

Petitioning for Involuntary Commitment for Chemical Dependency by Medical Services

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Patients who have chemical dependency (CD) are commonly encountered on medical and surgical wards, often for illnesses and injuries sustained as a direct result of their substance abuse. When these patients are repeatedly admitted to the hospital in certain states that provide a legal framework to commit chemically dependent persons to a treatment facility, clinicians often wonder whether they should initiate that process. Should consulting psychiatrists choose to initiate the commitment process, they put into motion a resource-intensive, time-consuming mechanism, with uncertain outcomes, both in the courtroom and at the bedside. Petitioning for involuntary commitment to chemical dependency treatment of a patient from medical and surgical services is poorly understood. In this study, we examined a series of patients for whom petitions for judicial commitment in the state of Minnesota were entered over a 12-month period, and evaluated the likelihood of commitment to treatment, the demographics of patients involved, and the outcomes for this series of patients. Three vignettes are presented to illustrate the severity of these patients' illnesses and potential outcomes of the process. We further describe potential limitations of the commitment system and alternatives to CD commitment that could be explored further.

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One of the fundamental assumptions of most addiction treatment programs is that patients must be invested in their recovery for the treatment to work; they must actively participate in groups and engage in intense introspection. In other words, addicted persons must make a decision on their own to pursue treatment.^{1,2} On the other hand, addicted patients who are clearly impaired and in need of treatment are encountered in hospital settings. When such patients refuse treatment, the question of commitment for chemical dependency arises. A comprehensive review of states' mental health statutes on involuntary chemical dependency (CD) commitment in 2014 indicates that 17 states have provisions for involuntary commitment of such patients.³ Another study exhaustively examined all states' laws, and the District of Columbia's, and concluded that most of the

states, 33, have laws governing and permitting the civil commitment of chemically dependent persons.⁴

Addicted patients admitted to the hospital for sequelae of their addiction are regularly encountered and present myriad challenges. Many voluntarily enter treatment programs, but a significant number do not. Because of numerous medical hospitalizations, they are believed to be incapacitated by their addiction, and the psychiatry consultation service is asked to address the question of involuntary commitment for chemical dependency. This is not a trivial matter. If commitment is pursued, the patient remains on the hospital's medical service after medical stabilization, often under 1:1 observation with occasional usage of security personnel, while awaiting the court hearing. If the latter finds no basis for the commitment, then it can appear that the intensive use of medical services was without benefit. It behooves clinicians who contemplate involuntary commitment in this population to have an understanding of the likelihood of a successful court-ordered commitment, the demographics of this patient population, the intermediate burden placed on the system by petitioning for commitment, and the

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clinical and social outcomes observed in this population.

Yang and colleagues⁵ qualitatively described the clinical and social circumstances of a sample of patients enrolled in compulsory drug treatment in China. Demographic information and clinical outcomes of a sample of 100 patients committed to private CD treatment in the United States have been described.⁶ Further, a recent summary from Sullivan and associates⁷ concluded that compulsory addiction treatment can be helpful; however, they were primarily examining coerced assisted-outpatient treatment programs. Indeed, most of the literature regarding involuntary CD treatment is focused on drug courts or other diversion programs.⁸⁻¹⁴ These studies typically demonstrate positive outcomes for most participants, defined by decreased lawlessness and complications stemming from chemical dependency. The patients admitted for medical and surgical sequelae of their addiction, the process of committing them, and their outcomes are not well characterized. In our hospital, we reviewed the outcomes of attempted chemical dependency commitments over one year to assess the use of services while awaiting the hearing, to identify the proportion of patients who were committed, and to catalogue subsequent outcomes.

The primary purpose of the study was to describe the rate of successful commitment to CD treatment. Secondary aims included patient demographics age, race, sex, and primary substance of abuse; clinical characteristics of the patient including the rationale for admission to the hospital, patient location at the time the county was petitioned for commitment (surgical versus medical service), the patient's chemical use history including age at the time of first use, number of prior inpatient CD treatments, chemical-related criminal convictions, and prior CD commitments; the nature of the commitment process, intermediate clinical outcomes, level of security needed during their stay after the initiation of the commitment process, and length of stay after the initiation of the commitment process; and clinical outcomes of the commitment process, including subsequent presentations to the emergency department (ED) related to substance use, hospital admissions for sequelae of substance use after petition or commitment, and subsequent legal entanglements because of substance use.

The study was approved by Mayo Clinic's Institutional Review Board.

Methods

To pursue commitment, the consult liaison psychiatrist drafts a letter petitioning the patient's county of residence, as required by Minnesota state law. We searched our electronic medical records for the specific codes associated with commitment petition letters for a 12-month period (January 1 to December 31, 2012). The investigators then ensured that these letters were written solely for chemical dependency on an inpatient medical or surgical service; commitment petitions for patients with comorbid mental illness and chemical dependency were excluded. Commitment petitions originating from an inpatient psychiatric ward were likewise excluded. There were 28 unique patients identified for whom the psychiatry consultation service had petitioned the county for commitment during this 12-month time frame.

The investigators reviewed the hospital admission, hospital progress, psychiatric consultation, addiction consultation, and discharge summary notes associated with these patients during their initial hospitalization. ED visitation and subsequent hospital admission notes were reviewed to assess for medical presentations secondary to chemical use over a 24-month period after discharge from the hospital during which the psychiatry service petitioned the county to commit the patient as a chemically dependent person. We additionally reviewed the patient's remaining record for 24 months before the hospitalization during which CD commitment was petitioned, and recorded any instances of medical contact for chemical use or consequences of ongoing chemical use. Finally, we reviewed the patient's criminal record within the state of Minnesota by searching the Minnesota Trial Court Public Access Remote View database. We recorded all-time criminal history of any chemical-related offenses (defined below). Criminal convictions for chemical-related offenses after the hospital-initiated commitment encounter were recorded solely within the 24-month follow-up period. All 28 charts were reviewed by the same licensed physician.

ED visits recorded for the purposes of this study were defined as patient encounters that were the result of substance use (e.g., intoxication and withdrawal), or the indirect consequence of substance abuse (e.g., traumatic injury while intoxicated, alcohol-induced gastritis, and rhabdomyolysis from

stimulant abuse). Hospitalizations were recorded according to similar criteria. For example, if a person with a known alcohol use disorder sustained a traumatic injury while working in a construction job but was not intoxicated at the time of the injury, this ED visit and subsequent hospitalization would not be recorded. If the same individual had been intoxicated on presentation or if a withdrawal seizure had been suspected as the mechanism of the injury, then the ED visit and subsequent hospitalization would be recorded. Relapses were defined as patients having a subsequent substance-related ED or hospital encounter, the presence of a positive drug screen at an outpatient visit, or patient self-report. We reviewed the primary service's hospital progress notes to determine the hospital date that the service deemed the patient medically cleared for discharge. Substance-related crimes were defined as either directly related to substance use (e.g., driving under the influence (DUI)) and unlawful possession of a substance, or occurred under the influence of a substance, such as an assault where there is mention that the patient was intoxicated at the time of the offense, or the presence of a concurrent charge/conviction related to intoxication. With some patients, the investigators found that the patients would report to providers that theft or forgery charges were related to attempts to finance their substance use, and in those cases, these crimes were recorded.

Results

Demographics were recorded (Table 1). Most patients were white (89.3%), male (67.9%), unmarried (82.1%), and unemployed (71.4%). The median age was 42.5 (SD 13.9) years. The median time of substance abuse was 18 (SD 12.8) years. Most patients (78.6%) identified alcohol as their primary substance of abuse, and the majority (92.9%) had at least one prior inpatient CD treatment opportunity. A minority of patients (32.1%) reported a history of psychiatric hospitalization. The majority of patients, 67.86 percent ($n = 19$) were hospitalized for substance intoxication or withdrawal; 21.4 percent ($n = 6$) were hospitalized for medical sequelae stemming from substance use, and 10.7 percent ($n = 3$) were hospitalized because of traumatic injuries sustained while under the influence of substances. These patients were admitted to a surgical service; the remaining 89.3 percent ($n = 25$) were admitted to medical services. The average additional hospital length of

Table 1 Demographic Information

Demographic Variable	Court Hearing Filed	Commitment Hearing Not Filed
Total ($N = 28$)	14	14
Sex		
Male	10	9
Female	4	5
Mean age (years)	42.1	43
Race		
White	12	13
Black	1	0
Native American	1	1
Married	2	3
Employed	2	6
Prior psychiatric hospitalization	5	4
Prior inpatient CD treatment	14	12
Drug of choice		
Alcohol	12	10
Opiates	0	4
Methamphetamines	2	0

stay (defined as days in the hospital after medical clearance for discharge) was 12.2 (SD 6.6) days. For those ultimately committed, it was 13.9 (SD 6.6) days. The average additional length of stay for those patients where commitment proceedings were not pursued by the county was 3.1 (SD 1.9) days. Petitioning for commitment resulted in a total of 215 additional hospital days for these 28 patients, during which time they were all maintained with a 1:1 sitter, frequently with hospital security personnel posted outside their rooms.

Of the 28 patients for whom commitment was petitioned, 25 percent ($n = 7$) were committed to involuntary CD treatment. Two patients were granted a stay of commitment (18.2%). A stay of commitment in the state of Minnesota results in a patient not being physically committed to a treatment facility, but mandated to adhere to certain court-ordered stipulations. Failure to adhere to the requirements can result in court proceedings leading to the revocation of the stay, in which case the patient is placed onto full commitment and physically ordered to a commitment facility. Half ($n = 14$) of the petitions were dismissed by the county assessors and did not proceed to a preliminary hearing. Two of the petitions that proceeded to trial were dismissed by the court (18.2%); therefore, 68.2 percent ($n = 16$) of all petitions were ultimately dismissed. A minority of commitment hearings were converted into competency hearings, 10.7 percent ($n = 3$), after the county assessors evaluated the patients. All of these

Table 2 Outcomes of Patients for Whom Commitment Was Not Filed

Pt	ED Visits		Hospitalizations		Criminal History	Criminal Acts Post Event	Death
	Pre Event	Post Event	Pre Event	Post Event			
1	7	7	3	4	Misdemeanors	Misdemeanors	No
2	0	5	0	3	Misdemeanors	DUI	No
3	0*	0*	0*	0*	Misdemeanors	DUI	Yes*
4	17	10	12	9	None	None	No
5	0	1	1	1	None	None	No
6	3	0	3	0	Misdemeanors	Misdemeanors	No
7	5	3	4	3	Felonies	Misdemeanors	No
8	4	4	4	1	None	None	Yes
9	5	5	1	1	None	Misdemeanors	No
10	0 [†]	0 [†]	0 [†]	0 [†]	Misdemeanors	Violent felony	No
11	1	0	0	1	None	None	Yes
12	4	6	4	4	None	None	No
13	10	7	10	7	Misdemeanors	None	No
14	4	1	2	0	Misdemeanors	Misdemeanors	No

Event, hospitalization during which the county was petitioned to commit the patient; Pre Event, 24 months before the event; Post Event, 24 months after the event; Criminal history/acts, any criminal conviction where substances of abuse were involved in the crime, either directly related to substance use or to the patient's intoxication at the time of the act. DUI, criminal conviction for driving under the influence.

* Cause of death was unspecified.

[†] Patient was airlifted far from place of residence for specialty care for advanced liver disease and subsequently transferred home after discharge.

patients were subsequently adjudicated incompetent and were appointed guardians; two of them died within the 24-month follow-up period from substance-related complications.

In the group of patients who were committed, all had at least two prior inpatient CD treatment opportunities, and 85.7 percent ($n = 6$) had at least one prior criminal conviction related to substance use. A majority (71.5 percent; $n = 5$), of these individuals had multiple criminal convictions or committed violent crimes. One patient in this group had a single criminal conviction, but also had borderline personality disorder and had an acquaintance smuggle alcohol onto the medical floor while awaiting evaluation by the county and then became severely intoxicated in the hospital. The only individual in this group who did not have a prior criminal history was 31 years old and had worsening multiorgan failure as a direct consequence of severe alcohol abuse. This patient adamantly expressed intention to the county to continue to abuse alcohol and would not voluntarily consider CD treatment. In one patient's case, court proceedings were started, but they were ultimately dismissed after he expressed interest in pursuing voluntary CD treatment. Another patient's proceedings were terminated after the county determined that they had spent an excessive amount of resources on the individual. The patient became intoxicated on

the day of discharge and was involved in an automobile crash that claimed the life of another motorist. He was subsequently taken into state custody and convicted of vehicular homicide several months later.

Clinical outcomes are presented in Tables 2 and 3. Of the 28 patients, there were four deaths determined to be caused by CD-related complications, representing a mortality rate of 14.3 percent related to substance use over the course of 24 months after the petition to commit the patient. We also noted a fifth death: Patient 3 died of unknown causes. Of the seven patients who were judicially committed to receive CD treatment, six relapsed almost immediately after discharge from the treatment facility. For one of those patients, there was no record of repeat medical encounters for CD-related problems, but it is unclear whether the patient relocated after discharge from the commitment facility. Of the 21 noncommitted patients, one had no clear evidence of relapse; this patient had multiple documented follow-up appointments that were attended, suggesting that he remained within the same geographic location. There was a second patient in the noncommitted group for whom there was no record of relapse; however, we note that she lived far outside our catchment area and, at the time of the petition event, was airlifted to our facility for advanced medical care not

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Table 3 Outcomes of Patients for Whom Court Paperwork Was Filed

Pt	Hearing Outcome	ED Visits		Hospitalizations		Criminal History	Criminal Acts Post Event	Death
		Pre Event	Post Event	Pre Event	Post Event			
15	Committed	2	2	2	1	Misdemeanors	None	No
16	Committed	0	6	1	1	Felonies	Misdemeanors	No
17	Committed	7	4	10	3	Felonies	None	No
18	Committed	1	20	1	5	Misdemeanors	None	No
19	Committed	0	0	0	0	Misdemeanors	None	No
20	Dismissed	28	0*	11	0*	Felonies	Felonies*	No
21	Stay	2	2	2	2	Misdemeanors	None	No
22	Committed	13	15	16	12	None	None	No
23	Dismissed	3	5	3	6	DUI	None	No
24	Stay	0 [†]	3	0 [†]	1	Misdemeanors	Misdemeanors	No
25	Committed	4	0 [‡]	3	0 [‡]	DUI	None [‡]	No
26	Guardian	2	1	2	0	Felonies	None	Yes
27	Guardian	3	0	2	0	DUI	None	Yes
28	Guardian	6	1	5	2	DUI	None	No

Event, hospitalization during which the county was petitioned to commit the patient; Pre-event, 24 months before the event; post-event, 24 months after the event; Criminal history/acts, any criminal conviction where substances of abuse were involved in the crime, either directly related to substance use or to the patient's intoxication at the time of the act. DUI, criminal conviction for driving under the influence.

* Patient was taken into state custody and incarcerated for the duration of the 24-month follow-up period.

[†] Patient moved to the area immediately before the commitment event.

[‡] Patient was not seen at our institution after commitment, making it likely that he relocated.

available near her place of residence. This individual was also incarcerated for much of the 24-month follow-up period. Patients for whom court hearings were filed were less likely to be convicted of crimes after hospitalization. Although not apparent in Tables 2 and 3, the number and severity of prior convictions of those who were committed was qualitatively more significant than for those who were not. We noted that many patients in the committed group had been charged with violent felonies, but were found guilty of misdemeanors, rarely the case for the nonpetitioned group.

Discussion

Caring for a person who has a medical illness and severe substance use disorder and is either refusing CD treatment or has demonstrated, through past behavior, no ability to follow through with treatment recommendations, presents a dilemma. The medical team must decide whether to consult a psychiatrist to assess the patient's candidacy for civil commitment for chemical dependency. The consulting psychiatrist is then faced with the same dilemma after the evaluation. On the one hand, there is an established, rapidly growing body of evidence that substance use disorders are neuropsychiatric in origin and that they substantially impair the ability to make decisions that are beneficial in the long-term, increase impulsivity,

and make the acquisition and use of the chemical of choice the individual's priority above all else.¹⁵ These changes appear to be mostly reversible with sobriety, and commitment could provide the individual with this opportunity. On the other hand, pursuing civil commitment is expensive and time-consuming. The increased length of stay on a medical/surgical ward under constant supervision consumes scarce medical resources and drives up the costs to care for these individuals. As most cases are dismissed before a hearing, resources are expended with no tangible benefit. Maynard and colleagues¹⁶ have suggested decreased use of emergency detoxification and inpatient psychiatric hospitalizations by patients after involuntary treatment for chemical dependence. Our data suggest that the cost of the increased length of stay in committed patients awaiting placement should be considered in the complex analysis of cost of commitment on the health care system. In addition, our data also did not seem to demonstrate a significant decline in ED visits by those who proceeded to commitment hearings. One notable caveat to our patients' overall poor clinical outcomes, however, is that in our data set, those patients who proceeded to a court hearing had fewer criminal convictions in the 24-month follow-up period than those who did not proceed to a court hearing. Our patients' poor clinical outcomes appear consistent with the

classic data presented by Vaillant¹⁷ in 1988, as our cohort had limited employment, few social supports, and overall impaired social stability, all of which were identified as strong predictors of relapse.

In our data set, most of those for whom the county agreed to pursue a petition for involuntary civil commitment had a history of multiple criminal convictions. This logically follows the Minnesota statutes governing civil commitment for chemical dependency: a significant criminal history unequivocally demonstrates that the respondent has a history of lawlessness that has placed self or others at risk of harm, lending objective credence to the likelihood the respondent poses a substantial likelihood of harm to self or others. In some cases, if the patient was willing to work toward voluntarily entering into CD treatment, the county would agree to drop the petition to the court for involuntary commitment.

That all patients for whom commitment was pursued were hospitalized for a medical complication of their substance use indicates that the patients were causing themselves significant physical harm and were at risk for further harm by virtue of their ongoing substance use. "Evidence of recent serious physical problems" demonstrates that the patient "poses a substantial likelihood of physical harm to self or others."¹⁸ Thus, at face value, it appears as though any patient repeatedly hospitalized as a direct consequence of substance use would meet statutory criteria for judicial commitment; however, the results from this study indicate otherwise. Our data demonstrated that for patients whose substance use primarily endangered themselves by virtue of multiple hospitalizations, the county's pre-petition screening team was unlikely to file commitment hearing requests with the county attorney. Thus, our data suggest the county pre-petition screening teams are focused on the more traditional "dangerousness" standard established in *O'Connor v. Donaldson*,¹⁹ rather than the more permissive standards set forth under the Minnesota revised statutes when deciding to petition the county attorney to commit a chemically dependent person.

Involuntary treatment of the chemically dependent person is a complex problem. Autonomy is certainly to be respected for all persons. However, the mounting data demonstrating the neurological changes caused by severe addiction¹⁵ may render the individual incapacitated and unable to make sound decisions. An alternative intervention,

therefore, is to pursue judicial review of the severely addicted patient's competency. Should the court choose to declare the patient incompetent and appoint a guardian, this person could then assist in placing the patient into an environment that could help ensure abstinence through restriction of access to the substance of abuse. Our data suggest that when patients are contained within a controlled environment, they are able to maintain sobriety. Once released to a less-structured environment, they are highly prone to relapse and at elevated risk of both medical and legal complications. We do, however, recognize that two of the three patients who were adjudicated incompetent died of their substance use; review of the records made it apparent that they were not in such environments. A comprehensive review of the literature over the past 30 years revealed that there are no studies examining guardianship as an intervention for severely chemically dependent persons. We posit that this would be an excellent topic for further investigation.

This study has several limitations. First, our sample size was small. A notable limitation is the lack of data with regard to the treatment provided to those who were committed. These data are available only for those committed patients who later relapsed and were re-evaluated by psychiatry or social work; in those cases, they typically stated that they were physically committed to the treatment facility for one month's time. There is very limited information in the electronic medical record discussing the aftercare commitment terms and conditions. Minnesota law limits the maximum duration of commitment to 12 months. However, patients are not physically present in a treatment facility or controlled environment for this duration. Some data suggest that this duration is too short to provide meaningful clinical impact.²⁰ In addition, our chart review was observational, and the data were coded by one physician and the results are subject to examiner bias.

This data set demonstrates a very low likelihood of treatment success in an admittedly very ill population and suggests that there is much work to be done in addressing the treatment of this cohort of patients, whose substance use results in medical compromise necessitating medical treatment in the hospital setting. It would logically follow that these patients have severe substance use disorders

and are most likely neurologically impaired and in need of intensive treatment to have any chance of clinical improvement. There is a need for further research into effective treatment interventions for these patients, as current modalities suggest limited efficacy in this group. It is therefore imperative that further research be conducted to identify clear criteria to aid the clinician in the decision of whether to pursue commitment for a chemically dependent person and the optimal treatment programming for a chemically dependent person committed by the courts. This research should then be applied to inform legislation governing the commitment of chemically dependent persons. Optimal policy would provide for individual autonomy, but balance the competing interests of public safety, beneficence, and the just allocation of finite medical and financial resources.

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