

# Broadening the Statutory Criteria for Civil Commitment: A Reply to Durham and La Fond

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In its Spring 1985 issue, this Review published an article by Professors Mary L. Durham and John Q. La Fond attacking the use of therapeutically oriented criteria for involuntary civil commitment of the mentally ill. In their article, Durham and La Fond sharply criticized such criteria in general and the American Psychiatric Association's 1983 Model State Law on Civil Commitment (the A.P.A. Model Law) in particular.<sup>1</sup>

Durham and La Fond based their attack on an empirical study of what happened when the state of Washington enlarged its civil commitment power by expanding the scope of the "gravely disabled" criterion in its Involuntary Treatment Act. In their view, the study demonstrated that more expansive criteria resulted in: (1) a significantly higher rate of involuntary commitment and (2) an increased probability that patients so committed would become chronic users of state psychiatric hospitals. Durham and La Fond further asserted that the surge in involuntary commitments precluded increasingly overcrowded and understaffed inpatient facilities from accepting voluntary patients. Generalizing from their interpretation of the Washington experience, the authors rejected all therapeutically oriented civil commitment criteria as counterproductive for mental health policy.

Durham and La Fond's article joined an ongoing national debate about the appropriateness of changing restrictive civil commitment criteria, which were typical of most state statutes in the 1960s and early 1970s. Their article's claim to significance is that it brought empirical data to bear on this debate rather than professional opinions or interests.

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1. Durham & La Fond, *The Empirical Consequences and Policy Implications of Broadening the Statutory Criteria for Civil Commitment*, 3 *Yale L. & Pol'y Rev.* 395 (1985).

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Durham and La Fond's research, however, should not guide policy decisions in this difficult area. They have drawn conclusions about therapeutically oriented criteria that go well beyond the data available to them. Indeed, subsequent empirical research by Dr. Steven K. Hoge and his associates flatly contradicts their conclusions, as I shall discuss below. Durham and La Fond have mischaracterized truly therapeutically oriented criteria, such as those the A.P.A. recommends, by equating them with the state of Washington's so-called "therapeutically oriented" standards. The latter merely expanded the state's commitment powers without making greater provision for actual therapeutic treatment.

As a principal author of the A.P.A. standards, I can assure readers that my colleagues and I fully anticipated the danger of a surge in confinements without a concurrent increase in the resources available for treatment. It was to avert this danger that the A.P.A. proposed that the criteria include a reasonable prospect of treatment at the institution to which a patient is committed. In addition, to limit the number of confinements and protect the rights of patients, the Model Law permits commitment only after a judicial finding that the patient is: (1) seriously mentally ill—that is, has a severe form of a serious mental disorder; (2) suffering; and (3) incompetent to make medical decisions.

### *I. Summary of Durham and La Fond's Article*

Durham and La Fond begin their article by outlining the background of the law of civil commitment. In their view, the state's authority to confine the mentally ill rests on two legal principles: (1) *parens patriae*, under which the state acts on behalf of individuals who are believed to be incapable of acting in their own best interest; and (2) police power, under which the state is authorized to confine persons in order to prevent harm to the community.<sup>2</sup> Durham and La Fond describe the current debate over involuntary civil commitment as focusing, at its extreme, on whether the state should continue to use its power of coercion to deprive mentally ill people of their liberty, or whether it should abolish civil commitment in favor of other systems of social control and care. They describe more moderate arguments as focusing on the proper grounds for

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2. *Id.* at 395.

justifying, defining, and controlling the state's civil commitment powers.<sup>3</sup>

The authors note that the historical context of the debate was the shift in the 1960s and early 1970s from "medical" models of civil commitment to "legal" models. Medical models grant mental health officials broad power to confine for treatment people they determine to be mentally ill. Legal models, in contrast, limit the authority of medical specialists by providing substantive requirements and procedural safeguards in the commitment process. Durham and La Fond note that the more recent trend is toward renewed use of medical models and an expansion of the scope of the state's authority to commit non-dangerous persons thought to be mentally ill.<sup>4</sup> They apparently view the A.P.A.'s Model Law as symptomatic of this trend because it would increase the *parens patriae* power of the state.<sup>5</sup>

Durham and La Fond use civil commitment legislation in Washington as a case study of changes in state mental health policy. In 1973, Washington enacted a restrictive civil commitment statute that emphasized dangerousness and narrowed the state's power to confine mentally ill persons against their will. In 1979, after significant negative reaction to the 1973 statute, the Washington legislature expanded the state's civil commitment powers by broadening the definition of those who could be involuntarily committed. The legislature did not, however, significantly alter the actual commitment procedures.<sup>6</sup>

After studying the Washington situation, Durham and La Fond report, among other findings, that: (1) persons in the state were committed under the new, expansive statutory criteria well *before* the effective date of the statute; (2) the number of involuntarily committed patients increased significantly, and many patients who had had no previous contact with state psychiatric hospitals were committed

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3. *Id.* at 396. Whatever the nature of the theoretical debate, no state has in fact abolished civil commitment. The current policy debate centers on choosing appropriate substantive criteria for commitment.

4. *Id.* at 397. Durham and La Fond's definition of legal and medical models is misleading in the present context. Due process safeguards are applied today in all civil commitment proceedings, whether the criteria are legally oriented to dangerousness or medically oriented to need for treatment. Durham and La Fond identify Alaska, North Carolina and Texas as states that, in addition to Washington, "have recently revised their commitment statutes by changing the substantive criteria for commitment to expand the scope of the state's authority to hospitalize coercively persons deemed mentally ill." Durham & La Fond, *supra* note 1, at 398 n.19.

5. *Id.* at 398-99.

6. *Id.* at 400.

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to these facilities for the first time; (3) the major state mental hospital became extremely overcrowded and tried unsuccessfully to limit new admissions; and (4) voluntary patients were virtually excluded from state mental hospitals. From this evidence, Durham and La Fond apparently conclude that *any* commitment plan that would expand a state's power without simultaneously increasing hospital funding would be an irresponsible policy.<sup>7</sup>

Given their assertion that restrictive legal criteria based on dangerousness are preferable to therapeutic criteria, one might hope that Durham and La Fond would present some objective review of their preferred approach, setting out its costs as well as its benefits. But not only do they fail to consider adequately the costs to patients and their families of restrictive dangerousness criteria; they also underestimate those costs they do acknowledge. This unfortunate weakness becomes all the more troubling when one reviews Durham's other publications dealing with this same research, in which she lists some of the costs of a restrictive policy.<sup>8</sup>

### *II. The Washington State Legislation and the A.P.A. Model Law*

A central question in the current civil commitment debate is whether to allow for the involuntary confinement and treatment of mentally ill patients who demonstrate clear signs of psychotic deterioration but who are not dangerous to others or to themselves. The A.P.A. Model Law answers this question in the affirmative, *if* the seriously mentally ill patient is suffering, treatable, and incompetent to make medical decisions, and *if* the patient has a reasonable prospect of receiving treatment (that is, if there is treatment available at the institution to which the patient would be committed).<sup>9</sup> The

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7. *Id.* at 401, 444-45.

8. See, e.g., Pierce, Durham & Fisher, *The Impact of Public Policy and Publicity on Admissions to State Mental Health Hospitals*, 11 *J. Health Pol., Pol'y & L.* 41, 42-43 (1986); Durham & Pierce, *Legal Intervention in Civil Commitment: The Impact of Broadened Commitment Criteria*, *Annals* 42, 43 (Mar. 1986); Pierce, Durham & Fisher, *The Impact of Broadened Civil Commitment Standards on Admissions to State Mental Hospitals*, 142 *Am. J. Psychiatry* 104 (1985). In these articles, Durham and her co-authors acknowledge criticisms that restrictive commitment criteria have resulted in: (1) denial of voluntary admission to some patients; (2) persons "falling through the cracks" in community outpatient service systems; (3) "psychiatric ghettos" in large urban areas; (4) migration of the mentally ill population from hospitals into jails and prisons; (5) relatives' abandonment of mentally ill persons who refuse voluntary commitment; and (6) professional and ethical problems for psychiatrists who want to commit gravely disabled and other persons who, in their professional judgment, need hospitalization.

9. Stromberg & Stone, *A Model State Law on Civil Commitment of the Mentally Ill*, 20 *Harv. J. on Legis.* 275 (1983) [hereinafter Stromberg & Stone]. It should be noted

A.P.A. recommended that these truly therapeutically oriented criteria be added to the three requirements for civil commitment common to most state statutes—"dangerous to others," "dangerous to self," and "gravely disabled."

No state has ever adopted the complete package of commitment criteria recommended by the A.P.A. The few states that have adopted the deterioration language of the A.P.A.'s therapeutically oriented criteria have not, to my knowledge, included in their statutes three elements key to the A.P.A. recommendations—patient suffering, patient incompetency, and treatment availability.

The 1973 Washington civil commitment statute created the most restrictive non-therapeutically oriented regime of any state;<sup>10</sup> the criteria were thus prototypical of those favored by most civil libertarians.<sup>11</sup> Under this regime, individuals could be involuntarily committed only if they met one or more of the narrow standards: dangerous to others;<sup>12</sup> dangerous to self;<sup>13</sup> or gravely disabled.<sup>14</sup> Furthermore, confinement—except of persons found dangerous to others—was strictly limited in duration. Suicidal patients were to be released in less than a month, even if they remained acutely suicidal.

The narrow scope of these criteria is exemplified by Washington's definition in 1973 of gravely disabled: "a condition in which a person as a result of a mental disorder is in danger of serious physical harm resulting from a failure to provide for his essential needs."<sup>15</sup> This provision made it clear that the degree of the person's mental suffering and the potential for mental deterioration were not rele-

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that La Fond had adopted a similar version of these therapeutically oriented criteria in a 1981 article, in which he claimed that such criteria were both morally and legally acceptable. La Fond, *An Examination of the Purposes of Involuntary Civil Commitment*, 30 *Buffalo L. Rev.* 499, 526 (1981). In this article, he also had speculated that these criteria would result in fewer, rather than more, commitments. *Id.* at 534.

10. Durham & La Fond, *supra* note 1, at 402-03. The statute is codified at Wash. Rev. Code Ann. §§ 71.05.010-.05.930 (1975) (as amended).

11. While Durham and La Fond do not claim to be civil libertarians, concerned about maximizing liberty, it should be noted that emphasizing civil liberties while slighting humanitarian goals obscures the social value of treating mentally ill people rather than simply banishing them to the streets.

12. Wash. Rev. Code Ann. § 71.05.020(3)(a) (1975). "The 'danger to others' criterion was satisfied by behavior which 'had caused harm or substantial risk of harm in the past, or which had placed others in reasonable fear of sustaining harm.'" Durham & La Fond, *supra* note 1, at 403. The authors also note that "[t]he statute was not specific regarding evidence that would establish dangerousness or harm to others." *Id.* at 403.

13. Wash. Rev. Code Ann. § 71.05.020(3)(b) (1975). "[A] person was dangerous to herself if she had threatened or attempted self-inflicted physical harm or suicide." Durham & La Fond, *supra* note 1, at 403.

14. Wash. Rev. Code Ann. § 71.05.020 (1975). See also Durham & La Fond, *supra* note 1, at 403.

15. Wash. Rev. Code Ann. § 71.05.020(1) (1975) (amended 1979).

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vant; only “physical harm” was relevant. As long as a family provided for the patient’s essential needs, the patient could not be treated involuntarily unless he or she actually became dangerous to self or others.

The apparent legal objective of the “gravely disabled” criterion was to draw a bright line between mental illness that is “harmless” for legal purposes and mental illness that results in starvation, dehydration, and physical exposure; the restrictive standard permits confinement only if the latter physical dangers are involved. Durham and La Fond criticize the 1979 expansion of this criterion in Washington because it allegedly caused a counterproductive increase in the number of persons involuntarily committed for treatment of legally harmless mental illness.

“Although there is no direct evidence on the point,” they argue, “it seems reasonable to conclude that, prior to their commitment, these individuals were coping adequately in the community at least to the extent of organizing a daily routine and providing for their shelter, food, and clothing needs.”<sup>16</sup> In my experience, however, families do not usually abandon to involuntary commitment loved ones who are “coping adequately” and “organizing a daily routine.” Nor do contemporary mental health professionals usually consider it appropriate to hospitalize such persons involuntarily. It seems more reasonable to conclude that the expanded standard alleviated the dilemma of families faced with either caring for or abandoning a recalcitrant mentally ill relative and allowed for the treatment of more individuals who needed help but were too ill to seek it.

Within months of passing its prototypical civil libertarian commitment law, the Washington legislature amended it in 1974 to allow for additional periods of confinement of persons not dangerous to others but gravely disabled or dangerous to themselves.<sup>17</sup> Five years later, in response to public pressure, the legislature voted to expand the criterion of gravely disabled to include a person who “manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and [who] is not receiving such care as is essential for his or her health or safety.”<sup>18</sup> The expanded criterion does not address the questions of whether the patient is actually treatable and whether the patient is competent to make medical judgments. This

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16. Durham & La Fond, *supra* note 1, at 431.

17. Wash. Rev. Code Ann. § 71.05.280 (1975) (amended 1979).

18. Wash. Rev. Code Ann. § 71.05.020(1) (Supp. 1986).

expanded requirement for commitment—*not* the therapeutically oriented criteria called for by the A.P.A.—was the basis of Durham and La Fond's empirical research. It is only through misinterpretation that Durham and La Fond apply their data to condemn the A.P.A.'s Model Law.

Durham and La Fond discuss recent state legislation, including that of Washington, as if it had expanded civil commitment criteria in a therapeutically oriented manner similar to that proposed by the A.P.A.<sup>19</sup> They relegate to a footnote the pivotal distinction between the A.P.A. Model Law and other state legislation, including the Washington statute: the A.P.A. Model Law, unlike most state standards, requires that the disorder be "treatable at or through the facility to which a patient is committed."<sup>20</sup> The A.P.A. proposes a mandatory probable cause hearing at which, within five working days of initial commitment, a judge must find that the disorder is "treatable at or through the facility;" otherwise the patient must be released.<sup>21</sup>

The distinction that Durham and La Fond fail to make is that between so-called therapeutically oriented criteria—which expand civil commitment solely by altering descriptions of mental illness to include mental deterioration—and truly therapeutically oriented criteria—which *also* require patient treatability, mental suffering, and incompetence to make treatment decisions and availability of treatment. Although Durham and La Fond conflate these two types of commitment criteria, only the A.P.A. standards should be characterized as therapeutically oriented. The A.P.A.'s provisions regarding the availability of treatment, treatability, mental suffering, and incompetence to make treatment decisions make its Model Law a bona fide therapeutically oriented approach. The Model Law is fundamentally different from the Washington and other state statutes, which are silent on these essential requirements.<sup>22</sup>

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19. Durham & La Fond, *supra* note 1, at 398-99.

20. *Id.* at 399 n.24 (quoting Stromberg & Stone, *supra* note 9, at 330).

21. Stromberg & Stone, *supra* note 9, at 322-23. Judges may of course ignore criteria such as "treatable" and "reasonable prospect of treatment." Indeed, this possibility is a common criticism of the A.P.A. Model Law, made by lawyers concerned that judges will have too much discretion under the Model Law. To design a civil commitment statute on the premise that judges cannot be trusted was not the task the A.P.A. set for itself, however, nor is it the premise on which Durham and La Fond criticize the A.P.A. Model Law.

22. As Durham herself noted in an earlier article, "Unlike the A.P.A. Model Law, Washington law does not require that the patient have a treatable condition or lack the capacity to make an informed treatment decision." Durham, *Implications of Need-for-Treatment Laws: A Study of Washington State's Involuntary Treatment Act*, 36 *Hosp. & Comm. Psychiatry* 975, 977 (1985).

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The false analogy between the Washington legislation and the A.P.A. Model Law leads Durham and La Fond to misapply their criticisms of the former to the latter. The 1979 Washington legislation allowed for an increased number of commitments, drawn from approximately the same number of referrals, without a corresponding increase in hospital resources; the result was a short-term inability to provide adequate care to hospitalized patients. From this specific set of circumstances, Durham and La Fond jump to the conclusion that therapeutically oriented criteria, including the A.P.A. standards, should be rejected as inherently expansive and counter-productive.

One does not need to undertake a costly empirical project, however, to argue that any expansion of civil commitment will cause medical and logistical problems unless more resources are allocated to the facilities charged with the increased responsibility. To assert that public policy on civil commitment must reflect this consideration is hardly a new or controversial conclusion. The most important lesson of recent civil commitment history is precisely that the central defect in implementing policies of civil commitment has been the failure to provide the necessary resources. The A.P.A. itself has argued that “[r]emedying this defect requires not only clarifying the basis for commitment, but also enforcing legal rights and providing adequate funds to ensure that the conditions of confinement accord with its theoretical purposes.”<sup>23</sup>

The A.P.A. Model Law, then, had already anticipated this obvious problem, which Durham and La Fond report as one of the main fruits of their empirical research, by including “treatable” and “reasonable prospect of treatment” in its recommended criteria. The A.P.A. criteria were intended specifically to prevent the pattern of confinement without treatment, a pattern that would defeat any regime of civil commitment. Under these truly therapeutically oriented criteria, confinement would be precluded when a lack of budgetary or physical resources left no reasonable prospect of treatment for the patient. A judge must make this determination at a mandatory probable cause hearing.

As one of the principal drafters of the Model Law, and a co-author of its commentary, I can attest that the intent of the A.P.A. criteria in any case was not to expand the number of citizens who would be committed. Rather, the intent was to change the focus of civil commitment and the categories of persons committed from those cur-

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23. Stromberg & Stone, *supra* note 9, at 283.

rently inappropriately committed to those likely to benefit from confinement. Durham and La Fond ignore sections of the A.P.A. Model Law and commentary that show the A.P.A.'s recognition of the problems of expansion as well as its attempts to build in protections against them.

The authors characterize as expansive the policy behind the therapeutically oriented A.P.A. criteria by quoting out of context. They claim that "[t]he commentary to the model statute indicates clearly that the intent of the drafters is to permit commitment of many citizens who are *not presently committable* under current legal standards."<sup>24</sup> Their footnote supporting this contention quotes a sentence that is only part of a summary paragraph: "In sum, the criteria in the Model Law are in some respects broader than those in some current state laws . . . ."<sup>25</sup> They omit the rest of the paragraph, which adds that "in other respects the criteria are stricter . . . ."<sup>26</sup>

In the actual commentary on the Model Law, Clifford Stromberg and I discuss some of those "other respects" in the section entitled, "Some Major Categories of Persons Who Do Not Meet the Criteria for Involuntary Commitment."<sup>27</sup> The first category of those not committable, "Does NOT Suffer From a 'Severe Mental Disorder,'" precludes from psychiatric confinement many persons now committable either as gravely disabled or as dangerous to self or others. The second category, "Does NOT Lack Capacity to Make a Reasoned Decision Concerning Treatment," precludes from confinement those persons confinable under most current state law as gravely disabled or as dangerous to themselves or others who are competent to make treatment decisions. The third category, "Is NOT Likely to Cause Harm to Himself or Others or to Deteriorate," precludes from confinement some persons now committable in some states as gravely disabled. The fourth category, "Is NOT Treatable," precludes from confinement all patients for whom civil commitment is now mere preventive detention.<sup>28</sup> These specified categories of persons *not committable* are especially noteworthy in a Model Law that Durham and La Fond label as counterproductively expansive.

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24. Durham & La Fond, *supra* note 1, at 399 (emphasis in original).

25. *Id.* at 399 n.25.

26. Stromberg & Stone, *supra* note 9, at 335.

27. *Id.*

28. *Id.* at 335-36 n.201.

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### *III. Empirical Evidence Contradicting Durham and La Fond's Conclusions*

Empirical evidence that the proposed A.P.A. criteria indeed would not prove to be expansive in practice can be found in a recent study by Steven K. Hoge, M.D., Paul S. Appelbaum, M.D., and Alexander Greer, J.D. These authors compare commitment criteria, which I developed and published in 1975 and which later became the basis of the Model Law criteria, to current civil commitment standards in Massachusetts<sup>29</sup> (which are similar to those enacted by Washington State in 1973). Hoge's study, flatly contradicting Durham and La Fond, finds that the Stone criteria would be substantially *more restrictive* than the Massachusetts statutory criteria based on dangerousness.<sup>30</sup>

Hoge's study addresses "prospectively the question of what effect adoption of the Stone (or closely related) criteria would have on the number of patients admitted to and excluded from a mental health system."<sup>31</sup> He found not only "that many currently committable patients would be uncommittable under Stone's scheme, but also that few patients now uncommittable would be added to the system."<sup>32</sup>

An earlier study by Monahan had reported that only 46% of California patients committed in an emergency setting would also meet the proposed Stone criteria.<sup>33</sup> But Monahan's study lacked data on how many patients *excluded* by California criteria would have been included under the Stone criteria; nor did the data permit an accurate determination of the effect of the incompetency requirement on the number of those committed. Nonetheless, Monahan's published empirical evidence had already suggested that the Stone criteria—and hence, the more recent, similar A.P.A. standards—would not expand the number of patients committed, despite the claims of Durham and La Fond.

Hoge's more recent study also demonstrates that if the Stone criteria replaced the Massachusetts standards, fewer patients with intractable and untreatable personality disorders would be committed

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29. Mass. Gen. Laws Ann. ch. 123, §§ 1-36A (West 1986 & Supp. 1987).

30. Hoge, Appelbaum & Green, An Empirical Comparison of the Stone and Dangerousness Criteria for Civil Commitment, abstract of a paper presented at the American Psychiatric Association Annual Meeting, Chicago, May 13, 1987 (on file with the Yale L. & Pol'y Rev.).

31. *Id.* at 5.

32. *Id.* at 13.

33. Monahan, Ruggiero & Friedlander, Stone-Roth Model of Civil Commitment and the California Dangerousness Standard, 39 Archives of Gen. Psychiatry 1267, 1268 (1982).

to hospitals and patients with more serious, treatable psychoses would predominate.<sup>34</sup> This conclusion suggests that the truly therapeutically oriented Model Law would in fact work as it was designed to.

My original conception of the A.P.A. Model Law criteria assumed that the only valid justification for involuntary confinement in a mental hospital is paternalism, or *parens patriae*. Dangerous people who are competent to make medical decisions should be the responsibility of the criminal justice, not the mental health, system. Mentally ill persons who are not suffering give those who would impose treatment no legal or moral justification for doing so. Only persons who suffer, who are incompetent to make treatment decisions, and who could be treated would be confined under the proposed criteria. Hoge's study suggests, as I have always believed, that criteria suggested by *parens patriae* principles are both more restrictive and more therapeutic than purportedly restrictive criteria based on dangerousness.

#### *IV. Limits of Durham and La Fond's Empirical Data*

The ostensible significance of Durham and La Fond's article lies in its rejection of therapeutically oriented civil commitment goals on the basis of empirical evidence—not mere professional opinion. The authors' attack on therapeutically oriented criteria is inadequate in part because they fail to ask important empirical questions.

In order for social scientists to evaluate significant changes in policy, they must compare the new configuration of costs and benefits with the old. Durham and La Fond fail to offer any empirical data on the costs and benefits of the original regime,<sup>35</sup> in spite of their concession that many mental health professionals and patients' families were considerably dissatisfied with the original restrictive commitment statute.<sup>36</sup> For example, they do not present any comparative

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34. Hoge, *supra* note 31, at 10.

35. If Durham and La Fond had studied the policy of deinstitutionalization in the same way they studied civil commitment, that is, by emphasizing only the short-term costs of deinstitutionalization and ignoring its potential long-term benefits, they would have had to conclude that no legislature should embark on a new policy of deinstitutionalization before planning and funding adequate community alternatives to institutionalization.

36. Durham & La Fond, *supra* note 1, at 406.

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empirical data on the successful prevention of violence or suicide under the new and the old regimes. Nor do they present any empirical data on the number of patients with serious and treatable mental disorders who went untreated under the restrictive regime. They do not present data on the number of homeless mentally ill, on the suffering of families whose schizophrenic members could not be confined involuntarily, or on the efficacy of treatment actually provided to those civilly committed under this old regime.

It is important to know whether restrictive regimes based on dangerousness select patients who need and can benefit from hospitalization. If they do not, then such regimes are counterproductive; they waste hospital resources, undermine the therapeutic mission of the professional staff, and eventually contribute to the deterioration of the quality of care available in the public sector. Admittedly, these are not easy subjects on which to conduct a quantifiable inquiry. But it is unacceptable to assume away these important empirical questions.

The study done by Durham and La Fond exploits a “natural experiment,” the Washington legislative change from the “restrictive” 1973 criteria to the “expansive” 1979 criteria for civil commitment. When using such natural experiments, however, it is particularly important to acknowledge that any generalizable conclusions must be drawn from the data with caution because the real situation imposes limitations on the research design.

For example, Durham and La Fond’s conclusion that the expanded law had significantly different impacts in different counties within Washington demonstrates the inherent limitations of their results when extended beyond the state itself. Durham and La Fond report that the “influence of county was so strong that we performed many of our analyses separately for each county;”<sup>37</sup> they explain that “[c]ounties differ with respect to administration, management and available resources.”<sup>38</sup> Because states differ just as dramatically in these respects, generalizing conclusions about the effects of expansive civil commitment laws from one state to another is a treacherous endeavor that should be approached with more scientific caution than Durham and La Fond demonstrate.

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37. *Id.* at 415.

38. *Id.*

V. *Misinterpretation of Data*A. *Treatment of Voluntary Patients*

Durham and La Fond's conclusion that "voluntary patients were virtually excluded from state hospitals"<sup>39</sup> serves as only one example of the distortions that result when conclusions are drawn from incomplete data. Data from the Washington study show that after civil commitment criteria were broadened, "voluntary admissions fell from 46.7% of total admissions to 25.3%, with the absolute numbers declining 26.3% from 518 to 382."<sup>40</sup> Yet the authors present no new data on the number of patients who actually *sought* voluntary admission and were *refused* under the new expansive regime—nor, for purposes of comparison, the number of those refused under the old restrictive one. Furthermore, there was *no substantial increase in the total number of patients referred* after 1979 to the County Designated Mental Health Professionals [CDMHP] (the organization that initiates civil commitments in Washington), even though the percentage of patients referred who were eventually involuntarily committed rose significantly.<sup>41</sup>

This limited data just as reasonably suggests that patients who might have accepted voluntary status were *not* excluded from treatment, but that the CDMHP simply processed some of them as involuntary patients. Clinical experience suggests that the CDMHP may simply have chosen to commit some of these patients involuntarily rather than invest the time and effort necessary to persuade them to accept voluntary status. Durham and La Fond, however, claim that the mental health system provided virtually no treatment to voluntary patients under the expanded regime, when the data available is simply inadequate to support such a misleading conclusion. The data at most document a decrease in the number of patients *labeled* as voluntary.

Durham and La Fond further confuse matters by arguing that patients who come to hospitals voluntarily respond better to treatment than involuntarily committed patients.<sup>42</sup> To support this argument, they refer to a body of literature that primarily deals with ethical questions about involuntary psychiatric treatment, not with the effectiveness of involuntary short-term biological psychiatric treat-

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39. *Id.* at 401.

40. *Id.* at 417.

41. *Id.* at 418.

42. *Id.* at 432.

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ment.<sup>43</sup> Their suggestion that voluntary treatment is more effective than involuntary treatment can be neither supported nor refuted on the basis of their study. Their misinterpretation of the data on voluntary patients thus leads them to the unfounded conclusion that the expansive Washington criteria caused state psychiatric hospitals to turn away patients who would have benefited more from treatment than those admitted. I find this conclusion particularly troubling because, in my experience, it is the restrictive criteria based on dangerousness that have caused psychiatric hospitals to turn away people who would have benefitted more from treatment than the patients admitted.

### *B. Mischaracterization of Patients*

Durham and La Fond's focus on legal definitions of the "chronically mentally ill" rather than on clinical realities<sup>44</sup> also exemplifies a failure to interpret their data properly. Some mental disorders, particularly schizophrenia, tend to follow a chronic course with recurring episodes of increased agitation, delusions, and decompensation in mental and social functioning. Although some patients with these disorders return to their prior level of functioning, many deteriorate over time. Long-term custodial care in inadequate institutions may contribute to deterioration, but deterioration certainly occurs outside institutions as well.<sup>45</sup>

Washington's community mental health act defines a chronic patient as someone "who has undergone two or more episodes of hospital care for a mental disorder within the two preceding years."<sup>46</sup> Durham and La Fond do not explain the purpose of this definition or its significance. In fact, patients can be chronically mentally ill whether or not they are hospitalized. If the legal definition of this condition is taken seriously, then a restrictive regime can reduce the numbers of chronically mentally ill patients in the state simply by refusing them admission to hospitals. The larger the population of homeless mentally ill under such a regime, the smaller the number of officially chronically mentally ill. On the other hand, if the state

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43. *Id.* at 432 n.155. A study of patients involuntarily admitted in 1974 to Harborview Hospital concluded that "the Seattle experience strongly suggests that if the needs of involuntary patients are appropriately addressed, then treatment can be equal to or better than that of their voluntary counterparts . . .," Sata & Goldberg, *A Study of Involuntary Patients in Seattle*, 28 *Hosp. & Comm. Psychiatry* 834, 837 (1977).

44. Durham & La Fond, *supra* note 1, at 421 n.122.

45. Schwartz & Goldfinger, *The New Chronic Patient: Clinical Characteristics of an Emerging Subgroup*, 32 *Hosp. & Comm. Psychiatry* 470 (1981).

46. Durham & La Fond, *supra* note 1, at 421 n.122.

offers access to inpatient care, the numbers of chronically mentally ill patients will increase. The "official" numbers thus reveal nothing meaningful about the real prevalence of chronic mental illness in Washington.

Durham and La Fond argue that "[g]rowth in the number of clients re-entering the commitment system has consequently increased the likelihood of the growth in the number of those *classified* as 'chronically mentally ill.'"<sup>47</sup> In a subsequent discussion of their findings, the authors drop the qualifier "classified" and conclude that "the stage may now be set for 'old' clients to become chronic patients in the future."<sup>48</sup> This twist of interpretation is misleading because it suggests that their empirical study has demonstrated that expansive commitment criteria—and, by implication, therapeutically oriented criteria—will create chronic mental patients. The hidden invalid assumption is that mental illness does not become chronic without the intervention of the state. Durham and La Fond fail to acknowledge not only that mental patients can become chronic without state intervention, but also that some of these patients may need and benefit from repeated state hospitalizations, especially during recurrent acute episodes.

### *Conclusion*

Durham and La Fond's research and findings cannot be credited as a guide to future policy in the difficult area of formulating civil commitment criteria. Their failure to recognize the basic limitations of their empirical data and their misapplication of their results to the A.P.A. Model Law clearly invalidate their rejection of therapeutically oriented criteria. Anyone concerned about mental health policy today recognizes that a policy of warehousing the mentally ill is an insupportable invasion of civil rights for no therapeutic purpose. But there are those who apparently do *not* realize that a restrictive civil commitment regime based solely on dangerousness also has significant costs; its result is often a haphazard system of preventive detention for some and non-therapeutic neglect for others.

There is an obvious need to chart a new course. That new course will have to reflect both the legal justifications for loss of liberty and the therapeutic goals society can reasonably expect to achieve. Civil commitment criteria that ignore legal justifications are unacceptable, as is confinement that serves no useful therapeutic purpose.

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47. *Id.* at 421 (emphasis added).

48. *Id.* at 422.

## Civil Commitment

Civil commitment criteria and policy must instead require both a legal justification for confinement *and* a medical determination that the person confined will benefit from the treatment available. The time for talking about medical versus legal models has passed; it is now time to talk about a medico-legal model.

The Model Law promulgated by the A.P.A. aims in the right direction. It rejects the expansion of civil commitment that leads to warehousing. It rejects the restrictive standards based on dangerousness that result in haphazard preventive detention for some and non-therapeutic neglect for others. It is a policy that makes the legal system, the state, and the mental health system accountable when civil commitment is invoked. Therapeutic goals are necessary but not sufficient; legal justifications for loss of liberty are necessary but not sufficient. Legal justifications and therapeutic goals together, with institutional and budgetary resources to support them, are necessary and sufficient to make civil commitment acceptable. A policy that ignores either of these essential elements will fail, and at a cost measured in human suffering. It is a cost that the mentally ill and their families have paid many times and in large measure for most of this nation's history.