Effects of a New Involuntary Commitment Law: Expectations and Reality

LARRY R. FAULKNER, MD
JOSEPH D. BLOOM, MD
and
KAY KUNDAHL—STANLEY, ACSW

During the last decade, there has been almost constant upheaval in the field of psychiatry, as the courts have examined and found inadequate many of its procedures and institutions. Formerly, it seemed the legal system did not realize that psychiatry existed, now it appears the psychiatrist must be prepared to defend in court everything he or she does or does not do. Court cases concerning civil commitment,[1,2] right to treatment,[3] right to refuse treatment,[4] and least restrictive alternatives[5] have dictated major changes in psychiatric procedures and practice.[6,7] In civil commitment, courts have supported a replacement of the medical model by the legal model and an emphasis on a state's police powers instead of its *parens patriae* authority,[8] with commensurate attention to due process procedures and protection of patients' rights.

In response to this legal activity, a number of authors have presented recommendations for civil commitment statutes[6,9,10] that attempt to strike a balance between protecting patients' rights and ensuring adequate treatment. Many state legislatures also have been busy rewriting commitment statutes to bring them in line with court decisions. The results of all this activity have left many psychiatrists feeling frustrated, helpless, and fearful that many mental patients will now have the privilege to "die with their rights on."[11]

Despite this controversy, there have been few reports in the literature about the effects of new civil commitment laws on mental health systems. Table 1 summarizes the effects described in several states. As can be seen, the reports are contradictory.[12,13] Generally, it is claimed that the numbers of court hearings have decreased,[14,15] the percentage of involuntary civil commitments has declined,[14,16] the length of stay has "declined dramati-

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At the time this work was done, Dr. Faulkner was Deputy Commissioner for Community Mental Health Services and Affiliated Programs, Arkansas Mental Health Services Division, and Assistant Professor of Psychiatry, University of Arkansas for Medical Sciences. At present Dr. Faulkner is Director, Residency Training Program, and Assistant Professor of Psychiatry, Oregon Health Sciences University. Dr. Bloom is Vice-Chairman, Department of Psychiatry, Director, Community Psychiatry Training Program, and Professor of Psychiatry, Oregon Health Sciences University. Ms. Kundahl-Stanley is Mental Health Information Systems Coordinator, Arkansas Mental Health Services Division.

Dr. Faulkner's address is Department of Psychiatry, Oregon Health Sciences University, 3181 SW Sam Jackson Park Rd., Portland, OR 97201.

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cally,"[16,17] the percentage of criminal commitments has increased,[14] and that more mentally ill are being managed by the criminal justice system.[18] These reports seem to indicate that stricter legal requirements inappropriately divert some patients from mental health systems and lend credence to the fears of mental health professionals that increased morbidity and mortality may result.[19]

Table 1. Reports on the Effects of New Commitment Laws.

Senior Author	State	% Vol Admits	# Court Hearings	# Civil Commits	Length of Stay	# Criminal Commits
Munetz[12]	PA		↑	↑	*	
Haupt[13]	PA	↓**			↑**	
Frydman[14]	KS	↑	↓	↓	*	↑
Kumasaka[15]	NY		↓			
McGarry[16]	MA	↑		↓	↓	
Hiday[17]	NC			↓	↓	
Abramson[18]	CA					↑

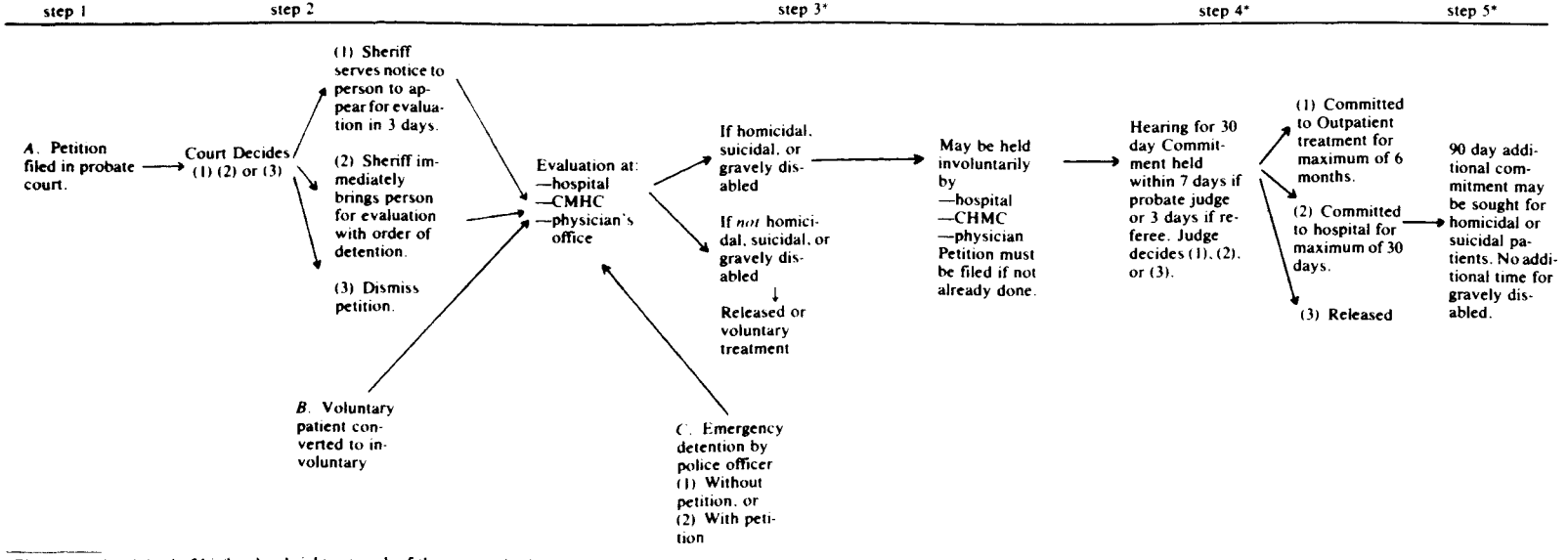
*No change
**Not significant

Evolution of a New Commitment Law

On July 18, 1977, a class action suit, *Wessel v. Pryor,*[20] was filed in the U.S. District Court for the Eastern District of Arkansas. It sought to have the court declare unconstitutional Arkansas's existing involuntary commitment statutes.[21] On May 31, 1978, the judge decided that the existing commitment law was "not unconstitutional on its face" since it was "silent in regard to the great majority of... constitutional rights."[22] He went on to state, however, "in practice, courts have failed to apply these statutes in a constitutional manner." At that time the Attorney General, ACLU, and Legal Aid reached a stipulated agreement known as the "Original Wessel Decree." This document outlined new procedures for involuntary commitment emphasizing due process and the protection of legal rights. It also established that commitment could be ordered only if "there is clear and convincing evidence to show that the respondent is mentally ill and dangerous to himself or society as evidenced by a recent overt act." Minor modifications in these procedures were made in a "Second Wessel Decree"[23] in December 1978.

From the beginning, the judge stated that his orders were to be viewed as "constitutionally acceptable procedures to be followed *until the legislature acts*." There ensued an arduous series of meetings between state and local mental health personnel, private psychiatrists, probate judges, and attorneys that resulted in the drafting and enactment of Arkansas's new involuntary commitment law.[24] It was signed by the Governor on April 10, 1979. Figure 1 is a summary of commitment procedures under the new law.

Figure 1. Summary of Commitment Procedures.



*The person is advised of his/her legal rights at each of these steps in the procedure.

Table 2. Comparison of Old and New Commitment Laws.

Content	Old	New
1. Clear definitions of terms	No	Yes
2. Encouragement of voluntary admissions	Yes	Yes
3. Specification of due process procedures	No	Yes
4. Provisions for emergency commitment	Yes	Yes
5. Admission by physician statement only	Yes	No
6. Petition for involuntary commitment	Yes	Yes
7. Probable cause hearing required	No	Yes
8. Observation and judicial review before final commitment	No	Yes
9. Dangerousness is the criteria for commitment	Yes	Yes
10. Burden of proof is "clear and convincing"	No	Yes
11. Patient's right to adequate treatment	No	Yes
12. Delineation of treater's rights	No	Yes
13. Separate procedure for determination of incompetency	Yes	Yes
14. Emphasis on least restrictive alternatives	Yes	Yes
15. Commitment not indeterminant	No	Yes

Table 2 presents a comparison of the old and new laws using a modified version of the Treffert and Krajeck format.[9] The new law differs considerably from the old and continues the emphasis on due process and protection of patients' rights initiated by the Original Wessel Decree. Table 3 summarizes the types of involuntary detention permitted under the old and new laws. In addition to probate court orders, the old law[21] provided for the admission of "any person suffering from mental illness... who requires immediate hospitalization... upon the written request of any... physician." It also allowed "emergency" admissions with a physician's statement and the certification of emergency by the "prosecuting attorney, county health officer, public health nurse, welfare department representative, or a representative of a community mental health center or clinic." In addition to probate court orders, the new law[24] provides for the "emergency" detention of a person by "any law enforcement officer" on his or her own initiative (without petition) or at the request of any interested citizen (with petition). It also allows the judge to issue an "order of detention" directing the sheriff to detain and transport a person for an evaluation of his mental condition. A major difference between the laws is the strict requirement, under the new law, for petitions to be promptly filed no matter how a person is detained.

Table 3. Types of Involuntary Detention—Old and New Laws.

Types of Involuntary Detention	Old Law	New Law
A. Petition Required		
1. Probate Court Order	Yes	Yes
2. Emergency	No	Yes
3. Order of Detention	No	Yes
B. No Petition Required		
1. Physician's Statement	Yes	No
2. Emergency with Physician's Statement	Yes	No
3. Emergency	No	Yes

Professional Expectations of the New Law

Mental health professionals at local and state levels were suspicious of the possible effect of the new law. During working meetings held to draft the statute, they expressed concerns in four main areas:

1. The belief the new procedures were too burdensome and time consuming, and they would prevent admission to the state hospital of patients desperately needing care.
2. The fear that psychiatric patients would be diverted into the criminal justice system with an increase in arrests, jail sentences, and criminal commitments.
3. The concern that emphasis on patient's rights, due process, and least-restrictive alternatives might force the early release of patients before they were adequately treated.
4. The expectation, as a result of early release, that patients would be more dysfunctional in the community, enter the "revolving door," and be readmitted more frequently.

Method of Study and Results

To study the effect of the new commitment law on Arkansas's mental health system, we examined state hospital admission and length-of-stay data for patients nineteen and older during fiscal years (July-June) 1977-78, 1978-79, and 1979-80.

Table 4 presents numbers of unduplicated and total admissions for these years by quarters. Unduplicated admissions are the number of separate individuals admitted while total admissions include readmissions during a

Table 4. State Hospital Admissions.

	Dates		Unduplicated No.	Unduplicated (Percent)	Total
	1977	Jul-Sep	428	(81)	530
		Oct-Dec	368	(79)	467
	1978	Jan-Mar	277	(67)	412
		Apr-Jun*	347	(76)	455
FY 77-78			1,420	(76)	1,864
	1978	Jul-Sep	318	(69)	464
		Oct-Dec	247	(60)	411
	1979	Jan-Mar	328	(80)	411
		Apr**-Jun	337	(80)	419
FY 78-79			1,230	(72)	1,705
	1979	Jul-Sep	372	(84)	445
		Oct-Dec	377	(92)	411
	1980	Jan-Mar	399	(85)	468
		Apr-Jun	393	(81)	486
FY 79-80			1,541	(85)	1,810

*Original Wessel Decree
**New Commitment Law

$p > .05$ (t test) for total admissions in all years and for unduplicated admissions FY 77-78 to FY 78-79 and FY 77-78 to FY 79-80.
$p < .05$ for unduplicated admissions FY 78-79 to FY 79-80.

Table 5. Total Admissions by Type.

Dates	Probate Ct.		M.D. Statement		Voluntary		Detention		Emergy. W/Pet.		Emergy W/O Pet.		Circuit Ct.	
	No.	(Percent)	No.	(Percent)	No.	(Percent)	No.	(Percent)	No.	(Percent)	No.	(Percent)	No.	(Percent)
1977 Jul-Sep	134	(25)*	222	(42)	125	(24)							49	(9)
Oct-Dec	77	(16)	251	(54)	94	(20)							45	(10)
1978 Jan-Mar	63	(15)	223	(54)	74	(18)							52	(13)
Apr-Jun**	75	(16)	251	(55)	80	(18)							49	(11)
FY 77-78	349	(19)	947	(51)	373	(20)							195	(10)
1978 Jul-Sep	89	(19)	194	(42)	128	(28)							53	(11)
Oct-Dec	83	(20)	154	(37)	114	(28)							60	(15)
1979 Jan-Mar	98	(21)	20	(4)	221	(47)							72	(15)
Apr***-Jun	93	(22)	2	(0)	261	(62)					17	(4)	46	(11)
FY 78-79	363	(21)	370	(22)	724	(42)					17	(1)	231	(14)
1979 Jul-Sep	125	(28)			261	(59)					5	(1)	54	(12)
Oct-Dec	51	(12)			235	(57)	55	(13)	5	(1)	11	(3)	56	(14)
1980 Jan-Mar	66	(14)			266	(57)	58	(12)	8	(2)	18	(4)	52	(11)
Apr-Jun	75	(15)			245	(50)	93	(19)	9	(2)	15	(3)	50	(10)
FY 79-80	317	(18)			1007	(56)	206	(11)	21	(1)	47	(3)	212	(12)

*Percentage of total admissions for respective time period
**Original Wessel Decree
***New Commitment Law

$p > .05$ (t test) for probate court and circuit court commitments in all years. $p < .05$ for voluntary admissions FY 77-78 to FY 78-79 and FY 78-79 to FY 79-80; $p < .001$ for FY 77-78 to FY 79-80. $p < .05$ for M.D. statements FY 77-78 to FY 78-79.

particular fiscal year. A slight decrease in the number of admissions occurred during FY 78-79 when the Wessel decrees were in effect, but, subsequent to the new law, admissions increased to nearly FY 77-78 levels. Similarly, there was a slight decrease in the percentage of unduplicated admissions in FY 78-79 but a subsequent increase to 85 percent in FY 79-80.

Table 5 summarizes the numbers of total admissions for the three fiscal years by type. Probate court (civil) and circuit court (criminal) commitments remained fairly constant throughout the period. Admissions by physicians' statement decreased as a result of the Original Wessel Decree and were eliminated by the new law. Voluntary admissions increased from 20 percent in FY 77-78 to 56 percent by the end of FY 79-80. A closer examination shows that voluntary admissions actually peaked at 62 percent during the last quarter of FY 78-79 and then declined to 50 percent by the last quarter of FY 79-80. Admission by order of detention, emergency with petition, and emergency without petition all increased during FY 79-80 with orders of detention comprising 19 percent of all admissions by the last quarter of the year.

Table 6 compares voluntary admissions with all types of involuntary admissions, except circuit court commitments, for the three-year period. Voluntary admissions increased from 22 percent in FY 77-78 to 63 percent by FY 79-80. Once again, it can be seen that voluntary admissions peaked at 70 percent during the last quarter of FY 78-79 and then decreased to 56 percent by the end of FY 79-80.

Table 6. Total Voluntary and Involuntary Admissions.*

Dates		Voluntary No.	Voluntary (Percent)	Involuntary	Total
1977	Jul-Sep	125	(26)	356	481
	Oct-Dec	94	(22)	328	422
1978	Jan-Mar	74	(21)	286	360
	Apr-Jun**	80	(20)	326	406
FY 77-78		373	(22)	1,296	1,669
1978	Jul-Sep	128	(31)	283	411
	Oct-Dec	114	(32)	237	351
1979	Jan-Mar	221	(65)	118	339
	Apr***-Jun	261	(70)	112	373
FY 78-79		724	(49)	750	1,474
1979	Jul-Sep	261	(67)	130	391
	Oct-Dec	235	(66)	122	357
1980	Jan-Mar	266	(64)	150	416
	Apr-Jun	245	(56)	192	437
FY 79-80		1,007	(63)	591	1,598

*This table excludes circuit court commitment
**Original Wessel Decree
***New Commitment Law

$p < .05$ (t test) for voluntary admissions FY 77-78 to FY 78-79 and FY 78-79 to FY 79-80. $p < .001$ for FY 77-78 to FY 79-80.
$p < .01$ for involuntary admissions FY 77-78 to FY 78-79 and FY 77-78 to FY 79-80. $p > .05$ for FY 78-79 to FY 79-80. $p > .05$ for total admissions.

Table 7. Average Length of Hospital Stay (Days).

	Types of Admission	
	Voluntary	Involuntary
FY 77-78	25.80	31.83
FY 78-79	25.94	36.05
FY 79-80	28.79	45.57

Table 7 reveals the average length of stay in days for voluntary and involuntary patients of all types except circuit court commitments. Length of stay for voluntary and involuntary patients increased each year. For the entire three-year period, probate court commitments under the old law had an average length of stay of 36.54 days. Under the new law, the average length of stay for probate court commitments was 57.53 days in FY 79-80.

Discussion

Comparing the results of our investigation with the expectations expressed by mental health professionals leads to several conclusions.

First, the belief that a significant number of admissions would be prevented does not seem to be valid. Despite an initial decrease in the number of admissions following the Wessel decrees, the more stringent procedures of these decrees and the new law do not appear to have had a major impact on the number of state hospital admissions (Table 4). Total FY 79-80 admissions were somewhat lower than FY 77-78 (1,810 to 1,864), but this must be viewed against a historical background of admissions that have been steadily decreasing for a number of years.[25] In addition, the number and percentage of probate court commitments remained fairly constant despite the extra procedures involved (Table 5).

The new procedures resulted in a dramatic increase in the number and percentage of voluntary admissions as the admissions by physicians' statements were eliminated (Tables 5 and 6). The number of voluntary admissions declined in FY 79-80 as orders of detention, emergency admissions with petitions, and emergency admissions without petitions increased to 15 percent of the total (Table 5). In the last quarter of FY 79-80, these three forms of involuntary admission actually accounted for 24 percent of the total number. They are similar to the physician's statement under the old law, as they allow a person to be picked up in his local community and taken directly to the state hospital for admission.

Large numbers of admissions by these mechanisms would be bothersome for a couple of reasons. Emergency admissions with and without petitions allow police officers to detain people and transport them directly to the state hospital, bypassing initial review by the local probate court and less restrictive forms of evaluation and treatment by local mental health professionals. It is true that a petition must subsequently be filed initiating commitment procedures, but only after the person has been admitted to the

hospital. Using an order of detention, a probate judge also can order the sheriff to transport a person directly to the state hospital for evaluation and treatment, again avoiding local mental health professionals. Our data indicate that the numbers of emergency admissions with and without petitions were small, but that orders of detention increased sharply to 19 percent of the total by the last quarter of FY 79-80 (Table 5). If this trend continues and judges view the state hospital as their primary evaluation and treatment resource, major problems for deinstitutionalization and community mental health efforts could result.

Second, it is doubtful that significant numbers of psychiatric patients were diverted into the criminal justice system. While arrest and sentencing data are not available, the numbers of circuit court commitments did not increase greatly (Table 5). In fact, there was a decline in FY 79-80. Large numbers of sentencings also would tend to reduce total admissions, which did not occur. It is also possible that excessive criminality by large numbers of psychiatric patients would have resulted in many emergency admissions with and without petitions. In FY 79-80 they accounted for only 4 percent of the total admissions (Table 5).

Third, the concern that the new law might force the early release of large numbers of patients before they were adequately treated does not seem to be justified. In fact, average lengths of stay for both voluntary and involuntary patients increased in both FY 78-79 and FY 79-80 (Table 7). This increase could not have been caused by the dumping of large numbers of long-term patients into the community from this state hospital, since these very chronic patients were treated in a separate intermediate care facility. These changes in lengths of stay could be explained by the shift to voluntary status of many previously involuntary patients (Tables 5 and 6). This shift would move sicker patients into voluntary status, with the likely result of increasing the length of stay for that group. The remaining involuntary patients would represent the most impaired group, which might be expected to have significantly longer hospitalizations. In fact, the average length of stay during the three years for probate court commitments under the old law was 36.54 days. This compares with 57.53 days for probate court commitments in FY 79-80 under the new law.

Fourth, the expectation that more "revolving-door" patients would be created and that readmission rates would increase also does not appear to be correct. Although long-term follow-up data are not available on these patients, the percentage of unduplicated cases did not decrease over the period studied (Table 4). In fact, it increased to 85 percent in FY 79-80, indicating that most patients were not readmitted during that year.

We believe that there are several factors that interact with Arkansas's new commitment law to produce the effects we have described.

Characteristics of the existing mental health system The effects of more stringent due process procedures will likely be different from state to state, depending on the nature of the existing mental health system. In states like

Arkansas, with small, acute care state hospitals, it is unlikely such a law would result in large decreases in hospital populations. Patients in mental health systems such as these already have been deinstitutionalized. Similarly in states with well-developed networks of community resources, as exist in Arkansas, it is doubtful a new law would result in dramatic increases in readmissions or the transfer of large numbers of patients to the criminal justice system. These well might occur, however, in states with inadequate community programs that rely heavily on state hospitals as primary treatment resources. Mental health and law enforcement personnel in these systems are left with few choices for disturbed patients except the hospital or the jail.[26]

Judicial attitudes It is obvious that the effect of any commitment law will depend in large measure on how it is interpreted and used by probate judges. Laws like the one in Arkansas allow considerable room for judicial interpretation, especially with respect to the criteria for commitment. It is unlikely that most judges would radically alter their subjective opinion about what type of person is committable. As we see from our data, the percentage of probate court commitments was fairly constant throughout the three-year study (Table 5). Faced with large numbers of cases, however, many judges may resort to techniques, such as Arkansas's order of detention, which bypass local resources. This also may be the result of traditional views about a mental health system that once consisted only of a state hospital. To counteract this trend, close working relationships will have to develop between local mental health programs and the judiciary. Local programs must be able to demonstrate their willingness and capability to manage these difficult patients before the concept of least restrictive alternatives becomes a reality.

Cooperation of law enforcement personnel and mental health professionals For any commitment law to work appropriately, there must be extensive cooperation of law enforcement personnel and mental health professionals. Faced with new and more time-consuming procedures that are not well understood, law enforcement personnel may be tempted to rely on a more familiar criminal justice system. No matter how well written, any commitment law will provide antagonistic mental health professionals with an opportunity to subvert its intent. Rigid interpretation of concepts can result in decreased admissions and large numbers of discharges that are not necessary. In Arkansas, we attempted to encourage cooperation by involving all interested participants in the development of the new law. In addition, we conducted a series of educational workshops for law enforcement officers, judges, and mental health professionals as quickly as possible after the passage of the law.

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In any given state, the effects of a new commitment law can be interpreted only with consideration of factors such as these. While we support efforts to design better model commitment laws, we believe the strength of

the mental health system will ultimately determine due process and the protection of patients' rights. Likewise, it seems somewhat inappropriate to blame new commitment laws for adverse effects on a mental health system without a critical analysis of the system itself prior to the new law. We have seen that it was possible to enact new statutes without grossly altering the mental health system in an adverse manner. We believe this was possible because, despite negative expectations, the mental health system in Arkansas was both capable and willing to adapt new statutes. Some systems may be neither capable nor willing. In those situations, it seems to us that concentration of effort toward improving these factors might be more constructive than mere criticism directed at new statutes.

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