

Civil Commitment Viewed from Three Perspectives: Professional, Family, and Police

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This study was designed to uncover differences in interpretation and implementation of civil commitment laws. Such problems in interpretation may contribute to mentally ill persons remaining untreated and potentially joining the thousands of homeless mentally ill persons in our communities or the incarcerated mentally ill persons in our prisons and jails. The study examines differences in the assessments of the severity of mental illness, and the appropriateness and judged feasibility for commitment in different commitment categories, made by emergency room admitting personnel, police officers, and families of mentally ill persons. The results demonstrate that police are significantly less likely than families or mental health professionals to perceive mental disability or a need for involuntary commitment on any grounds. Professional psychiatric staffs were much more likely than the other two groups to consider commitment in all three cases as legally feasible. Family ratings of appropriateness for commitment based on the presented symptomatology are similar to those of professionals. However, they are significantly less likely than professionals to judge the cases as legally feasible for commitment, and they interpret the laws similarly to the police raters in believing that commitment laws will not allow involuntary hospitalizations. Consequences and implications of these differences are discussed.

One of the delicate balances in the issues surrounding mental health care of the seriously mentally ill individual is the one between protection and freedom. The massive discharge of hospitalized mentally ill persons in the 1960s was at least

partially prompted by a reaction to the past abuses and neglect of this population, and the idealistic goal of returning hospitalized mentally ill individuals—with the help of newly developed neuroleptic medicines—to freedom in their welcoming communities. Unfortunately, as the state hospital population across the nation has been reduced from 559,000 in 1955 to approximately 68,000 in 1990, the estimated number of homeless mentally ill persons has increased to 600,000

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and the number of mentally ill inmates in the combined jail and prison population has reached an estimated 100,000.¹⁻⁹ Despite this suggestive correlation, there have been few successful efforts to increase the use of involuntary commitment to obtain treatment for persons with serious mental illnesses.¹⁰ Miller notes that even in states that have broadened their commitment laws to include clinical criteria such as need-for-treatment, most have not seen the expected increase in involuntary hospitalizations. Fiscal, political, procedural, and ideological constraints have been among those factors identified as preventing any major broadening of most civil commitment laws.¹¹⁻¹⁵

Because of the high value Americans place on individual liberties, patients' rights advocates continue to press for the patient's freedom to refuse hospitalization and to refuse medication, and laws have been passed and upheld to insure patients' greater choice in treatment, even when this choice is no treatment at all.^{14, 16} Proponents of involuntary commitment stress the inability of severely mentally ill individuals to make meaningful choices without support and structure, with the consequence being that they cannot function effectively in the community, and therefore alternate between homelessness or repeated hospitalizations and/or arrest.^{3-7, 12, 14} State laws vary in the criteria or procedures they specify as necessary for involuntary commitment, but they generally require that the patient be severely mentally ill, and as a result of that illness be (either) a danger to self or others or gravely disabled (i.e., unable to

provide for their own basic shelter, food, or clothing). The *need-for-treatment*, which was the standard for involuntary treatment prior to 1969, is no longer a sufficient consideration for commitment, and additional requirements of direct or indirect dangerousness, lack of less restrictive alternatives, available and effective treatments, and lack of patient capacity to choose those treatments have generally been added.¹⁵ However, as less restrictive alternatives have disappeared along with mental health system budget cuts, *dangerousness* has increasingly become the dominant basis for commitment.¹³

Disagreement over the interpretation of civil commitment laws creates problems in their implementation. Cheng¹⁷ suggests that clinicians and mental health professionals in California were still not sufficiently acquainted with civil commitment procedures even 15 years after enactment of the Lanterman-Petris-Short (LPS) Act, the California commitment law. Add to this the confused interpretations of relatives and police and the problems multiply. Commonly, when a patient decompensates into an acute psychotic state, the parents are advised by their ill family member's doctor to call the police for assistance in hospitalization; the police arrive, but refuse to intercede or take the patient to a hospital, because the patient pulls himself together and expresses no overt threats in their presence. Psychiatric Emergency Teams, despite their name, are too often unavailable when needed, since emergencies tend not to respect well staffed, "nine to five" office hours. Paradoxically, as soon as the hap-

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less patient is sufficiently psychotic and out of control, he will probably end up out on the street, euphemistically known as "the community." The all too frequent interface between relatives, mental health professionals, and police is dramatically depicted in the following example:

The police found a middle-aged woman wandering in a remote mountain area, disoriented and uncooperative. They called a relative, whose number she gave them, and he agreed to pick her up and drive her to a nearby county hospital. The woman refused to go into the hospital, and when the relative requested help from the hospital staff to have her admitted, he was advised to leave the hospital grounds and to call the police for assistance. He did so, the police arrived, and after much discussion with her relative and the police, the woman agreed to go to the hospital. The police followed them in a separate car. Upon arrival at the hospital, the woman again refused to go in. The police told her relative that he would have to forcibly bring her in. The officers refused to help, but followed him as he carried her, biting and screaming, into the hospital.

Of the family-professional-police triangle involved in events such as the above, the most mistrusted and discounted group has been the patient's family or parents, whom psychiatric lore historically has either condemned for their alleged contributions to mental illness or suspected of overreaction to minor crises. As a result, the family has not been expected to bear objective witness to the need for hospitalization of one of its members. With the increased recognition that schizophrenia and affective disorders are neurobiological brain disorders and not functional by-products of family or emotional conflict, the family is slowly gaining more credibility as an advocate and ally of the mental health team.

The role of the police is an intermediate one, and they have been described as the "gatekeepers" in determining the disposition of mentally ill persons in the community.¹⁸ Police are, by default, often the professionals who are called to respond to mental illness crises in the community. In most communities peace officers are given the authority to initiate involuntary commitment, although their willingness to do so is often influenced by the cooperation of emergency room admitting personnel and the ease and timeliness with which they can accomplish the patient's admission. Police officers generally have very limited training in recognition of psychopathology, have a limited understanding of mental illness, and almost certainly are less sensitive to covert symptomatology.^{8, 19} On the other hand, as Teplin²⁰ notes, police officers are generally aware of the stringent requirements for admission into the local psychiatric hospital—requirements that make it difficult to admit a patient unless he/she is actively delusional, violent, or suicidal. Ironically, the hospital staff is not eager to receive the patient who is perceived as "dangerous to others," making it more likely that such a patient has to be arrested to be removed as a public threat and thereby contributing to the criminalization of the mentally ill.²¹

Police may be even less sensitive to the other two criteria for involuntary commitment. The clues for suicidal intent are often subtle and disguised; withdrawal, preoccupation, and motor retardation are not likely to attract police attention. "Gravely disabled" is probably the category into which three-quarters of the

homeless mentally ill could be placed, but because they do not threaten themselves or others, they are allowed to continue their marginal existence unless the commission of a misdemeanor brings them to the attention of the police, and they are detoured through the criminal justice system.

As the specialists in treatment of mental illness, mental health professionals—especially psychiatrists—are the third group involved in decisions about involuntary hospitalization. The early research in this area emphasized the difficulties in professional prediction of low base rate behavior, such as dangerousness, and the resultant overprediction of violence. More recently, epidemiological catchment area studies have suggested that mental illness is in fact associated with a slightly higher rate of violence than that of the general population, although the majority of persons with active psychotic symptoms are not violent. Nor are they as dangerous as substance abusers, whose rates of violence are 12 to 16 times higher than those of the general population.^{22, 23}

Subsequent research focused primarily on professional judgments of dangerousness and the patient and clinician variables that affected commitment decisions on this basis.^{24–28} Studies have shown a reliable, although not necessarily predictive, concept of dangerousness in clinicians' commitment decisions.²⁹ While good interrater reliability has been shown for professional judgments of dangerousness and appropriateness for commitment, research has also shown that professionals are influenced by information other than the relevant legal criteria, for

example severity of psychopathology, social supports, and available resources.^{30, 31} Comparisons of the judgments for different commitment categories or between groups who interface on these decisions are less available, despite their relevance for implementing involuntary treatment.

The present study examines more closely the attitudes of the three groups most likely to come into contact with mentally ill persons: their families, the police, and the emergency room admitting personnel. The attitudes of these groups toward commitment and their interpretation of involuntary commitment laws are compared with respect to each of the three categories for which involuntary commitment can be obtained in California.

Method

Vignettes describing hypothetical mentally ill persons with symptoms indicating a potential need for psychiatric hospitalization were developed from prior research²⁴ and from actual case histories of patients who had been involved in commitment decisions. Symptoms in the vignettes were varied so as to emphasize one of the three grounds for commitment in California: (1) danger to others, (2) danger to self, or (3) gravely disabled. All vignettes incorporated the patient's denial of committable symptoms and unwillingness to accept hospitalization or treatment. Each of the three vignettes was presented in two different forms, one in which the patient was male and one in which the patient was female. All subjects in the study were given a set of three vignettes, one for each commitment

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category, with the gender of the vignettes randomly counterbalanced so that one of the three vignettes was of one sex, and two were of the opposite sex. Sets of the three vignettes, together with a definition of the California LPS Act describing the grounds for involuntary commitment, were distributed to three groups of raters: (1) parents or relatives of mentally ill patients attending several local affiliates of the National Alliance for the Mentally Ill; (2) mental health professionals with experience in involuntary commitment procedures at three different hospitals (a university-affiliated hospital, a county hospital, and a Department of Veterans Affairs hospital); and (3) peace officers in three different cities whose duties brought them into contact with mentally ill persons in their communities. The hospital-based professionals were predominantly psychiatrists, but also included psychologists, social workers, and psychiatric nursing staff with emergency room commitment experience. After reading an explanation of the LPS commitment law, each subject read the set of three vignettes, and for each vignette was asked to answer five questions: (1) a rating of appropriateness of involuntary commitment on a seven-point Likert Scale, (2) selection of the category under which commitment was appropriate, (3) a rating of dangerousness or disability on a three-point scale, (4) the factor that most influenced their commitment decisions, and (5) the feasibility of obtaining commitment for this individual under the present law. Sets of vignettes in which basic questions were incomplete were discarded, leaving 32 sets of data obtained from family members, 32 sets of data obtained from police, and 24 sets of data from mental

health professionals. Statistical analysis consisted of split-plot analysis of variance, using data from 24 randomly selected raters to equalize cells, with *post hoc* procedures when appropriate. When the data were in the form of percentages, chi-square tests using *post hoc* comparisons were made. The .05 level was used as the level of significance for all analyses.

Results

A two-way split-plot analysis of variance indicated that for judgments of appropriateness for commitment, significant differences were found between commitment categories ($F(2,69) = 17.16, p < .001$) and between rating groups ($F(2,138) = 11.32, p < .001$). The interaction was nonsignificant ($F(4,138) = 1.86, p = .122$). There were no significant differences due to the gender of the vignettes presented, for danger to others ($F(1,66) = 1.21, p = > .28$), danger to self ($F(1,66) = 2.16, p > .15$), and gravely disabled ($F(1,66) = .06, p > .81$); thus both genders were combined within each of the commitment categories for later analyses. Table 1 shows the mean ratings of judged appropriateness for commitment for each of the three rating groups.

Post hoc comparisons using the Scheffe method (F needed for significance = 6.12) revealed that danger to self was seen by all three groups as the most appropriate case for commitment, significantly more so than gravely disabled ($F = 20.61$) and danger to others ($F = 12.28$), which are viewed across groups as about equally appropriate for commitment ($F = 1.07$). The police are least likely to favor involuntary commitment on any grounds, while family members ($F = 31.30$) and professionals ($F =$

Table 1
Group Means of Judged Appropriateness for Commitment for Each Commitment Category^a

Commitment Category	Rating Groups			Mean Rating ^b
	Family members	Professionals	Police	
Danger to others	5.63	4.89	3.84	4.83
Gravely disabled	5.81	5.00	2.93	4.57
Danger to self	6.31	6.37	3.94	5.71
Mean rating ^c	5.96	5.44	3.71	

^aRated on a seven-point Likert scale.

^{b, c}Significant differences were found between commitment categories (*b*) and between rating groups (*c*), but there was no interaction effect.

18.51) are significantly more likely than police to do so. In summary, for ratings of dangerousness or disability, the professionals and family members were not significantly different from each other, while ratings of dangerousness by these groups were significantly higher than those of the police.

When each of the three categories for commitment were compared in a *post hoc* analysis, results indicated that across groups, the vignettes presenting a person who is a danger to others or gravely disabled were rated as equivalently disabled or dangerous ($F = 0.06$). Danger to others ($F = 32.72$) and gravely disabled ($F = 49.49$) vignettes

were both rated as significantly less dangerous than the danger to self vignette. These results are presented in Table 2.

An analysis of salient factors that determined the commitment-noncommitment decisions suggests that police consider primarily objective, overt behaviors in their decisions: overt threats, violent or bizarre behaviors, and the presence of a lethal weapon, with only one police officer referring to "loose thoughts" or violent fantasies as a reason for intervention. In contrast, approximately one-third of the professionals and family members indicated an awareness of psychotic symp-

Table 2
Ratings of Dangerousness or Disability^a

Commitment Categories	Rating Groups			Mean Rating ^b
	Family members	Professionals	Police	
Danger to others	2.33	1.92	1.75	2.0
Gravely disabled	2.25	2.17	1.46	1.97
Danger to self	2.58	2.69	2.27	2.51
Mean rating ^c	2.40	2.26	1.85	

^aRated on a three-point scale: 1 = not at all dangerous or disabled; 2 = moderately dangerous or disabled; 3 = extremely dangerous or disabled.

^{b, c}Significant difference was found between commitment categories (*b*) and between rating groups (*c*), but there was no interaction effect.

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toms as the reason for commitment; for example, paranoia, violent fantasies, delusions, or hallucinations. Family members were the most likely to erroneously interpret refusal of treatment as sufficient reason for involuntary commitment.

With respect to the gravely disabled persons, both families and professionals recognize and cite evidence of inability to care for self as grounds for commitment. Responses suggest that the police are much less likely than the other two groups to recognize the relevant symptoms or grounds for commitment in this category. Reasons against commitment given by four police officers focused on the lack of blatant symptoms, or the person's superficial presentation of reason and orientation. One police officer labeled the described patient as "unlucky"; another stated, "We'd have to lock up 50% of the downtown [homeless] population if we committed this type person." The three professionals who chose not to commit the individual described as gravely disabled based their decision on the fact the individual was able to find food (begging) and shelter (sleeping in the canyon), was marginally able to care for himself, and appeared oriented at time of contact. An overview of police reasons for noncommitment of a person whose psychotic symptoms make him or her a danger to self suggests that their threshold for committing such a person is higher because they tend to insist upon evidence of demonstrable, overt behavior.

Table 3 shows the percentages of respondents from each group of raters who would choose to commit on the designated grounds; a second set of compar-

isons for commitment on any grounds; and the judgments of feasibility for commitment under our current laws. The results of the first analysis indicate that the police are significantly more reluctant than families or mental health professionals to initiate commitment for grave disability ($p < .001$), and significantly less likely than mental health professionals to commit on the grounds of danger to self ($p < .01$). Regardless of the grounds for commitment, the police are the least likely to consider the mentally ill person as committable. For those seen as a danger to others or gravely disabled, families are the most likely to favor commitment, whereas mental health professionals are most apt to commit on the grounds of danger to self. With the choice of commitment on any grounds, however, the differences are intensified, and there is a highly significant difference between decisions for commitment by the police and by the other two groups ($p < .01$). Despite identifying characteristics of danger to others or grave disability, police are significantly less likely than families to commit on any grounds. Moreover, they are significantly less likely than either of the other groups to commit individuals presenting as a danger to self.

Judgments of the *feasibility* of commitment under our present laws present an interesting contrast with attitudes about the *appropriateness* of commitment. Chi-square analysis indicated that families and police are less likely than mental health professionals to judge the three cases as legally feasible for commitment, and for the categories of gravely disabled and danger to self, these differences in

Table 3
Summary of Raters' Commitment Choices and Judgments of Feasibility^a

	Danger to Others				Gravely Disabled				Danger to Self			
	Family, %	Professionals, %	Police, %	<i>p</i>	Family, %	Professionals, %	Police, %	<i>p</i>	Family, %	Professionals, %	Police, %	<i>p</i>
Would commit this person as (designated grounds)	65.6	54.2	37.5	.10 NS	71.9	70.8	18.8	<.0001***	84.4	100.0	65.6	.005**
Would commit this person on any grounds	96.9	79.2	50.0	.0003***	87.5	75.0	34.4	.004**	100.0	100.0	65.6	<.0001***
Believe commitment is feasible under present laws	34.4	66.7	43.8	.052 NS	37.5	79.2	28.0	.0004***	43.8	87.5	56.3	.005**
Personally choose commitment, but don't believe it's feasible	62.5	12.5	9.4	<.0001***	50.0	0	6.3	<.0001***	59.4	3.1	8.3	<.0001***

^aSample size for families and police was 32, for professionals 24. Data were analyzed by chi-square. For all analyses, *df* = 2. ***p* < .01; ****p* < .001.

judgments by mental health professionals and the other two groups are highly significant.

A final comparison was made of the percentage of raters in each group who would commit the described patients, but felt that involuntary commitment was not feasible under present laws. Both the police and professional staff are consistent in their choices to commit, and their belief that their commitment decisions are legally feasible. Both groups believe the law provides support for their judgments, even though they disagree markedly on what constitutes an appropriate commitment. By contrast, the families, however similar they are to professionals in their recognition of pathology, disability, and the need for commitment, clearly lack confidence that the legal system will support their view. They reveal extreme inconsistency, personally opting for commitment, while at the same time believing it is not feasible. These differences are highly significant (*p* < .00001).

Discussion

The results of the current study highlight two major problems in the interpretations and implementation of involuntary commitment laws such as California's LPS Act. One problem is the difference in subjective understanding of the criteria for commitment as delineated in the law. This is demonstrated by the fact that the two main groups who are responsible for initial implementation of the laws—emergency room mental health staff and police officers in the community—significantly disagree on when these laws may be applied. This situation may reflect a changing interpreta-

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tion of the laws, as a result of diminishing resources, in which dangerousness to self or others increasingly replaces need-for-treatment when such treatment is less available. Such disagreement may also reflect the basic ideologies of these two professional groups: one trained to provide treatment, the other to prevent violence. Since these raters all lived within a very large metropolitan county where a number of police and sheriff agencies have variable levels of interaction with mental health agencies, the differences may reflect confusion over different procedures for initiating commitment. Finally, the differences may point to a lack of adequate police training on mental illness, such that they are unable to recognize disabling symptoms.

Past efforts to identify differences in the interpretation of present laws have generally focused on the criteria that are necessary or sufficient for hospitalization, on the impact of those criteria on the numbers of seriously mentally ill persons who are committed for treatment, on the types of information that mental health professionals use in making commitment decisions, or on the objective patient characteristics that are associated with an evaluation of dangerousness.^{10, 29-32} This research investigates the subjective differences and subsequent procedural problems that may occur when families, mental health professionals, and the legal system collide on commitment decisions. Judicial decisions have confirmed the limited rights of the mentally ill person to refuse treatment^{12, 13, 26, 33, 34} at the same time that the growing number of homeless mentally ill persons has increased

their likelihood of entanglements with the criminal justice system.

While criminal interactions between the police and disturbed individuals are still infrequent events, peace officers, jails, and families report that they are increasing.⁷ Despite widespread myths, however, the mentally ill person is unlikely to commit a serious crime and is more likely to commit a misdemeanor or nonviolent crime.^{7, 21, 23, 26, 35, 36} Nonetheless, it is understandable that the typical peace officer, experienced in criminal law and trained to protect society, is much more responsive to overt threats and potentially criminal behaviors, and thus more likely to intervene in decisions for commitment on the grounds of dangerousness.

This study indicates that police are particularly unlikely to choose commitment for the most common commitment need, that of grave disability. If lethality seems imminent, police have fewer problems initiating commitment, but their tendency to perceive dangerousness is less than that of families or professionals. However, it is widely recognized that grounds of dangerousness to others are generally irrelevant, since the vast majority of mentally ill persons are distressing rather than dangerous.^{3, 23, 36} Although California, like many states, recognizes grave disability in its commitment criteria, police ratings and responses in this study suggest that if the police were summoned to the family home, they would be unlikely to accept family history in the absence of overt symptoms, would not perceive disability, and would not intervene to assist with involuntary hospitalization. To the extent

that police participation is an important factor in initiating commitment,¹⁸ it is probable that commitment will not be initiated for gravely disabled individuals. Insofar as gravely disabled persons are living a marginal and life-endangering existence in the community, under railroad trestles or in alleys, the likelihood of police intervention—considering their present understanding of commitment laws—is very slim. With no intervention, the number of homeless mentally ill persons, which is estimated to have doubled between 1978 and 1982, will continue to rise.³⁷

The second difficulty revealed by the current study is the differing ability of the three concerned groups to recognize the specific psychotic symptoms and degrees of disability which warrant involuntary commitment. Indeed, almost one-half of the police rated the description of the gravely disabled individual as “not at all disabled.” Such inability to perceive pathology results in the police underutilizing those criteria that clearly indicate an individual’s deterioration and need for medical intervention. Only when the case description (Danger to Self) included a potential weapon (a knife) did the majority of police feel commitment was appropriate.

The ability of the police to recognize severe psychiatric symptoms has been found to be limited, since they recognized only one-half of the mentally ill persons identified in the community by case workers.^{20, 21} This is hardly a surprise, as even trained, mental health professionals can disagree on symptoms and diagnoses. What is surprising is that police confi-

dence in their judgments is every bit as high as that of the experienced mental health professional, even when the decisions of these two groups are in opposition. If the police are to assist in the disposition of the mentally ill into the appropriate community agency, whether this diversion is to hospital, jail, or detoxification program, they must be better trained in recognizing symptoms of deterioration or disability, as well as in understanding commitment criteria, in order to take appropriate action. This might involve intensive training for select police units or better cooperation with psychiatric emergency teams who have experience and knowledge to make these diagnostic and commitment decisions.

The role of the family in this decision-making process can be one of experienced ally of the mental health professionals. This study indicates that the families are as able as the professionals to correctly identify the psychopathology that should necessitate involuntary treatment. Despite their sophisticated and valid recognition of the psychotic symptoms that suggest a need for psychiatric hospitalization, however, families are cynical and pessimistic about the feasibility of commitment under current laws—a probable outcome of past experience with “the system,” and repeated failures to obtain needed intervention. Improved communication between mental health professionals and families, which is possible only with better continuity of care, should permit cooperative input to the police when police assistance is requested, allay concerns about the family’s overreaction to symptoms, and allow timely treatment

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before the ill individual decompensates and endures greater self harm.

Understandably, both professionals and family members may have more experience than the police in recognizing the symptoms of mental illness. While mental health professionals are familiar with a wide range of symptoms and diagnoses, families are especially familiar with and sensitive to the particular pattern of symptoms, and the signs of improvement or deterioration for their relative in response to medications or stress. To the extent that patients can sometimes "pull themselves together" for a brief interval to hide underlying pathology, information provided by the family can be used to guide the professional's inquiry at the time of evaluation. Discontinuation of treatment and medication continues to be a major problem in community follow-up.³⁸

Our ability to generalize from this research is limited by the fact that it uses written descriptions of psychiatric cases, in order to present identical data to all raters, and raters might respond differently to *in vivo* presentations. Nonetheless, the repeated and significant differences found in the responses of rating groups are compelling. Future research may clarify the criteria each group uses in its decision making and delineate the necessary training and information collection procedures that will improve this decision making in accordance with the laws.

All groups of raters in this study lived and worked in a very heavily populated metropolitan county, served by one of the nation's largest county mental health systems, which was facing ongoing budget

shortfalls. A multitude of separate community police departments as well as sheriff substations varied greatly in their interface with the mental health department and in their reported training on mental health issues. Thus, results may not be generalizable to more rural counties or communities or other states in which laws, training, and agency cooperation are different.

The present study suggests that changes in the basic criteria for involuntary commitment, despite their accordance with the American Psychiatric Association's model law recommendations, and whether based on dangerousness and/or need-for-treatment, will not necessarily lead to changes in the implementation of such laws.³⁹ While California law allows commitment for grave disability and for dangerousness to self or others, the applications of the law for implementation and its interpretations by those responsible for its initiation show wide variations. The reluctance of peace officers to intervene in the lives of nonviolent, mentally ill street people allows severely disabled individuals to deteriorate without needed care. With better education of specially trained police units, and their increased cooperation with mental health professionals and families, the police may play an increased role in the diversion of homeless mentally ill persons and mentally ill offenders into treatment. This may increase the numbers of involuntary commitments initially and require more hospital beds.¹⁸ If 75 percent of the mentally ill are gravely disabled, and this has been the group that restrictive laws have excluded from treatment, then the in-

creased commitment would be a much needed correction. Early intervention, however, may reduce the need for more intensive long-term care in the future.

As more creative community shelters and outreach programs attempt to reach homeless mentally ill persons in the communities, ways to involve these people in "least restrictive treatment" away from the hospital may increasingly be developed and may serve to prevent flooding the hospitals beyond their capacity. Some studies have suggested that involuntary commitment to outpatient treatment, as well as variations of this commitment established for conditional release programs, may prove to be an important and necessary means of providing necessary treatment to disturbed individuals who cannot choose such ongoing treatment for themselves.^{40,41} Any fears of open-ended commitment ignore the fact that, at the present time, illnesses such as schizophrenia and bipolar disorders are "open-ended" illnesses. As long as the illnesses defy cure, impair judgment, and prevent individuals from functioning adequately in the community, the harm of periodic monitoring and the requirements for maintenance treatment via outpatient commitment appear far less damaging than the harm of protecting the "liberty interests of irrational, psychotic patients while they ruin their lives, alienate their families, and deteriorate into irreversible chronicity without timely treatment."⁴²

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Appendix

The following three vignettes were presented untitled as examples of the three commitment categories: Danger to Others, Gravely Disabled, or Danger to Self. The gender of each of the vignettes was counterbalanced as either male or female in presentations.

1. Danger to Others

Rick (Rita), a 23-year-old white single male (female), came to the hospital emergency room tonight requesting a blood test. Rick (Rita) is convinced that he (she) is suffering from an undiagnosed virus that is affecting his (her) thoughts. Rick's (Rita's) landlady for the past five years, who accompanied him (her) to the hospital, admits that she is concerned about Rick's (Rita's) recent "bizarre and irresponsible behavior." It seems Rick (Rita) has been sleeping very little the past month, investing a great deal of energy in unrealistic projects (e.g., running for different political offices at the same time). Lately he (she) has been overheard telling some of the neighbors that if they "don't stop spying on me, they'll be sorry." Although Rick (Rita) has no known history of violent behavior, he (she) admits to having fantasies about "getting even with my enemies." Recently, he (she) has been heard at night throwing things about, yelling out obscenities, and threatening neighbors from his (her) window.

During the hospital interview he (she) exhibited relatively loose thought processes, pressured speech, and some motor restlessness. However, Rick (Rita) has stated that he (she) will not consider taking any prescribed medication ("it could be poison"), or enter the hospital's psychiatric ward as a voluntary patient. Rick (Rita) insists that there is nothing wrong with him (her) and he (she) won't enter any "nut house."

The individual refuses any clinical and social interventions offered and there are only two alternatives: allow this person to go, or decide to initiate involuntary commitment procedures.

2. Gravely Disabled

A 30-year-old single male (female) was reported sleeping in a canyon near his (her) parent's home. He (she) had lost his (her) apartment for nonpayment of rent, was unbathed and poorly

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groomed; his (her) clothes were dirty and weed-covered. The previous evening, a neighbor had called the parents to report that their son (daughter) had knocked on the neighbor's door begging for food. The man (woman) had reportedly been hospitalized three times previously for self-mutilation and threats of self-harm. For the past month, he (she) had refused all medication and treatment. The mother reported he (she) was hearing voices, and told her of having delusions that he (she) was the devil. His (Her) car had recently been stolen, he (she) had lost his (her) job, and he (she) had spent all of his (her) savings irrationally in response to inner voices. The mother requested help taking him (her) to the hospital because he (she) refused to go. A police unit was sent out. The officers spent some time listening to the mother's story and talking to the young man (woman), who appears to be oriented. He (she) tells them clearly and coherently that he (she) is feeling fine, he (she) would agree to take his (her) medicines, and he (she) was just on his (her) way to a friend's house where he (she) was planning to stay. He (she) refuses any further clinical and social interventions offered, and there are only two alternatives: allow him (her) to go, or decide to initiate involuntary commitment procedures.

3. Danger to Self

A 25-year-old male (female) was observed by his (her) mother to be sharpening a butcher knife in the kitchen of the mother's home. He (she) had been acting agitated and confused in recent weeks and had asked several questions about *hara-kiri*. His (her) mother said he (she) sometimes heard voices suggesting he (she) should hurt himself (herself) and that everything would be all right if he (she) would cut his (her) eye out and give "an eye for an eye." His (her) emotions appeared to change quickly, for no clear reason. At times he (she) would angrily accuse the mother of trying to kill him (her) and at times he (she) would insist he (she) loved and trusted her. At other times he (she) appeared agitated and felt other people were trying to kill him (her). His (her) mother became increasingly alarmed and called the police. They arrived on the scene. The young man (woman) appeared to them to be calm, his (her) speech was coherent, he (she) denied suicidal intent, and he (she) stated that he (she) would refuse to take any medication or see a doctor.

The individual refuses any clinical and social interventions offered and there are only two alter-

natives: allow this person to leave, or decide to initiate commitment procedures.

References

1. Lamb HR: Deinstitutionalization and the homeless mentally ill. *Hosp Community Psychiatry* 35:899-907, 1984
2. Holden C: Broader commitment laws sought. *Science* 230:1253-5, 1985
3. Lamb HR, Mills MJ: Needed changes in law and procedure for the chronically mentally ill. *Hosp Community Psychiatry* 37:475-80, 1986
4. Coates RC: *A Street is Not a Home: Solving America's Homeless Dilemma*. Buffalo, NY: Prometheus, 1990
5. Fustero S: Home on the street. *Psychol Today* 18:56-63, 1984
6. Torrey EF, Erdman K, Wolfe MD, Flynn LM: *Care of the Seriously Mentally Ill: A Rating of State Programs* (ed. 3). Washington, DC: Public Citizens' Health Research Group and the National Alliance for the Mentally Ill, 1990
7. Torrey EF, Stieber J, Ezekiel J, *et al*: *Criminalizing the Mentally Ill*. Washington, DC: Public Citizens' Health Research Group and the National Alliance for the Mentally Ill, 1992
8. Husted JR: The last asylum: the mentally ill offender in the criminal justice system, in *New Directions in the Psychological Treatment of Serious Mental Illness*. Edited by Marsh DT. Westport, CT: Praeger, pp 50-76, 1994
9. Bloom JD, Faulkner LR: Competency determinations in civil commitment. *Am J Psychiatry* 144:193-6, 1987
10. Miller RD: Need-for-treatment criteria for involuntary civil commitment: impact in practice. *Am J Psychiatry*. 149:1380-4, 1992
11. Faulkner LR, McFarland BH, Bloom JD: An empirical study of emergency commitment. *Am J Psychiatry* 146:182-6, 1989
12. Mulvey EP, Geller JL, Roth LH: The promise and peril of involuntary outpatient commitment. *Am Psychol* 571-84, 1987
13. Turkheimer E, Parry CDH: Why the gap? *Am Psychol* 47:646-55, 1992
14. Talbott JA: Deinstitutionalization: avoiding the disasters of the past. *Hosp Community Psychiatry* 30:621-4, 1979
15. Stromberg CD, Stone AA: A model state law on civil commitment of the mentally ill. *Harv J Legis* 20:275-396, 1983
16. Morse SJ: A preference for liberty: the case

- against involuntary commitment of the mentally disordered. *Calif L Rev* 70:54-106, 1982
17. Cheng K: Civil commitment considerations in California. *West J Med* 144:497, 1986
 18. Durham ML, Carr HD, Pierce GL: Police involvement and influence in involuntary civil commitment. *Hosp Community Psychiatry* 35:580-4, 1984
 19. Murphy GR: Special care: improving the police response to the mentally disabled. Washington, DC: Police Executive Research Forum, 1986
 20. Teplin LA: Criminalizing mental disorder: the comparative arrest rate of the mentally ill. *Am Psychol* 39:794-803, 1984
 21. Teplin LA: The criminality of the mentally ill: a dangerous misconception. *Am J Psychiatry* 142:593-9, 1985
 22. Monahan J: Mental disorder and violent behavior. *Am Psychol* 47:511-21, 1992
 23. Torrey EF: Violent behavior by individuals with serious mental illness. *Hosp Community Psychiatry* 45:653-62, 1994
 24. Eather BA: Professional differences in assessing dangerousness and need for civil commitment. Presented at the Annual Meeting of the American Psychological Association, Los Angeles, CA, August 1985
 25. Monahan J, Ruggiero M, Friedlander H: The Stone-Roth model of civil commitment and the California dangerousness standard: an operational comparison. *Arch Gen Psychiatry* 39:1267-71, 1982
 26. Rubin LC, Mills MJ: Behavioral precipitants to civil commitment. *Am J Psychiatry* 140:603-6, 1983
 27. Nicholson RA: Correlates of commitment status in psychiatric patients. *Psychol Bull* 100:241-50, 1986
 28. McNeil DE, Binder RL: Predictive validity of judgment of dangerousness in emergency civil commitment. *Am J Psychiatry* 144:197-200, 1987
 29. Segal SP, Watson MA, Goldfinger SM, Averbuck JD: Civil commitment in the psychiatric emergency room, Parts I-III. *Arch Gen Psychiatry* 45:748-63, 1988
 30. Thompson JS, Ager JW: An experimental analysis of the civil commitment recommendations of psychologists and psychiatrists. *Behav Sci Law* 6:119-29, 1988
 31. Lidz CW, Mulvey EP, Appelbaum PS, Cleveland S: Commitment: the consistency of clinicians and the use of legal standards. *Am J Psychiatry* 146:176-81, 1989
 32. Hiday VA: Civil commitment: a review of empirical research. *Behav Sci Law* 6:15-43, 1988
 33. Appelbaum PS: *Washington v. Harper*: prisoners' rights to refuse antipsychotic medication. *Hosp Community Psychiatry* 41:731-2, 1990
 34. O'Connor VD v. Donaldson, 422 US 563 (1975)
 35. Hiday VA, Scheid-Cook TL: A follow-up of chronic patients committed to outpatient treatment. *Hosp Community Psychiatry* 40:52-9, 1989
 36. Husted JR, Charter RA, Perrou B: California law enforcement agencies and the mentally ill offender. *Bull Am Acad Psychiatry Law*, 23:315-29, 1995
 37. Appleby L, Desai PN: Documenting the relationship between homelessness and psychiatric hospitalization. *Hosp Community Psychiatry* 36:732-7, 1985
 38. Gralnick A: Build a better state hospital: deinstitutionalization has failed. *Hosp Community Psychiatry* 36:738-41, 1985
 39. Rubenstein LS: APA's model law: hurting the people it seeks to help. *Hosp Community Psychiatry* 36:968-72, 1985
 40. Lamb HR, Weinberger LE, Gross BH: Court-mandated community outpatient treatment for persons found not guilty by reason of insanity: a five-year follow-up. *Am J Psychiatry* 145:450-6, 1988
 41. Shon SP: The Effectiveness of the Conditional Release Program. Sacramento, CA: California Department of Mental Health, 1990
 42. Stone AA: A response to comments on APA's model commitment law. *Hosp Community Psychiatry* 36:984-9, 1985