The Forensic Mental Health Services Census of Forensic Populations in State Facilities

Joseph D. Bloom, MD, and David Novosad, MD

This article focuses on the development of a Forensic Mental Health Services Census (FMHSC), proposed to differentiate between five different patient populations institutionalized in state facilities. The FMHSC would comprise patients who are civilly committed for mental illness or sexual dangerousness, those found incompetent to stand trial, those committed after a verdict of not guilty by reason of insanity, and those voluntarily committed. The census would be performed by state mental health authorities for each of these populations within the particular jurisdiction and then would be reported to a national coordinating organization. These data are important because of the large number of persons involved and the significant resources devoted to the management and treatment of each involuntary group. The census is necessary for clinical, research, and policy purposes, to provide more rational management of these populations, both within and across jurisdictions.

J Am Acad Psychiatry Law 45:447–51, 2017

This article proposes the development of a Forensic Mental Health Services Census (FMHSC) for institutionalized populations of patients with mental illness committed to state psychiatric facilities. Traditionally, data for state facilities have been reported in aggregate terms, such as number of beds, number of patients, or both, in hospitals in a particular state. For example, in 2010 the Treatment Advocacy Center (TAC) reported that there were 43,318 beds in state psychiatric hospitals in the United States.[1] Two years later that number had decreased to 37,679, with 20,000 civil beds and 17,601 forensic patients.[2] The TAC also provided a breakdown of these numbers for each state. These reports are important, but they do not adequately describe the census of the different populations of patients who have been involuntarily institutionalized and who make up significant portion of the population of any state's inpatient facilities. In the past, state mental hospital populations consisted primarily of patients who were voluntarily and civilly committed, with only a small number of patients committed to hospitals by the criminal courts. These numbers have changed. Now, many public psychiatric institutions serve dramatically fewer voluntary patients. Their current census is made up almost entirely of patients committed involuntarily by courts under several civil and criminal statutes.[3] It is important to know the sizes of the different involuntary patient populations in state facilities, because in significant ways, their legal status dictates their future, from entry into the hospital, to their course in the hospital, and at some point, to their discharge into the community.

The FMHSC would focus on five institutionalized patient populations admitted to mental hospitals under distinctly different statutory schemes in each jurisdiction. Two are involuntarily committed by civil courts under statutes governing the civil commitment of the patients with mental illness and those who are believed to be sexually dangerous, while the other two groups come from the criminal courts and include patients committed after being deemed incompetent to stand trial, and those committed as the result of a judgment of not guilty by reason of insanity. We know that each state has a civil commitment statute, whereas fewer have a commitment statute governing the civil commitment of those judged sexually dangerous. On the criminal justice side,

Dr. Bloom is Clinical Professor, Department of Psychiatry, University of Arizona College of Medicine-Phoenix, Phoenix, AZ. Dr. Novosad is Staff Psychiatrist at the Atlanta VA Medical Center, Atlanta, GA. Address correspondence to: Joseph D. Bloom, MD: University of Arizona College of Medicine, 550 East Van Buren, Building 3, Phoenix, AZ 85004. E-mail: bloomj@ohsu.edu.

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

all states have a process covering competency to stand trial evaluation and restoration, which, for the most part, is carried out in state mental health facilities. Most states will also have a functioning insanity defense with provisions for postjudgment commitment.[4]

The census is focused on these four involuntarily committed populations but will also include patients who were voluntarily committed to these same facilities. Knowing the number of patients voluntarily committed will give a fuller picture of how state hospital beds are apportioned across the country. Further, we believe that the number of patients voluntarily admitted to state hospitals has dramatically decreased in recent years. It is important to confirm or refute this belief.

If a state does not have a statutory process in a particular commitment category, it would be asked to define the different mechanisms used to handle these individuals in that jurisdiction. The census would cover all institutional state settings (hospitals and similar facilities), under the jurisdiction of the designated state mental health authority. The census would include the following variables reported for a defined time period: the average number of beds occupied in each commitment category; the average length of stay for patients in each category; and the average costs of hospitalization per day. This proposal is designed to make the census as user-friendly as possible, to capture the data on these populations on a regular basis. In addition to these basic variables a particular state could add additional variables desired by that jurisdiction at a point in time for program evaluation or research purposes.

We envision that the FMHSC would need a single national coordinating organization that would work with state mental health authorities to provide census information on a periodic basis for each of these five categories of interest. Such national organizations are already in existence. The census could be coordinated by Substance Abuse and Mental Health Services Administration (SAMHSA)[5] or one of its contract organizations, such as the GAINS Center for Behavioral Health and Justice Transformation.[6] Another possibility is the National Association of Mental Health Program Directors Research Institute (NRI),[7] which is a research-focused organization that works with state and federal agencies and other entities to define, collect, and analyze data on public behavioral health systems. On the private side, the Treatment Advocacy Center,[8] a nonprofit advocacy and research organization, has interests and a demonstrated capacity to collect data in this area. The National Alliance on Mental Illness (NAMI)[9] also has collected national mental health system data at various intervals and has an unquestioned interest in these programs and in the welfare of the patient populations represented in the census. Funding most likely would have to come from a federal source, such as SAMHSA, to ensure that data are gathered continuously.

At the present time, data covered by the census on the four court-committed populations are not transparent, either on a state level or in the national debate about mental health planning and policy development. Such data, made available on a periodic basis, would be very useful in each jurisdiction for mental health planning, policy development, and fiscal management, as patients who are involuntarily hospitalized represent a large number of individuals who occupy a significant proportion of publicly financed institutional beds. Further, their management and treatment consume significant portions of state mental health budgets, making expert knowledge of the management system of each group critically important for public policy initiatives, both within and across states.

Research Associated With the FMHSC

For each of these four groups that are involuntarily institutionalized, there is a strong need for empirical studies related to how statutes associated with these populations actually operate, if needed; how states could make their statutes more workable and, at the same time, provide adequate protection for the hospitalized populations and the public at large. Each of the types of civil or criminal court commitments described by the census lends itself to empirical research. Each is theoretically time limited. Each statute proceeds from involuntary entry into the process, to a precommitment phase, to a trial or hearings phase, to a posttrial commitment to an institution, and theoretically, to eventual conditional release or discharge. This sequence of events lends itself to schematic representation, which can be used as the format for organizing person and system characteristics for each commitment group in each jurisdiction. Each decision point delineates a moment in time in the movement of individuals through the process, as determined by various decision makers, who them-

selves can be identified and studied. (See Faulkner *et al.* for an example of such research.[10])

The FMHSC would be a place to make these populations visible on a state-by-state basis. Such information is important for each group. Just as an example, including the sexually dangerous group in the census is indicated, because these patients represent a civilly committed population hospitalized in state facilities for management and treatment. Overall, such programs also consume significant state resources. Yet, there are few empirical studies in this area. Currently, we have to turn to the popular press to learn more about this population. In 2007, there were approximately 4,534 individuals committed in some 20 states under sexually violent person (SVP) statutes.[11] The public press has highlighted problems with several laws regarding sexual dangerousness. Under its SVP statute[12] the state of Washington recently had some 300 individuals housed in a prison-like, nonhospital facility on an isolated island in Puget Sound. Problems emerged related to the costs of the program, the isolation of the population, and the fact that few committed patients were being placed on conditional release or discharged. Concerns about similar problems were recently raised in the state of Minnesota where a federal district court judge declared the state's SVP commitment law unconstitutional. On appeal, the U.S. Court of Appeals for the Eighth Circuit ruled that the original state law was constitutional. The plaintiffs plan an appeal to the U.S. Supreme Court.[13]

Discussion

The FMHSC is an outgrowth of health services and mental health services research[14,15] designed to provide detailed information about involuntary forensic populations in state facilities. The census, coupled with a robust research component, would provide useful information in the overlapping areas of law, mental health services, and public policy. We can approach the importance of this subject from several vantage points. As mentioned, in 2016, TAC reported that there were slightly more than 37,679 beds in our public mental health system[2] almost equally divided between civil and forensic patients. However, on the civil side TAC did not differentiate between civil patients who were voluntarily or involuntarily committed. The census described in this article would make that differentiation between these two groups. Further, as mentioned, it is the authors' belief that there are far fewer voluntary patients left in state facilities than in the past. We believe that most beds are now occupied by patients who were involuntarily committed. How many are in each group would be determined by developing the information from this census.

As an illustration, on April 29, 2016, there were 598 patients in Oregon's only state hospital: 130 (22%) were civilly committed, 214 (36%) were hospitalized for competency evaluation and restoration, and 212 (35%) were insanity acquittees. Forty-two patients (7%) had guardians and were generally difficult-to-place geriatric patients (Britton J, personal communication, April 29, 2016). Oregon does not have a civil commitment statute for SVPs. Individuals who might fall into this category can receive augmented sentences as dangerous offenders[16] within the criminal justice system. In prior years, Oregon had the highest proportion of its hospital beds occupied by insanity acquittees, which is now effectively replaced by an increasing population of those hospitalized for competency evaluation and restoration, along with a small number of patients who are civilly committed.[17] Thus, except for the geriatric patients, all of Oregon's beds are taken by three of the four patient populations covered in the proposed FMHSC. There are few to no patients who were voluntarily committed currently in the state hospital in Oregon. As mentioned, voluntary populations are included in the census to round out the complete picture of the use of state facilities and because voluntary hospitalization was one of the key goals of the community mental health movement from its beginning. Now, voluntary hospitalization has virtually ceased to exist in the Oregon hospital. How does voluntary hospitalization fare in the rest of the country's state hospitals?

In each state, the four involuntarily committed populations are subject to that state's rules determining the process of transition from the legal to the mental health system, and eventually, after various lengths of time, to discharge into the community. Because the rules of these pathways vary among all of these groups, the creation of models for each process in each jurisdiction is essential. Such models allow for a more discrete approach to public policy in each area. Making each component of the census more transparent can lead to more informed legal and mental health services changes that can result in improvements in the approach to each group. These

types of explorations can lead to comparisons within the system at different time points in time, to changes in the data when legal or mental health system modifications are introduced or enacted by state legislatures, or to comparisons of subcomponents of the system such as rural versus urban differences, or to differences among counties within a state, or to the economic costs of the process itself, and ultimately to studies comparing similar processes in the various states.[18]

There are limitations to this proposal. First, the article was focused only on state institutional data. Of all possible choices, these data may be the easiest to obtain and are extremely important. After all, as reported by TAC, we are still talking about 37,679 beds in the state hospitals, and this number will most likely increase when the sexually dangerous populations are surveyed in the census. However, there are very important community mental health services in each of the census areas. State hospitals have come to represent only a portion of the larger systems in place to manage and treat the populations described in the census. This is true in the area of civil commitment. As pointed out by the TAC, state hospital beds continue to decline, and this trend will probably continue as more service requirements are transferred to community inpatient and outpatient settings.[19] After an initial implementation, the census could be expanded to include community services, or a state might want to add community services to its own edition of the census to capture more of the totality of resources invested in these systems. In the future the census could be expanded by the addition of data from such organizations as the Center for Medicare and Medicaid Services (CMS)[20]and the Joint Commission.[21] These organizations may be interested in combining some of their current data collection activities to develop uniform data collection instruments across psychiatric institutions of all types.

A second major limitation is that the census does not include the problem of the persons with mental illness in our nation's jails and prisons.[22] This latter area was left out of this discussion because of the complications of trying to get the relevant data on a periodic basis from jurisdiction to jurisdiction. However, whenever we talk about these populations, we must acknowledge the large number of persons with mental illness in jails and prisons, and methods should be developed to obtain accurate and timely reporting in efficient ways that might be added to a state census.

In conclusion, the legal status of individuals committed in one of the four involuntary groups in the census in many ways defines their destiny for important parts of their lives. We believe that in this case legal status is destiny. Certainly this is true for insanity acquittees and for individuals committed as SVPs. These two patient groups are facing long periods of hospitalization before any monitored conditional release or system discharge is even contemplated. The civil commitment of persons with mental illness has a long history of statutory reform with well-prescribed patient rights, including limits on commitment. The question among this group is how these statutes are used today. We have little nationwide information on this group. The institutionalization for most individuals found incompetent to stand trial is generally time limited, either by effective treatment of their mental illnesses, or by statutes protecting them from excessively long hospitalizations in the trial competency status. There are problems in this group, as generally there appears to be a great increase in individuals sent to state hospitals for competency restoration.

Regardless of the particular involuntary commitment status there is substantial stigma associated with any involuntary commitment whether the involuntary commitment is short or prolonged. It would be our goal that a focus on each component of the census could lead to more informed public policy in each area, and may improve the lives of those involuntarily involved in each system.

References

1. Torrey EF, Fuller DA, Geller J, *et al*: No Room at the Inn: Trends and Consequences of Closing Public Psychiatric Hospitals 2005–2010. Arlington, VA: Treatment Advocacy Center, July 19, 2012. Available at: http://www.treatmentadvocacycenter.org/storage/documents/no_room_at_the_inn-2012.pdf/. Accessed March 16, 2017
2. Fuller DA, Sinclair E, Geller J, *et al*: Going, Going, Gone: Trends and Consequences of Eliminating State Psychiatry Beds, 2016 (updated for Q2 data), Arlington, VA: Treatment Advocacy Center, June 2016. Available at: http://www.treatmentadvocacycenter.org/storage/documents/going-going-gone.pdf/. Accessed March 16, 2017
3. Bloom JD, Krishnan B, Lockey C: The majority of inpatient psychiatric beds should not be appropriated by the forensic system. J Am Acad Psychiatry Law 36:438–42, 2008
4. Steadman HJ, McGreevy MA, Morrissey JP, *et al*: Before and After Hinckley, Evaluating Insanity Defense Reform. New York: The Guilford Press, 1993
5. About Us. Rockville, MD: Rockville, MD: Substance Abuse and Mental Health Services Administration, (SAMHSA). Undated.

Available at: http://www.samhsa.gov/about-us/. Accessed October 12, 2016
6. GAINS Center for Behavioral Health and Justice Transformation. Rockville, MD: Substance Abuse and Mental Health Services Administration (SAMHSA), undated. Available at: https://www.samhsa.gov/gains-center. Accessed October 12, 2016
7. NRI Home Page: No person's life will be limited by mental illness or addiction. Falls Church, VA: NRI, 2016. Available at: http://www.nri-inc.org/. Accessed August 1, 2016
8. Treatment Advocacy Center (TAC): Who We Are and What We Do. Arlington, VA: TAC, 2016. Available at: http://www.treatmentadvocacycenter.org/about-us/. Accessed August 1, 2016
9. National Alliance for Mental Illness (NAMI): About NAMI (home page). Arlington, VA: NAMI, 2016. Available at: http://www.nami.org/About-NAMI/. Accessed August 1, 2016
10. Faulkner LR, McFarland BH, Bloom JD, *et al*: A method for quantifying and comparing civil commitment processes. Am J Psychiatry l43:744–50, l986
11. Williamson C: Waiting on Predator Island: Chronic delays drive up cost. Seattle Times, January 22, 2012, updated on January 25, 2012. Available at: Seattle Times, http://www.seattletimes.com/seattle-news/waiting-on-predator-island-chronic-delays-drive-up-cost/. Accessed January 23, 2014
12. Sexually Violent Predator Statutes: Wash. Rev. Code § 71.09 (2017)
13. Tomlinson A: Federal appeals court rules Minnesota sex offender detention program constitutional. The Jurist, January 3, 2017. Available at: http://www.jurist.org/paperchase/2017/01/federal-appeals-court-rules-minnesota-sex-offenders-program-constitutional.php. Accessed 3/16/2017
14. Lohr KN, Steinwachs D: Health services research: an evolving definition of the field. Health Serv Res 37:15–17, 2002
15. National Advisory Mental Health Council's (NAMHC) Services Research and Clinical Epidemiology Workgroup: The road ahead: research partnerships to transform services. Rockville, MD: National Institute of Mental Health, NAMHC, May 12, 2006
16. Oregon Revised Statutes 161, 725. Standards for sentencing of dangerous offenders. https://www.oregonlegislature.gov/bills_laws/ors/ors161.html/. Accessed April 25, 2016
17. Bloom JD: Civil commitment is disappearing in Oregon. J Am Acad Psychiatry Law 34:534–7, 2006
18. Faulkner LR, McFarland BH, Bloom JD: An empirical study of emergency commitment. Am J Psychiatry 146:182–7, 1989
19. Pinals DA: Forensic services, public mental health policy, and financing: charting the course ahead. J Am Acad Psychiatry Law 42:7–19, 2014
20. Center for Medicare and Medicare. Home page. Washington, DC: CMS, 2016. Available at: http://www.cms.gov/. Accessed October 12, 2016
21. The Joint Commission. Home page. Available at: http://www.jointcommission.org/. Accessed October 12, 2016
22. Bloom JD: The "Incarceration Revolution": the abandonment of the seriously mentally ill to our jails and prisons. JL Med & Ethics 38:727–35, 2010