Why the Gap?
Practice and Policy in Civil Commitment Hearings

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The failure of civil commitment procedures to meet statutory requirements is one of the more reliable findings in the applied social sciences. Most states now require specific legal procedures and behavioral standards for involuntary hospitalization. Nonetheless, empirical studies have demonstrated that commitment hearings are rarely adversarial and clinical concerns continue to take precedence over legal issues. These findings are analyzed in the context of three related issues: the grounds for commitment that are used in civil commitment hearings, the particular difficulties of recommitment hearings, and the shortcomings of the national policy of deinstitutionalization. The authors conclude that a primary cause of the gap between legal standards and actual practice is the absence of viable, less restrictive alternatives to inpatient treatment.

During the past four decades, civil commitment legislation has followed a pendular course from paternalistic approaches emphasizing medical concerns to highly restrictive criteria stressing legal rights of patients (Appelbaum, 1982; Hiday, 1981a). During the same period, changes have also occurred in the balance between institutional and community treatment at a national policy level. In this article we consider empirical studies of civil commitment hearings in the context of broader changes that have affected national mental health policy as a whole. Our thesis is that two very different levels of analysis—the microstructure of legal proceedings and broad issues of national mental health policy—are complementary, so that one cannot be understood without reference to the other.

The Pendulum in Civil Commitment Legislation

Until the late 1960s most state commitment processes were medical rather than judicial. Under the state's parens patriae powers, physicians had authority to confine and treat the mentally ill. The most common form of commitment was the two-physician certificate, whereby patients could be hospitalized on the statement of two physicians, without advice of counsel, a hearing, or any recourse other than a writ of habeas corpus (Levenson, 1986; Miller & Fiddleman, 1983). More recently, mental health legislation has reflected a concern for the legal rights of the mentally ill (Durham & Pierce, 1982). Two landmark cases spurred the drive to reform civil commitment legislation. First, in Lake v. Cameron (1966), a federal appeals court outlined the principle of the least restrictive alternative (LRA; Fisher & Pierce, 1985). Later, in Lessard v. Schmidt (1972-1976), a federal district judge in Wisconsin mandated more restrictive commitment standards and greater attention to due process in civil commitment. Legislative changes were occurring as well. In 1969, California's Lanterman-Petris-Short Act was passed, and by 1978 all but two states had changed their commitment codes to make similar modifications (Hiday & Markell, 1980; Lamb & Mills, 1986).

The civil commitment reforms were both procedural and substantive. Procedurally, most states mandated due process safeguards, including prior notice, authority for judicial officials over clinicians, legal counsel, the right to call and confront witnesses, more rigorous standards of proof, LRAs, limited commitment periods, right to appeal, and regular court review (Durham & La Fond, 1985; Ehrenreich, Roddy, & Baxa, 1982; Fisher & Pierce, 1985; Hermann, 1986; Hiday, 1988; Keilitz, Conn, & Giampetro, 1985; Levenson, 1986; Scheid-Cook, 1987). Substantively, the standards for involuntary commitment were changed from simple requirements for mental illness and need for treatment to legal standards of dangerousness to self or others and, in some states, grave disability or inability to care for self (Fisher & Pierce, 1985; Hermann, 1986; Lamb & Mills, 1986; Levenson, 1986; Monahan & Shah, 1989; Shah, 1981). The emphasis on dangerousness reflected a move away from parents patriae concerns toward police power bases for commitment (Wexler, 1981).

The Gap in Civil Commitment Hearings

Changes in the civil commitment system have occasioned a substantial body of empirical research, which has been virtually unanimous is demonstrating that attorneys, judges, and clinical examiners do not perform in a manner consistent with revised commitment standards and procedures (Koch, Mann, & Vogel, 1987; Peters, Miller,....
Schmidt, & Meeter, 1987; Warren, 1977). For example, many attorneys function as guardians ad litem or as mere bystanders (Hiday, 1983c). They are often poorly prepared, limit their questions to general inquiries, fail to cross-examine hospital clinicians (Lelos, 1981), and often appear to have limited experience with mental health law (Koch et al., 1987). When attorneys do assume an adversarial role, however, there is a significant reduction in the number of respondents involuntarily committed (Hiday, 1977a).

In many instances, judges discourage attorneys from taking an active part in commitment hearings (Shah, 1981), or they take over the role of questioning respondents and witnesses (Ehrenreich et al., 1982; Hiday, 1981a, 1982; Koch et al., 1987). Proceedings are often extremely informal, and judges frequently fail to advise respondents of some or all of their rights (Ehrenreich et al., 1982). Moreover, judges, like attorneys, often defer to clinical recommendations in the determination of mental illness and dangerousness (Hiday, 1981a). Statutory requirements for consideration of treatment in the least restrictive environment are often not observed. Rates of noncompliance as high as 55% have been reported in a number of jurisdictions in Virginia (Ehrenreich et al., 1982; Grouse, Avellar, & Biskin, 1982), and even when LRAs are considered they are rarely used (Hiday, 1981b; Hiday & Goodman, 1982).

Although fewer studies have examined the behavior of clinical examiners, their recommendations appear to be important determinants of hearing outcome (Ehrenreich et al., 1982; Hiday, 1977a; Lelos, 1981). Although there is no clear evidence concerning the reliability or validity of examiners’ conclusions, data suggest that examiners do not always interview respondents prior to hearings (Ehrenreich et al., 1982) and that nonlegal factors exert considerable influence on the recommendations of clinicians in commitment hearings (Thompson & Ager, 1988).

Another body of evidence has shown that legislative reforms frequently do not have the desired impact on rates of involuntary commitment and often seem to have no effect at all (Luckey & Berman, 1979; Monahan, Ruggero, & Friedlander, 1982). Bagby and Atkinson (1988) reviewed empirical studies of legislative changes to commitment laws in 15 states and Ontario, Canada, and concluded that although attempts to increase clinical perogative usually produced the desired results, attempts to restrict commitment criteria were generally unsuccessful.

**Why the Gap?**

The gap between the letter and practice of the law in civil commitment hearings no longer requires empirical verification. A more interesting problem is why the gap continues to exist. This article will propose that an important reason for the gap in civil commitment hearings is the unwillingness of hearing participants to release patients into a community that is unable to care for them. We begin by reviewing two sources of evidence: analysis of the standards for commitment that are applied in civil commitment hearings, and empirical findings about recommitments, a neglected subset of the civil commitment process.

**Commitment Criteria**

Although much of the reform to civil commitment statutes was informed by a preference for dangerousness standards of commitment (Hermann, 1986), at least 30 states also allow for involuntary commitment if a person is so gravely disabled as a result of mental illness as to be unable to care for his or her own needs (Schwitzgebel & Schwartzgebl, 1980). The dangerousness standard authorizes the state to confine individuals for the prevention of harm to themselves or others, whereas the grave disability standard entitles the state to protect persons who are unable to care for themselves (Durham & La Fond, 1985; Levenson, 1986; Mulvey, Geller, & Roth, 1987; Peters et al., 1987; Shah, 1981).

Grave disability serves a somewhat ambiguous role among contemporary commitment standards. In one sense, it provides a parens patriae standard in a system that is otherwise concerned with police powers and dangerousness (Miller, 1985); in another sense, many gravely disabled individuals may be considered dangerous, if not imminently so, that they are unable to provide for basic survival needs or make adaptive judgments about appropriate social behavior (Gab, 1984); moreover, many patients are both imminently dangerous and gravely disabled.

In any case, grave disability appears to be the most frequent basis for civil commitment. A review of seven studies, conducted in California, Virginia, Pennsylvania, and Washington state (Durham & La Fond, 1985; Ehrenreich et al., 1982; C. W. Lidz & E. P. Mulvey, personal communication, March 1991; Morris, 1988; C. D. H. Parry, Turkheimer, & Hundley, in press; Warren, 1977; Yesavage, Werner, Becker, & Mills, 1982), indicated that a median of 78% of respondents in commitment hearings are committed on the basis of grave disability, both with and without an additional finding of danger to self or others.

Civil commitments appear to become based less on dangerousness and more on grave disability, the longer patients remain in the hospital. Warren (1977), studying commitment procedures in California, found that the percentage of patients committed only on the basis of grave disability increased from 11% at the hearing for an emergency 72-hour commitment to 52% at a subsequent habeas corpus hearing. Similarly, Monahan et al. (1982) found that a majority of emergency commitments were based on dangerousness to self or others, to the exclusion of grave disability; whereas for a sample of 14-day commitments, there was a significant decrease in dangerousness commitments and a significant increase in grave disability commitments. As will be discussed later in greater detail, C. D. H. Parry, Turkheimer, Hundley, and Creskoff (1991) have shown that, of patients being recommitted after the termination of their initial commitment, more than 90% were recommitted for grave disability alone.
Unfortunately, the grave disability criterion is often vaguely worded and therefore the most difficult criterion for attorneys to defend (Durham & La Fond, 1985; Morris, 1988). In a study of clinical judgments of commitment, Lidz, Mulvey, Appelbaum, and Cleveland (1989) found that judgments of ability to care for self were only moderately reliable (intraclass correlation of .44) and substantially less reliable than judgments of dangerousness or suicidality (intraclass correlations of .67 and .66, respectively). Whereas the assessment and prediction of dangerousness has generated an enormous theoretical and empirical literature, the concept of grave disability has attracted little theoretical or scientific attention.

**Recommitment**

Most research on the commitment process has considered only initial commitment hearings, which begin or reinitiate a patient’s involuntary treatment. Many patients, however, require treatment for longer periods than is permitted by the initial commitment order and must be re-committed if they are to remain in involuntary treatment. Interpolation of available figures suggests that the number of recommitment hearings exceeds 170,000 per year and that considerable resources are expended in processing them (Goldman & Manderscheid, 1987; Rosenstein, Milazzo-Sayre, MacAskill, & Manderscheid, 1987). Nevertheless, recommitment has rarely been the object of empirical investigation; it has usually been included only as an adjunct to research concerned with initial commitments (Ehrenreich et al., 1982; Hiday, 1983a; Hiday & Goodman, 1982; Peters et al., 1987). One study (Decker, 1987) that did focus exclusively on recommitment hearings was not concerned with recommitment as such; rather, the recommitment hearings were used to reach conclusions about the civil commitment process in general.

Recommitment has been neglected on a policy level as well. For example, the National Task Force (1986), in its extensive Guidelines for Involuntary Civil Commitment, gives scant attention (1 out of 105 pages) to recommitments, and the model civil commitment statutes recommended by the American Psychiatric Association (Stromberg & Stone, 1983) and the Mental Health Law Project (J. Parry, 1986) provide little more.

We have recently completed a prospective study of 190 initial and 184 recommitment hearings at a large state hospital in Virginia, covering a rural and urban catchment area with a population of more than 2,000,000 (C. D. H. Parry et al., in press; C. D. H. Parry et al., 1991). Respondents in initial and recommitment hearings were found to represent distinct populations varying in age, chronicity, presence of acute psychological symptoms, and treatment history. Recommitment respondents were significantly older, less likely to have ever been married, and more likely to have severe medical problems or a diagnosis of organic mental disorder. In general, recommitment respondents showed signs of chronic deteriorating mental disorders; compared with initial respondents, they were less paranoid, depressed, anxious, suicidal, or homicidal; displayed less bizarre behavior; and had lower rates of sleep and appetite disturbance, substance abuse, and affective or adjustment disorder.

Every inadequacy that has been reported for commitment hearings in general was as bad, and usually worse, in recommitment hearings. Recommitment hearings were essentially nonadversarial. Attorneys were less active and were less likely to confer with their clients, question them, or challenge the conclusions of the clinical examiner. Clinical examiners were less likely to question the respondent in recommitment hearings. Judges were less likely to consider voluntary admission or explain respondents’ right to appeal, and 98% of the hearings resulted in involuntarily commitment, compared with 70% of initial commitment hearings. Recommitments were almost exclusively based on the grave disability standard alone (94%), whereas 78% of initial commitments were based on this standard alone.

**Summary**

Our analysis of the gap in civil commitment procedures is based on two assertions that we believe are reasonably well established: (a) Contemporary civil commitment statutes are based on a combination of dangerousness and grave disability criteria, of which the dangerousness criterion is the better understood, but grave disability the more frequently used; and (b) a similar distinction exists between initial commitments, which have been the focus of considerable empirical research, and recommitments, which have largely been ignored. Recommitment hearings appear to epitomize the gap between the letter and practice of the law in civil commitment.

Our conclusion is that as currently formulated, the civil commitment system is attempting to serve two functions. On the one hand, it is a system for the primarily legal adjudication of imminent dangerousness. This process more often involves patients who periodically require shorter treatments to mitigate dangerousness during acute episodes of mental illness. On the other hand, it is a system for the evaluation of grave disability and need for treatment, a decision that more often involves patients who, although not imminently dangerous, require longer term continuing care for their disabilities. Finally, we observe that the current civil commitment system appears to function better in the former than in the latter role. Patients for whom the civil commitment system appears ill suited are older, have been hospitalized for longer periods of time, are often medically as well as mentally ill, and are no longer imminently dangerous. This population has always been the Achilles’ heel of public mental health policy (Goldman & Morrissey, 1985).

**Practice and Policy**

Following Abel (1980), who suggested that reasons for the failure of legislative reforms are often not to be found in the specific characteristics of the reformed system, but rather in the legal and social context within which the system operates, we will direct our attention to the relationship between civil commitment hearings and the
broader mental health policy of which civil commitment is a part.

**Deinstitutionalization**

Reforms to the civil commitment process occurred in an era during which deinstitutionalization was the centerpiece of national mental health policy. Deinstitutionalization has involved two complementary movements: dismantling of state mental hospitals, leading to a 75% decrease in the average daily number of committed patients (Kiesler, 1982; Mechanic, 1987; Stromberg & Stone, 1983), and development of a network of community mental health centers (CMHCs), which in 1981 serviced approximately 75% of the country's population (Kiesler & Sibulkin, 1987) and provided treatment for more than four million episodes per year (Hafner, 1987; Sharfstein, 1987). (CMHCs have not received direct federal funding since 1981, so current nationwide data are not available.) In addition, there have been substantial improvements in the quality of care provided to mentally ill patients in inpatient settings (Hafner, 1987). For a detailed history of deinstitutionalization, see Heller (1984), Kiesler and Sibulkin (1987, pp. 27-40), and Rochefort (1988).

Nevertheless, deinstitutionalization is widely viewed as a failure and has been described as incoherent, uncoordinated, and unstructured (Drinan, 1983; Kiesler, 1980; Kiesler & Sibulkin, 1987; Pepper, 1987; Turner & TenHoor, 1978). A major criticism is that it has resulted in **transinstitutionalization**: Approximately 750,000 of the chronic mentally ill now live in nursing homes, with hundreds of thousands more living in board-and-care homes or other group residences (Appelbaum, 1987), where the quality of care is marginal at best (Bachrach, 1987; Sharfstein, 1987). Many of these patients require periodic rehospitalization. This phenomenon, in conjunction with federal funding mechanisms and private insurance policies that provide incentives for brief inpatient treatment, accounts for the increase in institutional episodes over the past 20 years (Kiesler et al., 1983; Price & Smith, 1983).

Hundreds of thousands of mentally ill persons have drifted away from any form of mental health care (Stromberg & Stone, 1983). Mentally ill persons constitute a substantial portion of the homeless population (Appelbaum, 1987; Bassuk, Rubin, & Lauriat, 1984), and many others are not receiving the broad range of services that are necessary to keep them functioning optimally in the community (Goldman & Morrissey, 1985; Kiesler & Sibulkin, 1987; Turner & TenHoor, 1978). Coordination of services that are available has been poor (Pepper, 1987).

Many of the nonhospitalized mentally ill lack adequate housing, and there have been reports of "psychiatric ghettos" developing in urban areas (Fisher & Pierce, 1985; Peters et al., 1987). The mentally ill in the community have also faced stigmatization by the general public (Kiesler et al., 1983), a prejudice most evident in the enforcement of zoning restrictions precluding the establishment of group homes or other residences (Drinan, 1983). Finally, deinstitutionalization has been criticized for having a "criminalizing" effect, with many of the mentally ill in jails (Bort, 1985; Meyers, 1985; Steadman, Monahan, Duffee, Hartstone, & Robbins, 1984; Swank & Wiener, 1976; Teplin, 1984).

**Treatment of the Gravely Disabled**

Despite reductions in hospital census, there are still many patients residing in state hospitals who have derived maximum benefit from hospital care (Gab, 1984). They continue to be recommitted at the termination of each commitment period because judges are aware that there is a shortage of LRAs (Ehrenreich et al., 1982). National estimates suggest that between 43% and 75% of the total inpatient population (no estimates exist for recommitment patients in particular) could safely be treated in the community (Kiesler, 1980).

A high percentage of such patients appear to be gravely disabled, as opposed to imminently dangerous to themselves or others. Bigelow, Cutler, Moore, McCoomb, and Leung (1988) assessed 81 patients who were identified as being "hard to place" outside the state hospital; 22 were rated as having a medium or high risk of committing an assault (an additional 28 were rated as having a low risk), 7 of harming themselves, 4 of committing suicide, and 7 of setting a fire. In contrast, 70 were rated as having few or no self-care skills, and 73 had few or no social-interpersonal skills.

Elderly persons are a good example of a group that is often treated in mental hospitals but could probably be treated in less restrictive settings (Drinan, 1983). Our study of recommitment (C. D. H. Parry et al., 1991) showed that recommitment patients were significantly older than patients in initial commitments. The vast number (>95%) of commitments of elderly persons were based on the grave disability standard. Jones, Parlour, and Badger (1982) studied 36 consecutive involuntary admissions of elderly demented patients to a geriatric unit of a state hospital in Alabama. Only 5 were found to meet statutory commitment criteria. At the time of the study, 31 had been recommended for release and had remained in the hospital for an average of eight months because of the absence of alternative services. Age over 60 has recently been shown to be the best predictor of nonrecidivism among hospital patients discharged to less restrictive settings (Geller, Fisher, Simon, & Wirth-Cauchon, 1990).

**Performance of Hearing Participants**

Evidence suggests that the desultory performance of participants in civil commitment hearings may be related to the absence of less restrictive treatment alternatives. The only direct evidence that is available concerns attorneys. Studies have shown that attorneys often assume that release might mean that their client will not get necessary help (Hiday, 1983c; Shuman & Hawkins, 1980). Attorneys also do not wish to appear to be socially irresponsible by vigorously advocating the release of respondents who appear to be too disorganized to function on their own.
A first-hand account by an attorney who participated in civil commitment procedures (Galie, 1978) makes a compelling case that attorneys cannot be expected to advocate for release of clients when it is obviously not in the clients best interest. Moreover, the institutional structure of commitment hearings serves to discourage adversarial behavior on the part of attorneys. Judges typically do not require more than a perfunctory representation of respondents and often give overt or covert suggestions to attorneys to expedite the proceedings (Ehrenreich et al., 1982; Hiday, 1982, 1983b; Litwack, 1974). In many jurisdictions, pressure from judges is exacerbated by the fact that attorneys are appointed by the court (Engum & Cuneo, 1981; National Task Force, 1986).

Conclusion

The gap between the letter and practice of the law in civil commitment hearings is a truism, but it is also a signpost to important problems in mental health policy. Under present commitment statutes, an adversarial commitment process would sometimes release disturbed patients who are not imminently dangerous into a community that would then have to live in proximity to them and finance less restrictive treatment settings. Gravely disabled patients are often highly appropriate for less restrictive services, but when these services are not available, the responsible clinician will not recommend patients' release, the responsible attorney will not advocate it, and the responsible judge will not permit it.

Our model of the interdependency of commitment hearings and mental health policy is outlined in Table 1. On the level of commitment hearings, a system ostensibly designed for adjudication of dangerousness continues to operate primarily on the grave disability standard, which is less well defined and has been much less intensively studied. On the level of mental health policy, the grave disability criterion offers a means of providing basic mental health and life-support services to a population that would otherwise be released into a community that has limited means to care for them, to the detriment of both the community and the patients. Adequate nonhospital services are not provided, but society is protected from the consequences (e.g., homelessness, criminalization, and close contact with the unpleasantly mentally ill) by a commitment process that hospitalizes impaired but non-dangerous patients.

Recommendations

The shortcomings of two apparently disparate systems—the legal process for civil commitment and the implementation of community-based care on a national level—are conceptually and causally interrelated. Attempts to change the civil commitment process, therefore, must necessarily consider national mental health policy. In recommending changes to current civil commitment procedures, we will specifically avoid taking a position on whether the civil commitment system ought to be more or less restrictive of patient rights, or more or less legal, as opposed to clinical. Instead, we will define changes that would more accurately reflect the broad intentions of present civil commitment statutes: protection of patients' legal rights, protection of society from the dangerously mentally ill, and provision of necessary care in the least restrictive environment.

Civil Commitment Legislation

Discussions of civil commitment legislation generally present the opposition between legalistic concerns about patient rights and clinical concerns about patient treatment as though the goal were to formulate a single commitment standard that provides a balance between them. The analysis we have presented suggests that this view may not be correct. For some patients, acutely ill and possibly dangerous, a legal emphasis may be more appropriate; for others, chronically ill and gravely disabled, clinical concerns may need to take precedence.

The often-noted pendulum in civil commitment legislation is better understood in this light. When clinical discretion is ascendent in commitment statutes, chronically ill patients are more likely to obtain care, but it becomes too easy for society to commit the unpleasantly deviant on a convenient clinical basis. When civil commitment statutes compel an adversarial process, man-

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<th>Table 1</th>
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<td><strong>Relationship Between Civil Commitment and National Mental Health Policy</strong></td>
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<tr>
<td>Level of analysis</td>
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<tr>
<td>Micro (civil commitment hearing)</td>
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<td>Danger to others/danger to self emphasis</td>
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<tr>
<td>Consider LRAs</td>
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<td>Macro (mental health policy)</td>
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<td>Fund community services</td>
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Note. LRAs = least restrictive alternatives.
Erroneous hearings for obviously helpless patients tend to become "time-consuming minuets," and judicial release of patients against clinical advice leads to outrage among those who find it difficult to accept a legal process that results in inadequate patient care (Appelbaum, 1987; Treffert, 1973).

There is, however, no a priori reason that a single set of commitment procedures must apply to a floridly psychotic manic patient and a 70-year-old schizophrenic who has been hospitalized for 40 years. Although it is not our goal to make specific recommendations about commitment legislation, a two-part commitment statute might offer a way off the pendulum. For the acutely ill patient at the beginning of treatment, the currently (but decreasingly) popular, legally based hearings, primarily concerned with dangerousness, may be most appropriate. As patients are treated for longer periods, becoming less dangerous but more obviously in need of care, another model, based more on conservatorship and using a guardian ad litem in place of a legal advocate, may be more meaningful (cf. Lamb & Mills, 1986, although we do not agree with all of their recommendations). Although some avenue for obtaining complete release must always be left open, a regular hearing that is concerned not with whether a chronic patient requires any treatment at all, but rather with how such a patient might be treated most effectively and least restrictively, would better serve the needs of the long-term disabled and free hearing participants from pointless and expensive judicial hearings.

**Performance of Hearing Participants**

We have suggested that hearing participants, especially defense attorneys, often fail to take an active role in civil commitment hearings, in part because the civil commitment process discourages them from doing so and also because the paucity of less restrictive alternatives means that respondents released from involuntary commitment will probably receive inadequate care. These conclusions are based on somewhat limited empirical data. The relationship between hearing performance and treatment alternatives would be a productive focus of future investigation. (We would predict, for example, that states with the greatest number of high-quality alternatives to hospitalization would also have the most effective civil commitment process.) Assuming that our analysis is correct, several recommendations follow.

Attorneys and clinical examiners require independence from the judicial system, especially in jurisdictions in which they are appointed by the court. Full-time, independent public defenders tend to perform better than private attorneys appointed by the court from an approved list (Hiday, 1977b, 1982; Luckey & Berman, 1979), because they have access to social workers who can assist them in getting in touch with family members and conducting an independent investigation of L.R.A.s. They are also in a better position to investigate their client's behavior in the hospital, identify and prepare credible witnesses, and negotiate with clinicians (Decker, 1987; Hoffman & Dunn, 1975; Litwack, 1974).

Moreover, like any other defense attorney, those representing respondents in civil commitment hearings should be explicitly evaluated in terms of their success in securing less restrictive alternatives for their clients. Although our analysis suggests that it is unreasonable to expect attorneys to advocate vigorously for the release of patients for whom there is no reasonable alternative to hospitalization, attorneys who are invariably unsuccessful in defending their clients should be replaced. Otherwise, attorney behavior will be shaped by a hospital environment that encourages nonadversarial behavior. Judges' records of committing and releasing patients should be scrutinized to guard against unwarranted deference to clinical opinion or release of committable patients. Finally, clinical examiners should be evaluated for thoroughness in their examinations. Encouraging attendance of hospital staff, patient advocates, CMHC representatives, and members of patients' families would be one way to enhance accountability and public confidence.

**Commitment Criteria**

Available evidence indicates that the majority of patients are committed, and especially recommitted, under the grave disability standard. For better or for worse, the behavior of the system demonstrates a perceived need to hold nondangerous patients involuntarily when they require care and no less restrictive options are available. If mentally ill persons who are not imminently dangerous must be committed, the commitments should proceed according to carefully specified statutory requirements. The nature of grave disability must therefore be specified in greater detail, and evidentiary requirements established for civil commitment hearings.

The concept of grave disability requires greater attention from social scientists, legal scholars, and policymakers. The intensive scientific and legal examination of dangerousness could serve as a model for the study of grave disability. We have learned a great deal, for example, about the limitations of clinical predictions of dangerousness (Monahan, 1977), but studies of clinical predictions of inability to care for self have not been undertaken. A useful start would be compilation of national data on the employment of the various commitment criteria, for which a necessary first step would be careful recording of the criteria used on a local and state level. The key legal distinction of whether grave disability is a subspecies of dangerousness or a separate parens patriae standard has not been resolved. Gab (1984) described a new commitment standard, "discharged pending placement," that could help separate dangerousness from need for treatment in the concept of grave disability.

Our model suggests that the availability of L.R.A.s plays a crucial role in the operation of the civil commitment system, especially for the gravely disabled. Many statutes require that patients be treated in the least restrictive alternative, but provide no means of establishing the presence or absence of L.R.A.s. Other states, such as Virginia, do require investigations of L.R.A.s, but our investigation of civil commitment procedures in one Vir-
Virginia hospital (C. D. H. Parry et al., in press) showed that the requirement was completely ignored. Many gravely disabled patients are committed to inpatient facilities because they require treatment and because no LRA is available. Evidentiary procedures for demonstrating the absence of LRAs would protect the rights of patients and at the same time provide ongoing documentation of the need for less restrictive treatments for patients being held under the grave disability standard.

Policy Issues

In the absence of viable alternatives to hospital treatment, civil commitment reform could easily lead to an exacerbation of the problems of homelessness and institutionalization among the mentally ill. Hudson (1987) has shown that in 1983, states spent roughly twice as much money on institutional treatment as on community treatment. Obviously, more money must be spent on nonhospital treatment if such alternatives are to be provided. In the meantime, reallocation of money that is already being spent on mental health services could produce major improvements in funding of noninstitutional treatment. At the federal level, enactment of a new Social Security title would combine into a single funding source the billions of dollars now disbursed for care of the mentally ill under other programs, such as Medicaid (Mechanic, 1987; Sharfstein, 1987). Stipulations of Medicaid, Medicare, and Supplemental Security Income (SSI) could be changed to encourage less restrictive treatment of long-term mental patients (Price & Smith, 1983; Roybal, 1988). Money from the U.S. Department of Housing and Urban Development could be allocated to assist mentally ill patients who desire to live in group homes (Drinan, 1983). Incentives should be provided for private insurers to increase coverage of outpatient mental health care (Kiesler et al., 1983; Price & Smith, 1983).

At the state and local level, reallocation of federal block grants could provide greater support for the needs of this population in the community (Oltkin, 1984). Creation of an integrated system of care, in which services and money follow the patient, would prevent different parts of the state mental health system from competing for limited resources in counterproductive ways (Deiker, 1986; Mechanic, 1987; Sharfstein, 1987).

Although the need for more extensive community services has been universally recognized, one reason they have not come about is that the civil commitment system continues to provide inpatient treatment for the very population the community mental health system was designed to provide for. Our recommendations would result in more patients either being released into the community or held for the explicit reason that no LRAs are available. Either outcome would make the shortage of less restrictive treatment options more difficult to ignore and would pressure policymakers to address the problem directly.

Treatment Options

Viewing the treatment of the chronic mentally ill in terms of the problems they pose for the civil commitment system provides a framework for determination of the treatment options that may be most helpful. Treatments are required that would allow participants in civil commitment hearings to feel justified in releasing patients who no longer meet the specific requirements of civil commitment statutes.

A patient released from the hospital on the basis of a civil commitment hearing faces several possible outcomes, ranging from completely independent living to involuntary residence in an institution only marginally less restrictive than the hospital. He or she may (a) leave the mental health system altogether, returning to a completely independent life, (b) continue to receive clinical care on outpatient basis, (c) eventually return to an institution, such as a prison or a nursing home, that is not primarily a mental health facility, or (d) be placed in alternative inpatient setting, such as a board-and-care or halfway home.

All of these contingencies can and should be associated with continuing mental health treatment. For the patient who either does not need or chooses to avoid future treatment, economic and social support services are paramount (Talbott, 1980). In addition to the obvious need for medication management and other types of psychiatric treatment, the chronic mentally ill often require psychosocial and support services: social and vocational rehabilitation, housing (adult homes, transitional living arrangements, and group homes), public assistance (entitlements and income supports), education, legal assistance, transitional employment and job placement, recreation, transportation, basic medical care, and drug and alcohol treatment services (Bachrach, 1987; Hafner, 1987; Goldman & Morrissey, 1985; Mechanic, 1987; Peterson, 1987; Rock, 1987; Sharfstein, 1987; Talbott, 1980; Turner & TenHoor, 1978). Furthermore, there is a need for emergency and crisis intervention services to deal with extraordinary situations, to prevent inappropriate admissions to inpatient facilities, and to facilitate inpatient treatment should it be necessary (Kiesler & Sibulkin, 1987; Mechanic, 1987).

Outpatient commitment has the potential to satisfy the calls for expanded commitment powers and for greater use of community services (Fisher & Pierce, 1985). Currently, every state except New York permits outpatient commitment (Miller, 1988). Despite some ethical and practical criticisms (Brooks, 1987; Miller, 1988; Mulvey et al., 1987; O'Meara, 1984; Scheid-Cook, 1987), evidence suggests that outpatient commitment is successful in diverting patients from inpatient to outpatient care and in maintaining compliance with treatment (Hiday & Scheid-Cook, 1987, 1991). Our analysis suggests that the viability of outpatient commitment depends on providing sufficient means for providing outpatient treatment. If outpatient commitment is permitted by statute but difficult to actually obtain, participants in civil commitment hearings are unlikely to advocate its use.

Some of the chronic mentally ill, if they are not hospitalized, inevitably find their way to institutions, such as jails (Teplin, 1990), nursing homes (Roybal, 1988),
and shelters for the homeless (Lamb, 1990). How to provide quality mental health in such settings is already a focus of empirical research (Caton, Wyatt, Grunberg, & Felix, 1990; Marcos, Cohen, Nardacci, & Brittain, 1990). Finally, some of the nonhospitalized mentally ill will reside, either voluntarily or involuntarily, in alternative mental health institutions, such as halfway houses and board-and-care homes. Although most such institutions currently do not provide an attractive alternative to hospitalization, there is no structural reason why they could not, given appropriate structure and funding (e.g., Guzman & Shore, 1984; Pepper, Kirshner, & Ryglewicz, 1981; for an opposing view, see Arnhoff, 1975).

Conclusion

Recently, the civil commitment pendulum has shown signs of changing direction once again, this time in a more clinical direction. Frustrated with a legal system that appears to guarantee inadequate care for the most needy patients, clinicians have called for nonadversarial patient representatives, longer commitment periods, and relaxation of evidentiary requirements (Herrmann, 1986; Lamb & Mills, 1986). Aware as we are of the inadequacies of the status quo, we doubt that such measures would accomplish the commendable goals of those who have proposed them. Sooner or later, someone would point out that many of the chronically ill don't recover, despite long-term inpatient treatment, and that some patients have been denied years of freedom in the cause of well-intentioned involuntary care. Also, it is not at all clear that more clinically oriented commitment criteria, if interpreted strictly, would result in greater numbers of patients being committed (Hoge, Appelbaum, & Greer, 1989).

The civil commitment system must find a way to balance the equally valid principles of civil liberty and right to treatment. Indeed, this task is faced not by the civil commitment process in isolation, but by the entirety of the public mental health system (Abel, 1980). The balance is unlikely to be found in the minutiae of legal requirements for civil commitment hearings, because the conduct of these hearings is governed as much by the system in which they operate as in the statutes that regulate them (Hoge, Sachs, Appelbaum, Greer, & Gordon, 1988). Rather, a balance must be created between the treatment systems from which the participants in commitment hearings must choose. If the public mental health system were built around an array of desirable options in and out of the hospital, participants in civil commitment hearings would have the important job of selecting among them, while protecting quality of treatment, patients' rights, and society's safety. Failure to provide such a range of care will perpetuate dissatisfaction with the civil commitment system and condemn the chronically mentally ill to a choice between long-term institutionalization and inadequate community care.

REFERENCES


