Civil Commitment — The American Experience

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Abstract: The evolution of U.S. civil commitment law needs to be understood within the context of changes in psychiatry and medicine, as well as larger social policy and economic changes. American civil commitment law has reflected the swinging pendulum of social attitudes towards civil commitment, oscillating between more and less restriction for both procedural and substantive standards. These standards have evolved from a “need for treatment” approach to a “dangerousness” rationale, and now may be moving to a position in which these justifications are combined, particularly in the context of involuntary outpatient commitment. Civil commitment in the United States has been shaped by multiple factors, including sensitivity to civil rights, public perception of psychiatry, availability of resources, and larger economic pressures. We suggest that current American commitment practice is influenced more by economic factors and social perceptions of mental illness than by changing legal standards.

Introduction

Involuntary civil commitment is often considered the primary intersection of psychiatry and law, and is typically one of the most publicly visible and contentious roles of psychiatrists within the larger society. In the United States, the legal struggles and changes in the process of civil commitment over the past 200 years reflect social ambivalence about the extent to which an individual’s right to liberty can be restricted for the ostensible sake of protecting his interests or the interests of others (1). The evolution of U.S. civil commitment law needs to be understood within the context of changes in psychiatry and medicine, as well as larger social policy and economic changes. American civil commitment law has reflected the swinging pendulum of social attitudes towards civil commitment, oscillating between more and less restriction for both procedural and substantive standards. As Israeli psychiatrists, jurists and policy makers consider their own civil commitment laws, it may be helpful to consider the American experience (2, 3).

In this article, we briefly trace the historical evolution of civil commitment in the United States, describe some of the past and current controversies, reflect on the empirical data relevant to these processes, and offer analysis and perspective that may inform other nations working to improve their own civil commitment laws (4).

History

In Colonial times (i.e., pre-1776) and the early years of the United States, there was little formal legal regulation of the care of the mentally ill — likely due in part to the few options for treatment or institutional care (5). Mentally ill persons who could not care for themselves and lacked family care and support were typically ignored or managed in jails or almshouses for the poor. This approach had no real therapeutic aspects, but served purely as containment or punishment. From a social perspective, the practices were driven largely by the interests of public safety (the “police power” of the state), with little consideration of treatment or the rights and needs of mentally ill persons. Conditions in jails and almshouses were universally poor, with only basic sustenance in typically filthy settings, invariably mixing the mentally ill with criminals, vagrants, the retarded, the senile, and other social outcasts.

As jails and almshouses became crowded with mentally ill persons, there were some early efforts to
develop private psychiatric units and hospitals, sometimes with public funds, albeit with little legal regulation. The first psychiatric admission in the colonies occurred in Philadelphia in 1752; by the early decades of the 19th century, a few small private and public facilities had developed across the states. Admissions were involuntary (“insane” persons were considered by definition to be unable to recognize their own interests and make decisions about hospitalization), typically initiated by family or friends, and the length of stay was linked to ongoing private financial support. It is important to point out here, especially for the sake of comparison to Israel or other national systems, that institutional care of the mentally ill—and the regulations guiding that process—is largely a state-specific issue in America (6). Although federal court decisions and national health and welfare programs have had some impact on commitment practices, civil commitment laws and regulations are devised by each state—there are over 50 jurisdictions (including the District of Columbia and Puerto Rico), each with their own specific system and regulations. As we describe below, there are considerable similarities between the different jurisdictions, and evolutionary changes or experiments in a few states have often quickly spread to other jurisdictions.

As America moved into the middle decades of the 19th century, reformers fought for a more humane alternative to jails and almshouses, inspired by English models for “moral treatment” of the mentally ill (7). For the first time, therapeutic optimism and concern for the care of the individual began to guide state policy. This led to the broad development of state-supported asylums, beginning in 1833 with Worcester (Massachusetts) State Hospital. The movement was spurred across the country by the work of reformers such as Dorothea Dix, who traveled the nation in the 1840s and 1850s documenting the poor conditions of almshouses and arguing for the construction of hospitals to treat the insane. As state-run hospitals proliferated, there was now a need for enabling legislation and some degree of regulation. These early commitment laws focused more on need for treatment—the state acting in its parens patriae function, the traditional power to care for those incapable of caring for themselves. Judicial involvement was typically limited to endorsing medical opinions of need for treatment, and may have also served cost control and resource allocation (8).

By the start of the U.S. Civil War in 1860, commitment was predicated only on a mentally ill person requiring care, and state-run asylums were assumed to be the best places to care for such people. Admission was made simple, essentially left in the hands of family members and physicians whenever possible. Hospitalizations were involuntary and treatment was coerced, since it was presumed that all mentally ill patients had compromised reason to the extent that they were unable to request (or refuse) care on their own behalf.

Over the next 100 years, changes to commitment laws focused almost entirely on procedures. After the Civil War, allegations were made of sane persons being forced into mental institutions by greedy relatives and unscrupulous physicians. Reformers advocated for jury trials or formal judicial hearings for persons faced with involuntary hospitalization, and other procedural safeguards borrowed from the criminal justice system. Physicians were required to examine patients before testifying to the need for commitment, and confirm they were not related to the patient nor had a financial interest in the hospitalization. States broadened the scope of regulations to apply to non-public facilities. Further procedural adjustments cycled along with public sentiment towards psychiatry and concern for civil liberties. In the Progressive Era prior to World War I, “psychopathic hospitals” were developed in major cities, dedicated to caring for acute cases, in the hope that early intervention and treatment would have greater therapeutic impact. States developed special emergency commitment procedures that would bypass time-consuming judicial hearings, allowing physicians (and sometimes police) to hospitalize patients emergently for brief periods of time without court review. Later concern about potential adverse consequences of rigorous, criminal style procedures (including mentally ill persons being detained in jail or by law enforcement personnel as part of the process) led to proposals to abolish mandatory judicial hearings, with the power to commit given to one or two physicians and patients having the right to request a hearing after the fact if they desired. In 1948, the prestigious Group for the Advancement of Psychiatry released a report complaining about excessive
criminal-like regulations and procedures (9). In 1951, the newly established National Institute of Mental Health (NIMH) issued the landmark “Draft Act Governing Hospitalization of the Mentally Ill” which proposed streamlining commitment procedures, including a certification process that was entirely in medical hands (10). The substantive standard for commitment remained largely linked to the state’s parens patriae powers, although by the mid-20th century critics began to question the state’s role in forcing those able to make decisions to undergo unwanted treatment. The NIMH Draft Act proposed a modified version of the traditional “need for treatment” formula — to be commitment a patient must be “in need of care or treatment in a mental hospital, and because of his illness, lacks sufficient insight or capacity to make responsible application therefore,” limiting parens patriae to those genuinely unable to make decisions for themselves.

By the late 1960s, civil commitment became caught up in wider changes within psychiatry and larger society. The legitimacy of psychiatric diagnosis and the concept of mental illness were being challenged from many quarters (11); there was increased recognition that little effective treatment was being provided in many state hospitals, which seemed to offer primarily containment in increasingly rundown facilities (12); and American psychiatry itself began to embrace an ideology of “community psychiatry” that questioned the benefit of long-term hospitalization. With the advent of antipsychotic medications in the mid-1950s and federal support for community-based mental health services, states began the “deinstitutionalization” process of closing large state hospitals due to questionable efficacy and increasing cost. With fewer hospital beds available, the practical availability of civil commitment began to be a factor. While these changes were stirring within psychiatry, wider social policy evolved, including several decisions from the U.S. Supreme Court that emphasized the rights of the individual against the state, restricting practices that infringed on individual liberty or violated constitutional rights to equal protection and due process.

In this context, states began to shift away from the traditional “need for treatment” standard to a narrower set of circumstances defined by “dangerousness” to self or others. Although self-danger as a basis for commitment was justified by an appeal to parens patriae principles, it was limited to more urgent, life-threatening situations. Commitment of those dangerous to others was seen as a pure exercise of the state’s police powers. Dangerousness as the sole ground for civil commitment was first adopted by the District of Columbia in 1964 and then by California, the most populous state and frequently a trend-setter for the rest of the nation. California’s 1969 Lanterman-Petris-Short Act — permitting civil commitment only for those who were imminently dangerous to themselves or to others, or who were so “gravely disabled” as to be unable to meet their minimal needs for survival (a variant on danger to self) — became a model quickly adopted by many other states. Need for treatment was no longer a substantive factor for civil commitment. Court decisions embraced the dangerousness model and need for tighter procedural standards, led by the Wisconsin federal district court decision in Lessard v. Schmidt (1971, p. 13). That court criticized earlier vague “need for treatment” statutes, and subsequent decisions in other states endorsed a constitutional rationale for the belief that the state can intervene only when the lives of the patient or others are in danger.

By the end of the 1970s, nearly every state had revised its commitment statutes to conform to the dangerousness criteria (14).

As noted above, American civil commitment laws, and the responsibility of care for the mentally ill, are responsibilities of the individual states. In fact, the U.S. Supreme Court has never clearly spoken on the question of whether dangerousness criteria must be preferred over need for treatment in civil commitment. In its only case directly addressing civil commitment criteria, O’Connor v. Donaldson (1977), the Court’s comments (particularly the words “without more”) were so ambiguous that they could be interpreted to support either position (15). Declaring that a state cannot constitutionally confine “without more” a non-dangerous individual who could safely survive in freedom, the Court appeared to say that commitment was unconstitutional if a non-dangerous patient was confined without something “more” being provided to improve his condition (i.e., without treatment). Thus, if treatment is provided or if the patient is dangerous, commitment can continue. Others, including the Court itself in later cases, read
the decision as more clearly endorsing the dangerousness model.

A later Supreme Court case, Zinermon v. Burch (1990), requiring patients to be competent to give informed consent for voluntary psychiatric hospitalization, also seemed to side with the dangerousness standard for involuntary civil commitment (16). Despite the lack of clarity from the U.S. Supreme Court, most states and lower federal courts moved aggressively towards the dangerousness model and more rigorous procedural protections. On procedural issues, the U.S. Supreme Court again has been more cautious than lower courts. In Addington v. Texas (1979), the Court did not equate civil commitment to a criminal prosecution (which requires the strictest standard of evidence, “beyond a reasonable doubt”), accepting the more moderate “clear and convincing” evidence standard for the state to prove need for civil commitment (17). In Parham v. JR (1979), the Court allowed parents to authorize a non-consenting minor’s psychiatric admission without the full due process protections that adults would receive (18). Although the Supreme Court has been more flexible about commitment procedures, most states as a matter of state law have adopted models grossly analogous to the criminal system, including several states opting for proof “beyond a reasonable doubt.”

Recent Evolution

Over the past 20 years, the pendulum has begun to change directions, as policymakers have recognized the value of commitment for persons who are chronically at risk, but perhaps not imminently dangerous. Several states have broadened the definition of “grave disability” for inpatient commitment to include the prospect of severe deterioration, disabling illness, or general inability to care for self. This may reflect the perception (further discussed below) that civil commitment was too difficult to achieve with the strict dangerousness model, or that too many patients needing treatment were being excluded.

The major focus of evolution over the last two decades has been a growing trend towards involuntary outpatient commitment (IOC). Although many states had some legislative provisions for IOC, they were confusing and infrequently used until the mid-1980s (19). The next 20 years have seen increasing attention to the use of IOC as a “less restrictive alternative” to involuntary hospitalization, with treatment mandated for individuals with impaired capacity and the potential to deteriorate into dangerousness. This trend has been fueled by several factors, including limited inpatient resources and brief hospital stays, insufficient community-based resources, a growing homeless mentally ill population, and highly publicized cases of untreated mentally ill persons and substance abusers causing havoc or harm (20). Pilot programs, first started in states such as North Carolina, Georgia and Hawaii, have become a growing movement now, with the majority of states having IOC statutes (at least 38 as of 2002) (21). However, these programs are often limited in impact depending on available community resources and enforcement mechanisms.

In 1987, the American Psychiatric Association (APA) issued model guidelines for IOC, revised in 2000 (22). These updated guidelines propose a renewable commitment after a court finds by clear and convincing evidence that the person suffers from a severe mental disorder, needs treatment to prevent a relapse or severe deterioration that would predictably result in danger to self or others or inability to care for himself ("grave disability"), due to the mental disorder is unlikely to seek or comply with needed treatment without the court order, and has been hospitalized for treatment within the last two years and fails to comply with prescribed outpatient treatment. The guidelines require a detailed treatment plan, close monitoring of compliance, and engagement with the local responsible treatment team and physician. The patient under IOC may not be forced to take medications without an additional legal process to determine incapacity. Many state legislatures have included some aspects of the APA guidelines when writing their statutes, which generally fall into three basic patterns: conditional release for involuntarily hospitalized patients; “less restrictive alternative” to hospitalization for those patients who meet inpatient commitment criteria; and as an alternative for patients who do not meet inpatient commitment criteria, but are at risk for severe decompensation. This latter "preventive commitment" or "predicted deterioration" model has been seen by some as a move away from imminent “dangerousness” back towards
a “need for treatment” model. In this approach, a
court may order IOC for a patient who is not cur-
cently dangerous, but who has historically demon-
strated the potential for substantial risk of violent or
self-injurious behavior without treatment.

Analysis and Critique

The reactions of psychiatrists to the evolution of
American commitment law mirror the shifting ten-
sions and perceptions of psychiatry, society and the
resources available for the mentally ill. Initially, psy-
chiatrists were enthusiastic about some of the proce-
dural reforms, embracing the idea that involuntary
hospitalization should be used infrequently and with
careful due process, as reflected in a 1972 APA posi-
tion statement (23). Psychiatrists were less enthusi-
astic about dangerousness-based criteria, and were
not ready to abandon the need for treatment model.
As changes in commitment law gained momentum
and more psychiatrists acquired experience working
under the new statutes, critics became more vocal,
arguing that their patients were being turned away
from care and “dying with their rights on” (24).
Citing anecdotal cases, psychiatrists called for a
more reasonable middle ground between unlimited
hospitalization and the current “belegaled” restric-
tive approach. Three general attacks were made on
the dangerousness standard: the system made it too
difficult to obtain involuntary treatment for those
patients who are not overtly or imminently danger-
ous, but desperately in need of care; dangerousness is
not reliably determined by clinicians, who now were
asked to predict dangerousness without any particu-
lar skills or expertise; and basing commitment on
dangerousness, particularly to others, changes the
treatment mission of the mental health system to a
quasi-police function of protecting the public from
harm.

Critics suggested that as the threshold for invol-
untary hospitalization became too restrictive, pa-
tients would needlessly suffer or end up in the
criminal justice system due to illegal behavior that
did not meet strict imminent dangerousness criteria.
They also cited an additional challenge posed by re-
moving treatment need from the commitment crite-
ria. When commitment was explicitly for the
purpose of treatment, the question of whether invol-
untary patients might have the right to refuse treat-
ment never arose — if they were involuntarily com-
mitt ed due to need for treatment, that was logically
assumed to allow for involuntary treatment, if neces-
sary. However, when the criteria shifted to danger-
ousness, courts began to consider whether the state
was allowed to intervene beyond confinement, to
force involuntary treatment. Beginning in the early
1980s, a number of state and federal court decisions
created a right to refuse treatment based on patients’
constitutional rights to privacy and due process (25).
This typically led to further processes to determine
incompetence and need for appropriate involuntary
treatment as determined by an outside reviewer,
with procedures varying by jurisdiction in terms of
the medical and legal roles and standards. The
disjunction between criteria for involuntary com-
mitment and criteria for involuntary treatment
could create a group of committed patients who can-
not be treated and for whom the psychiatric hospital
becomes simply a place of detention. This seeming
paradox reflected public and legal ambivalence in
balancing individual autonomy rights versus the
public protection afforded by involuntary confine-
ment for non-criminal behavior. The clinically chal-
lenging outcome illustrates the frustrating tensions
facing a mental health system designed for treat-
ment, but with goals increasingly linked to public
safety.

A particularly influential critic of the new civil
commitment laws was psychiatrist Alan Stone, a
professor at Harvard Law School who served as pres-
ident of the APA in 1979-80. He raised concerns
about particular procedural requirements, but fo-
cused his opposition on the exclusive dangerousness
standard (26). Stone proposed a “thank you” theory
of civil commitment, emphasizing patients’ need for
treatment, incapacity to make their own decisions,
and reasonable expectations that they might benefit
from care. He suggested that, after successful treat-
ment, these patients would be grateful that commit-
ment and helpful treatment had occurred. Building
on Stone’s theory, the APA developed a model statute
that allowed civil commitment beyond the typical
dangerousness-based criteria if the untreated patient
would suffer severe emotional distress causing func-
tional impairment, lacked capacity to make in-
formed decisions regarding treatment, and
treatment was available in the facility in accord with the least restrictive alternative (27). Overall, the APA model law tried to incorporate many of the procedural reforms of the 1960s and 1970s, but allowed a partial return to treatment-oriented commitment criteria. No state adopted in full the reforms suggested by the APA model law, but as noted above, several states have moved towards expanding the “grave disability” parens patriae-oriented criteria or have developed IOC alternatives.

The critiques offered by American psychiatrists were typically grounded in anecdotal evidence. Many of the published studies were observational or had serious methodological flaws. For the few well-done empirical studies, it was difficult to assess causality and the impact of other factors separate from commitment standards. Several researchers looked at aggregate statistical data from different states before and after the change in criteria, testing the hypothesis that stricter commitment laws would lead to fewer involuntary hospitalizations. In some states, researchers found dramatic decreases in total admissions and involuntary commitments, with a smaller rise in voluntary admissions (28). However, the majority of studies in other states have shown little or no permanent effect of the statutory changes on aggregate commitment rates (29). Analyzing these studies, Bagby and Atkinson explained the contradictory results by noting that the studies with significant changes generally limited their observations to one year post-reform (30). For studies that followed admissions over a longer period of time, initial drop-offs were followed by a gradual return towards pre-reform commitment rates. A 1992 study suggested that changes in commitment rates more likely reflected other changes in the mental health system (i.e., availability of beds, financing patterns) even after some states liberalized their commitment laws in the 1980s (31).

Several studies evaluated the characteristics of the patient population, both those committed and not committed under the dangerousness criteria, testing the hypothesis that the tighter standards would lead to a sicker and more dangerous committed patient population. Studies in California, Pennsylvania and other states suggested no significant changes in the characteristics of committed patients from before to after a statutory change. In some cases, fewer patients were committed on the basis of suicidality or danger to others, but more were committed on the grounds of inability to care for their basic needs — the “grave disability” standard that had become a catch-all for patients who appeared to need hospitalization on clinical (i.e., need for treatment) grounds (32). Looking at patients who were not committed after emergency room evaluation, researchers found few if any patients who were rated high on need for treatment, but low on committability (33). Ill patients who were unwilling to sign in voluntarily were usually evaluated as dangerous and were committed. Patients who were not in need of treatment were typically not referred for emergency evaluation (34). Again, some researchers suggested that local financial, administrative and logistical factors and barriers had more impact on what happens to patients than specific statutory or procedural requirements. Overall, despite claims that uncommitted patients were “dying with their rights on” due to an overly restrictive commitment process, the studies tended to show that the new dangerousness-based laws had far less impact than expected on the nature and number of committed patients. Although there was often regional variation, predictions of widespread patient and community suffering went unproven, and analysts struggled to explain the discrepancy between the dire predictions and actual outcomes.

Observers of the commitment system, such as California sociologist Carol Warren, described a “common sense” approach, where judges, attorneys, families and physicians all seemed to work together towards a consensus outcome, hospitalizing patients whom they all believed were clearly in need of care, regardless of the statutory details (35). In actual practice, these participants in a nominally adversarial and legally bound process seemed reluctant to place liberty rights above obvious suffering and need for treatment. Although the vast majority of committed cases appeared to meet the state’s dangerousness criteria, when it came to the cases at the margins that most concerned opponents of the restrictive statutes, the impact appeared to be modulated by a generally “beneficent” willingness to achieve what all agreed was the most practical result (36). Similar studies found that attorneys tended to think of their clients’ best interests rather than auto-
matically advocating for their clients’ expressed desire for outright release (37). Attorneys frequently advocated for a more restrictive disposition than their client-patient wanted, and defense attorneys would often share the perception that some individuals needed to be hospitalized for treatment, collaborating in that process. Despite training to take a more aggressive adversarial stance, attorneys in one study continued to believe that their clients would benefit from treatment and commitment (38). Psychiatrists similarly seemed to find ways of flexibly using the commitment criteria to achieve desired clinical outcomes, such as increased use of the “grave disability” standard to hospitalize patients who may require care but did not appear imminently dangerous (39). Similar language was seen in commitment petitions filed by family members, presumably coached in the process to “say the right thing” to get their ill family member into the hospital and needed treatment (40). Overall, these studies suggested that many lawyers, judges, families, and physicians were working together, guided by clinical/legal realism and Warren’s “common sense” model even in the context of restrictive standards and procedures, to commit those patients in clear need of treatment who were unprepared or unable to obtain it for themselves. Even with all of these studies suggesting that the statutory changes in criteria towards dangerousness had less impact than expected (or feared), there still remain several unanswered questions about civil commitment, including whether mentally ill persons actually fare better or worse with one or another set of substantive and procedural standards.

Most recent research has been directed at involuntary outpatient commitment (IOC), increasingly the focus of legislative and programmatic efforts in the states. The limited body of empirical studies suggests generally positive results, although outcomes depend largely on adequacy of community resources and system coordination/implementation. A number of studies in North Carolina, the first state to allow less restrictive criteria for mandated outpatient treatment, found significantly improved compliance and higher retention in treatment for IOC patients compared to patients who were involuntary hospitalized or released at the hearing without further treatment. A study of 4,000 patients assigned to IOC over three years claimed an 82% decline in readmissions and shorter lengths of stay, although the study did not adequately control for other factors that may have affected hospitalization (such as institutional changes in the mental health care system) (41). A later randomized controlled trial of IOC in North Carolina showed positive outcomes on multiple measures (42). Studies in different states demonstrated similar outcomes, while other states reported no significant impact from IOC, including an early randomized controlled trial in New York City (which may have been limited by study design and lack of enforcement mechanisms at the time) (43). A more recent 2005 study from New York suggests more positive results (44). Overall, these studies suggested that aggressive case management with adequate community supports was more likely to lead to improved outcomes for IOC patients (45). By contrast, for states where inadequate resources were provided along with inconsistent implementation, mere passage of an IOC statute seemed to accomplish little. Proponents see IOC as offering more consistent care for those who need it (a return to the need for treatment approach), increased availability of community resources (“committing the system” to care of the patient), and an answer to the “revolving door” problem of brief inpatient stays alternating with outpatient non-compliance or irregular community support (46). Treatment can be offered in familiar community surroundings with significantly more freedom and flexibility, allowing for rapid interventions before a patient deteriorates to the point of a significant risk of violence or self-harm. Opponents of IOC fear more state coercion and loss of the right to refuse treatment, less regulatory oversight, and overburdening of limited community resources (47). In an era of increasingly limited inpatient resources, IOC seems a useful “treatment”-driven model, if adequately monitored, resourced and enforced, but it remains unclear who are the most appropriate patients for IOC, and whether legislatures are willing to provide the community resources necessary to support the court-ordered treatment.

Discussion

It seems fair to conclude that changes in American commitment law towards more restrictive substan-
tive and procedural criteria had less impact than originally expected, for a variety of reasons as noted above. At the same time, it is obvious on urban streets throughout the United States that there is a large homeless, often untreated, population of chronically mentally ill patients. Similar visits to our state prisons and county jails reveal large numbers of violent and non-violent criminals with mental health issues, some with clear severe and persistent mental illness, who in an earlier era might have been long-term residents of a state hospital. A variety of financial, economic and policy factors have had a much more dramatic impact on who gets hospitalized than the language of commitment laws. The changes in American commitment laws over the past 35 years coincided with enormous changes in the public mental health system brought on by deinstitutionalization, a deliberate process of reducing the inpatient population in public psychiatric hospitals. In 1955, there were over 550,000 public inpatient (typically long-term) psychiatric beds in the U.S., for a population of 165 million. Spurred first by the successful advent of anti-psychotic and other psychotropic medications, then by the growing community psychiatry movement, and later by underfunding of state facilities and fiscal pressures, the number of these beds fell rapidly, to 150,000 in 1980 (for a population of 227 million) and to fewer than 60,000 in 2000 (for a population of 281 million). Although many of these patients could be maintained in the community with improved treatment and adequate supports, often these community-based alternative resources were not fully funded. Acute inpatient bed capacity in general hospitals and private facilities did not fill the gap. With fewer public inpatient beds available, there would be increased pressure to admit only those patients most severely in need of commitment; once admitted, there would be pressure to discharge quickly to keep up with demand for the reduced number of beds. When mentally ill patients, especially the chronically ill and indigent, fail to gain admission to psychiatric facilities, this may not be due to restrictive commitment standards or overly rigorous legal procedures. There may simply be no appropriate place to which to admit them.

Financial factors also play an important role. Traditionally, states were responsible for much of the cost of public mental health services, and the federal government provided limited if any funding for state-run hospitals. As state hospitals closed, general medical hospitals began to fill the gap with acute inpatient psychiatric wards, which allowed the states to shift part of the hospital costs to the federal government through the Medicaid and Medicare programs. A similar shift of formerly long-term inpatients "transinstitutionalized" to nursing homes, rest homes or other community-based living also allowed increased sharing of costs with the federal government. Faced with internal fiscal pressures, state mental health authorities seek to maximize opportunities to get the federal "matching share" for Medicaid expenditures. [Although the Medicaid programs for the indigent are operated and funded at the state level, each state receives a federal reimbursement match, a minimum of 50% of the state's expenditures.] Over the past 15 years, the U.S. has seen increasingly managed mental health care, both in the private and public sector, in an effort to contain costs and ration care. These efforts have pushed towards increasingly shorter lengths of stay in acute inpatient units; thus, even if a patient is legally committable, the stay is typically brief (one week or less) except for the most severely ill individuals. For patients without private insurance or financial resources, waiting lists abound for underfunded public mental health resources in the community, as well as for the rare long-term inpatient beds left in the dwindling number of state hospitals.

As other nations analyze their commitment laws, and more generally, their approach to providing care for the mentally ill, it can be useful to draw some lessons from the American experience. Civil commitment in the U.S. has been shaped by multiple factors, including sensitivity to civil rights, public perception of psychiatry, availability of resources and larger economic pressures. The American experience has been that clinicians, families and courts generally find a legally acceptable way to commit individuals who "need" it, regardless of the substantive and procedural details of the statute. There is significant local variability based on 50+ legal jurisdictions and resource issues. (This may be less problematic in a smaller country such as Israel with national regulations and coordination of resources. Furthermore, Israeli civil commitment does not rely on judicial
process, although the courts oversee appeals and supervision.) Although we should not underestimate the impact of changing legal commitment standards, we also must not underestimate the substantial impact of economic factors, cost shifting and availability of sufficient inpatient and outpatient resources in shaping actual commitment patterns. Our review suggests that, when writing new inpatient or outpatient civil commitment statutes, it would be naïve to think that legal changes alone will address desired social goals without adequate alternative resources and consistent implementation. From the clinical perspective, improved treatment options and better clinical risk prediction and management would also help serve both the *parens patriae* and police power functions of civil commitment. Whatever changes are made in civil commitment processes, there is the challenge of good empirical studies of the impact of these changes. It would be ideal to devise and fund an effective prospective evaluation process in tandem with any proposed legal changes. Balancing the desire to help the unfortunate and the fear of restricting personal liberty, American civil commitment law has evolved over the past 200 years — but we have not yet developed commitment statutes that are consistently fair, reasonable and compassionate. Perhaps we will also learn something from the experience and the experiments of other nations.

References

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