons, scholars and clinicians have questioned whether compulsory treatment is therapeutic.¹⁰⁷ Thus far, their questions have not been conclusively answered, and the challenges of unraveling the myriad of variables that could measure compulsion and therapeutic success combined with the ever-changing landscape of mental health treatments make it unlikely that a definitive answer will soon emerge.¹⁰⁸

There is evidence that voluntary patients have better outcomes than involuntary patients.¹⁰⁹ But to study the ultimate therapeutic effectiveness of involuntary treatment, one would have to compare the outcomes of peo-

104. WINICK, *supra* note 3, at 6.

105. I use the term "compulsion" rather than "coercion," which is often used elsewhere, because coercion involves using force or threats and often carries a negative connotation. "Compulsion" carries a less negative connotation, involuntary treatment is legal after all, and it describes the state of being forced to do something and not the means through which it is done. The means in this case are not as simple as coercion would imply.

106. See Herschel Hardin, *Uncivil Liberties*, VANCOUVER SUN, July 22, 1993, available at http://www.northshoreschizophrenia.org/Uncivil_Liberties.htm.

107. WINICK, *supra* note 3, at 23–24

108. *Id.*

109. SAKS, *supra* note 9, at 62.

ple who received it versus those who never receive treatment. Such studies raise ethical and practical problems that have been difficult to overcome. With a paucity of information about the therapeutic value of compulsory treatment in general, the therapeutic foundation for a first-episode standard rests on clinical theories and the experiences of people who have already been through involuntary treatment under other standards.

Elyn R. Saks says the first-episode standard gives an individual the chance to actualize a psychiatrist's fantasies.¹¹⁰ Alan Stone dubbed this the "thank you" theory of civil commitment, "he will be treated, with treatment he will recover, and on recovery he will be immensely grateful to the therapist."¹¹¹ Needless to say, this does not always happen. Many times upon release, individuals go off their medications and wind up back in the hospital a few months later, in a common phenomenon known as the revolving door syndrome.¹¹² However, the "thank you" theory is also based in reality. Individuals often do recover and are grateful they were compelled to receive treatment when they needed it most. I am an example of that, but I am not alone. A number of different studies have surveyed former involuntary patients to learn their present feelings about their past treatment. The studies vary widely in design, but across the board, substantial numbers of individuals, usually around 50%, had positive things to say about involuntary treatment—especially when asked if the treatment was effective.¹¹³ Treatment can and does help most people who receive it—whether they get it involuntarily or voluntarily.

B. *Is a First-Episode Standard Constitutional?*

Because a first-episode standard does not currently exist, its constitutionality has not been considered by the Supreme Court. If it were to go before the Court, it is likely the main question the Court would answer is whether a first-episode involuntary treatment violates substantive due process. Most likely, the answer would be no.

110. *Id.* at 59.

111. *Id.*

112. See, e.g., Gustavo Fernandez & Sylvia Nygard, *Impact of Involuntary Outpatient Commitment on the Revolving-Door Syndrome in North Carolina*, 41 HOSP. & CMTY. PSYCHIATRY 1001, 1001–04 (1990).

113. See TREATMENT ADVOCACY CENTER, *The Effects of Involuntary Commitment and Involuntary Medication on Individuals with Serious Mental Illnesses – Backgrounder* (Mar. 2011), www.treatmentadvocacycenter.org/resources/briefing-papers-and-fact-sheets/159/467.

1. *The Legal Landscape of Involuntary Treatment Has Been Continually Shifting Over the Past Fifty Years*

Over the course of his life, Bruce J. Ennis appeared as counsel in 250 cases before the Supreme Court.¹¹⁴ The first client he represented before the Court was Kenneth Donaldson. In 1957, Donaldson was civilly committed to a Florida State Hospital because his family thought he was having delusions. During the next fifteen years, Donaldson often requested release, pointing to the facts that he was not dangerous, he was not being given treatment, and he had a support system willing to help him live safely in the community, but his requests were denied. When Ennis heard Donaldson's story, he was outraged. Ennis was the director of the Mental Illness Litigation Project of the American Civil Liberties Union and, before reaching the Supreme Court, he published Donaldson's story in *Prisoners of Psychiatry*. Donaldson's story was one of four that Ennis used to illustrate the

[E]normous disparity between what mental hospitals are supposed to be and what they really are. They are supposed to be places where troubled people receive care and attention from a gentle and dedicated staff. They are, instead, places where sick people get sicker and sane people go mad, where the hours are filled not with compassion, but with neglect.¹¹⁵

With these conditions in mind, Ennis's goal was "nothing less than the abolition of involuntary hospitalization."¹¹⁶ Ennis and his contemporaries pursued that goal with fervor.

Believing commitment to do more harm than good, Ennis and other civil liberties lawyers advocated for strict commitment standards. In 1969, before a U.S. Senate subcommittee, Ennis testified: "Commitment because of alleged danger to self or to others should require proof beyond a reasonable doubt, based on a recent overt act or threat, that the person would, if at liberty, inflict substantial physical injury upon himself or others within the immediate future."¹¹⁷ This was a popular standard throughout the legal community and Milwaukee Legal Services fought for it in a class action that hoped to completely overhaul Wisconsin's mental health delivery system.¹¹⁸

114. Wolfgang Saxon, *Bruce J. Ennis, 60, Lawyer Who Fought for Civil Liberties*, N.Y. TIMES, Aug. 2, 2000, <http://www.nytimes.com/2000/08/02/us/bruce-j-ennis-60-lawyer-who-fought-for-civil-liberties.html>.

115. BRUCE J. ENNIS, *PRISONERS OF PSYCHIATRY: MENTAL PATIENTS, PSYCHIATRISTS, AND THE LAW* 81-82 (1972).

116. *Id.* at 232.

117. TORREY, *supra* note 58, at 78.

118. *Id.*

In *Lessard v. Schmidt*,¹¹⁹ the United States District Court of Wisconsin set “the high water mark for involuntary commitment law.”¹²⁰ The protections it describes for individuals facing involuntary treatment were the furthest reaching during that era of reform.¹²¹ In commitment proceedings, the district court held that the proper standard of proof for determining mental illness and dangerousness was beyond a reasonable doubt (now it is clear and convincing).¹²² To impose involuntary treatment “the state must bear the burden of proving that there is an extreme likelihood that if the person is not confined he will do immediate harm to himself or others.”¹²³ While recognizing that future predictions are suspect, the court “believe[d] civil confinement can be justified in some cases if the proper burden of proof is satisfied and dangerousness is based upon a finding of a recent overt act, attempt or threat to do substantial harm to oneself or another.”¹²⁴ *Lessard* was never appealed to the Supreme Court, but most states adjusted their involuntary treatment laws to adopt parts of the *Lessard* decision.¹²⁵

In 1972, when *Lessard* was decided, the dangerousness standard was novel. Washington, D.C. was the first jurisdiction in 1964 to pass involuntary treatment laws requiring dangerousness as a factor for involuntary treatment, but in the wake of *Lessard* most states followed by the end of the 1970s.¹²⁶

In the hundred years prior to the 1970s, dangerousness was not required for involuntary treatment. States allowed for the civil commitment of individuals on the finding that they had a need for treatment.¹²⁷ By the start of the Civil War in 1860 civil “commitments were predicated only on a mentally ill person requiring care, and state-run asylums were assumed to be the best places to care for such people.”¹²⁸ Today, those asylums are largely dismantled and there are no signs of our mental health delivery system returning to a state-managed affair.

As can be seen from cases like *Donaldson*, much of the civil commitment reforms of the 1970s were in response to the abuses resulting from the intertwined realities of treatment-oriented legal standards and state-run institutions. With the state-run institutions dismantled, the strict commitment

119. *Lessard v. Schmidt*, 349 F.Supp. 1078 (E.D. Wisc. 1972).

120. TREATMENT ADVOCACY CENTER, *Lessard v. Schmidt* (2011) (internal memorandum), available at <http://www.treatmentadvocacycenter.org/component/content/article/344>.

121. *Id.*

122. *Lessard*, 349 F.Supp. at 1095.

123. *Id.* at 1093.

124. *Id.*

125. See TREATMENT ADVOCACY CENTER, *supra* note 120, at “Significance”.

126. Stuart A. Anfang & Paul S. Appelbaum, *Civil Commitment—The American Experience*, 43 *ISR. J. PSYCHIATRY RELAT. SCI.* 209, 211–18 (2006).

127. *Id.* at 210.

128. *Id.*

standards states adopted in the wake of *Lessard* are loosening.¹²⁹ *Parens patriae* legal standards for involuntary treatment have been slowly expanding. So far, there has not been a return to the abuses of old. With stringent due process protections in place and powerful state institutions gone, the traditional value of getting treatment to mentally ill people seems to be *safely* re-emerging. Thus far, the broader standards of grave disability, need for medical treatment, or damage to property “have either been upheld in court as constitutional under the Due Process Clause of the Fourteenth Amendment or have yet to be challenged.”¹³⁰ The same Supreme Court decisions under which these recent expansions of involuntary treatment have been upheld would also permit the adoption of a first-episode standard.

2. *The Supreme Court Has Not Wholly Addressed the Substantive Due Process of Parens Patriae Involuntary Treatment*

The Supreme Court’s involuntary treatment substantive due process jurisprudence has followed a rather simple equation.¹³¹ “As a threshold matter, due process limits the *purposes* that a state can seek to promote through the auspices of civil commitment. In turn, the *nature or conditions* and *duration* of commitment must ‘[a]t the least . . . bear some reasonable relation’ to the espoused purpose of the commitment.”¹³²

The first-episode standard, as conceptualized here, should only raise concerns about the State’s purposes, since the nature of the treatment and its duration have already been addressed.¹³³ The legitimate purposes for the State’s exercise of *parens patriae* power to involuntarily treat an individual were discussed in the seminal case of *O’Connor v. Donaldson*, with Ennis representing Donaldson.¹³⁴ In that case, the question was whether an individual who is harmless, has support to live safely in the community, and is not receiving treatment can be indefinitely confined by the state on a mere finding that he is mentally ill.¹³⁵ The Court’s answer:

The Jury found that Donaldson was neither dangerous to himself nor dangerous to others, and also found that, if mentally ill, Donaldson had not received treatment. That verdict, based on abundant evidence, makes the issue before the Court a narrow one. We

129. Even in Wisconsin, where *Lessard* was decided, the commitment standard has relaxed from “immediate harm to self or others” to “substantial probability of physical harm” and “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 adequate treatment.” WIS. STAT. § 51.20(1)(a)2 (2012).

130. Pfeffer, *supra* note 21, at 289–93.

131. Janus & Logan, *supra* note 100, at 338.

132. *Id.* (quoting *Jackson v. Indiana*, 406 U.S. 715, 738 (1972)).

133. See *supra* Section III(C).

134. *O’Connor v. Donaldson*, 422 U.S. 563 (1975).

135. *Id.* at 574–75.

need not decide whether, when, or by what procedures, a mentally ill person may be confined by the State on any of the grounds which, under contemporary statutes, are generally advanced to justify involuntary confinement of such a person – *to prevent injury to the public, to ensure his own survival or safety, or to alleviate or cure his illness* . . . For the jury found that none of the above grounds for continued confinement was present in Donaldson’s case.

Given the jury’s findings, what was left as justification for keeping Donaldson in continued confinement?¹³⁶

At that point, the dicta and confusion begins. In its search for some justification for Donaldson’s confinement, the Court dances around the three actual purposes generally advanced by the fifty states for involuntary treatment—“[1] to prevent injury to the public, [2] to ensure his own survival or safety, or [3] to alleviate or cure his illness”—but the court never discusses them directly.¹³⁷ It never explains what constitutes an injury to the public or what is meant by “ensur[ing] his own survival or safety.”¹³⁸ The court uses the buzzwords of injury, harm, safety, and danger throughout without ever discussing what they mean. Instead of addressing the State’s purpose of alleviating or curing illnesses, the Court states that “[t]here is no reason now to decide . . . whether the State may compulsorily confine a non-dangerous, mentally ill individual for the purpose of treatment.”¹³⁹

Instead of addressing those questions, the Court opts to ask such questions as “[m]ay the State confine the mentally ill merely to ensure them a living standard superior to that they enjoy in the private community?”¹⁴⁰ And, “[m]ay the State fence in the harmless mentally ill solely to save its citizens from the exposure to those whose ways are different?”¹⁴¹

The questions the Court asked and those it did not reveal the Court’s concerns. It was not so much concerned with the stated justifications of the fifty states as with their unstated ones—to give the mentally ill a supposedly better living standard and to keep them out of sight. Through Bruce Ennis and his colleagues’ tireless advocacy, those illegitimate purposes were largely snuffed out. Since then, the Court has not revisited the three traditional purposes of the State in compelling involuntary treatment. The concepts of harm and treatment have never been deeply explored on their own terms. Such a discussion would be incredibly helpful in the creation of a first-episode standard, and so I’ve begun it here.

136. *Id.* at 573–74 (emphasis added).

137. *Id.*

138. *Id.*

139. *O’Connor*, 422 U.S. at 573.

140. *Id.* at 575.

141. *Id.*

3. *The Generally Advanced State Purposes of Preventing Harm and Alleviating Illness Support the Use of First-Episode Standards*

Thus far, expansions of *parens patriae* involuntary treatment have been tied to physical harm, but the first-episode standard involves a different view of harm. First episodes can be harmful to individuals even at the point when physical harm has not developed. Individuals who are having first episodes lack insight to a greater degree than people already with chronic conditions.¹⁴² This leaves them, and their families, more vulnerable to their illnesses. Before reaching a point of physical harm, individuals' lives can unravel as a result of their episodes. Education, employment, and relationships become very difficult,¹⁴³ which inevitably can lead to drop-outs, job-loss, and isolation. The longer episodes go untreated, their effects continue to snowball and can lead to arrests or homelessness¹⁴⁴—which dangerousness standards often only address after the harm is done. From a medical standpoint, intervening early and effectively gives individuals the best chance of having a long-term healthy prognosis.¹⁴⁵ A healthy prognosis means fewer episodes.¹⁴⁶ Fewer repeated episodes of psychosis lead to better long-term health, whereas repeated episodes may cause permanent damage to the brain or a “kindling” effect for mood disorders.¹⁴⁷

This view of harm is not precluded by the Supreme Court in *O'Connor v. Donaldson*. The decision uses the terms harm, injury, safety, and danger, but nowhere does it limit those concepts by physicality. Webster's definitions are also not physically limited. For example, “harm” means “physical or mental damage”¹⁴⁸ and “danger” means “exposure or liability to injury, pain, harm, or loss.”¹⁴⁹ The *Donaldson* decision does not discuss the nature of harm or danger because that was not the Court's concern. The Court was concerned with improper uses of civil commitment, and civil commitment for the purpose of preventing harm—tangible or intangible—was not among the class of improper State purposes that the Court identified.

The State's purpose to alleviate illnesses would also support the use of a first-episode standard. The first-episode standard is limited to situations where treatments exist, and the period of compulsion only lasts as long as necessary for treatments to take effect, and even then could have definite time limitations. Treating mental illnesses at their early onset gives individ-

142. *See supra* Section II(B).

143. *Id.*

144. *Id.*

145. *Id.*

146. *Id.*

147. *Id.*

148. *See, e.g.*, MERRIAM-WEBSTER ONLINE, www.merriam-webster.com/dictionary (the primary definition is “physical or mental damage”).

149. *Id.*

uals the best chance of quickly achieving stability and maintaining it in the long run.¹⁵⁰ Treatment is needed for almost every episode, but the crisis is most acute during the first episode, and the benefits of treatment are never greater.

4. *People Experiencing First Episodes Do Not Need Individual Competency Determinations*

At the heart of the legal debate on involuntary treatment is the tension between honoring a mentally ill person's desire not to be treated and the community's belief that the individual would benefit from treatment. These values are hard to reconcile and their champions often come from different camps. Courts and legal scholars commonly look upon involuntary hospitalizations as a "massive curtailment of liberty."¹⁵¹ For those who have not witnessed a mentally ill person in the midst of a serious episode, this is a natural observation; but for those who have, the liberty interest at stake takes on a different meaning. Herschel Hardin, a Canadian author, commentator, and father of a schizophrenic child, argued in an article, *Uncivil Liberties*, that "[t]he opposition to involuntary committal and treatment betrays a profound misunderstanding of the principle of civil liberties. Medication can free victims from their illness—free them from the Bastille of their psychoses—and restore their dignity, their free will and the meaningful exercise of their liberties."¹⁵² Hardin twists the accepted view of involuntary treatment on its head—instead of being a curtailment of liberty, it is a great liberating force. His view is not widely held, but it exposes the complexities that mental illness introduces to the civil liberties arena.

One concept Hardin struggles with is something scholars and courts have struggled with as well—the autonomy of the mentally ill. This paper would be incomplete without a discussion of competency. Some states' involuntary commitment standards explicitly include determinations of competency, while others do not.¹⁵³ The first-episode standard does not require individual competency determinations.

In *Donaldson*, the Court stated that "[a] finding of 'mental illness' alone cannot justify a State's locking a person up against his will and keeping him indefinitely in simple custodial confinement."¹⁵⁴ The first-episode standard would involuntarily confine a person based on a finding of mental illness alone, but it would be a time-limited commitment, even shorter than existing civil commitments. In his concurrence, Chief Justice Burger, stated that "[a]t a minimum, a particular scheme for protection of the mentally ill must rest upon a legislative determination that it is compatible with the best

150. See *supra* Section II(B).

151. *Humphrey v. Cady*, 405 U.S. 504, 509 (1972).

152. Hardin, *supra* note 106.

153. WINICK, *supra* note 3, at 99.

154. *O'Connor v. Donaldson*, 422 U.S. 563, 575 (1975).

interests of the affected class and that its members are unable to act for themselves.”¹⁵⁵ To enact first-episode standards, legislatures would need to make such a determination.

The best analogy to the first-episode standard’s approach to competency is the Supreme Court’s treatment of the admission of minors to psychiatric hospitals. I worry this analogy may be offensive—to liken adults to children—but the first psychotic or manic episode does place individuals in a position where they are dependent on others for care, and unlike future episodes, they have much less experience managing that state of mind on their own.

In almost every state, minors can be voluntarily admitted to psychiatric hospitals upon their parents’ application, even if the child protests.¹⁵⁶ The Supreme Court “has recognized that natural bonds of affection lead parents to act in the best interests of their children.”¹⁵⁷ Since “most children, even in adolescence, simply are not able to make sound judgments concerning many decisions, including their need for medical care or treatment,” the Court recognizes that parents “can and must” make those decisions.¹⁵⁸ Where natural parents are not present, and children are wards of the State, the Court does not require different admissions procedures as long as the State is required to act in the best interests of the child.¹⁵⁹ The Court protects children from arbitrary commitments by their parents or the State by requiring that “the admissions staffs of the hospitals have acted in a neutral and detached fashion in making medical judgments in the best interests of the children.”¹⁶⁰

The first-episode standard adopts this approach to competency. People experiencing first episodes are not necessarily presumed to be incompetent, but they are presumed, as a class, to be less capable of making decisions in their best interests than their families, state actors, and medical professionals.¹⁶¹ As a result, it is not necessary for hospital staff or courts to make individual competency decisions when utilizing a first-episode standard.

155. *Id.* at 583.

156. These laws were found to be constitutional in *Parham v. J.R.*, 442 U.S. 584, 620–21 (1979).

157. *Id.* at 602–03.

158. *Id.* at 603.

159. *Id.* at 618–19.

160. *Id.* at 616.

161. Eric S. Janus suggested that I consider an emergency guardianship rather than, or in addition to, a first episode commitment. The idea being that parents can voluntarily apply for the admission of their adult child, resulting in a voluntary admission under which the family would have more power and access to information. I am fascinated by this idea and think it may even be preferential in some cases to the first episode standard I propose. The main challenge I faced is its legal construction. While it is most likely possible, it is a topic for another paper, not necessarily written by me.

CONCLUSION

The law and mental illness are an odd couple. One makes rules, the other breaks them. One demands adherence, the other demands accommodations. One relies on reason, the other defies it. With such different natures, it is no wonder that the law and mental illness have never quite clicked. Their incompatibility is of no consequence, however. There is a marriage of necessity. They are inextricably part of human existence. As long as there are people, some will be mentally ill, and all will be subject to laws. So there is no escaping the task before us. We, the makers of laws and the carriers of illnesses, must find a way for these human accessories to fit together.

A first-episode standard is an attempt to make the law more responsive to the realities faced by people impacted by mental illness by creating a streamlined pathway to treatment during the critical moment of an individual's first episode. A first-episode standard rests upon the belief that mental health treatment is something that most people in a healthy state would want were they to envision themselves having a serious episode of a mental illness. A first-episode standard attempts to assist families in crises and position individuals, as much as possible, to live healthy lives with a mental illness. A first-episode standard recognizes that the most significant harm often caused by first episodes is intangible.

This paper leaves many questions unanswered. While it advocates for the eventual passage of first-episode laws, many steps must be taken beforehand. A deeper discussion of many aspects of this paper is warranted, particularly on the interaction between police and those having first episodes and the proper time to end a first-episode commitment. Further study of the therapeutic value of involuntary treatment would be illuminating, as would an analysis of any costs associated with a first-episode standard. Finally, this standard would affect many stakeholders and all of them should be heard. Politicians, social workers, medical professionals, advocacy groups, lawyers, families, and people with mental illnesses all have a stake in this.

A first-episode standard is an exception to the general rules requiring physical harm; but, as an exception, it is intended for exceptional circumstances. First episodes are turning points in individuals' lives, and the law, whether passively or actively, will always play some role in the direction that an individual winds up following. A first-episode standard encourages individuals along a path generally valued by the community. Not some amorphous community, but individuals' friends and families, who want their loved ones to get treatment so that they will flourish and stay connected to those who love them. The law, during first episodes, should stand on the side of that love.