DEVELOPMENTS IN MENTAL HEALTH LAW

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Reforming Civil Commitment in Virginia*

By Leroy Rountree Hassell, Sr., Chief Justice of the Supreme Court of Virginia

I am truly honored to welcome you today to this conference that is sponsored by the Supreme Court of Virginia and the Virginia State Bar.

When I began my tenure as Chief Justice, one of my most important priorities was to reform Virginia's mental health laws and judicial processes that relate to the mental health laws. Many have raised the questions: Why does the Chief Justice care about this issue? Why is this issue important to Virginia's judiciary? Why does the Supreme Court of Virginia care about this issue? I care. The courts care. You care, and we care because we are committed to improving the quality of mental health services provided to those Virginians who are least able to care for and help themselves.

We are also committed to an outstanding judicial process that is fair and impartial and that respects the rights of people who are subject to Virginia's involuntary civil commitment process. I believe that all persons and all institutions that are involved in Virginia's mental health system – mental health practitioners, law enforcement personnel, including sheriffs (who are extremely important in this process), judges, attorneys, magistrates, special justices, patients, patients' families and friends – must always exhibit attitudes of care. We must care that we provide the appropriate mental health services to those in need; care that we have the available resources to help mental health patients, including sufficient patient beds; care that persons are afforded mental

Also in this issue:

* Edited introductory remarks presented on December 9, 2005, in Richmond, Virginia, at a conference on "Reforming the Involuntary Commitment Process: A Multidisciplinary Effort" sponsored by the Virginia State Bar at the behest of Virginia Chief Justice Leroy Rountree Hassell, Sr.

health treatment as opposed to unwarranted imprisonment; care for society's public safety needs; care for each individual who has mental health issues; and care that we always exhibit dignity and respect for those persons who have mental illnesses.

As we all know, the solutions to the problems that confront Virginia's mental health system and legal processes are complex and subject to great debate. Today's conference is the beginning of a journey that I am confident will culminate in reforms to Virginia's mental health laws and reforms to Virginia's civil commitment process.

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Reforming Civil Commitment: Serving Consumers' Needs While Protecting Their Rights[1]

By Richard J. Bonnie[2]

Preface

I am pleased to be here and to share the podium with the Chief Justice. For many years I have studied the laws that affect people with mental illness and have many thoughts about what these laws should look like. But I have been asked to be here for a specific reason—to sound the keynote and to set the tone for today's conference on "Reforming the Involuntary Commitment Process" in the Commonwealth of Virginia.

So it is best to begin with the unvarnished truth—the involuntary commitment process in Virginia does need to be reformed. Many of you were among the 300 participants in this process who completed questionnaires recently sent out by the Chief Justice seeking your opinions on the current practice of civil commitment in the Commonwealth. These responses reveal a great deal of dissatisfaction with this practice across a broad range of issues.[3]

What is most striking are the responses to a question that asked what you would do if you could "fix just one thing." Many of you refused to play by the rules, saying that there are so many things that need to be fixed that you could not pick out only one thing. Moreover, the scope of the challenge we face is shown by the fact that you picked many different things. But to sum up your responses in three phrases, you want more beds, higher fees, and fewer handcuffs. Other sources of dissatisfaction are the lack of less restrictive alternatives to hospitalization, the absence of adequate mechanisms to implement mandatory outpatient treatment, the unrealistic nature of current statutory time requirements, and a failure to provide a meaningful opportunity to appeal.

We have an historic opportunity to set in motion the engine of reform for a part of the mental health code long overdue for change. It has been more than twenty years since the last time legislative attention was focused on this topic. I remember it well because I still bear the scars of battle from that failed initiative. Perhaps I ought to say a few words about this history.

Prior Efforts at Reform

The story begins in 1982 when three separate activities converged. The most important development was the appointment of a Joint Subcommittee of the General Assembly to study the commitment process. This legislative initiative was stimulated and chaired by a young Delegate from Arlington, Warren Stambaugh, who observed and participated as counsel in a number of commitment hearings. He felt that the process needed to be fixed.

A second strand was the interest of the State Human Rights Committee (SHRC), which I then chaired. Responding to complaints about civil commitment in Virginia, the SHRC appointed several task forces to look at the commitment process, including an examination of particular concerns associated with the involuntary hospitalization of children, people with substance abuse disorders, and long-term patients in state facilities.

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[1] Edited remarks from the Keynote Address presented on December 9, 2005, in Richmond, Virginia, at a conference on "Reforming the Involuntary Commitment Process: A Multidisciplinary Effort" sponsored by the Virginia State Bar at the behest of Virginia Chief Justice Leroy Rountree Hassell, Sr.

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[3] Responses to this questionnaire are on file with Patricia A. Sliger, Executive Assistant, Virginia State Bar Association, 707 E. Main St., Suite 1500, Richmond, Virginia 23219-2800, (804) 775-0500.

The third thread was research conducted by the Institute of Law, Psychiatry and Public Policy (ILPPP). We had conducted a study involving systematic observations of about 200 commitment hearings across several Virginia jurisdictions. The data showed that most hearings took only a few minutes, with very little participation by the person for whom involuntary hospitalization was sought, or even by the attorney appointed to represent the person. There were also distinct variations in attitude and practice among the special justices conducting these hearings, ranging from solicitous concern to apparent indifference.

Following a conference featuring the ILPPP's research findings, the SHRC and the Joint Subcommittee held a joint meeting in Charlottesville in the summer of 1982 and took the first step in what became a two-year process of consensus-building in the drafting and re-drafting of legislation. After several false starts, the proposed legislation passed the Virginia House of Delegates, unanimously as I recall, but eventually failed in the Virginia Senate by one vote in 1984.

Current Environment

Here we are, more than twenty years later, with many of the same complaints: a lack of due process, a lack of clarity in the statutory requirements, and a lack of uniformity in the interpretation and application of these requirements. The result is great variation in the implementation of civil commitment, not only across jurisdictions but even within a given jurisdiction. And some problems have gotten worse, such as a shortage of beds for evaluation and temporary detention, as well as for involuntary admissions.[4] This shortage of beds, as well as the layered evaluation and detention sequence, have also increased the demands on sheriffs and other law enforcement officers charged with transporting individuals subject to civil commitment.

I invite you to take a look at the survey results; they are quite sobering. What they clearly show is that reforming involuntary hospitalization is a complicated assignment. The structure and practice of involuntary commitment cannot be understood or designed in isolation. It must always be viewed in the context of the services that are available in the mental health system.

On the one hand, an effective and accessible services system—with suitably intensive services in the community for people in crisis—can reduce the need for involuntary commitment. On the other hand, a weak system with many service gaps leads to more commitments. It also causes distortions in an already strained services system. For example, people who might have participated voluntarily if an adequate crisis intervention system had been available may have deteriorated to the point where there is no alternative to commitment. These service gaps also lead, inevitably, to more criminal arrests, as the jails become the overload valve for a system in distress.

In short, we should look at civil commitment reform not as a simple task of "fixing" a fairly arcane chapter of Title 37.2 of the Code of Virginia, but rather as a component of a larger vision for improving mental health services in Virginia, both public and private.

The Vision

So what is that vision?

In part, it is a vision that has remained unfulfilled for thirty years, namely, shifting the locus of mental health services from large

[4] Under existing Virginia law, an individual can be detained (1) pursuant to an emergency custody order (ECO) for a maximum of four hours for an assessment of that person's need for hospitalization or treatment (Va. Code § 37.2-808 (2006)), (2) pursuant to a temporary detention order (TCO) for a maximum of forty-eight hours (not inclusive of weekends or legal holidays) (Va. Code § 37.2-809 (2006)), and (3) pursuant to an involuntary admission order for a maximum of 180 days (Va. Code § 37.2-817 (2006)).

state institutions to communities where a full array of service modalities is available in a timely manner to people who need them. Such an approach minimizes the disruption to the lives of the persons to whom these services are being provided, as well as to their families and loved ones. At the same time, high-quality, short-term residential services in down-sized and modernized state-operated facilities should be in place to assist those individuals for whom community services have proven ineffective.

Governor Warner's proposed budget for the upcoming biennium would constitute a great leap forward in this direction.[5] Our first assignment should be to help Commissioner Reinhard persuade the General Assembly to make these long-overdue investments in mental health services.[6]

Moving from the general need to enhance the mental health system to focusing on civil commitment reform per se, I would sketch a three-part vision: (1) close the service gaps, especially for people in crisis; (2) facilitate voluntary engagement to the maximum possible extent; and (3) when coercion is necessary, do it with a genuine commitment to due process. Let me elaborate.

It Should Be Easier for People in Crisis to Get Access to the Mental Health Services They Need

Individuals experiencing a mental health crisis should receive effective services in the least restrictive and least costly setting when that will satisfy their needs, but they should also be able to access care in a more intensive setting when that is what is needed.

We now have many gaps in the system, including a shortage of inpatient beds in many communities and waiting lists in state facilities. As recently pointed out by Inspector General Jim Stewart in an excellent report on the Emergency Services Programs of Virginia's Community Services Boards (CSBs),[7] we also have large gaps in the continuum of community services, especially intensive crisis intervention services. Ideally we would be able to plug all these gaps, but—even under the most optimistic scenario—funding will not be adequate to do all these things. We will need to set priorities. Three specific goals should guide us in setting these priorities.

- We must continue to build community capacity to provide intensive crisis intervention services.[8] Filling this gap will relieve some of the pressure on the civil commitment system.

- We must end unnecessary criminalization of people with mental illness. People in mental health crises should have access to services of appropriate intensity. Keeping people with a mental illness out of jail will undoubtedly increase pressure on state mental health facilities, but the diversion of people with a serious mental illness from our jails is a moral imperative.

- Whenever a person with mental illness needs to be taken into protective custody for evaluation or treatment, secure transportation should be provided in emergency services vehicles with an appropriate capacity for restraint, not in police cars where shackles and handcuffs may be mandated. This

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[5] The announcement by Gov. Mark H. Warner of his proposed budget and mental health restructuring can be found at http://www.governor.virginia.gov/Press_Policy/EventsandSpeeches/2005/BudgetSpeech-Dec05.htm#9. On January 14, 2006, Timothy M. Kaine succeeded Gov. Warner as the new Governor of Virginia.

[6] A description of how Gov. Warner's proposal would be implemented, as provided by James S. Reinhard, M.D., Commissioner of the Department of Mental Health, Mental Retardation, and Substance Abuse Services, can be found at http://www.dmhmrsas.virginia.gov/PressReleases/admPR-CommissionerBudgetMessage.htm.

[7] JAMES W. STEWART, III, OFFICE OF THE INSPECTOR GENERAL FOR MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES, REVIEW OF THE VIRGINIA COMMUNITY SERVICES BOARD EMERGENCY SERVICES PROGRAMS (Report #123-05) (Aug. 2005).

[8] *See id.*

transition will take time and money, but we should not shy away from it.

When the process of involuntary commitment is initiated, it is the government's responsibility to ensure that there is a suitable facility for evaluation and treatment within a reasonable distance from the individual's home. If there are insufficient "willing facilities," appropriate incentives should be offered to induce their participation. Ultimately the responsibility to make suitable arrangements with CSBs and private facilities for needed services should lie with Virginia's Commissioner of Mental Health, Mental Retardation and Substance Abuse Services.

The System Should Encourage and Facilitate Voluntary Engagement During a Mental Health Crisis or While the Individual's Condition Is Deteriorating Rather Than Waiting Until Individuals Reach Committable Status or Find Themselves in Jail

This point is closely linked to the first one. Making high-quality services accessible to people in need, and thereby attracting or pulling them into services they want, reduces the occasions for pushing them into unwanted services. Today, unfortunately, too many people who seek care are unable to get it voluntarily in either the private or public systems.

Let me say a word about voluntary hospitalization in this context. By embracing dangerousness as the sole clinical indication justifying hospitalization, managed care plans, especially when their plans do not cover intensive crisis stabilization services, have been too restrictive in approving admission. I stand to be corrected if I am wrong, but I understand state facilities have followed suit.

I think this is a mistake. When clinically indicated, intensive stabilization services should be available to people in crisis, even in the absence of dangerous behavior or threats. Similarly, voluntary hospitalization should be available if no other suitable stabilization modality is available. The failure of private plans or Medicaid to cover intensive stabilization interventions while restricting hospitalization is not good care and tends to delay needed interventions when individuals are most likely to accept them. The result of such a truncated services system is to increase the use of involuntary commitment, and to necessitate its use at a later time when it has become more difficult to provide needed care and treatment. To address this failure, it may be necessary to mandate increased mental health benefits and to enhance needed Medicaid waivers.

When Individuals in Crisis Do Refuse Treatment, They Are Entitled to a Fair, Respectful, and Impartial Review Process Before Involuntary Commitment Can Be Ordered

This was and continues to be one of the genuine weaknesses of the commitment process in Virginia. One sometimes hears of cases in which the individual for whom commitment is sought reports that the judge never made eye contact with the person. The fees for attorneys, judges, and independent evaluators should be raised so that a lack of fees can not be cited as a rationale for failing to devote the proper time and attention to these proceedings.

At the time a temporary detention order (TDO) is executed, the person for whom commitment is sought should be given notice of the hearing and counsel should be appointed. The attorney should actually interview the person and carry out the other investigative and adjudicative responsibilities specified in the Virginia Code.[9] The hearing itself should

[9] *See* VA. CODE § 37.2-814(E) (2006) ("To the extent possible, during or before the commitment hearing, the attorney . . . shall interview his client, the petitioner, the examiner . . . , the community services board or behavioral health authority staff, and any other material witnesses. He also shall examine all relevant diagnostic and other reports, present evidence and witnesses, if any, on his client's behalf, and otherwise actively represent his client in the proceedings.").

be conducted with genuine respect for the person's dignity and his or her right to be heard, the most fundamental requisites of due process.

Some will say that the trappings of due process in this context are a charade. For example, one of the lawyers filling out the Chief Justice's questionnaire observed that many of the persons who are the focus of these hearings are so disordered that they lack the capacity to participate meaningfully in the proceedings. That may be true of some, but is not true of most. Plus, these persons will know whether they have been treated with dignity and respect, and whether the judge and the lawyer paid attention to them. In fact, when the MacArthur Research Network on Mental Health and the Law studied the outcomes of 1000 acute admissions in various sites across the country almost a decade ago, we found that one of the strongest predictors of whether patients perceived that they had been coerced into a mental health facility was whether they felt that (1) they had been treated fairly during the hospital admission process and (2) the participating psychiatrists and judges had cared about hearing their side of the story.[10]

Along the same line, some of the respondents to the Chief Justice's questionnaire said that the lawyer's role should be to represent the best interests of the person for whom civil commitment is sought, as a guardian ad litem, rather than advocating on behalf of that person's declared wishes, as the Virginia Code prescribes.[11] Even if permitted by law, taking this approach would be a mistake. Providing due process is in the person's best interests. The testifying clinicians can describe why intervening best promotes the interests of the person, and the judge or special justice has the responsibility for achieving the beneficent purposes of civil commitment (within the contours of the statutory criteria). The lawyer's role is to assure that the person's voice has been heard. Protecting that person's rights also serves the person's needs and is a responsibility to which the attorney should remain faithful.

Another objection to genuine due process is that it costs money. It was the price tag that doomed commitment reform in 1984. Here is where the rubber meets the road. If we are going to honor the constitutional demand for due process articulated by the United States Supreme Court in *Addington v. Texas* in 1979,[12] we have to pay for it. As the reform process moves forward, it will be important to specify the costs and make the necessary financial projections.

I want to take a small detour here. I earlier noted the state's obligation to meet the needs of individuals with a mental illness by establishing and supporting an adequate system of mental health services. My immediately preceding comments have focused on respecting the rights of individuals for whom civil commitment is sought. Some of you may wonder whether it is really possible to do both. It is often said that there is a basic tension in mental health law between beneficence and autonomy, or, in this case, between serving the needs of individuals in a mental health crisis and respecting these individuals' rights. Err too far in the direction of serving the person's mental health needs and one runs the risk of denigrating his or her prerogative to shape his or her own life, including making his or her own choices about mental health treatment. Err too far in the other direction by honoring the person's right to be left alone, and one takes the risk that the person will "die with their rights on."

I readily concede that such a conflict cannot always be avoided, but one lesson that I have learned during thirty years in this field is that

[10] MACARTHUR RESEARCH NETWORK ON MENTAL HEALTH AND THE LAW, THE MACARTHUR COERCION STUDY (May 2004), http://www.macarthur.virginia.edu/coercion.html.

[11] *See* VA. CODE § 37.2-814(E) (2006) ("The role of the attorney shall be to represent the wishes of his client, to the extent possible.").

[12] 441 U.S. 418.

civil commitment is not a zero sum game. Again, protecting the person's right to be heard is not incompatible with serving the person's needs. The overwhelming majority of consumers of mental health services understand and accept the need for hospitalization in a crisis, even over their objection, as long as (1) the care is of high quality, (2) treatment choices are guided, to the maximum possible extent, by their previously expressed preferences, and (3) their residual capacity for making their own decisions is respected. For similar reasons, this respect for the individual should also carry over into the hospital environment.

Possible Proposed Changes to the Virginia Code

I now want to start the conversation that will be continued in the coming months about specific changes to the Code that should be considered as we move forward. The changes we make should be designed to enhance access to needed treatment, including hospitalization, while reducing unnecessary restraint and stigmatization and strengthening due process protections for individuals for whom involuntary hospitalization is sought. In other words, these changes are attentive to "needs" as well as "rights." I have already mentioned a number of ideas in sketching the vision that should inspire civil commitment reform. I will now add some other ideas to the list.

(1) Let me start with a symbolic suggestion. As part of the effort to de-stigmatize and decriminalize mental health treatment, I suggest that we eliminate the word "detention" from the vocabulary of civil commitment. All restrictions should be regarded as protective custody, not detention. Although I will not try to invent a new vocabulary here, the initial two orders in the Virginia civil commitment scheme might be called, in sequence, the temporary evaluation order and the emergency custody order.

(2) People who are seriously mentally ill should not be in jails and prisons. I understand that a number of advisory groups are recommending that the provisions for the involuntary hospitalization of prison inmates[13] be expanded to permit emergency evaluation and custody pursuant to an ECO/TDO, that the criteria for the involuntary hospitalization of prison inmates be applied as they are for all other persons in need of involuntary admission, and that the fact that the inmate is currently in custody in a secure environment should not be taken into account in determining whether the inmate needs hospitalization. I agree wholeheartedly with these recommendations.

(3) It seems that everyone agrees that the four-hour maximum for an ECO is too short. Perhaps we should lengthen the time for an evaluation under an ECO to six hours, or allow one renewal of an initial four-hour order for good cause, which would include a need for additional time to (a) obtain a medical evaluation, (b) identify a suitable facility for placement pursuant to a TDO, or (c) transport the person to the TDO facility.

(4) One important question about the current process is whether the forty-eight hours (exclusive of weekends and legal holidays) now allowed for the evaluations conducted in conjunction with a TDO is the right amount. Some of the survey respondents suggested that the time be shortened in order to expedite judicial review of the basis for involuntary hospitalization. However, many more respondents, and many other people with whom I have spoken, believe that the evaluation process should be lengthened rather than shortened. Why forty-eight hours? What is the right length of time?

I realize that increasing the TDO period has fiscal implications, which I want to put to one side for a moment. There are two arguments for a longer evaluation period before a commitment hearing is held. The first is that more time will permit a more thorough evaluation, not only by the attending clinician,

[13] *See* VA. CODE § 53.1-40.2 (2006).

but also by the "independent evaluator,"[14] thereby allowing a more reliable decision to be made regarding the person's need for commitment, both by the clinicians and by the judge at the hearing. The second argument is that allowing more time would most likely lead to fewer hearings and fewer commitments. Individuals would have more time to become sufficiently stabilized during the evaluation process to allow them to be discharged prior to a hearing. Additionally, during this extended period more individuals will accept voluntary hospitalization, also dispensing with the need for a hearing. The longer the evaluation period, the greater the likelihood these outcomes will occur.

I do not want to devalue the person's right to an expeditious hearing, but the Constitution does not require a hearing in forty-eight hours. Virginia's process is much more expedited than it is in most states. So I would like to put on the table the possibility of allowing the evaluation period for a TDO to extend for up to four days.

Full disclosure is in order at this point. I made a similar suggestion in 1982 when we were beginning the reform effort the last time around, and I had not studied the possible cost implications. However, I would like to raise this issue once again. When the costs are calculated, the accounting should take into account (1) the reduced number of commitment hearings that will result and (2) the possibility that the length of subsequent hospital stays will be reduced, with an associated decrease in overall hospitalization costs.

One complicating factor may be that the costs associated with extending the TDO evaluation period may fall disproportionately on the locale or the facility where the evaluation is taking place. For an indigent individual, the cost of care during this period may be the responsibility of the locale or the facility where the individual is hospitalized. In contrast, the cost of care during involuntary admission for such individuals may be the responsibility of the state. Involuntary admissions may be decreased by lengthening the TDO evaluation period, thereby saving the state money, but with an increase in the financial burden placed on the locale or facility. If this time period is extended, it may be necessary for the state to assume responsibility for the proportional increase in costs that occur, recognizing that it will incur a net financial savings by decreasing the overall length of time the person is involuntarily hospitalized.

(5) We also need to take a look at the various screening and gatekeeper functions that are served by the attending clinician, the "prescreener,"[15] and the independent evaluator in light of the goals of the commitment process, and consideration given to the incentives that now exist for them to either favor or oppose commitment in general. For example, a prescreener may feel an obligation to help a state facility manage its census by applying civil commitment criteria in a narrow manner to limit the number of involuntary admissions, while an attending clinician may be applying the criteria in a less restrictive manner – perhaps due to worries that the patient is too ill to be released or perhaps due to a desire to move the patient to a state hospital (if a bed is available there).

I do not believe the commitment criteria should constitute a "moving target." Ultimately, however, it is the responsibility of the judge or special justice to hear the full range of evidence and to resolve what may be a relatively few number of cases where conflicting recommendations are generated. Because such pressures or biases may exist, none of the reports generated should be

[14] Prior to the involuntary commitment hearing, the person for whom hospitalization is sought must be examined by a licensed and qualified psychiatrist or psychologist, or, if not available, by a licensed and qualified mental health professional. VA. CODE § 37.2-815 (2006).

[15] Prior to the involuntary commitment hearing, a preadmission screening report from a community services board or behavioral health authority must be generated. VA. CODE § 37.2-816 (2006).

binding or outcome determinative. For example, a prescreener's determination that commitment is not warranted should not preclude a commitment hearing when the attending physician or the independent evaluator thinks commitment is warranted. Neither the prescreener nor the independent evaluator should be regarded as gatekeepers with veto power.

(6) Where should hearings be held? Although most are held at the facility where the person for whom commitment is sought is in custody, some are held in courtrooms at the local courthouse. Perhaps local variation should be permitted, and the matter studied. However, my view is that the additional transportation required for courthouse hearings is costly and clinically undesirable. The fees for the judges and lawyers involved, however, should be increased in part to offset the costs and inconvenience they incur in the "circuit riding" that is necessitated as they attend hearings at facilities. At the same time, judges and lawyers should remain mindful of their duty to maintain their independence when facility-based hearings are held.

(7) I do not envision major changes in the commitment criteria. However, I do want to put one idea on the table. Perhaps the "imminence" requirement should be removed from the criteria for emergency custody,[16] temporary detention,[17] and involuntary admission.[18] Only a handful of states are so restrictive, and the meaning of this term seems to be a significant source of confusion and inconsistency around the Commonwealth. One possible formulation is that the person must present a significant risk of causing serous injury to himself or others in the near future.

(8) With enhancements in medical treatment, long-term hospitalization is infrequently needed these days. I suggest that we reduce the length of involuntary admission orders to thirty days. Even if the period of time associated with a TDO is extended, the opportunity for evaluation and observation prior to an involuntary admission hearing is limited. By reducing the length of involuntary admission orders, an opportunity is provided for a prompt re-examination of the initial order. In the rare cases when extended involuntary hospitalization is needed, a genuinely adversarial hearing should be afforded with a meaningful opportunity for appeal.

(9) Mandatory outpatient treatment in appropriate cases should be made a real option in Virginia.[19] As New York's recent experience in implementing outpatient commitment under Kendra's Law has demonstrated, such an approach can be successful if needed community resources and services are in place and a viable monitoring mechanism is instituted.[20] While I have discussed the need for increased community services, the capability of CSBs and behavioral health authorities to provide a

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[16] Before an emergency custody order can be issued under existing law, a magistrate must have probable cause to believe the person "presents an imminent danger to himself or others as a result of mental illness or is so seriously mentally ill as to be substantially unable to care for himself." VA. CODE § 37.2-808(A) (2006).

[17] Before temporary detention can be ordered under existing law, a magistrate must find that the person "presents an imminent danger to himself or others as a result of mental illness or is so seriously mentally ill as to be substantially unable to care for himself." VA. CODE § 37.2-809(B) (2006).

[18] Before involuntary admission can be ordered under existing law, the judge or special justice must find that "the person presents an imminent danger to himself or others as a result of mental illness or has been proven to be so seriously mentally ill as to be substantially unable to care for himself." VA. CODE § 37.2-817(B) (2006).

[19] Although mandatory outpatient treatment is infrequently utilized as the result of a lack of less restrictive alternatives to hospitalization and the absence of adequate implementation mechanisms, it is available under existing law. VA. CODE § 37.2-817(C) (2006).

[20] *See* OFFICE OF MENTAL HEALTH, NEW YORK STATE, KENDRA'S LAW: FINAL REPORT ON THE STATUS OF ASSISTED OUTPATIENT TREATMENT (March 2005).

meaningful monitoring mechanism when outpatient treatment is ordered should also be enhanced, and their willingness to provide this service encouraged. Also, short-term hospitalization (perhaps for up to three days) of a person who is non-compliant with a mandatory outpatient treatment order should be considered. Perhaps hospitalization should be available when it becomes apparent that the person's condition is deteriorating without waiting until the involuntary admission criteria are met. However that issue is resolved, it should be possible to mandate outpatient treatment for up to either 90 or 180 days, at which point a hearing and judicial renewal should be required.

Need for Better Training

Clearly we need better training for all the participants in the legal process, as so many of you observed in response to the Chief Justice's survey. Specifically, we need:

- a mechanism for continuing judicial training, and for clarifying ambiguities in the law and promoting its fair and consistent administration;

- specialized training opportunities for lawyers, independent evaluators, and prescreeners designed to promote fair and consistent administration of the civil commitment process; and

- a mechanism for judicial oversight of this process, such as periodic observations of commitment hearings by designees of the Circuit Courts, the Court of Appeals, or the Supreme Court (e.g., they might rate the level of respect given to the individual's right to be heard and to be treated with dignity).

Closing Thoughts

I want to close these remarks with two questions. I do this to stimulate creative thinking rather than to move the discussion toward any concrete proposals. Each of these questions could serve as themes for subsequent conferences.

First, are there ways in which we can use the law to assist and support the recovery movement and the consumer-driven approach to recovery?[21] For example, can we facilitate the beneficial use of such tools as psychiatric advance directives? Can we build a legal framework that promotes access and engagement rather than coercion? Using a catchy phrase, can we move from coercion to contract?

Second, do we want to develop tools for quality assurance in the civil commitment process?[22] And, if so, what would they be? This is the irony of the OIG report. There is no such mechanism now. Even appellate review, the customary mechanism that provides judicial oversight of a state's activities, is all but absent in civil commitment.[23]

We are just at the beginning of a long road. I ask whether you are prepared to commit yourselves to the task that the Chief Justice has set before you—to identify the major problems associated with civil commitment and the shape of the most plausible solutions to these problems, to develop a well-crafted legislative proposal that encompasses these solutions, and then to see this bill through the political process. This will take at least two years. But the Chief Justice thinks that it can be done, I am willing to help him, and I hope all of you will be willing to join us.

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[21] For a call for a consumer-driven and recovery-oriented approach in the mental health system in general, see THE U.S. PRESIDENT'S FREEDOM COMMISSION ON MENTAL HEALTH, FINAL REPORT TO THE PRESIDENT (2003).

[22] For a discussion of the need for and use of quality assurance mechanisms in the mental health and substance abuse fields, see COMMITTEE ON CROSSING THE QUALITY CHASM, INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, IMPROVING THE QUALITY OF HEALTH CARE FOR MENTAL AND SUBSTANCE-USE CONDITIONS (2006).

[23] Virginia does authorize the appeal of involuntary admission or certification orders. *See* VA. CODE § 37.2-821 (2006). However, various barriers associated with this mechanism have resulted in its virtually never being used.

UPCOMING ILPPP MENTAL HEALTH AND LAW EDUCATIONAL PROGRAMS

3/16-17: *Juvenile Evaluation Update*, Charlottesville, VA

3/24: *Jail Diversion: Innovative Practices That Work*, Omni Hotel, Charlottesville, VA
Fred Osher, M.D.
Director, Center of Behavioral Health, Justice, & Public Policy
University of Maryland School of Medicine
"Responding to Co-Occurring Disorders in the Justice System"

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A History of Civil Commitment and Related Reforms in the United States: Lessons for Today[1]

By Paul S. Appelbaum[2]

I am pleased to be here with you today. The discussions conducted thus far have focused on Virginia's existing civil commitment statute and its procedures, and related successes and failures. My intent here is to add a historical dimension to your considerations by describing the history of commitment law in the United States. This law has evolved over time primarily through cycles of reform and reaction, which I will briefly describe. I will then address what we know about the consequences of the latest round of reform, which began in the 1970s, and end with a few thoughts about the implications of this research for future reform efforts, including changes that you are considering at this conference.

Colonial and Early America

During the colonial era of this country, individuals with a mental illness were generally not dealt with in a systematic manner. If possible, they were ignored. When it was not possible to ignore them, they were frequently confined in local jails.

Colonies in New England also had a quaint custom that was called "warning out." Each township, the equivalent of counties in other colonies, was responsible for the people in that jurisdiction. If an individual with mental illness disturbed the peace, that individual was walked or bodily carried to the township line and "warned out," that is, told to get out and never come back. If you had a mental illness, you could see a good part of New England this way as you were transported from one town to another.[3]

If not warned out and not confined in a local jail, significantly incapacitated individuals with mental illness typically were subject to confinement under the poor laws. Each township or county generally had an almshouse and a set of poor laws based on those that existed in England at the time. Under these laws, an individual who failed to pay his or her debts could be placed in an almshouse until these debts were redressed. Because this placement generally precluded the individual from generating any revenue, confinement was often lengthy. Individuals with a severe mental illness, unable to work or otherwise support themselves, were often swept up by these laws and forced to reside for a long and indefinite time in an almshouse.

By the end of the Colonial Period and into the early years of the Republic, jails and almshouses were filled with people with mental illness. These individuals were subject to neglect when they were lucky and overt abuse when they were not.

There were a small number of people with mental illness who were treated in the few hospitals that existed at the time. Indeed, the second patient admitted to the Pennsylvania Hospital, which opened in 1751 in Philadelphia as the first hospital of any kind in the United States and which continues to exist today, was a mentally ill person. The facility

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[1] Edited remarks presented on December 9, 2005, in Richmond, Virginia, at a conference on "Reforming the Involuntary Commitment Process: A Multidisciplinary Effort" sponsored by the Virginia State Bar at the behest of Virginia Chief Justice Leroy Rountree Hassell, Sr.

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[3] Ironically, a variant of this approach exists today in some parts of this country, sardonically referred to as "Greyhound" therapy.

found such a demand for care for people with mental illness that it soon devoted a whole floor to them and quickly thereafter opened what later became the Institute of the Pennsylvania Hospital, a separate campus just for the treatment of the mentally ill.

If persons with a mental illness required hospitalization during this era, they were dealt with as any other medical patient was, that is, they were usually signed in and out by their families. The only other routine requirement prior to admission was that a deposit be made to cover the costs of care.

One additional requirement that began to develop during this period was that of a doctor's concurrence. This requirement necessitated that a doctor agree that hospitalization was necessary and appropriate, often referred to as "signing-off" on the admission. There still exists a slip of paper signed by Benjamin Rush, one of the signers of the Declaration of Independence and the man whose image appears on the Seal of the American Psychiatric Association and who is often thought of as the founder of American psychiatry. Benjamin Rush's note on this scrap of paper said, "[p]lease admit this patient, B. Rush." This slip of paper appears to be the original, albeit rushed, form of medical certification that is widely employed today.[4]

In general, what existed during this time was an informal system that evolved without statutory authority, criteria, or procedures, and that placed commitment decisions entirely in the hands of family members and the medical profession, without any role for the state or the courts. This approach, in fact, was endorsed in 1845 in a famous opinion of the Supreme Judicial Court of Massachusetts in a case called *In re* Josiah Oakes.[5] In its ruling, the Massachusetts court cited the "great law of necessity and humanity" as supporting the right of "[t]hose who are about him," including family members, friends, and acquaintances, to involuntarily hospitalize an apparently mentally ill person for that person's own benefit. The court saw no need for any authorizing law, but found this authority extant since the time the Constitution was adopted.

First Cycle of Reform: 1830-1865

The process just examined essentially existed almost everywhere in the early Republic until the 1830s, when the first cycle of reform occurred. The period from the 1830s to roughly the end of the Civil War, 1865, was one in which recognition began to arise that jails and almshouses are poor places to care for people with mental illness.[6]

Reformers during this era, such as Dorothea Dix from Cambridge, Massachusetts, drove this change in popular sentiment. Dix, sometimes ungenerously referred to as a spinster school teacher, began visiting jails and almshouses and discovered to her amazement that they were full of people with mental disorders. Dix traveled the country documenting this occurrence and writing extensive memos to state legislatures to persuade them both that a problem existed and to propose a solution, namely the establishment of state psychiatric facilities.

[4] The completion of a medical certification form by one to three physicians is frequently a prerequisite for involuntary hospitalization under current civil commitment laws. *See, e.g.,* VA. CODE § 37.2-815 (2006) (establishing that prior to involuntary admission, a psychiatrist or psychologist must provide oral or written certification that he or she has personally examined the person and address (1) whether the person presents an imminent danger to self or others as a result of mental illness or is so seriously mentally ill as to be substantially unable to care for self, and (2) whether the person requires involuntary inpatient treatment).

[5] *In re* Josiah Oakes, 8 Law Reporter 122 (Mass. 1845), http://www.disabilitymuseum.org/lib/docs/1305.htm?page=print (last visited Jan. 5, 2006).

[6] We may soon reach this advanced state of awareness again, at which point hopefully a new cycle of reform will begin. Currently, there are vastly more people with a serious mental illness confined in American jails and prisons than in all psychiatric facilities combined.

Indeed, the state hospital system as we know it today dates to the 1830s. This movement is often cited as beginning in Worcester, Massachusetts, where Worcester State Hospital was established.[7] The model provided by this facility rapidly spread throughout the rest of the country.[8]

With the establishment of state facilities and government involvement, however, came a concomitant need for legislation authorizing the use of these facilities. No longer could admission decisions be left in the hands of family members and physicians, at least not without some sort of formal recognition of this practice. Legislation ensued although, not surprisingly, most early pre-Civil War statutes merely codified existing practices. Families presented patients for admission. Doctors certified them in and out.

The basis for admission was simply whether the individuals for whom admission was sought were mentally ill and in need of treatment. To the extent that the courts were involved—and this is when they first became involved—this involvement was required only for indigents, for whom counties would be responsible for the costs of their care. Judicial involvement was seen largely as a cost-control measure. Governmental officials did not want to allow family members and facilities to admit everyone they thought might benefit from hospitalization at public cost. Some public official had to oversee the process, and this is how the judiciary first became involved in this country in overseeing the civil commitment process.

[7] The University of Massachusetts Medical School now exists on these grounds.

[8] Although the facility constructed in Worcester served as a model for similar facilities across the country, the first building in North America devoted solely to the treatment of individuals with a mental illness was established in Williamsburg, Virginia. The Public Hospital for Persons of Insane and Disordered Minds admitted its first patient on October 12, 1773. Public Hospital, http://www.history.org/Almanack/places/hb/hbhos.cfm (last visited Jan. 5, 2006). A second public facility was built, of all places, on the frontier in Kentucky.

Second Cycle of Reform: 1865-1890

The period before the Civil War was dominated by therapeutic optimism based on principles first developed in England. Kindness was a cornerstone of care, individuals with a mental illness were viewed as people like everyone else, and they were given what is called today occupational therapy as preparation for their reentry into society. This optimism diminished in the years following the Civil War.

Dissatisfaction with the mental health system began to be expressed widely as the costs of the institutions increased and the quality of the care provided declined. Legislators who thought there would be just a few mentally ill citizens who required hospitalization were taken aback at the numbers who poured out of almshouses and jails into the new public facilities. They watched the portion of their budgets devoted to these facilities climb. They were not prepared to cut back on the number of existing facilities; indeed, they could not even avoid building new ones. But they certainly did not want to pay for the quality of care or the level of care that was provided prior to the Civil War.

In many states, reluctance to provide increased financial support to the mental health system was driven in part by the increased number of residents of these asylums, as they were often called, who were members of unpopular and disfavored populations. For example, Massachusetts' Taunton State Hospital, which still exists today, was built originally as an asylum for Irish immigrants suffering from mental illness. The first significant wave of Irish immigration to this country began in the 1840s, with Massachusetts a prime destination for Irish immigrants. Many of the Yankee settlers who had dominated the state until then resented this influx. They saw the Irish as something less than human or certainly inferior to themselves and believed it was inappropriate to mix Irish and Yankee patients in the same facility. As a result, Taunton State was built just for the Irish.

A sense that individuals with a mental illness from classes of persons perceived to be inferior should be placed in separate facilities became very widespread in this country. Similar segregated treatment was frequent for black persons with a mental illness, although they often were not even considered eligible for hospitalization until well after the Civil War. The care provided for members of these disfavored groups was only reluctantly and minimally funded by governmental officials. Perceptions that they constituted a growing proportion of the mentally ill population dampened further the dwindling enthusiasm legislators felt for supporting facilities for the mentally ill in general.

Ultimately, however, complaints of family members about conditions in these post-bellum facilities began to arise. Further, people who had been hospitalized were able to publish reports that were circulated nationally that alleged that they had been railroaded into these facilities by disingenuous family members and conniving physicians.

The most famous of these reports was by Elizabeth Packard from Illinois.[9] She asserted that her husband, with the cooperation of a physician friend, had gotten her certified into a state facility in an effort to get her out of the way. There had been nothing wrong with her, she declared, but she had been unjustly hospitalized for many months before she could win her freedom. She claimed that her husband, a preacher, was disconcerted by statements she had made that seemed to suggest that she was a re-embodiment of the Virgin Mary. Embarrassed when these statements circulated among his parishioners, her husband had sought to have her removed from the community.

A review of Mrs. Packard's story suggests that it is possible that this woman may have been experiencing delusions and needed hospitalization, and as a result this placement did not constitute railroading. But that was not the widely-held view at the time. Mrs. Packard was an outspoken and popular lecturer and writer on these issues. As part of her efforts, she pushed for a particular reform. She believed no person should be involuntarily committed to a state hospital unless that person was found by a jury to be insane.

In the years following the Civil War, procedural reform occurred in many states. One of the most popular reforms was the institution of trial by jury.[10] Along with this option, many states in the 1870s and '80s mandated judicial review of civil commitment;[11] established a right to representation by an attorney and an associated right of free communication with the attorney; and dictated the process through which individuals could be certified as mentally ill and in need of hospitalization, including that physicians could not benefit financially from the certification and must

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[9] E. P. W. PACKARD, MODERN PERSECUTION, OR INSANE ASYLUMS UNVEILED, AS DEMONSTRATED BY THE REPORT OF THE INVESTIGATING COMMITTEE OF THE LEGISLATURE OF ILLINOIS (1973) [reprint of 1875 edition].

[10] There are still states that retain a right to a trial by jury for people who are alleged to qualify for involuntary commitment, with Texas being the place where such trials occur most frequently. *See, e.g.*, TEX. HEALTH & SAFETY CODE § 574.032 (2005) (directing that a hearing for temporary mental health services may be held before a jury if the proposed patient or his or her attorney requests it, and a hearing for extended services must be held before a jury unless the proposed patient or his or her attorney waives it). *But cf.* VA. CODE § 37.2-821 (2005) (limiting the right to jury trial to appeals of involuntary admission rulings previously made by a district court judge or special justice).

[11] This mandated review approximates the hearing process used in many states today. *But see* NEB. REV. STAT. § 71-915(2) (2005) (requiring that civil commitment proceedings be presided over by a three-member "mental health board" consisting of a lawyer and two of the following: a physician, a psychologist, a psychiatric social worker, a psychiatric nurse, a clinical social worker, or a layperson with a demonstrated interest in mental health and substance dependency issues).

actually have seen these patients before certifying them.

Interestingly, one change that was implemented in the early 1880s is something that might have been assumed to have existed all along. In Massachusetts in 1881 and New York in 1882, the first statutory recognitions of voluntary hospitalization were adopted. Involuntary commitment existed in practice for more than a century in this country before anybody recognized that people with a mental illness requiring hospitalization might retain the capacity to sign themselves into the hospital. Only with this wave of reform did the concept of voluntary hospitalization become embedded in this country's laws.

What did not happen during this reform period, which essentially lasted until 1890, was any change in the substantive criteria for civil commitment. The criteria that continued to be applied were basically that an individual must be mentally ill and in need of treatment before involuntary hospitalization could occur.

Subsequent Cycles of Reform: The Twentieth Century

Reform efforts since the 1890s have gone through repeated cycles driven primarily by whether the public at the time is (1) concerned that people with mental illness are not getting the treatment they need or (2) focused on the possibility of unjust detention. As a result, reforms have tended to alternate between making it easier to get people into the hospital and increasing procedural protections that limit this hospitalization.

For example, during the progressive era in the early part of the twentieth century, police were allowed on their own initiative to petition for involuntary hospitalization. In many states, a so-called "2 PC" (two physician certificate) procedure was implemented whereby the courts could be by-passed at least for the initial emergency hospitalization if two physicians certified the patient as meeting involuntary commitment criteria.[12]

In contrast, in the 1930s when there was less concern that individuals with a mental illness needed to be rapidly hospitalized and more concern about a lack of procedural protections, changes were adopted that made the process more akin to the procedures required within the criminal justice system. Provisions such as judicial approval of warrants prior to detention and tighter restrictions on hospitalization began to be imposed. Again, however, the substantive criteria were not challenged. The criteria for commitment remained whether the person was mentally ill and in need of treatment.

During the 1970s, however, a combination of factors came together that led to dramatic changes in these historical approaches. In the '60s, a group of influential sociologists, the so-called labeling theorists, began to raise questions about the reality of mental illness.[13] Their highly influential arguments asserted that mental illness does not exist as an entity in any objective sense. Rather, because society has adopted expectations that individuals with mental illness will act in a prescribed deviant manner, once people are labeled as mentally ill, they feel compelled to fill this role. Thus, by labeling people as mentally ill, society induces the behaviors that are used to justify the designation.

At the same time, some influential psychiatrists, such as Thomas Szasz and R.D. Laing, began to claim that mental illness is either a myth or simply an alternative form of consciousness, and perhaps even a preferable form of consciousness to the one in

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[12] In many states, a procedure similar to this continues to exist. *See* N.Y. MENTAL HYG. LAW § 9.27 (2006) (establishing that the director of a hospital may admit and retain any person alleged to be mentally ill and in need of involuntary care and treatment upon the certificates of two examining physicians for up to sixty days).

[13] *See* Thomas J. Scheff, *Cultural Stereotypes and Mental Illness*, 26 SOCIOMETRY 438 (1963).

which most of the rest of society is mired.[14] Simultaneously, a new breed of sociological critics began to question the value of long-term hospitalization, provided exposes on abuses within state facilities, and pointed to community-based alternatives as preferable to institutional care.[15] Legislators, who noticed that mental health constituted the single largest line item in their budgets by the middle part of the twentieth century, began to ask why so much money was being spent to treat disorders that do not exist in ways that professionals were now telling them made patients worse instead of better.

Potentiating these changes was a revolution in constitutional law in the '50s and '60s that began with the civil rights revolution for blacks but which extended to other disenfranchised groups and ultimately encompassed the mentally ill. For the latter, the revisions that resulted were first embodied by statute in Washington, D.C., in the Ervin Act of 1964,[16] and followed by the Lanterman-Petris-Short Act in California in the late '60s.[17] By the end of the '70s similar provisions were enacted in almost every state in the country.

The result of these revisions was that if physician control over commitment was acceptable at all, it was only acceptable for a short period of time, a matter of a few days at most, after which judicial review was required. Further, commitment could no longer take place merely because somebody was mentally ill and in need of treatment. Any standard broader than dangerousness to one's self or others fell outside the legitimate scope of the state's powers and was unjustified.

By the end of the 1970s, every state, either by court decision or more typically by statute, had both constricted its substantive standard for commitment to dangerousness to self or others (with grave disability or inability to meet one's basic needs being a subcategory of the self-danger criterion), and provided procedural protections that until that point had been characteristic of the criminal justice process but had not been seen in full-fledged form in mental health proceedings. These procedural protections included rights to notice, to counsel, to confront and cross-examine witnesses, to exclude hearsay (in many states), and the like.

Although there has been some tinkering since then, the most significant of which has been the authorization of outpatient commitment as an alternative to hospitalization in approximately a third of the states, this is basically the structure employed today. What happened in the 1970s still controls the use of civil commitment around the country today.

Impact of These Reforms

It is worth considering how much of a change in practice these significant alterations in civil commitment law in the 1970s actually caused. On paper, the process is far different than when Benjamin Rush admitted patients to the Pennsylvania hospital. Physicians and family members are no longer the sole decision makers, the judiciary is routinely involved, procedural protections are in place to guide its use, and only individuals dangerous to themselves or others can be hospitalized.

But there are good reasons to believe that the changes in who gets hospitalized and under what circumstances are much less profound than they appear on paper. There are

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[14] *See* R. D. LAING, THE POLITICS OF EXPERIENCE (1967); THOMAS S. SZASZ, THE MYTH OF MENTAL ILLNESS: FOUNDATIONS OF A THEORY OF PERSONAL CONDUCT (1961).

[15] *See* RICHARD BARTON, INSTITUTIONAL NEUROSIS (1959); ALBERT DEUTSCH, THE SHAME OF THE STATES (1948); ERVING GOFFMAN, ASYLUMS: ESSAYS ON THE SOCIAL SITUATION OF MENTAL PATIENTS AND OTHER INMATES (1961); MIKE GORMAN, EVERY OTHER BED (1956); GERALD GROB, FROM ASYLUM TO COMMUNITY: MENTAL HEALTH POLICY IN MODERN AMERICA (1991).

[16] D.C. CODE §§ 221-501 to -509 (Supp. V. 1966), *reprinted in* R.C. ALLEN, E.Z. FERTSER, & J.G. RUBIN, READINGS IN LAW AND PSYCHIATRY 277-84 (1975).

[17] CAL. WELF. & INST. CODE § 5150ff.

substantial variations in how strictly the laws are applied across jurisdictions, and differences in involuntary hospitalization today compared with the 1950s and '60s probably have more to do with changes to the mental health system than with any changes to civil commitment law.

A study done shortly after legislators in Pennsylvania in the 1970s tightened that state's civil commitment law provides an example of an absence of effects resulting from this new generation of laws.[18] Conducted by Mark Munetz and his colleagues at the Western Psychiatric Institute and Clinic, the study looked at the records of three groups of fifty patients each. One group was drawn from the pre-reform era when all that was required for involuntary hospitalization was a showing of mental illness and a need for treatment, with few procedural protections in place. They also examined a second group shortly after the reforms were implemented. A third group consisted of patients involuntarily hospitalized two years after the statutory reforms were put in place.

The researchers found no significant differences in demographic or diagnostic composition across the three groups. Fewer patients were committed on the basis of suicidality after the change in the law because it became more difficult to establish that this condition met the criteria for hospitalization. Offsetting this reduction, however, the authors found that more patients were hospitalized based on their inability to care for their basic needs. The authors inferred that this latter category constituted a catch-all for patients who did not meet the specific criteria in the statute but for whom hospitalization appeared to be warranted on clinical grounds.

Although this is just one study from one jurisdiction, in fact it is typical of the empirical literature from other jurisdictions as well.[19] I have not found a study in this country showing significant changes before and after statutory reform, at least if you look more than a year or two after statutory reform, that can be attributed to changes in the statute rather than to trends that were ongoing prior to the statutory adoption.

The reasons for a lack of effect from alterations in civil commitment statutes may be worth contemplating as you undertake to reform civil commitment in Virginia. Although these statutes are enacted based on the assumption that they control the behavior of the participants in the civil commitment process, the last wave of reform in the '70s indicates that everybody involved in this process has a great deal more discretion than we imagine or than it looks like on paper.

For example, studies have shown repeatedly that one reason why the statutes have limited impact is because judges, the ultimate protectors of due process, flex the criteria to permit the hospitalization of people who they think need to be in the hospital.[20] Consider the following comment by a Virginia lawyer responding to the survey conducted in preparation for this conference. He or she wrote:

> The statute goes too far in protecting a patient's civil rights. In my view over 90% of the patients I represented have not met the statutory criteria, yet it has been in the best interest of the same percentage of patients to be committed. Fortunately, the local special justice pays more attention to the patient's needs than to his rights,

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[18] Mark R. Munetz, Kenneth R. Kaufman, & Charles L. Rich, *Modernization of a Mental Health Act: I. Commitment Patterns*, 8 BULL. AM. ACAD. PSYCHIATRY & L. 83 (1980).

[19] *See, e.g.*, ENKI RESEARCH INSTITUTE, A STUDY OF CALIFORNIA'S NEW MENTAL HEALTH LAW (1969-1971) (1972).

[20] *See* Virginia A. Hiday & Lynn N. Smith, *Effects of the Dangerousness Standard in Civil Commitment*, 15 J. PSYCHIATRY & L. 433 (1987); Carol A. B. Warren, *Involuntary Commitment for Mental Disorder: The Application of California's Lanterman-Petris-Short Act*, 11 L. & SOC'Y REV. 629 (1977).

> fudges the criteria, and commits the patient for the treatment he need[s].

If that suggests a certain degree of flexibility among at least some judicial decision makers, it also suggests some flexibility, if you want to call it that, among attorneys representing the individuals for whom involuntary hospitalization is sought.

Indeed, there have been studies of attorney behavior under the new more rigorous statutes suggesting that many of them—particularly the more experienced attorneys who have had an opportunity to see people come back three, four, or five times through the process—moderate their advocacy for the liberty interests of their clients.[21] The basic finding of these studies is reinforced by a very compelling study that Norm Poythress did in Texas some years ago.[22] He trained attorneys in all the arguments that could be used to rebut testimony by psychiatrists regarding their clients' need for involuntary commitment. He followed up six months later to determine whether they were using the information that he gave them and discovered that almost none of them were. When he asked them why not, they said roughly: well, we represent these very sick people, and we couldn't sleep at night if we went home and knew that we helped these people stay out of the hospital when that's what they really needed.

This attitude is not true of all judges and attorneys or in all jurisdictions. Some judges and attorneys follow the letter of the law. But others believe they have more leeway in their behavior.

If judges and attorneys exercise a good deal of discretion, so do mental health professionals and families. Mental health professionals have been shown to allege a need for hospitalization under whatever criterion is available.[23] Thus, in states that have gotten rid of the grave disability criterion, an increase occurs in the number of petitions based on the suicidality criterion. Conversely, when the grave disability criterion is added, petitions based on suicidality diminish and grave disability petitions increase.

Similarly, families have learned to shape the accounts they provide to meet the criteria for hospitalization.[24] In fact, mental health professionals often train them to do so. Further, I have seen attorneys train them to do so. For example, a family member is told: "Well, you know, it might be different if your husband had punched you and even a punch in the arm would give us something to work with here." Lo and behold, it seems the husband actually did punch his wife in the arm and, even though there is no bruise, she was certainly frightened by it. As a result, the husband is involuntarily hospitalized.

The various parties that I have described here seem to be responding to some common-sense notion of who should be hospitalized and are massaging the system to make it happen. This is not to say that everybody behaves in this way or that reforms have no effect. But in the borderline cases, the ones that could go either way, there is often a tendency to flex the standards and the

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[21] *See* Virginia A. Hiday, *The Attorney's Role in Involuntary Civil Commitment*, 60 N.C. L. REV. 1027 (1982); Robert D. Miller, Rebecca M. Ionescu-Pioggia, & Paul B. Fiddleman, *The Effect of Witnesses, Attorneys, and Judges on Civil Commitment in North Carolina: A Prospective Study*, 28 J. FORENSIC SCI. 829 (1983); Serena D. Stier & Kurt J. Stoebe, *Involuntary Hospitalization of the Mentally Ill in Iowa: The Failure of the 1975 Legislation*, 64 IOWA L. REV. 1284 (1979).

[22] Norman G. Poythress, *Psychiatric Expertise in Civil Commitment: Training Attorneys to Cope with Expert Testimony*, 2 LAW & HUM. BEHAV. 1 (1978).

[23] *See* ENKI RESEARCH INSTITUTE, *supra* note 19; Munetz et al., *supra* note 18; Roger Peters et al., *The Effects of Statutory Change on the Civil Commitment of the Mentally Ill*, 11 LAW & HUM. BEHAV. 73 (1987).

[24] *See* Jonathan I. Marx & Richard M. Levinson, *Statutory Change and 'Street-level' Implementation of Psychiatric Commitment*, 27 SOC. SCI. & MED. 1247 (1988).

procedures because it is perceived to be in the individual's interest to receive care.

And yet it is common knowledge that the number of hospitalized persons has dropped sharply over the last thirty-five years. If that is not the result of statutory changes, what did cause it? I suggest that this trend started in 1955 when deinstitutionalization began to take off and it continues essentially unchanged, regardless of the nature of the civil commitment laws that are in place, as hospital beds are closed, particularly in public facilities.[25]

Ultimately, the availability of beds has had more of an impact on the use of civil commitment than any statute ever written (just as the availability of community alternatives can have a huge impact on the need for hospitalization today). The reason why psychiatric beds and private psychiatric facilities are closing is because facilities tend to lose money on psychiatric beds, and when the charity becomes too much to bear, they simply close these units.

More recently, managed care has had a similar impact. These organizations have adopted a de facto admission standard of dangerous to self or others. If this standard is not met, insurers will not pay for hospitalization, whether it be voluntary or involuntary. With an increasingly smaller number of publicly-funded beds available, if managed care does not sign-off on admission, admission does not occur, regardless of the existing criteria for civil commitment.

[25] *See* RAEL J. ISAAC & VIRGINIA C. ARMAT, MADNESS IN THE STREETS: HOW PSYCHIATRY AND THE LAW ABANDONED THE MENTALLY ILL (1990); ANN B. JOHNSON, OUT OF BEDLAM: MYTHS OF DEINSTITUTIONALIZATION (1990); Joseph Morrissey, *Deinstitutionalizing the Mentally Ill*, *in* DEVIANCE AND MENTAL ILLNESS 147 (Walter R. Gove ed., 1982); E. FULLER TORREY, NOWHERE TO GO: THE TRAGIC ODYSSEY OF THE HOMELESS MENTALLY ILL (1988); Paul S. Appelbaum, *Crazy in the Streets*, 83(5) COMMENTARY 34 (1987).

Conclusion

Does this mean that reform of civil commitment law is pointless because people are going to do what they are going to do anyway and external factors are outcome determinative? Clearly not.

Although it is true that the impact of commitment law reform may be greater if the unavailability of services is not a significant barrier to admissions, it is also clear that subpopulations can be identified that can benefit from focused reforms. For example, outpatient commitment statutes adopted in many states target what you might call "rapid cyclers," people with a mental illness who come in and out of hospitals repeatedly and become destabilized after failing to take their medication soon after discharge. If these individuals can be kept on their medications while they are in the community, that cycle of ten, fifteen, sometimes even twenty hospitalizations a year can be broken.

It is also clear that there are discrete dysfunctions in our statutes and procedures that can be identified and ameliorated. For example, the frequent transportation of patients by law enforcement officers in handcuffs, which seems to be a problem in Virginia, can be addressed. Similarly, provisions that leave inadequate periods of time in which to conduct meaningful and reliable evaluations can be ameliorated.

But there is another reason to try and get it right, and that is because the law has symbolic as well as practical value. To the extent that we get it wrong and every player in the system feels a need to circumvent the law, we undermine the legitimacy of our legal system as a whole. After all, for many people the commitment process will be their only contact with the legal system. Moreover, a just and well-functioning system is important for the well-being of those persons subject to the civil commitment process. Therefore, there is value in bringing statutes into closer conformance with what are perceived as the realities of the situation, at least as embodied

in the views and practices of the participants. That may be the most important reason to look carefully at what we do both on paper and in practice, and try to get it right.

Thank you very much for your time.

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Jessie M. Kokrda, *Juvenile Sex Offenders and the Virginia Transfer Statute: Let Treatment Fit the Crime*

Adria N. Bullock, *Parents Forced to Relinquish Custody to Get Treatment for Their Children*

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