DDTT preliminary thoughts on the civil commitment piece of the criminalization of the mentally ill phenomenon.

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Dorothea Dix: mission possible

Broken Promise #1

In June, 1874 Dorothea Dix visited the Northern Hospital for the Insane (now Winnebago Mental Health Institute) and presented the hospital with a handsome mounted kaleidoscope. Dr. Walter Kempster wrote that Ms. Dix had spent her life in doing good, laboring incessantly for the welfare of the insane. He went on to say that "in the evening of life when most persons seek the quiet repose of home, Dorothea Dix's interest remained unabated, leading her to travel thousands of miles to speak words of advice and comfort to those whose interests she had made her own. Although it was impossible to thank her then, that in the hereafter many, whose sorrow and suffering she had mitigated, would rise up and call her blessed". (Dorothea Dix was 72 years old at the time of that Wisconsin visit and she died three years later in 1887)

The many hospitals that Dorthea Dix helped establish were built to take the mentally ill from jails and prisons and put them into an "asylum"—not a harsh word then—"a place of security and retreat." That was done with a promise that such placement would be an improvement for those "broken on the wheels of living" to use Dr. Kempster's words. Unfortunately over time that promise was broken by inadequate funding and 'getting away' became 'putting away' in many jurisdictions.

Broken Promise #2

I came into Psychiatry at another time of great promise. In the 1955 558.000 patients resided in state and county mental hospitals in the U.S. There were no anti-psychotics, no anti-depressants, no benzodiazapines. Only barbiturates or other sedatives. Insulin shock was common, electroshock frequent and lobotomies plentiful.

But then came thorazine, a drug as dramatic to mental illness as penicillin was to infections. Patients at Winnebago who had to be immobilized for a haircut, for example, became cooperative and for the first time went on home visits, according to one of the Superintendent's report regarding this 'miracle' drug. Then came meprobamate and other 'tranquilizers' as an alternative to deep sedatives. And soon thereafter the anti-depressants.

With these treatments specific now for various types of mental illness, mental hospital population for the first time began to decrease.

In 1955 the Federal Government launched a study of mental health in America and issued a report *Action for Mental Health*. Transmitted to congress in 1960 the report caught the attention of President Kennedy who gave a Presidential message to Congress that resulted in the Mental Retardation Facilities and Community Mental Health Centers Construction Act which was to begin a new era in Federal support for mental health services. The community mental health centers were to replace out-dated large mental hospitals and were to provide comprehensive follow-up treatment for the large numbers of patients being released from mental hospitals. The dollars spent on in-patient care at large hospitals was to follow the patients into the community where care, while closer to home and less restrictive, was in fact, if provided in needed quantity

and quality would be equally expensive. But the dollars have not followed the patients. "Savings" from closing hospitals were eagerly accepted by states, but those dollars were not given to the counties or local boards to whom responsibility had been conveniently transferred. As a result, along with changes in civil commitment laws, mentally ill patients were 'criminalized' to where in 2012 more mentally ill persons reside in jails and prisons than in mental hospitals regardless of auspices. We are back to what Dorothea Dix faced more than a century ago. The mental health system is broken.

Legal 'rites' and "dying with your rights on"

In 1973 the de-instituionalization movement (begun with good intentions) became even more of a crisis with the *Lessard* decision in Wisconsin. At that time clinicians in Wisconsin were concerned that the civil commitment criteria—"mentally ill and in need of treatment"—was too vague, and due process too lacking. There was an effort to correct those deficiencies with a new mental health act. But before that could be accomplished in the usual legislative fashion, the *Lessard* decision was handed down by the Supreme Court requiring "imminent physical dangerousness" as the sole criteria for emergency detention or civil commitment. *Parens Patriae* concerns and provisions were thrown out entirely. Gradually all of the states, including Wisconsin, revised their mental health acts to where the only cause for emergency detention or civil commitment was "dangerousness" narrowly defined—imminent physical dangerousness to self or others. Embedded in those new statutes were some needed due process provisions including prompt detention hearings and prompt final hearings when necessary. There was a right to counsel and general provisions and procedures to deal with the right to refuse treatment. Dispositions were to be to least restrictive settings and rights to re-hearings in reasonable time spans.

The due process provisions were generally accepted. But because of too restrictive detention and civil commitment criteria, immediately around the country a series of cases where patients 'died with their rights on'—where scrupulous concern for patient's rights over-shadowed reasonable concern for the patient's life—began to occur. At the same time forensic commitments increased (as much as 70% in Wisconsin) as obviously mentally ill patients were put into jails, prisons and forensic units as at least one way to get them off the streets and into an at safer (if not therapeutic) setting.

Soon it became apparent that homicidal and suicidal threats and behaviors, narrowly defined, were creating situations where seriously mentally ill persons who were in need of protection and treatment were not 'qualifying' for such treatment and they were either simply left untreated, or jailed for their own safety. Such confinement, though inappropriate, was better than nothing and while police officers were not experts with respect to identifying and testifying regarding psychosis, they did know disorderly conduct, or failure to pay a restaurant bill when they saw it and they did have the power to arrest and confine on those criminal charges.

A third standard—Gravely Disabled

As some of these tragic scenarios emerged, it became apparent that danger to self and danger others--'imminent physical dangerousness' narrowly defined—were not sufficient standards for detention or civil commitment. One by one states added a third standard for detention or civil commitment for the 'gravely disabled"—a person who evidences behavior by recent acts or omissions that, due to mental illness, the person is unable to satisfy basic needs for nourishment, medical care, shelter or safety without prompt and adequate treatment so that a substantial probability exists that death, serious physical debilitation or serious physical illness will ensue unless the individual receives prompt and adequate treatment for this mental illness.

These third standards generally still rely on physical incapacitation due to mental illness

A fourth standard—need for treatment or assisted out patient treatment

As time went on it was apparent that many 'obviously ill' psychiatric patients were still being deprived of treatment but what were seen by many as legal 'rites' rather than a sensible balance between the right to be sick and the right to be rescued. This was particularly apparent in the chronically, obviously ill psychiatric population. These were patients with a history of serious mental illness, often with repeated hospitalizations and re-hospitalizations (or arrests) who were reasonably well functioning when on medication and in treatment, but who would relapse after discontinuing medication and treatment, with a quite obvious and predictable deterioration toward 'dangerousness' such that, given time, they would qualify for detention (or arrest) without any intervention. It seemed an intervention *before* such deterioration could interrupt this cycle of repeated hospitalizations, or arrests and jailings.

Forty-four states now have such a fourth-standard in one form or another.

Detention or commitment to in-patient status

Some states, such as Wisconsin, put in place a fourth standard that provides in-patient status that can be converted into out-patient status if the patient qualifies. I use the example of the Wisconsin fourth standard because it was challenged constitutionally and the Wisconsin Supreme Court found the standard *did* meet constitutional muster.

The actual language occurs in Wisconsin State Statute 51.20 (1, e) (In the literature this Wisconsin provision is often called the 5th standard because Wisconsin has two fourth, gravely disabled, standards). To meet the elements of this standard the following must apply: a) the person is incapable of understanding the advantages, disadvantages or alternatives of accepting medication or treatment or its alternatives such that they cannot make an informed choice in that regard; b) *evidences a substantial probability, as demonstrated by both the individuals treatment history and his or her recent acts or omissions, that the individual needs care or treatment to prevent further disability or deterioration and substantial probability that he or she will, if left untreated, lack services necessary for his or her health or safety and suffer severe mental, emotional, or physical harm that will result in the loss of the individual's ability to function independently in the community or the loss of cognitive or volitional control over his or her actions.*'

This provision allows intervention before deterioration to dangerousness narrowly defined.

Emergency detention can occur under this provision. Inpatient treatment is limited to 30 days but treatment can occur on an out-patient basis. If the out-patient treatment conditions are violated an additional 30 day in-patient commitment can occur. Involuntary administration of medication requires a separate hearing and 'order to treat' by the court. Prior to final hearing the county (in Wisconsin the commitment is to the county mental health agency, not a specific

institution) must provide a recommended treatment plan for goals, type of treatment and providers)

Assisted Outpatient Treatment (AOT)

Other states have gone to what can be classified as Assisted Treatment provisions on either an in-patient or out-patient basis or combination thereof. Generally speaking the criteria are those expressed in the Model Treatment Act of the Treatment Advocacy Center. There must be clear and convincing evidence that: a) the person has a severe psychiatric disorder; b) the person is chronically mentally ill; and c) likely to benefit from assisted treatment. Placement is to be in the least restrictive setting and there can be an initial placement in an in-patient setting for 30 days with out-patient placement up to 180 days. Services provided on an in-patient or out-patient setting can include medication, individual or group therapy, day treatment, educational and vocational training or activities, supervised living arrangements, AODA counseling etc.

There are many variations among the states as to the exact provisions of Assisted Outpatient Treatment. But the results are quite uniform and dramatic. Following Kendra's law in New York State arrests for AOT participants were reduced by 83%. Florida reported a 72 percent reduction in days spend in jail among participants from 16.1 days to 4.5 days. The Duke University study showed a decrease of 74% in arrests in participants with arrest rate 12% among participants compared to 47% for those who had services without a court order. There were similar reductions (44%) in these populations in harmful behaviors (physical harm to self or others or damage to property).

Similarly impressive reductions in hospital days and re-hospitalizations were demonstrated in a number of such studies. There is much more formal data from various studies that underscores the usefulness of assisted treatment but that data is too huge to document here. But it does exist with not only treatment/outcome implications, but vast accompanying fiscal savings as well.

In short, the fourth standard works in terms of earlier intervention (before 'smoke from the gun') with formal, supervised, mandatory follow-up treatment. Such treatment has demonstrated positive effects on reducing in-patient days over-all, re-hospitalization rates, arrests and days in jail, and harmful and violent behaviors. Compliance with treatment is enhanced and, most important, quality of life for participants vastly improved.

So what?

In his chapter on Criminalization of Persons with Severe Mental Illness in Kaplan and Sadock's Comprehensive Textbook of Psychiatry, Dr. Lamb points out the criminalization of the mentally ill has resulted from a number of interactive, complex issues. Suffice it to say that according to Dr. Lamb the number of persons in jails and prisons with severe mental illness was at least 360,000. The jails and prisons by default have become the largest mental 'hospitals' in the country.

The too harsh pendulum swing from overly vague *parens patriae* civil commitment criteria to imminent physical dangerousness narrowly defined has contributed in part to seriously mentally ill persons entering jails and prisons instead of hospitals. That certainly is not the entire cause of this tragic diversion but it is a part of the problem. Lack of resources of course is another huge contributor.

To the extent changing civil commitment criteria have contributed to the problem, certain remedies do exist. Rather than propose a model treatment act in its entirety (the Treatment Advocacy Center has such a model act) in my view the following elements need to be addressed in each of the 50 states as they update and revise their mental health acts. Some of the states

have, in my view, better statutes than other states and when taking into account these elements perhaps a search of the various state statutes can provide a 'best practice' example that other states can eventually use. These are the elements to be considered:

1. Voluntary admission is encouraged whenever possible.

2. There should be four basic criteria for detention and civil commitment:
   - Danger to self
   - Danger to others
   - Gravely disabled
   - "need for treatment" which can provide intervention before the standard for dangerousness narrowly defined is met. 44 states already have some such provision on either an inpatient or outpatient basis, or both and are generally referred to as Assisted
   - Treatment. The provisions of these 4th criteria vary and an effort to find the 'best' among them should yield the most effective, 'best practice' one.

3. Emergency Detention should be available to the court when reviewing a civil commitment petition; should be available to police in emergency circumstances when any of the four civil commitment standards above are pertinent; and should be available to clinicians familiar with the patient in emergency circumstances as well as the police.

4. Vigorous due process provisions should allow the patient to have counsel; detention periods before first hearing should be very short; period of time to final hearing should likewise be reasonably brief.

5. A separate procedure to determine the right to refuse treatment, except in emergency circumstances, should occur at the detention and final hearing.

6. There should be a formal provision for a stipulation that permits the patient, with counsel, to agree voluntarily to a treatment plan that may include outpatient appointments, adherence to the treatment plan that may include medication, supervised living arrangements, social work case planning, vocational rehabilitation and other such modalities. If there is compliance with the treatment plan at the end of the specified time the entire matter of civil commitment can be dropped so the patient can honestly say in the future that he or she has never been adjudicated mentally ill.

7. In those cases where civil commitment occurs, such commitment should be to a community based agency with responsibility for providing mental health services within whatever jurisdiction applies rather than to a specific hospital or institution. The community based service then accepts the case management responsibility and can transfer the patient to the appropriate treatment setting as treatment needs dictate.

8. Typically appropriation of funds for mental health services is done separately from the mental health act itself. I don't even know if it is possible but if there is some language that would require adequate funding, under some penalty or forfeiture, that could be inserted as a 'right to treatment' provision. (If there is a right to refuse treatment, there should be a corresponding right to treatment)

9. While not a civil commitment issue as such, the Institution for Mental Disease (IMD) provision often does interfere with making adequate bed space available for patients with major mental illness who do require an intensive care setting which cannot be provided in a comprehensive and safe fashion in a small, detached 16 bed unit in the community. There is a place for such units of that size perhaps, but as a supplement to, not in lieu of, some psychiatric beds specifically dedicated to 'intensive care' along the lines of that seen when caring for physical illnesses. The idea that these patients can be cared for in general hospital in-patient units simply doesn't hold up. Again, general hospital units are useful for certain patients, but the obviously ill, disruptive and sometimes dangerous patient exceeds the capability of these general hospital units. A better model is to have an 'intensive care' unit of whatever size needs to carry out these highly skilled and comprehensive treatment modalities in a best practice center of excellence. Repeal of the IMD exclusion would permit funding now prohibited to be appropriately channeled to these units. Those funds are being spent in IMD's already so this would simply be a redirecting of those assets.

This is merely a preliminary proposed menu, not the meal. I welcome input to the menu and suggestions as to how best to prepare the whole meal. Someone once said about a number of proposals that it is often handing a starving man a menu. Hopefully DDTT can gender enough resources after we prepare the menu to hand the 'starving' mentally ill some real substance.

Two valuable resources when looking a current state mental health acts are two items on the Treatment Advocacy Center website. These list and compare statutory provisions state by state:
"Know the law in your state"
"Assisted outpatient treatment laws"

TAC also does have very detailed Model Act