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Notes

FALLING THROUGH THE CRACKS: THE NEED FOR ENHANCED SUPERVISION IN THE INVOLUNTARY OUTPATIENT CIVIL COMMITMENT SETTING

I. INTRODUCTION

A young boy living in Virginia began showing signs of emotional abnormality, gradually worsening to the point of severe social anxiety and depression.¹ Fortunately, because he was living at home, any risk he posed to himself or the community was mitigated by his parents' commitment to take him to weekly therapy sessions.² In time, this boy grew into a young man who would go off to college, abnormal behaviors in tow.³ While at college, he no longer had a support system, causing his abnormal behaviors to intensify.⁴ After several run-ins with the police, he told his room-

1. See VA. TECH REVIEW PANEL, MASS SHOOTINGS AT VIRGINIA TECH: REPORT OF THE REVIEW PANEL 31-40 (2007), <http://www.governor.virginia.gov/TempContent/techPanelReport-docs/FullReport.pdf> [hereinafter VA. REPORT] (discussing mental health history from birth to high school of perpetrator of Virginia Tech 2007 shootings). During the young man's early years, he was quiet and would often sweat, become pale, or cry when called upon in class. See *id.* at 32 (discussing Virginia Tech perpetrator's mental health during early childhood). During middle school, his family took him to various counseling and psychiatric sessions; one psychiatrist diagnosed the boy as having "selective mutism" (an anxiety disorder) and "major depression: single episode." See *id.* at 34-35 (discussing young man's mental health during middle school). During high school, the young man barely communicated with teachers or peers, and when he did communicate, his speech was hard to understand. See *id.* at 36 (noting young man's speech difficulties in high school).

2. See *id.* at 39 (finding that young man's withdrawn behaviors categorized him as "high risk"). While at home, the young man's problems were mitigated by a support system that included his family and high school. See *id.* at 40 (finding that hometown school and family supervision were positive influences that ended when young man left home). Due to the young man's poor communication skills, his high school provided him with an Individualized Education Plan to help him succeed. See *id.* at 36-37 (finding that school's accommodations played important role in mitigating any threat posed by young man).

3. See *id.* at 37 (finding that guidance counselor advised young man to go to small school close to home, but young man was persistent in wanting to go to Virginia Tech). Before the young man left for college, his guidance counselor provided him with contacts near the college, but he never utilized any of these contacts. See *id.* at 38 (discussing guidance counselor's concerns about young man going to large school).

4. See *id.* at 42 (describing how young man took out knife and stabbed carpet while at get-together with friends). Classmates were scared of the young man after he read his writings to his creative writing class. See *id.* (noting that while young man read piece, he wore hat pulled down low and reflector sunglasses, and spoke in low voice). The writing was a dark, violent piece that insinuated he was dis-

mate that he might kill himself.⁵ Concerned, the roommate called the authorities, and the young man was taken for a psychiatric evaluation.⁶ A social worker classified the boy as mentally ill and suggested that he seek voluntary treatment, but he refused.⁷ Consequently, involuntary civil commitment proceedings were initiated.⁸ A special justice found that the

gusted by everyone in the class and hoped they all burned in hell. *See id.* (observing that piece read aloud was expression of frustration at fact that teacher previously used class time for off-topic discussion about eating animals). For a further discussion of young man's abnormal behaviors, see *infra* notes 5-6.

5. *See id.* at 47 (stating that young man told suitemate he "might as well kill [himself]" after police officer warned young man that he should have no further contact with certain girl). This was not the young man's first run-in with the police; a month earlier, the police had been called to talk with the young man after a girl reported that he had constantly sent her text messages and, on one occasion, had gone to her room wearing sunglasses and a hat, knocked on her door, and stated "I'm question mark." *See id.* at 45 (discussing abnormal behaviors of young man one year and four months prior to shootings).

6. *See id.* at 47 (discussing suitemate's report of suicide threat). When the young man was taken to be evaluated by a social worker, the police officers spoke with the young man's roommate. *See id.* (recounting how police spoke to roommate away from young man's presence). The social worker who assessed the boy spoke with the suitemate and the young man's roommate. *See id.* (finding that social worker talked with suitemate and roommate via phone). The suitemate and roommate were well acquainted with the young man's abnormal behaviors. *See id.* at 42 (discussing abnormal behaviors during fall 2005). They reported that the young man would write the lyrics to heavy metal music on the walls of their suite. *See id.* (describing suitemates' encounters with young man). Also, on a few occasions, when the suitemates would return to their suite, it would smell of burnt paper. *See id.* (same). Additionally, the young man would leave the room, call the suitemates, and identify himself as "question mark." *See id.* (same).

7. *See id.* at 47 (finding that social worker deemed young man mentally ill and danger to himself or others after speaking with young man, his roommate, and his suitemates).

8. *See id.* (noting that, pursuant to statutory procedures, social worker requested and received temporary detention order following classification of young man as mentally ill). In accordance with Virginia's Code, prior to its 2008 amendments, the police initially had authority to detain the young man based on an emergency custody order. *See* VA. CODE ANN. § 37.2-808(F)-(H) (West 2007) (permitting individual to be detained under emergency custody order until temporary detention order is issued or time of detention has exceeded four hours). Around 10:00 p.m., the young man was transported to a nearby hospital and, during the hospital's pre-admission assessment, the staff discovered that the young man had access to a firearm. *See* VA. REPORT, *supra* note 1, at 47 (discussing how treating facilities screen for potential violence and noting that information may not be entirely accurate). The following morning, the young man met with an independent clinical psychologist for fifteen minutes. *See id.* (stating that Virginia law requires evaluation by independent evaluator). He then met with the hospital's attending psychiatrist. *See id.* (noting that during interview young man was extremely quiet but did not seem dangerous). Both psychiatrists found that the young man was mentally ill, but neither found that he met the criteria for involuntary treatment. *See id.* (noting that neither psychiatrist found young man to be danger to self or others in spite of his mental illness). Both psychiatrists made these findings without reviewing any records of the young man's past or, unlike the social worker, without talking to the young man's roommates. *See id.* (discussing procedure of evaluations).

young man met the criteria necessary for involuntary *inpatient* civil commitment; however, due to the state's adherence to the "least restrictive doctrine," the justice allowed the young man to receive involuntary treatment on an *outpatient* basis.⁹

On the day the justice issued the commitment order, the boy attended one counseling session, but unbeknownst to all involved in the civil commitment proceeding, he never received any follow-up treatment.¹⁰ He slipped through the cracks of a civil commitment system that lacked "central direction and oversight."¹¹ As a result, the young man's condi-

9. See *id.* at 48 (discussing civil commitment proceeding). Neither the young man's suitemates, roommates, the social worker, nor the psychiatrists were present at the proceeding. See *id.* at 57 (finding that young man was only person to testify at hearing, and that he remained quiet during proceeding). There was no information regarding prior patient history, toxicology reports, or the hospital admittance form that indicated that the young man had access to a firearm. See *id.* (citing lack of information given to special justice). The holding that the young man met the criteria for involuntary civil commitment required the justice to find that the young man "present[ed] an imminent danger to himself or others as a result of mental illness . . ." See VA. CODE ANN. § 37.2-817(B) (West 2007) (setting forth threshold finding for involuntary commitment order). The young man was ordered to receive outpatient treatment, as opposed to inpatient treatment, based on the state's adherence to the least restrictive doctrine. See VA. REPORT, *supra* note 1, at 56 (finding that "less restrictive alternative to involuntary admission . . . was suitable"); see also Dora W. Klein, *Autonomy and Acute Psychosis: When Choices Collide*, 15 VA. J. SOC. POL'Y & L. 355, 382 n.150 (2008) ("The doctrine of the least restrictive alternative . . . refers to treatment in a setting that preserves the individual's freedom and autonomy to the greatest extent possible." (quoting Ilissa L. Watnik, Comment, *A Constitutional Analysis of Kendra's Law: New York's Solution for Treatment of the Chronically Mentally Ill*, 149 U. PA. L. REV. 1181, 1185-86 (2001))). For further discussion of the least restrictive doctrine, see *infra* notes 32-36 and accompanying text.

10. See VA. REPORT, *supra* note 1, at 49 (noting that counseling center's policy was "to allow patients to decide whether to make a follow-up appointment"). Under Virginia law, the treating physician has no duty to monitor compliance. See VA. CODE ANN. § 37.2-817(F) (West 2008) ("The order shall require the community services board to monitor the implementation of the mandatory outpatient treatment plan and report any material noncompliance to the court."). Further, at the time of the civil commitment proceeding, Virginia law did not clearly define the party responsible for monitoring compliance. See VA. CODE ANN. § 37.2-817(C) (West 2007) (stating that outpatient treatment could be monitored by community services board, behavioral health authority, or designated provider); see also VA. REPORT, *supra* note 1, at 61 (recommending that Virginia Code be amended to indicate party responsible for reporting non-compliance and responsibilities of monitor).

11. See VA. REPORT, *supra* note 1, at 59 (citing ELIZABETH MCGARVEY, CIVIL COMMITMENT PRACTICES IN VIRGINIA: PERCEPTIONS, ATTITUDES, AND RECOMMENDATIONS 1-2 (2007), http://www.courts.state.va.us/cmh/civil_commitment_practices_focus_groups.pdf) (discussing study that indicated that professionals and family stakeholders were frustrated with Virginia's civil commitment laws for various reasons). Many survey participants expressed frustration over the "lack of direction and oversight" in the administration of Virginia's civil commitment system. See *id.* (analyzing common complaints identified by study). In the case of the Virginia Tech tragedy, the order for outpatient commitment *could* have been a useful device for providing necessary medical services, but it failed because it lacked speci-

tion continued to deteriorate, ultimately culminating in a shooting spree that ended with his suicide, thirty-two dead, twenty-six injured, and countless more emotionally distraught.¹²

Although this may sound like a tragic work of fiction, this is the true story of the events leading up to the April 16, 2007 shootings at Virginia Tech.¹³ Following the tragedy, a review panel was formed to provide insight into the incident and offer recommendations in order to prevent future occurrences of such destruction.¹⁴ In particular, the panel spent a substantial amount of time addressing Virginia's policies and procedures with respect to involuntary civil commitment.¹⁵ One of the panel's main concerns was the state's procedures for monitoring individuals placed on involuntary outpatient civil commitment pursuant to the "least restrictive doctrine."¹⁶

ficity regarding the type of care that should have been provided, and because it lacked adequate mechanisms to enforce compliance. *See id.* at 58 (finding order provided no information regarding type of treatment, who was to provide treatment, or who was to monitor treatment).

12. *See id.* at 49-52 (discussing mental health of young man after civil commitment proceedings). One professor indicated that the boy was very quiet and wrote violent stories. *See id.* at 49 (finding that professor was concerned based on both content of young man's stories and his shyness). One of these stories portrayed a young man enraged by the happiness of all the students around him and described his desire to kill them. *See id.* at 50 (discussing disturbing content of story one year prior to shootings). Another professor raised concerns with the dean's office after the boy refused to make eye contact and showed up to class with a hat pulled low. *See id.* at 51 (explaining one professor's analysis of young man). The young man's roommate indicated that the young man barely talked. *See id.* at 51 (discussing young man's behavior during semester immediately prior to shootings). A little over a year after the civil commitment proceedings, the boy began buying guns and ammunition, and his class attendance decreased. *See id.* at 52 (discussing young man's activities in months leading up to shootings). The boy's deterioration resulted in a shooting spree that killed and injured over fifty-eight people. *See id.* at 135 (discussing results of shooting spree).

13. *See generally id.* (discussing April 16, 2007 events at Virginia Tech).

14. *See id.* at vii-viii (discussing purpose of review panel and expertise of those on panel). The panel was independent of the Commonwealth and offered various suggestions to revamp Virginia's laws on issues ranging from privacy laws to the procedures for firearms purchases. *See id.* at 68-70, 76 (citing recommendations for improving privacy laws and laws governing firearms purchases).

15. *See id.* at 60-62 (discussing panel's recommendations regarding Virginia's mental health laws). For example, the panel had many reservations about the current system and the lack of information made available to those responsible for evaluating possible involuntary commitment patients. *See id.* at 56-58 (citing concerns about lack of information given to special justice and independent evaluator). Additionally, the panel had concerns about the lack of specificity in outpatient orders. *See id.* at 58, 61 (noting that order at bar did not specify type of treatment, provider, or monitor). Specific orders are necessary so that supervisors can easily identify noncompliance. *See id.* at 59 (stating that because treatment order was unclear, there was confusion as to whether young man was noncompliant by not scheduling follow-up appointments).

16. *See id.* at 58, 61 (examining commitment procedure in this incident and recommending Virginia's Code be amended to specify who is responsible for reporting noncompliance, to whom noncompliance should be reported, and how

The panel's concerns with Virginia's statutorily mandated procedures for involuntary outpatient commitment are equally applicable to many states' outpatient commitment statutes.¹⁷ These states' outpatient civil commitment statutes generally share at least three common problems: (1) they fail to provide a clear mandate as to who is responsible for ensuring compliance with an outpatient order; (2) they fail to specify a supervisor's duties; and (3) they place the burden of reporting noncompliance on the treating professional.¹⁸ These problems lead to inadequate enforcement of involuntary outpatient treatment orders.¹⁹ As a result, outpatients diagnosed as mentally ill may, due to their illness, deny they are sick and reject the treatment they were ordered to receive.²⁰

outpatients should be monitored). To support the panel's conclusion that there needs to be clarification in the state's civil commitment laws, the panel cited a study that indicated that a major concern regarding civil commitment was a lack of oversight. See *id.* at 59 (citing MCGARVEY, *supra* note 11, at 1-2) (discussing study that involved interviews with sixty-four professional participants, sixty family members of individuals with mental illness, and eighty-six people who have been civilly committed).

17. See Jillane T. Hinds, *Involuntary Outpatient Commitment for the Chronically Mentally Ill*, 69 NEB. L. REV. 346, 354-55 (1990) (noting that "Institute on Mental Disability and the Law" (IMDL) cautions against use of involuntary outpatient civil commitment due to lack of procedures for monitoring compliance). The author specifically discussed Nebraska's involuntary outpatient civil commitment procedures and noted that "[t]he lack of clear procedures and guidelines for outpatient commitment often results in infrequent use . . ." *Id.* at 353; see also RALPH REISNER ET AL., *LAW AND THE MENTAL HEALTH SYSTEM* 725 (3d ed. 1999) (identifying one barrier preventing successful outpatient treatment as lack of "judicial mechanisms and personnel to adequately supervise outpatient care" (citing Steven Schwartz & Cathy Costanzo, *Compelling Treatment in the Community: Distorted Doctrines and Violated Values*, 20 LOY. L.A. L. REV. 1329, 1377 (1987))); Reese McKinney, Jr., *Involuntary Commitment, A Delicate Balance*, 20 QUINNIAC PROB. L.J. 36, 43 (2006) (finding outpatient civil commitment is unsuccessful because counselors' caseloads are too high to allow for necessary follow-up).

18. See, e.g., VA. CODE ANN. § 37.2-817(C) (West 2007) (showing that prior to statute's 2008 amendments no single authority was designated to monitor treatment). The last sentence of the statute provided that "[t]he community services board, behavioral health authority, or designated provider shall monitor the person's compliance with the treatment ordered by the court . . ." *Id.*; see also IDAHO CODE ANN. § 66-329(12) (2008) (failing to provide single authority to monitor compliance); N.D. CENT. CODE § 25-03.1-21(2) (2008) (same); OKLA. STAT. ANN. tit. 43, § 5-416(B) (West 2008) (same); VT. STAT. ANN. tit. 18, § 7618(b) (2008) (same); Hinds, *supra* note 17, at 353 (stating that Nebraska allows involuntary outpatient civil commitment but it is rarely used because no clear procedures or guidelines exist); see also ALA. CODE § 22-52-10.3(e) (2008) (requiring that treatment provider report noncompliance); D.C. CODE § 21-546(a) (2008) (same); GA. CODE ANN. § 37-3-82(b) (2008) (same); 405 ILL. COMP. STAT. ANN. 5/3-812 (West 2008) (same); IND. CODE ANN. § 12-26-14-9 (2008) (same); MONT. CODE ANN. § 53-21-151(1) (2008) (same); N.D. CENT. CODE § 25-03.1-21(3) (2008) (same); TEX. HEALTH & SAFETY CODE ANN. § 574.037(c) (Vernon 2008) (same).

19. For an example of how these problems can lead to inadequate oversight, see *supra* notes 10-12 and accompanying text.

20. See Hinds, *supra* note 17, at 376 ("Enforcement of outpatient orders is considered essential for effectiveness."); Ken Kress, *An Argument for Assisted Outpatient Treatment for Persons with Serious Mental Illness Illustrated with Reference to a Pro-*

To ensure that those ordered to receive involuntary outpatient treatment comply with their orders, states must centralize oversight by statutorily requiring individuals placed on involuntarily outpatient civil commitment to have supervisors who perform activities analogous to the activities performed by probation officers.²¹ Part II of this Note provides insight into the current system of outpatient involuntary civil commitment, highlighting the benefits of the system and the reasons why stricter mechanisms of supervision are essential to its success.²² Part III discusses the underpinnings of the probation system and the important roles of probation officers that could be adopted by outpatient supervisors in the civil commitment setting.²³ Part IV illustrates the benefits of statutorily providing for outpatient supervisors with clearly defined duties that parallel the duties performed by probation officers.²⁴ Finally, Part V concludes this Note by briefly summarizing the inherent benefits of using the probation system to guide the reconfiguration of the outpatient civil commitment system in the wake of the Virginia Tech tragedy.²⁵

II. OVERVIEW OF OUTPATIENT CIVIL COMMITMENT

To fully comprehend the benefits arising from an adequately enforced system of involuntary outpatient civil commitment, it is essential to understand the various meanings attached to the term “involuntary civil commitment.”²⁶ Additionally, it is important to understand the benefits stemming from outpatient care, the need for adequate supervision in the involuntary outpatient care setting, and the current problems hindering

posed Statute for Iowa, 85 IOWA L. REV. 1269, 1274 (2000) (“[M]any individuals who suffer from serious mental illness reject services because they deny they are ill.”). Hinds’ discussion of one Nebraska study illustrates why compliance is an area of concern. See Hinds, *supra* note 17, at 354 (finding that out of three inpatients selected to receive outpatient care, two did not keep their appointments and one moved).

21. See John Parry, *Involuntary Civil Commitment in the 90s: A Constitutional Perspective*, 18 MENTAL & PHYSICAL DISABILITY L. REP. 320, 320 (1994) (stating there must be “a fundamental reworking of the theories and practices that guide involuntary civil commitment nationwide”).

22. For a description of the system of involuntary civil commitment, as well as a discussion of involuntary civil commitment’s benefits and problems, see *infra* notes 28-55 and accompanying text.

23. For a discussion of probation’s history, methods of enforcement, and the roles of probation officers, see *infra* notes 58-107 and accompanying text.

24. For a discussion of what outpatient supervision entails and how the patient would benefit from such supervision, see *infra* notes 108-54 and accompanying text.

25. For a summary of the benefits that would arise from statutorily providing for supervisors who perform duties analogous to those of probation officers, see *infra* notes 155-60 and accompanying text.

26. For a discussion of the term “involuntary civil commitment,” see *infra* notes 28-31 and accompanying text.

adequate supervision of those placed on involuntary outpatient commitment.²⁷

A. *Involuntary Outpatient Civil Commitment Based on the Least Restrictive Doctrine*

Aside from the customary vagueness of involuntary outpatient statutes, “outpatient civil commitment” generates substantial confusion because there are at least three different definitions of this term.²⁸ Depending on why the person was placed on outpatient civil commitment, and what criteria the person met in order to be placed on outpatient commitment, the term could refer to (1) conditional release,²⁹ (2) preventative outpatient treatment,³⁰ or (3) the least restrictive doctrine.³¹

The rationale used for placing the perpetrator of the Virginia Tech shootings on outpatient commitment, and this Note’s focus, is outpatient commitment based on the “least restrictive” doctrine.³² This doctrine is an outgrowth of the deinstitutionalization movement, and is premised on

27. For a discussion of outpatient civil commitment’s benefits and burdens, see *infra* notes 37-55.

28. For a discussion of these three terms, see *infra* notes 29-31 and accompanying text.

29. See REISNER ET AL., *supra* note 17, at 780 (relating conditional release to parole). A patient is put on conditional release only after receiving inpatient care. See *id.* (discussing inpatient release procedures). The individual is permitted to leave inpatient care on the condition that the patient adheres to a particular outpatient treatment plan, and if the patient fails to adhere to the plan, then the patient can be immediately rehospitalized. See *id.* (discussing conditional release procedures). Conditional release has been unsuccessful due to a lack of outpatient resources and a lack of communication between all involved. See *id.* at 781 (finding that conditional release has been generally ineffective in practice).

30. See Kress, *supra* note 20, at 1291 (stating that preventative outpatient statutes are applicable when individual *may* become danger to self or others); see also Klein, *supra* note 9, at 382 n.132 (providing examples of preventative statutes). Preventative outpatient statutes have created much controversy because they “expand the reach of involuntary treatment,” and therefore allow an individual who does not satisfy the criteria for involuntary inpatient treatment to be placed on outpatient commitment if the individual fulfills a lower standard. See Klein, *supra* note 9, at 382 (discussing New York’s Kendra’s Law, which is well-known preventative outpatient commitment statute that allows individuals to be placed on outpatient commitment if they meet standards lower than those necessary for inpatient commitment). Commitment standards for preventative outpatient treatment ease the traditional requirements for institutionalization. See REISNER ET AL., *supra* note 17, at 724 (stating that such statutes require “that the individual will soon meet the traditional standards for institutionalization”).

31. For a thorough discussion of the least restrictive doctrine, see *infra* notes 32-36 and accompanying text.

32. See VA. REPORT, *supra* note 1, at 56 (stating that special justice found young man to be imminent danger to self but did not order inpatient care because less restrictive alternative to involuntary care was appropriate); see also VA. CODE ANN. § 37.2-817(B) (West 2007) (stating that, to order involuntary inpatient commitment, judge must find that (1) person presents imminent danger to self or others and (2) less restrictive alternatives to involuntary inpatient care are unsuitable).

the principle that individuals in outpatient commitment should be afforded the maximum liberty consistent with the government's interest in protecting from harm both the person placed on commitment and the community at large.³³ The doctrine requires that when a person meets the criteria for involuntary inpatient civil commitment, or similar criteria, the court must consider all alternative methods of treatment and their effectiveness before placing the person in inpatient care.³⁴ Generally, inpatient care requires that the individual be mentally ill, and as a result of that mental illness, is a danger to oneself or others, or is gravely disabled.³⁵ If a judge finds that an individual meets the aforementioned criteria, the least restrictive doctrine permits the judge to evaluate alternative methods of treatment, and decide whether to place the individual in inpa-

33. See Hinds, *supra* note 17, at 346-47 (stating that public awareness of abuse of mentally ill while institutionalized led to deinstitutionalization movement, and one of movement's goals was to provide treatment in least restrictive setting); Parry, *supra* note 21, at 324 (stating that although consideration of less restrictive means is not constitutionally required, most states recognize doctrine via statute or case law). Parry explained that the Supreme Court, in *Shelton v. Tucker*, 364 U.S. 479 (1960), established the principle that "even legitimate governmental purposes may not be pursued in ways that intrude on fundamental personal liberties when the same purposes can be achieved using less intrusive means." Parry, *supra* note 21, at 324 (citing *Shelton*, 364 U.S. 479). Parry noted that although *Shelton* seems to require states to consider the least intrusive means of care, the Court has resisted concluding that inpatients have a right to outpatient care. See *id.* (noting that Court recently upheld Kentucky law, even though less restrictive means were available, because law had rational basis).

34. See Klein, *supra* note 9, at 381 (stating that outpatient civil commitment statutes under least restrictive doctrine typically provide for "someone who meets the criteria for involuntary treatment to receive that treatment in either an inpatient or an outpatient setting"); Kress, *supra* note 20, at 1297 (finding that forty-one states have outpatient laws, and in about sixteen of these states criteria for inpatient and outpatient are identical).

35. See, e.g., ALASKA STAT. § 47.30.755(a) (2008) ("The court may commit the respondent to a treatment facility . . . if the court or jury finds . . . that the respondent is mentally ill and as a result is likely to cause harm to self or others, or is gravely disabled."); ARIZ. REV. STAT. ANN. § 36-540(A) (2008) (stating standard for commitment is that "patient, as a result of mental disorder, is a danger to self, is a danger to others, is persistently or acutely disabled or is gravely disabled and in need of treatment . . ."); COLO. REV. STAT. § 27-10-111(1) (2008) ("The court or jury shall determine that the respondent is in need of care and treatment [if] . . . the person has a mental illness and, as a result of the mental illness, is a danger to others or to himself or herself or is gravely disabled."); 50 PA. CONS. STAT. ANN. § 7301(a) (West 2008) (stating that person may be subject to involuntary care if, as result of mental illness, person cannot "exercise self-control, judgment and discretion in the conduct of his affairs and social relations or to care for his own personal needs is so lessened that he poses a clear and present danger of harm to others or to himself"); see also TREATMENT ADVOCACY CTR., STATE STANDARDS FOR ASSISTED TREATMENT: STATE BY STATE CHART (2007), http://www.psychlaws.org/LegalResources/documents/StateStandards-TheChart_000.pdf (identifying criteria of all fifty states' civil commitment laws).

tient care or allow the person to receive treatment while remaining in the community.³⁶

B. *The Benefits of Involuntary Outpatient Civil Commitment*

Although involuntary outpatient care does not allow for twenty-four hour care and supervision, outpatient treatment has various benefits.³⁷ First, outpatient civil commitment saves states money because the federal government does not subsidize the costs of inpatient care for mentally ill Medicaid patients; however, the federal government will contribute to the costs of these patients' outpatient care.³⁸ Furthermore, outpatient care is significantly cheaper than inpatient care.³⁹ Finally, outpatient care benefits the individual ordered to receive involuntary treatment because it promotes the maximum amount of liberty and prevents any stigmatization associated with inpatient psychiatric care.⁴⁰

C. *The Need for Adequate Supervision of Involuntary Outpatient Commitment Orders*

For involuntary outpatient commitment to succeed, the program must contain adequate enforcement mechanisms, because people who suffer from mental illness commonly deny having any illness at all and are therefore more likely to reject services.⁴¹ For example, one study indi-

36. See Klein, *supra* note 9, at 381 (referring to least restrictive doctrine as "hospital diversion").

37. For a further discussion of the benefits related to constant inpatient supervision, see *infra* notes 44-45 and accompanying text. For a discussion of the benefits related to outpatient civil commitment, see *infra* notes 38-40 and accompanying text.

38. See Kress, *supra* note 20, at 1275-76 (explaining why implementation of preventative outpatient treatment statute will save state millions of dollars per year).

39. See *id.* at 1341 (finding that, in 1998, one day of inpatient care in Iowa hospital cost \$1,200). On the other hand, Kress pointed out that an intensive outpatient program costs about \$10,000 per year. See *id.* at 1354 n.374 (observing that, as alternative to incarceration, individual could receive community treatment for forty percent of incarceration's cost). Multiplying \$1,200 by 365 days means a year of inpatient hospitalization amounts to \$438,000, which is about forty-three times the cost of an intensive outpatient program. Cf. *id.* at 1341, 1354 n.374 (discussing costs associated with inpatient care and community treatment).

40. See Hinds, *supra* note 17, at 347 n.7 (observing that outpatient care promotes "objective of maintaining the greatest degree of freedom, self-determination, autonomy, dignity, and integrity of body, mind, and spirit for the individual while he or she participates in treatment or receives services" (quoting 1 PRESIDENT'S COMM'N ON MENTAL HEALTH, REPORT TO THE PRESIDENT FROM THE PRESIDENT'S COMMISSION ON MENTAL HEALTH 44 (1978))); McKinney, *supra* note 17, at 37 (discussing deinstitutionalization and goal of creating system that allows for mentally ill to be "treated as individuals with basic humans rights, as opposed to faceless masses of insanity").

41. See Hinds, *supra* note 17, at 376 ("Without adequate monitoring of compliance, outpatient treatment may, in practice, be no different from unconditional release or no treatment."); Kress, *supra* note 20, at 1341 (stating that as individual's

cated that out of 13,540 people seen in different outpatient facilities, over forty percent terminated their treatment after one session.⁴² Another study suggesting a need for closer supervision of individuals placed on outpatient commitment compared the outcomes of three different groups: (1) individuals ordered to receive outpatient treatment; (2) individuals released into the community; and (3) individuals who voluntarily accepted inpatient treatment.⁴³ The study revealed that those who were not in inpatient care were more likely to skip appointments or other programs than those who were receiving inpatient care.⁴⁴ The study also showed that out of sixty-nine patients put on outpatient treatment, only thirty-one actually began the treatment.⁴⁵

Supervision is also important because noncompliance with ordered psychiatric care is linked to “increased clinical, social, and economic costs . . . relapse, rehospitalization, and poor outcome among patients with a major mental illness.”⁴⁶ Supervision is particularly important for those individuals who are on outpatient care and have been ordered to take medication.⁴⁷ Empirical research suggests that those with serious mental illnesses are no more dangerous than the general public when they take

mental illness worsens, patient becomes less in touch with reality and is less likely to be aware of illness and to seek treatment). For a further discussion of the importance of supervision, see *supra* note 20.

42. See Hinds, *supra* note 17, at 352 & n.30 (citing Stanley Sue, Herman McKinney & David B. Allen, *Predictors of the Duration of Therapy for Clients in the Community Mental Health System*, 12 COMMUNITY MENTAL HEALTH J. 365 (1976)) (discussing benefits of outpatient services but explaining why such treatment is not successful with mentally ill individuals).

43. See *id.* at 372, 374 & n.163 (citing Virginia A. Hiday & Teresa L. Scheid-Cook, *A Follow-Up of Chronic Patients Committed to Outpatient Treatment*, 40 HOSP. & COMMUNITY PSYCHIATRY 52, 52-59 (1989)) (concluding that patients should not be allowed to refuse medication because results of study indicate that patients commonly reject services). It must be noted that the study only examined those patients who were chronically mentally ill, had a history of medication refusal, or had a history of violence. See *id.* at 374 (discussing characteristics of study's participants).

44. See *id.* at 374-75 (presenting study's findings).

45. See *id.* at 374 (explaining that those on outpatient commitment are less compliant with orders compared to those on inpatient commitment because inpatient institutions provide constant supervision, and patients are not allowed to forget appointments).

46. See Franca Centorrino et al., *Factors Associated with Noncompliance with Psychiatric Outpatient Visits*, 52 PSYCHIATRIC SERVICES 378, 378 (2001) (discussing results of study that examined what factors are associated with adherence to outpatient visits). For further discussion of the study, see *infra* note 124.

47. See Kress, *supra* note 20, at 1272 (emphasizing correlation between mental illness and violence). One doctor stated that “[t]he data . . . suggest that individuals with serious mental illnesses are not more dangerous than the general population when they are taking their antipsychotic medication.” *Id.* (quoting E. Fuller Torrey, *Violent Behavior by Individuals with Serious Mental Illness*, 45 HOSP. & COMMUNITY PSYCHIATRY 653, 659 (1994)).

their prescribed medications.⁴⁸ In accordance with these research findings, one commentator suggested that “providing [adequate] treatment will reduce violence by persons who suffer from serious mental illness.”⁴⁹

D. *Impediments to Adequate Supervision of Individuals in Involuntary Outpatient Commitment*

Current outpatient statutes generally contain at least one of three problems: (1) they fail to provide a clear mandate as to who is responsible for supervision; (2) if they specify a monitor, they fail to state this individual’s duties; and (3) they place the burden of monitoring compliance on the treatment provider.⁵⁰ When the involuntary outpatient commitment system is burdened by inadequate oversight, there is a higher risk that those ordered to receive such care will fall through the cracks because information relating to their compliance will likely go unreported.⁵¹ Furthermore, putting the burden of monitoring outpatients on those providing the treatment is not a sound solution, because these providers are typically responsible for the care of too many patients.⁵²

48. *See id.* at 1285 n.61 (citing authorities confirming that mentally ill individuals who are properly treated are no more violent than general population). For example, one commentator found that “[m]edication noncompliance was associated foremost with threatened or potential violent behavior towards others.” *Id.* (quoting Leta D. Smith, *Medication Refusal and the Rehospitalized Mentally Ill Inmate*, 40 HOSP. & COMMUNITY PSYCHIATRY 491, 493 (1989)).

49. *See id.* at 1285 (noting that numerous studies found that mentally ill individuals who follow prescribed medication regimens are significantly less dangerous than those who do not follow such regimens).

50. For citations to statutes manifesting these problems, see *supra* note 18.

51. *See* VA. REPORT, *supra* note 1, at 58-59 (explaining that disconnect between all parties involved in commitment process caused person actually responsible for monitoring court order to lack notification of such responsibility). The report also indicated that the relevant statute failed to specify how the party responsible for monitoring outpatient compliance should be notified of noncompliance. *See id.* at 59 (finding that statute poses no obligation on treatment provider to report noncompliance). Due to privacy restrictions, the treating facility was unsure whether it could report noncompliance. *See id.* (discussing restrictions of Virginia privacy laws). Also, the vagueness of the statute prompted the panel to recommend that it be amended to clarify specifically who is responsible for reporting noncompliance and to whom this information should be reported. *See id.* at 61 (citing panel’s recommendations after reviewing Virginia’s civil commitment laws).

52. *See* McKinney, *supra* note 17, at 43 (stating that deinstitutionalization tried to resolve staff-to-patient ratio but failed to do so). “For every counselor doing outpatient therapy in a public mental health center, there are often hundreds of patients assigned to his or her caseload.” *Id.* at 53. The problem is worsened by the fact that some states put a heavy burden on treating facilities. *See* MONT. CODE ANN. § 53-21-151(2)(c) (2008) (stating that when patient is noncompliant, judge can put burden on practitioner to bring about compliance); Hinds, *supra* note 17, at 379 (noting that North Carolina and Hawaii require physicians to make all reasonable efforts to solicit compliance before notifying court of noncompliance).

One commentator noted that a usual consequence of inadequate supervision and noncompliance is “jail[] or worse.”⁵³ Given the importance of supervision in the life of an individual placed on outpatient civil commitment, and given the inability of current statutes to provide for such supervision, states must revamp their outpatient statutes and provide for more specific guidance and centralized systems of supervision.⁵⁴ Accordingly, the criminal probation system provides a model capable of addressing many of the flaws of current outpatient civil commitment statutes.⁵⁵

III. OVERVIEW OF PROBATION

To sufficiently import aspects of the system of probation into the system of involuntary civil commitment, legislators must first understand the goals of probation.⁵⁶ In addition, legislators must understand the benefits of probation, the role of supervision in probation, and how such supervision is performed within the probation setting.⁵⁷

A. Past and Present Goals of Probation

Probation emerged in 1841 as a result of one man’s aspiration to rehabilitate offenders.⁵⁸ This man, John Augustus, strived to achieve this goal by posting bail for offenders and supervising them while they lived in the community.⁵⁹ Similar to a modern-day probation officer, Augustus would investigate each offender whom he considered rehabilitating, provide supervision for each offender, and keep records on the offender.⁶⁰

53. See McKinney, *supra* note 17, at 43 (noting that deinstitutionalization has not resulted in better care due to lack of financial resources, thereby causing individuals to fall through cracks).

54. See VA. REPORT, *supra* note 1, at 60-61 (urging that current state statute be amended to provide for clarity). For a further discussion of the importance of supervision, see *supra* notes 41-49 and accompanying text.

55. For a further discussion of the current system of probation and its application in the realm of outpatient civil commitment, see *infra* notes 58-154.

56. For a discussion of the goals of probation, see *infra* notes 58-70 and accompanying text.

57. For a discussion of these aspects of probation, see *infra* notes 58-107 and accompanying text.

58. See Wayne A. Logan, *The Importance of Purpose in Probation Decision Making*, 7 BUFF. CRIM. L. REV. 171, 174-75 (2003) (stating that founder’s goal was to reform criminals and prevent crime through rehabilitation rather than through malicious punishment).

59. See HOWARD ABADINSKY, PROBATION AND PAROLE THEORY AND PRACTICE 28 (8th ed. 2003) (stating that Augustus’s interest in rehabilitating offenders was sparked when one offender charged with being drunkard told Augustus that if Augustus would post bail for him then he would never drink again). Augustus rehabilitated all types of offenders; significantly, of two thousand cases, only ten offenders ran away during rehabilitation. See *id.* (discussing birth of probation).

60. Compare *id.* (discussing various aspects of Augustus’s system of probation), with 18 U.S.C. § 3603 (2006) (providing list of probation officer’s duties, which include supervising offenders, keeping records, and reporting to court), and 18

After Augustus died, probation's popularity spread throughout New England, and every state had a probation system for adults by 1956.⁶¹ Today, the probation system is complex and consists of various agencies responsible for supervising the roughly four million people currently within the system.⁶²

The original goal of probation was to rehabilitate offenders by focusing on the reasons why they engaged in unlawful behavior, and by creating personalized sentences to restore offenders to society.⁶³ In the 1970s, however, the notion of rehabilitation as a goal of the criminal justice sys-

U.S.C. § 3552(a) (2006) (requiring probation officer to make presentence investigation of defendant before sentence is imposed); *see also* Sharon M. Bunzel, Note, *The Probation Officer and the Federal Sentencing Guidelines: Strange Philosophical Bedfellows*, 104 YALE L.J. 933, 940-44 (1995) (describing investigation involved in presentence reports under rehabilitative model of probation); Am. Prob. & Parole Ass'n, Probation Position Statement (1997), http://www.appa-net.org/eweb/Dynamicpage.aspx?site=APPA_2&webcode=IB_PositionStatement&wps_key=DC223702-d690-4830-9295-335366a65d3e (finding that officers' main duties are (1) to provide investigation and reports to court, (2) to aid in developing conditions of probation, and (3) to supervise probation). Under the rehabilitative model of probation, there is a focus on creating individualized sentences appropriate for a particular offender's needs. *See* Bunzel, *supra*, at 938 (stating that foundation of probation was to achieve goal of offender rehabilitation via individualized sentences). To achieve the goal of rehabilitation through effective probation, the court requires complete information about each offender. *See id.* at 940 (finding that presentence report is necessary for rehabilitative model to be successful). Probation officers gradually received the duty of creating formal presentence reports, which provided judges with "a thorough understanding of the person to be sentenced." *See id.* at 941 (stating that presentence report is key component in issuing individualized sentences adapted to offender's needs); *see also* ABADINSKY, *supra* note 59, at 77, 89 (describing effects of sentencing guidelines on probation officer's presentence report duty).

61. *See* ABADINSKY, *supra* note 59, at 29 (discussing how Massachusetts legislature enacted first probation statute and how probation eventually gained popularity in other New England states). The juvenile court movement expanded the use of probation in many states. *See id.* at 29-30 (discussing acceleration of probation movement).

62. *See id.* at 2 (recognizing that overcrowding and high cost of imprisonment have resulted in many being put on probation). Today, more than two thousand separate agencies administer probation. *See id.* at 31 (discussing administration of probation).

63. *See* Logan, *supra* note 58, at 174-75 (stating that founder's intent was to rehabilitate). Logan noted that during the Progressive Era there was a strong movement aimed at promoting the goal of rehabilitation in the criminal justice system, and this movement culminated in the Supreme Court's acknowledgment that "[r]eformation is no longer the dominant objective of the criminal law. Reformation and rehabilitation of offenders have become important goals of criminal jurisprudence." *See id.* at 177, 179 (discussing history of probation (quoting *Williams v. New York*, 337 U.S. 241, 248 (1949))); *see also* Bunzel, *supra* note 60, at 935 (stating that philosophy that rehabilitation should exist in criminal justice scheme led to programs such as probation). Bunzel observed that "for over a century after probation's introduction in America, 'the concept of rehabilitation [was] at the heart of any official statement of mission regarding probation.'" *Id.* at 940 (quoting EUGENE H. CZAJKOSKI, *Issues in Probation and Parole in the Administration of Justice System* 351, 354 (Donald T. Shanahan ed., 1977)).

tem came under attack, as various studies indicated high recidivism and crime rates among individuals in the probation system.⁶⁴ As a result of these new studies, the public urged politicians to instead emphasize the goals of retribution and incapacitation, thus resulting in the “justice model” of probation.⁶⁵ This new model permitted probation officers to engage in more aggressive, enforcement-oriented strategies to facilitate compliance with court orders.⁶⁶

Although the justice model shook the rehabilitative foundation of probation, state legislatures still recognize rehabilitation as one of the primary goals of probation.⁶⁷ Probation’s other primary motives include concerns about the overcrowding of jails and the costs of imprisonment.⁶⁸

64. See Logan, *supra* note 58, at 189-90 (discussing 1970s study showing failure of rehabilitative efforts, thus prompting many to question value of rehabilitation ideology).

65. See *id.* at 191 (stating that although rehabilitation was linchpin of probation, probation survived because it adjusted and established “justice model” of probation); MARCUS PURKISS ET AL., *Probation Officer Functions—A Statutory Analysis*, 67 FED. PROBATION 12, 12 (2003) (stating that rehabilitative model of criminal justice was criticized and subsequently led to change in probation’s goals). Purkiss noted that these new primary goals were “community protection and offender control.” See Purkiss, *supra* (discussing effects of new “get tough” stance in response to crime).

66. See Logan, *supra* note 58, at 192 (describing aggressive strategies of supervision that included “boot camps; intensive supervision; house arrest and electronic monitoring; halfway houses; day-reporting centers; community service; restitution; day fine programs; weekend sentencing; and enhanced monetary penalties”); PURKISS ET AL., *supra* note 65, at 12 (discussing 1992 study of state statutes that indicated that many state legislatures mandated probation officers to perform enforcement-oriented tasks).

67. See Purkiss et al., *supra* note 65, at 13 (discussing study that indicated that state statutes are beginning to, once again, mandate probation officers to engage in rehabilitation duties); see also ABADINSKY, *supra* note 59, at 288 (stating that two primary goals of probation are protection of community and rehabilitation); Andrew M. Hladio & Robert J. Taylor, *Parole, Probation and Due Process*, 70 PA. B. ASS’N Q. 168, 171 (1999) (arguing that probation’s main goal is to provide rehabilitation without incarceration). A 1992 study of state statutes indicated that probation officers mainly performed law enforcement tasks, suggesting that, at least as of 1992, the main goals of probation were punishment and public safety. See Purkiss et al., *supra* note 65, at 13 (discussing study findings with regard to probation’s objectives). In contrast, Purkiss’s 2002 study of states’ probation statutes indicated that there are twenty-three prescribed functions of probation officers, and five of these functions are oriented towards rehabilitation. See *id.* at 13 (reviewing findings of recent study of probation statutes). These five functions require a probation officer to assist in rehabilitation, counsel offenders, develop community service programs, locate employment for offenders, and write presentence reports. See *id.* (citing statutorily mandated rehabilitative duties). Thus, the study revealed a slow growing trend in favor of mandating probation officers to perform rehabilitative tasks. See *id.* (indicating increase in legislatively mandated rehabilitative duties between 1992 and 2002).

68. See ABADINSKY, *supra* note 59, at 5 (stating that consequence of prisons being overcrowded and underfunded is that more people are put on probation or parole). Abadinsky pointed out that, on average, it costs about \$1,500 a year to supervise an individual on probation. See *id.* at 18 (discussing average yearly cost of probation). On the other hand, it typically costs a state \$12,000 a year to house an

Many regard probation as an attractive alternative to imprisonment because it “accomplish[es] the goal of rehabilitation, reform, reduction of cost of keeping an individual imprisoned, while also allowing the individual more freedom and opportunity to pay taxes, and be productive.”⁶⁹ Finally, probation is driven by achieving the goals of offender punishment, deterrence, and public protection.⁷⁰

B. *Probation’s Benefits*

The probation system provides various benefits to both individuals and society.⁷¹ First, it helps control crime at relatively low costs to the states.⁷² Second, it allows the offender to have maximum liberty while, at the same time, punishing the offender and protecting the community.⁷³ Third, even if rehabilitation is not a goal of a state’s probation statute, probation nevertheless promotes rehabilitation because it permits the offender to maintain a normal daily life.⁷⁴ This is an especially important aspect of probation, as it allows offenders to avoid the problems associated with reintegrating back into the community after a period of imprisonment.⁷⁵

inmate under the age of fifty and \$60,000 a year for inmates over the age of fifty. *See id.* at 18-19 (comparing costs of probation to costs of imprisonment). These costs are considerably higher than the costs of an order for intensive supervision, which can cost anywhere from \$4,500 to \$1,300 depending on the state. *See id.* at 18 (discussing costs of imprisonment and intensive supervision). Abadinsky stated that “according to most estimates imprisonment costs from 10 to 13 times as much as probation.” *Id.* at 36-37.

69. Hladio & Taylor, *supra* note 67, at 176. In Pennsylvania, there are more offenders serving their sentences on probation than in jails. *See id.* (highlighting popularity of probation due to overcrowding and cost concerns).

70. *See* Logan, *supra* note 58, at 196 (stating that probation achieves rehabilitation, but that rehabilitation is not probation’s primary goal).

71. For a discussion of the benefits of probation, see *infra* notes 72-75 and accompanying text.

72. For a discussion of the costs saved by ordering probation over imprisonment, see *supra* note 68.

73. *See* ABADINSKY, *supra* note 59, at 37 (discussing some of probation’s advantages over imprisonment).

74. *See id.* (discussing advantages of probation over imprisonment); *see also* Logan, *supra* note 58, at 180 (arguing that “[p]robation enables the offender to reshape his life in the framework of normal living conditions; it preserves family life and other normal social relationships Probation avoids the shattering impact of imprisonment on personality; it avoids imprisonment’s stimulation of hatred . . . [and] it avoids the stigma attached to imprisonment.” (quoting NAT’L PROB. & PAROLE ADVISORY COUNCIL FOR JUDGES, GUIDES FOR SENTENCING 16 (1957))).

75. *See* ABADINSKY, *supra* note 59, at 318, 372 (discussing labeling and stigmatization associated with those previously imprisoned). Additionally, when an inmate is released from jail, the offender is usually given a small stipend that is barely enough to cover immediate housing and food expenses. *See id.* at 356 (explaining financial problems offender faces following release from prison). Recent research suggests that financial difficulties faced by a released offender should be alleviated

C. *Supervision in Probation*

Because probation is a product of state and federal statutes, the legislative branch defines the duties of probation officers.⁷⁶ An examination of state and federal probation statutes indicates that a primary duty of probation officers in the vast majority of states is to act as supervisors.⁷⁷ More specifically, one study indicated that, as of 2002, forty-six statutes required a probation officer to fulfill the duty of supervisor.⁷⁸

Most of these statutes also provide clear guidance as to what supervision entails.⁷⁹ For example, many statutes require offenders to make reports to an officer or require the officer to visit the offender's home.⁸⁰ Other statutes require probation officers to supervise probationers in accordance with directions provided by the sentencing court.⁸¹ In addition, the federal judiciary has elaborated upon the duty of supervision, providing that supervision requires the officer to inform the offender of the court's expectations, meet with the offender at home or work, monitor the offender's compliance with the court order, and deal with issues of noncompliance.⁸²

via support payments because such payments have been shown to reduce recidivism. *See id.* (discussing impact of problems associated with release).

76. *See, e.g.*, 18 U.S.C. § 3603 (2006) (discussing duties of probation officers); ALA. CODE § 15-22-53(a) (2008) (same); ARIZ. REV. STAT. ANN. § 12-253 (2008) (same); COLO. REV. STAT. § 16-11-209 (2008) (same); IND. CODE § 11-13-1-3 (Sec. 3) (2008) (same); KY. REV. STAT. ANN. § 439.480 (West 2008) (same); MONT. CODE ANN. § 46-23-1011 (2008) (same); N.H. REV. STAT. ANN. § 504-A:12 (2008) (same); N.J. STAT. ANN. § 2A:168-11 (West 2008) (same); N.C. GEN. STAT. § 15-205 (2008) (same); OR. REV. STAT. § 137.630 (2008) (same); VA. CODE ANN. § 53.1-145 (2008) (same); WYO. STAT. ANN. § 7-13-401 (2008) (same).

77. *See* Purkiss et al., *supra* note 65, at 13-14 (elaborating on 2002 study of all states' probation statutes that indicated that supervision is most prescribed task among states); Admin. Office of U.S. Courts, Probation and Pretrial Supervision, <http://www.uscourts.gov/fedprob/supervise.html#what> (last visited Mar. 30, 2009) [hereinafter U.S. Courts] (stating that core responsibilities of probation officers are supervision and investigation); U.S. DEP'T OF LABOR, BUREAU OF LABOR STATISTICS, OCCUPATIONAL OUTLOOK HANDBOOK 1 (2008-09 ed.), <http://www.bls.gov/oco/pdf/ocos265.pdf> (stating that supervision is one primary duty of probation officers).

78. *See* Purkiss et al., *supra* note 65, at 13-14 (calculating number of states that partake in each of twenty-three legislatively mandated duties of probation officers).

79. *See, e.g.*, ALA. CODE § 15-22-53(a) (2008) (stating that supervision is achieved by "visiting, requiring reports and in other ways"); N.H. REV. STAT. ANN. § 504-A:12(II) (2008) (same); N.C. GEN. STAT. § 15-205 (2008) (same); OR. REV. STAT. § 137.630(1)(e) (2008) (same); WYO. STAT. ANN. § 7-13-401(a)(iv) (2008) (same).

80. *See, e.g.*, N.C. GEN. STAT. § 15-205 (2008) (requiring officer to keep informed of probationer "by visiting, requiring reports, and in other ways"). For a further discussion of statutes providing similar clear guidelines, see *supra* note 79.

81. *See* 18 U.S.C. § 3601 (2006) (mandating that offender placed on probation be subject to supervision of probation officer).

82. *See generally* U.S. Courts, *supra* note 77 (providing information about probation and pretrial services). The website provides a definition of supervision, emphasizing that probation is "a way to monitor the activities of those released to the

One important aspect of probation, which is related to supervision, is the "initial interview."⁸³ Supervision begins with an initial interview that takes place at the probation office and allows the probation officer and offender to enter into a counseling relationship.⁸⁴ At this interview, the probation officer explains the court order, answers questions, and discusses how the offender will stay in contact with the probation officer.⁸⁵ Following the interview, the probation officer makes a plan of action that is designed to ensure that all supervision activities facilitate compliance with the court order.⁸⁶ In some instances, the probation officer will negotiate the case plan with the offender.⁸⁷

When a condition of probation is psychiatric treatment, the officer will make a referral to a community-based agency where a team of psychologists and a psychiatric social worker will evaluate the offender and render a treatment plan.⁸⁸ The officer will then develop a case plan designed to carry out the treatment plan.⁸⁹ Depending on the risk posed by the of-

community" *Id.* Additionally, the website stresses that supervision accomplishes the goals of enforcing court orders, protecting the community, and providing treatment and assistance. *See id.* (providing overview of what supervision entails).

83. *See* ABADINSKY, *supra* note 59, at 355 (describing initial interview as "sizing up" process and discussing various questions raised during interview); John P. Storm, *What United States Probation Officers Do*, 61 *FED. PROBATION* 13, 14-17 (1997) (discussing initial interview and its purpose).

84. *See* ABADINSKY, *supra* note 59, at 355-56 (describing initial interview, and stating that interview can be difficult due to its nonvoluntary nature).

85. *See id.* at 356 (discussing several aspects of probation that are emphasized at initial interview). The items discussed at the interview may change according to the special conditions set forth in the offender's court order. *See id.* (providing example of alcoholic offender's interview in which probation officer discouraged use of alcohol); *see also* Storm, *supra* note 83, at 16 (clarifying that probation officers are responsible for ensuring probationer understands the purpose of each condition of probation).

86. *See* ABADINSKY, *supra* note 59, at 359-60 (discussing supervision planning process). Typically, the officer will review the conditions of release, the risk posed by the offender, and the characteristics of the offender in order to create a supervision plan that addresses the individual's particular needs. *See id.* (discussing drafting of case plan). The officer's goals in creating the plan include facilitating compliance with the court order, providing protection to the community, and providing for correctional treatment. *See id.* at 360 (discussing drafting of case plan). The case plan will provide only for the supervision of activities necessary to achieve these goals. *See id.* (explaining why there is emphasis on particular activities of probation as opposed to frequency). Consequently, "the quality of supervision depends on what is accomplished by a particular activity rather than its frequency." *Id.*

87. *See id.* at 357 (noting that, in some jurisdictions, officer will negotiate plan with offender and both parties will develop conditions of probation that are necessary to ensure compliance).

88. *See id.* at 42 (discussing how Philadelphia probation system handles offenders in need of special treatment for drug, alcohol, or other mental health problems).

89. *See id.* at 42-43 (elaborating upon Philadelphia's system of providing mental health services to offenders). The author also cited a Wyoming case plan

fender, the officer may include within the case plan a requirement that the officer make periodic visits to the offender's home.⁹⁰ Home visits play an important role in the probation system because they allow the officer to better understand the social influences acting on the probationer, thereby allowing the officer to adjust the case plan to better accommodate the offender's needs and to bring about compliance.⁹¹

Another important aspect of probation is the "risk/needs assessment," which the probation officer conducts to determine how much supervision a particular offender requires.⁹² This assessment requires the officer to quantify variables relating to (1) the possibility that the offender will recidivate and (2) the amount of assistance the offender requires.⁹³ The officer then compares the two numbers, and whichever number is higher will determine whether the offender requires a reduced, regular,

to illustrate how that jurisdiction handles the special condition that an offender seeks drug treatment. *See id.* at 357 (providing sample negotiated case plan). In order to ensure compliance with the drug facility's treatment plan, the burden is on the officer to periodically verify with the mental health agency that the offender is complying with his or her treatment plan. *See id.* (examining "plan of action" column of negotiated case plan); *see also* Sam Torres, *The Substance-Abusing Offender and the Initial Interview*, 61 FED. PROBATION 11, 14-15 (1997) (elaborating on case plans of substance-abusing probationers).

90. *See* ABADINSKY, *supra* note 59, at 364-65 (discussing role of home visits in ongoing treatment of probationer).

91. *See id.* at 299 (stressing that home visits not only allow probation officer to directly observe probationer's environment, but also allow officer to interact with probationer's family members in order to involve them in rehabilitating offender). Additionally, home visits allow the probation officer to provide support for the probationer's family. *See id.* (discussing benefits of home visits). To avoid any stigmatization that could result from the officer's visits, it is imperative that the officer protect the confidentiality of the case and avoid drawing attention to the home visit. *See id.* at 365 (indicating that confidentiality of offender's probation status is important area of concern). For example, to facilitate confidentiality, Florida requires all officers to use unmarked vehicles and to send correspondences in inconspicuous envelopes. *See id.* (discussing Florida's requirements for keeping offender's probation status confidential).

92. *See id.* at 348 (stating that "risk/needs assessment" was developed in 1970s and early 1980s in order to accurately categorize offenders, so they could receive proper level of supervision). The risk/needs assessment accounts for all factors relevant in determining the proper level of supervision for an offender, is easy to use, and helps officers manage caseloads. *See id.* (stating benefits of risks/needs assessment that account for its widespread use). *See generally* James Byrne, *Introduction to Special Issue on Risk Assessment*, 70 FED. PROBATION (SPECIAL ISSUE) i, i-ii (2006) (introducing magazine that includes various expert articles evaluating risks/needs assessments).

93. *See* ABADINSKY, *supra* note 59, at 348-53 (stating that although jurisdictions differ in exact risk/needs assessment used, all strive to quantify factors relating to level of supervision needed to prevent any risk that offender poses to community and to provide adequate supervision to satisfy offenders' needs). Abadinsky provides a representative risk/needs assessment form that identifies some of the various factors examined when quantifying an offender's risks and needs. *See id.* at 348-49 (identifying factors such as age of first conviction, attitude, drug usage problems, employment, emotional stability, and health).

close, or intensive level of supervision.⁹⁴ The level of supervision will identify certain activities the probation officer must perform to ensure that the offender does not recidivate (e.g., facilitating mental health treatment, job training, or scheduled meetings).⁹⁵ After the appropriate department of probation determines what level of supervision is necessary for a particular offender, the department will assign that case to an officer, depending on that officer's ability to meet the offender's needs while maintaining his or her current caseload.⁹⁶

D. *Duties Stemming from the Role of Supervisor*

One commentator has broken down the probation officer's duty of supervision into ten sub-roles; this Note focuses on the three of these roles that are most conducive to the system of involuntary outpatient civil commitment.⁹⁷ One role the probation officer plays is that of "broker."⁹⁸ This role requires the officer to act as a liaison between the offender and the services that are beneficial to the offender.⁹⁹ While acting as a broker, there is an emphasis "placed on the close working relationship between the probation officer and the staff members of community social services."¹⁰⁰ By putting the offender in touch with service programs such as

94. *See id.* at 348-50 (describing Pennsylvania's risk/needs assessment, which is typical of most jurisdictions).

95. *See id.* at 351-52 (describing duties required by different levels of supervision in Georgia and Nebraska). For example, in Georgia, minimum supervision requires the probationer to have monthly telephone contact with the officer. *See id.* at 351 (discussing duties corresponding with each level of supervision). On the other hand, maximum supervision requires "[f]our monthly face-to-face contacts, two monthly field contacts, and two monthly collateral contacts." *Id.*

96. *See id.* at 350-51 (describing caseload distribution in Texas, Georgia, and Nebraska). In Texas, a probation officer is permitted to have a one hundred point workload. *See id.* at 350 (illustrating caseload distribution in Texas). After a risk/needs assessment is done, the offender is classified as requiring Level I, II, III, or IV supervision, and each level has a corresponding workload point value (e.g., Level I = 4.00 workload points). *See id.* (explaining that higher workload point value indicates that probation officers must perform more supervision duties). This system allows probation officers to manage their caseloads by making sure that they do not take on more than one hundred points at a time. *See id.* (explaining how probation officers manage their workloads by considering how many total workload points they have at any given time).

97. *See id.* at 322-23 (stating that probation officers are information managers, evaluators, enablers, educators, brokers, advocates, mediators, community planners, detectors, and enforcers).

98. For a further discussion of the role of broker, see *infra* notes 99-101 and accompanying text.

99. *See* ABADINSKY, *supra* note 59, at 323 (summarizing broker's role). While acting as broker, the probation officer will break down any barriers and aid the probationer in obtaining needed services. *See id.* at 327 (noting that outside services may attach unwarranted stigma to probationer, thus making it hard for probationer to receive necessary services).

100. *Id.* at 327. Some argue that when acting as broker, counseling and guidance should be left to professionals; that is, there should not be an emphasis on the officer's relationship with the offender. *See id.* (analyzing whether brokerage

drug rehabilitation or a job agency, the officer invokes positive changes in the offender's life, and the offender partakes in activities that facilitate rehabilitation.¹⁰¹

A second role the probation officer plays is that of "detector."¹⁰² This role requires the probation officer to determine when an offender is at risk for recidivating.¹⁰³ If the officer determines that the offender is at risk, then the officer must take steps necessary to alleviate the risk.¹⁰⁴

A third role played by the probation officer is that of "enforcer."¹⁰⁵ This role places the burden of ensuring compliance with the offender's court order on the probation officer, and when there is noncompliance the officer is responsible for initiating proceedings for revocation of probation.¹⁰⁶ When probation officers engage in these and other statutorily defined roles, they adequately provide supervision and help ensure the probation system's success.¹⁰⁷

approach should be different than rehabilitative approach). On the other hand, a strong relationship between the two parties will help the officer understand which services will best suit the probationer's particular needs. See *id.* at 297-301 (discussing social casework theory of achieving rehabilitation in probation).

101. See *id.* at 288 (stating that when probation officers partake in certain activities, such as referring offenders to drug programs, officers facilitate rehabilitation). One way rehabilitation is achieved is through social caseworkers. See *id.* at 294-95 (discussing social casework theory of achieving rehabilitation in probation). When a probation officer acts as a broker, the officer is essentially acting as a social caseworker because the officer is "develop[ing] . . . a relationship . . . within a problem-solving context, and coordinat[ing] with the appropriate use of community resources." See *id.* at 294 (quoting Brennan et al., *Forensic Social Work: Practice and Vision*, 67 SOC. CASEWORK 340, 342 (1986)). Central to adequate social casework is the notion that the parties must have an open relationship, so that the officer can aid the probationer in finding services that fit the offender's particular needs. See *id.* at 299 (discussing ego support provided by social caseworker).

102. For a further discussion of the role of detector, see *infra* notes 103-04 and accompanying text.

103. See ABADINSKY, *supra* note 59, at 323 (observing that three objectives of officer in his or her role as detector include identifying individuals that are experiencing difficulty, identifying conditions in community that are contributing to individuals' personal problems, and determining when community is at risk).

104. See *id.* at 43-46 (stating that, in some jurisdictions, when offender violates probation, officer will typically deal with violation and try to restore compliance without involving sentencing judge).

105. For a further discussion of the role of enforcer, see *infra* note 106 and accompanying text.

106. See ABADINSKY, *supra* note 59, at 323 (defining role of enforcer); see also *Gagnon v. Scarpelli*, 411 U.S. 778 (1973) (holding that hearing and counsel are required for revocation of probation). In *Gagnon*, the Court held that when there is revocation of probation, a hearing and due process must be afforded because revocation results in loss of conditional liberty. See *Gagnon*, 411 U.S. at 782 (relating revocation of probation to revocation of parole and citing case where court held revocation of parole required due process).

107. See generally Purkiss et al., *supra* note 65, at 14-22 (identifying all statutorily defined roles of probation officers). For a further discussion of the history and growth of probation, see *supra* notes 58-62 and accompanying text.

IV. LESSONS FROM PROBATION: REVAMPING OUTPATIENT CIVIL COMMITMENT LAWS

Outpatient civil commitment is a complex process that involves various actors and places significant responsibility on the mentally ill patient.¹⁰⁸ Accordingly, state civil commitment statutes should use the probation system as a model, and centralize all oversight of those placed on outpatient commitment in one figure who performs duties similar to those of a probation officer.¹⁰⁹ The probation system provides adequate guidance for revamping involuntary outpatient commitment statutes because the probation system has generally facilitated compliance with court orders without the use of twenty-four hour supervision.¹¹⁰ Additionally, the probation system is a useful model because, like outpatient civil commitment, it emphasizes rehabilitation and community protection.¹¹¹

Statutorily providing individuals in outpatient commitment programs with supervisors who must perform duties similar to those of probation officers will rectify the current problems of outpatient civil commitment statutes.¹¹² More specifically, such a system would (1) provide a clear mandate as to who is responsible for supervision, (2) provide the supervisor with specific duties, and (3) take the burden of supervision off of treating professionals.¹¹³ Furthermore, providing for such supervisors would create an efficient outpatient system that would free up judicial resources and eliminate the costs associated with noncompliance.¹¹⁴ Finally, al-

108. See VA. REPORT, *supra* note 1, at 47-48 (identifying that parties involved in civil commitment process include police officers, social workers, psychiatrists, hospital personnel, clinical support representatives, judicial magistrates, and university counseling centers). For a discussion of Virginia Tech Counseling Center's particular outpatient civil commitment policy, which allowed patients to decide whether to receive follow-up treatment, see *supra* note 10.

109. Cf. VA. REPORT, *supra* note 1, at 59 (discussing study that indicated that main concern regarding outpatient commitment among patients and families of patients was "lack of central direction and oversight" (citing MCGARVEY, *supra* note 11, at 1-2)).

110. For a further discussion of probation's growth and success, see *supra* notes 61-62 and accompanying text. Notably, when deciding cases involving outpatient care, the Supreme Court has looked to the probation system for guidance. See Hinds, *supra* note 17, at 381-84 (discussing Supreme Court cases in which probation and parole cases provided guidance when Court had to determine due process issue regarding revocation of outpatient care).

111. See REISNER ET AL., *supra* note 17, at 647 (stating that civil commitment is "based on a perceived need for incapacitation or treatment, or both"). For a further discussion of probation's goals, see *supra* notes 63-70 and accompanying text.

112. For a discussion as to why one supervisor should monitor each individual placed on outpatient civil commitment, see *supra* notes 17-20 and accompanying text. For a discussion of all the parties involved in the outpatient commitment process and the problems stemming from the participation of too many actors, see *supra* note 108 and accompanying text.

113. For a further discussion of these three issues, see *supra* notes 18-20, 51-52, and accompanying text.

114. For further discussion of the benefits relating to judicial resources and state costs, see *infra* notes 144-54 and accompanying text.

though such supervision may place additional restraints on the committed individual's liberty, the individual will still enjoy more freedom than he or she would enjoy in inpatient treatment.¹¹⁵

A. *Determining What an Outpatient Monitor's Role as Supervisor Entails*

To succeed, all outpatient statutes should delegate the duty of supervisor to outpatient monitors.¹¹⁶ In the probation system, the role of supervisor is the most developed duty under the applicable legislative guidelines.¹¹⁷ Consequently, when defining what this duty entails, legislatures seeking to amend current outpatient commitment statutes should look to how this duty is fulfilled in the realm of probation.¹¹⁸ In the probation system, the supervisory duties of an officer vary depending on the offender's risk of recidivating and his or her particular needs.¹¹⁹ Once placed on probation, the offender undergoes a risk/needs assessment that determines whether the offender requires low, medium, or high supervision.¹²⁰ This classification then signifies what duties the officer must perform while acting as supervisor.¹²¹

State civil commitment statutes should require a similar assessment procedure for individuals placed on outpatient civil commitment that, in turn, would aid outpatient monitors in determining their supervision duties.¹²² To determine the outpatient's necessary level of supervision, this assessment would have to quantify variables relating to the risk of the individual's noncompliance and the individual's therapeutic needs.¹²³ Variables to consider when quantifying the patient's risks and needs include: the status of the patient at the beginning of treatment, the regularity of

115. See *id.* at 398 (stating that patients placed in outpatient commitment enjoy more freedom than would be enjoyed in inpatient treatment, "but their freedom is not complete").

116. For a discussion of the role and responsibilities of outpatient monitors, which would parallel those of probation officers, see *infra* notes 117-28 and accompanying text.

117. See Purkiss et al., *supra* note 65, at 13 (finding that as of 2002 forty-six states prescribe probation officers to act as supervisors).

118. For a discussion of how this duty has been defined in the probation system, see *supra* notes 77-82 and accompanying text.

119. See ABADINSKY, *supra* note 59, at 348-50 (discussing assessment used to determine what level of supervision offender needs, and identifying activities officer must perform depending on this level).

120. For a further discussion of the risks/needs assessment, see *supra* notes 92-95.

121. For a further discussion of the risks/needs assessment, see *supra* notes 92-95 and accompanying text.

122. For a further discussion of how the risks/needs assessment could be used in outpatient commitment, see *infra* notes 123-24 and accompanying text.

123. Cf. ABADINSKY, *supra* note 59, at 348 (stating that in probation system, all assessments quantify variables relating to (1) level of supervision needed to prevent any risk offender poses to community and (2) level of supervision needed to provide adequate supervision to satisfy offenders' needs).

the patient's scheduled appointments, and the nature of the patient's appointments.¹²⁴

In the probation system, after the risk/needs assessment determines the appropriate level of supervision, the probation officer will then create a case plan that specifies the conditions of probation, how these conditions are to be met, and the probation officer's duties.¹²⁵ The case plan can be created by the officer or it can arise from negotiations between the officer and the offender.¹²⁶ Negotiated case plans would be particularly beneficial in the outpatient civil commitment system because such plans would add a voluntary component to the involuntary commitment process and, in turn, would promote treatment success.¹²⁷ Further, a negotiated case plan would facilitate open dialogue about the committed individual's court order, thus clarifying and reinforcing the expectations of commitment.¹²⁸

B. *Benefits of Particular Supervision Duties*

In probation, depending on the offender's necessary level of supervision, a probation officer's duties may entail monthly phone calls, daily phone calls, weekly face-to-face meetings, or periodic home visits.¹²⁹ Home visits would serve an essential role in the outpatient commitment system because such visits would enable a supervisor to understand the environmental pressures affecting the civilly committed patient's daily life, and allow the supervisor to adjust treatment accordingly.¹³⁰ For example, in the incident at Virginia Tech, a court order requiring home visits would

124. See Centorrino et al., *supra* note 46, at 378-80 (discussing results of study in which authors identified factors associated with adherence to scheduled outpatient visits). The authors found that those who were acutely ill at the beginning of treatment were more compliant, and noncompliance was associated with those who had periodic appointments or appointments solely for the purpose of receiving medication. See *id.* at 379-80 (citing study of ninety-four patients and their outpatient compliance over period of three months).

125. See ABADINSKY, *supra* note 59, at 357 (illustrating sample case plan that identifies court-ordered conditions, objectives, plan of action, and goal completion date). For a further discussion of case plans, see *supra* note 86 and accompanying text.

126. For a further discussion of negotiated case plans, see *supra* note 87 and accompanying text.

127. See Bruce J. Winick, *Coercion and Mental Health Treatment*, 74 DENV. U. L. REV. 1145, 1165 (1997) (stating that voluntary treatment leads to patient internalization of goals and creates atmosphere of trust that facilitates healing).

128. Cf. VA. REPORT, *supra* note 1, at 58-59 (finding that court order was vague and did not specify type of treatment or treatment provider, thus making it unclear whether perpetrator was noncompliant).

129. See ABADINSKY, *supra* note 59, at 351 (discussing supervision levels and corresponding duties in Georgia).

130. Cf. *id.* at 299 (observing that, in probation system, home visits allow officers to incorporate more information into offender's case plan by providing officer with further insight into offender's life). Also, such visits allow the officer to work directly with the offender's spouse, parents, and roommates. See *id.* (stating such contacts allow officer to broaden avenues for delivery of help). For a further

have provided a monitor an opportunity to talk with the young man's suitemates and evaluate his living arrangements—information that may have given notice to school officials about the young man's abnormal behaviors.¹³¹ Nevertheless, if a monitor is to make home visits, it is imperative that the monitor remain inconspicuous to ensure that the committed individual is not stigmatized by others in the community because such stigmatization may interfere with treatment.¹³²

Even if home visits are unnecessary, however, those placed on outpatient civil commitment would benefit from weekly or monthly interactions with a monitor because such interactions would hold the patient accountable and provide an opportunity for the officer and patient to establish a meaningful relationship.¹³³ Furthermore, such interactions would allow the monitor to take on a role similar to the probation officer's role of detector because these interactions would provide additional opportunities for the monitor to determine whether the patient is at an increased risk of harming the patient's own life or the community.¹³⁴ In the incident at Virginia Tech, such a system of accountability would have benefited the perpetrator because the Virginia Tech counseling center's policy allowed patients to decide whether to schedule follow-up appointments.¹³⁵ A supervisor could have encouraged the perpetrator to attend treatment, which would have provided him with a support system analogous to the one he had as a boy.¹³⁶

discussion of the benefits stemming from home visits, see *supra* note 91 and accompanying text.

131. See VA. REPORT, *supra* note 1, at 42 (discussing suitemates' observations of young man's abnormal behaviors). For a further discussion of the young man's abnormal behaviors, see *supra* notes 5-6.

132. See Maria A. Morrison, *Changing Perceptions of Mental Illness and the Emergence of Expansive Mental Health Parity Legislation*, 45 S.D. L. REV. 8, 9 (2000) ("[I]ndividuals who may benefit from mental health services often resist treatment in order to avoid the stigma that society attaches to mental illness.").

133. Cf. ABADINSKY, *supra* note 59, at 357 (depicting sample case plan that contains column where probation officer must indicate date when offender achieves case plan goal). A strong relationship between the parties will allow the monitor to encourage or discourage certain behaviors and provide the patient with a sympathetic ear when the patient has nowhere else to turn. Cf. *id.* at 299 (examining techniques used by probation officer when officer acts as social caseworker).

134. See Kress, *supra* note 20, at 1299 (stating that when condition of those on outpatient care deteriorates, patient may require inpatient care). For a further discussion of the criteria for inpatient care, see *supra* note 35 and accompanying text. For a further discussion of the role of detector, see *supra* note 103 and accompanying text.

135. For a further discussion of the school's scheduling policy and the problems surrounding this policy, see *supra* note 10 and accompanying text.

136. Cf. VA. REPORT, *supra* note 1, at 39-40 (discussing key findings of perpetrator's school years). As a boy, the perpetrator had a strong supportive network that consisted of his parents, a psychiatrist, and his high school faculty. See *id.* (same).

In the probation system, a duty incidental to the role of supervisor that could be performed by monitors in the involuntary civil commitment system is that of broker.¹³⁷ When a probation officer acts as a broker, there is an “emphasis . . . placed on the close working relationship between the probation officer and the staff members of community social service agencies.”¹³⁸ Providing outpatients with monitors who have close working relationships with treatment providers will enhance compliance with outpatient orders because such monitors can verify compliance with court-ordered treatment.¹³⁹ As opposed to statutes that do not clearly specify who is responsible for reporting noncompliance or that put the burden of reporting on treatment providers, the monitor will directly verify that the patient attends all treatment sessions.¹⁴⁰

If the monitor contacts the provider and discovers that the patient has been noncompliant, this may lead the monitor to take on a role analogous to the probation officer’s role as enforcer and initiate inpatient commitment proceedings.¹⁴¹ When a probation officer acts as enforcer, the officer has the duty of identifying noncompliance and initiating revocation of probation if necessary.¹⁴² When there is a violation, many officers meet with the offender, attempt to rectify the situation, and inform the offender that additional violations will require court intervention.¹⁴³

137. See ABADINSKY, *supra* note 59, at 323 (defining broker as liaison between offender and community resources); Purkiss et al., *supra* note 65, at 13 (identifying statutes that require officers to assist in rehabilitation, counseling, developing community service programs, and locating employment, which are all duties performed while officer is acting as broker). For a further discussion of the role of broker, see *supra* notes 99-101 and accompanying text.

138. ABADINSKY, *supra* note 59, at 327.

139. *Cf.* VA. REPORT, *supra* note 1, at 59 (finding that fact that perpetrator did not receive follow-up treatment went unreported). Using outpatient monitors who act as liaisons between the treatment provider and the patient will provide a clear mandate as to who is responsible for verifying compliance, an improvement over current statutes that lack clear guidance. See, e.g., IDAHO CODE ANN. § 66-329(12) (2008) (failing to provide single authority to monitor compliance); N.D. CENT. CODE § 25-03.1-21(2) (2008) (same); OKLA. STAT. ANN. tit. 43A, § 5-416(B) (West 2008) (same); VT. STAT. ANN. tit. 18, § 7618(b)(2008) (same); see also Hinds, *supra* note 17, at 353 (stating that Nebraska allows involuntary outpatient civil commitment, but it is rarely used because no clear procedures or guidelines exist).

140. *Cf.* ABADINSKY, *supra* note 59, at 357 (depicting sample case plan that required offender to seek drug treatment and officer to talk with treatment facility to ensure offender compliance). For a further discussion of how a probation officer monitors an offender’s compliance when the offender must receive mental health treatment, see *supra* notes 88-89 and accompanying text.

141. For a further discussion of the role of enforcer, see *supra* note 106 and accompanying text.

142. See ABADINSKY, *supra* note 59, at 323 (stating that changes in status quo allow officer to revoke supervision).

143. See *id.* at 43-44 (stating that probation agencies vary in how they deal with violations, but many attempt to minimize judicial intervention by dealing with first instance of noncompliance and informing offender that further violations will lead to stricter sanctions).

Noncompliance with outpatient orders could be handled in the same manner, which would free up judicial and legislative resources by allowing supervisors to personally monitor individuals placed on outpatient commitment.¹⁴⁴ Similar to probation, revocation of outpatient treatment typically requires court intervention such as notice and a hearing.¹⁴⁵ Therefore, in order to free up judicial resources, only continually noncompliant or high risk patients should be referred to the court.¹⁴⁶ Many states currently keep minor instances of noncompliance out of the courts by legislatively mandating that treatment providers identify non-compliance and work with the patient to bring about compliance.¹⁴⁷ Given the high caseloads of treatment providers, shifting the burden of dealing with noncompliance onto a monitor will ensure that instances of noncompliance receive adequate attention.¹⁴⁸ Monitors will be able to provide sufficient attention to each outpatient because, as in probation, caseload distribution can be managed according to the outpatient's particular level of supervision, as well as the monitor's ability to provide that level of care while managing the monitor's other cases.¹⁴⁹ Furthermore, monitors who reinforce compliance and hold outpatients accountable will save states the economic expenses associated with noncompliance.¹⁵⁰

There are additional economic burdens placed on a state when an outpatient is noncompliant because noncompliance often leads to rehospitalization and imprisonment.¹⁵¹ The costs of hospitalization and impris-

144. For a further discussion as to why such a system would free up judicial resources, see *supra* note 143 and accompanying text.

145. See Hinds, *supra* note 17, at 377-79 (finding that most states require judicial intervention in order to change order for outpatient treatment to order for inpatient treatment when patient is noncompliant).

146. For a further discussion as to how judicial resources are conserved when there is noncompliance in the probation system, see *supra* note 143 and accompanying text.

147. See Hinds, *supra* note 17, at 379 (finding that North Carolina and Hawaii require treatment provider to make "all reasonable effort" to solicit compliance" (quoting HAW. REV. STAT. § 334-129(c) (1985) & N.C. GEN. STAT. § 122C-273(a)(1) (1998))). For a further discussion of statutes that require treatment providers to deal with noncompliance, see *supra* note 18.

148. See McKinney, *supra* note 17, at 43 (finding that providers' caseloads are too high to allow for necessary follow-up).

149. Cf. ABADINSKY, *supra* note 59, at 348-50 (identifying how risk/needs assessments ensure probation officers have manageable caseloads). For a further discussion of how the risk/needs assessment acts as a source of case management, see *supra* note 96 and accompanying text.

150. For a further discussion as to the costs associated with noncompliance, see *infra* notes 151-52 and accompanying text.

151. See Centorrino et al., *supra* note 46, at 378 (discussing study that showed that noncompliance is associated "with increased clinical, social, and economic costs, and . . . is closely linked to relapse, [and] rehospitalization"); Kress, *supra* note 20, at 1353 (stating that sixteen percent of national prison population has mental illness); McKinney, *supra* note 17, at 43 (stating that those who are noncompliant typically find themselves in jail).

onment far exceed the costs of an efficient outpatient system.¹⁵² For example, a year of imprisonment can cost a state up to \$50,000, while a year of intensive outpatient care will only cost about \$10,000.¹⁵³ If the cost of a monitor analogous to a probation officer is added to the cost of an intensive outpatient treatment plan, the total cost is still less than the cost of inpatient care or incarceration.¹⁵⁴

V. CONCLUSION

By using past successes to guide the future, legislatures can create a system of involuntary outpatient civil commitment that will better ensure compliance with outpatient orders and save states certain costs associated with noncompliance.¹⁵⁵ The probation system has been in use for over one hundred years and has developed into an efficient scheme that is utilized in every state.¹⁵⁶ In the probation system, the probation officer is the central authority responsible for supervising the probationer and facilitating all conditions of a probation order.¹⁵⁷

States should borrow from the probation system and legislatively mandate monitors to perform duties analogous to those of probation officers within the setting of involuntary outpatient civil commitment.¹⁵⁸ Requiring monitors to supervise treatment would help rectify the problems surrounding involuntary outpatient civil commitment statutes because a clear mandate would be established as to who is responsible for supervising individuals placed on outpatient commitment, and these monitors' duties

152. See Kress, *supra* note 20, at 1353-54 & n.374 (discussing why increased use of outpatient care would save state millions of dollars per year). For a further discussion of the costs associated with incarceration, see *supra* note 68. For a further discussion of the costs associated with hospitalization, see *supra* note 39 and accompanying text.

153. See Kress, *supra* note 20, at 1353-54 & n.374 (comparing costs of outpatient treatment with costs of hospitalization and imprisonment).

154. See *id.* at 1354 n.374 (finding that intensive outpatient program costs about \$10,000 per year); *Development in Law: Alternatives to Incarceration*, 111 HARV. L. REV. 1875, 1893 (1998) (examining state data and finding that probation tends to cost \$1,000 per year); *FY 2005 Costs of Incarceration and Supervision*, THE THIRD BRANCH (Admin. Office of U.S. Courts, Wash., D.C.), May 2005, available at <http://www.uscourts.gov/ttb/may05ttb/incarceration-costs/index.html> (finding supervision by probation officers costs \$9.46 daily, \$287.73 monthly, and \$3,452.72 yearly).

155. For a further discussion of implementing the successes of the probation system in the system of involuntary outpatient civil commitment, see *supra* notes 108-54 and accompanying text.

156. For a further discussion of the history and growth of probation, see *supra* notes 58-62 and accompanying text.

157. For a further discussion of the probation officer's duties, see *supra* notes 76-82, 97-107, and accompanying text.

158. For a further discussion of transposing the features of probation onto the system of involuntary outpatient commitment, see *supra* notes 108-54 and accompanying text.

would be clearly defined.¹⁵⁹ By using probation as a guide for revamping involuntary outpatient civil commitment statutes, the enforcement issues associated with outpatient civil commitment can be remedied, and those in need of mental health treatment can be prevented from falling through the cracks and perpetrating another Virginia Tech tragedy.¹⁶⁰

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159. For a further discussion of the current problems associated with involuntary outpatient civil commitment, see *supra* notes 17-18 and accompanying text. For a further discussion as to how these problems will be rectified by implementing aspects of probation in the system of involuntary outpatient civil commitment, see *supra* notes 108-54 and accompanying text.

160. See McKinney, *supra* note 17, at 42-43 (noting that under current system of involuntary outpatient civil commitment, many individuals get lost in system and end up in jail or worse); VA. REPORT, *supra* note 1, at 46-52 (discussing failure of involuntary outpatient commitment system in relation to perpetrator of 2006 Virginia Tech shootings).