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Involuntary commitment and the crisis care gap

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Involuntary commitment (IC) — also called "civil commitment" — is a legal process for a court to order a person into treatment for their mental illness or substance abuse disorder. This treatment can be in a hospital (*inpatient*) or in the community (*outpatient*).[1] Sometimes this process is referred to as "pink-slipping,"[2] a reference to the color of the forms filled out to initiate the process, although Ohio's Application for Emergency Admission Form is now online (and no longer pink).[3]

Involuntary commitment highlights just how connected the criminal legal and mental health systems are in Ohio, and how policymakers criminalize people experiencing mental illness. Far too few Ohio families can access mental health services when someone is in crisis, but there are solutions to this problem other than involuntary commitment.

Read more:
Disability Rights Ohio, Civil Commitment: Understanding Your Rights.

A social model of disability

People with disabilities, including those with mental health conditions, often still struggle against the perception that they cannot make decisions for themselves or live independently. This assumption is ableist: It is rooted in prejudice against people with disabilities.[4] When ableism is the basis for decisions about medical treatment — and when that treatment involves stripping a person of their civil rights and autonomy[5] — a prejudiced belief risks becoming a form of systemic oppression.

Many in the medical establishment subscribe to the medical model of disability,[6] or the idea that being disabled is linked to a person's medical condition or impairment, as the standard. However, the social model of disability,[7] which sees a person's disability as an identity and a mismatch between a person and their environment, is perhaps a more valuable framework for discussions about involuntary commitment.

The social model insists that when disabled people can access the care they need, they can thrive and maintain their independence. For someone living with a severe mental health condition, this means access to psychiatric care, non-police crisis response, and support services for family members. Building policies that center the access needs of people with disabilities, rather than criminalizing them, is the key to success.

Author's note: *This piece is part of a series on bioethics issues in health and medicine.*

[1] Disability Rights Ohio (2016). Understanding Your Rights: Civil Commitment.

[2] Kasick, D. (2023). "Pink Slips and Pink Slip Disorders" Presentation. The Ohio State University Wexner Medical Center: Clinical Psychiatry and Behavioral Health/Psychiatry.

[3] The Application for Emergency Admission can be found here.

[4] Eisenmenger (2019). Ableism 101. Access Living.

[5] Murgic, L., Hébert, P. C., Sovic, S., & Pavlekovic, G. (2015). Paternalism and autonomy: views of patients and providers in a transitional (post-communist) country. BMC medical ethics, 16(1), 65.

[6] Olkin, R. (2022, March 29). Conceptualizing disability: Three models of disability.

[7] See footnote 33.

Involuntary commitment, race, and the criminalization of mental illness

Claims of mental illness have been used to strip away individual civil rights ever since institutions were introduced in the United States in the early 19th century.[8] This tactic has been used against poor Black women to rationalize forced sterilization,[9] in cases of wealthy white women like Rosemary Kennedy,[10] and, most recently in the news, the case of Britney Spears conservatorship battle.[11] Even the privileges of wealth and fame are not adequate to protect people from the stigmas surrounding mental illness and disability.

The modern era of mental health care began with the period of *deinstitutionalization*, or the process of re-integrating people with severe disabilities into society, which began in the 1960s and 70s.[12] In 1964, a Washington, D.C., law established the legal standard of *dangerousness* — evidence of an imminent threat to oneself and/or others — as a requirement for commitment for a mental illness.[13] This standard was later adopted by other states and upheld in *O'Connor v. Donaldson* (1975).[14] Most recently, the U.S. Supreme Court case *Olmstead v. L.C.* (1999)[15] ruled that the Americans with Disabilities Act (ADA) prohibits unnecessary segregation of people with disabilities, who have a right to live and receive services in the most integrated setting appropriate.

Racial bias and stigma continue to play a part in poor mental health care outcomes and diagnoses. Research suggests that Black people are more likely to be diagnosed with a psychotic condition, despite little evidence that the conditions are more prominent in the population overall.[16] A 2023 study found that Black individuals were 2.4 times more likely to receive a diagnosis of schizophrenia than white people.[17]

Black Americans in general face greater barriers to care than other groups. Data collected from 2015-2019 by the Substance Abuse and Mental Health Services Administration (SAMHSA) indicate that among Black adults with SMI (Serious Mental Illness) who had an unmet need, 40.8% did not receive services because of cost or insurance, and 39.6% did not receive services because of stigma.[18]

By involving police in mental health services, involuntary commitment creates additional risks for Black people, who are disproportionately likely to be killed by police.[19] A 2021 report in the medical journal the Lancet found that Black Americans were 3.5 times more likely to experience fatal police

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[8] For examples, see Testa, M., & West, S. G. (2010). Civil commitment in the United States. Psychiatry (Edgmont), 7(10), 30.
[9] Buck v. Bell, 274 U.S. 200 (1927). Also see Antonios, Nathalie and Raup, Christina (2012). "Buck v. Bell (1927)". Embryo Project Encyclopedia. ISSN: 1940-5030.
[10] Learn more about the story of Rosemary Kennedy.
[11] Read the stories of Britney Spears and others who have been impacted by conservatorship.
[12] Stiker, H. (2018). Deinstitutionalization. Encyclopedia Britannica.
[13] See footnote 3.
[14] O'Connor v. Donaldson, 422 U.S. 563 (1975). Other cases, such as Addington v. Texas (1979), affirmed this ruling and held that the "clear, unequivocal, and convincing" evidence standard (a middle standard) should be used regarding cases of commitment, because a psychiatric evaluation may not always be reliable evidence.
[15] Olmstead v. L. C., 527 U.S. 581 (1999).
[16] Schwartz, R. C., & Blankenship, D. M. (2014). Racial disparities in psychotic disorder diagnosis: A review of empirical literature. World journal of psychiatry, 4(4), 133.
[17] For more information, read: Faber, S. C., Khanna Roy, A., Michaels, T. I., & Williams, M. T. (2023). The weaponization of medicine: early psychosis in the Black community and the need for racially informed mental healthcare. Frontiers in psychiatry, 14, 1098292. Also see Olbert CM, Nagendra A, Buck B. Meta-analysis of Black vs. White racial disparity in schizophrenia diagnosis in the United States: do structured assessments attenuate racial disparities? J Abnorm Psychol. (2018) 127:104–15.
[18] Center for Behavioral Health Statistics and Quality. (2021). Racial/ethnic differences in mental health service use among adults and adolescents (2015-2019) (Publication No. PEP21-07-01-002). Rockville, MD: Substance Abuse and Mental Health Services Administration.
[19] The Washington Post (2023). "Fatal Force."

violence than white Americans — and that more than half of police killings in the U.S. go unreported.[20]

When crafting mental health policy, officials should take this all into account, and prioritize increasing cultural competency among mental health professionals, expanding career pathways for Black and other underrepresented communities in the field, and decreasing the amount of potential contact with police during a crisis.

Read more:
For a timeline of events and requirements in Ohio law for civil commitment, see Disability Rights Ohio.

Involuntary commitment in Ohio (2019 – 2023)

Ohio has six psychiatric hospitals that manage inpatient involuntary commitment cases, each covering a different region: Northwest, Northcoast, Heartland, Twin Valley, Appalachian, and Summit.[21] In total, the psychiatric units in these facilities can hold fewer than 1,100 people.[22] From 2019-23, these six hospitals reported 14,405 admissions through the involuntary commitment process. Twin Valley Behavioral Health Center (Columbus) and Northcoast Behavioral Health Center (Cleveland) reported the highest number of involuntary commitments, together accounting for more than half of the statewide total.

Ohio MHAS Facility	Region	Location	5 Year Total
Appalachian Behavioral Health	Southeast	Athens	1,286
Twin Valley Behavioral Health	Central	Columbus	4,064
Northcoast Behavioral Health	Northeast	Northfield/Cleveland	4,959
Summit Behavioral Health	Southwest	Cincinnati	160
Heartland Behavioral Health	Northeast	Massillon	2,658
Northwest Behavioral Health	Northwest	Findlay	1,278
Total (2019-2023)	**All**	**All**	**14,405**

Source: Freedom of Information Act request to the Ohio Department of Mental Health and Addition Services (Ohio MHAS) in December 2023. The data represent admissions to the six psychiatric facilities in the state after individuals are assessed to meet the criteria for commitment. The data provided by the Ohio MHAS did not include race or gender demographic information, although it was requested.

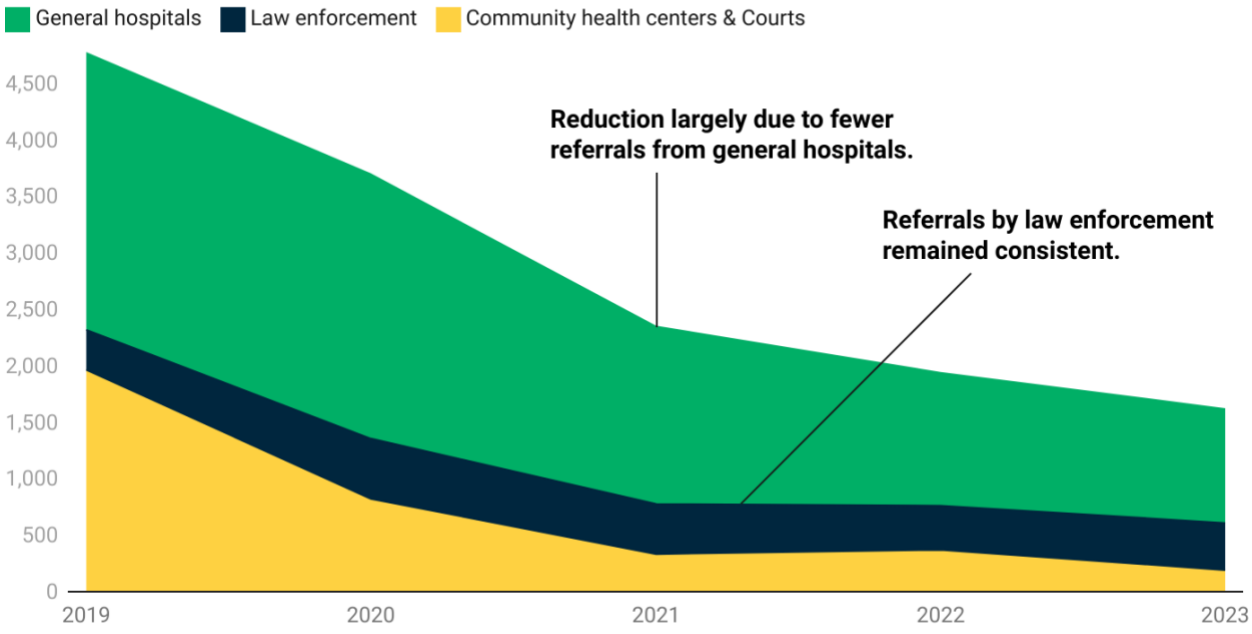
[20] The Lancet (2021) More than half of police killings in the USA are unreported and Black Americans are most likely to experience fatal police violence.
[21] Ohio previously had eight psychiatric hospitals but closed two in 2008 due to the financial crisis. For an overview of Ohio MHAS's system of hospitals, see this fact sheet from Ohio MHAS.
[22] See Ohio MHAS's daily census of patients in the state's regional psychiatric hospitals.

The number of Ohioans being forced into these hospitals has dropped significantly in the last five years, with a 66% decrease in involuntary commitments.[23] Ohioans can be referred for involuntary commitment by general hospitals, community health centers, law enforcement, or through the courts. From 2019-23, general hospitals were by far the most common source for involuntary commitment referrals, accounting for 8,587 in that time, nearly 60% of the total. The downward trend illustrated in Figure 1 is largely due to a decrease in admissions from general hospitals.

Figure 1

Involuntary commitments drop 66% in 5 years

Number of involuntary commitments to Ohio's psychiatric hospitals, by referral source, 2019-23



Source: Ohio Department of Mental Health and Addiction Services. • Created with Datawrapper

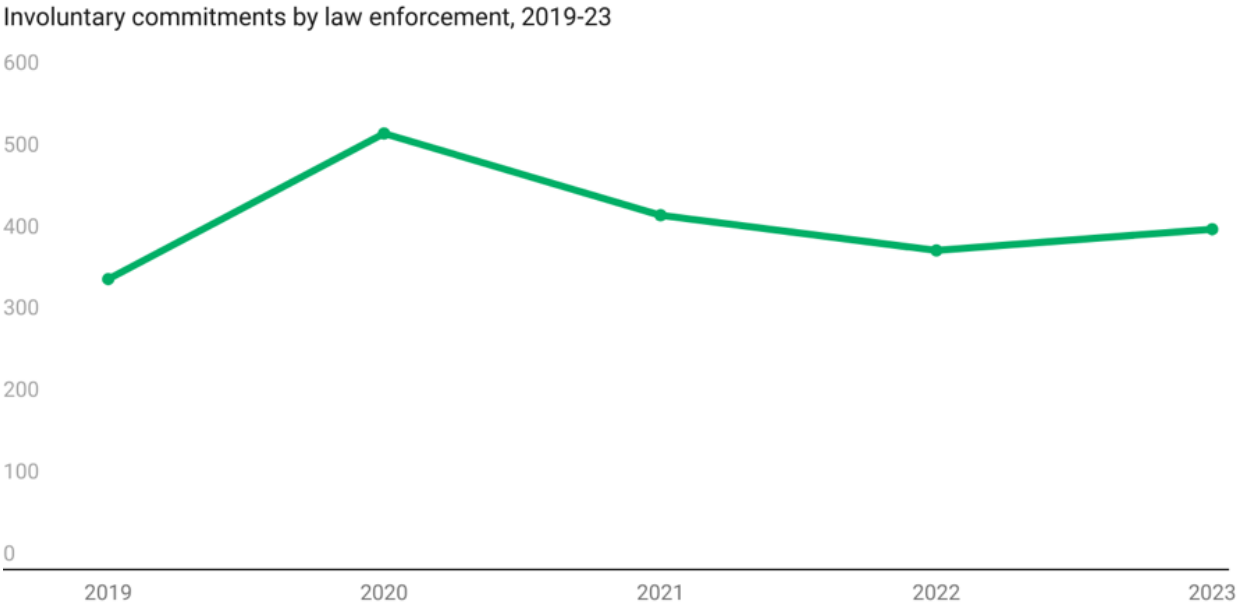
Law enforcement officers made 2,127 involuntary commitments during that time — 15% of the total. Aside from an uptick in 2020, the annual number of involuntary commitments by law enforcement has remained relatively stable in the last five years, highlighted in Figure 2.

Community mental health centers referred 1,239 involuntary commitments, accounting for less than 9% of the 2019-23 total. Courts ordered 299 involuntary commitments making up just 2.1% of the five-year total.

[23] Data provided by the Ohio Department of Mental Health and Addiction Services for 2018 – 2023.

Figure 2

Annual number of involuntary commitments by law enforcement remained stable



Combined numbers from Ohio's 6 ODMHAS Treatment Hospitals.

What changed?

The reported 66% decrease in involuntary commitments over five years, particularly the decrease in admissions by general hospitals, is worth exploring.

First, the COVID-19 pandemic strained every part of the health care system and resulted in many general hospitals lacking the beds to support patients experiencing other kinds of health crisis. It's possible that this impacted general hospital numbers and should be noted as a factor during this period. However, because the downward trend was consistent throughout the pandemic years and into modern day, it's likely not a primary driving factor.

Another possible explanation is that Ohio's psychiatric hospitals simply don't have enough room. That is almost entirely because of how many people Ohio courts send to these facilities to receive pretrial treatment to ensure they are competent to stand trial (a practice that is not considered involuntary commitment, and not included in our data). Normally that treatment could be delivered in the jail where they are serving pre-trial detention, or, for those out on bail, at an outpatient facility. But Ohio's jails and mental health system are so poorly resourced that they cannot meet the mental health treatment requirements imposed by the courts.[24]

[24] Another barrier: A federal ban on inmates receiving Medicaid, which often affects their ability to access mental health services. Read more at Widra (2022). Why States Should Change Medicaid Rules to Cover People Leaving Prison. Prison Policy Initiative.

As a result, more than 9 of every 10 beds in Ohio's psychiatric hospitals is occupied by someone "sent there by the courts to be restored to competency so they can stand trial."[25] So, depending on the day, that leaves fewer than 1,100 beds available for other Ohioans experiencing mental health crises.

In other words, what appears to be an encouraging reduction in the number of involuntary commitments may in fact be the result of a broader systemic failure to adequately fund mental health services both in and out of Ohio's jails.

In Ohio, the decrease in admissions to Ohio's psychiatric facilities is likely a combination of factors, primarily a drop in admissions from hospitals. This in turn is likely related to the criminal legal system's overreliance on pre-trial commitments, which prevents other patients from accessing these facilities, voluntarily or not. This is just one example of how Ohio has both criminalized mental illness and failed to provide mental health care for the people we incarcerate because of their mental illness, reducing access for Ohioans outside the criminal legal system as well.

Read more:
Why States Should Change Medicaid Rules to Cover People Leaving Prison.

Medicaid's Evolving Role in Advancing the Health of People Involved in the Justice System.

LSC Brief: Involuntary Treatment for Mental Illness.

Limitations of the data

Additional data reporting is needed to ensure improved tracking of involuntary commitment and additional data regarding the number of available psychiatric beds over the last five years. In Ohio, it's unknown how many people are admitted to general hospitals and do not fit the criteria to be transferred to a psychiatric hospital or opt in to in-patient treatment, the race and sex of patients committed, and the number of patients who receive voluntary outpatient services.

Involuntary commitment is difficult to track for many reasons, but specifically because the definitions of what counts as civil commitment are different from state to state. Even national surveys have noted the lack of data on the practice.[26] As one scholar put it, "This is the most controversial intervention in mental health — you're deprived of liberty, can be traumatized and then stigmatized — yet no one could tell how often it happens in the United States."[27]

Improving the mental health and criminal legal systems

Advocates have suggested many solutions to improve Ohio's mental health system. A strong first step would be for the legislature to fund crisis services focused on decriminalizing mental illness. Cities across the country and here in Ohio are developing non-police care response systems that

[25] Bischoff, Laura. Columbus Dispatch. Gov. Mike DeWine wants twin fix: more psych beds, better mental health care in jails. Feb. 27, 2024.
[26] Lee, G., & Cohen, D. (2021). Incidences of involuntary psychiatric detentions in 25 US states. Psychiatric services, 72(1), 61-68. Ohio was not included in this survey because of the lack of available data.
[27] Dunseith, Les. (2020). Study finds involuntary psychiatric detentions on the rise. UCLA Newsroom.

dispatch mental health professionals and trained peer responders to deliver care in some cases of behavioral and mental health crisis. The state should do all it can to advance and expand these programs and other alternatives to police response.

Those experiencing mental health crises have often fallen into the "crisis care gap": the lack of (or barriers to) mental health services between the onset of significant, life-disrupting symptoms and the moment they meet criteria for admission to an appropriate facility.

Recent legislation, **House Bill 249**,[28] is a wrong-headed attempt to fill that gap. It would expand the circumstances in which someone can be involuntarily committed, allowing intervention as soon as a person is deemed "likely to deteriorate." As detailed throughout this report, the limited capacity of psychiatric hospitals would render this legislation ineffective. Worse still, it encourages the most extreme, life-altering form of mental health care — in cases where it may not even be necessary — while doing nothing to treat symptoms before they become critical or help people before they are approaching crisis.

Simply put, removing someone's medical decision-making power and civil rights should *never* be our first option when there are other strong alternatives. While there are legitimate reasons in rare circumstances for involuntary commitment, it should be seen as an absolute last resort.[29]

Policy options to fill the crisis care gap include:

- Expand access to mental health services for people with certain psychiatric conditions at family members' request during a crisis period, or after a mental health emergency, by applying for an 1115 Medicaid Waiver.
- Expand Medicaid coverage of mental health services to include incarcerated people. This too would require an 1115 waiver. Vermont, Utah, and Montana have applied for waiver that would allow coverage of incarcerated people nearing their release date, to ensure post-release support and reduce the likelihood of re-incarceration.[30]
- Expand mental health services in Ohio's prison system, both for adults and youth, and cap the share of beds in Ohio's six psychiatric institutions that may be used for the criminal legal system.
- Support the people who provide mental health care — and improve retention in the mental health workforce — by increasing Medicaid reimbursement rates for mental health providers and social workers.
- Expand the availability of out-patient services and crisis care by continuing to fund Mental Health Stabilization Centers. In the 132nd General Assembly (HB 49), a line item was added under Continuum of Care Services that established $1.5 million per year for Mental Health Crisis Stabilization Centers to be built in each of the six regions that were covered by the psychiatric hospitals to provide additional mental health stabilization services. Programs like this are essential to providing out-patient community support programs.

[28] Ohio House Bill 249 (135th General Assembly).
[29] The effectiveness of involuntary commitment as a treatment has mixed results across medical literature and is highly dependent on condition, time of commitment, and other factors like race, sex, and socioeconomic class. Most researchers agree that more research needs to be done in this area and that commitment should only be used as a last resort. For more information see: Morris, N. P., & Kleinman, R. A. (2023). Taking an Evidence-Based Approach to Involuntary Psychiatric Hospitalization. Psychiatric Services, 74(4), 431-433.
[30] Haldar and Guth (2021). State Policies Connecting Justice-Involved Populations to Medicaid Coverage and Care. KFF Health News.

- Create a Community Crisis Projects Granting program using General Revenue Funds to support community-led non-police crisis response initiatives all over the state. For example, programs are underway in Cleveland[31] that could be expanded using state resources.

Conclusion

The stigma and criminalization of involuntary commitment means that for many, just one bad day could change the rest of their life. Whether someone couldn't access their medication because of cost, couldn't afford transportation, a series of events they couldn't control, or simply the resurgence of a chronic mental health condition — a single event shouldn't dominate the rest of someone's life. Ohioans deserve improved access to mental health resources and services and further separation between the criminal legal system and the mental health crisis services available.

[31] Easterling, Schleiffer, and van Lier (2024). "Make sure you treat people how you want to be treated." Policy Matters Ohio, and van Lier (2022), Creating a Care Response in Cleveland. Policy Matters Ohio.