# EMPIRICAL ANALYSES OF CIVIL COMMITMENT: CRITIQUE AND CONTEXT

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Civil commitment recently has come to replace the insanity defense as the most controversial issue in mental health law. While the resident population of state mental hospitals has plummeted in the past decade, cries that commitment be abolished altogether are heard with no decrease in fervor. Many others feel that the pendulum has swung too far, that patients' rights and community care have been seized upon by fiscally conservative legislatures to cease providing any care at all to mentally disordered persons.

The controversies over commitment have been framed as issues of philosophy and constitutionality. The ontological status of mental illness is repeatedly contested (Szasz, 1976, 1977); the legality of preventive confinement for the allegedly dangerous is challenged (Dershowitz, 1974). Research has been introduced into the debate on commitment primarily as ammunition to support or refute the empirical assumptions that justify the confinement of mentally ill persons (e.g., the reliability of psychiatric diagnoses and the predictability of violent behavior). The studies by Warren (1977) and Hiday (1977) join a small but growing body of empirical literature (e.g., Wexler, Scoville *et al.*, 1971; ENKI, 1973) that focuses upon the actual commitment process. The basic question that each of these studies addresses is *how civil commitment is being operationalized in given jurisdictions.* As such, they provide a crucial feedback loop between the theoretical justifications for state intervention in the lives of the mentally ill and the realities encountered in courtrooms and hospitals applying commitment statutes. They are examples of what I believe to be the logical, and essential, next step in the commitment debate: the empirical evaluation of how theoretically inspired policy changes ("natural experiments") have affected the manner in which persons believed to be mentally ill are dealt with in the community.

The methodology of the two studies will be criticized first and then their findings will be placed into the policy context.

## CRITIQUE

Warren presents a great deal of extremely valuable data on the diagnostic and behavioral antecedents to civil commitment.

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She found substantial variance in the statutory criteria invoked for commitment under California's Lanterman-Petris-Short Act depending upon the stage in the commitment process that had been reached. Reworking her figures somewhat, it appears that though the great majority of committed patients were held to be gravely disabled at both the point of initial commitment (78 percent) and the habeas corpus hearing three days later (74 percent), there was a substantial reduction in the claims of danger to self during that time (from 54 percent to 37 percent) and a very substantial reduction in claims of danger to others (from 62 percent to 28 percent). As Warren notes, this may either be because the patients are actually less dangerous after 72 hours on medication, or because dangerousness is difficult for the government to prove at the hearing, and so that ground for commitment is abandoned. If the latter interpretation is accepted, it is still not the case that danger to self or others at the point of initial commitment is "bargained down" to grave disablement at the habeas corpus hearing, since the proportion of cases alleging grave disablement does not increase between the two points in time (in fact, it decreases slightly). Rather, what appears to be occurring is that claims of danger to self or others made *in addition to* claims of grave disability "drop out" by the time of the hearing. Thus the group of patients alleged to be dangerous to others, dangerous to self, *and* gravely disabled decreases from 44 percent to 12 percent between the initial confinement and the hearing, while the proportion of patients alleged to be gravely disabled without being dangerous to themselves or to others jumped from 11 percent to 52 percent. Although commitment for dangerousness is sometimes "bargained down" to commitment for grave disability, it might be more accurate to speak of *selective targeting* on the part of the government concerning which of several arguably applicable criteria to pursue. The difficulty, indeed, the impossibility (Stone, 1975) of proving dangerousness and the relative ease of shoehorning many behaviors into the category "grave disability" determine the manner in which the criteria will be selectively narrowed. It would be extremely interesting for further research to determine how much of the change in criteria over the first three days of commitment is merely a strategic legal ploy ("bargaining down" or "selective targeting") and how much represents a professional judgment that the patients are actually less dangerous to themselves or others. If the latter predominates—if the proportion of patients dangerous to others actually can be reduced from 62 percent to 28 percent in three days—this would speak powerfully for the efficacy of short-term hospitalization. In any event, Warren's study points to the absolute necessity of studying commit-

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ment *over time*, that is, following subjects from initial "emergency" confinement through longer institutionalization, and *in context*, that is, studying the interaction between the various commitment criteria.

The principal limitation on generalizing from the Warren study is the nature of the sample upon which it is based: a 10 percent sample of the 10 percent of the civilly committed population who initiate a habeas corpus proceeding. The obvious question is: how representative is this sample of the 90 percent of committed patients who do not make a habeas corpus request? Are these petitioners the "borderline" cases who should not have been committed in the first place? Can the filing of a petition for release be taken as evidence that they are not severely mentally disordered (Szasz, 1976)? Or are they the most severely disturbed patients because they cannot recognize their own need for treatment? The representativeness issue must be addressed in future studies before Warren's results can be generalized to the California population of civilly committed persons.

Hiday's study concluded that, as a result of the 1973 North Carolina statutory reforms, commitment hearings are less a pro forma rubber-stamping of psychiatric opinion and more a genuinely independent investigation of facts. She based this conclusion on two findings: commitment hearings are taking more time (18.5 minutes), and judges are less likely to agree with psychiatric recommendations for commitment (75 percent agreement) than previously reported. She correctly compares her data with accounts from jurisdictions with statutes similar to that of North Carolina prior to 1973, since data for the latter are not available.

The study is on weaker methodological ground when it attempts to qualify this conclusion and assert that undue deference is still being paid to psychiatric judgment. Two findings are given in support of the qualification: 20.5 percent of all respondents were committed without a preponderance of the evidence in support of imminent danger; and in 37.1 percent of contested cases neither judge nor counsel probed for evidence supporting commitment.

The difficulty in interpreting the first finding is that it derives from a discrepancy between the judge's fact-finding and the opinion of the researcher. Despite the fact that the researcher deliberately (and creatively) used a standard of proof lower than that required by statute to compensate in part for "the observer's subjective appraisal of evidence," it is still unclear whether it is the judge or the researcher who is erroneously assessing the evidence. It would have been interesting to know how much agreement there

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would have been between two independent observers assessing the same evidence. It is essential to have such a reliability check in future research. In addition, Hiday operationalized her measures in a reasonable but arbitrary manner. An "imminent" danger was one expected to happen within a week, and the dangerous acts or threats that precipitated commitment had to occur on the day of petition. There was no attempt to find out whether these were the criteria used by the *judge*. If instead the judge defined "imminent" as meaning something likely to occur within *two* weeks, or included dangerous acts that occurred the day *before* the petition, many fewer cases actually may have been decided without a preponderance of the evidence supporting them. Rather than erroneous commitment, the data may simply reflect "unsynchronized definitions" of the criteria between the researcher and the decision-maker (in this case, the judge) (Monahan, 1977).

The finding that neither judge nor counsel probed for evidence supporting commitment in 37.1 percent of the cases, and that this lack of probing affected the ultimate disposition of the case, requires that some assumptions be made concerning the nature of the *written* record before the judge and the counsel. If the written record alone strongly indicated commitment, there might not be as much perceived need for probing questions as there would be where the written record was weak or ambiguous. The fact that commitment was less likely to be ordered if the judge or counsel asked probing questions may simply reflect a third variable (the inadequacy of the written record) which determined *both* that questions would be raised and that commitment would be less likely. Therefore, without some statistical control for the evidence contained in the written record, Hiday's inference is tenuous that "were [the judge or counsel] to press witnesses for evidence of imminent danger, commitment would further decline."

## CONTEXT

Taken together, the studies by Warren and Hiday provide a wealth of data relevant to the current policy debate on civil commitment. Several of the most important issues on which these studies bear will be considered.

### Remaining Abuses of Commitment Power

The most disturbing finding in both studies is the extent to which flagrant abuses in civil commitment still occur. In 11 percent of Warren's cases the state psychiatrist testified that the patient was not mentally ill and yet the patient still had not been released. In 15.6 percent of Hiday's cases the judge made an ex-

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plicit statement that he was ordering commitment based on a psychiatric recommendation despite the fact that he found no evidence to support it. Although lapses in judgment are inevitable in any legal proceeding, the fact that in 11-15 percent of the cases the protagonists *admit* they are acting illegally is appalling. One cannot help but wonder how many additional cases exist in which the bases for commitment are equally flimsy but more discreet psychiatrists or judges have imaginatively invented them. The data point to the continuing need for effective representation by counsel at commitment hearings, so that patently spurious confinements are not ordered. Unfortunately, as noted below, this is more easily urged than accomplished.

**The Role of Counsel**

Warren found that committed patients were represented by public defenders who routinely failed to challenge psychiatric findings of mental illness and who "generally refrained from vigorous advocacy of their clients' legal rights." More evidence was introduced by district attorneys to support commitment than by the public defenders to oppose it. The participants at the hearing did, indeed, "all work together here." Despite the difficulty in interpreting Hiday's finding that neither judge nor defense counsel asked witnesses for evidence of imminent danger in 37.1 percent of the cases brought before the court, her data are at least suggestive of complacency on the part of the appointed counsel. Taken together, the studies support Litwack's observation that the right to counsel in civil commitment cases "is largely an empty one; with few exceptions, patients receive considerably less than adequate legal assistance" (1974:874). While it formerly was believed that the provision of counsel would go far to protect the rights of patients in civil commitment, it now appears that merely having a lawyer present is not enough, since he or she often fails to exercise adversarial skills during the proceedings. This situation is so serious that one court recently mandated minimum standards for commitment hearings that include an "adversary counsel" who must represent a client "zealously within the bounds of the law" (*Memmel* v. *Mundy*, 249 N.W.2d 573, Wisc. 1977).

It may be, however, that the traditional criminal law model of courtroom behavior cannot be imposed upon commitment proceedings by fiat. It is not that counsel are prone to countenance the overt violations of procedural standards observed by both Warren and Hiday in a minority of their cases. The difficulty arises when the client wishes to resist commitment but the patient's counsel believes that the legal criteria for commitment have been met. In the criminal law, the attorney safely can, and ethically must,

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assume that it is in the client's "best interests" to achieve acquittal and regain freedom. But in civil commitment, if the attorney believes that the client fulfills the legal criteria for commitment and that treatment is available, it may be unclear to counsel what course of action will in fact further the client's "best interests." That attorneys in commitment hearings are not often seen jumping from their seats yelling "Objection!" or delivering impassioned closing arguments against commitment may reflect the "existential crisis" (Abramson, 1972) of the mental health lawyer more than laziness or indifference to the fate of the client. The attorney who represents a juvenile in delinquency proceedings, or parents in a neglect proceeding, often confronts a similar dilemma (see Forer, 1970; Stapleton and Teitelbaum, 1972).

The problems of legal ethics raised by the representation of committed patients are perplexing ones on which reasonable people disagree. One of the most lucid discussions of the issue is presented by Stone (1975:248), who concludes that:

> The mental health bar has labored hard to halt the reign of coercive and warehouse psychiatry. It now faces the equally disheartening prospect of benevolent abandonment [of the mentally ill by society]. Its challenge is to place itself squarely in the vacuum and to help the mental health profession fashion a mediated flexible system of care for the mentally ill. The new system must use law, but it ought not succumb to a purely legal model just when it has broken with a purely medical model.

**The Role of the Family**

Warren's findings that the family, directly or indirectly (i.e., through the police), was the source of almost half of the emergency commitments in her sample, and that rejection by the family was a principal factor in sustaining commitment under all three California criteria, are noteworthy. They provide strong support for Stone's observation that "a principal social function of the law-mental health system is to provide technical care for those individuals who are temporarily or permanently extruded from society's principal caretaking unit, the family" (1975:13; see also Bittner, 1967). Clinically, these data may be seen as supporting a family-oriented approach to the treatment of mental disorder since, without a change in the family's behavior and attitude, the individual will not be expeditiously released from the hospital, and may be readmitted more frequently. Legally, the data caution against the tendency of the courts to appoint family members as conservators or guardians of patients, since it often may be his or her family from which the patient most needs protection. Together with the well-known findings on the frequency of police intervention in family disputes and the high incidence of intrafamilial violence, these data again point to the importance of studying

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legal intervention, both civil and criminal, in the family context in which it occurs.

**The Role of the Police**

Warren's study also underscores the importance of the police in civil commitment. The police directly initiated 34 percent of the emergency 72-hour commitments in her sample, responded to requests from family or friends in another 14 percent, and in 6 percent of her cases transferred a prisoner from jail to emergency commitment. Thus a total of 54 percent of the emergency commitments involved police intervention. (Hiday's findings differ, perhaps because she is studying the population of an essentially rural, southern state, where people are still embedded within strong family and neighborhood networks; residents of Los Angeles often lack those ties.) Given the seriousness of many of the acts and threats that precipitated commitment in the studies of both Warren (Table 5) and Hiday (Table 2), the interesting question is why the police did not arrest the disturbing person rather than initiate commitment.

Matthews suggests that police may commit rather than arrest "because of the trouble such persons may cause when placed behind bars, because police officers, like citizens generally, balk when obviously sick people are denied medical care, and because the critical decision about hospitalization is merely being temporarily postponed [by an arrest]" (1970: 293). Police may also be reluctant to arrest because "a disorderly conduct complaint will irritate the disturbed person, and possibly result in reprisal [against the complaining party]" (*ibid.*: 293).

According to Bittner (1967:283) the five types of cases in which police will file a petition for emergency commitment rather than make an arrest or take no action, are: (1) when the person has attempted suicide; (2) when signs of serious mental disorder are accompanied by distortions in appearance (e.g., nudity, bizarre posturing); (3) when the person appears in an agitated and possibly violent state; (4) when the person is gravely disoriented and creating a public nuisance; and (5) when requested to commit by someone in an "instrumental relationship" to the person (e.g., an employer or physician). Bittner concluded that "the general impression one gets from observing the police is that, except for cases of suicide attempts, the decision to take someone to the hospital is based on overwhelmingly conclusive evidence of illness" (*ibid.*: 285).

Bittner also suggests several reasons why the police refrain from initiating an emergency commitment when arguably they might do so: (1) like others, the police "deny" the existence of

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mental illness and do not wish to confront it; (2) the police routinely deal with marginal persons and are uncomfortable singling out those who are truly mentally ill from the garden variety "nuts" who manage to survive in the community; (3) the police believe that handling the mentally ill is not a "proper" police function: it is "stylistically incompatible with the officially propounded conception of the policeman's principal vocation" of enforcing the law; (4) police believe they will be frustrated by the mental health system bureaucracy if they try to commit someone; and (5) the police empathize with the allegedly disturbed person and do not wish to place him or her in the hospital with more disturbed patients (*ibid.*: 280).

Given the importance of the police in the commitment process, much more research needs to be done in this area. In how many commitment cases do the police believe they could have made a legitimate arrest, and on what charges? Why did they not arrest, and does this relate to the commitment statutes and quality of the mental health system in a given jurisdiction? Of those whom the police do arrest, how many do they believe they could have committed, under what criteria, and why did they not commit them? The level of debate on whether the narrowing of commitment criteria is "criminalizing" mentally disordered persons (Abramson, 1972), or whether commitment is still "psychiatrizing" persons who belong in jail (Monahan, 1973), can only be raised by data concerning the police decision-making process in arrest and commitment.

**The Question of Dangerousness**

Perhaps the most intriguing finding in either study is the fact that only 4 percent of the committed patients were "simply" dangerous to others (i.e., dangerous to others without at the same time being dangerous to self or gravely disabled) at the point of initial commitment, while an additional 58 percent were judged to be dangerous to others as well as dangerous to self, gravely disabled, or both (Warren, 1977). Therefore, if dangerousness to others were made the *sole* criterion of involuntary confinement, as some have suggested, 38 percent of those now being committed might not be, since they are not dangerous to others. (Some of this group, of course, might be reclassified as dangerous to others if that were the only way to obtain their commitment.) If, on the other hand, dangerousness to others were *eliminated* as a criterion for commitment, as proposed by Stone (1975), only 4 percent of the currently committable population would no longer be subject to commitment, since that is the proportion classified as "simply"

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dangerous.[1] Given the finding, mentioned previously, that those committed for dangerousness to others have generally engaged in violent acts and threats, it may well be that this 4 percent would be subject to arrest and prosecution if the commitment option were not available.

If it is indeed true that dangerousness to others could be abandoned as a criterion for commitment without occasioning the "bloodbath" predicted by some, this might also eliminate one of the most troublesome aspects of the new commitment "reforms"—their emphasis upon the one activity that is clearly beyond the ability of mental health professionals, namely, predicting violence to others. It is, as Stone notes, a bizarre system "which confines only those who cannot be identified" (1975:37). To the extent that Warren's data are generalizable, dangerousness to others could be eliminated from California's criteria for commitment with virtually no effect on the numbers of persons restrained, whether by commitment or incarceration.

## CONCLUSION

The philosophical and constitutional arguments for and against civil commitment have been well articulated. No breakthroughs appear on the horizon in such "basic" research areas as diagnostic reliability, predictive accuracy, or the efficacy of therapeutic treatment. Therefore, the best hope for improving public policy in dealing with the psychologically disturbed lies not in increasingly redundant polemics or in rehashing familiar data on the primitive level of mental health expertise. Rather, the task at hand is empirically to exploit the numerous social experiments currently under way in the area of commitment reform so that in the future we might make a more informed assessment of the array of policy alternatives. The studies by Warren and Hiday are important steps in this direction.

1. Stone (1975), to be sure, would do more than eliminate danger to others from the criteria for civil commitment. He proposes a five-step commitment procedure: (1) a reliable diagnosis of severe mental illness; (2) an immediate prognosis involving major distress to the patient; (3) the availability of effective treatment; (4) a finding that the patient is incompetent to refuse treatment; and (5) a "balancing test" that a reasonable person in the patient's condition would accept treatment. It is unknown what portion of patients currently found to be dangerous to themselves or gravely disabled would fulfill these criteria.

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