Civil Commitment Laws and Population Health

January 22, 2015
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Civil Commitment Law and Population Health

INTRODUCTION

SAFETY  PATERNALISM

AUTONOMY  RIGHTS

Jeffrey Swanson, PhD (Moderator)
Dept. of Psychiatry & Behavioral Sciences
Duke University School of Medicine
Presenters

- **Jeffrey Swanson**
  Ph.D., Professor in Psychiatry and Behavioral Sciences — Duke University School of Medicine. (Moderator)

- **Paul Appelbaum**
  M.D., Professor of Psychiatry and Director, Division of Psychiatry, Law, and Ethics, Department of Psychiatry — College of Physicians and Surgeons of Columbia University.

- **Richard Bonnie**
  LL.B., Harrison Foundation Professor of Law and Medicine, Professor of Public Policy, Professor of Psychiatry and Neurobehavioral Science, and Director of the Institute of Law, Psychiatry and Public Policy — University of Virginia.

- **John Monahan**
  Ph.D., Shannon Distinguished Professor in Law, Professor of Psychology and Psychiatry and Neurobehavioral Sciences — University of Virginia.
Prevalence of serious mental illness among US adults (2012)

Only about 40% get any treatment in a year:
Estimated 3.5 million adults with serious mental illness go without treatment

$318 billion per year
Commitment selects persons with certain types of serious mental health impairments

Distribution of major psychiatric diagnoses in community-based vs. involuntarily-committed samples of persons with serious mental illness

Population-representative epidemiological survey (NCS)

- Schizophrenia: 13%
- Bipolar disorder: 32%
- Major depression: 55%

Involuntarily-committed sample in North Carolina who also ordered to outpatient commitment upon discharge (N=331)

- Schizophrenia: 68%
- Bipolar disorder: 27%
- Major depression: 5%
INTERPERSONAL VIOLENT BEHAVIOR

Percent violent within 6 – 12 months

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>General population without mental illness</td>
<td>2%</td>
</tr>
<tr>
<td>Outpatients in treatment</td>
<td>8%</td>
</tr>
<tr>
<td>Emergency departments</td>
<td>23%</td>
</tr>
<tr>
<td>Involuntarily committed inpatients</td>
<td>36%</td>
</tr>
<tr>
<td>First-episode psychosis patients</td>
<td>37%</td>
</tr>
</tbody>
</table>

Higher risk identified at times and in settings where people encounter service system in a mental health crisis, e.g., involuntary commitment.

Commitment rates vary greatly across states

Voluntary admission status and involuntary commitment among patients admitted to state psychiatric facilities in 2012: average among states reporting

<table>
<thead>
<tr>
<th></th>
<th>Percent of patients admitted voluntarily</th>
<th>Percent of admitted patients who are involuntarily committed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Range</strong></td>
<td>1% - 79%</td>
<td>2% - 98%</td>
</tr>
<tr>
<td><strong>Median</strong></td>
<td>7%</td>
<td>55%</td>
</tr>
<tr>
<td><strong>Mean</strong></td>
<td>13%</td>
<td>52%</td>
</tr>
</tbody>
</table>

Source: NASMHPD Research Institute (NRI) State MH Surveys
Private hospitals now play a big role in providing emergency psychiatric treatment and involuntary commitment.

Percent of short-term involuntary holds and commitments that occurred in state psychiatric hospitals vs. private or other facilities in 2012: average across 9 states reporting.

Short-term involuntary holds

Involuntary commitments

Data source: NASMHPD Research Institute State Mental Health Agency Profiling System: 2013 (selected states)
Fix treatment barriers first?
The Origins and Purpose of Civil Commitment

Paul S. Appelbaum, MD
Dollard Professor of Psychiatry, Medicine, and Law
Columbia University/NY State Psychiatric Institute
Goals

- To review the history of civil commitment in the United States
- To consider the justifications for civil commitment and the reasons for its continued use
History of Civil Commitment

- Coercive approaches to people with serious mental illness predate the development of formal mental health laws
Pre-institutional period (1607-1751)

- Approaches to dealing with mentally ill persons
  - Commitment under the poor laws
  - Jailing for minor offenses
  - “Warning out”
Early Institutional Period (1752-1833)

- Hospitalization limited; few public or private facilities
- Controlled by family and physician
- No legal oversight
- Identical to process for other medical disorders
Development of Public Hospitals (1833-1881)

- System of large state hospitals is developed as progressive reform

- First commitment laws adopted:
  - Preexisting system codified
  - Family/physician control maintained
Voluntary Hospitalization Authorized (1881)

- Massachusetts is first state to enact voluntary admission provision
- Prior to this, never considered as a legitimate option
- Other states soon follow suit
Involuntary Treatment Predominates (1882-1980)

- Despite voluntary admission statutes, majority of admissions remain involuntary
- Why?
Factors Reinforcing Coercive Approaches - 1

- Presumption that committed, mentally ill persons are incompetent
  - Written into statutes until mid-20th century
  - Burden on committed person to demonstrate that competence has been restored
- If incompetent, patients’ consent was considered irrelevant and interventions used regardless of their desires
Factors Reinforcing Coercive Approaches - 2

- Association between mental illness and violence
  - Common assumption in the popular mind—notwithstanding the empirical data
- Police power rationale preempts patients’ decisions, so again treatment can be undertaken regardless of patients’ desires
New Approach to Psychiatric Treatment (1960-1979)

- From a psychiatric perspective, institutional care—especially if involuntary—viewed as inherently inferior to community-based care—especially if voluntary
  - Evolution from CMHC movement to recovery movement
- From a legal and moral perspective, the legitimate scope of the state’s power to intervene seen as limited to danger to self/others
- Movement for statutory change draws on both and is explicitly aimed at reducing use of coercion
Results of Legal Reform

- By 1979, every state limits commitment criteria to danger to self/others.
- By mid-1980s, most states adopt rules restricting involuntary treatment of committed patients.
  - Variety of approaches, but most aimed at reducing extent of coercive treatment.
  - Medications, ECT, seclusion and restraint were all targets.
- Similar changes internationally.
Expectations of Reformers

- Involuntary hospitalization will be uncommon
- Most treatment will be voluntary
- Coercive approaches will wither away
Aftermath of Reform: Civil Commitment Still Common

- Majority of patients in public facilities again are civilly committed
- Commitment has been extended to the community: outpatient commitment
- More subtle forms of pressure for treatment have been developed ("leverage")
What Accounts for Persistence of Commitment and Other Forms of Coercion/Leverage?

- Coercion/leverage extraordinarily prevalent and diverse
- Could factors other than fear/stigma be operative?
- Might commonsense view that coercion is often necessary be based in reality as well?
Nature of Mental Illness Plays a Role in Prevalence of Coercion

- Severe mental illnesses impair decision making in a subset of persons
  - Competence to consent to treatment may be limited
  - Unawareness of illness may lead to failure to get treatment
  - Typical finding: 57% of patients with schizophrenia had “moderate to severe unawareness of having a mental disorder”

(Amador, et al., 1994)
Justification for Soft Paternalism

- Legitimate to intervene when people
  - Badly in need of treatment
  - Likely to suffer harm
  - Cannot recognize illness/need for treatment
Nature of Mental Illness Plays A Role in Prevalence of Coercion-2

- Some people with mental illnesses likely to be violent
- Risk is increased compared with general population
  - Attributable risk varies by country/base rate of violence
  - Relative risk for schizophrenia may be 2-3xs risk of general population
Justification for Hard Paternalism

- Society has right to protect citizens from danger
- Degree of competence may not be material
- Threshold lower if benefit provided
Coercive Approaches Reflect Belief That Paternalism is Justified

- Expectation of eliminating coercion appears to have been overly ambitious.
- Hence, coercion has moved from institutions to the community along with patients.
- New forms of leverage have been developed.
Appropriate Use of Coercion Requires Caution

- Blanket endorsement unwarranted
  - Many people with mental illnesses can and should make decisions for themselves

- Blanket rejection also unwarranted
  - Nature of mental illnesses may justify coercive intervention
Challenges for Policy Makers

- Limit use of coercion by identifying circumstances that justify it.
- Even within these contexts, encourage maximum possible exercise of autonomy.
Designing and Administering Civil Commitment Law: Aspirations and Challenges

Richard J. Bonnie
Harrison Foundation of Law and Medicine
Director of Institute of Law, Psychiatry and Public Policy
University of Virginia
Outline

- Principles of modern civil commitment law and their policy implications
  - Use Virginia as a case study
- Overview of important variations in civil commitment laws
- Challenges of connecting civil commitment process to gun violence restrictions
Principles/Aspirations

- Promote and facilitate voluntary treatment and self-determination
- Use involuntary treatment as last resort only when necessary to prevent harm or restore “capacity”/competence/autonomy
- But use involuntary treatment effectively when it is necessary
- Respect individual dignity always, even when competence is impaired or involuntary treatment is being utilized
Why Prefer Voluntary Treatment?

- Respect individual liberty and dignity
- Reducing burden of disease
  - Untreated mental illness is huge burden
  - Best strategy is to increase awareness, reduce stigma, integrate behavioral health and physical health care, remove impediments to preventive services and increase treatment engagement
- A mental health system perceived and experienced as coercive will reduce population health and well-being
Some Policy Implications

- Provide safe, non-stigmatizing transportation in crises**
- Remove funding impediments to voluntary care
- Promote empowerment, treatment engagement and effective crisis response through advance directives
Use coercion effectively when necessary

- The civil commitment process is only legal tool for responding to mental health crises when the person resists treatment –
- Civil commitment practice is shaped by important structural variations re (1) organization of emergency services (evaluation, referral, treatment); (2) connections among mental health system, health care system, social welfare system, public health infrastructure and public safety apparatus; (3) and availability of services, especially psychiatric services. hospital beds, and intensive alternatives to hospitalization
- AND by substantial state variations in civil commitment law
Virginia as a case study: A note about scale

- April 2013 - 4500 face-to-face emergency evaluations of conducted by community mental health agencies (CSBs) in Virginia (>50,000/year). This doesn’t count undetermined # of cases in jails and in emergency departments that don’t require CSB review
- Involuntary commitment proceedings initiated in 40% of evaluations
- In FY 2014, there were approximately 22,000 commitment hearings leading to about 13,500 commitments (60% committed, 20% voluntary conversions and 20% dismissed)
- Another 2500 recommitments
Variations in state law and practice on key issues

- Criteria for inpatient commitment
Criteria in Virginia (1)

Pre-2008: “The person presents an imminent danger to himself or others as a result of mental illness.”

2008: “There is a substantial likelihood that, as a result of mental illness, the person will, in the near future, cause serious physical harm to himself or others, as evidenced by recent behavior causing, attempting, or threatening harm.”
“A ‘one-in-four’ estimated risk of serious harm in the near future is sufficient [for civil commitment], A ‘substantial likelihood’ is not meant to mean ‘more likely than not’ (51%).”

“Near future” means “up to about one week.”
Criteria in Virginia (2)

Pre-2008: “The person is substantially unable to care for himself as a result of mental illness.”

2008: “There is a substantial likelihood that, as a result of mental illness, the person will, in the near future, suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs.”
Variations in state law and practice on key issues

- Criteria for inpatient commitment
- Procedure: medical certification v judicial model
- Time period before judicial hearing must be held
- Major state practice variation** (esp vol v invol and judicial involvement)
- Highly localized practice even within the same state
- Mandatory outpatient treatment (outpatient commitment, AOT)
  - Preventative
  - Step down from hospitalization
Challenges of connecting civil commitment law to firearm restrictions (1)

- Disqualification based on mental health history is grossly under- and over-inclusive re risk of violence. Consortium recommends evidence-based criteria demonstrating elevated risk of violence or suicide that would include violent misdemeanors and alcohol-related offenses.

- Regarding mental illness, occurrence of involuntary commitment is also over-inclusive and fair opportunity for restoration is essential.

- Federal law disqualifies based on “involuntary commitment to a hospital” and regulations specifically exclude “voluntary admissions” This is sensible policy because a more sweeping disqualification would deter voluntary treatment.

- Federal regulation also specifically excludes “mandatory observations” which is also sensible because such hospitalizations are not grounded on a specific finding sufficient to warrant a loss of rights.
Challenges of connecting civil commitment law to firearm restrictions (2)

- That said, what is a “commitment”? Does it require a judicial order? If so, the great majority of hospitalizations in medical certification states are not “commitments”
- Many hospitalizations that begin as involuntary convert to voluntary. Are they commitments?
- Many hospitalizations that are “formally” involuntary are REALLY “voluntary”
Challenges of connecting civil commitment law to firearm restrictions (3)

- What about mandatory outpatient treatment? Not a “commitment to a hospital”, but it might count as an adjudication of dangerousness under another provision of federal law if it were specifically based on such a finding.

- Should a short term of emergency hospitalization based on a medical certification but no judicial order be a basis for disqualification?

- A promising innovation is to make the initial hospitalization a basis for a temporary removal of firearms. That basic concept should be broadened to apply to authorize removal from persons based on indicators of elevated risk even if they are not mentally ill.
Civil Commitment Laws and Population Health

The science (and scientific challenges) behind civil commitment practice

John Monahan, Ph.D.
University of Virginia School of Law
Goals

To review research findings on two topics:
- the risk assessment of violence to others
- mandating mental health treatment in the community
MacArthur Violence Risk Assessment Study
Monahan, Steadman, Silver, Appelbaum, Robbins, Mulvey, Roth, Grisso, & Banks

• 1,100 patients discharged from short-term psychiatric facilities in 3 states
• Measured 134 possible risk factors for violence to others
Kraemer et al, *Coming to Terms with the Terms of Risk*, 54 Archives of General Psychiatry 337 (1997)

- Factor Is Associated With Outcome?
  - Yes → A Correlate
  - No → Factor Precedes the Outcome?
    - Yes → A Risk Factor
    - No → ...
MacArthur Violence Risk Assessment Study
Monahan, Steadman, Silver, Appelbaum, Robbins, Mulvey, Roth, Grisso, & Banks

- 1,100 patients discharged from short-term psychiatric facilities in 3 states
- Measured 134 possible risk factors for violence to others
- 5 month community follow-up; self-report, collateral report, arrest and hospital records
- Violence: weapon use, threat with a weapon in hand, battery resulting in injury, or sexual assault
- Comparison group: 500 people, matched for neighborhood, age, and race, randomly sampled from the same communities as the discharged patients.
Risk Factors for Violence in the MacArthur Study

• What the person “is”
• What the person “has”
• What the person “has done”
• What has been “done to” the person
Risk Factors for Violence in the MacArthur Study

WHAT THE PERSON “IS”

- Age: 1-yr increase in age, violence ↓ 20%
- Anger control: 1 SD increase in anger, violence ↑ 52%
- Gender: M 51% ↑ violent than W
Risk Factors for Violence in the MacArthur Study

WHAT THE PERSON “HAS”

• Major mental disorder, or
• Personality disorder
Violence in First 10 Weeks by Patient Groups and Community Group

- Community-Pittsburgh: 4.6%
- Patients-Schizophrenia: 8.1%
- Patients-Bipolar: 15.5%
- Patients-Depression: 18.8%
- Patients-Personality Disorder: 22.7%
Common Risk Factors for Violence in the MacArthur Study

WHAT THE PERSON “HAS”

• Major mental disorder
• Personality disorder
• Substance abuse disorder
Violence in First 10 Weeks After Discharge, by Substance Abuse Symptoms - Pittsburgh

<table>
<thead>
<tr>
<th>% Violent</th>
<th>Community (17.5)</th>
<th>Patients (31.5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Without Substance Abuse</td>
<td>3.3</td>
<td>4.7</td>
</tr>
<tr>
<td>With Substance Abuse</td>
<td>11.1</td>
<td>22.0</td>
</tr>
</tbody>
</table>
Risk Factors for Violence in the MacArthur Study

WHAT THE PERSON “HAS DONE”

- Prior crime and violence
Risk Factors for Violence in the MacArthur Study

WHAT HAS BEEN “DONE TO” THE PERSON

• Pathological family environment: father used drugs, violence ↑ 100%

• Victimization: seriously abused as a child, violence ↑ 51%
Risk Classes

Classes

Probability of Violence 95% Confidence Interval
Can Voluntary Community Treatment Reduce Violence?
Violence in 2nd 10-Weeks After Discharge, by Outpatient Treatment Sessions Attended in 1st 10 Weeks

p < .0001, controlling for age, gender, race, education, marital status, substance use, diagnosis, and prior violence. Community comparison group = 4.6% violent.
Can *Mandated* Community Treatment Reduce Violence?
<table>
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<tr>
<th></th>
<th>Mandated Institutional Tx</th>
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<tr>
<td>Housing</td>
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<td>Order maintenance</td>
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<tr>
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<td>Hospital</td>
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</tr>
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<td>Treatment</td>
<td>Hospital</td>
</tr>
</tbody>
</table>
Housing as “Leverage”

A standard lease for a subsidized apartment for a person with mental illness

“Refusing to continue with mental health treatment means that I do not believe I need mental health services. I understand that since I am no longer a consumer of mental health services, it is expected that I will find alternative housing. I understand that if I do not, I may face eviction.”

In 41 states, the mean rent for a 1-bedroom apartment exceeds 100% of federal disability benefits.
Money as “Leverage”
Money managers (“Representative payees”)

“You are receiving benefits based on the mental health problems that you have. The Social Security Administration requires that you be involved in mental health services so that you will feel better. [Otherwise,] you may lose your benefits.”

~ 1,000,000 people in the U.S. receive benefits for psychiatric disability through a “rep payee”
Jail as “Leverage”
Treatment as a condition of probation

“The court may provide, as further conditions of a sentence of probation...that the defendant ... undergo available medical, psychiatric, or psychological treatment.” 18 U.S. Code § 3563.

In addition, ~400 mental health courts are now in operation in the U.S.
Hospitalization as “Leverage”  
“Outpatient Commitment”

A civil court-order requiring a person to accept mental health services in the community.

- **Conditional discharge**: meets inpatient commitment criteria
- **Alternative to hospitalization**: meets inpatient commitment criteria
- **Preventive commitment**: does not meet inpatient commitment criteria.
The Prevalence of Mandated Treatment in the Community
## Prevalence of Mandated Community Treatment

<table>
<thead>
<tr>
<th>Form of Leverage</th>
<th>% with Leverage</th>
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</thead>
<tbody>
<tr>
<td>Obtaining Housing</td>
<td>32</td>
</tr>
<tr>
<td>Avoiding Jail</td>
<td>23</td>
</tr>
<tr>
<td>Avoiding Hospital</td>
<td>15</td>
</tr>
<tr>
<td>Obtaining Money</td>
<td>12</td>
</tr>
<tr>
<td>At Least 1 Form</td>
<td>51</td>
</tr>
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</table>
Can *Mandated* Community Treatment Reduce Violence?

Outpatient Commitment
New York State
Assisted Outpatient Treatment
Program Evaluation

Submitted under Contract with the New York State Office of Mental Health

Duke University
School of Medicine

Marvin S. Swartz, MD, Principal Investigator
Jeffrey W. Swanson, PhD, Co-Principal Investigator
Department of Psychiatry and Behavioral Sciences
Duke University School of Medicine
Durham, NC

Henry J. Steadman, PhD, Co-Principal Investigator
Pamela Clark Robbins, Project Director
Delmar, NY

John Monahan, PhD, Director
The MacArthur Foundation Research Network on
Mandated Community Treatment
University of Virginia School of Law
Charlottesville, VA
Outpatient Commitment in NYS: “Assisted Outpatient Treatment”

- People on AOT Order: ~3,000 per year
- Average length on AOT: ~12 months
- “Removals” from home by police: ~500 per year
Finding 1: Increased Medication Possession

Exhibit 3.10 Adjusted percent* with at least 80% medication possession in month by AOT status

*Adjusted probability estimates were generated from repeated measures regression models controlled for time, region, race, age, sex, diagnosis, and co-insurance status. Models were also weighted for propensity to initially receive AOT and to receive more than 6 months of AOT.

Source: Medicaid and OMH records.
Finding 2: Reduced Inpatient Admissions

Exhibit 3.8 Adjusted percent* with psychiatric inpatient admission in month, by AOT status

*Adjusted probability estimates were generated from repeated measures regression models controlled for time, region, race, age, sex, diagnosis, and co-insurance status. Models were also weighted for propensity to initially receive AOT and to receive more than 6 months of AOT.

Source: Medicaid claims and OMH admissions data.
Finding 3: Reduced Inpatient Days

Exhibit 3.9. Adjusted* average inpatient days during any 6 month period, by AOT status

*Adjusted mean estimates were generated from repeated measures regression models controlled for time, region, race, age, sex, diagnosis, and co-insurance status. Models were also weighted for propensity to initially receive AOT and to receive more than 6 months of AOT.
Source: Medicaid claims and AOT Evaluation database.
Finding 4: Reduced Threatened Violence and Actual Violence to Others (NYS OMH, 2013)

Threatened Violence (%)

- Baseline
- On AOT for 6 mos
- On AOT for ~1 yr

Actual Violence (%)

- Baseline
- On AOT for 6 mos
- On AOT for ~1 yr
Finding 5: Comparable Self-Report Ratings Between AOT and Non-AOT Recipients

No significant differences in

- perceived coercion
- working alliance
- treatment satisfaction
- life satisfaction.
Finding 6: AOT is Cost-Effective

Mandating Community Treatment May be Useful for Some People with MI

Outpatient Commitment

- is seldom experienced as coercive, if done with “procedural justice”
- can lead to increased adherence to TX and to reduced hospitalization and violence
- to be successful, depends on the availability of high-quality services in the community
- can save taxpayers’ money by reducing expensive hospitalization costs.
Q&A

Please type your questions in the Q&A panel.
Please join us for this upcoming webinar:

**When Public Health Goes to Court: Judicial Structure and Functions**

Co-Sponsored by CDC’s Public Health Law Program and the Network for Public Health Law

Thursday, February 5 at 1p.m. (ET)

The judicial system plays a critical role in advancing public health goals, and it is critical that public health practitioners, legal counsel and other partners understand how the court system works and how courts are involved in public health matters. This webinar looks at the structure and essential functions of the state and federal court systems, explores the Tribal court system, and examines the role of court watch programs in addressing public health issues.

Learn more and register at: networkforphl.org/webinars