

Screening Services in Civil Commitment of the Mentally Ill: An Attempt to Balance Individual Liberties with Needs for Treatment

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Screening services are a central feature of New Jersey's new civil commitment law. This law, more commonly referred to as the screening law, exemplifies a nationwide trend in civil commitment legislation, attempting to balance liberty interests and the need to treat the mentally ill. Screening services, designated as the preferred process of entry into involuntary hospitalization, were expected to prevent unnecessary commitment and to provide community mental health services. When deemed necessary, commitment in local general hospitals rather than in state mental hospitals was to occur. This paper reports results of a study of screening centers that were already in operation in New Jersey prior to the implementation of the new law. It assesses the function of screening services and their potential impact on the commitment process in light of the objectives of the law. Data were obtained from in-depth interviews with key informants from the screening centers as well as from their environment, and from statistical reports on hospitalizations in state hospitals, admissions to screening centers, and admissions to psychiatric inpatient units of general hospitals. Analysis suggests that without more resources for alternative community facilities, screening services cannot achieve their objectives and the new reform may not live up to expectations. Shortage of alternatives to hospitalization and lack of incentives to develop and use them appeared to be counterproductive to achieving the objectives of the law. The availability of screening service and psychiatric units in general hospitals for involuntary hospitalization, on one hand, and the lack of alternatives in the community, on the other, may actually lead to inappropriate commitments and an increase in the number of civil commitments. Furthermore, findings indicated that screeners encouraged hospitalization readily even if other, less restrictive environments could have been pursued. Screening centers may become "gate openers" instead of playing their expected role as "gate keepers."

During the last 25 years, public policy regarding civil commitment of the men-

tally ill in the United States has been swinging like a pendulum between two

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opposing models: the medical-psychiatric model and the legalistic model. The changes in the laws on mental commitment in the U.S. during the late 1960s and the 1970s reflected a civil libertarian, legalistic approach.^{1, 2} The model that introduced legal assurances and procedural safeguards into the mental commitment laws prevailed over the medical-treatment model in these reforms.^{3, 4}

Almost before the ink of the newly written laws had a chance to dry, however, a heated debate started over the direction, extent, and results of the mental health reforms.⁵⁻⁹ Critics of the reforms argued that the emphasis on the rights of patients resulted in neglect of their medical needs.^{8, 10-14} Violent acts of mental patients that ended in tragedy,¹⁵ as well as the widely publicized plight of the homeless mentally ill,¹⁶⁻¹⁸ have encouraged a change in course.^{19, 20}

By the early 1980s there were signs that the balance has started to shift toward a relaxation of the restrictive commitment laws.²¹ Some changes were made in the procedures as well as in the substance of the civil commitment process. Brooks,²² in discussing the concept of dangerousness in civil commitment of the mentally ill, concluded that the latest developments in U.S. constitutional law were that the definition of dangerousness and the psychiatric data base for defining it had been expanded during the early 1980s. He stated that the concept of "dangerousness" continued to move further away from the libertarian protectiveness approach with which it had been originally con-

ceived.^{22, p. 307} Some states, such as Washington, Alaska, North Carolina, Texas, Hawaii, and Arizona, have changed their laws by either broadening the substantive commitment criteria or altering procedural safeguards, reflecting the new orientation.^{19, 23, 24}

It seems, however, that the direction of the new course of the commitment process across the U.S. would not reflect major substantive changes in state statutes, but rather other alterations in the commitment procedures or in the mental health service system that affect the commitment process. Miller,²⁵ in a recent review of civil commitment in the U.S. concluded that relatively few substantive changes had been made during the past decade in state statutes governing civil commitment.

Research has shown the dependence of the commitment processes on the structure and function of the mental health service system as well as other social factors.^{26, 27} It has suggested that in analyzing and attempting to reform the civil commitment system, more attention should be paid to the environment and the service system in which the process of commitment takes place. A study of the effects of the revision of the state of Washington's commitment law attributed part of the increase in involuntary commitments to the service system that shifted scarce resources from voluntary to involuntary hospitalization.²³ Based on such evidence, the National Task Force on Guidelines for Involuntary Civil Commitment, established by the National Center of State Courts,²¹ "called into question the

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preoccupation with periodic calibrations of statutory commitment criteria as an effective way to deal with the problem of providing mental health care to those who need it" (p. 416). Rather than focusing on the "law on the books," it recommended focusing on the organizational and structural arrangements of the system in which commitments are practiced.^{28, 29}

New Jersey's new civil commitment statute, implemented in June 1989,³⁰ is an example of the new service orientation of commitment laws. Although the statute made several substantive changes in the standards and procedures governing civil commitment, its major innovation was the attention paid to and changes made in the structure and function of the service system related to the commitment process. The most significant changes introduced by the new law were related to the early stages of the commitment process. This legislation required the establishment of screening services as the preferred process of entry into involuntary hospitalization.

Screening services are a central feature of New Jersey's new commitment law. The importance of screening services in the new law is perhaps best illustrated by the common description of this law as the "screening law" (hereinafter referred to as the screening law). This law intended to balance the value of liberty of the individual with the need for safety and treatment. Screening services were seen as major mechanism by which the law would achieve its objective. These services were expected to screen and assess referrals and to provide accessible

crisis intervention, evaluation, and referrals in the least restrictive environment, based on patients' needs. The goal of the screening services, as envisioned by the new legislation, was to avoid unnecessary commitment and to provide effective community services, including voluntary hospitalization. In its service orientation, this law in general, and screening services in particular, exemplifies a new nationwide trend in civil commitment legislation.²⁴ Thus, this particular law and screening services are of broader interest, beyond the New Jersey scene.

In an effort to improve the mental health system, and in anticipation of the passage of the legislation, New Jersey had already established crisis and screening services before the new law was enacted. In fact, screening services had been already fully operative in several counties in New Jersey prior to the screening law's enactment. Their structure and function were similar to those conceived by the new legislation. In view of these facts, and to allow early detection of problem areas in the operation and function of screening services, it was decided to study screening services prior to the implementation of the law. It was believed that an early analysis of screening services would help policy makers detect and illuminate problem areas in this major component of the new legislation and identify desired policy changes.

The objectives of the study were to analyze the structure and processes of screening services, and to assess how these services operated and performed

their function within their environment. The study examined how screening services affected hospital admissions and commitment decisions, and how they interacted with other service organizations related to mental health services.

Due to the lack of previous basic knowledge about the crisis/screening services, as well as time and budgetary constraints, the format of exploratory study was chosen. Although no generalizations can be made from this type of study, it can highlight areas requiring attention.

This article consists of four parts. The first part includes a short description of the data sources and the methods used to collect the data. Following these, a brief description of the new screening law is presented. Since screening services are the interest of this study, the discussion of the new commitment law will focus on these services and the manner of entry into the commitment process. The third part which presents the major findings will follow with a discussion and policy recommendations.

Method

The screening centers Three screening centers (SCs), from three distinct areas, were selected for examination. Although the number and the nature of SCs that were in operation at the time of the study, as well as the scope of the study, did not allow an attempt to choose representative SCs, an effort was made to assure that the selection of the centers would represent different geographical areas and organizational arrangements.

One of the SCs was administratively part of a private general hospital with a psychiatric inpatient unit. This unit served as a resource for voluntary hospitalization, and also provided 72-hour stabilization beds. The hospital was located in an urban area in one of poorer counties of New Jersey. The center was physically located in the hospital.

The second SC was part of a not-for-profit private organization providing various outpatient mental health services. The agency provided screening services at two sites located at two general hospitals with which it had contracted affiliations. The two hospitals provided voluntary psychiatric hospitalization. One of the hospitals also provided 72-hour stabilization beds. One of the hospitals was located in a poor inner city whereas the other hospital was located in a more affluent suburban community.

The third SC was part of a community mental health center (CMHC), which was a public nonprofit agency administered by the county. Screening services were provided during regular working hours at the CMHC. During evenings, and on weekends and holidays, services were provided at the hospital. However, this SC was the only one that did not have a contractual agreement with the local general hospital nor did it have a strong affiliation with the psychiatric unit operating in this hospital. This SC was located in a suburban area, serving one of the more affluent counties in the state, and served more rural areas than the other two centers. This SC was the least developed among the three studied.

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Its services were less comprehensive than the other two centers, and it did not have a mobile outreach unit as did the other two centers.

Data The major source of data was in-depth interviews with key informants from the three screening centers, and interviews with administrators and staff from agencies interacting with these centers in relation to referring clients and providing mental health services to them, including involuntary hospitalization. In addition, we examined descriptive statistics compiled by the state and by the three SCs on admissions to screening centers, state and county mental hospitals, and inpatient psychiatric units in general hospitals. The data analyzed were for the 1987 fiscal year. In addition to the number and rates of admission to and from each of the three SCs, the data described the characteristics of the population and the services provided by the SCs.

The interviews were the major data source for the qualitative analysis of the structure and function of the screening centers. In total, 132 interviews were conducted with 101 individuals. The interviews were conducted by the principle investigator and four graduate students who were specially trained for the project. Interviewers used an unstructured interview format that was guided by the study's areas of inquiry and its conceptual framework. More details about data sources, nature of the data, and the methods of its collection can be found elsewhere.³¹

Conceptual framework The concepts used to describe the structures of

the organization and its environment were the *domain* and *task environment*. The term domain³² denotes problems covered, populations served, and services rendered by the organization at a given time. The concept of task environment³³ is used to describe those elements in the organizational environment that are relevant to goal setting and goal attainment. In this study, the relevant environment was defined as those organizations that provided the SCs with the critical input and output resources in terms of clients, money, manpower, and legitimacy.

Using this conceptual framework directed our attention to the different perceptions within the organization and in its task environment with regard to the domain of the organization, its task environment, and exchanges that take place within the system. The study focused on how the SCs, in terms of the population served, problems covered, and services rendered by the organization, were viewed by the line workers, by their administrators, and by relevant outside organizations (e.g., the state Division of Mental Health and Hospitals, other state agencies, county administrations, welfare departments, police, etc.).

This study addressed questions such as: Who are the clients and who should be the clients? What conditions, symptoms, behaviors, and problems justify the intervention of the SCs? What type of services (in terms of availability, accessibility, and desirability) does the organization provide? Finally, we also tried to learn how the task environment is perceived by the organization, in

terms of the provision and reception of critical resources (i.e., clients, money, and personnel). Qualitative data were content analyzed and discussed by the research team as a basis for analysis and conclusions.

Before reporting the major findings a brief description of screening services according to the provisions of the statute will be presented.

New Jersey's Screening Law

The Screening Law was enacted in 1987 after a process that had started 13 years earlier. Through the years, the emphasis and the orientation of the proposed legislation shifted from a civil liberties emphasis to a service orientation. Although service orientation was part of the proposed law from the inception of the legislative process, it was less pronounced in the earlier stages than in the later ones.³¹ The reform in the civil commitment legislation that swept across the country during the late 1960s and 1970s bypassed New Jersey. Until 1987, New Jersey did not change its antiquated mental commitment statute, last amended in 1965. The old New Jersey civil commitment statute did not even reflect the state's case law governing standards and procedures for commitment, which resulted from New Jersey's courts active involvement in this area since the mid 1970s.

The Old New Jersey Commitment Statute The old commitment statute in New Jersey was not based on the criterion of dangerousness but rather on the "need for treatment" standard. Also, the statute did not provide mechanisms,

or procedural safeguards, that would increase the likelihood that only those who actually needed treatment and care would be committed.³⁴

Purpose and Basic Features of the Screening Law The purpose of the screening law was to provide a comprehensive revision of the laws pertinent to voluntary and involuntary hospitalization and to improve the mental health treatment and care system. Its objectives were to lessen inappropriate commitments, protect individual liberties, and decriminalize the procedure of commitment and provision of treatment according to the person's clinical needs. Also the legislation called for the development and strengthening of the statewide community mental health system and the reduction of the reliance on psychiatric institutions and unnecessary hospitalizations.³⁰

The law attempted to achieve its objectives by the following provisions:

1. Authorization for the development and establishment of new outpatient and inpatient mental health service components (i.e., screening services and short term care facilities (STCF) for involuntary hospitalization).

2. Redefinition and clarification of the major components of the standards for voluntary and involuntary hospitalization, including the terms mental illness and dangerousness.

3. Establishment of clear procedures for screening, emergency mental health services, assessment, and voluntary and involuntary hospitalization. The law provides for easier routes of assessment

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and hospitalization for persons who need these services.

4. Provision of emergency procedures assigning responsibilities to screening services and law enforcement officers for assessment and assistance, respectively, making it possible to get a psychiatric assessment of an unwilling person without resorting to criminal law.

Since screening services are a central component of the law, and since a description of the statute can be found elsewhere,³⁵ the focus here will be only on the portions of the statute that refer to screening services.

Screening Services, Evaluation, and Involuntary Commitment The legislation called for the establishment of screening services in each geographical area, often defined by county boundaries. The provision of screening services covered only adults and the public mental health system. Staff at the new screening centers were expected to screen and assess referrals, and to provide accessible crisis intervention, evaluation, and referral services in the least restrictive environment based on patient needs. The goal is to avoid unnecessary commitment and to provide effective community services, including voluntary hospitalization. When deemed necessary, commitment should be made to local general hospitals rather than to state mental hospitals. Advocates for the new legislation expected a reduction in inappropriate commitments, a decrease in the number of hospitalizations in state hospitals, and an increase of referrals to community mental health services.

Screening assessment may take place

at the screening service facility or through an outreach visit. An outreach visit may be dispatched if the person who is believed to be in need of involuntary hospitalization is unable or unwilling to come to a screening service. While the establishment of a screening service for every geographic area was mandatory, having a mobile outreach unit remained optional, though highly recommended. The major reason for this was financial.

There are two levels of screening. The first level is provided by a mental health screener. A mental health screener was defined by the law as a person in any of the following professions—psychiatry, psychology, social work, and nursing—or another individual, trained for this purpose, as determined by the regulations concerning the law. When a person is assessed by a mental health screener to be in need of commitment, the screener provides information regarding the person and his/her history on a screening document. The screener is expected to consider alternative facilities instead of involuntary inpatient services and should provide on the screening document a rationale for why these facilities are deemed inappropriate and commitment necessary. The standard set by the statute to be used by the screener in determining the need for commitment is the “reasonable cause” standard.

The second level of screening and assessment is conducted by a psychiatrist. Considering the information provided by the screener, and in conjunction with the psychiatrist’s own complete assessment, the psychiatrist may conclude that

the person is in need of commitment. The psychiatrist must complete a screening certificate if convinced that commitment is necessary.

At this point the screening service should determine the appropriate type of facility for the person and arrange for commitment and transportation to the appropriate facility as soon as possible. A screening service may provide emergency and consensual treatment for the person receiving the assessment, and may transport the person. Also, it may detain the person up to 24 hours for the purposes of conducting the assessment or treatment.

Although the preferred point of entry into involuntary hospitalization is through the screening services, the statute provides for an alternative route for commitment. This route requires a temporary court order based on two physicians' certificates, at least one of them signed by a psychiatrist. This route was retained from the procedure of the old commitment law as a compromise in order to accommodate the private sector, psychiatric and private hospitals as well, and was described by some as a "safety valve."³¹

The statute provided for the involvement of law enforcement officers in the process of involuntary hospitalization. Law enforcement officers, as well as the mental health screeners and staff of Short Term Care Facility (STCF), are provided by the statute with an immunity from civil liability for their actions taken in accordance with the new statute.

The legislation gave the screening

services a much broader task than just assessing persons for commitment. Screening services were expected to provide emergency services, crisis intervention, and referral services. If the person assessed by the screeners was found not to be in need of commitment, the law requires the screener to refer the person to an appropriate community mental health or social service agency or, as a voluntary patient, to an inpatient psychiatric unit in a general hospital.

Involuntary Admission and Continued Commitment Involuntary admission can take place in a psychiatric unit of a general hospital designated for involuntary patient and defined as a STCF, or in a state or county mental hospital. However, to enable the mentally ill person to receive acute inpatient care near the person's community, the legislation clearly preferred the general hospitals. A STCF can accept persons referred only by a screening service. A person admitted involuntarily on the referral of a screening service may be detained for no more than 72 hours from the time the screening certificate was executed. During this time, the facility determines whether continued commitment is necessary, and, if it is, the facility initiates court proceedings. If the court finds that there is a cause for commitment, it issues a temporary commitment order. The standard of proof for a temporary commitment order is a "probable cause." An individual who was involuntarily committed is required to receive a court hearing within 20 days from the initial inpatient admission to the facility.

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The standard of proof at this level is the "clear and convincing evidence" one.

The statute requires periodic court hearings for committed patients. Unless the patient has been administratively discharged, such hearings should be held 3, 9, and 12 months from the date of the first hearing, and annually thereafter. The law requires that a psychiatrist on the patient's treatment team who has conducted a personal examination of the patient in no more than five days prior to the court hearing should testify at the hearing to the clinical basis for involuntary commitment. The law also requires that any patient subject to involuntary commitment should have counsel present at the hearing.

The statute deals with other matters such as discharge, court proceedings, and patient rights. Without minimizing the importance of other components of the statute, it is the screening service that has been the most fundamental change introduced by this new legislation. The proponents of the new law have been anticipating that through the establishment and operation of screening centers, the number of inappropriate commitments would be reduced, admissions to state hospitals would decline, persons in need of mental health services would be referred to appropriate community services, and, in general, the entire mental health service system would be improved.

Results

The most interesting findings were provided from the interviews. Although we also analyzed statistical data on ad-

missions to SCs and inpatient facilities, as well as data on the operation of the SCs, different reporting systems and problems with the reliability of the data limited its usefulness. Because of this, and since a detailed report of the descriptive statistics for each of the SCs can be found elsewhere,³¹ this paper will focus on reporting findings from the qualitative analysis of our interviews, using quantitative information only in relation to data provided by our interviews. The report will start with a short section on the organization and function of the SCs.

The Screening Centers: Organization and Function

The more comprehensive screening centers provided the following services: crisis intervention and counseling, screening and assessment for commitment and referral, walk-in crisis services, telephone hotline, mobile outreach services, 24-hour holding bed capacity, 72-hour stabilization bed capacity for voluntary patients, follow-up services, and education and consultation services. Although outreach mobile services were judged by staff of the SCs, as well as by other personnel of agencies interacting with the SCs, as essential services, not all of the centers studied provided such services.

One of the three SCs we studied was less developed than the other two and did not have an outreach mobile unit. This center significantly differed from the other two in the volume of services provided. Whereas the rates of admission to the two more developed centers

were 67.3 and 54.3 per 10,000 residents of the county, the comparable rate for the third SC was 25.8.

Although all three SCs employed similar types of personnel, they varied a great deal in the size, composition, and professional background of their staffs. This variation reflected budgets, policy regarding the extent of services, and the professional reputation of each of the centers. Most typically, clinical staff of a center held predominantly psychology, social work, education, and nursing degrees. At the time of our study, none of the centers employed full time staff psychiatrists on a 24-hour, 7-day-a-week basis. Centers used a variety of arrangements such as part-time and on-call psychiatrists. Conflicts between psychiatrists and screeners regarding the necessity for commitment or hospitalization were reported as not uncommon. Respondents believed that some of these conflicts were a result of not having staff psychiatrists and that this fact had a negative effect on the SC quality of services.

There was a general agreement among interviewees that tasks performed by SCs required the availability of nursing personnel on their staff. Centers had problems in finding and hiring qualified nurses. It seemed that the shortage of nursing staff adversely affected the performance of the centers and their outreach services, especially in areas of initial triage of physical medical problems, administering and monitoring medication, and providing nursing care.

The administrative regulations pertinent to the screening law require that a screening center be physically located in

a hospital.³⁶ However, the specific administrative arrangements with such hospitals were not specified. The regulations state only that a screening center should be either directly operated or formally affiliated by written agreement with the hospital.

One of the three centers studied was not formally affiliated with a general hospital. This center reported difficulties in gaining voluntary admission for clients, and more frequently used state mental hospitalizations than the other centers. Thirty-two percent of all inpatient admissions referred by this SC were to state hospitals compared with 10.9 percent and 13.0 percent of those types of referrals by the other two centers. Also, we found differences in the rates of admission to state hospitals from the three counties served by the SC we studied.

Affiliation with an inpatient psychiatric unit of a general hospital was believed to improve access to hospitalization in this hospital. However, findings revealed a great deal of variation in the numbers, rates, and types of hospitalizations.³¹ Findings showed that the rate of psychiatric admission to general hospitals per the total number of the resident population in the county was the highest in the county where the SC was administratively part of the general hospital. Whereas the rates of admissions in the two other counties served by the SCs we studied were 24.4 and 25.7 per 10,000 resident population, the rate in the third county, in which the SC was administratively part of the general hospital, was 41.3. One may wonder

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whether higher rates of hospitalization were not related to organizational arrangements, where the SC was administratively an integral part of the hospital that had also an inpatient psychiatric unit. Whereas the physical location and the affiliation with a hospital seemed to enhance SC functioning and improve access to general hospital psychiatric services, the outcome of these, and the specific organizational arrangements between the hospital and the centers are matters that require further research.

Unnecessary Admissions

Interviews and observations revealed us that screeners tended to encourage hospitalization too readily, even if other, less restrictive environments, could have been pursued. Respondents attributed this preference to five factors:

1. Pressures exerted on the SC by families and agencies "to remove the person" and relieve the family or community of burden.
2. Lack of alternatives in the community.
3. Screeners' and psychiatrists' concern with liability.
4. Easy access to inpatient services.
5. Lack of organizational incentives to find alternative, less restrictive environments.

Workers at the SCs were often pressured by both families and community agencies to hospitalize. Interviewees reported that in view of insufficient satisfactory alternatives, their ability to withstand the pressure diminished. The fact that two of the SCs studied were either a part of a hospital with inpatient psy-

chiatric services, or were affiliated with hospitals with such departments, also simplified the referral of persons for inpatient services. Although it was not uncommon that a SCs worker would refuse to recommend hospitalization, the SC did not have organizational incentives (aside from a vague ideological commitment) to avoid hospitalization and use community services.

Lack of Alternatives to Hospitalizations

Lack of resources for the SCs and for mental health services in general was one of our major findings and perhaps the most alarming one. One of the strongest points made by those interviewed was the shortage or lack of community resources. The availability of screening services was believed to increase referrals by a variety of service agencies and police to this service. However, the lack of alternatives to hospitalization forced staff to recommend, at times, inpatient admission, although the clinical condition of the person called for a facility of a less restricted environment in the community. It was also believed that emphasis on the development of STCF in general hospitals, while neglecting the development of other community mental health services, could result in a "revolving door syndrome" of acute psychiatric care in general hospitals, with great costs to individual patients and the system in general.

The structure and the budgetary principles of the system did not reward the SC or any other agency for reducing hospitalizations. It seems that providing

easier access for admission to inpatient psychiatric services without the availability of appropriate community resource would tip the balance of the new law toward hospitalization.

Unnecessary Commitments

Inpatient units have discretion with respect to admitting or refusing admission. It was reported to us that, quite often, psychiatric units of general hospitals refused voluntary admissions of those considered as "undesirable." These were patients who either exhibited violent behavior or whose symptoms indicated substance abuse problems. These also included the indigent, "classical state hospital patients," as one interviewee said. There was no statistical recording on such matters. However, this "preference" appeared to be a common knowledge within the system.

Respondents reported that staff at psychiatric units of general hospitals, where referrals for admission were attempted, expressed concern that those "undesirable patients" would affect the "therapeutic atmosphere on the ward"—to quote one of our respondents. In addition, there was concern that these patients would "chase away" the traditional, paying, middle class, patients. Furthermore, the psychiatrists on the ward had no incentive to pick-up these patients for their private practice once they were discharged from inpatient care. Whereas the hospital was fully compensated for inpatient care for the uninsured by a state trust fund, the level of financial compensation for physician's services were minimal.

The selective practices of general hospitals affected the SC and psychiatric admission practices in another way as well. Staff in the SCs believed that hospitals in their areas "dumped" many "undesirable" patients on the centers. When a hospital's admission policies were rather restrictive and discriminatory, workers had to spend extended periods of time canvassing inpatient psychiatric units in nearby areas in an attempt to gain admission for those patients considered in need of hospitalization.

Because of the difficulties that SCs encountered in obtaining placements for voluntary admissions and the deflection by hospitals of "undesirable" patients to the SCs, it was reported to us that persons agreeable to voluntary hospitalization were, all too often, referred for commitment in the state hospital. For these patients to be accepted, it was necessary, on occasion, for symptoms and conditions to be exaggerated.

As already indicated, findings revealed that the rate of voluntary admissions was higher in those SCs that were affiliated with inpatient psychiatric units of general hospitals, whereas those that did not have a contractual arrangement or a strong affiliation with general hospitals had higher rates of involuntary commitments. Some of these commitments were judged by the state hospital admission authorities as inappropriate.³¹ Since there was neither a built-in review nor an advocacy system at either the SCs or emergency rooms of general hospitals, the system, most often, operated "too

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smoothly" and commitment took place without notice.

Unclear Standards and Procedural Guidelines

Interviews revealed that problem definitions, eligible clientele, and criteria for commitment were unclear and un-specific. Much was left to the discretion of the screeners and other persons involved in the system.

Since 1975, the civil commitment standard in New Jersey has been the "dangerousness" criterion.³⁷ However, we found this standard to be unclear and insufficiently specific. In assessing a person's appropriateness for commitment, professionals were not clear about what criteria to use for determining the type and level of danger. Most clinicians defined the concept in broader terms and maintained a conservative stance regarding commitment. Many asserted that "it was important to err on the side of safety," to quote one of our respondents.

"Dangerousness" was not the only concept that was unclear. We found that criteria for inpatient admission differed widely among clinicians and had to do with "global and somewhat vague notions," as one interviewee stated. Criteria for hospitalization were not specified in writing, nor did we observe any use of a standardized instrument by which screeners determined the need for hospitalization.

Personnel Issues

Also personnel issues seemed to contribute to inappropriate hospitalizations and commitments. It seemed that the

relatively low level of education and experience prerequisite for the screener position, insufficient training, and a lack of career ladder options for screeners affected the quality of their job performance. Most often, the rationale given for not requiring a master's degree as a prerequisite for a screener's position was the lack of state funds needed to upgrade this position. However, their relatively low status position vis-a-vis other mental health professionals made screeners more vulnerable to pressures exerted upon them by private psychiatrists, other mental health workers, and different people in the community to commit persons under inappropriate circumstances.

Discussion: Can Screening Services Bring About a Balanced System of Commitment?

This study focused on the structure and function of screening services in the commitment process. Screening services are a central feature of New Jersey's new civil commitment law, which exemplifies a new trend in mental health legislation in the United States. The legislation, adopting a strong service orientation in its new civil commitment law, viewed screening services as a major mechanism to achieve a balanced commitment system, balancing the basic value of liberty with the need for safety and treatment. Thus, assessing major components of the commitment process required by this law, such as screening services, has implications beyond the borders of the state.

Admittedly, one should be careful in

generalizing the findings of this study of three screening centers in New Jersey to all screening services. Nor can we draw conclusions on the potential success of the New Jersey mental health legislation or on the accomplishments of the new trend in civil commitment procedures in the U.S. However, this study provides clues and guidelines to researchers and policy makers regarding certain areas related to the operation of screening services and their function in the civil commitment process.

Our findings show what has been also pointed out by others,^{27,29,38} that success of reform in civil commitment is contingent on other components of the system and on changes that must be made in the mental health system as well as outside of it. Neither the law by itself nor screening services can be a panacea for all the mental health problems the state faces. One should not place excessively high expectations on screening services alone. There is a danger that screening services could be used as a "scapegoat" for other ill-performing components of the system, or as an excuse for policy makers not to take needed action with respect to the mental health service system.

In examining the screening services within the total mental health service system, it became apparent that the structure of the service system and the incentives provided to organizations responsible for the implementation of the law were far from being conducive to the type of change intended by the legislation. SCs were not financially or professionally rewarded for preventing

unnecessary hospitalizations. The lack of such incentives appeared to make the SCs more vulnerable to formal and informal pressures by service agencies and other community elements trying to solve problems of persons in need of mental health services, or efforts of communities attempting social control of disruptive behaviors resulting from mental illness via the hospitalization route.

A lack of organizational incentives also appeared to exist on the state level. Since funds saved as a result of the diversion of patients from state hospitalization to local hospitalization or other community facilities are not left in the budget of the State Division of Mental Health and Hospitals (DMH&H), there is a lack of, or at least limited, organizational incentive for the DMH&H to divert patients to alternative community facilities. In fact, under current state budgetary principles, reducing the state hospital population and limiting the use of state hospitals may actually be perceived by the state mental health agency as a potential threat to its budget and, therefore, to the scope of its operations.

To allow screening services to realize their function intended in the new civil commitment procedure of reducing inappropriate commitment and providing mental health services in the least restrictive environment according to the patients' needs, a financial and organizational incentive system must be established. Arrangements should be made for money to follow the patient to the community and for alternative community resources to be developed.

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No doubt, professionals and other community agents will continue to exert pressure on the SCs to commit people, and the lack of alternative resources would make it difficult for the SCs to resist these pressures. Even if the SCs succeed in avoiding unnecessary commitments, there is always the alternative route that can be utilized.³⁷ One wonders if this route, requiring certification by two physicians and a judge's order, will not circumvent the screening services to commit those not committed by the SCs.

Contrary to the intent of the legislation, it does not seem that screening services alone could prevent the continued existence of a two-tier public mental health system. Interests of the private sector, psychiatrists, and hospitals alike lessen the possibility of lower socioeconomic status mentally ill people being voluntarily hospitalized in psychiatric units in general hospitals. Indeed, as we have mentioned earlier, findings indicated inappropriate commitments in state mental hospitals because of the refusal of psychiatric units at general hospitals to admit certain patients on a voluntary basis.

Given our findings, one may question whether complete reliance of the public mental health system on the private sector for acute inpatient services is either realistic or justified. Forceful regulatory measures undertaken by the state, and intensified efforts at restructuring the incentive system affecting the private sector, may rectify the situation. If this is not accomplished soon, this mental health system may have little chance to

be equitable and effective, and many people in need may "fall between the cracks."

The screening law and the establishment of screening centers are, no doubt an improvement over the situation that existed in New Jersey under the old system. The effect of the SCs and the new civil commitment procedures is a matter that still requires a careful empirical assessment. It remains to be seen if the goal of creating a balanced system, providing treatment and care to those in need while at the same time guarding the liberties of individuals making use of the system, has been fulfilled. Our results indicate that unless more resources are provided for creating alternative community facilities, the new reform may not live up to expectations. In fact, the availability of the screening service and psychiatric units in general hospitals for involuntary hospitalization, on one hand, and the lack of alternative, less restrictive facilities in the community, on the other, may lead to an increase in commitments. Screening centers may become "gate openers" instead of their expected role as "gate keepers."

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