Articles

The Empirical Consequences and Policy Implications of Broadening the Statutory Criteria for Civil Commitment†

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I. Introduction

Traditionally, the power of the state has included the power to commit mentally ill citizens to psychiatric hospitals against their will.¹ The state’s authority to confine the mentally ill rests upon two distinct legal doctrines: parens patriae and police power. Under its parens patriae authority, the state acts on behalf of certain individuals who are believed incapable of acting in their own best interest.² The police power authorizes the state to confine certain persons for prevention of harm to the community.³

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² See generally, La Fond, An Examination of the Purposes of Involuntary Civil Commitment, 30 Buffalo L. Rev. 499 (1981) [hereinafter cited as La Fond, Purposes of Commitment] and Developments - Civil Commitment, supra note 1.
³ See La Fond, Purposes of Commitment, supra note 2. Criteria in commitment statutes based on police power range from the very general criteria, e.g., R.I. Gen. Laws §40.1-5-7 (1984) (“person . . . in need of immediate care and treatment and is one whose continued unsupervised presence in the community would create an imminent likelihood of serious harm . . .”); to requiring evidence of specific past conduct, e.g., Pa. Stat. Ann. tit. 50, §7301(B) (Purdon Supp. 1985) (clear and present danger to self or others shown by establishing that within the past thirty days the person inflicted or attempted to inflict serious bodily harm and such behavior will probably recur, or is unable to avoid serious physical debilitation); or requiring that it be more likely than not that the person will cause serious bodily harm to self or others in the near future, e.g., N.M. Stat. Ann. §43-1-3(M) (Supp. 1984).
Over the last two decades, involuntary civil commitment of the mentally ill has provoked heated public controversy. The debate has raged with special intensity because it implicates competing political ideologies, moral values, decision-making models, and claims of expertise. At its extreme, the debate over civil commitment has focused on whether the state should continue to use its power of coercion to deprive mentally ill persons of their liberty, or whether involuntary civil commitment should be abolished in favor of other systems of social control and care. The middle ground of the debate has centered on whether the state, in committing individuals involuntarily, should do so under its police power or its parens patriae power, and on how legal regimes should define, delegate, and control such state authority.

4. See, e.g., T. Szasz, LAW, LIBERTY, AND PSYCHIATRY (1963); T. Szasz, THE MYTH OF MENTAL ILLNESS (rev. ed. 1974). “Political ideologies” in this context refers to the preferences citizens have either for the state to act coercively against an individual in order to maximize public safety and welfare, or for the state to maximize individual autonomy and minimize state intervention into the lives of its citizens.

5. Compare, e.g., Szasz, THEOLOGY OF THERAPY: THE BREACH OF THE FIRST AMENDMENT THROUGH THE MEDICALIZATION OF MORALS, 5 N.Y.U. REV. L. & SOC. CHANGE 127 (1975) with Chodoff, THE CASE FOR INVOLUNTARY HOSPITALIZATION OF THE MENTALLY ILL, 133 AM. J. PSYCHIATRY 496 (1976). “Moral values” in this context refers to the sense of obligation based on an ethical sense of rightness that each citizen has either to act paternalistically to help one whom he feels cannot help himself, or, in the alternative, to respect the expressed choices of another as a legitimate assertion of individual autonomy.


9. See supra note 2; Comment, OVERT DANGEROUS BEHAVIOR AS A CONSTITUTIONAL REQUIREMENT FOR INVOLUNTARY CIVIL COMMITMENT OF THE MENTALLY ILL, 44 U. CHI. L. REV. 562 (1977); Ennis & Litwack, supra note 7; Herman, PREVENTIVE DETENTION, A SCIENTIFIC VIEW OF MAN AND STATE POWER, 1973 U. ILL. L. F. 673. See also supra note 3 and accompanying text (discussion of the police power).

10. See, e.g., Morse, supra note 8; Livermore, MALQUIST & MEEHL, ON THE JUSTIFICATIONS FOR CIVIL COMMITMENT, 117 U. PA. L. REV. 75 (1968); La Fond, PURPOSES OF COMMITMENT, supra note 2. See also supra notes 2-9 and accompanying text (discussion of the parens patriae power).

11. “Legal regimes” refers to the system for civil commitment of the mentally ill provided by the legal system. As noted above, see supra note 1, only the state has the inherent power to confine coercively its adult citizens to hospitals on account of mental
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The historical context of this debate is important. In the 1960's and early 1970's, public opinion shifted abruptly from widespread support of extensive civil commitment to support of significant limits on the state's commitment authority. As a consequence of changed attitudes, important legislative changes were made in state commitment systems. "Medical" models of civil commitment, which conferred broad authority on mental health experts to hospitalize coercively persons they deemed mentally ill and in need of hospitalization, were changed drastically in favor of "legal" models of commitment. Under a "medical" model a medical specialist, such as a psychiatrist, has broad authority under the law to evaluate and hospitalize a patient he finds mentally ill and in need of treatment. Under a "legal" model, significant substantive and procedural safeguards limit the authority of medical specialists to commit persons deemed mentally ill.12

Several potent forces propelled this move from the medical model to the legal model of commitment. First, there was increased recognition that commitment to a mental hospital entailed a serious loss of liberty even if undertaken for an apparently benign purpose.13 Moreover, enhanced public awareness of the stark conditions existing in state mental health facilities raised the question of whether confinement to such facilities might make patients worse off than if the state had not committed them.14 The increased emphasis on more protective criminal procedures for criminals and juveniles sensitized courts to the absence of any meaningful legal protection in the mental health commitment processes of most states.15 Developments in constitutional jurisprudence enunciating rights to make decisions concerning one's own body influenced public attitudes about the privacy of such decisions.16 Finally, many problems inherent in the medical or "therapeutic" model came to light, including the opportunities it created for unlimited application and for abuse.17

12. For an excellent discussion of these models, see Morse, supra note 8, at 54-57.
13. Developments — Civil Commitment, supra note 1, at 1193, 1272.
14. See Morse, supra note 8, at 80.
During this period many states thoroughly revised their commitment laws by providing additional procedural protections and by adopting more restrictive substantive criteria for commitment.\textsuperscript{18} Strong evidence suggests, however, that today the pendulum of public attitudes and state policy is swinging again toward the medical model. At least four states, including 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.\textsuperscript{19} There is also increasing public agitation for adoption of statutes that return more power to mental health professionals to confine mentally ill persons against their will.\textsuperscript{20} Much of this agitation is based on the claim, usually made by psychiatrists, that restrictive state commitment statutes operate to deprive many mentally ill persons of essential therapeutic services that could humanely and effectively treat their illness and thereby substantially improve their well-being.\textsuperscript{21}

The American Psychiatric Association has proposed a Model State


\textsuperscript{19} Alaska has recently expanded its statutory definition of "gravely disabled" to include persons who as a result of mental illness will, if not treated, suffer distress which impairs judgment, reason or behavior, "causing a substantial deterioration of the person's previous ability to function independently." Alaska Stat. §47.50.915(7)(B) (1984). North Carolina has expanded its definition of "danger to self" to include an inability to exercise self-control, judgment, and discretion in daily responsibilities or social relations, and has enacted a statutory presumption that patients are unable to care for themselves if they engage in grossly emotional or inappropriate behavior or display other signs of severely impaired insight and judgment. N.C. Gen. Stat. §122-58.2(1981). In 1983, Texas revised its commitment law to permit commitment of a person who "will, if not treated, continue to suffer severe and abnormal mental, emotional, or physical distress and will continue to experience deterioration of his ability to function independently and is unable to make a rational and informed decision as to whether or not to submit to treatment." Tex. Stat. Ann. art. 5547-50(b)(2)(iii) (Vernon Supp. 1985). See also infra notes 89-99 and accompanying text (description of how Washington revised its civil commitment statute).

\textsuperscript{20} See infra notes 22-25 and accompanying text.

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Commitment Statute which gives significant weight to the *parens patriae* interest of the state.\(^2\) Under this statute a person may be involuntarily admitted to a treatment facility for a brief period of emergency evaluation and treatment if, *inter alia*, the examining physician concludes that the person is suffering from a severe mental disorder and, as a result of such disorder, is incapable of making an informed treatment decision and is likely to suffer substantial mental deterioration.\(^2\) The statute also authorizes commitment for an additional 30 days if, *inter alia*, a court in a judicial hearing based on medical testimony concludes that the person continues to suffer from a severe mental disorder and without treatment is likely to suffer severe mental deterioration.\(^2\) The 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.\(^2\)

In the continuing controversy over civil commitment, tremendous energy has been expended arguing about the appropriate wording

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23. In Section 4, the statute permits an examining psychiatrist to confine a person in an evaluation and treatment facility if he determines that: "the person suffers from a severe mental disorder as the result of which: he lacks capacity to make an informed decision concerning treatment; and he is (a) likely to cause harm to himself or to *suffer substantial mental or physical deterioration*, or (b) likely to cause harm to others; and immediate hospitalization is necessary to prevent such harm." (emphasis added.) *Id.* at 321.

In its "definitions" section 3, the statute specifies that: "likely to cause harm to himself or to *suffer substantial mental or physical deterioration*, means that, as evidenced by recent behavior, the person (1) is likely in the near future to inflict substantial physical injury upon himself, or (2) is substantially unable to provide for some of his basic needs such as food, clothing, shelter, health, or safety, or (3) will if not treated suffer or continue to *suffer severe and abnormal mental, emotional, or physical distress*, and this distress is associated with significant impairment of judgment, reason or behavior causing a substantial deterioration of his previous ability to function on his own." (emphasis added) *Id.* at 302 and 303.

24. The Statute provides that an individual committed pursuant to a Section 4 emergency procedure may be committed for an additional 30 days if the court in a judicial hearing based on medical testimony determines under a "clear and convincing" evidentiary standard that: "(1) the person is suffering from a severe mental disorder; and (2) there is a reasonable prospect that his disorder is treatable at or through the facility to which he is to be committed, and such commitment would be consistent with the least restrictive alternative principle; and (3) the person either refuses or is unable to consent to voluntary admission for treatment; and (4) the person lacks capacity to make an informed decision concerning treatment; and (5) as the result of the severe mental disorder, the person is (a) likely to cause harm to himself or to *suffer substantial mental or physical deterioration*, or (b) likely to cause harm to others." *Id.* at 330.

25. The commentary section, which is acknowledged as the "heart of the Model Law," *id.* at 331, focuses on the need for treatment, the incapacity of the individual to make a rational treatment decision, and the availability of treatment as the core requirements for civil commitment. It further states: "We believe that . . . many severely disordered people who are *not now committable as gravely disabled* could be committed under the Model Law." (emphasis added.) *Id.* at 335.
of statutory criteria used to identify those persons who are subject to involuntary civil commitment.\textsuperscript{26} A basic assumption in this debate appears to be that the particular language of statutory criteria makes a significant difference in commitment practice. Previous empirical studies have not provided a clear basis for testing this crucial first premise, or for ascertaining what consequences, if any, might follow from changing the statutory criteria for commitment to expand the scope of the state's commitment authority.\textsuperscript{27}

In 1973, Washington enacted a restrictive civil commitment statute\textsuperscript{28} which considerably narrowed the power of the state to confine mentally ill persons against their will.\textsuperscript{29} In 1979, after public agitation by mental health professionals and citizen advocacy groups,\textsuperscript{30} Washington revised its civil commitment statute, greatly expanding the civil commitment power of the state without significantly altering commitment procedures.\textsuperscript{31} This dramatic change in a state's mental health policy, and its implementation through revision of the statutory criteria for commitment, provided a unique opportunity to

\textsuperscript{26} See, e.g., Dix, Major Current Issues Concerning Civil Commitment Criteria, 45 Law & Contemp. Prosbs. 137 (Summer 1982) at 137; La Fond, Purposes of Commitment, supra note 2; Stromberg & Stone, supra note 22.

\textsuperscript{27} Compare, e.g., Haupt & Erlich, The Impact of a New State Commitment Law on Psychiatric Patient Careers, 31 Hosp. & Comm. Psychiatry 745 (1980) (1976 Pennsylvania Mental Health Procedure Act, containing more restrictive commitment criteria and more stringent procedural due process than the prior commitment statute did not significantly change the number or relative percentage of patients admitted voluntarily or involuntarily for the eight month period before and after the effective date of the statute nor did it affect significantly the average length of stay for voluntary and involuntary patients) with A. Stone, Mental Health and Law: A System in Transition 60-65 (1975) (suggests, albeit with some reservations, that the enactment in 1969 of California's Lanterman-Petris-Short Act, see supra note 18 and accompanying text, with its very restrictive commitment criteria and substantially increased procedural due process accorded committees, resulted in reducing the average length of hospitalization for involuntary committees; a significant number of patients could no longer be coercively committed to the state's mental health system and have consequently found their way into the criminal system). Some commentators have concluded that procedural changes in the commitment process rather than substantive changes in the commitment criteria are more likely to affect the likelihood of commitment and the structure of service delivery within the involuntary commitment system. See Roth, supra note 21, at 391. There is evidence to the contrary, however, which clearly suggests that procedural changes in a commitment system are frequently and flagrantly disregarded by medical and judicial system participants. Comment, Involuntary Hospitalization of the Mentally Ill in Iowa: The Failure of the 1975 Legislation, 64 Iowa L. Rev. 1284 (1979) [hereinafter cited as Comment, Involuntary Hospitalization].


\textsuperscript{29} See infra notes 53-56 and accompanying text.

\textsuperscript{30} See infra notes 86-88 and accompanying text.


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c conducive empirical research and to collect relevant data on the impact of such changes on Washington's civil commitment system. In 1981, the National Institute of Mental Health funded a research project to assess the impact of Washington's statutory change.32 This project is the first empirical study to analyze systematically the consequences that follow from revising the statutory commitment criteria to expand the substantive authority of a state to confine mentally ill persons against their will. The project's findings are the focus of this article.

The data gathered from studying the Washington experience support the following conclusions: 1) persons were committed under the new statutory commitment criteria substantially before the effective date of the statute;33 2) the number of patients committed involuntarily increased significantly, and many patients who had had no previous contact with state hospitals were committed to psychiatric facilities;34 3) these new patients stayed in hospitals longer than other patients and became chronic users of the state mental hospitals;35 4) the major state mental hospital became extremely overcrowded and tried unsuccessfully to put a limit on new admissions;36 5) voluntary patients were virtually excluded from state hospitals;37 and 6) litigation outcomes in contested cases seem to have been affected by structural arrangements for providing indigent persons with legal representation at commitment hearings.38

These findings pose serious concerns for mental health policymakers considering expanding the substantive power of the state to commit, raise significant questions regarding the ability of both law and the courts to control the bureaucrats to whom the coercive power of the state has been delegated, and present issues of constitutional dimension.

II. Involuntary Civil Commitment in Washington

A. The 1959 Civil Commitment Law

Prior to 1973, Washington's civil commitment law was fairly typical in its criteria for determining who could be subject to involun-

32. Durham, Legal Intervention in Involuntary Civil Commitment, Center for Studies on Antisocial and Violent Behavior, N.I.M.H. Grant No. R01MH36220.
33. See infra notes 112-116 and 173-177 and accompanying text.
34. See infra notes 112-123 and 134-136 and accompanying text.
35. See infra notes 117-122 and 144-145 and accompanying text.
36. See infra notes 100-106 and 166-172 and accompanying text.
37. See infra notes 112-116 and 153-157 and accompanying text.
38. See infra notes 129-133 and 204-224 and accompanying text.
tary hospitalization. Under the 1959 law, a peace officer or chief medical officer of a licensed hospital could, in an emergency, apprehend or detain for 12 hours a person believed to be mentally ill and dangerous to himself, others, or property.\textsuperscript{39} Within 12 hours of detention, examination by a licensed physician was required.\textsuperscript{40} If the examining physician found him to be mentally ill, the individual could be confined and treated in a hospital for up to 72 hours.\textsuperscript{41}

In addition, any person could file a petition seeking non-emergency commitment of the patient beyond the 72-hour period.\textsuperscript{42} The superior court considered these petitions for involuntary hospitalization as a matter of probate.\textsuperscript{43} At a court hearing, at least two licensed physicians who had examined the detainee were required to testify; the detainee could present his own evidence.\textsuperscript{44} At the court's discretion, a guardian could be appointed to represent the detainee, or he could be represented by counsel.\textsuperscript{45} He also had the right to a jury trial.\textsuperscript{46} If the court determined that the person was mentally ill,\textsuperscript{47} it could order his commitment to a hospital.\textsuperscript{48} While the statute is not entirely clear, it appears that the commitment was indeterminate, without mandatory judicial review, and that primary releasing authority was vested in the superintendent of the hospital.\textsuperscript{49}

B. The 1973 Involuntary Treatment Act

In 1973, Washington enacted a revised civil commitment statute that reflected a fundamental shift in commitment philosophy toward the "legal" model.\textsuperscript{50} This new statute drastically limited the scope

\textsuperscript{40} Id. §5(3) at 866.
\textsuperscript{41} Id. §6 at 866.
\textsuperscript{43} Id. §71.02.110.
\textsuperscript{44} Id. §71.02.170 at 85.
\textsuperscript{45} Id. §71.02.190 at 85 (guardian, counsel), §71.02.140 at 84 (counsel).
\textsuperscript{46} Id. §71.02.210 at 86.
\textsuperscript{47} Id. §71.02.101 at 80. WASH. REV. CODE ANN. §71.02.010 (West 1959) defines "mentally ill person" as "any person found to be suffering from psychosis or other disease impairing his mental health, and the symptoms of such disease are of a suicidal, homicidal, or incendiary nature which would render such person dangerous to his own life or to the lives or property of others."
\textsuperscript{48} Id. §71.02.240 at 87.
\textsuperscript{49} Id. §71.02.650 at 93.
\textsuperscript{50} WASH. REV. CODE ANN. §71.05 et seq. (West 1975). The background material contained in Section II has been largely adapted from Durham & Pierce, Beyond Deinstitutionalization: A Commitment Law in Evolution. 33 Hosp. & COMM. PSYCHIATRY 216 (1982).
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of the state's commitment authority and imposed significant procedural safeguards on the process of commitment.

1. Commitment Criteria

In 1973 the law was revised to allow commitment of people who "as a result of a mental disorder present[ed] a likelihood of serious harm to others or [themselves] or [were] gravely disabled." Behavior that threatened or attempted harm to the individual or to others established "likelihood of serious harm." A person was dangerous to herself if she had threatened or attempted self-inflicted physical harm or suicide. The "danger to others" criterion was satisfied by behavior which "had caused harm or substantial risk of harm in the past, or which placed others in reasonable fear of sustaining harm." The statute was not specific regarding evidence that would establish dangerousness or harm to others.

"Gravely disabled" was defined as 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 human needs." The state was not to commit individuals involuntarily if they could live independently or with the assistance of family or friends.

This restrictive definition of "gravely disabled" often prevented families from securing commitment of a family member they believed needed involuntary treatment. Mental health authorities objected to the restrictive criteria on the grounds that as long as the family provided essential human needs, commonly understood as food, clothing, and shelter, a non-dangerous patient had to enter the mental health system voluntarily or not at all.

Under the statutory provisions governing voluntary admission to state mental health facilities, a patient signed an application for admission which the county mental health professional and the direc-

51. See infra notes 53-56 and accompanying text.
52. See infra notes 63-70 and accompanying text.
53. WASH. REV. CODE ANN. §71.05.150(1)(a) (West 1975). Several commentators praised the 1973 ITA as a model for civil commitment statutes. See, e.g., Treffert & Krajeck, In Search of a Sane Commitment Statute, 6 PSYCHIATRIC ANNALS 56 (1976).
54. WASH. REV. CODE ANN. §71.05.020 (West 1975).
55. Another notable revision in the 1973 ITA was the removal of property destruction as behavior for which a person could be detained involuntarily. Several observers have recently claimed that omission of the property destruction provision was the result of oversight rather than a philosophically based decision. Personal communication with Steven Hosch, Assistant Attorney General, State of Washington (January - March 1980).
56. WASH. REV. CODE ANN. §71.05.020 (West 1975).
57. In 1971, the patient population at Washington state hospitals was approximately 2,485. By 1976, the patient population had dropped to 1,202, a decrease of 51.7 percent. The decline in patient population leveled off by the mid 1970's and did not begin to rise until the year prior to the enactment of ITA 1979.
tor of the facility or his designate then had to approve. A voluntary patient would stay in the facility until she or the director determined that treatment was no longer appropriate. In any event, a voluntary patient would have her case reviewed by the medical staff at least every 180 days. She could not continue as a patient for more than a year without reapplying for admission. The patient also had the right to leave the facility at any time unless involuntary commitment proceedings were initiated. The availability of voluntary admission could be limited when the lack of adequate staff or facilities dictated restricted access.

2. Procedural Protections

Another major change in the 1973 statute was the addition of procedural protections to end indefinite commitment and to shorten the length of hospital detentions. The 1973 ITA authorized one 72-hour evaluation period followed, when appropriate, by commitments of 14 days and 90 days (not renewable), and 180 days (renewable). The law provided for a probable cause hearing prior to the non-renewable 14-day detention period. Detention for lengthier stays (90 and 180 days) required evidence that the patient had attempted or had inflicted physical harm on another person either as the reason for his custody or during the evaluation and treatment period. After the 14-day treatment period, the patient could be confined for a period not exceeding 90 days only if he in fact exhibited threatening behavior. A petition to a court and a subsequent judicial hearing, with the right to a jury trial if requested, were required to hold a patient for 90 days. Successive 180-day

64. Wash Rev. Code Ann. §71.05.230 (West 1975).
66. Id.
68. Wash Rev. Code Ann. §§71.05.280, 71.05.320 (West 1975). In addition, if the state seeks to confine the patient beyond the 14-day period authorized at the probable cause hearing, a committee is entitled to a jury trial and a determination of whether the state has established these facts. Wash Rev. Code Ann. §71.05.310 (West 1975). Recently, the Supreme Court of Washington has held that the government must establish such facts by clear, cogent and convincing evidence and that a less than unanimous jury verdict on these issues satisfies constitutional due process requirements. Dunner v. McLaughlin, 100 Wash.2d 832, 843-845, 676 P.2d 444, 451-452 (1984).
commitments were permissible only when the court issued a valid order authorizing them. A single order could never be authorized for a period exceeding 180 days.70

The 1973 ITA was designed to establish a formal involuntary commitment scheme under judicial supervision characterized by significant procedural protections. Prior to 1973, Washington, like many other states, had used a model of commitment which placed the primary authority to evaluate and commit a patient in the hands of licensed practicing physicians who were required to recommend to a probate court that a person was in need of inpatient care.71 After enactment of the 1973 ITA, counties were required to appoint County Designated Mental Health Professionals ("CDMHPs") who investigated and evaluated all complaints of mental disorder which might lead to confinement. The mental health professional had to be a psychiatrist, clinical psychologist, psychiatric nurse, social worker, or some other individual with special training or experience in mental health.72 The institution of a system of county-based facilities within a state-wide involuntary commitment network marked a dramatic departure from the commitment procedure in effect prior to 1973. Under the 1973 ITA, the mental health professional, after investigating and evaluating the specific facts alleged, could at his discretion summon an individual to appear at an appropriate facility for not more than a 72-hour evaluation and treatment period.73

This commitment process, still largely in effect, functions as a funnel whereby far fewer people are retained in the system than are referred to it at each of the critical decision points—72 hours; 14, 90 and 180 days.74 Although anyone in the community can make referrals to a CDMHP, the CDMHP evaluates the referral and decides whether the client should be held for 72 hours. During this 72-hour period, the patient is evaluated by medical personnel at the Evaluation and Treatment (E&T) facility to determine whether detention for an additional 14 days is warranted. If the patient does not elect voluntary status and the CDMHP or E&T facility believes a 14-day commitment is appropriate, a probable cause hearing must occur within 72 hours of the initial admission. A court commissioner or superior court judge presides at this hearing; the patient is represented by a private attorney or, if indigent, a court-appointed

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71. See supra notes 39-49 and accompanying text.
73. Wash. Rev. Code Ann. §71.05.150(1)(a) (West 1975). This provision was recently struck down as unconstitutional due to its failure to require prior judicial approval of the summons. In Re Harris, 98 Wash. 2d 276, 287, 654 P.2d 109, 114 (1982).
74. See Figure 1.
attorney or public defender.\textsuperscript{75}

At any time during the 14-day commitment, professional staff at the detention (E&T) facility or the CDMHP may file a petition for a 90-day commitment.\textsuperscript{76} Since the E&T staff member, rather than the CDMHP, is the person who is in daily contact with the patient, the CDMHP is rarely involved in the filing of petitions beyond the 14-day detention. A probable cause hearing or arraignment must be held on the first working day after the petition is filed.\textsuperscript{77} Within five days of the probable cause hearing, a fact-finding hearing must be held.\textsuperscript{78} Provisions for legal counsel are the same as for the 14-day hearing, and at 90- and 180-day hearings the patient is entitled to a jury, although a jury is rarely impaneled.\textsuperscript{80}

3. Reaction to the 1973 Statute

Following enactment of the 1973 ITA, families and mental health professionals expressed great dissatisfaction with the law.\textsuperscript{81} Criticism of the nationwide trend toward narrow commitment criteria came from people in many states where similar laws were being enacted.\textsuperscript{82} "Psychiatric ghettos" were reportedly developing in large

\textsuperscript{75} Wash. Rev. Code Ann. §71.05.200(b) (West 1975).
\textsuperscript{76} Wash. Rev. Code Ann. §71.05.290 (West 1975).
\textsuperscript{77} Wash. Rev. Code Ann. §71.05.300 (West Supp. 1985).
\textsuperscript{78} Wash. Rev. Code Ann. §71.05.310 (West Supp. 1985).
\textsuperscript{81} Wash. Rev. Code Ann. §71.05.320 (West Supp. 1985).
\textsuperscript{82} See supra note 18. See also Miller & Fiddleman, Involuntary Civil Commitment in North Carolina: The Result of the 1979 Statutory Changes, 60 N.C.L. Rev. 985, 993-999 (1982).
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FIGURE 1—Involuntary Detention "Funnel,"
Washington State, 1977-81
REFERRALS TO CDMHPS (100%)

HELDS FOR 72 hrs (32% of all referrals)

HELDS FOR 14 days
(57% of 72 hr holds)

HELDS FOR 90 days (38% of 14 day holds)

HELDS for 180 days

cities where former mental patients lived in squalor and isolation. Psychiatrists claimed that restrictive civil commitment laws had the effect of decreasing human dignity and diverting the mentally ill into jails and prisons.

In Washington, psychiatrists claimed that county mental health professionals, most of whom were non-medically trained individuals, were not qualified to assess the appropriateness of the initial commitment decision. Family members were often opposed to restrictive commitment criteria since such laws frequently prevented them from securing a relative’s commitment to a mental institution. “Patient advocate” support groups, such as Family Action for the Seriously Emotionally Disturbed (F.A.S.E.D.) and Washington Advocates for the Mentally Ill (W/AMI) lobbied the legislature to expand the commitment authority of the state.

Efforts to change the commitment law received significant impe-

83. See, e.g., N.Y. Times, May 21, 1978, §6 (Magazine), at 14; id., Nov. 18, 1979, at 1; id., Nov. 19, 1979, at B1; id., Nov. 20, 1979, at B1.
87. Id. at 16-17.
tus from the 1978 murder of a wealthy Seattle couple by their 23-year-old next door neighbor, Angus MacFarlane, who had been denied voluntary admission to Western State Hospital only hours before the murder. The publicity surrounding the homicide and the trial portrayed Washington's mental health system as poorly financed and inaccessible. The MacFarlane case did not directly involve a violent crime committed by a mentally ill person whom the state had tried and failed to commit involuntarily, but it did help publicize the plight of families who had been unable to secure involuntary treatment for family members under the existing "grave disability" or "likelihood of serious harm" standards. This case, and the public outcry that accompanied it, appear to have been instrumental in persuading the Washington legislature to revise the 1973 ITA.

C. Involuntary Treatment Act of 1979

The Washington state legislature enacted changes in the Involuntary Treatment Act which went into effect on September 1, 1979. The basic structure of the 1973 Involuntary Treatment Act remained. Senate Bill 2415, which became the 1979 ITA, specifically stated that its intent was to accomplish the purposes of and to reaffirm the 1973 Act. However, it is quite clear from the legislative history of the 1979 ITA that the Washington State Legislature intended to create a "wider net" for involuntary commitment. The legislative history of the 1979 ITA indicates that lawmakers were responding to public concern that the 1973 ITA commitment standards were too restrictive. By expanding the definition of "gravely disabled," persons in need of treatment but who fell outside the scope of the 1973 ITA criteria could be reached under the 1979 ITA. In creating "a much wider net," the state legislature realized that the proposed budget might be inadequate to address the anticipated influx of new patients under the more expansive commitment criteria.


89. WASH. REV. CODE ANN. §71.05.015 (West Supp. 1985).


91. Senator McDermott, a legislator who had worked as a psychiatrist for the King County Jail, acknowledged this problem openly "[w]e are putting quite an increase into the mental health budget but I am not really sure that it will cover all the people who will now fall under this bill. I hope so and think we may be faced with a supplemental appropri-
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The fundamental change sought in 1979 was the expansion of the substantive power of the state to commit persons involuntarily. Consequently, the legislature revised the criteria for civil commitment to accomplish this objective. The revised criteria 1) expanded the definition of "gravely disabled," and 2) expanded the definition of "likelihood of serious harm" to include destruction of property. Though the statute also provided for minor changes regarding recommitment of patients who violated the terms of their conditional release and permitted spousal testimony in commitment hearings, the 1979 ITA did not change any of the procedures governing involuntary commitment of individuals to mental health facilities.

1. **Expansion of the Definition of "Gravely Disabled"**

As the 1979 law defined it, "[g]ravely disabled means a condition in which a person, as a result of a mental disorder a) is in danger of serious physical harm resulting from a failure to provide for his essential human needs of health or safety, or b) manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety." This change in the definition...
of "gravely disabled" expanded the scope of the state's *parens patriae* power; it authorized mental health professionals to commit involuntarily people who could not function independently in the community or who manifested severe deterioration in routine functioning because of mental impairment.

The 1973 ITA had provided that involuntary commitment of a non-dangerous mentally ill person was available only if she could not minimally satisfy her basic "human needs." In 1979 the phrase "human needs of health or safety" was added to expand the scope of the commitment standard. Thus, families seeking to commit a mentally ill member may now establish that her essential health needs cannot be provided outside a hospital, even though the family may be able to assure the individual's physical safety.

It had been observed that discharged patients were often able to care for themselves in the community without great difficulty for several months. However, after approximately 60 to 90 days, many stopped taking their prescribed medication, and exhibited rapid deterioration in their ability to function independently. The expansion of the definition of grave disability under the 1979 ITA allowed evidence of such "decompensation" as a basis for commitment, where evidence of deterioration is thought to indicate a reasonable probability that the person is, or will imminently become, gravely disabled without treatment.

2. Inclusion of Property Damage

The 1979 amendments also redefined "likelihood of serious harm" as follows:

a) a substantial risk that physical harm will be inflicted by an individual upon his own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on one's self; b) a substantial risk that

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95. See supra note 56 and accompanying text.

96. Decompensation is a progressive deterioration of routine functioning supported by evidence of repeated and escalating loss of cognitive or volitional control of actions. The definition is incorporated in the statute. See WASH. REV. CODE ANN. § 71.05.020(1)(b) (West Supp. 1985). This term is used to diagnose the presence of mental illness. See, e.g., DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 5 (3rd ed. 1980) [hereinafter cited as DSM-III].
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physical harm will be inflicted by an individual upon another, as evidenced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm; or c) a substantial risk that physical harm will be inflicted by an individual upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others.97

This type of police power authority was often sanctioned in early mental health legislation and remains a part of the laws in several states.98 The fact that property damage may include tampering with any object that is of some value to another person confers wide discretion on mental health professionals in making commitment decisions.99

D. The Mental Health System Responds to the Change

The broadened commitment criteria of the 1979 statute significantly increased the likelihood that more patients would be committed to public mental health facilities in circumstances that would not have justified commitment under the 1973 ITA. However, while the revised statute made it easier to commit more people to state mental facilities, expansion of mental health resources did not match the expansion of authority to detain patients involuntarily.100 Staffing and bed space did not expand apace to accommodate the growing number of patients in the system.

Following passage of the 1979 ITA, it was immediately apparent that increased admissions would result. In fact, an avalanche of involuntary admissions practically overwhelmed the institutional resources available in the state.101 In response to a 180 percent

99. In Suzuki v. Yuen, 617 F.2d 173 (9th Cir. 1980), the United States Court of Appeals for the Ninth Circuit struck down as unconstitutionally broad a Hawaii commitment statute containing a commitment criterion almost identical to this provision of the 1979 ITA. Though no constitutional attack has yet been made on the Washington criterion, it appears vulnerable to challenge. After the opinion in the Suzuki case, Washington commitment personnel were discouraged in state-sponsored training sessions from committing individuals solely on this ground. Durham & Pierce, supra note 50.
100. In the 1977-79 Biennium, the ITA expenditures of state and federal funds amounted to $9.7 million. These funds covered administrative costs such as investigation, direct court costs, transportation, and local hospital costs. In the 1979-81 Biennium, these expenditures amounted to $15.7 million to cover the same costs, thereby increasing by 61.8%. (These figures do not include that portion of the state hospital budget devoted to support of the ITA program.) L.B.C., supra note 86, at 32-33.
101. In the two years before the implementation of the 1979 ITA, there were 1485 commitments (Sept. 1977-Aug. 1978) and 1889 commitments (Sept. 1978-Aug. 1979) in King and Pierce counties. In the two years following the 1979 ITA, there were 2463 commitments (Sept. 1979-Aug. 1980) and 2449 commitments (Sept. 1980-Aug. 1981)
increase in involuntary admissions, Western State Hospital (WSH), which serves all of western Washington, opened another ward that filled up immediately. Faced with increasing pressure to admit involuntary patients, and the attendant demand on staff and resources, WSH instituted a “limited admissions” policy which restricted admissions to 90 percent of bed capacity. This amounted to an effective cap on admissions to the hospital.

Other psychiatric units in Pierce County, where WSH is located, were filled to 100 percent capacity for months at a time. The overflow of psychiatric patients was handled on an emergency, makeshift basis. Patients stayed in medical units of local hospitals or in nursing homes until beds could be found in evaluation and treatment units. The Office of Involuntary Commitment in Pierce County notified all community hospitals, social agencies, and CDMHPs, apprising them of the situation and warning them that referrals to the Pierce County E&T facility might not lead to detention because of the limited availability of bed space at WSH. Weary of shopping around for openings in an evaluation and treatment facility, the Pierce County CDMHP obtained a temporary restraining order in those counties. This phenomenon of an increase in the number of involuntary patients, following revision of statutory commitment criteria to expand the state’s commitment authority, has occurred elsewhere. In 1979 North Carolina revised its commitment law in such a manner and, on a sample basis, experienced a significant increase in the number of patients committed. However, it is not clear whether North Carolina’s increase is attributable to the change in commitment criteria or to a change in the conception of the attorney’s role from that of an advocate for freedom to that of an advocate for the best interest of the client. See Miller & Fiddleman, supra note 82. This pronounced increase in the number of involuntary patients in Washington and North Carolina contrasted sharply with the national experience prior to these statutory changes.

Between 1971 and 1976, the number of state and county mental hospital residents in the U.S. declined from 308,983 to 170,619. M. J. Witkin, Provisional Patient Movement and Selective Administrative Data, State and County Mental Hospitals, Inpatient Services by State; United States, 1976, Mental Health Statistical Note 153, N.I.M.H. (1979).

102. Western State Hospital (“WSH”) is located in Pierce County and is the major mental health facility in the state. As of 1982, it had an acute care inpatient psychiatric bed capacity of 52 beds specifically designated to serve involuntarily committed patients.

103. During August 1981, there were 24 persons admitted to WSH via temporary restraining orders and 46 persons who had to wait in restraints in the Harborview Hospital Emergency Room (“ER”) for the first available bed. The average waiting time in restraints was 7.7 hours per case. As local and state bed occupancy continued to exceed capacity, more patients had to be restrained in the ER to wait for a bed, and temporary restraining orders became a major mechanism for admitting patients to involuntary inpatient care. Hospitalization Utilization Study, Dec. 29, 1981, at 5. The 1981-83 expenditure rate for ITA patients in community hospitals exceeded projections by approximately $146,000 per month. The reasons stated were “inflation in costs of services, particularly daily hospital bed rates and hospital utilization rates near 100%.” L.B.C., supra note 86, at 89-90.
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order forcing WSH to accept all persons detained under the 1979 ITA regardless of bed space. Other counties joined Pierce County and obtained a permanent injunction requiring WSH to admit involuntarily detained patients despite the unavailability of beds.

At the same time, state mental health officials instituted a policy designed to decrease the length of stay for patients in community facilities. The state would no longer reimburse providers in the private sector for services rendered after the 14th day of commitment unless the Division of Mental Health gave special approval, thus ensuring that virtually all 90- and 180-day commitments would be at state hospitals. In instituting this policy, the state sought to lower the cost of lengthier commitments since hospitalization at state hospitals costs the state less than inpatient care in private facilities.

The 1979 ITA brought extreme pressure on the mental health system to provide services for a rapidly growing involuntary patient population. The research reported here describes a variety of effects which resulted from the statutory change.

III. Research Methodology

A. Design

The change in Washington’s civil commitment law presented an opportunity to study the direct as well as the indirect (and unanticipated) effects of a legislative change in commitment criteria. Study of the new law’s impact called for a close examination of commitments of a large number of clients two years prior to and two years following the legal change. By examining a computerized file of all patients committed to state mental hospitals and a large sample of individual case records in two county offices of involuntary commitment, the investigators were able to construct a longitudinal time

104. Pierce County v. Western State Hospital, 97 Wash. 2d 264, 644 P.2d 131 (1982). The Washington State Department of Social and Health Services ("DSHS") was very concerned with conditions at Western State Hospital. In its brief for the Washington Supreme Court, DSHS described Western State Hospital as "dangerous, overcrowded and not conducive to the providing of adequate care and treatment." Brief for Appellant at 21, Pierce County v. Western State Hospital, 97 Wash.2d 264, 644 P.2d 131 (1982).


106. See CIVIL COMMITMENT IN KING COUNTY, FINAL REPORT OF THE COMMITTEE ON KING COUNTY INVOLUNTARY CIVIL COMMITMENT, June 26, 1981, at 32. State Hospital costs were estimated to be about $77 per patient per day (inclusive of medical charges), while private community inpatient hospitalization cost from $175 - $245 per day (exclusive of medical charges). Id. at 33.
series which compared the pre-1979 with the post-1979 ITA patterns.

B. Data for the Study

The study is based on two primary data sources. The first one derives from Washington’s Department of Social and Health Services\textsuperscript{107} which maintains a computerized data base for all patients admitted to state mental hospitals; this includes information on each patient’s demographic characteristics, diagnoses, admission status (voluntary or involuntary) and prior admission history. The second group of data consists of individual case records of a randomly selected group of 3,570 individuals who were referred to the Offices of Involuntary Commitment in King and Pierce counties from September, 1977 through August, 1981. Review of individual case records allowed a more detailed analysis of the commitment process than was possible using only the state’s computerized data base. The 3,570 individuals sampled accounted for 8,100 referrals to the civil commitment system and 3,900 commitments. Clients who were examined by county designated mental health professionals but not subsequently committed are included in the sample of 3,570 along with those committed under applicable Washington law for 72 hours or longer.

C. Two County Analysis

1. Rationale for a Two County Analysis

Although the state’s computerized file was obtained for each year of the study period, it was also important to analyze the effect of the statutory change on commitments occurring outside the state hospital system. Study of client activity at the county level was useful because admission to state mental hospitals is strongly influenced by the availability of resources within a particular community. Communities that lack inpatient mental health resources will find some other way to control the behavior of disturbed or disturbing people, such as outpatient commitment or arrest for petty crimes.\textsuperscript{108} County offices of involuntary commitment make local arrangements

\begin{footnotesize}
\textsuperscript{107} By statute, this department has the following responsibilities: “The department of social and health services is designed to integrate and coordinate all those activities involving...care for individuals who...require financial assistance, institutional care, rehabilitation or other social and health services. The department will concern itself with changing social needs and will expedite the development and implementation of programs designed to achieve its goals.” WASH. REV. CODE ANN. §43.20A.010 (West 1983).

\textsuperscript{108} See supra note 85 and accompanying text.
\end{footnotesize}
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for most emergency and short-term commitments, and reserve transfer to state mental hospitals for those patients requiring lengthier stays. Increased demand for commitment at the county level was investigated to determine its influence on demand at state mental hospitals. The impact of the legal change on shorter detentions which occurred solely at the local level was also measured.

Two of Washington's counties were analyzed in depth. King and Pierce Counties were selected because approximately 40 percent of Washington's involuntary commitments occur there, making it possible to collect a large number of client records within a short timeframe. Pierce County was particularly important as a study site because it is the location of the state's largest mental hospital, and the influence of the hospital's presence on involuntary commitment patterns could be studied.

Our data indicate that the variable "county" influences most aspects of the involuntary treatment system. Counties differ with respect to administration, management, and available resources. The influence of "county" was so strong that we performed many of our analyses separately for each county to determine the varying influence of key factors on commitment and retention decisions.

2. King and Pierce Counties

The State of Washington is divided by the Cascade Mountain Range. King and Pierce counties are located in the western half of Washington and comprise the major urban center of the Pacific Northwest. Just over 1.3 million people live in King County with the greatest number (500,000) residing in Seattle. Pierce County is located immediately south of King County and has 501,000 residents, 160,000 of whom live in Tacoma.

In the period studied, the counties differed significantly in number and type of resources available to commitment authorities. More resources per capita, in the form of dollars and CDMHPs, were available in King County than in Pierce over the study period. In 1981, ITA administrative funding$ was $1.42 per capita total population for King County, compared with $1.31 for Pierce County.110 In the same year, ITA administrative funding per ITA detention was somewhat lower in King County ($924.00) than in

109. Administrative funds are those intended to cover the costs of ITA emergency services, investigations, court processes, transportation and other minor administrative expenses associated with county implementation of the ITA. This excludes the cost of inpatient care at either the local or state hospital. L.B.C., supra note 86, at 47-48.
110. Id. at 47. This report states that there may be inaccuracies in the exactness of these figures, but that they are accurate to illustrate county differences.
Pierce ($977.71). Over the period studied, four hospitals handled the initial and short-term detentions in King County. Only four months after the 1979 ITA went into effect, King County increased its CDMHP staff from 11 to 27. This lowered the ratio of CDMHPs per 100,000 population in King County, making it smaller than the ratio for Pierce County.

Pierce County employed only 4 full-time and 5 part-time CDMHPs over the study period and relied primarily upon one local facility and the state hospital for emergency detentions. During that time, lengthy detentions for both counties were referred to Western State Hospital in Pierce County.

Assignment of legal counsel for indigent patients also varied between King and Pierce counties. In Washington State the most common arrangements for assigning counsel involve a) relying on a public defender, b) contracting with a local law firm, or c) assigning an attorney on a rotation basis from a county-maintained list. Most candidates for commitment in King County were represented by public defenders during the study period. In Pierce County they were represented by counsel appointed from a list approved by the county commissioners. In sum, there were important differences between King and Pierce counties in the availability of commitment resources to mental health authorities and clients.

IV. Major Findings

The examination of state mental hospital data and individual case records from the two counties yielded information on a variety of aspects of Washington’s mental health system. The findings discussed herein relate specifically to changes resulting from the state’s 1979 revision of its involuntary commitment law.

A. “Anticipation Effect” and Reinstitutionalization of the Mentally Ill

Analysis of state mental hospital admissions and discharges before and after the implementation of the 1979 ITA reveals that involuntary admissions began to rise nine months before the effective date of the new statute (see Table 1). Moreover, an even greater increase in the number of commitments to state hospitals occurred throughout Washington in the four months after the 1979 ITA went into effect. Involuntary admissions to state hospitals during the first four month period after the effective date of the 1979 ITA increased from 591 to 858, a 45.2 percent increase. Voluntary admis-

111. Id.
TABLE 1

Admission to State Mental Institution in Washington by Authority September 1977 through August 1980

<table>
<thead>
<tr>
<th>Current Admission Authority</th>
<th>Involuntary Admissions</th>
<th>Voluntary Admissions</th>
<th>Total**</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>% of Total</td>
<td>Number</td>
</tr>
<tr>
<td>1977 9-12</td>
<td>325</td>
<td>33.9</td>
<td>634</td>
</tr>
<tr>
<td>1978 1-4</td>
<td>333</td>
<td>35.2</td>
<td>613</td>
</tr>
<tr>
<td></td>
<td>404</td>
<td>41.8</td>
<td>563</td>
</tr>
<tr>
<td></td>
<td>396</td>
<td>40.5</td>
<td>581</td>
</tr>
<tr>
<td>1979 1-4</td>
<td>486</td>
<td>45.3</td>
<td>586</td>
</tr>
<tr>
<td></td>
<td>591</td>
<td>55.3</td>
<td>518</td>
</tr>
<tr>
<td>*9-12</td>
<td>858</td>
<td>66.0</td>
<td>442</td>
</tr>
<tr>
<td>1980 1-4</td>
<td>872</td>
<td>66.4</td>
<td>441</td>
</tr>
<tr>
<td></td>
<td>1,129</td>
<td>74.7</td>
<td>382</td>
</tr>
</tbody>
</table>

* ITA79 in effect as of September 1, 1979
** Total admissions exclude state mental hospital patients on legal offender status.

These trends suggest two important conclusions. First, there was an "anticipation effect" indicated by an abrupt increase in involuntary admissions during the year before the effective date of the new law. Empirical evidence from the two counties indicates that the increase occurred both at Western State Hospital and at the local...
level. It has been argued elsewhere\textsuperscript{114} that the increase in involuntary commitments at WSH was influenced by the MacFarlane murder of August 1978 mentioned above. Immediately following that well-publicized event, involuntary monthly admissions to the state hospital increased from King County where the murder occurred, but not from elsewhere in the state. The MacFarlane murder seemed to have a much less dramatic effect on commitments to county facilities than on commitments to WSH. In the six months following the murder, commitments in King County increased by only 11.7 percent, while in Pierce County there was a slight drop in the number of persons committed. In contrast, both King and Pierce Counties experienced a substantial increase in the volume of commitments (29.3 percent and 21.3 percent, respectively) in the six months prior to the effective date of the 1979 ITA.\textsuperscript{115} These data suggest that there was an independent local effect of the MacFarlane event on admissions from King County (both to the state hospital and, to a lesser degree, in local facilities), and a general anticipation effect in both counties attributable to the law in the six months prior to the statutory change.

Interestingly, throughout the entire period of this study, the demand for involuntary services (i.e., the number of referrals brought to the attention of the CDMHP) increased only slightly. Yet in spite of the small increase in the number of clients referred to CDMHPs for initial evaluation, commitment rates increased significantly during the year prior to and immediately following the effective date of the 1979 ITA.

The second important conclusion highlighted by the data on admissions is that the sharp increase in involuntary commitments and the concomitant disappearance of voluntary patients from state hospitals cannot be attributed to an acceleration of a "revolving door" pattern of rapid admission, discharge and readmission. Patients were involuntarily committed regardless of their previous commitment status. Table 2 establishes that, in the year following the enactment of the 1979 ITA, the probability of an involuntary

\textsuperscript{114} See Pierce, Durham, \& Fisher, The Impact of Public Policy and Publicity on Admissions to State Mental Health Hospitals, \textit{J. Health Politics, Policy \& Law} (1985).

\textsuperscript{115} In King County, the random sample identified 486 commitments in the six month interval from April, 1978 to August, 1978. In the six months following the murder (Aug. 1978- Mar. 1979), 543 commitments were identified in the sample (11.7% increase), followed by 702 commitments (29.3% increase) in the six months prior to the statutory change. In Pierce County, the number of commitments in the sample dropped from 354 (six months prior to the MacFarlane murder) to 291 (six months following) but rose by 21.3 percent to 353 in the six months prior to the statutory change.
(admission to Washington state mental hospitals increased both for first time admissions (from 47.3 to 63.2) and for patients previously admitted on a voluntary basis (from 25.1 to 41.7).116 Thus, some of the increase in involuntary commitment following enactment of the 1979 ITA is attributable both to patients entering the system for the first time and to patients previously admitted voluntarily being committed involuntarily.

B. Changes in Use of Commitment Authority

1. Shift Toward Grave Disability

In conjunction with the growth in the number of involuntary commitments following the 1979 ITA, Washington experienced a shift toward a *parens patriae*-dominated civil commitment system. While grave disability was the primary justification for commitment authority even before implementation of the 1979 ITA, the use of grave disability began to increase dramatically after the statute was promulgated. By 1981 three of every four commitments relied on the grave disability standard. The use of dangerousness to others and dangerousness to self as a basis for commitment decreased, in-

116. See Table 2. There was a statistically significant increase in the proportion of first time admissions ($X^2=33.7$, df=1, $p<.001$) and the proportion of patients previously admitted voluntarily ($X^2=21.6$, df=1, $p<.001$). See Pierce, Durham & Fisher, supra note 113.

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### TABLE 2

Probability of Involuntary Admission by Prior Admissions Status and Authority, September 1, 1977 through August 31, 1980

<table>
<thead>
<tr>
<th>Current Admission</th>
<th>No Prior Admission</th>
<th>Prior Voluntary</th>
<th>Prior Involuntary</th>
<th>Total Involuntary Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year Month</td>
<td>% (N)</td>
<td>% (N)</td>
<td>% (N)</td>
<td>% (N)</td>
</tr>
<tr>
<td>1977 9-12</td>
<td>28.6 (153)</td>
<td>17.9 ( 72)</td>
<td>43.4 ( 35)</td>
<td>25.5 ( 325)</td>
</tr>
<tr>
<td>1978 1-4</td>
<td>32.9 (171)</td>
<td>17.9 ( 74)</td>
<td>39.3 ( 77)</td>
<td>26.6 ( 333)</td>
</tr>
<tr>
<td>9-12</td>
<td>36.9 (195)</td>
<td>19.9 ( 77)</td>
<td>52.0 (116)</td>
<td>31.2 ( 404)</td>
</tr>
<tr>
<td>1979 1-4</td>
<td>40.7 (227)</td>
<td>21.9 ( 86)</td>
<td>59.0 (151)</td>
<td>36.2 ( 486)</td>
</tr>
<tr>
<td>5-8</td>
<td>47.3 (278)</td>
<td>25.1 ( 97)</td>
<td>65.8 (187)</td>
<td>42.4 ( 591)</td>
</tr>
<tr>
<td>9-12</td>
<td>58.3 (380)</td>
<td>36.0 (134)</td>
<td>72.4 (302)</td>
<td>54.3 ( 858)</td>
</tr>
<tr>
<td>1980 1-4</td>
<td>54.8 (359)</td>
<td>41.6 (150)</td>
<td>74.3 (330)</td>
<td>55.2 ( 872)</td>
</tr>
<tr>
<td>5-8</td>
<td>63.2 (489)</td>
<td>41.7 (139)</td>
<td>79.7 (458)</td>
<td>62.1 (1129)</td>
</tr>
</tbody>
</table>

* ITA79 in effect as September 1, 1979
** Percentages will not sum to 100 percent because counts of cases are duplicated where more than one prior admission status was involved.
volving only 29.7 percent and 25.7 percent of commitments respectively. Moreover, the data indicate that clients committed for grave disability were more likely to be ordered to 90- or 180-day confinements than clients detained for dangerousness; the latter were usually released after 72 hours or 14 days.

This markedly increased reliance on the grave disability, as opposed to the dangerousness, ground for commitment occurred despite the fact that the 1979 ITA expressly provided for commitment of persons dangerous to property.\textsuperscript{117} Thus, although the 1979 ITA provided an expansion of both police power and parens patriae power, the system relied almost exclusively on the increased parens patriae authority, virtually ignoring the expanded police power authority (see Table 3).

### TABLE 3

<table>
<thead>
<tr>
<th>Year</th>
<th>New Clients</th>
<th>Old Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Grave disability</td>
<td>Danger to self</td>
</tr>
<tr>
<td>New Clients</td>
<td>443 (46.9)</td>
<td>578 (51.4)</td>
</tr>
<tr>
<td>Old Clients</td>
<td>257 (53.9)</td>
<td>376 (48.6)</td>
</tr>
<tr>
<td>New Clients as % of Total Commitments</td>
<td>943 (66.5)</td>
<td>1125 (62.3)</td>
</tr>
<tr>
<td>Old Clients as % of Total Commitments</td>
<td>476 (33.5)</td>
<td>680 (37.7)</td>
</tr>
<tr>
<td>Total Commitments</td>
<td>1419 (100.0)</td>
<td>1805 (100.0)</td>
</tr>
</tbody>
</table>

* Counts of cases are duplicated where more than one authority was cited as a basis for commitment. Percentages will therefore not sum to 100%.

2. \textit{Changes in Clientele}

This shift toward the use of the grave disability ground raises two questions: First, is the growth in the committed population in

\textsuperscript{117} See supra notes 97-99 and accompanying text.
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Washington due to an influx of new clients or to an increase in re-commitments of old clients? Second, is the new emphasis of the mental health system on *parens patriae* commitments due to increased admissions of *new* clients as gravely disabled rather than dangerous, or to a redefinition of *old* dangerous clients into a gravely disabled category?

a. *New Clients and Old Clients*

The growth in commitments that occurred in the years before and after the statutory change may be attributed to an increase in the number of both *new* and *old* clients. Although the absolute number of newly committed clients exceeded the absolute number of recommitments in each study year, the ratio of new to old clients narrowed considerably as time went on (see Table 3). By 1981 the number of new client admissions decreased (from 1482 to 1345), while the number of readmissions increased (from 897 to 1003). The evidence indicates that, while the CDMHPs continued to detain large numbers of new clients, former involuntary patients began to return with increased frequency. This trend suggests a certain “snowball” effect characterized by the later readmission of those new clients committed during 1978 and 1979. Thus, continuing relationships with the involuntary commitment system seem to have been set in motion by the 1979 ITA, creating a pattern of recurring institutional placement which appears difficult to break.

Growth in the number of clients re-entering the commitment system has consequently increased the likelihood of growth in the number of those classified as “chronically mentally ill”. Over the four years of the study, 26.8 percent of all those committed were classifiable as chronic patients under Washington’s definition. Though constituting only a quarter of those committed, chronic patients were admitted more frequently, accounting for over half (53.2

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118. A “new” client is defined as an individual who has not been previously committed in Washington State.
119. An “old” client is an individual with a prior commitment history in Washington State, whether voluntary or involuntary.
120. There was a statistically significant drop in the number of new client admissions between the year following the legal change and the end of the observation period (August 31, 1981) ($X^2=12.1$, df=1, $p<.001$).
121. For a more thorough analysis of the implications of these data, see infra notes 134-136 and accompanying text.
122. Washington’s Community Mental Health Service Act [codified at WASH. REV. CODE ANN. §71.24.025(4)(a),(b) (West 1985)] defines as “chronically mentally ill” an individual who has undergone two or more episodes of hospital care for a mental disorder within the preceding two years, or has experienced a continuous psychiatric hospitalization or residential treatment exceeding six month’s duration within the preceding year.
percent) of the total of those committed during the four-year study period and averaging 5.5 referrals and 3.2 commitments per individual. Although there was no significant increase in the number of chronic patients in the year immediately following the statutory change, the number of chronic patients did increase gradually over the study period. Thus, the stage may now be set for “old” clients to become chronic patients in the future.

Table 3 indicates that in each year of the study, grave disability was the statutory ground used most frequently to commit both new and old clients. However, the use of grave disability increased by a greater proportion for old than for new clients. During the final year of the study, 80 percent of the increase in commitments for grave disability was due to the recommitment of former clients. This indicates that while a sizeable part of the increase in the number of commitments for grave disability was attributable to new clients, more and more of the gravely disabled population had a prior history of commitment.123

b. Redefinition of Old Clients: the Use of Police Power Authority

Together with the increased use of grave disability as a commitment ground, the data reflect a tendency to replace the use of dangerousness (i.e., police power authority) with the use of grave disability (i.e., parens patriae authority). This trend was ascertained by examining a) changes in the pattern of authority used to commit a single patient over time, and b) changes in the type of commitment authority used in situations involving violent behavior (the type of behavior most likely to invoke police power authority).

(1) Reclassification. The commitment history of a group of 747 formerly committed patients revealed that more than one third (34.6%) had been committed as dangerous to others or themselves in years prior to the effective date of the 1979 ITA but were afterwards committed as gravely disabled. To explore further this increase in the number of commitments for grave disability, we examined the distribution of commitments between the two subtypes of grave disability, “health and safety”124 and “cognitive and volitional impairment.”125

The data indicate that the number of commitments for health and

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123. We found that the use of a grave disability finding to recommit returning clients increased throughout the study period. By 1981, 80 percent of the increase in commitments for grave disability was due to recommitment of clients who then fit Washington’s definition of “chronically mentally ill.”

124. See supra note 94 and accompanying text.

125. Id.
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safety reasons increased gradually between 1977 and 1981. If any peak occurred in the volume of such commitments, it was in the six months prior to the 1979 ITA. This increase may be attributed to the dramatic decline in the use of “gravely disabled—unspecified”. CDMHPs appear to have abandoned the use of “unspecified” as a ground for commitment, in favor of “gravely disabled for cognitive and volitional impairment reasons.”

While there was an actual increase in the use of cognitive and volitional authority by CDMHPs following the 1979 ITA, some of the change was due to the increase in the use of multiple grounds for commitment. CDMHPs often cited grave disability along with dangerousness as the reason for involuntary detention.

(2) Violent behavior. Figure 2 summarizes the types of behavior most often associated with different commitment grounds. “Bizarre” behavior is mentioned with great frequency in all categories of authority. Such behavior is troublesome and annoying to the community (e.g., disruptive or disturbing behavior which may be harmful to others), and is most often mentioned in conjunction with other types of behavior. “Health and safety” and “unspecified” categories of grave disability show many similarities; both suggest, for instance, a degree of “passive neglect” on the part of the client. Cognitive and volitional impairment has some elements of passive neglect but also appears to imply more active, threatening behavior. “Dangerousness to self” is most often characterized by an affirmative act of self-destruction (e.g., suicidal behavior or drug or alcohol abuse). Table 4 presents evidence that people who engage in violent behavior may be committed as “dangerous to others” and/or as gravely disabled. Trends from 1977 to 1981 indicate that there was a shift in the primary statutory authority used to detain individuals who engage in violent behavior. In 1977, danger to others was used as the commitment authority in 79.4 percent of cases where the client engaged in violent behavior, compared to 32.5 percent of cases where grave disability was used. By 1981, grave disability was used more often to detain clients who behaved violently (65.1%) than dangerousness to others (60.7%) (see Table 4).

126. In our sample, the number of gravely disabled-cognitive and volitional doubled in the year after implementation of the 1979 ITA. The number of gravely disabled-unspecified fell by 35 percent.

127. “Bizarre” behavior is based on behaviors cited in the mental health record, including active hallucinations, delusions, paranoia, obsessions, incoherent speech, and poor impulse control not stated as harmful or hazardous but as disruptive or disturbing to others. See Teknekron, Inc., Improving California’s Mental Health System: Policy Making and Management in the Invisible System (Report for California Assembly Permanent Subcommittee on Mental Health and Developmental Disabilities) (1978).

128. For individuals who engaged in violent behavior, there was a statistically signifi-
FIGURE 2 — Types of Behavior Associated with Commitment Authority, 1977-81*

<table>
<thead>
<tr>
<th>TYPE OF AUTHORITY</th>
<th>CHARACTERISTIC BEHAVIOR†</th>
</tr>
</thead>
<tbody>
<tr>
<td>GRAVELY DISABLED:</td>
<td>Bizarre (61.3)**, health &amp; safety (52.2), cog. &amp; volitional (53.8)</td>
</tr>
<tr>
<td>GRAVELY DISABLED:</td>
<td>Bizarre (67.0), violent behavior (36.3), health &amp; safety (43.4), cog. and volitional (50.8), emotionally upset in active way (agitated, verbal abuse) (32.5)</td>
</tr>
<tr>
<td>COGNITIVE &amp; VOLITIONAL</td>
<td>Bizarre (60.9), viol. behavior (45.6), cog. and volitional (44.9)</td>
</tr>
<tr>
<td>DANGEROUS TO OTHERS</td>
<td>Bizarre (62.0), violent behavior (68.3), violent threat (42.3), cog. &amp; volitional (33.0)</td>
</tr>
<tr>
<td>DANGEROUS TO SELF</td>
<td>Emotionally upset- passive (46.8), suicide ideas (37.3), suicide attempts (33.2), bizarre (36.1).</td>
</tr>
</tbody>
</table>

† Bizarre Behavior — active hallucination, delusions, paranoia, obsessions, incoherent speech, poor impulse control not stated as harmful or hazardous but disruptive or disturbing to others (Teknekron, 1978).

Health and Safety — neglecting self; not eating; losing weight; no money; wandering; “non-responsible” of self, environment, children; incontinent, not washing, can’t sleep.

Cognitive and Volitional — confused; disoriented; dazed; memory loss; “decompensation” mentioned in file.

Violent Behavior — explicit act of violence to others which did or could have done harm.

Violent Threat — threat of violence to others (verbal threats, gestures, harassment).

Emotionally Upset -
  a. active — agitated, running away, verbal abuse.

Suicidal Ideation — suicidal ideas mentioned as reason for referral.

Suicide Attempt — unsuccessful, explicit suicide attempt by an active means.

** Reasons for detention are recorded by the CDMHP in the mental health record. Since numerous behaviors (reasons) may have been recorded for a single client, these percentages exceed 100%.


In sum, the observation that the parens patriae approach dominates the present commitment system in Washington state is supported by: 1) a continuing trend toward substituting police power commitments with commitments under parens patriae authority; and 2) increased use of the gravely disabled designation for new patients. In particular, there has been a definite shift in the reliance by CDMHPs cant change in the proportion of commitments for grave disability as compared with danger to others between 1977 and 1981 ($X^2 = 11.1$, df = 1, $p < .001$).
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away from "dangerousness to self or others" toward "grave disabil-
ity" to commit those engaged in violent behavior.

TABLE 4
Comparison of Authority Used to Commit
Violent Behavior Over Time,
1977-1981

<table>
<thead>
<tr>
<th>Year</th>
<th>Month</th>
<th>Gravely Disabled</th>
<th>Number (%)*</th>
<th>Danger to Others</th>
<th>Number (%)*</th>
<th>Violent Commitment</th>
<th>TOTALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>77-78</td>
<td>Sep-Feb</td>
<td>79 (32.5)</td>
<td>193 (79.4)</td>
<td></td>
<td></td>
<td></td>
<td>243</td>
</tr>
<tr>
<td>78</td>
<td>Mar-Aug</td>
<td>124 (40.1)</td>
<td>231 (74.8)</td>
<td></td>
<td></td>
<td></td>
<td>309</td>
</tr>
<tr>
<td>78-79</td>
<td>Sep-Feb</td>
<td>108 (34.5)</td>
<td>233 (74.4)</td>
<td></td>
<td></td>
<td></td>
<td>313</td>
</tr>
<tr>
<td>79</td>
<td>Mar-Aug</td>
<td>167 (41.5)</td>
<td>309 (76.8)</td>
<td></td>
<td></td>
<td></td>
<td>402</td>
</tr>
<tr>
<td>79-80</td>
<td>Sep-Feb</td>
<td>201 (50.0)</td>
<td>300 (74.6)</td>
<td></td>
<td></td>
<td></td>
<td>402</td>
</tr>
<tr>
<td>80</td>
<td>Mar-Aug</td>
<td>278 (58.5)</td>
<td>307 (64.6)</td>
<td></td>
<td></td>
<td></td>
<td>475</td>
</tr>
<tr>
<td>80-81</td>
<td>Sep-Feb</td>
<td>272 (72.1)</td>
<td>256 (67.9)</td>
<td></td>
<td></td>
<td></td>
<td>377</td>
</tr>
<tr>
<td>81</td>
<td>Mar-Aug</td>
<td>270 (65.1)</td>
<td>252 (60.7)</td>
<td></td>
<td></td>
<td></td>
<td>415</td>
</tr>
</tbody>
</table>

* Counts of cases are duplicated where more than one authority was cited as a basis for commitment. Percentages will therefore not sum to 100%.

3. Litigation Outcomes

It is apparent from the data that King and Pierce Counties exhibited very different detention rates at each step in the commitment process. Beginning with the initial detention for 72 hours, King County committed a significantly greater proportion of referees (those referred for commitment to CDMHPs) than did Pierce County—one of every three individuals committed in King versus one of every four in Pierce.

Since client detention beyond 72 hours requires a judicial hearing, litigation outcomes were examined to estimate any county variations (see Table 5). "Litigation outcomes" refers to the decision to release, detain, or order a less restrictive alternative (LRA) once a

129. The sample represents 2,007 commitments in King, and 1,786 in Pierce County ($X^2=77.1, df=1, p<.001$).

130. A "less restrictive alternative" is a treatment environment which curtails individual freedom only to the extent necessary to secure a legitimate community interest. Its objective is to maintain the greatest degree of freedom, self-determination, autonomy, dignity and integrity while the patient is undergoing treatment for mental illness. See Chambers, Community-Based Treatment and the Constitution: the Principle of the Least Re-
petition for hearing has been filed. Dramatic variations were observed in the litigation outcomes between the two counties studied. As noted in Table 5, in Pierce County the state won virtually all 14- and 90-day hearings, while in King County public defenders won on behalf of detainees in as many as 13 percent of the cases. The likelihood of commitment varied according to 1) the length of the proposed detention and 2) the type of authority under which the client was detained (see Table 5).

In both counties detention was more likely to occur at the hearing for a 14-day commitment than at the hearings for a subsequent 90-day commitment. This was due, in part, to the greater number of LRAs which were ordered in lieu of 90-day inpatient stays. The 90-day detention rate in King (43.3%) was less than half that of Pierce (91.2%), as a consequence in part of the extensive use of LRAs in King County (see Table 5). However, the pattern of no release in Pierce County was consistent across all types of commitment authority.

Patients committed under certain types of commitment authority had varying likelihoods of release. For example, at the 14-day hearing a client alleged to be “dangerous to property” was twice as likely to be released as one detained for “cognitive and volitional impairment.” Data from Table 5 indicate that rather than releasing cognitively and volitionally impaired clients, the courts were likely to order a LRA—especially if the hearing was for a lengthier commitment. “Dangerousness to self” exhibited the same pattern; outright release was unusual but LRAs were quite common in King County at 14 days (22.1 percent) and at 90 days (42.0 percent). Clients who were judged as dangerous to others had high detention rates at 14-day hearings (95 percent in Pierce and 75 percent in King) but were often given LRAs at 90-day hearings in King County (see Table 5). While Pierce County had a much lower detention rate at 72 hours, mental health officials there rarely lost a hearing for 14- or 90-day petitions (see Table 5).

Data from this study cannot be interpreted as conclusive evidence that the high release rate for longer stays in King County was due solely to the method of assigning legal counsel. Any explanatory

\[N\text{.\textsuperscript{strictive Alternatives in Alternatives to Mental Hospital Treatment 23}-39 (1975); President's Commission on Mental Health: Report to the President from the President's Commission on Mental Health (1978).}\]

131. There was a statistically significant difference in the proportion of 90 day detentions (excluding LRAs) in King County versus Pierce County \(X^2 = 50, df=1, p<.001\).

132. Thus, CDMHPSs in Pierce County are less likely to hold a patient referred to them for initial evaluation for 72 hours in an evaluation and treatment center when compared with their counterparts in King County.

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TABLE 5
Litigation (% Committed) Outcomes by Authority by County, 1977-81

<table>
<thead>
<tr>
<th>Type of Disposition Ordered</th>
<th>Grave Disability: Health &amp; Safety</th>
<th>Grave Disability: Cog &amp; Volitional</th>
<th>Grave Disability: Unspecified</th>
<th>Danger to Self</th>
<th>Danger to Others</th>
<th>Danger to Property</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>14-Day Hearing</td>
<td>Pierce</td>
<td>King</td>
<td>Pierce</td>
<td>King</td>
<td>Pierce</td>
<td>King</td>
<td></td>
</tr>
<tr>
<td>Release</td>
<td>0.0</td>
<td>14.8</td>
<td>0.0</td>
<td>10.7</td>
<td>2.6</td>
<td>14.7</td>
<td>1.1</td>
</tr>
<tr>
<td>LRA</td>
<td>3.5</td>
<td>12.6</td>
<td>2.9</td>
<td>15.5</td>
<td>1.9</td>
<td>9.7</td>
<td>5.4</td>
</tr>
<tr>
<td>Detention</td>
<td>96.5</td>
<td>72.6</td>
<td>97.1</td>
<td>73.8</td>
<td>95.5</td>
<td>75.6</td>
<td>93.5</td>
</tr>
<tr>
<td>90-Day Hearing</td>
<td>Pierce</td>
<td>King</td>
<td>Pierce</td>
<td>King</td>
<td>Pierce</td>
<td>King</td>
<td></td>
</tr>
<tr>
<td>Release</td>
<td>0.0</td>
<td>16.1</td>
<td>0.0</td>
<td>6.5</td>
<td>1.6</td>
<td>22.5</td>
<td>3.6</td>
</tr>
<tr>
<td>LRA</td>
<td>10.2</td>
<td>41.9</td>
<td>11.8</td>
<td>48.4</td>
<td>5.2</td>
<td>27.5</td>
<td>3.6</td>
</tr>
<tr>
<td>Detention</td>
<td>89.8</td>
<td>41.9</td>
<td>88.2</td>
<td>45.2</td>
<td>93.2</td>
<td>50.0</td>
<td>92.9</td>
</tr>
</tbody>
</table>

* Sample size insufficiently small for analysis.
effort must include factors such as the limited capacity for lengthier inpatient detentions in King County (Pierce County has Western State Hospital close at hand) or Pierce County's more effective prescreening of mental health clients prior to 14- or 90-day hearings.133

C. Conclusions

In sum, the 1979 ITA drastically increased the number of patients confined in the state's public mental health facilities. All involuntary patients were more likely to be admitted as gravely disabled following enactment of the 1979 ITA. Gravely disabled patients stayed the longest in the public psychiatric facilities and became repetitive users of the system. Simultaneously, patients seeking treatment on a voluntary basis were virtually unable to obtain inpatient treatment. Also, these data indicate that some patients previously admitted as voluntary returned as involuntary patients.

The state's psychiatric facilities became so crowded that the major public mental health facility in the state refused to accept all patients referred to it for involuntary care and treatment. The highest court in the state, however, ordered the hospital to take all patients so referred regardless of the bed-space and treatment resources available.

In addition, the sudden influx of involuntary patients into the public mental health system preceded the effective date of the 1979 ITA. Moreover, contested commitment cases in two adjacent counties which use different systems for providing legal representation reflected a wide disparity in outcomes.

V. Implications for Policy-makers

A. Effective Health Care in the Involuntary Civil Commitment System

1. Increase in Number of Patients Committed as Gravely Disabled

Some of the increase in the number of persons committed under

133. Since data on litigation outcomes are available for only two counties in Washington State, one with public defender and the other with assignment of private counsel, it is impossible to complete an analysis which would identify the most decisive factor in determining litigation outcomes. Future research should be conducted which include a larger number of counties under a variety of methods of assigning legal counsel. In other words, future analyses should ascertain whether other counties with public defenders have outcomes similar to those in King County despite their dissimilarities to King County in regard to other characteristics (urban/rural, large/small, small volume of commitment activity/large volume of commitment activity). For a more thorough discussion of the role of alternative factors influencing litigation outcomes, see infra notes 223-224 and accompanying text.
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the 1979 ITA may be accounted for by involuntary commitment of formerly voluntary patients. However, most involuntary patients were new entrants into the state’s mental health system. Thus, the enactment of liberalized commitment criteria extended the net of civil commitment to reach a new group of mentally ill individuals who had not previously been users, either voluntary or involuntary, of the state’s institutional mental health system.134

Some generalizations may be made regarding these new patients, most of whom were committed as gravely disabled. Many were judged as suffering from cognitive or volitional impairment (see Figure 2) and appear to have been committed on the basis of behavior described by mental health professionals as “bizarre.”135 Prior to the revision of the statutory commitment criteria, a significant number of these individuals may not have been subjected to social control through the mental health system.136

As mentioned above, mental health professionals used “grave disability” as a ground to commit persons who had previously been committed solely as dangerous to self or others.137 This phenomenon strongly suggests the increased use of multiple commitment grounds to insure the “clutchability”138 of those persons for whom involuntary commitment was sought. The 1979 ITA required proof of explicitly dangerous behavior in order to commit a person as dangerous to self or others.139 In contrast, commitment for grave disability/cognitive or volitional impairment, is more subjective and hence elastic since it is phrased in diagnostic terms.140 Moreover, it does not require proof of specific types of behavior. Consequently, this criterion may encourage excessive judicial deference to the opinions of mental health professionals, thereby effectively insulat-

134. Some of these involuntary patients had been voluntary patients prior to enactment of the 1979 statute. See supra note 116 and accompanying text.
135. See supra Section IV B.2.b.(2) and Figure 2.
136. See supra notes 119-122 and accompanying text.
137. See supra notes 123-126 and accompanying text.
138. “Clutchability” refers to establishing the right of the state to hold a mentally ill person coercively and without his consent. Joel Feinberg popularized the term in his essay “Crime, Clutchability, and Individuated Treatment.” See J. FEINBERG, DOING AND DESERVING 252-271 (1970). There is some empirical evidence suggesting that psychiatric and judicial personnel will simply interpret even restrictive commitment criteria in whatever way they deem necessary to insure that mentally ill persons whom they wish to commit are involuntarily retained in the public mental health system. See Warren, Involuntary Commitment for Mental Disorder: The Application of California’s Lanterman-Petris-Short Act, 11 LAW & SOC’Y 629, 633, 646 (1977); Comment,Involuntary Hospitalization, supra note 27.
139. See supra notes 89-93 and accompanying text. The 1979 ITA did not revise the definition of “dangerousness” provided in the 1973 ITA.
140. See supra notes 94-96 and accompanying text.
ing their commitment recommendations from judicial review. This is especially significant when considered in conjunction with recent empirical evidence which casts doubt on the claimed expertise of mental health professionals to predict dangerousness with any degree of accuracy. In addition, inappropriate judicial deference to professionals’ commitment recommendations based on “grave disability” may also be encouraged, since there is empirical evidence indicating that expert witnesses seldom testify on behalf of patients at commitment hearings.

The data also indicate that persons committed as gravely disabled/cognitive or volitional impairment, are likely to remain in the involuntary commitment system for a longer period of time than are those committed under alternative statutory grounds. There is also evidence that this group has the greatest number of “chronically mentally ill” patients. Though there are no firm conclusions that can be drawn from these findings, they are nonetheless troubling.

The immediate question raised is whether the forced hospitalization of these patients has resulted in obtaining treatment of the disability for which the person was coercively committed. Although the “right to treatment” has had an erratic history in the courts, there appears to be a consensus that, when the state deprives a person of his liberty for purposes of treatment, it is constitutionally required to provide treatment. Also, there is the distinct possibility that in reaching out for a new patient population, the state mental health system has selected precisely the patients for whom it can do the least good and for whom institutional treatment will consume the most resources.

The findings provide evidence of the debilitating effect of institu-

141. See infra notes 176-177 and accompanying text.
142. See, e.g., Morse, supra note 8; La Fond, Purposes of Commitment, supra note 2; Ennis & Litwack, supra note 7. But see Haddad, Predicting the Supreme Court’s Response to the Criticism of Psychiatric Predictions of Dangerousness in Civil Commitment Proceedings, 64 NEB. L. REV. 215 (1985).
143. See, e.g., Comment, Involuntary Hospitalization, supra note 27, at 1337.
144. See supra Section IV.B.1.
145. See supra note 122.
146. See infra note 165.
147. See supra notes 118-119 and accompanying text.
148. Actual expenditures by DSHS for implementation of the 1979 ITA increased from $6.2 million in fiscal year 1980 to $14.6 million (estimated) in fiscal year 1983. Measured biennially, DSHS expenditures for ITA implementation increased from $9.7 million in 1977-79 to $15.7 million in 1979-81 (61.8 percent); expenditures rose to $26.4 million in 1981-83 (68.2 percent increase over previous biennium). For 1983-85, the requested budget is $36.3 million (37.5 percent increase). L.B.C., supra note 86, at 32, 33, 96.
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tionalization. There is a significant body of literature asserting that prolonged confinement in an institution where virtually all important decisions are made for an individual by others creates a dependency on the institutional environment which diminishes her ability to function on her own. It is instructive to note that most of the individuals confined under the 1979 ITA as gravely disabled/cognitive and volitionally impaired had not been committed to state facilities under the 1973 ITA. Although there is no direct evidence on the point, 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. At a minimum, society generally expects that coercive treatment in a psychiatric hospital should enhance a person's ability to return to the community and live a more normal life. In contrast, the data from our study suggest that involuntary commitment may, at least for some patients, actually result in successive hospitalization rather than in independent living in the community.

Many experts in the field of public mental health argue that, for most mentally ill individuals, placement in the community with adequate care provides more effective treatment than institutionalization. The findings of this study lend support to this hypothesis. It may be a wiser expenditure of limited public funds to provide services in the community such as food and shelter for the mentally ill, thereby enhancing their ability to function as self-directing human beings, rather than sweeping them into overcrowded mental hospitals to which they are likely to return with alarming frequency.

2. Exclusion of Voluntary Patients From the Mental Health System

As indicated above, the 1979 ITA resulted in the virtual de facto exclusion of voluntary patients from the state's public mental

150. See E. Goffman, supra note 149; T. Szasz, supra note 149.
151. President's Commission on Mental Health: Report to the President from the President's Commission on Mental Health (1978).
152. See supra Section IV.B.
153. See supra Section IV.A.
154. There is evidence that many patients admitted to state mental health facilities as "voluntary patients" are in fact not willing patients at all, but rather are coerced to apply for voluntary admission under threat either of involuntary commitment or arrest for a criminal offense. Gilboy & Schmidt, Voluntary Hospitalization of the Mentally Ill, 66 Nw. U. L. Rev. 429 (1971).
health institutions. Consequently, many mentally ill individuals who had recognized their illness and voluntarily sought institutional treatment on past occasions could not receive such treatment after 1979.155

There is a significant body of literature which argues that treatment is more effective when rendered on a voluntary basis.156 Patients who have sufficient insight into their condition to seek out professional assistance may be precisely those most benefited by treatment. As a result of the statutory changes, the Washington State mental health system excluded those mentally ill patients for whom its treatment might be most effective157 and included a new group of patients for whom it might do the least good.158 Policymakers must carefully consider whether this dramatic change in patient population resulted in the most efficient and effective expenditure of limited state resources.

3. 'Demand' Exceeded 'Supply'

The state's institutional capacity could not accommodate the number of patients for whom the state sought long-term commit-

155. Ironically, based on a study of patients admitted in voluntarily in 1974 to Harborview Hospital in Seattle, two researchers concluded: "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 & Goldenberg, A Study of Involuntary Patients in Seattle, 28 Hosp. & COMM. PSYCHIATRY 854 (1977).

It is possible, but unlikely, that voluntary patients sought care in the private sector, including community mental health centers. Over 90 percent of the clients in this sample were unemployed at the time County Designated Mental Health Professionals made their initial investigation for detention. Clients without income or health insurance are unlikely to seek mental health services from private providers. Reduction in mental health coverage from Medicaid during the study period in Washington State reduced the availability of private mental health services even further. L.B.C., supra note 86, at 35.


157. See notes 112-116 and accompanying text. By September 1983, the percentage of voluntary admissions to mental institutions had dropped from a high of 66.1 percent in late 1977 to approximately 3 percent of total civil admissions. See Pierce, Durham & Fisher, supra note 114.

158. See supra notes 118-123. These data also suggest that persons who are considered "gravely disabled" may be less amenable to the treatment available in state mental health facilities. It may be that such persons in fact suffer from problems in daily living that are better dealt with through other social and human services. See generally Morse, supra note 8.
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In 1979, in response to the resultant flood of commitments, Western State Hospital sought unsuccessfully to limit the admission of involuntarily committed patients to its wards. In revising the 1973 ITA, the state legislature did not appropriate adequate additional funds to enable the state’s public mental health system to accommodate the increased number of patients generated by the statutory change. The significant increase in patient population in the major public mental health facilities without an equivalent allocation of additional resources raises serious questions for policy-makers. In particular, there is the distinct possibility that the sudden influx of additional involuntary patients without sufficient resources effectively insured that most patients were not receiving adequate and appropriate care or treatment. Put bluntly, the state may have shifted to a system in which “warehousing” rather than treatment became the de facto ethos of commitment. Although no legal action was taken in Washington, the circumstances were certainly ripe for lawsuits to be filed seeking to enforce patients’ rights to treatment.

159. See supra note 103.
160. See supra note 104 and accompanying text. In Pierce County v. Western State Hospital, 97 Wash. 2d 264, 644 P.2d 131 (1982), the Washington Supreme Court held that Western State Hospital was required by law to accept all patients who qualified for involuntary civil commitment regardless of the hospital’s ability or capacity to accommodate them.
161. See L.B.C., supra note 86, at 32.
162. The Washington State Supreme Court effectively required the public mental health system to do the best it could with whatever resources were available. The court refused to order WSH to provide adequate treatment to involuntarily committed patients or to order the state legislature to appropriate sufficient funding to permit WSH to provide such treatment. The court evidently decided not to intervene directly in the management of the state’s major mental health facility as the federal district court had done in Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971).
163. There is serious concern about whether state mental health facilities in general provide even minimally adequate treatment services for the large number of involuntary patients under their care. See Morse, supra note 8, at 79-84 and sources cited therein.
164. “Warehousing” is a term used to indicate that placement in a state hospital is solely for custodial purposes without any significant benefit to those so confined other than maintaining them at a minimal level of subsistence, including food, clothing, and shelter.
165. Wash. Rev. Code Ann. §71.05.360(2) (West Supp. 1985) provides that: “Each person involuntarily detained or committed pursuant to this chapter shall have the right to adequate care and individualized treatment.” Nonetheless, the Washington Supreme Court, in holding that Western State Hospital must accept persons committed to the hospital for evaluation and treatment even if it did not have sufficient bed capacity to accommodate such persons, acknowledged that such persons would not receive the “right to adequate care and individualized treatment” required by the statute. Pierce County v. Western State Hospital, 97 Wash. 2d 264, 268, 644 P.2d 131, 133-134 (1982). The court concluded that “treatment delayed and inadequate must surely be better than no treatment at all.” Id. at 270, 644 P.2d at 134.

There has been a great deal of case law and commentary that forcefully suggests that states must, as a constitutional imperative, provide some minimal level of effective treat-
4. The Worst of Both Worlds

As indicated above, the number of involuntary patients committed to public mental health facilities increased dramatically in Washington just before and after enactment of the 1979 ITA. This increase in unwilling patients outstripped the state's institutional capacity to house them, let alone treat them. In all probability, the system overload also resulted in these patients not receiving the quality of treatment appropriate to their needs as mandated both by statute and the Constitution. Moreover, mentally ill patients (many of whom were indigent) who voluntarily sought institutional care from the state were largely excluded from state institutions and were left to seek care and treatment as best they could.

These consequences were in large part attributable to two factors. First, the legislature failed to appropriate the adequate additional funding necessary to provide institutional care and treatment for the increased patient demand for services generated by the 1979 ITA. Second, the Washington Supreme Court insisted that major state mental health facilities continue to admit involuntary patients regardless of bed capacity and staffing resources.

It is very likely, then, that Washington's public mental health system provided inadequate treatment for most patients and provided virtually no treatment for many patients who voluntarily sought institutional care for mental illness.

Any state legislature contemplating expanding the scope of the state's commitment authority by revising the statutory commitment criteria should seriously consider the fact that such action will generate a large number of additional patients within the state's mental health facilities. It is essential that substantial additional funding for mental health care and treatment in these facilities accompany any such statutory change if the state legislature wishes to avoid a mental health system that provides the worst of both worlds—inadequate care to patients committed involuntarily for treatment, and that failure to provide such treatment exposes the state and mental health officials to civil liability and other legal sanctions. See, e.g., Wyatt v. Stickney, 325 F.Supp. 781 (M.D. Ala. 1971); Speece, Preserving the Right to Treatment: A Critical Assessment and Constructive Development of Constitutional Right to Treatment Theories, 20 ARIZ. L. REV. 1 (1978); Katz, The Right to Treatment: An Enchanting Legal Fiction, 36 U. CHI. L. REV. 755 (1969); Kaufman, The Right to Treatment Suit as an Agent of Change, 136 AM. J. PSYCHIATRY 1428 (1979).

166. See supra notes 112-116 and accompanying text.
167. See supra notes 101-106 and accompanying text.
168. See supra note 165.
169. See supra note 155 and accompanying text.
170. See supra notes 115-116 and accompanying text and Tables 1 and 2.
171. See supra note 91.
172. The Supreme Court of Washington virtually conceded this in its opinion in the Pierce County case. See supra note 165.
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quate treatment for institutionalized patients and no treatment for voluntary patients.

B. Implications for Effective Legal Regulation of the State's Coercive System of Hospitalization

1. Controlling Bureaucracy

The impact of both the MacFarlane murder case and the "anticipation effect" call into question the adequacy of the legal system's control over the state's involuntary commitment process. The data suggest that administrative agencies to whom a limited power had been delegated employed this power before they were permitted to do so under the express terms of the legislative authorization.

Perhaps more importantly, the findings cast doubt on the ability of the legal process to confine the exercise of delegated coercive state power within the proper scope of the statutory authorization. If the courts were applying the applicable statutory criteria, an increase both in the number of commitments under the broadened statutory criteria and in commitments based on grave disability would have occurred following the effective date of the new statute— not nine months prior to this date. In addition, these findings strongly suggest that, at least for the brief period of time from January 1, 1979, to September 1, 1979, the Washington involuntary commitment system erred substantially on the side of "over-inclusiveness" and tolerated an unacceptably high number of "false-positives" given the statutory commitment criteria then in effect. Arguably, a significant number of patients may have been committed as "gravely disabled" who in fact did not meet the legal criteria in effect prior to September 1, 1979.

The data also suggest that during the nine-month period prior to September 1, 1979, the judiciary was excessively deferential to the judgments of experts who recommended hospitalization of patients who did not meet the more restrictive criteria still in effect. In

173. See supra notes 112-116 and accompanying text.
174. "Over-inclusiveness" refers to the commitment of persons who in fact do not meet the relevant criteria for coerced hospitalization but are confined anyway due to erroneous evaluation or decision-making.
175. "False-positives" in this context refers to the number of persons falsely determined in the commitment process to be mentally ill and either gravely disabled or presenting a likelihood of serious harm to others or themselves. In common parlance the term refers to the number of "mistakes" made in involuntary commitment.
the absence of such judicial behavior, it would have been reasonable to expect a more stable increase in the rate of commitments as "gravely disabled" rather than the sudden surge that occurred.\textsuperscript{177} In any event, this empirical evidence provides a basis for concern that during this period the judicial system failed to protect against unwarranted loss of personal liberty and other civil rights due to inappropriate commitment.

There can be no doubt that both the 1973 ITA and the 1979 ITA allocated final commitment authority to a judicial officer in the case of the 14-day commitment\textsuperscript{178} and to a jury in the case of a 90- or 180-day commitment.\textsuperscript{179} This assignment of responsibility demonstrates a clear policy choice by the legislature that the decision to commit a person to a mental health facility is ultimately a legal decision and not solely a medical one.\textsuperscript{180} Medical testimony is certainly relevant to the decision, but it is not to be substituted for the legal determination. To the extent that medical testimony, and implicitly, medical standards, are coextensive with the legal criteria for commitment, undue reliance on the expert and on his opinion may be encouraged in the decision-making process.

This problem has also manifested itself in the criminal justice system when the defense of insanity has been litigated.\textsuperscript{181} Revisions of state commitment statutes which define commitment crite-

\textsuperscript{177} It may be that courts were also anticipating the implementation of the revised commitment criteria. In theory, of course, courts are supposed to apply the law in effect at the time of decision and not to anticipate changes in the law.

\textsuperscript{178} See supra note 67 and accompanying text.

\textsuperscript{179} See supra note 69 and accompanying text.


\textsuperscript{181} See, e.g., United States v. Brawner, 471 F.2d 969 (D.C. Cir. 1972); Washington v. United States, 390 F.2d 444 (D.C. Cir. 1967) and Appendix thereto (setting forth instructions which state the appropriate role of an expert witness when insanity is an issue in a criminal trial).
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tria in terms similar to those used for medical diagnosis may well invite the same confusion of roles as has been experienced in the criminal justice system. Moreover, suffusing legal standards with medical terminology makes the task of counsel for the patient even more difficult because she is faced with disproving a medical diagnosis rather than focusing on the impact the alleged medical illness has on the patient’s ability to live outside an institution.

The prolonged duration of forced hospitalization referred to above also raises a question of fundamental import to policy-makers and legislators: are courts in fact capable of effectively reviewing the continued and prolonged confinement of persons who are committed as gravely disabled with cognitive or volitional impairment?

In addition, the overcrowding of the state’s mental health facilities after enactment of the 1979 ITA, the longer duration of average patient stays in confinement, and the increased occurrence of recidivist admissions cast doubt on whether patients were receiving the appropriate treatment to which they were clearly entitled under Washington law. These facts suggest that the internal administrative apparatus designed to ensure that patient rights are protected within public mental health facilities may not have functioned effectively to enforce their right to treatment.

2. Control Mechanisms: Standards or Procedures?

As previously discussed, in the past two decades there have been important changes in state commitment statutes designed to alter the ways in which mental health systems work. Initially these adjustments included restrictive commitment criteria and additional procedural safeguards for committees. More recently, some states have expanded commitment criteria and provided less stringent procedural protection. There have been conflicting

182. See supra Section IV.B.1.
183. See supra notes 101-106 and accompanying text.
184. See supra Section IV.B.1.
185. See supra notes 118-123 and accompanying text.
186. See supra note 165.
187. WASH. REV. CODE ANN. §70.124. et seq. (West Supp. 1984) provides a statutory scheme for mandatory reporting and investigation of alleged instances of patient abuse or neglect in state hospitals either to law enforcement agencies or to the State Department of Social and Health Services.
188. See supra notes 18-19 and accompanying text.
189. See supra note 18 and accompanying text.
190. See supra note 19 and accompanying text.
191. See, e.g., TEX. REV. CIV. STAT. ANN. art. 5547-49(a) (Vernon Supp. 1985) (current statute provides a hearing before a court unless jury trial is requested; prior to 1983 amendment, art. 5547-49(e) automatically provided for a jury trial unless waived).
views expressed on whether changes either in commitment criteria\textsuperscript{192} or in procedural safeguards\textsuperscript{193} make any real difference in the operation of public systems of involuntary civil commitment.

Some commentators have argued that commitment procedures are much more influential than the standards for commitment in determining the likelihood of commitment.\textsuperscript{194} Others assert that statutes adopting more restrictive commitment criteria and providing additional procedural safeguards do not significantly change the number of patients or the relative percentage of patients admitted involuntarily into public mental health facilities.\textsuperscript{195} More recent studies indicate that alternative formulations of commitment criteria (stressing police power commitment based on dangerousness as opposed to stressing \textit{parens patriae} treatment of seriously ill patients) would probably not result in significant differences either in the number or identity of patients committed involuntarily.\textsuperscript{196} Thus, there is substantial skepticism that statutory revisions of either a substantive or a procedural nature can in practice determine the number or kinds of patients committed involuntarily.

In light of this controversy, the 1979 ITA and the impact it wrought in commitment practices may be of special significance. Except for two minor changes discussed above,\textsuperscript{197} this statute broadened the criteria for commitment while leaving the procedural safeguards provided committees unchanged. As the study makes clear,\textsuperscript{198} expanding the scope of the state's authority to commit through broader commitment criteria resulted in a substantial increase in the number and kind of patients committed involuntarily to state public mental health facilities. It seems likely, then, that mental health professionals will use expanded commitment authority to include patients in the involuntary mental health system whom they had not previously included. It may be that restrictive commitment criteria do not necessarily operate to limit the population of involuntarily committed patients. It may also be that procedural safeguards, rather than commitment criteria, is a more relevant vari-


\textsuperscript{194} See Roth, supra note 21, at 391.

\textsuperscript{195} See Comment, Involuntary Hospitalization, supra note 27; but see Stromberg & Stone, supra note 22.

\textsuperscript{196} Monahan, Ruggiero & Friedlander, supra note 192.

\textsuperscript{197} See supra notes 92-93 and accompanying text.

\textsuperscript{198} See supra notes 112-115 and accompanying text.
able in explaining the level and nature of involuntary commitment. Both of these hypotheses, however, await further empirical study.

3. Multiple Commitment Grounds

As noted above, the 1979 ITA not only resulted in an increased involuntary patient population in the public mental health system, but it also provided CDMHPs and hospital staff with expanded power to commit and retain patients. In addition, the study clearly indicates that committing personnel relied increasingly on multiple grounds to justify commitment.

This practice has implications for judicial control of the commitment process. In particular this practice makes it more difficult for courts to decide at each of the statutorily specified instances of judicial review whether to continue to retain a patient in confinement. Since each of the criteria for commitment is an independent or sufficient ground for initial or continued confinement of a patient, the use of multiple grounds by mental health professionals to justify commitment and retention increases the likelihood that a judge or jury will agree with a mental health professional’s decision to commit or retain. The data compiled to date tend to substantiate this hypothesis.

4. The Impact of Structural Arrangements for Providing Counsel

This research also provided an opportunity to explore whether structural arrangements for providing legal representation for patients make a significant difference in litigation outcomes during the commitment process. Most studies to date have focused on how much time is spent conducting a formal commitment hearing or on whether attorneys act as advocates zealously asserting the
pressed wishes of their client, or, alternatively, act as guardians *ad litem* pursuing the best interests of the the client as perceived by the attorney.\textsuperscript{206}

Two adjacent counties in the State of Washington, King County and Pierce County, which account for 40 percent of all involuntary commitments in the state,\textsuperscript{207} use very different systems of providing indigent defendants with legal representation. The data clearly indicate that patients represented by counsel appointed from an approved list on a rotating basis are almost always committed at contested 14-day hearings and at 90-day hearings.\textsuperscript{208} In sharp contrast, patients represented by public defender attorneys, who acquire expertise, retain significant contact with their clients, and are not subject to review by public authorities for their time charges, fare much better in resisting continued civil commitment.\textsuperscript{209}

Of course, there may be a number of causal explanations for such extreme discrepancies in litigation outcomes in the two adjacent

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\item \textsuperscript{206} L.B.C., *supra* note 86, at 41.
\item \textsuperscript{207} See *supra* note 82, at 1003-1004.
\item \textsuperscript{208} As Table 5 shows, the prosecuting attorney in Pierce County wins 95.6 percent of contested cases at the 14-day hearings, and 91.2 percent of contested cases at the 90-day hearings.
\item \textsuperscript{209} Prosecutors in King County succeed in committing far fewer patients for detention to inpatient institutional care; only 71.5 percent of their cases result in such detention, while 15.9 percent of the patients are committed to less restrictive alternatives. Almost 13 percent of the patients are released outright at 14-day hearings in King County.
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The data nonetheless provide very strong evidence that the structural arrangements for providing legal representation for committees are crucial in determining litigation outcomes. It is quite likely that attorney expertise makes a significant difference in litigation involving special areas of knowledge such as mental health. Attorneys who practice in the mental health field for several years, and who are associated with others also practicing in that field, are more likely to develop special competence. Conversely, attorneys, many of whom have been recently admitted to the bar, who practice only occasionally in the mental health field are unlikely to acquire expertise in the field.

Some commentators suggest that public defender representation of indigent committees provides a superior defense function than does representation by attorneys appointed from a volunteer list. They argue that public defender or legal service representation would have three advantages: 1) public defense attorneys "are presumably less subject to social and professional pressures that apparently prevent members of the private bar from undertaking an aggressive defense in commitment cases"; 2) their lawyers would "become more experienced in their defense work and . . . [would] gain some expertise in mental health law and commitment defense"; and, 3) they would "tend to cultivate a strong communal feeling with one another." The data raise serious questions as to whether some mentally ill persons represented at commitment proceedings by attorneys appointed by the court from a county commissioner-approved list are receiving the quality and competency of representation mandated under the Constitution. It is clear that citizens threatened with the loss of liberty and other civil rights are constitutionally entitled to the effective assistance of counsel at commitment proceedings.

210. It is possible that differences in the patient populations, the demographic factors, the discretion the C.D.M.H.P. has in filing commitment petitions, the attitudes of judges, magistrates, or juries, and other variables also explain the differences in outcomes.
211. Judge David Bazelon has suggested: "Ideally, there should be a specialized, experienced bar skilled in legal problems revolving about mental illness." Thornton v. Corcoran, 407 F.2d 695, 702 (D.C. Cir. 1969).
212. See generally L.B.C., supra note 86, at 41-45.
213. Comment, Involuntary Hospitalization, supra note 27, at 1422.
Effective representation is especially critical when the state, in seeking involuntary civil commitment, is indirectly asserting that the patient lacks competence to make important decisions on his own behalf.\textsuperscript{216}

The litigation outcomes also raise significant questions of substantive due process. As the Supreme Court stated in Jackson v. Indiana, "[a]t the least, due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed."\textsuperscript{217} This "rule of reason" has generated case law\textsuperscript{218} and commentary\textsuperscript{219} which conclude that persons should suffer no greater loss of liberty than is necessary to accomplish the legitimate state purposes being furthered. In the area of civil commitment, this rule of reason has been generally articulated as the "least restrictive alternative" doctrine.\textsuperscript{220} Many states,\textsuperscript{221} including Washington,\textsuperscript{222} mandate that patients being committed involuntarily be placed in the least restrictive alternative available.

The data clearly indicate that many more patients secure placement in a less restrictive alternative when detained in a county where a public defender is provided than in a county where patients are represented by appointed counsel.\textsuperscript{223} This in turn suggests that

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  \item \textsuperscript{216} See, e.g., Chodoff, supra note 5; Slovenko, \textit{Civil Commitment in Perspective}, 20 J. PUBL. L. 3 (1971); Katz, supra note 21.
  \item \textsuperscript{217} 406 U.S. 715, 738 (1972) (emphasis supplied).
  \item \textsuperscript{218} See, e.g., Youngberg v. Romeo, 457 U.S. 307 (1982) (a dangerous mentally retarded person is constitutionally entitled to reasonable care and safety and may be deprived of no more liberty than is reasonably necessary to accomplish that objective); Rennie v. Klein, 655 F.2d 836 (3rd Cir. 1981), \textit{vacated and remanded}, 458 U.S. 1119 (1982) (an involuntarily committed mentally ill person has a constitutional right to refuse antipsychotic drugs unless administration of these drugs is, in the exercise of professional judgment, deemed necessary to prevent danger to the patient or others); Johnson by Johnson v. Breje, 701 F.2d 1201 (7th Cir. 1983) (a civilly committed mentally ill patient has a constitutionally protected right to move about).
  \item \textsuperscript{219} See, e.g., La Fond, \textit{Purposes of Commitment}, supra note 2.
  \item \textsuperscript{222} \textit{Wash. Rev. Code Ann.} §70.05.240 (West Supp. 1984).
  \item \textsuperscript{223} See supra notes 131-133 and 208-209 and accompanying text and Table 5.
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Other researchers have shown that ignorance of community alternatives to involuntary hospitalization is significant in determining whether patients are civilly committed. Solomon, \textit{The Admissions Process in Two State Psychiatric Hospitals}, 32 HOSP. & COMM. PSYCHIA-
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many patients are being deprived completely of their liberty when placement in a less restrictive alternative would suffice to accomplish the state's purpose in seeking commitment. While there may be other explanations for this discrepancy between counties, including the availability of less restrictive placement facilities, availability of long-term institutionalization, the assistance of specialists in locating these less restrictive placements, and funding arrangements; the data are consistent with the conclusion that specialized attorneys who practice in association in the mental health field and who have more information about and assistance in securing available opportunities for less restrictive placements provide significantly more effective representation than their court-appointed counterparts.

The study raises disturbing questions about the impact structural arrangements for legal representation have on the efficacy and quality of the defense function in commitment proceedings. Compared with patients represented by public defender agencies, patients represented by appointed counsel not only lose much more frequently in all instances of contested commitment proceedings, but also are confined much more frequently as inpatients to mental health facilities rather than placed in less restrictive environments.

Conclusion

During the 1960's and 1970's, many states enacted restrictive civil commitment statutes for involuntary hospitalization of the mentally ill. These statutes contained narrow commitment criteria and stringent procedural protections that made it more difficult than under prior commitment statutes to confine persons considered mentally ill and in need of treatment. Currently, powerful forces are arguing

TRY 405 (1981). Attorneys without practice experience in the mental health field are unlikely to be aware of such alternatives. During the period of our study, however, the Seattle-King County Defender Association in Seattle employed social workers who were familiar with placement alternatives in the community. A portion of one social worker's time was allocated to the Civil Commitment Division specifically for assistance in locating less restrictive courses of treatment. In addition, the Defender Association in King County will, in selected cases where the state is seeking a 90 or 180 day commitment, request the court to appoint a professional person to seek less restrictive alternative courses of treatment and to testify on behalf of the committee as authorized by WASH. REV. CODE ANN. §71.05.300. The court in King County has always granted such requests. The individual appointed is a professional person in private practice who is knowledgeable about treatment alternatives in the community. Interview with John H. Hertog, Jr., The Defender Association, in Seattle, Washington (February 20, 1985).

224. In Washington, the state will not pay for "least restrictive alternative" placement beyond 14 days. Consequently, there are significant incentives for counties to seek long-term care for involuntary commitment in state hospitals rather than in out-patient or other least restrictive placements. See supra notes 105-106 and accompanying text.
persuasively that these restrictive commitment statutes condemn many mentally ill individuals to lives of abject misery outside appropriate institutions, and that timely intervention by the state, while coercive, would restore these individuals to a more productive and humane life. The American Psychiatric Association has adopted a model statute that would expand the power of the state to commit persons not presently commitable under most state statutes. Washington, Alaska, Texas, and North Carolina have enacted statutes that accomplish this objective. Other state legislatures will surely consider similar legislation. It is imperative that policy-makers involved in these decisions consider carefully the consequences and implications of such legislation.

This study provides strong empirical evidence that revising statutory commitment criteria to expand the state's authority to confine and treat mentally ill persons for therapeutic purposes will significantly increase the number of individuals involuntarily committed to psychiatric facilities. Many of these persons will be new entrants into the coercive public mental health system and many of them will return to the system on a regular basis. Without adequate additional resources, other mentally ill persons, most of whom are probably indigent, who had previously sought and received inpatient care and treatment from the public mental health system on a voluntary basis will be unable to obtain these services and will be left to fend for themselves as best they can. Enacting a civil commitment statute that expands the power of the state to commit mentally ill persons for therapeutic purposes also raises the strong possibility that a large number of persons will become institutionally dependent for the first time in their lives. Many of these patients may well become chronic users of state psychiatric hospitals. Serious consideration should be given to whether more effective treatment can be provided through community care than through institutionalization.

This study also warns that, if a state legislature is determined to expand dramatically the reach of the involuntary civil commitment system, it must at the same time appropriate adequate additional resources if it is to have any hope of achieving the therapeutic purposes sought. Failure to provide sufficient funding for such a legislative initiative could result in overcrowded state mental health institutions with potentially harmful consequences to patients.

A strong case can also be made that any statutory proposal to expand the commitment authority of the state should contain detailed projections of anticipated increases in patient loads and the corre-
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sponding level of increased resources necessary to provide effective
care and treatment for these patients. Such a projection would
then make explicit the costs of fully funding such a legislative initia-
tive and provide a basis for comparing alternative solutions to the
perceived problem. If such funding is not included in the pro-
posed legislation, those professional and other organizations pro-
moting expansion of the state's commitment authority would have
to face the ethical dilemma of supporting increased coercive hospi-
talization of the mentally ill fully aware of the probable adverse con-
sequences an inadequately funded commitment scheme will have on
the very individuals they seek to help. It is no longer clear that the
American Psychiatric Association and others who have a genuine in-
terest in the welfare of the mentally ill can responsibly and ethically
support the expansion of state involuntary commitment schemes
without insisting upon clearly adequate funding as a necessary con-
dition of any such enactment.

The data collected in this study also raise grave doubts about the
legal system's capacity to monitor and control the delegation of the
state's power of coercive confinement and treatment to mental
health bureaucrats. Washington State bureaucrats charged with ini-
tiating commitment of the mentally ill seemingly anticipated a statu-

tory grant of expanded commitment authority by at least nine
months. Courts charged by statute with final responsibility for com-
mitment did not effectively prevent such usurpation of legal author-
ity. The new commitment criterion for therapeutic commitment
contained in the 1979 ITA was used liberally by mental health pro-
essionals. This new ground, suffused with medical terms of art,
also seemed to encourage significant judicial deference to the opin-
ions of mental health experts and to make the task of defense coun-
sel more difficult in contested commitment proceedings. Under the
1979 ITA, mandatory periodic judicial review had less impact than

225. It will undoubtedly be difficult to generate precise projections of patient loads
and resource needs. However, the experience in Washington State should provide a
point of departure for constructing adequate predictive models. Further experience in
other states may also shed light on the problem. It is imperative, however, that policy-
makers develop an accurate systemic approach to estimating true "costs" in state invol-
untary commitment schemes to avoid the type of situation which occurred in Wash-
ington State as a result of the passage of the 1979 ITA.

226. Cost-benefit analysis of the various alternatives could then be done with more
useful and complete data available.

227. Such an inadequately funded commitment system might well violate a funda-
mental ethical tenet of the medical profession, the oath of Hypocrates, which provides in
part: "I will prescribe my regime for the good of my patients according to my ability and
my judgment and never do harm to anyone." STEADMAN'S MEDICAL DICTIONARY 650 (5th ed. 1982) (emphasis added).
legislators might have assumed in effectively insuring that persons committed to mental health facilities were released or placed in less restrictive alternatives when their condition no longer warranted continued retention in state hospitals.\textsuperscript{228} In addition, the data suggest that structural arrangements for providing counsel for involuntary committees significantly affect the outcomes of judicial commitment proceedings.

The fierce debate over involuntary civil commitment will undoubtedly continue. It is an area of the law especially influenced by the ebb and flow of public sentiment about the appropriate role of the state in pursuing the collectivist goal of preserving community security and the humanitarian goal of providing care for individuals who may need psychiatric treatment. As a system of social control that seeks to realize these goals, involuntary civil commitment must be evaluated in light of the findings of this study.

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