Broader Commitment Laws Sought

The American Psychiatric Association has a model law based on evident need for treatment; "potential dangerousness" is current criterion in most states

Last month a 19-year-old girl pushed a woman in front of the train at a Times Square subway station. She had been recently released by court order, against doctors' recommendations, from psychiatric treatment at Kings County Hospital Center. In Wisconsin recently a man barricaded himself in his house and sat with a rifle in his lap, muttering "kill, kill, kill." A judge ruled that the man was not demonstrably violent enough to qualify for involuntary commitment.

These types of episodes have contributed to a growing clamor for broader, more discretionary laws on involuntary civil commitment of the mentally ill. Civil libertarians claim these are exceptional cases which do not justify lowering the safeguards against inappropriate institutionalization. But many mental health professionals say they represent only the most visible aspect of a serious failure to compel treatment for those who are obviously incompetent to seek it.

Deinstitutionalization of the mentally ill, a process that began in 1955, has precipitated a large and growing social problem, the evidence of which is readily apparent in every large American city. There are an estimated 2 million to 3 million homeless individuals at any given time; of these, between 25 percent and 50 percent are mentally ill. All are clearly in need of more care than they are getting; some are clearly getting worse.

Should they be hospitalized (or, more often, rehospitalized)? If so, can they be effectively treated? Who should make the decisions? Will treatment do any good when there are no outpatient services for them once they are released?

Lawyers and psychiatrists have been battling over these questions since the early 1970's when, in response to activism by civil libertarians, reform of involuntary civil commitment laws swept the country. Due process procedures including right to counsel, right to treatment, and limited duration of stays were installed. At the same time, the vast majority of states also narrowed their standards for involuntary commitment, dropping the subjective criteria related to "need for treatment" and focusing on an individual's dangerousness to himself or others.

The changes have pretty much eliminated the grossest abuses: arbitrary commitments, "warehousing" with no treatment, and indeterminate hospital stays. But they have also resulted in a situation in many localities where it is extraordinarily difficult to get a person who is obviously psychotic and incompetent—and even overtly suicidal—admitted for care.

Families of the mentally ill and mental health professionals have been complaining about the situation for years. Now, to employ the oft-used metaphor, the pendulum is swinging back and there are moves afoot in most state legislatures to broaden commitment criteria.

Many states are attempting to follow the lead of the American Psychiatric Association's new model law on involuntary civil commitment proposed by Alan A. Stone, joint professor at the Harvard schools of law and medicine. The model statute would reduce the emphasis on police powers (potential dangerousness) as the main criterion by restoring the concept of "significant deterioration"—a version of the "need for treatment" standard abandoned in the civil rights sweep. Many states now include "gravely disabled" in their dangerousness criteria, which means that a patient can be committed if he is clearly incapable of tending to his physical needs. The significant deterioration standard would permit treatment of a person who was not yet, but likely to become, gravely disabled or dangerous. After much consultation with psychiatrists around the country, the latest version of the model statute, composed by Stone and lawyer Clifford D. Stromberg, was published in the September issue of *Hospital and Community Psychiatry*, along with criticism from a variety of commentators.

The debate between the espousers of the legal versus the medical model for commitment is taking on new urgency. According to psychologist Leona Bachrach of the University of Maryland, "it is safe to say categorically, based on local and anecdotal evidence, that the number of homeless is increasing very rapidly and the percentage of mentally ill among the homeless is also increasing rapidly."

This is occurring for a number of reasons. First, deinstitutionalization: although the numbers of long-term patients being released has dwindled in the past 10 years, the phenomenon continues at a rate of about 120,000 a year. A more potent contributor is demography: members of the baby boom generation (64 million people born between 1945 and 1961) have reached the age of risk for mental illness, and more and more young people, many of whom have never been institutionalized, can now be seen sleeping on grates, panhandling, and traveling aimlessly around the country ("Greyhound therapy" some call it). At the same time resources are diminishing. Federally funded service programs have been replaced by block grants to states, and few states put high priority on serving a politically powerless (and for the most part, harmless) population. State hospital funds are also decreasing as their populations shrink, and even voluntary patients are turned away for lack of beds. On top of this, low-cost housing is increasingly unavailable. Shervert Fra-

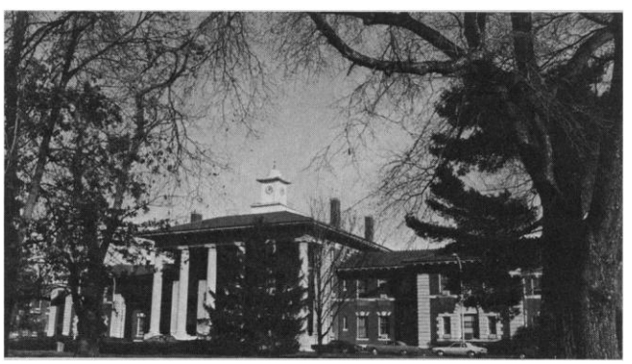
Constance Holden

Care of the homeless is a major issue.

zier, head of the National Institute of Mental Health, who calls homelessness "the social ill of the eighties."

Involuntary civil commitment, then, is a very small part of a very large problem. Nonetheless, the issue is one of great theoretical importance in determining where the law ends and psychiatry begins (or vice versa).

The spectrum of opinion is represented on one end by the Mental Health Law Project, creator of a 1970 model law, which contends that abuses can be curbed only by allowing judges to decide on commitment using objectively verifiable criteria (chiefly, dangerousness). On the other side are psychiatrists who contend that the lawyers want to "criminalize" mental illness and are more concerned with patients' legal rights than their best interests.



St. Elizabeths hospital in Washington, D.C.

Both sides attribute the narrowest motives to each other: Wisconsin psychiatrist Darold Treffert, head of the Fond du Lac County Health Care Center, characterizes the lawyers' stance as allowing the mentally ill to "die with their rights on." The civil libertarians, in turn, accuse psychiatrists of professional arrogance and overreaching.

In fact, though, the debate is not as polarized as it used to be, according to Leonard Rubenstein of the MHLP. Rubenstein is heavily critical of the APA model statute's commitment criteria and due process provisions, but he is not claiming that the system will regress to pre-1970's days. While the civil libertarian agenda used to be nothing less than the eradication of mental institutions, they are now acknowledged to be necessary, but Rubenstein fears already-overloaded hospitals will be swamped if broader criteria are adopted. Even now, "people are being committed to the waiting rooms at Bellevue." But more important, he contends that "in many cases hospitalization is not the proper intervention." Outpatient treatment is almost always preferable to institutionalization, he says, and if none is available, many people are better off left in the streets than committed. (Although some researchers have claimed that most hospitalized mental patients would be better off with outpatient care, there are no data on how many would be better off with no treatment at all.)

Other mental health advocacy groups, such as the National Mental Health Association, oppose the model law on the grounds that it will reinforce the hospital system. What has happened since 1955 is that the patients have become deinstitutionalized but the money has not. More money to state systems, compelled by larger patient loads, will mean even less for community outpatient facilities. David Goodrick of the Alpha Center in Washington, who formerly headed the Wisconsin Office of Mental Health, maintains that a strict commitment law has, in effect, a technology-forcing element in that it compels states to be more creative in devising alternatives to hospitalization.

Another view is represented by Ingo Keilitz, director of the Institute for Mental Disability and the Law at the National Center for State Courts in Williamsburg, Virginia. "The two warring camps are at each others' throats," he says, and the battle is being fought largely on abstract, philosophical grounds. Keilitz and others contend that the wording of commitment law is almost irrelevant because of the enormous discretion allowed to judges. He is promoting what he calls a third, "common sense" approach which entails developing procedural guidelines for civil commitment. Keilitz claims that 90 percent of civil commitment cases are resolved before they ever reach a judicial hearing; therefore the focus should be on developing a community-based screening system (rather than relying on one or two physicians), and seeing to it that decision-makers are thoroughly informed about the range of available treatment facilities.

The people the most intimately involved with the mentally ill are their relatives, who have been coming together in a fast-growing and increasingly powerful lobby group, the National Alliance for the Mentally Ill, which is mainly active through state groups. According to William Snavely, president of the Northern Virginia alliance, "the issue has arisen largely because of inadequate community capability." Like many family members, Snavely is not particularly concerned about the right of the psychotic not to be treated and he thinks the model law should be extended to involuntary outpatient treatment as well.

In fact, involuntary outpatient commitment is a little-used resort (although many judges could order it if they wanted to) and may hold promise in localities where the services exist. North Carolina and Hawaii recently passed laws to that effect, but developments are too recent for evaluation. Civil libertarians are ambivalent on the issue. As Rubenstein points out, outpatient treatment is appropriate as a "least restrictive alternative" if the criteria for commitment are the same as for inpatient commitment. But if a looser standard is adopted, that raises a host of new issues—involuntary medication being the primary sticking point. Stone himself is adamantly opposed to mandating outpatient treatment, which he believes raises the spectre of the "therapeutic state."

The psychiatric association has a task force looking into the matter, however. And psychiatrist Loren Roth of the University of Pennsylvania says "some form of involuntary commitment in the community—with adequate safeguards—is proper and probably inevitable if deinstitutionalization is to be maintained." But there is very little experience with it and no data.

The absence of compelling documentary support for any position is, in fact, one of the most striking aspects of the overall dilemma. Proponents of various positions usually claim the existence of some study or other to back them up, but the fact is, as Richard Wyatt of NIMH has eloquently argued, deinstitutionalization is an example of a major social experiment embarked on with no preparation and no research to guide it. Now there is little information on how well it has worked. There are no quantitative data on how many people ought to be hospitalized but are not, which enables Rubenstein to say there is no evidence that the problem is a major one and Stone to say the evidence is everywhere. Political liberals claim the evidence shows outpatient care is almost invariably preferable to inpatient care—but it is impossible to ascertain how many

"outpatients" have been lost to treatment altogether. Besides, as Wisconsin psychiatrist Robert Miller of the Mendota Mental Health Institute points out, treatment "in the community" may be quite the opposite for individuals whose home circumstances triggered their illnesses.

There are other unsubstantiated or unsubstantiable claims: Rubenstein, for example, says "where decent treatment is available people come in droves." But even in Wisconsin, which probably devotes a higher share of its resources to community-based treatment than any other state, the problem is such that several bills are pending to broaden the state's involuntary commitment law. Then there is the matter of whether more commitments would swamp hospitals. Although most observers believe they will, Treffert claims that if people are committed in the early stages of their illness (before they become dangerous or "gravely disabled"), hospital stays will be shorter and the overall institutionalized population will not increase.

Whether or not psychiatrists alone should be called on to say who should be committed is, of course, another topic of debate. But even Rubenstein will admit that psychiatrists are probably more competent than judges to predict the clinical course of a mental disorder. Ironically, dangerousness is a subject on which it is generally agreed that no one is very good at predicting. Miller, who favors broader commitment criteria, says dangerousness "is an absolutely irrelevant concept to the treatment of the mentally ill . . . an artificial standard, and a bizarre way to ensure treatment." Miller, who works with both criminal and civil mental illness cases, says the dangerousness criterion has skewed the civil population so that the institutionalized are more dangerous than the rest of the population but not necessarily mentally ill by legal definition (that is, psychotic). Moreover, he says the narrow standard has led many police to do criminal "mercy bookings" of sick people in order to get them institutionalized.

Much of the criticism of the APA model statute stems from frustration over the absence of a range of treatment options. But, as Stone points out, the intent of the law is not to force changes in the system but rather to rectify to a small degree policies on commitment which are widely perceived to be inadequate. Stone says no one can make the states put more resources into community facilities, and judicial orders to that effect have made little difference. Miller agrees: "there are only two changes that have dramatic impact on commitment practices," he says. One is the formation of an active cadre of mental health law attorneys, which has been shown to be very effective in keeping commitments down in places such as Manhattan. The other is compelling counties to pay for hospitalization—as is the case in Wisconsin—which forces them to develop less costly community-based alternatives.

A trend toward increasing numbers of civil commitments seems likely for the foreseeable future. That trend is being reinforced by federal and Supreme Court cases of recent years that have reasserted the parens patriae role of the state in treating a patient for his own good. And it is inevitable so long as states fail to develop treatment networks to supplement hospital systems, and insurance carriers—particularly Medicare and Medicaid—provide only marginal subsidies for outpatient care. APA president Carol Nadelson believes the proposed statutory changes are needed, but acknowledges that they are powerless to affect the trends: "I hate to say this, but that's the way we're going."

—CONSTANCE HOLDEN

New University-Industry Pact Signed

A "joint collaboration" establishes an institute for basic neuroscience research at Georgetown, supported by an Italian drug company

Despite the enthusiasm of 3 to 4 years ago for joint research ventures between industry and academia, relatively few such arrangements materialized on a large-scale. Now, an Italian drug company, FIDIA S.p.A., has made a major financial commitment to support the FIDIA–Georgetown Institute for the Neurosciences. The institute is a joint collaboration between the FIDIA Research Foundation and Georgetown University, with Erminio Costa as its first director.

According to John Rose, vice chancellor of the Georgetown University Medical Center and a member of the board of directors of the institute, it was agreed that "this would be an institute devoted to basic research, to the discovery of fundamental mechanisms in the brain, without commercial objectives, and that the work would be published freely in the scientific literature, and that the ethical and scientific guidelines of the university would be observed. . . . " Rose made his comments at a recent press conference held on the Georgetown Medical Center campus.

The FIDIA–Georgetown Institute will receive $3 million a year (adjusted annually for inflation) for 20 years, putting it in the same financial league as the Hoechst AG agreement with the Massachusetts General Hospital and Harvard University. The money comes from FIDIA S.p.A., is channeled through the nonprofit FIDIA Research Foundation, given to the FIDIA–Georgetown Institute, which then dispenses it to Georgetown. Carl Pergler, who is president of the FIDIA Research Foundation and manages the transfer of funds from it, says that this arrangement provides for a "double shielding" of the money through two not-for-profit organizations.

The FIDIA Research Foundation was created in the spring of 1985, preceding its agreement with Georgetown to establish the FIDIA–Georgetown Institute for the Neurosciences. It was essential to Georgetown that all of the arrangements involving the institute be conducted with a nonprofit entity disassociated from the parent pharmaceutical corporation. Another incentive for setting up the institute this way was to satisfy the District of Columbia's zoning authorities. According to Frank Standaert, chairman of the Department of Pharmacology at Georgetown and a member of the board of directors of the institute, the zoning council had to be convinced that research sponsored by the institute would be noncommercial and in keeping with the traditional academic roles of the university. Creating the nonprofit foundation as a collaborative partner for Georgetown helped satisfy these criteria.

The idea for the institute began with Costa and Francesco della Valle, direc-