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A Descriptive Study of Commitment Practices in a Selected Jurisdiction

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A DESCRIPTIVE STUDY OF COMMITMENT PRACTICES IN A SELECTED JURISDICTION

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ABSTRACT

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PRACTICES IN A SELECTED JURISDICTION

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This study examines the application of commitment procedures in one urban community in Virginia. The study investigated: the concordance rates of clinical recommendation for treatment and the outcome of the commitment hearing, the time lapse between detention of an individual and the hearing outcome, the presenting symptomatology and outcome, and the pre-detention compliance to treatment and outcome. The study's findings showed a concordance rate of 64% between clinical recommendation and outcome. It provided no significant differences in symptomatology/outcome, compliance/outcome, and time lapse/outcome. The lack of any significant findings seems to suggest that application of commitment laws might benefit from institution of clearer guidelines. In addition, a more meaningful outpatient commitment law in Virginia might facilitate a "least restrictive alternative" for the chronically mentally ill population.

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CHAPTER 1

INTRODUCTION

Court battles and controversy flourish across the country surrounding civil commitment of the mentally ill person. Resulting court decisions have established the patient's rights to treatment, to refuse treatment, and to the least restrictive environment (Klerman, 1990). Dissatisfaction with current standards and procedures for civil commitment persists and numerous proposals for reform have been introduced (Appelbaum & Roth, 1988). Are current civil commitment standards inadequate or is it the implementation of these standards which are inadequate?

The chronically mentally ill (CMI) is a grouping of diagnostic categories including: Schizophrenia, Schizoaffective Disorders, BiPolar Disorders, and in some cases, Personality Disorders. In 1984, Goldman estimated that there were two million chronically mentally ill people in the United States, less than half of whom were institutionalized. Today, it is estimated that one out of 100 people in the United States is mentally ill (Sage, Jr., 1990). In Virginia the mentally ill population is estimated at nearly 1

million people (Shepard, 1990). In the city where this study was undertaken, the public mental health system served an estimated 700 CMI persons as of June 1989. During the period from July 1988 through June 1989, there were 394 persons detained for possible commitment.

Chronic patients are considered difficult to treat for a variety of reasons. Most of them belong to the lowest socioeconomic groups and are undereducated, unskilled, socially isolated, and engage in treatment only in crisis or emergency situations (Chacko, 1985). These crisis situations involve the patient and his/her primary living group and are usually the last of a series of social systems crisis between environmental forces, social systems conflict and individual problems.

Since the early 1960's, the federal government has initiated a plan that transferred the care of the mentally ill from long term, hospital in-patient care to short term stays and return to community mental health centers due to the advent of new, more effective drug treatments capable of stabilizing some of the more chronic mental illnesses (Baker, 1989). The emphasis of community-based programs has been to assist psychiatric patients to adjust to the community (Joyce,

Staley, & Hughes, 1990). Public policy, as well, firmly encourages community-based services and provides a broad range of programs designed to meet the needs of CMI individuals in community settings (Scallet, no date). These programs included: financial, health care, social services, mental health care, legal services, housing, food, rehabilitation.

Community mental health programs' ultimate goal is primary prevention of mental and behavioral disorders (Costin & Draguns, 1989). This goal involves three main functions: (1) intervening as early as possible in the crises that affect people's adaptive thinking and behavior; (2) helping clients to recognize their strengths; and (3) seeking to make changes in the social organization of the community and the broader society to alleviate the conditions that contribute to mental and behavioral disorder (Bloom, 1980).

With the trend toward deinstitutionalization of the CMI, the tightening of statutory commitment criteria occurred to make it more difficult to place people in institutions and to keep them there, and to improve the capacity of institutions to provide services enabling patients and clients to return to, and live successfully in, the community (Bonnie, 1986). Other changes in law and procedure affecting

the care of the chronically mentally ill include the limited implementation of a constitutionally based right to treatment and the partial recognition of a right to refuse treatment (Lamb & Mills, 1986).

Court decisions supporting the right to refuse treatment have rested primarily on constitutional arguments that the involuntary administration of medication violates the patient's bodily integrity and personal autonomy (Schwartz, Vingiano, & Perez, 1988). Furthermore, the courts presume that treatment refusals are made autonomously and therefore require due-process protection. Protection of these rights at the expense of the patient's needs seems to many to fly in the face of clinical realities and may leave psychotic patients who refuse treatment "rotting with their rights on" (Appelbaum & Gutheil, 1980).

The understanding of autonomy differs greatly between the legal and clinical perspective. Legal interpretation takes the patient's stated wishes and assumes that such statements are accurate reflections of the patients true intent. Autonomy from a clinical perspective places highest value on the patient's actual intent or meaning, which may be different from what he says at any point in time (Schwartz et al, 1988).

In day-to-day practice with patients, their families, and their crises, there clearly exists a serious gap in civil commitment laws in the United States for patients who are obviously psychotic, in need of and likely to benefit from treatment, but not yet deteriorated to the point of being dangerous (Treffert, 1985). Drug noncompliance remains a leading cause of schizophrenic relapse--68% in the first year post discharge (Hogarty, Schooler, Ulrich, Mussare, Herron, & Ferro, 1979). The chronically mentally ill during periods of severe crisis usually lack the capacity to make an informed decison concerning treatment because of their illness (Treffert, 1985). While legal changes have by no means been the sole cause of the problems of implementing deinstitutionalization, they have certainly contributed to the current problems encountered by the chronically mentally ill and the stress of caring for these individuals. "Amidst the flurry of high court opinions, with their reliance on abstract principles of constitutional and state law, it is all too easy to lose sight of the human issues at stake" (Appelbaum, 1983). Courts have increasingly insisted that treatment refusal is a judicial rather than clinical issue in establishing the right to refuse treatment

(Schwartz et al, 1988). When due-process protections are extended at the expense of treatment, patients may be placed at significant risk (Schwartz et al, 1988). It is imperative that service and legal systems be designed that allows for and encourages support of both the rights and the needs of mentally disabled patients (Ziegenfuss, Jr., 1986).

STATEMENT OF THE PROBLEM

Protection of minority rights began in the 1950's. Shortly thereafter, in the 1960's deinstitutionalization of the chronically mentally ill patient started. To protect this populations' rights there were changes in the commitment laws to make it more difficult to involuntarily place an individual in the hospital. While these changes were designed to protect these individuals, the result has been no treatment as denial of the illness and noncompliance with treatment is common.

PURPOSE OF THE STUDY

The purpose of this study was to examine the current criteria of the Virginia civil commitment law and how this law is implemented.

JUSTIFICATION FOR THE STUDY

This study provides a descriptive assessment of the occurrence of inability to access treatment for the chronically mentally ill clients who are in need of treatment. With the possibility of severe consequences as a result of lack of treatment for this population, legal and clinical standards must be developed and instituted to protect both the rights and needs of the chronically mentally ill person.

ASSUMPTIONS

The following assumptions are present in this study:

1. An accurate assessment of the client's mental status/behavior was presented on the prescreening form.
2. The prescreening form was available and used during the commitment hearing.

DELIMITATIONS

The following delimitations are present in this study:

1. The sample was secured from a specific population of mentally ill clients.
2. The sample included only adults, age 18 or

older.

3. The sample was limited to those who met the DSM-III/IIIR classification of major mental illness.
4. The sample was taken from those who had a temporary detaining order (TDO).

LIMITATIONS

The following limitations are present in this study:

1. Information was obtained from the prescreening form.

DEFINITIONS

1. Civil law--used to distinguish that part of the law concerned with noncriminal matters (Guido, 1988).
2. Chronically mentally ill--those with organic brain syndrome, schizophrenia, depressive and manic-depressive disorders, paranoid and other psychoses, plus other disorders that may become chronic (Goldman,1983).
3. Commitment--legal procedure of admitting a mentally ill person to an institution for psychiatric treatment (Ford, 1987).

4. Compliance--the extent to which a person's behavior coincides with medical or health advice (Haynes, Taylor, & Sackett, 1979).
5. Deinstitutionalization--transfer of care of the mentally ill from hospital to community mental health centers (Baker,1989).
6. Denial--a refusal to believe or accept (Webster's, 1966).
7. Parens patriae--the state's duty to protect citizens who cannot protect themselves (Stuart & Sundeen, 1988).
8. Treatment--medical, surgical or psychiatric management of a patient (Taber's, 1963).

CHAPTER 2

REVIEW OF LITERATURE

This chapter will provide a review of the literature regarding the treatment of the mentally ill population from ancient times to the present. It will overview the prevailing social, political and legal issues that has influenced the treatment of this unique population. With no other illness can one so clearly see the impact of legal issues determining the course of treatment.

It is estimated that 1 out of 100 people in the United States is mentally ill (Sage, Jr., 1990). In Virginia alone, almost one million adults suffer from one or more mental illnesses (Virginia Alliance for the Mentally Ill, 1990). While there is no cure for mental illness, many can be controlled on antipsychotic medication. Drug non-compliance, however, remains a leading cause of schizophrenic relapse. The individuals right to refuse medication has been upheld in the courts. As a result, court action by mental health professionals is not uncommon in their attempts to obtain treatment for this population.

HISTORY

Mental illness. Historically, prevailing beliefs of the society determined not only how the mentally ill were viewed but also governed the laws that dealt with their treatment (Moffett, 1988). In ancient times the mentally ill individual was believed to be possessed by demons and that the illness was imposed as punishment by supernatural beings; treatment methods were bizarre and often brutal (Moffett, 1988). At the time of Hippocrates and during the Roman era, mental illness gradually came to be regarded as primarily a medical problem rather than a religious problem; treatment consisted of a soothing environment (Moffett, 1988). Mental illness was again considered to be the result of possession by devils during the Middle Ages: treatment consisted of exorcism by various elaborate ceremonies (Moffett, 1988). In the 1400s in England individuals confused and disorderly were perceived as outcasts and a special institution was established to house them--Bethlehem Royal Hospital, or "Bedlam" (Levine, 1989).

In 17th century England, Lord Coke summarized the laws of insanity and classified individuals who were to be considered not of sound mind, and so, not legally responsible, or non compos mentis, into four types: the idiot or natural fool; he who was of good and sound memory, and by the visitation of God has lost it; lunatics who are sometimes lucid and sometimes non compos mentis; and those who by their own acts deprive themselves of reason, such as the drunkard (Brakel & Rock, 1971). In colonial America laws dictated the treatment of the mentally ill person. They were classified in two ways: violent or indigent. The violent individuals were treated as common criminals in jails while the indigent were governed under the settlement laws that penalized paupers and vagabonds who were often left wandering the countryside homeless. Communities began to deal with mental illness in a more organized way at the end of the 18th century and beginning of the 19th century. As the community was concerned only with the violent or indigent insane and there were no commitment laws, they were easily placed in poorhouses or jails (Moffett, 1988).

In May 1751, in response to a petition by Benjamin Franklin, the Pennsylvania Assembly authorized the establishment of the first general hospital to receive and cure the mentally ill. It was the only hospital in the country until 1824, when the Eastern Lunatic Asylum was established in Lexington, Kentucky (Brakel & Rock, 1971). Early in the 19th century, Benjamin Rush and others advocated for moral treatment of the insane with the belief that mental illness could be cured or treated rather than punished. Resocialization of the individual within an institution was advocated and a few asylums were established to institute this type of treatment. With this belief of a possible cure and the crusade of Dorothea Dix for humane care of the mentally ill, the establishment of public facilities for the care of the mentally ill began (Monahan, 1976).

"The establishment of public facilities represented a change in governmental policy, with acceptance by the government of broad responsibility for the mentally ill. Public institutions could not be selective in their admission policies, and within a short period of time, bed capacities were exceeded and patient turnover was almost nonexistent. State institutions became, for the most part, custodial

rather than therapeutic. During this period of rapid growth of public institutions, a concern for the rights of individuals who had been committed to these institutions developed, though there was more concern for protecting sane indiviuals from wrongful commitment than there was concern over the rights of the mentally ill." (Moffett, 1988)

The civil rights movement of the 1960s and the growth of public legal servies in the 1970s significantly changed American attitudes concerning the rights of the mentally ill. The mentally ill, as other minority groups had done before, began to assert their right to equal protection and decent treatment under the law (Weiss, 1990). Also at this time, society grew intolerent of the prevalent degrading conditions in many of the public mental institutions (Weiss, 1990). This protest movement, along with the advent of psychotropic medication, resulted in the deinstitutionalization effort. This effort was intended to humanize the delivery of psychiatric servies for the mentally ill population (Bachrach, 1982).

Laws. One of the earliest legal references to the mentally ill can be found in the Twelve Tables of Rome, 449 B.C. These laws as well as those of 17th

century England dealt with conservatorship of property and of the person, and provided for jury trial and custody of the individual while sanity was being determined (Brakel & Rock, 1971).

At the time public facilities were being established to house the mentally ill in this country, a number of states enacted strict commitment laws that included a right to jury trial. It is felt that this approach contributed to the stigma attached to mental illness since it utilized a criminal-judicial model and promoted the public's identification of civil commitment with the criminal justice system (Monahan, 1976). After World War II model statutes were drafted permitting commitment based solely on psychiatric certification rather than on judicial procedure which placed a great deal of power in the hands of psychiatrists and hospital administrators (Moffett, 1988).

With deinstitutionalization, commitment laws underwent another change. Before 1970 civil commitment criteria in all of the states were vague and loosely defined; they overemphasized parens patriae powers and easily invoked police powers (Treffert, 1985). California's new and unique civil commitment law, the Lanterman-Petris-Short Act, went

into effect in 1969; within a decade every state and Puerto Rico modified their commitment code to make similar changes (Lamb & Mills, 1986). The changes encompassed three areas: (1) commitment criteria; (2) duration of commitment; (3) provided civilly committed persons access to the courts, public defenders, and, in some cases, jury trials. In Wisconsin, the Lessard v. Schmidt (1972) case also provided impetus for changing commitment criteria.

Also in the last decade other changes affecting the character of psychiatric treatment has been the reshaping of the laws regarding the rights of mental patients (Herr, Arons, & Wallace 1983). These changes have included the right to treatment as well as the right to refuse treatment.

Court cases. The Eighth and Fourteenth Amendments have been the foundation for many cases establishing the right to mental health treatment (Alexander, 1989). In Robinson v. California (1961) the court addressed and conceded on three issues: (1) the state cannot punish an individual for a status or illness; (2) the state can forcibly treat an individual whose illness is threatening to society; (3) the only constitutionally justifiable reason for an individual who has an illness and is confined in a

state mental institution is to get treatment. "Without treatment, the individual is being punished--by the deprivation of his or her liberty--for having a particular illness or status." (Alexander, Jr., 1989) Several subsequent cases have also upheld the right to treatment decision: Rouse v. Cameron (1966); Wyatt v. Stickney (1971); Youngberg v. Romeo (1982); Ohlinger v. Watson (1980); Goodwill v. Cuomo (1984).

While some courts were deciding on right to treatment, others were conceding a person's right to refuse treatment. In 1975 the Supreme Court cast significant doubt on a constitutionally derived right to treatment in the case of O'Connor v. Donaldson (Lamb & Mills, 1986). In 1983 the case of Rogers v. Commissioner conceded that committed patients have the right to refuse medication on a routine basis but does provide that a patient may be medicated during emergencies (Lamb & Mills, 1986). More recently, in 1987, the city of New York tried unsuccessfully to treat a homeless individual against her will--the case of Billie Boggs. Another recent court case supporting the right to refuse treatment is Rivers v. Katz (1986).

Virginia civil commitment history. "Civil commitment in Virginia has been a judicial procedure from pre-Revolutionary times until the present. The first statute, enacted in 1794 and entitled An Act to Make Provision for the Support and Maintenance of Idiots, Lunatics and Other Persons of Unsound Mind, was directed primarily at persons wandering about the colony without means of support or family or friends willing to take care of them. Mental health treatment was not medical in nature. The judge committed patients as he saw fit, his discretion unfettered by statutory standards of commitment or procedural requirements, and uninformed by medical testimony. The hospital at Williamsburg had discretion to turn away or discharge patients who had been committed. Some of the overflow from the hospital became the charges of the local overseers of the poor.

By 1899 the medical profession had gained a prominent role in commitment, as the aims of that process became more paternalistic. Commitment was ordered by a commission composed of one judge and two physicians. For a brief period after that commitment could be achieved just by the 'certification' of a physician, a practice still followed in New York and other states.

The 1973 Virginia law required a judicial commitment hearing but its procedures were informal by today's perspective. The criterion of indeterminate, and often life-long, commitment was whether there was 'sufficient cause to believe that such person is or may be mentally ill.'

In 1974, Virginia, in response to successful constitutional challenges of similar commitment laws in other states, began to reshape commitment along more libertarian, criminal justice lines.

The standard of commitment became that of 'dangerousness'. The procedures came to resemble those of a criminal trial.

By the late 1970's appellate courts, including the United States Supreme Court began to give state legislatures signals that commitment could be less adversarial and more dependent upon expert opinion. And about this time the social problems of the homeless mentally ill began to emerge. These factors have led to a recent re-examination of the commitment process in most state legislatures. One proposal for de-judicializing civil commitment is that of the American Psychiatric Association." (Spaulding, 1989)

The principle stages of the commitment process in Virginia are: detention, preliminary hearing, involuntary commitment hearing, and possible admission (Spaulding, 1989). Spaulding summarizes the standards to the commitment procedures as follows:

"The provisions of a civil commitment statute can be divided into standards and procedures. The procedures are intended to assure fair and accurate enforcement of the standards. The standards express the goals of the commitment process, confine the discretion of the decision makers in the process, permit review of their actions on appeal, give notice to the public of behavior that may serve as the basis for commitment, prevent the commitment process from being applied in an overly broad manner to eccentric but legitimate conduct, and enforce legislative preferences regarding the use of the civil commitment proccess and state mental health resources.

While there is a widespread belief (which may in some places be reflected in practice), that the commitment standard is one of dangerousness, there are many statutory standards in the commitment process. The relevant standards can only be determined by reference to particular points in the commitment process.

Each commitment standard bears a conjunctive or disjunctive relationship to other standards. For example, the standards for involuntary hospitalization require mental illness and either imminent dangerousness to self or others because of mental illness or inability to care for self because of mental illness.

Many commitment standards are open-textured, in the sense that they permit the decision maker widely varying degrees of discretion in defining as well as applying the standard. For example, the court in applying the standard of imminent dangerousness to self or others is also giving that standard an operational definition that reflects the court's and community's values, and the equities of the particular case, and well as the broad legislative policies expressed in the statute. Open-textured standards also offer an opportunity for advocacy to influence the outcome of the commitment process, as long as they are not so vague as to give neither the advocate nor the decsion maker any guidance at all."

Effective July 1, 1990, the Virginia general assembly amended the code relating to the involuntary detention of persons believed to be mentally ill. According to Spaulding, the changes included: 1)

authorization of an emergency custody order not to exceed four hours whereby an individual could be evaluated; 2) extension of the temporary detention period from 72 to 96 hours; 3) requirement for the prescreening evaluation of an individual be done face to face by an authorized representative of the CSB.

The Community Service Board (CSB), which is the local agency responsible for mental health, mental retardation and substance abuse programs, has been tasked by Virginia statute to ensure reports needed for the commitment hearing are present as well as have to provide input for least restrictive alternatives to involuntary hospitalization. In the community where this study was undertaken, the mental health services program has been designated by the CSB to perform this function.

CONCLUSION

With the shift in treating the mentally ill person from the hospital to the community--deinstitutionalization--the delivery of psychiatric care has undergone tremendous change. These changes have been brought about in part from legal reforms since deinstitutionalization. Legal reforms were designed to protect the rights of the mentally ill,

including stricter commitment laws. In Virginia, as in other states, dangerousness is one of the criteria for commitment. However, it is not the only criteria in Virginia. While inability to care for oneself is also a criteria and frequently cited on the preadmission screening report, it is questionable if it is used by the court to involuntarily place a mentally ill person in the hospital for treatment.

Previous studies (Scheff, 1964; Cohen, 1966; Wenger & Fletcher, 1969; Wexler et al, 1971; Fein & Miller, 1972) suggest a high concordance rate (96.1% to 100%) between clinical recommendation to the court and outcome of the commitment hearing. These studies were conducted before or at the beginning of the deinstitutionalization movement. The literature suggests that reform of present commitment criteria is needed as treatment of the mentally ill individual is not being accomplished by current standards. Are these recommendations for reform based on outdated information?

CHAPTER 3

METHODS

This chapter provides a discussion of the methods to be used in this study. The topics include the research questions, selection of the sample, selection of the instrument, description of the instrument and protocol for the study.

RESEARCH QUESTIONS

The purpose of this study was to assess the application of the commitment law among the chronically mentally ill population of a urban community in Virginia.

There were five research questions generated:

1. What was the percentage of agreement of clinical recommendations to treatment and the outcome of the commitment hearing?
2. What was the percentage of agreement of clinical recommendations to treatment and outcome of the commitment hearing by presiding justice?
3. Did presenting symptomatology differ between committed and non-committed persons?

4. Did pre-temporary detaining order compliance differ between committed and non-committed persons?
5. Are there significant differences in the outcome of the commitment hearings as a result of the time lapse between the detaining of an individual and the hearing?

CLINICIAN

A mental health clinician is responsible for completing the prescreening form on all individuals being considered for admission to a state facility. A clinician is one who is experienced in the assessment and treatment of mental illness. These professionals include, but is not limited to: psychiatric nurse, social worker, psychologists.

INTERRATER RELIABILITY

According to Polit and Hungler (1983), interrater reliability is estimated by having 2 or more trained observers watching some event simultaneously, and

independently recording the relevant variables according to a predetermined plan or coding system (p.392). For this study, 5 clients were used for interrater reliability. These 5 clients were assessed by using the preadmission screening form. Both raters were clinicians, one a psychiatric nurse and the other a social worker.

PEARSON'S PRODUCT MOMENT CORRELATION

Polit and Hungler (1983) stated that the purpose of the Pearson's product moment correlation is to test that a correlation is different from zero (i.e. that a relationship exists) (p. 525). The Pearson *r* statistic is both descriptive and inferential. A correlation coefficient is an index whose values range from -1.0 for a perfect negative correlation, through zero for no relationship, to +1.0 for a perfect positive correlation. The higher the absolute value of the coefficient, the stronger the relationship. For most variables of a social or psychological nature, an *r* of .70 is quite high (Polit & Hungler,1983).

Pearson's product moment correlation was used to test the reliability of the preadmission screening form used in this study. The correlation coefficient was an *r* of 0.67.

SELECTION OF SAMPLE

Setting. The setting for the study was an urban community in Virginia. The magistrates of the community were the individuals who issued a temporary detaining order upon a petitioner, in sworn testimony, presenting probable cause of mental illness, and in need of hospitalization. The local mental health agency was responsible for ensuring the preadmission screening form was available for the commitment hearing on commitment defendants residing within their catchment area.

Subjects. From the preadmission screening form, information was obtained on 87 adult persons who were detained from July 1990 to September 1990. Only those who had a diagnosis of a major mental disorder were included in the study. A total of 87 preadmission screening forms were reviewed. While all the subjects had a major mental disorder, they were not excluded if they carried other diagnosis as well.

Human subjects issues were not a factor in this study as no identifying information of individuals was obtained and results were presented in an aggregate manner. In addition, no direct contact was made with any of the detainees.

INSTRUMENT SELECTION

The preadmission screening form (see appendix A) was used to obtain the information under investigation. This form has been devised by the Department of Mental Health in Virginia and to be completed by qualified professionals designated by the Community Servies Board for individuals who have been found to meet criteria for voluntary or involuntary admission to a state psychiatric hospital. The form is divided into six sections which include: personal data, clinical assessment, documentation of need for voluntary or involuntary hospitalization, legal data, current or previous treatment history, treatment and discharge planning.

The clinical assessment section has a list of symptoms and behaviors. The clinician filling out the preadmission screening form checks off the symptoms and/or behaviors displayed by the client at the time a TDO is sought.

Section III, documentation of need for voluntary or involuntary hospitalization, consists of three choices the clinician can make regarding treatment recommendation. Three choices are available: involuntary hospitalization, voluntary hospitalization, outpatient treatment.

PROTOCOL

All preadmission screening forms for the months of July through September 1990 who met the study criteria were reviewed. The information under investigation obtained included: age and sex from section I; symptoms and behaviors from section II; clinical recommendation from section III; compliance from section V. Outcome and special justice information was obtained from the Court Form: Alternatives to Hospitalization/Court Hearing form (see Appendix B).

SUMMARY

This chapter reviews the research questions and discussion of the sample selection, instrument selection and protocol for the study.

CHAPTER 4

ANALYSIS OF RESULTS

The purpose of this study was to assess the application of the commitment law among the chronically mentally ill population of an urban community in Virginia. Chapter 4 presents an analysis of the procedures to this end. This chapter is divided into 5 sections:

1. Discussion of Sample Characteristics
2. Demographics
3. Discussion of Instrument Reliability
4. Discussion of Research Questions
5. Summary

SAMPLE CHARACTERISTICS

The participants of this descriptive study were obtained from the preadmission screening forms of an urban community mental health agency. All individuals who were prescreened and met the criteria of the study were included in the study. A total of 87 preadmission screening forms from July through September 1990 were reviewed which met the study criteria of having a major mental diagnosis. Individuals were not excluded if they carried other diagnosis as well.

DEMOGRAPHICS

There were 87 cases reviewed in this descriptive

study of which 45 were male (51.7 percent) and 42 were female (48.3 percent). Data provided by the prescreening forms indicated that the median age for an individual was 35 and the mode was 27. The ages ranged from 19 to 82. A substantial percentage, 52.9 (N=46), tended to be white; 19 (21.8 percent) were black. They were generally single, 41 (47.1 percent), with only 18 (20.7 percent) being married. Twenty (23.0 percent) were not employed (those who do not work) and 25 (28.7 percent) were unemployed (those who were out of work temporarily). The employment status of 36 (41.4 percent) cases was unknown. Hospitalization data indicated the following: 20 (23 percent) with none; 14 (16.1 percent) with medicaid; 13 (14.9 percent) with medicare; 12 (13.8 percent) with private; 4 (4.6 percent) with champus. The characteristics are presented in Table 1.

DISCUSSION OF INSTRUMENT RELIABILITY

The purpose of this descriptive study was to examine the current criteria of the Virginia civil commitment law and how this law is implemented. The prescreening admission form is currently required to be completed for all individuals who have been found to meet the criteria for voluntary or involuntary admission to a state psychiatric hospital. This form

TABLE 1

Characteristics of Detained Individuals

Characteristic	N	%
Sex		
Male	45	51.7
Female	42	48.3
Race		
White	46	52.87
Black	19	21.84
Other	5	5.75
Unknown	17	19.54
Age		
19-29	32	36.78
30-39	26	29.88
40-49	14	16.09
50-59	6	6.90
60-69	3	3.45
70-79	3	3.45
80-89	1	1.15
Unknown	2	2.30
Marital Status		
Single	41	47.1
Married	18	20.7
Divorced	12	13.8
Separated	6	6.9
Widowed	2	2.3
Unknown	8	9.2
Employment Status		
None	20	22.98
Employed	5	5.75
Unemployed	25	28.74
Retired	1	1.15
Unknown	36	41.38

was devised by the Department of Mental Health in Virginia and assesses an individual's mental status and level of functioning. A mental health clinician is responsible for completing the preadmission screening form.

Inter-rater reliability for this descriptive study was assessed by comparing the ratings of 2 raters who were mental health clinicians proficient in using the preadmission screening form. These 2 raters simultaneously assessed 5 clients and independently recorded their assessment of these clients on the preadmission screening form.

Inter-rater reliability for this instrument was computed by using the Pearson's product moment correlation. The Pearson r statistic is both descriptive and inferential. For most variables of a social or psychological nature, an r of .70 is quite high (Polit & Hungler, 1983). The correlation coefficient for this instrument was an r of 0.67.

ADDRESSMENT OF RESEARCH QUESTIONS

This section states the research questions and their respective results.

1. What was the percentage of agreement of clinical recommendations to treatment and

the outcome of the commitment hearing?

Of the 87 cases reviewed, the clinician recommended involuntary hospitalization for 86 of the individuals and voluntary hospitalization for one individual. The total number of committed persons was 56. Clinical recommendation for one of these cases was voluntary hospitalization; therefore, the overall concordance rate for commitment was 64 percent (N=55). Of the clinical recommendation for voluntary hospitalization, the concordance rate was 0 percent (N=0). The concordance rates are presented in Table 2.

2. What was the percentage of agreement of clinical recommendations to treatment and outcome of the commitment hearing by presiding justice?

In this jurisdiction commitment hearings are presided over by special justices. There are three special justices appointed who hear these cases on a rotating basis. Of the 87 cases reviewed, Special Justice 1 presided over 34 (39.1 percent), Special Justice 2 presided over 27 (31.0 percent), and Special Justice 3 presided over 26 (29.9 percent). A breakdown of the commitment hearing outcomes by presiding justice is presented in Table 3. Of the 34 cases heard by Special Justice 1, agreement with the clinical

TABLE 2

Percentage of Agreement Between Clinical Recommendation for Treatment and Commitment Hearing Outcome

	Clinical Recommendation N=87	Outcome	Concordance Rate %
Involuntary commitment	N=86	N=55	64
Voluntary hospitalization	N= 1	N= 0	0

TABLE 3

Commitment Outcome
by Special Justice

	N/(%)	INVOL N=56	VOL N=18	OP N=8	CWD N=5
Special Justice 1	34(39.1)	22	7	4	1
Special Justice 2	27(31.0)	19	5	3	0
Special Justice 3	26(29.9)	15	6	1	4

COMMITMENT HEARING OUTCOME

INVOL= Involuntary hospitalization
VOL = Voluntary hospitalization
OP = Outpatient treatment
CWD = Continued, withdrawn, dismissed

recommendation occurred in 21 cases (61.76 percent). Of one of the cases committed by Special Justice 1, the clinical recommendation had been voluntary hospitalization. Special Justice 2 concurred with the clinical recommendation in 19 cases (70.37 percent). Of the 26 cases heard by Special Justice 3, the concurrence rate was 57.68 percent (N=15). The concordance rates by presiding justice are presented in Table 4. Due to the low number of cases by each presiding justice, no specific trends could be stated.

3. Did presenting symptomatology differ between committed and non-committed persons?

A comparison of presenting symptomatology with commitment hearing outcome was performed by using the pooled variance t-test. The results of these tests showed no significant differences among presenting symptoms and commitment hearing outcome. Ranges on the t-test were from .153 to .967. Percentages were calculated for each presenting symptom according to outcome. No specific trends by symptomatology/outcome were noted. The low number of cases in three of the outcome categories makes any results inconclusive. The symptomatolgy distribution by outcome is presented in Figure 1.

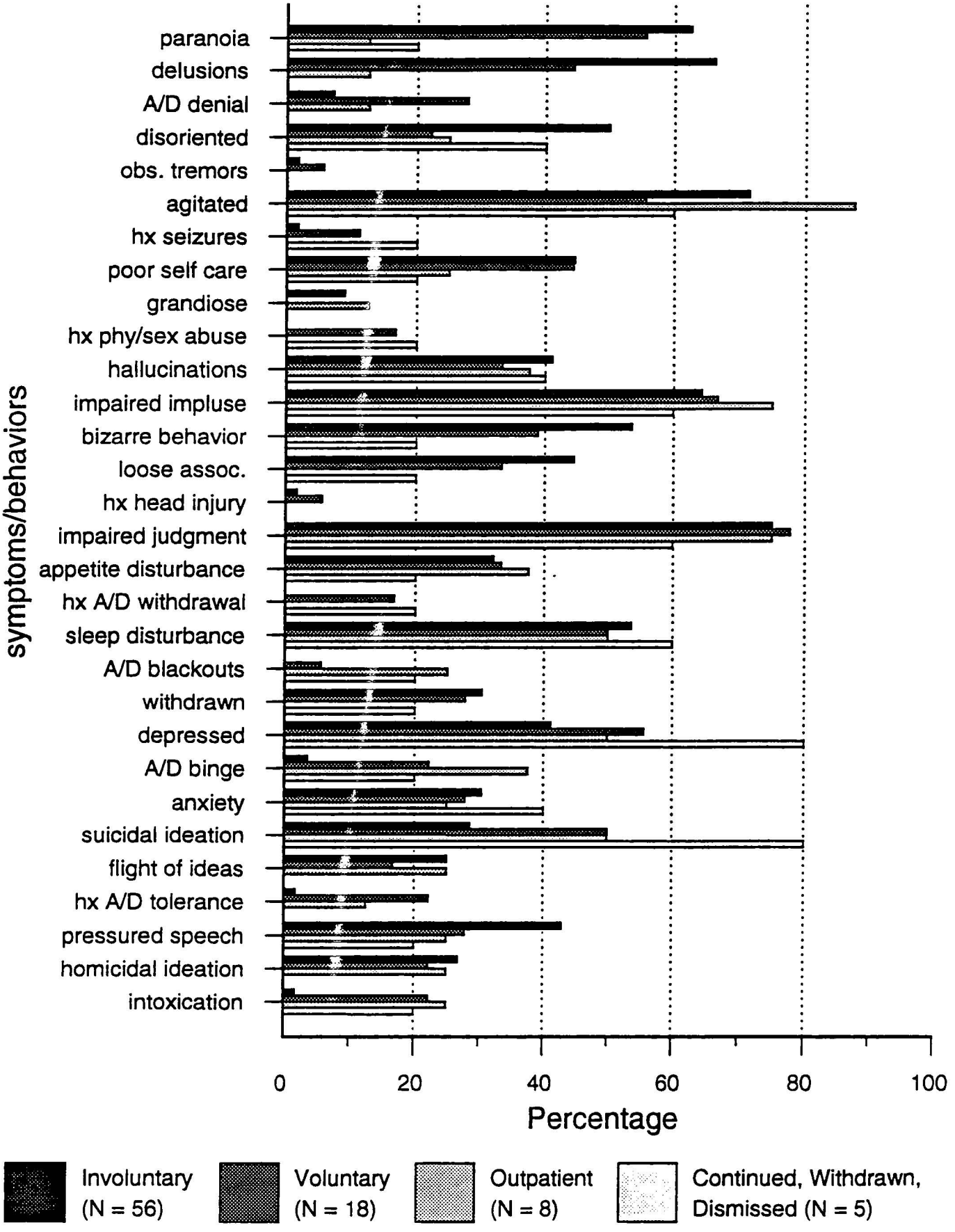
4. Did pre-temporary detaining order compliance

TABLE 4

Concordance Rate
by Special Justice

	N	N Agreement	Concordance Rate
Special Justice 1	34	21	61.76
Special Justice 2	27	19	70.37
Special Justice 3	26	15	57.68

Percentage of occurrence of symptoms/behaviors within each commitment hearing outcome category



differ between committed and non-committed persons?

An analysis of pre-temporary detaining order compliance to commitment hearing outcome was done using the pooled variance t-test. No significant differences were found. Ranges on the t-test were from .204 to .574. Percentages of compliance within each outcome category were also obtained. Percentages are presented in Figure 2.

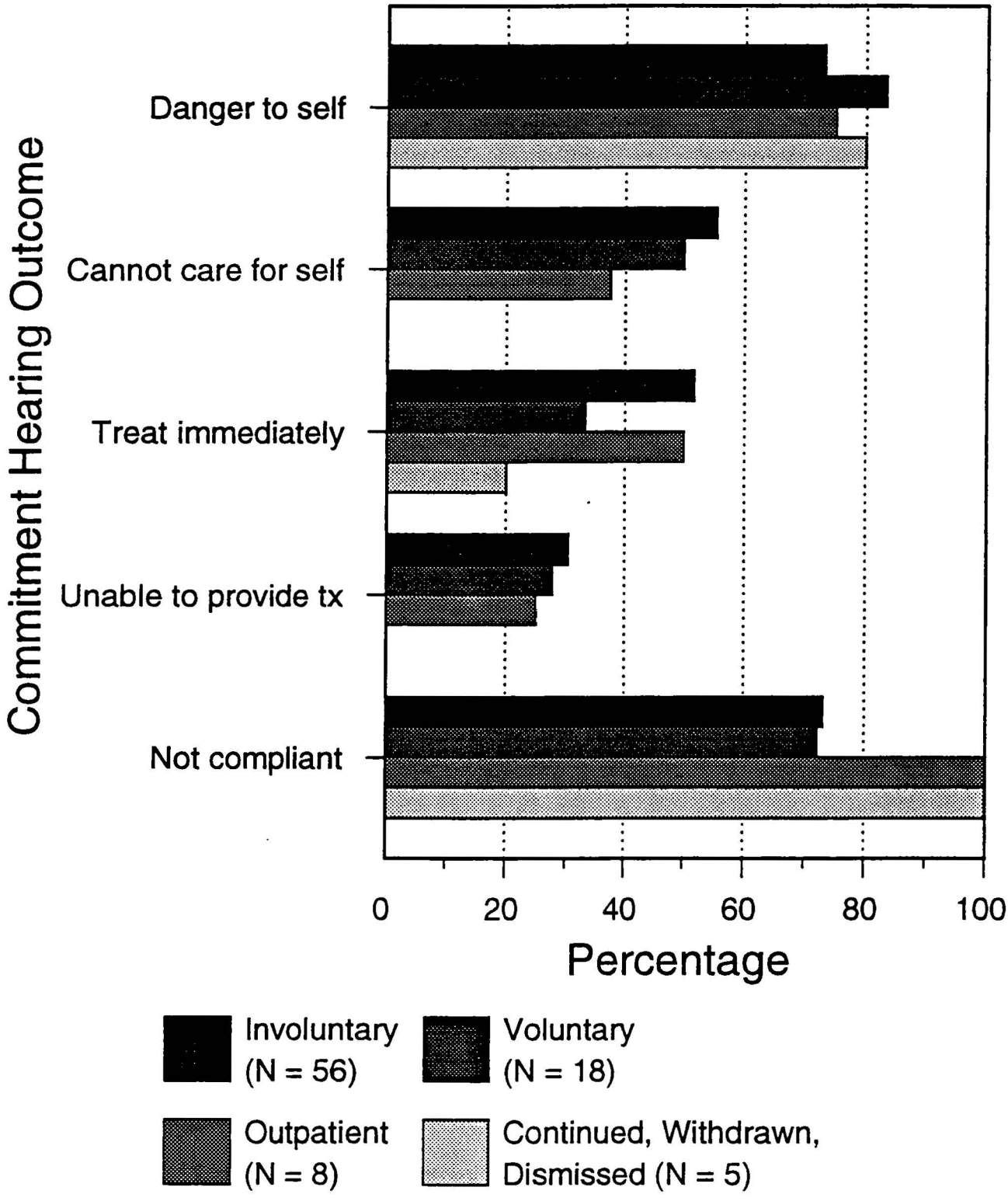
5. Are there significant differences in the outcome of the commitment hearings as a result of the time lapse between the detaining of an individual and the hearing?

An analysis of the data from the length of time a person was detained and the outcome of the commitment hearing was done using the pooled variance t-test. No significant differences were found. Ranges on the t-test were from .238 to .619.

SUMMARY

This chapter presented a discussion of the analysis of the results of this descriptive study. This chapter was divided into 5 sections: sample characteristics, demographics, instrument reliability, research questions, and summary. There were 87 cases

Percentage of occurrence of documentation of need for hospitalization and noncompliance within each commitment hearing outcome



reviewed in this descriptive study of which 45 were male (51.7 percent) and 42 were female (48.3 percent). The 87 cases reviewed for this study were obtained from the preadmission screening forms of individuals detained from July 1990 throught September 1990. Only adults who had a diagnosis of a major mental disorder were included in the study. Individuals were not excluded if they carried other diagnosis as well.

There were no significant differences found between pre-temporary detaining order compliance and outcome, presenting symptomatology and outcome, or time lapse between detention and outcome. The percentage of agreement of clinical recommendations to treatment and outcome of the commitment hearing by presiding justice ranged from 57.68 percent to 70.37 percent. The overall concordance rate was 64 percent.

CHAPTER 5

SUMMARY AND RECOMMENDATIONS

The following discussion presents the summary and recommendations for this descriptive study. This chapter is divided into 4 parts: summary, interpretation and implications, conclusions, and recommendations.

SUMMARY

The purpose of this study was to provide a descriptive assessment of the commitment practices as applied in an urban community in Virginia. The following specific research questions were generated for this purpose:

1. What was the percentage of agreement of clinical recommendations to treatment and outcome of the commitment hearing?
2. What was the percentage of agreement of clinical recommendations to treatment and outcome of the commitment hearing by presiding justice?
3. Did presenting symptomatology differ between committed and non-committed persons?
4. Did pre-temporary detaining order compliance differ between committed and non-committed persons?

5. Are there significant differences in the outcome of the hearings as a result of the time lapse between the detaining of an individual and the hearing?

The participants of this descriptive study were obtained from the preadmission screening forms of an urban community mental health agency. There were 87 cases reviewed. All of the cases were adults who carried a diagnosis of a major mental disorder. Inter-rater reliability for this descriptive study was assessed by comparing the ratings of 2 raters who were mental health clinicians proficient in using the preadmission screening form. These 2 raters simultaneously assessed 5 clients and independently recorded their assessment of these clients on the preadmission screening form. The reliability for this instrument was an r of 0.67. There were no significant differences found between pre-temporary detaining order compliance and outcome, presenting symptomatology and outcome, or time lapse between detention and outcome. The percentage of agreement of clinical recommendations to treatment and outcome of the commitment hearing by presiding justice ranged from 57.68 percent to 70.37 percent. The overall concordance rate was 64 percent.

INTERPRETATION AND IMPLICATIONS

The principle stages of the commitment process in Virginia are: detention, preliminary hearing, involuntary commitment hearing, and possible admission (Spaulding, 1989). While there is a widespread belief that the commitment standard is one of dangerousness, there are many statutory standards in the commitment process. In Virginia, as in other states, dangerousness is one of the criteria for commitment; however, it is not the only criteria. Inability to care for oneself is also a criteria and frequently cited on the preadmission screening report. Of the 87 cases reviewed in this study, inability to care for oneself was identified on 43 (49.4 percent) of the preadmission screening forms. Of these 43 cases, 31 (70.46 percent) were involuntarily hospitalized.

In the early 1970's, Virginia's commitment procedures resembled those of a criminal trial (Spaulding, 1989). By the late 1970's, Spaulding (1989) states that appellate courts, including the United States Supreme Court, began to give state legislatures signals that commitment could be less adversarial and more dependent upon expert opinion. Previous studies (Scheff, 1964; Cohen, 1966; Wenger &

Fletcher, 1969; Wexler et al, 1971; Fein & Miller, 1972) have suggested a high concordance rate (96.1 to 100 percent) between clinical recommendation to the court and outcome of the commitment hearing. The concordance rate for this study was 64 percent.

According to Spaulding (1989), Virginia's civil commitment statute includes procedures which are intended to assure fair and accurate enforcement of the standards. This descriptive study showed no significant differences between committed and non-committed individuals with regard to presenting symptomatology, pre-detention compliance, and time lapse between detention and hearing.

CONCLUSIONS

The following review of findings is based upon research questions and methodologies outlined in Chapter 3 and data provided in Chapter 4.

1. Comparing clinical recommendations to treatment and the outcome of the commitment hearing showed a concordance rate of 64 percent.
2. Comparing clinical recommendations to treatment and the outcome of the commitment hearing by presiding justice showed concordance rates from 57.68 percent to 70.37 percent. The number of cases heard by

each special justice was too small to make any findings conclusive.

3. There were no significant differences found between presenting symptomatology and outcome (committed versus non-committed) of the commitment hearing.
4. Inter-rater reliability was performed and an $\underline{r}$ of 0.67 was obtained.
5. There were no significant differences found between committed and non-committed persons and pre-temporary detaining order compliance.
6. There were no significant differences found between the length of time a person was detained prior to the hearing and the outcome of the hearing.

RECOMMENDATIONS

Upon completion of this study, the following recommendations are suggested:

1. Clearer guidelines be established to better delineate the application of Virginia's commitment criteria.

Spaulding (1989) reports that while there is a widespread belief (which may in some places be reflected in practice), that the commitment standard is one of dangerousness, there are many statutory standards in the Virginia commitment process. For

example, the standards for involuntary hospitalization require mental illness and either imminent dangerousness to self or others because of mental illness or inability to care for self because of mental illness.

Many of Virginia's commitment standards are open-textured, in the sense that they permit the decision maker widely varying degrees of discretion in defining as well as applying the standard. While Virginia already has criteria/standards in place other than that of dangerousness, the application of these standards/criteria as indicated by this study is far from uniform.

2. Development of outpatient commitment standards which would allow a person to be treated in the community.

Presently, when a person is committed to outpatient treatment there are no means available to ensure that that person complies with treatment. Usually, that person has been non-compliant with treatment recommendations prior to obtaining a temporary detaining order. This thereby necessitates the need for the treating individual to again initiate court action in attempt to get the person into treatment.

Studies conducted in the mid-1970's suggested that mentally ill persons were arrested more frequently than the general population and some workers have suggested that as many as 10 percent of incarcerated persons may have a severe mental illness such as psychosis (McFarland, B., Faulkner, L., Bloom, J., Hallauz, R. & Bray, J., 1989). Involuntary treatment in the community may be beneficial for some chronically mentally ill persons; it may serve to minimize their utilization of the criminal justice system. Certainly there is indication of the importance of close collaboration between mental health and criminal justice personnel (McFarland et al, 1989).

Commitment to outpatient treatment can be a preferable alternative to involuntary hospitalization for a specific population of patients--for example, those with psychotic illnesses whose condition responds well to antipsychotic medication and who have a demonstrated pattern of non-compliance with medication after discharge from inpatient treatment (Bonnie, 1986). "By the same token, however, any outpatient commitment order must be predicated upon a specific treatment plan prepared by the program to which the patient would be committed. This is necessary not only to assure clarity of expectations and procedures but

also to assure that the procedure is used only for those patients the program is willing to accept; a judge would not be able to commit someone to clinically inappropriate outpatient treatment simply because it is perceived as being 'less restrictive' than hospitalization." (Bonnie, 1986)

3. Better collaboration between the judicial system and the clinical system needs to be established if the goal is to protect the rights of the mentally ill.

The tightening of statutory commitment criteria occurred to make it harder to place people in institutions and to keep them there, and to improve the capacity of institutions to provide services enabling patients and clients to return to, and live successfully in, the community (Bonnie, 1986). The legal system, both civil and criminal, results in creating additional stress in attempts to care for the chronically mentally ill.

There has been increasing concern recently about criminalization of the chronically mentally ill and the diversion of clients from the mental health system to the criminal justice system (McFarland et al, (1989). McFarland et al (1989) undertook a study which indicated that substance abuse and noncompliance with

psychiatric medications were significant predictors of arrest. Overwhelmingly, family members in this study attributed the arrests to psychiatric crises, and in about half the cases a failed attempt at commitment had preceded the arrest.

Court decisions supporting the right to refuse treatment have rested primarily on constitutional arguments that the involuntary administration of medication violates the patient's bodily integrity and person autonomy (Schwartz et al, 1988). It is imperative that service and legal systems be designed that allows for and encourages support of both the rights and the needs of mentally disabled patients (Ziegenfuss, Jr., 1986).

In looking at protection of patients' rights, Schwartz et al (1988) sugggests that treatment refusal is primarily a psychotherapeutic and medical issue as clinicians have shown themselves to be capable of protecting the legal rights of their patients while providing for their clinical needs. They further believe that while judicial review should always be available as a last resort, clinical review is the most appropriate way to balance the competing demands of treatment needs and individual rights.

The commitment process should make use of informal rules of evidence as it would make the judicial hearing much less countertherapeutic than it has been and more appropriate for a commitment hearing than the model based on courtroom procedures for criminals (Lamb & Mills, 1986). Both in the hospital and in the community, the right to treatment should be better defined. Included in this, legislation permitting medication of involuntarily committed patients without their consent. "Non-consensual treatment is what involuntary commitment is all about" (Lamb & Mills, 1986). Also, advocated by Lamb & Mills (1986) is the use of guardianship and conservatorship as they are important resources for that relatively small proportion of the chronic mentally ill who need ongoing legal controls in the community as an alternative to total control in a hospital.

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