Commentary: Civil Commitment Statutes—40 Years of Circumvention

William H. Fisher, PhD, and Thomas Grisso, PhD

There is a longstanding body of literature that describes how states' civil commitment statutes have been stretched or circumvented to accommodate institutional and systemic needs. The paper by Levitt and colleagues provides yet another example of this phenomenon: Arizona's use of its civil commitment statutes to detain unrestorable, incompetent criminal defendants for whom other provisions have not been developed. This commentary provides a brief overview of other examples of the stretching of commitment laws, providing a broader context for viewing the findings of Levitt and colleagues.

J Am Acad Psychiatry Law 38:365–8, 2010

Civil commitment statutes are in many ways social peculiarities. Like criminal codes, they allow the state to deprive individuals of liberty, but unlike those codes, commitment statutes, while more narrowly constructed now than a half century ago, are decidedly lacking in specificity regarding what behavior may or may not justify confinement. Instead, key components of those statutes, such as mental illness and dangerousness, are left to be defined largely on a case-by-case basis by clinicians charged with making decisions about involuntary hospitalization. In some cases, this vagueness has allowed significant latitude in the way a statute is applied and to whom. And often, variation in a given statute's applications are driven, not so much by variance in the judgment of clinicians, as by a range of social, political, and even economic factors.

Levitt and colleagues[1] highlight a source of variation in this process—persons' prior status as criminal defendants—that has not been described. Typically, when a person is found incompetent to stand trial and incapable of being restored to competence, most states require that the charges be dismissed (with or without prejudice) and allow the state to file for civil commitment. The legal criteria for civil commitment in such circumstances are the same as for the civil commitment of persons who have not been criminal defendants: present mental illness and danger to self or others. But Levitt *et al.* report that in Arizona, civil commitment standards appear to be applied much differently to persons who have been found nonrestorably incompetent to proceed to trial than to persons civilly committed under ordinary circumstances.

The study highlights the seemingly rigid, yet often fungible, interpretation and implementation of states' commitment statutes. To emphasize the place of these important findings in a longstanding body of literature on civil commitment, we briefly describe other instances in which flexibility in commitment practices has been observed and how the findings of Levitt *et al.* contribute to this historical line of research.

Before the late 1960s, commitment standards were so ill-defined that nearly unlimited latitude was available to judges and to interested parties seeking to have an individual admitted to and retained in a psychiatric institution.[2] In this period, the findings Levitt and colleagues report would have been relatively uninteresting, but, beginning with California's passage of the Lanterman-Petris-Short Act in 1969, civil commitment reform swept the nation, as one state after another followed California's lead in reforming their statutes governing involuntary hospitalization.[3,4]

By all accounts, these reforms had been long overdue. The denial of due process in both admission and discharge, as well as the flimsy grounds on which a commitment could be sought, were egregious and fell far short of what would be encountered in a criminal proceeding. The activists who brought about the

Drs. Fisher and Grisso are Professors of Psychiatry, University of Massachusetts Medical School, Worcester, MA. Address correspondence to: William H. Fisher, PhD, University of Massachusetts Medical School, 55 Lake Avenue North, Worcester, MA 01655. E-mail: bill.fisher@umassmed.edu.

Disclosures of financial or other potential conflicts of interest: None.

court cases that spurred these reforms worked from the belief that the civil rights of persons subject to commitment needed better safeguards than those in place at the mid-20th century. The revised statutes, while differing somewhat from state to state, generally restricted grounds for commitment to dangerousness to self or others or grave disability, due to a mental illness, and instituted rigorous routine hearings in which facilities seeking to retain individuals involuntarily were required to prove that grounds for commitment were still met. Viewed broadly, the effects of these reforms were to make involuntary admission to and retention in psychiatric hospitals more difficult.

But how difficult? And how rigid are these laws in actual practice? More than 20 years ago, one of us (W.F.) and two colleagues wrote an article entitled "How Flexible Are Our Commitment Statutes?"[5] In that paper, we examined several instances in which clinicians charged with making commitment decisions displayed a significantly increased probability of signing off on commitments in the aftermath of tragic events involving persons with mental illness. One example was the increase in commitments at Washington's Western State Hospital following the high-profile shooting of an elderly Seattle couple by a man who had a psychiatric illness and had been denied voluntary admission to that facility.[6] This trend anticipated by several months the legislature's move to broaden what had been a particularly restrictive law, the Involuntary Treatment Act of 1978.[7] Thus, while the commitment law had not yet changed, those charged with making commitment decisions behaved as though the change had already occurred. To our knowledge, none of the decisions was challenged. Other examples of sudden non-statutorily based broadening of commitment law, identifiable as aftermaths of episodes associated with the failure of mental health authorities to admit persons who went on to commit heinous crimes, were also cited. As we showed, the application of commitment laws and the conceptualization of mental illness and dangerousness can vary from case to case and over time, but not altogether randomly.[5]

Nor is the process always extralegal. In fact, states have been given broad latitude in their use of involuntary hospitalization by no less an authority than the U.S. Supreme Court. In *Kansas v. Hendricks*,[8] the Court heard a case challenging a new use of Kansas' civil commitment law, which had been designed to govern involuntary hospitalization of persons with psychiatric illnesses. At issue was a new application for the Kansas commitment statute, the confinement of persons who were completing prison sentences for sexually violent crimes and who were seen as still posing a significant threat to the community. Writing for the majority, Justice Clarence Thomas indicated that, for purposes of civil commitment, states could define mental illness however they wished. Pedophilia, Hendricks' diagnosis, could thus be construed as perfectly legitimate for this purpose.[9] This ruling had the effect of opening civil commitment floodgates in state after state, as authorities welcomed the availability of an option for post-incarceration detention of sex offenders they saw as continued threats to public safety.

The examples of flexibility in commitment practice described so far have been ones in which involuntary passage through the front door of an institutional setting has been made to seem easier than would be expected. There are examples, however, at the back door as well. There are cases in which discharge has occurred or at least been proposed despite clinicians' expressed opinion that the committed persons in question continue to be a danger to themselves or others and thus continue to meet commitment criteria. These examples come from the collision between civil commitment admission and discharge standards and the principles of managed care, in which preadmission certification and concurrent review govern admission and discharge. Ostensibly, these functions are quite similar. Both seek to limit unnecessary hospitalization as well as the durations of those hospitalizations that do occur. The underlying motivations, however, are quite different, and reflect in part the changing organization and financing of mental health treatment.

The civil commitment statutes passed in the 1960s and 1970s were designed to safeguard civil liberties and to limit exposure to the large state institutions that had fallen into disfavor; but most of the acute psychiatric admissions in the United States today are to the acute units of general hospitals, where limited beds and reliance on public and private third-party payers for financing are the real limiting factors on length of stay. Managed-care organizations, which dictate what and how many inpatient days insurers will pay for, have largely superseded the clinicians who make commitment decisions as the major players in determining who is admitted and for how long.

Some years ago, cases were reported in which persons representing patients' insurers told hospitals that they would not reimburse additional hospital days for certain patients, despite treating clinicians' arguments that those patients remained a danger to themselves or others. In *Varol v. Blue Cross and Blue Shield*,[10] cited by Petrila,[11] the courts held that physicians have an ethical and legal obligation to provide appropriate treatment, regardless of gatekeepers' (i.e., insurers) approval. Thus, while an insurer cannot force a patient's discharge, hospitals face a dilemma if they need to continue providing nonreimbursible treatment.[11] This incentive structure, which arose in the context of insurers' efforts to reduce reimbursements for inpatient treatment, stands in sharp contrast to a practice described in an earlier period when commitment practices appeared to be dictated by the need to fill empty hospital beds.[12] Nonetheless, both situations reflect the malleability of commitment practices under the influence of economic considerations.

Levitt and colleagues[1] provide yet another example of the flexibility of commitment practice—in this case, one that is systemic rather than responsive to recent events, political pressures, or economic exigencies and one that makes exits more difficult for one class of individuals. Specifically, their data demonstrate a double standard with respect to the application of Arizona's commitment standards to persons who have faced criminal charges and been found not competent and not restorable (NCNR) and those who are committed and are not members of that class. Levitt and colleagues find that NCNRs remain hospitalized longer than do non-NCNRs and in some cases are detained well beyond the point where they can be said to constitute a danger to themselves or others on purely clinical grounds. Extralegal, nonclinical concerns dictate practice in a way that is not unrelated to the issues that have driven some of the other examples offered. The Arizona practice they describe appears grounded in the belief that persons who have committed a crime, in some cases a serious one, cannot simply be allowed to walk away because of their psychiatric illnesses. Just as at Western State Hospital in the late 1970s, concern that the public will see the mental health and legal systems as poor guardians of public safety drives commitment decisions that meet neither the letter nor the spirit of the statutes governing that practice.

Levitt and colleagues provide data that point to another matter that has significance for mental health systems as a whole: the use of state psychiatric hospitals and similar facilities as all-purpose settings for the placement of any class of individuals who seem not to fit anywhere else. The use of these facilities has declined by more than 95 percent in the past half century. Many of those open in the mid-20th century have closed or been dramatically downsized. Those that remain open often have unused capacity that can seem inviting to public officials faced with a need to detain certain classes of individuals in secure facilities. This use has been seen in many states where unused state hospital and public mental health system capacity was appropriated for housing civilly committed sex offenders following the *Hendricks* decision. As the use of these facilities as settings for treating the general population of persons with serious mental illness has declined, the census of many state hospitals has come to be increasingly dominated by "forensic patients," persons who have been referred from the courts for evaluation of competency to stand trial or criminal responsibility, those ordered for treatment in hopes of restoring competency, persons found not criminally responsible, and so on.[13] In addition, however, there appear to be jurisdictions in which civil commitment is used as an adjunct to these forensic statutes, as in Arizona.

While a state's use of its resources for pragmatic purposes may be appropriate, the practices such as the one described by Levitt *et al.*[1] do damage to both policy and human rights. Regarding policy, they block efforts to close or downsize more of the remaining state hospitals, facilities that in many cases are antiquated and expensive to maintain. Regarding rights, they misuse civil commitment laws in a way that discriminates against nonrestorably incompetent persons who are no longer under criminal custody by applying different criteria in a way that increases the likelihood of their deprivation of liberty. It is well known anecdotally that Arizona is not the only state to engage in these and similar practices, merely the only one in which practices have been studied and exposed.

Hiding behind the pages in Levitt *et al.* is a burning question: Where are the lawyers? States must provide for representation of indigent mentally ill persons when they are subject to civil commitment proceedings. It is difficult to imagine that states with discriminatory applications of its civil commitment

standards could operate *sub rosa* if the system provided for adequate legal representation of its mentally ill citizens when they are threatened with indefinite loss of liberty.

The findings of Levitt *et al.*, along with our observations of ways in which civil commitment laws have been stretched and circumvented, call into question whether these now 40-year-old statutes are being used in ways that continue to reflect the intent of their framers. There is little current research on those uses. The field would do well to follow the lead of Levitt and colleagues in developing a research agenda focused on contemporary use of civil commitment statutes and areas in need of oversight and possible reinforcement. Doing so may be the only way to ensure that statutes designed to protect the civil liberties of persons with mental illness continue to serve that purpose.

References

1. Levitt G, Vora I, Tyler K, *et al*: Civil commitment outcomes of incompetent defendants. J Am Acad Psychiatry Law 38:349–58, 2010
2. Brakel SJ, Rock RS: The Mentally Disabled and the Law (ed 2). Chicago: University of Chicago Press, 1971
3. Warren CEB: The Court of Last Resort: Mental Illness and the Law. Chicago: University of Chicago Press, 1977
4. Appelbaum PS: Almost a Revolution: Mental Health Law and the Limits of Change. New York: Oxford University Press, 1994
5. Fisher WH, Pierce GL, Appelbaum PS: How flexible are our civil commitment statutes? Hosp Community Psychiatry 39:711–14, 1988
6. Pierce GL, Durham ML, Fisher WH: The impact of public policy and publicity on admissions to state mental hospitals. J Health Politics Policy Law 11:41–66, 1986
7. Durham ML, Fisher WH, Pierce GL: The impact of broadened civil commitment laws on admission to state mental hospitals. Am J Psychiatry 142:104–7, 1985
8. Kansas v. Hendricks, 521 U.S. 346 (1997)
9. Grudzinskas AJ, Henry MG: Case report: *Kansas v. Hendricks*. J Am Acad Psychiatry Law 25:607–12, 1997
10. Varol v. Blue Cross and Blue Shield, 708 F.Supp. 826 (E.D. Mich. 1989)
11. Petrila J: Who will pay for involuntary civil commitment under capitated managed care?—an emerging dilemma. Psychiatr Serv 46:1045–8, 1995
12. Lidz CW, Mulvey EP: Institutional factors affecting psychiatric admission and commitment decisions, in Social Science: Perspectives on Medical Ethics. Edited by Weiss G. Boston: Kluwer, 1990, pp 83–98
13. Fisher WH, Geller JL, Pandiani J: Assessing the role of state psychiatric hospitals in contemporary mental health systems. Health Affairs 28:676–84, 2009