4-21-1994

Wisconsin's Chapter 51 - The Mental Health Act, and the Proposed Fifth Standard of Dangerousness for Civil Commitment Legislation: A Policy Analysis

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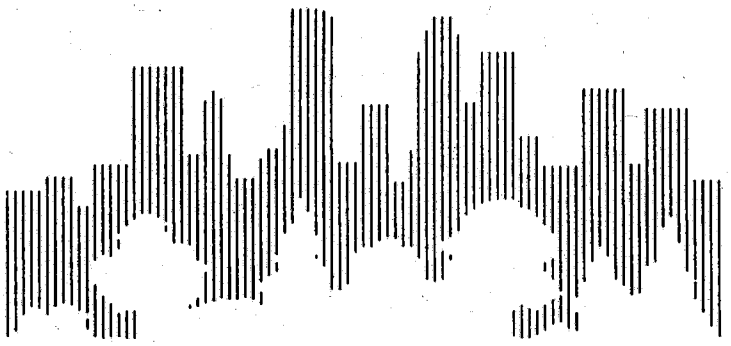

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MASTERS IN SOCIAL WORK THESIS

Kathryn M. Huston

Wisconsin's Chapter 51 -The Mental Health Act, and the Proposed Fifth Standard of Dangerousness for Civil Commitment Legislation: A Policy Analysis

1994

WISCONSIN'S CHAPTER 51 - THE MENTAL HEALTH ACT, AND THE PROPOSED FIFTH STANDARD OF DANGEROUSNESS FOR CIVIL COMMITMENT LEGISLATION: A POLICY ANALYSIS

by

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A Thesis

Submitted to the Graduate Faculty

of

Augsburg College

in Partial Fulfillment of the Requirements

for the Degree

Master of Social Work

Minneapolis, Minnesota

May, 1994

MASTER OF SOCIAL WORK
AUGSBURG COLLEGE
MINNEAPOLIS, MINNESOTA

CERTIFICATE OF APPROVAL

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Date of Oral Presentation: April 21, 1994

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DEDICATION

To all of my family and friends

who provided love, support and

encouragement throughout my life and in the

last year during graduate school.

Thank you all for always being there for me.

WISCONSIN'S CHAPTER 51 - THE MENTAL HEALTH ACT,

AND THE PROPOSED FIFTH STANDARD OF DANGEROUSNESS

FOR CIVIL COMMITMENT LEGISLATION:

A POLICY ANALYSIS

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MAY 1994

ABSTRACT OF THESIS

The purpose of this study was to analyze policy implications which sought to explore Chapter 51 of the Wisconsin statutes, the Mental Health Act, and the proposed fifth standard of dangerousness of civil commitment. Civil Commitment is a process that affords the mentally ill with necessary treatment for their illness on a court ordered involuntary basis. The proposed fifth standard legislation would introduce a need for treatment criteria to Wisconsin's current four standards of dangerousness that would be designed to be preventive in nature; to provide treatment at the onset of mental regression vs. allowing a person to become dangerous to self or others before treatment is provided. There are ethical concerns with the proposed legislation: 1) the denial of civil rights, primarily, inappropriate civil commitments, and 2) failure to provide treatment to those in need.

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Introduction

Chapter 51 of the Wisconsin statutes, the Mental Health Act, is designed to regulate the responsibilities of the state and counties to afford Wisconsin residents (both adults and juveniles) services pertaining to voluntary admissions to inpatient psychiatric units, the civil commitment standards (and process of obtaining civil commitment), and residents' rights pertaining to mental health treatment (The Wisconsin Mental Health Law of 1990). The purpose of this study is to analyze this act in terms of its effectiveness in reducing false negative errors without increasing the probability of false positive errors. False negative errors are defined as a failure of the system to commit people who needed, or would have benefitted from treatment. False positive errors are defined as those instances where people were inappropriately committed resulting in a denial, or reduction of their civil rights.

Thesis: 1) Strategies for reduction of false positive errors may increase the probability (likelihood) of false negative errors. Or, 2) Strategies in reduction of false negative errors may increase false positive errors.

Statement of Problem

Many people with chronic mental illness could constructively utilize involuntary inpatient psychiatric hospitalization (civil commitment) but do not receive these services due to the narrow definitions of the current standards. Wisconsin's

existing standards of dangerousness (or dangerousness criteria) are: 1) suicide or serious bodily harm, 2) harm to others, 3) impaired judgement, and 4) inability to satisfy basic needs.

Two issues: 1) Wisconsin statutes do not (as currently written) adequately provide for the care of people with chronic mental illness when in a decompensated (mentally regressed) state - false negative error and 2) civil rights of individuals can be denied when people are inappropriately committed to a psychiatric hospital -- false positive error. In other words, it is desired that people who are in need of treatment receive it, while at the same time being cautious that people are not subjected to treatment if they are not in need. Those not hospitalized who are in need (false negative error) have been subjected to the narrowly defined standards and unfortunately do not meet the dangerousness criteria. By the time people with chronic mental illness meet the criteria, they have significantly decompensated (or mentally regressed) with regard to their mental status and mental health treatment. A prolonged length of stay may then be required to assist the person in regaining his or her previous level of community functioning, thus, a preventative (need for treatment) approach may be useful. Those who are inappropriately committed to a psychiatric hospital (false positive error), are protected in that they can only be initially detained for 72 hours. If a false positive error has occurred, the person may be released after 72 hours has elapsed, or any time prior to that if a doctor approves the discharge and dismisses the detention.

Research Question: What does the legislative constituency need to know to

CHAPTER 2

The Review of Related Literature

Introduction

The review of the related literature consists of seven sections and two appendices. These sections are: 1) the definition of civil commitment, 2) a historical overview - which provides a history of the civil commitment process dating back to the colonial era, 3) deinstitutionalization - which is said to be a contributing factor to homelessness and civil commitment due to a lack of adequate treatment and services to the chronic mentally ill, 4) proponents and opponents of civil commitment - which presents both sides of the civil commitment issue, 5) need for treatment explains the clinically based alternative to dangerousness standards, 6) schizophrenia - (its etiology, response to treatment, and relationship to dangerousness to self or others) is also delineated as a contributing factor to civil commitment, and 7) the homeless - growing as a social and psychiatric problem.

Civil Commitment

> "Civil commitment is a procedure for providing treatment for a mentally ill person who is ordered by a court to receive treatment for his or her condition on an involuntary basis. The purposes behind commitment are twofold: one is to protect the mentally ill person and others from the mentally ill person's

dangerous behavior; the other is to provide treatment and improve the ill person's condition" (Chapter 51 - The Wisconsin Mental Health Law of 1990).

There is a bill that was introduced into Wisconsin legislation in 1991 (Assembly Bill 203 - AB203 for short) that would "create an alternative to the 'dangerous' standard for purposes of involuntary civil commitment" (Drafting Records of the 1991-1992 Legislative Session; Wisconsin Assembly Bill 203; microfiche). It is based on a need for treatment. It would provide for persons to be involuntarily committed if based on a history of "mental illness, drug dependence or developmental disability, there is a substantial probability that the person will suffer substantial mental deterioration or develop chronic mental illness unless he or she receives immediate treatment" (Drafting Records of the 1991-1992 Legislative Session; Wisconsin Assembly Bill 203; microfiche).

Historical Overview

The history of the civil commitment process dates back to the colonial era. "The first asylums in America for the mentally ill were established in the middle of the eighteenth century, and for about a hundred years thereafter the 'commitment' of patients to the asylums was affected with ease and informality: (Gove, Tovo, and Hughes, 1985, p. 296). Legislative changes began to occur in the 1940's and the 1950's. In the period from 1940-1950, increased consideration was being placed on clients clinical needs with emphasis on restoration of functioning via treatment. This focus was carried so far as to overlook the fact that people may have been committed

inappropriately (false positive errors).

The dangerousness criteria was introduced in 1960 in only two states: Arizona and Washington. The criteria simply required that a person be a danger to self, others or property before a civil commitment could be instituted. It seemed progressive at the time, however, "the criteria were open to a fairly broad interpretation. In all other jurisdictions a person could be hospitalized if he or she was 'in need of treatment' or if such hospitalization would benefit the 'welfare of self or others'."

Many states clearly spelled out criteria, while at the same time, other states were very vague in their criteria for commitment. Length of commitments were "for an indefinite period of time."

In 1970, there was an increase (from 2 to 8) in the number of states that recognized and implemented the dangerousness criteria. All other states continued to operate under the vague, and broadly defined need for treatment criteria. Length of commitment continued to be indefinitely in most states however, "in four states the length of commitment was for a specified period of time (the maximum period being six months)" (Gove et al. 1985, p. 294-296).

In 1981, criteria resembled that which necessitated an emergency hospitalization (see table 1); length of commitments were also addressed and 36 states then would "specify the period of commitment" (Gove et al., 1985, p. 302-306).

Wisconsin passed legislation in 1974 ("The Involuntary Civil Commitment Law") prohibiting commitment of people with mental illness who refused treatment and were not a danger to themselves or others (Goodrick, 1989, p. 39). A landmark

case in Wisconsin, Lessard vs. Schmidt, held that it was unconstitutional to involuntarily commit a person with mental illness refusing treatment unless they were a danger to themselves or others. It also provided that treatment be afforded "in the least restrictive environment appropriate for the person's needs" (The Wisconsin Mental Health Law of 1990, p. 10).

Hundreds of thousands of people with chronic mental illness are avoiding any type of mental health services. Many others are simply not receiving a multitude of services needed to assist them in maintaining optimal community functioning. This is a direct result of deinstitutionalization (Turkheimer and Parry, 1992, p. 649).

Deinstitutionalization

Deinstitutionalization of state mental hospitals is said to have greatly contributed to the problem of homelessness and the large number of people with chronic mental illness people living in the community. Deinstitutionalization...of state mental hospitals...[has led to]

> a 75% decrease in the average daily number of committed patients and development of a network of community mental health centers (CMHCs), which in 1981 serviced approximately 75% of the country's population and provided treatment for more than four million episodes per year (Turkheimer and Parry, 1992, p. 649).

Table 1. Laws Relating to Involuntary Hospitalization.

	Emergency Detention: Reasons				Emergency Detention: Evaluation of Patient			Emergency Detention: Hearing				Civil Commitment: Reasons			Civil Commitment: Rights			Civil Commitment: Length of Initial Commitment			Civil Commitment: Length of first Recommitment		
	Danger to self or other	Danger to property	Gravely disabled	Anyone may initiate	Only professionals may initiate	Medical Certification	Examination at time of hospitalization	Not required	If requested	Required	Length	Danger to self or other	Danger to property	Gravely disabled	Lawyer	Jury trial	May appeal all rulings	Specified length	Indefinite but reviewed	Indefinite — no review	Specified length	Indefinite but reviewed	Indefinite — no review
na	X			X				X			7 days	X			X		X		X				
	X		X	X			X	X			15 days	X		X	X	X				X			
a	X		X	X			X		X		72 hours	X		X	X		X	180 days			no mention		
sas	X		X	X						X	30 days	X		X	X	X	X	30 days[a]			90 days[b]		
nia	X		X	X		X	X		X		14 days	X			X	X		90 days			90 days		
ido	X		X		X		X		X		3 months	X		X	X	X	X	6 months			6 months		
cticut	X		X	X		X			X		30 days	X		X	X		X		X[c]				
are	X	X				X					12 days	X	X		X		X	6 months				X	
a	X		X	X			X				5 days	X		X	X		X	6 months			1 year		
ia	X		X	X		X					5 days	X		X	X		X	6 months			6 months		
i	X	X		X			X				48 hours	X	X		X		X	90 days			180 days		
	X						X[d]				5 days	X			X		X	90 days				X	
s	X		X	X		X	X				5 days[e]	X		X	X		X	60 days			60 days		
a	X		X	X		X					2-10 days[e]	X		X	X		X	90 days[e] (temporary)	X[f] (regular)		90 days (temporary)		
	X			X						X	20 days[g]	X[h]			X		X		X				
s	X		X	X			X		X		9-16 days	X		X	X	X	i		X				
cky	X			X	X				X		21 days[j,k]	X			X	X		60 days			360 days		
iana	X		X	X	X		X			X	15 days	X		X	X		X		X				
:	X		X	X		X	X	X			5 days	X		X	X		X	4 months			1 year		
land	X			X		X				X	96 hours	X			X	X			X				
achusetts	X		X	X			X			X[l]	10 days	X		X	X		X	6 months			1 year		
gan	X			X			X	X			5 days	X			X	X	X	60 days			90 days		
esota	X				X		X	X			72 hours	X		X	X		X	45 days[m]			1 year		
sippi	X			X			X	X			7 days[e]	X		X	X		X	20 days				X	X
uri	X			X			X			X	25 days	X			X	X	X	21 days			90 days		
ana	X				X			X			1 day[e]	X		X	X	X	X	3 months			6 months		
aska	X		X	X			X			X	19 days[e]	X		X	X		X	60 days				X	
da	X		X	X		X		X			9 days	X		X	X		X	6 months			6 months		
Hampshire	X			X		X				X	10 days	X			X		X	2 years			2 years(?)		
Jersey	X			X		X		X			20 days	X		X	X		X			X			
Mexico	X				X	X				X	30 days	X			X	X	X	6 months			6 months		
York	X				X		X		X		15 days	X			X	X	X	60 days			6 months		
n Carolina	X			X		X		X			10 days	X			X		X	90 days			180 days		
h Dakota	X			X		X	X			X	14 days	X			X			90 days				X[n]	
	X		X		X		X		X		till "full hearing" for involuntary commitment[o]	X		X	X		X						
homa	X		X	X			X		X[p]		till "full hearing" for involuntary commitment[q]	X		X	X		X			X[r]			
on	X				s		s			X	15 days	X		X	X		X	180 days			180 days(?)		
sylvania	X			X			X			X	20 days	X			X		X	90 days[s]			180 days[s]		
de Island	X				X		X	X			10 days	X			X		X	6 months			6 months		
h Carolina	X			X			X	X[u]			20 days	X		X	X		X			X[v]			
h Dakota	X					w	X	X			5 days	X			X		X	1 year			1 year(?)		
nessee	X				X					X	15 days	X			X	X	X			X			
s	X			X		X	X			X	14 days	X		X	X	X	X	90 days					X
	X			X			X[c]	X			till commitment proceedings[x]	X		X	X			6 months		X[y]			

Table 1. Laws Relating to Involuntary Hospitalization.

States	Emergency Detention: Reasons			Emergency Detention: Evaluation of Patient			Emergency Detention: Hearing			Emergency Detention: Length	Civil Commitment: Reasons			Civil Commitment: Rights			Civil Commitment: Length of Initial Commitment			Civil Commitment: Length of first Recommitment		
	Danger to self or other	Danger to property	Gravely disabled	Anyone may initiate	Only professionals may initiate	Medical Certification	Examination at time of hospitalization	Not required	If requested	Required		Danger to self or other	Danger to property	Gravely disabled	Lawyer	Jury trial	May appeal all rulings	Specified Length	Indefinite but reviewed	Indefinite no review	Specified Length	Indefinite but reviewed	Indefinite no review
Vermont	X			X			X[e]		X		till commitment proceedings[z]	X		X	X		X	90 days					X
Virginia	X			X				X			72 hours	X		X	X	X[aa]	X	180 days			180 days		
Washington	X		X		X					X	17 days	X	X	X	X	X		90 days			180 days		
West Virginia	X			X			X			X	30 days	X			X		X	either 6 months or 2 years			either 6 months or 2 years		
Wisconsin	X		X		X					X	till commitment proceedings[bb]	X		X	X	X	X	6 months			1 year		
Wyoming	X				X					X[e]	10 days	X		X	X	X	X			X			

[z]not recommitment if gravely disabled

[b]only if suicidal or homicidal during initial phase of hospitalization, no subsequent recommitment

[c]patient may request a hearing annually

[d]patient admitted only after evaluation by a court designated examiner

[e]excluding Saturday, Sunday and Holidays

[f]patient may receive either a temporary or regular commitment

[g]7-day extension possible

[h]includes the inflicting of serious emotional injury to others who cannot avoid contact

[i]may file for discharge hearing after 6 months of original order

[j]persons may be held for only 72 hours unless involuntary commitment filed

[k]hearing must be held in 7 days if detainment initiated by police officer

[l]hearing may be waived

[m]if patient deemed "dangerous to public" may commit for an indefinite period

[n]if patient is hospitalized for alcoholism, recommitment may not be for more than 30 days after which time patient must be released

[o]if involuntary commitment is not sought, patient cannot be held for more than 3 days

[p]if district attorney files for involuntary commitment, right to hearing may be denied

[q]if voluntary commitment is not sought, patient cannot be held for more than 72 hours

[r]hearings are held upon request of patient or council to review commitment order

[s]person may be committed by a licensed physician or by 2 persons by an affidavit filed with the court, patient must be examined upon admission by staff physicians if admission based on affidavit

[t]for the severely mentally disabled, period not to exceed 1 year

[u]probate court reviews application within 5 days; patient is detained for more than five days only if county board of mental illness acts on petition and decides to hospitalized

[v]patient may petition for reexamination 6 months following commitment

[w]county board of mental illness acts on petition and decides whether or not to hospitalize

[x]if involuntary commitment is not sought, patient cannot be held for more than 24 hours,[e] if commitment is sought, medical certification is required

[y]patient may be committed for period not to exceed 6 months or for an indefinite period

[z]if involuntary commitment is not sought, patient cannot be held for more than 96 hours[e]

[aa]right to jury trial only on appeal to court order

[bb]if involuntary commitment is not sought, patient cannot be held for more than 72 hours

Many feel that as a result of deinstitutionalization, the mental health system has experienced significant difficulty in providing adequate treatment and services to people with chronic mental illness that have been discharged to the community. Some of the reasoning is that most of these people residing in the community do not technically meet the civil commitment criteria and refuse treatment. Others would say that the mental health system was, and is still not adequately equipped to address the needs of the chronic mentally ill. Also factored in is the lack of understanding with regard to "inadequate funding, political issues, turf issues," and I would say most importantly, "disregard of the needs of families and of their potentially important role in the treatment process" (Lamb and Mills, 1986, p. 475).

In conclusion, some would say deinstitutionalization has been hailed as long overdue, and necessary to afford people with chronic mental illness people with an opportunity to live in the community. The concept was good in theory but lacked organization, cohesion and structure resulting in "transinstitutionalization," a transfer from one type of institution (state mental hospital) to another (for example: board-and-care, group residences, or nursing homes) (Turkheimer and Parry, 1992, p. 649).

Proponents and Opponents of Civil Commitment

Broadening the criteria for civil commitment has both proponents and opponents. Proponents (many families of people with chronic mental illness, psychiatrists, general public) would like to see statutes pertaining to civil commitments broadened so as to possibly better address "unmet treatment needs" of individuals with

chronic mental illness. This broadening of civil commitment criteria would include hospitalization on an involuntary basis for the treatment of those persons with a mental illness that do not pose a threat of dangerousness and in particular, those who are homeless, or about to become homeless via eviction (Parry and Beck, 1990, p. 102).

The opposition (clients themselves, mental health workers/advocates and sometimes attorneys) argue that better services and greater accessibility for persons which chronic mental illness are needed. Furthermore, such criteria for commitment restricts a person's civil rights including the right to choose; and involuntary hospitalization, it is argued, is not the end all - the best, or even the most appropriate course of action (Parry and Beck, 1990, p. 102).

An important issue with relation to the civil commitment process and a person's loss of rights is one of dealing with the "systems." The system (for purposes of this study) will be referred to as those components that comprise and deliver services to persons in need. Most often, clients who enter the system are rendered powerless; they are viewed to be in a one-down position, meaning they are viewed as inferior, with the one-up position being held by the mental health professional, meaning they are viewed as being superior to the person(s) in the one-down position, thus creating the power differential. Client input into his or her own treatment is highly scrutinized and suspect by staff and frequently disregarded.

According to Chandler (1992) there are three views on civil commitment.

1) Mental health professionals. Mental health professionals are committed to the provisions of services to persons with chronic mental illness. "They hold that it is

unconscionable to deny treatment to a person who is too sick to know what treatment is needed." The overall view is that sometimes short, involuntary hospitalization is at times required as an intervention strategy to "decrease the need for hospitalization and re-hospitalization and improve the level of functioning of seriously mentally ill people."

2) Consumers. Consumers often believe their interaction with the mental health system has left them feeling "dehumanized" and wounded. They find more support from others who have had similar experiences than from mental health professionals. Consumers would like:

a) to change the views of the mental health professionals from a dualistic (either/or) to a dialectic (both/and) perspective which would allow for professionals and clients to work together on a more cooperative basis;

b) to modify the medical model's emphasis on what is wrong with the clients and his or her weaknesses or deficits, and focus more on client assets, strengths and abilities;

c) to better define "competence and incompetence;" and

d) to strive for economic stability with entitlement programs that serve the poor, mentally ill.

3) Family. It is very difficult for some families with a relative with mental illness to 1) accept the mental illness and how it changes the life of the person afflicted, as well as the lives of the family members; and 2) to have to watch and

wait for their relative to mentally regress to a point of endangering himself/herself or others before involuntary hospitalization and treatment is initiated. By this time, it may be too late for the person to fully recover to a previously attained level of community functioning. "Most often, family members express a strong desire to secure mental health treatment designed to protect their loved ones (Chandler, 1992, p. 131). A false negative error occurs when a client needs treatment and does not receive it. This issue speaks directly to the resurfacing of need for treatment criteria in several states in the United States.

Need for Treatment

An increasing number of states are re-examining the issue of a need for treatment criteria due to the perception that clients are not receiving the treatment necessary to maintain community living. The narrowly focused dangerousness criteria is being blamed as it restricts commitment (Appelbaum, 1984, p. 147).

In contrast to the above, Aldige-Hiday and Newhart-Smith (1987) conducted a state-wide study that sought to challenge the concept of the dangerousness criteria for housing people with mental illness people who are in need of treatment and not receiving it. Their results "do not support the criticism of the dangerousness standard as causing the abandonment of nonviolent mentally ill persons and the filling of mental hospitals with the violent." They go on to outline three reasons they believe that the dangerousness criteria is getting a bad rap: 1) there are a few memorable cases that create a great deal of disruption and therefore receive labels, 2) anxiety is

created when weighing individuals' civil rights "and benevolence in commitment law," and 3) there are actually problems that create the need for dangerousness criteria such as homelessness, the mentally ill in jails and the reverse, ex-criminals in long-term inpatient psychiatric facilities. The authors argue that these problems exist because of economic adversity "and major social changes such as deinstitutionalization, greater recognition of mental health problems, and medicalization of deviance" (p. 448-450).

Apprehension in adopting clinically-based need for treatment commitment criteria is due to the belief that it would cause an inundation of inpatient psychiatric admissions. The questions then becomes: Is the system prepared to deal with this? Washington state experienced a doubling of hospital admissions after they adopted a clinically-based need for treatment criteria. The increase happened, however, months before the statute was enacted and most likely as a result of a 'horror story' in which a person with mental illness requested a voluntary hospitalization, was denied admission and subsequently committed a double murder (Miller, 1992, p. 1381).

The example above illustrates a false negative error in which a person in need of treatment did not receive it and begins to define for the general public, and legislative constituency, what the issues are and what might be necessary to adequately address them. "To our knowledge, however, there have been no published efforts to assess public attitudes about the relative value of false negative and false positive predictions of violence" (Mossman and Hart, 1993, p. 182).

Miller (1992) does not find support for the fear that the broadening of commitment criteria, to include need for treatment, results in the deluge of inpatient

admissions. In contrast, he found that admissions decreased in some state. Moreover, "any observed increases in commitments may be due as much to the social pressures leading to statutory changes as to the changes themselves" (p. 1383).

"The civil commitment system" must now seek strategies that will bring balance to the tenets of individuals' civil rights and their right to receive treatment. This change is not the sole responsibility of "the civil commitment process" but also the community/"public mental health system." If this is not accomplished there will be continued "dissatisfaction with the civil commitment system" and clients with a severe mental illness will be sentenced to what can hardly be called "a choice between long-term institutionalization and inadequate community care" (Turkheimer and Parry, 1992, p. 653).

Schizophrenia

Schizophrenia can be defined as one who experiences disorder of thoughts. This can cause auditory and/or visual hallucinations, i.e. hearing and seeing things that are not actually there, and delusions - believing things that are not real. People with schizophrenia may often be 'tangential,' meaning they have no logical progression of thought; thoughts are random. This random, illogical progression of thought makes sense to people with schizophrenia while it seems very dissociative to those around them (Constans, 1991, p. 78).

There are various classifications of schizophrenia such as paranoid, catatonic, and undifferentiated. Those afflicted with schizophrenia, paranoid type, experience

sensitivity and mistrust of others; they may often respond to voices in their heads telling them they are worthless and do not deserve to live. They are unable to stop the voices. It all seems very real to the afflicted, but does not make sense to those around them (Constans, 1991, p. 78).

Due to the persecutory nature of the voices of a person with paranoid schizophrenia, he or she is likely to be more dangerous to self vs. others.

Treatment of schizophrenia (as a major mental illness) is necessary to restore individuals to previously attained levels of community functioning. Treatment can be provided on either a voluntary or involuntary basis. Sometimes when treatment is not provided, "mentally ill individuals end up in jails and prisons after being arrested for disorderly behavior, disturbing the peace, vagrancy, and a variety of other charges" (Gove et al., 1985, p. 310).

The example above illustrates a false negative error that has detrimental effects. The criminal justice system is not equipped to administer clinically to the chronic mentally ill. The result is inappropriate management and injustice in needed treatment services for the chronic mentally ill.

The response to treatment of a person with schizophrenia is explained in detail in a section so named, forthcoming in this report.

Etiology

There have been numerous studies that have investigated the etiology of schizophrenia. As with most mental illness, schizophrenia can be hereditary -

genetically passed down through generations. Some research has cited complications both before and during birth as cause for the development of schizophrenia. It is said to be attributed/linked to neurons, either "missing or abnormally sized" (Bower, 1993, p. 346). "Other studies suggest that glitches in brain development during adolescence make their own contributions to schizophrenia" (Bower, 1993, p. 347). Research also suggests that schizophrenics are usually "born in the winter or early spring" (Horgan, 1990, p. 40), when there is a higher incidence of viral infections.

Scientifically, we also know that in 14 of 15 schizophrenics at least one ventricle was enlarged and it was shown that they had smaller temporal lobes, "hippocampus and the volume of the left temporal lobe's gray matter. The widely dispersed brain abnormalities occur in areas considered crucial to regulating emotion and motivation" (Bower, 1990, p. 182).

Schizophrenia is not only genetically predisposed but is also affected by environmental factors. King (1990) states "the risk is compounded by a family environment characterized by communication deviance, a negative affective climate, emotional over-involvement, and a general disturbance in parent-child relations" (p. 83).

Response to Treatment

Researchers are still questioning the diagnosis of schizophrenia. Some have come to believe that schizophrenia is not one disease, but several. This would provide some rationale as to why schizophrenics' response to pharmacotherapy (medications)

varies greatly. The classification of drugs most often used with schizophrenics are the neuroleptics which block receptors for the neurotransmitter, dopamine.

The effects of neuroleptic medications are: clients appear and feel dulled; their symptoms are present, but masked with medications. There are various side effects, depending on the individuals, that result from neuroleptic medications. A serious side effect, 'tardive dyskinesia,' is a nervous disorder "which causes spasmodic twitching of the muscles" (Horgan, 1990, p. 39).

Side effects and a perceived remission from symptomatology are the most common cause of schizophrenics prematurely discontinuing their medications. Horgan (1990) found that "at least 36 percent over a one-year period" discontinue their medications (p. 39). Premature discontinuation of needed neuroleptic medication increases the probability that relapse (of symptomatology) will occur.

Other studies indicate that approximately one-third of all schizophrenics "do not respond at all to conventional neuroleptics" (Horgan, 1990, p. 39).

Early detection and assessment of decompensation (mental regression) can make a difference with how intense the psychotic episode becomes. To intervene early, social workers, psychiatrists, nurse clinicians, families, and others can utilize a combination of prior history and assessment strategies such as level and severity of psychosocial and environmental stressors, stress management/coping skills, medication compliance, social/community integration (or the opposite, social isolation) and client, family and community education. Early intervention may prove to be key in reducing false positive errors.

'Dangerousness' to Self or Others

Research is not clear on what constitutes a danger to self or others. Most states however, have adopted similar dangerousness criteria. Wisconsin's four criteria for dangerousness involve: 1) threats or attempts of "suicide or serious bodily harm;" 2) "harm to others" evidenced by recent behavior, a recent act in which others are placed in reasonable fear of violence, a recent attempt or threat to impose serious bodily harm and creates a reasonable fear of sustaining such harm; 3) "impaired judgment" evidenced by recent neglect via "acts or omissions" that suggest a probability that "physical impairment" will result; and, 4) "unable to satisfy basic needs" meaning that without basic nourishment needs such as food, clothing, and shelter a "probability exists that death, serious physical injury, serious physical debilitation or serious physical disease will imminently ensure unless the individual receives prompt and adequate treatment for this mental illness" (The Wisconsin Mental Health Law of 1990, p. 46-48).

Many people with chronic mental illness are not any more dangerous than the average "normal" person. As stated previously, people with chronic mental illness are more often dangerous to themselves than they are to others. People with chronic mental illness who are violent (or dangerous) and commit crimes are subjected to the news media's sensationalism, they are then labelled and stigmatized. The general public would like to believe that people with chronic mental illness are in control when in fact, if they are treatment resistant and non-medication compliant, they are not (in control).

As the dangerousness criteria are currently written in the Wisconsin statutes, a person must mentally regress so far as to place himself/herself or others in danger before involuntary treatment is provided.

If, due to their chronic mental illness, they are not able to accept the need for treatment voluntarily, and do not meet the standards for commitment because of this narrowness, they may be subjected to false negative errors. These errors need to be reduced (without increasing false positive errors) so that other social problems (such as homelessness) are not created as a result of inadequate and/or inappropriate treatment service opportunities for the people with chronic mental illness. "Recent concern about the homeless mentally ill has highlighted this issue" (Hoge, Appelbaum and Greer, 1989, p. 170).

The Homeless

There is no one, accepted definition that is used to describe the homeless. The Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) defines 'homeless' as "anyone who lacks adequate shelter, resources, and community ties" (Levine, 1984, p. 6). Bassuk and Buckner (1992) define it as "an extreme manifestation of poverty and residential instability" (p. 330). And, Drake, Wallach, and Schuyler-Hoffman (1989) define homelessness as "both lack of adequate shelter and disaffiliation from other people and social institutions" (p. 46). The reality is homelessness is growing as a social and psychiatric problem (Drake, et al., 1989, p. 46).

In 1989, it was estimated that 500,000 to one million people were homeless (Drake et al., 1989, p. 46). In 1990, 30% of the 500,000 were afflicted with a mental illness. Of the 500,000 homeless, 160,000 mentally ill face street and shelter living nightly (Bassuk and Buckner, 1992, p. 330). These statistics have increased significantly in recent years.

Numerous people with chronic mental illness who are not hospitalized also lack appropriate and adequate housing which in turn has evolved into what is being termed as "psychiatric ghettos" (Turkheimer and Parry, 1992, p. 649). The debate is whether mental illness causes homelessness or homelessness causes mental illness.

Deinstitutionalization is usually identified as a contributing factor in the mentally ill becoming homeless because sufficient and appropriate services and resources are not available. Other causes include: low socioeconomic status, insufficient availability of low-income housing, overall economy, unemployment and social stigma (Levine, 184, p. 7).

Attempts to reach out and involve the mentally ill homeless in services aimed at reducing the previously stated causes for homelessness, is now causing some to support "involuntary hospitalization." They go on to state that 'many of the homeless are overtly psychotic, yet have adapted to the life in the streets and are not at significant risk.' "In actuality, few mentally ill homeless persons meet these criteria unless the criteria are stretched beyond their intended meanings and thereby threaten the protection of human rights" (Cohen and Thompson, 1992, p. 820). Civil libertarians have been said to have fostered client empowerment to the point that

clients protected by strict commitment laws are able to make their own choices which may result in their perishing "in the street with 'their rights on'" (p. 820).

Consumers of mental health services surveyed via a needs assessment revealed what is needed. Consumers mostly desire to live in "normalized" settings - apartments, and given adequate funding, homes. The key barrier is living on a fixed income. All people with chronic mental illness should be afforded the same opportunities as others (without a chronic mental illness) have: that is to live in modest, affordable and stable housing free from fear (safety); maximizing their strengths and abilities to function independently and integrate into their community (Carling, 1990, p. 973).

Lamb (1990) stated, "By giving up a little of their liberty, many patients can remain outside of hospitals and thus retain most of their liberty" (p. 651). Therefore, it is believed that to eliminate homelessness among people with chronic mental illness, the following need to be addressed:

1. policies and program development
2. further research into causes of housing instability among this population
3. outreach and advocacy to develop rapport and trust, to build relationships of mutual respect
4. resource development
5. acquire funding for programs
6. remain consumer focused (Bassuk and Buckner, 1992, p. 331) (Chandler, 1992, p. 133) (Rife, First, Greenlee, Miller and Feichter, 1991, p. 66).

CHAPTER 3

Methodology

Statement of Problem

Many people with chronic mental illness could appropriately be served by an involuntary psychiatric hospitalization (civil commitment) but do not receive these services (false negative error) due to the narrow definitions of the current standards of dangerousness. However, in order to protect their civil rights, they must not be admitted to psychiatric facilities when they are not in need of civil commitment (false positive error).

Thesis. 1) Strategies for reduction of false negative errors may increase the probability of false positive errors. Or, 2) strategies in reduction of false positive errors may increase the probability (likelihood) of false negative errors.

Definitions.

1) False negative errors are defined as a failure of the system to commit people who needed or would have benefitted from treatment.

2) False positive errors include those instances where people were inappropriately committed resulting in a denial, or reduction of their civil rights.

Research question. What does the legislative constituency need to know to participate in strategies for the reduction of false negative errors without increasing the

probability of false positive errors?

The principal investigator intentionally chose the names of Representatives (legislators) who were instrumental in proposing fifth standard legislation that would create a need for treatment criteria alternative to the dangerousness standard for the purposes of involuntary civil commitment, hereafter referred to as Amended Bill 203 (AB203).

The principal investigator sought names (provided by the Wisconsin Legislative Reference Bureau) of legislators to interview that would provide updated insight into the proposed legislation. Legislator biographies, including office and district phone numbers, and voting and mailing addresses, were found in the State of Wisconsin Blue Book, 1993-1994.

Ethical considerations. The subjects were sent a letter in advance of a phone interview, explaining the intent and purpose of the research. Enclosed was a copy of the questions to be asked during the interview for their review and preparation (See Appendix A and B). Due to the potentially sensitive nature of the interview questions (personal opinions and convictions), subjects were informed of the voluntary nature of the research and freedom to terminate the interview at any time.

In response to the research question, the literature was reviewed and interviews with legislators conducted. The strengths and limitations of the proposed fifth standard legislation were evaluated via a hypothetical individual. This individual did not reflect any identifying characteristics of any particular individual(s). Rather it was a composite.

The collected research material responded to the research question in terms of a proposed framework for and educational program for the legislative constituency. The elements of the framework were defined, but not fully addressed as that was considered outside the parameters of the study.

CHAPTER 4

Presentation of Findings

For approximately thirty years, most states have adopted and implemented a dangerousness criteria to civil commitment standards. Currently, states are starting to adopt and implement a need for treatment criteria to civil commitment standards as more and more people with chronic mental illness are not receiving mental health treatment promptly when they decompensate (mentally regress).

This chapter will discuss the principle research findings that were a result of phone interviews with legislators.

Participants

Six cover letters (with enclosed interview questions - see Appendix B) were mailed out to two senators from Oshkosh and Eau Claire, and four representatives from Amery, Whitehall, Milwaukee, and Monroe prior to phone contact. Initial phone contact was made with all of the legislators. Of the six legislators contacted, a 67% response rate was obtained (4 out of 6). During the researcher's continued follow-up, the response rate dropped to its final rate of 50% (3 out of 6). This was due to a legislator needing to withdraw from the study due to time constraints and a crisis in her district.

Backgrounds of the legislators interviewed consisted of a former Corporation

Counsel who has just recently been appointed as a judge, a former employee of Trempeleau County Health Care Center which is in part, an Institution for Mental Disease (IMD) or long-term inpatient unit for the chronic mentally ill, and one identified himself as a family member.

Legislative Interviews

Interview questions asked of legislators (see Appendix B) were directed at: 1) obtaining their position on AB203 (see page 5 for definition), 2) the concern of their constituency with regard to the need for treatment vs. inappropriate civil commitment, 3) the potential effects of AB203 on people's civil and constitutional rights, 4) the potential benefits/limitations of AB203, and 5) what were viewed as indicators that people may need treatment more than their civil rights.

Position on AB203. Unanimously, all three legislators interviewed support AB203 and do not feel that the current law (Chapter 51) is effective as written. All interviewed stated that the 'law needs to change.' The law was enacted to protect people from the abuses of unnecessary civil commitment (false positive error). However, Representative #1 stated, "The pendulum has swung too far." Representative #3 states, "We need to recognize that we've gone too far and we need to come to some middle of the road, this is imperative."

Concern of constituency. Only two out of three legislators adequately addressed this question. The consensus indicated that their constituency favored the need for treatment. Representative #1 felt that if his constituency was polled, they

would support readier access to treatment for clients in need. He comes from a rural area and can remember at least two cases that went to a jury trial in which it took the jury all of five minutes to look at the person and state that he or she needed help. He stated that he hears about these issues mostly from families.

Representative #2 identified constituency as his family of origin. He had personal family experience with civil commitment. This representative "realizes the need for protection of civil rights" but would like to "turn civil rights on its head" as he believes that due to the mental illness, they are prevented from asking for or accepting treatment. He further stated that he does not want to see the "bad days" return whereby "a husband could commit his wife because it was convenient."

Representative #3 differed from the other two in that she was unable to adequately address this question as she lacked sufficient knowledge about the concern of her constituency with regard to this issue.

Potential effects of AB203 on civil and constitutional rights. All three legislators conveyed similar beliefs on this issue. Representative #1 is comfortable with the procedural safeguards in place and knows that those safeguards cannot be taken away. He feels that "as long as the process remains fair and orderly, the civil and constitutional rights are protected."

Representative #2 does not think that Wisconsin's residents civil and constitutional rights will be affected too much and even went so far as to say that the rights may not be affected at all. If the rights are affected, he would consider it to be a "minor infringement as rights are not an absolute anyway." He stated that it is a

"delicate balancing act, but would help society overall."

Representative #3 felt that when a person "reached the point of not being able to make a decision about whether or not to receive health care, the decision is beyond their control."

Potential Benefits and Limitations of AB203.

Benefits: All three legislators stated the benefits as being: affording the clients with treatment sooner, and sparing families from what Representative #2 described as "tantamount torture" to watch a loved one experience mental or physical disorders associated with a psychotic episode of chronic mental illness. A second point made relative to the issue of family was that it was frustrating for families not to be able to obtain help for their loved one. Representative #3 had a unique view (separate of the other two) of providing treatment sooner so that clients are returned to their homes sooner.

Limitations: The response to this question varied. Limitations were seen as the potential increased costs to counties who are ultimately responsible for civil commitments which are very costly to county budgets. One representative acknowledged that AB203 has been slowed in the legislature due to budget increases that would be necessary, and lack of adequate community resources (across the board) to provide care for the chronic mentally ill once they return to their home community. Contrary to Representative #1, Representative #2 believes that a cost savings may be realized if clients are treated and released sooner. Representatives #2 and #3 shared

views on the rights of clients being a limitation. Representative #2 viewed it as "marginal erosions of civil rights." He was also concerned that there may be inappropriate uses of the law, but was quick to point out that that happens with any law.

Indicators of need for treatment. With regard to what would be indicators that people may need treatment more than their civil rights, Representative #1 stated, "People need both. When intervention is provided earlier, people are able to return to their community and be productive."

Representative #2, who had a more personal investment, witnessed his family members "getting sicker and sicker because of their civil rights." He feels that if there is "clear and present evidence of deterioration then possibly early intervention could prevent the deterioration and help the people to improve." He stated an indicator of need for treatment vs. civil rights as being homeless and living on the streets.

Representative #3 provided an extensive, but not exhaustive, list of indicators of need for treatment including: "inappropriate behaviors, attempting but not successful with normal daily activities, bizarre actions, attempting to hurt families, destroying property, irresponsible i.e. walking down the middle of the highway without recognizing the danger of this, attempting to cut on themselves, and not taking their medications. She again stressed that "professionals need to be able to act more quickly and appropriately."

CHAPTER 5

Discussion

Prior to the 1960's, civil commitment was based primarily on an individual's need for treatment. As the 1970's approached, more states were beginning to adopt criteria based upon an individual posing a danger to self or others. Some have said that 'the pendulum swung too far' and it has become too difficult to obtain civil commitments in Wisconsin. There is support and opposition for allowing the pendulum to begin to swing the other way, toward again adopting a need for treatment criteria.

Through a review of the related literature and interviews with legislators, it was found that most would err on behalf of the chronic mentally ill in need of treatment and like to see false negative errors reduced. This is not to minimize the fact that there is concern that some may be committed inappropriately. However, there is not significant data to support this position.

Research indicated that people with chronic mental illness are characterized by chronic unemployment and low paying jobs which contribute to a third characteristic of homelessness. It was found that one-third of this population was homeless in 1990. Homelessness was also found to be a contributing factor in civil commitment. Most of these individuals have been hospitalized (for their psychiatric condition) at least once, with up to "fifty percent returning to psychiatric hospitals within a year of their

last hospital discharge" (Rosenfield, 1992, p. 299). They are often isolated socially from their community reducing opportunities for integration. Psychotic episodes may also stress family, social and romantic relationships resulting in alienation. People with chronic mental illness have also been considered to be a disadvantaged population that experience significant stigmatization.

The chronic mentally ill may mentally regress as a result of any of the "disabling functional deficits" (Lamb, 1990, p. 650) previously cited or in combination with medication and/or treatment non-compliance. This may result in the person becoming dangerous to self or others.

The results of this study find support for implementing a need for treatment criteria - the proposed fifth standard legislation in Wisconsin (AB203).

The following topics will be addressed in this chapter: a) implications of proposed fifth standard legislation - AB203, b) what is needed, c) outline of educational framework, d) recommendations for further study, and e) summary.

Implications of Proposed Fifth Standard Legislation - AB203

Strengths: The benefits to adopting and implementing a need for treatment criteria would be, in part, its focus on early intervention. The criteria is designed so that a person with a history of mental illness and dangerousness, having started to decompensate, may be hospitalized involuntarily for necessary treatment if they are unable or unwilling to accept the need for treatment on a voluntary basis.

If people are not allowed to deteriorate to the point of satisfying the

dangerousness criteria, they will require a shorter hospitalization resulting in improved cost effectiveness and prolonged residence in the community.

A second benefit that may be realized is one of reducing the stress of families and significant others. It is difficult to watch a relative mentally regress and realize there is nothing that can be done (if the person is resistant) short of that person endangering him/herself, or others. Experience and research have indicated that most families would prefer preventive treatment, such as clinically-based civil commitment criteria, instead of waiting for a possible tragedy to strike. Again, if there was an early intervention focus, then perhaps family or significant other stress would be greatly reduced.

Limitations: Perhaps one of the largest barriers to this legislation (AB203) being enacted is cost. For this reason, the Wisconsin legislature is proceeding slowly with AB203, according to one legislator interviewed. The Wisconsin legislative general session is over for 1994. No bills were passed. All bills that were proposed in this session are now considered 'dead' until the next legislative general session reconvenes in January 1995. The concerns about costs are primarily being voiced by counties whose responsibility it is to regulate civil commitments. The costs of civil commitments come directly out of county budgets and can pose a fiscal challenge for counties.

Another limitation is often resources in addition to community and/or treatment resources, there are also legal resources such as : 1) corporation counsel that acts on behalf of the petitioner (usually the County Human Services Board) in civil

commitment proceedings, 2) the judge, 3) possibly a jury, and 4) use of the court.

Community and treatment resources are more of an issue for smaller, rural counties as they do not have access to a plethora of resources (i.e. public transportation so the chronic mentally ill can get to appointments) nor do they have large budgets to develop resources when needed.

These strengths and limitations can be evaluated via a hypothetical individual. Karen suffers from schizoaffective disorder, a disorder that is a combination of schizophrenia and affective symptoms, meaning she may experience disorder of thought coupled with symptoms of affect (mood) impairment. Karen is a 45 year old female married for fifteen years with two children aged fourteen and twelve. In the spring, Karen felt an improvement in her mood and stopped taking her medications without the approval of her family or doctor. Soon she began to believe that a prominent local politician was involved in a drug operation in the house next door to hers.

She believed that he was controlling her through this drug operation by sending special threatening messages to her on the radio telling her to keep quiet about it all or they would hurt her. She continued to be suspicious (paranoid) and began calling the politician at his office and home until he had to threaten to press charges for harassment.

Her family pleaded with her to resume taking her medications and follow-up with her psychiatrist and social worker, all of which she refused. Soon the stress on the family became too much even though Karen was never a danger to herself or

others, nor did she make any threats that police could involuntarily hospitalize her for.

Her marriage ended in divorce with custody of the children being awarded to her ex-husband. She lost her job and 'refuses money from the government.' She lives out of her (barely operational) 1980 Chevrolet Citation. Local teenagers make fun of and harass her. She continues to refuse any type of treatment.

Clearly, the benefits previously cited would also have benefitted Karen from a clinical standpoint. If treatment intervention could have been provided shortly after she discontinued her medications, a brief hospitalization could possibly have enabled Karen to resume her medications and stabilize her before significant deterioration occurred.

Mental health professionals would support early treatment intervention in Karen's case. According to Chandler (1992) mental health professionals "hold that it is unconscionable to deny treatment to a person who is too sick to know what treatment is needed." The overall view is that sometimes short, involuntary hospitalization is at times required as an intervention strategy to "decrease the need for hospitalization and re-hospitalization and improve the level of functioning of seriously mentally ill people" (p. 131).

Her family could have also possibly been kept intact as early intervention would have prevented the deterioration that caused the family so much stress.

Representative #2 stated, if people can get treatment when they need it, receive the proper care at the proper time, then perhaps families can be spared "the tantamount torture" of watching their family member mentally regress.

Research also stated, "most often, family members express strong desire to secure mental health treatment designed to protect their loved ones" (Chandler, 1992, p. 131).

Financial limitations would be of concern if the county did not adequately budget to provide for the care of people with chronic mental illness via civil commitment. Limitation of resources was not a significant factor as County X had ample resources which were offered, but refused by Karen. Without any mandate, services cannot be forced upon an individual if they refuse them.

Representative #1 also identified financial limitations as an issue. He stated that cases such as Karen's become costly to society as no one directly pays. The cost issue results in reluctance to pass legislation because counties are concerned about increasing budgets.

As a result, Karen is now homeless and does not have an involved family. She continues her destructive routine and has not accepted the need for treatment. Although she is not a danger to herself or others, she is mentally ill and has a right to be as long as she is not hurting anyone. The literature and Representatives interviewed support the concept that due to Karen's mental illness, she was not able to recognize or accept the need for treatment voluntarily. She did not meet the standards for commitment because of the narrowly defined dangerousness criteria; and was, therefore, subjected to a false negative error. She is living out her civil rights as they currently exist at the expense of her right to treatment.

It has been documented in the literature and legislative interviews that, as

Representative #1 stated, "the pendulum has swung too far." There is growing support for reversing the trend of affording people their ultimate civil rights at the expense of their treatment rights. It was stated in the literature that proponents would like to see statutes pertaining to civil commitments broadened so as to better address "unmet treatment needs" of individuals with chronic mental illness (Parry and Beck, 1990, p. 102).

The three legislators interviewed all agreed that civil commitment laws need to change to better allow for treatment rights. All three acknowledged that civil rights of individuals with chronic mental illness will, and should, continue to be an important issue. However, they believe at this time, treatment rights must take precedence so that people with chronic mental illness are furnished with the necessary treatment.

What is Needed

People with chronic mental illness experience cycles, or episodes of their illness and depending on the individual, the cycles may occur frequently, i.e. spring and fall. A cycle may or may not follow a pattern. After their last hospitalization for symptom stabilization, they were discharged to the community on medications. Outpatient follow-up was most likely recommended, so they engaged in outpatient treatment services for a period of time. Soon, they began to challenge the usefulness and worth of treatment and medications received. They began to feel that treatment is ineffective and may even become paranoid that ill effects will ensue, so they discontinue their medications. Eventually, they will decompensate to the point of

requiring inpatient stabilization, and the cycle starts all over again (Appelbaum, 1986, p. 1270).

This is what is known to occur among many people with chronic mental illness. The question is: What can and should be done?

One solution gaining acceptance is outpatient commitment (also known as preventive commitment and/or involuntary outpatient civil commitment). All three types of commitment share a common premise: Providing mental health care and treatment in the least restrictive environment. The purpose is to treat those in need in their home community with the hope that inpatient stabilization can be avoided.

Involuntary outpatient commitment (IOC) is defined as "the legal and psychosocial process whereby an allegedly mentally disordered and dangerous person is forced to undergo mental health treatment or care in an outpatient setting" (Keilitz and Hall, 1985, p. 378). IOC is seen as a potential solution as it affords treatment to those who do not need inpatient stabilization, but who are also treatment resistant "in voluntary settings less restrictive than a hospital" (Keilitz and Hall, 1985, p. 378).

The preventive commitment has a slightly different focus; one of prevention of "predictable deterioration of a person's mental condition that will lead to eventual inpatient commitment. It is characterized by a lower commitment standard than that for institutionalization and often is accompanied by fewer procedural protections" (Stefan, 1987, p. 288). The benefits of preventive criteria, some would argue, are: 1) broadening of "the class of people subject to commitment," and 2) expansion of "the conditions under which the state can intervene in a person's life" (Stefan, 1987, p. 296).

There is controversy relative to the effectiveness of outpatient commitment. Some reports "clearly support the effectiveness of outpatient commitment" (Zanni and deVeau, 1986, p. 942). Others have also shown success with outpatient commitments, but recommend further research to assess the extent to which community mental health centers will invest in making outpatient commitments work (Aldige-Hiday and Scheid-Cook, 1987, p. 230).

Limitations of outpatient commitment include: 1) procedures for "enforcement mechanisms for patients who do not comply with court-ordered outpatient treatment, are not effective in practice," and 2) if hospitalization is required before an "outpatient commitment can be ordered" and/or "automatic hospitalization" occurs in the case of noncompliance, both procedures "interfere with one of the major advantages of outpatient commitment, that of continuity of community-based treatment" (Miller, 1985, p. 266).

A second solution gaining support is the development of Community Support Programs (CSPs). CSPs in Wisconsin are mandated to provide mental health services for people with chronic mental illness who reside in the community. Services provided include: 1) general assessment to obtain diagnostic and clinical impressions of the person, specific and ongoing assessments of the person's social, emotional, cognitive and behavioral functioning as well as abilities to perform necessary tasks (i.e. grooming, hygiene, housekeeping) to maintain community residence, 2) educational/recreational services to address social needs, and 3) employment services to assist with income also necessary to maintain community residence. Psychiatric,

psychological and nursing services are integral and most often essential to the CSP.

Pallak (1990) found that CSPs in "Colorado and Wisconsin, have been able to reduce the number of days of hospital care per capita to as much as 50% below the national average" (p. 1239). The report also stated that "people in community programs have fewer symptoms, greater life satisfaction, more positive social relationships, and spend less time unemployed than do comparable people who remain in the hospital" (Pallak, 1990, p. 1239).

A key issue with community mental health treatment is funding. Turkheimer and Parry (1992) reported "that in 1983, states spent roughly twice as much money on institutional treatment as on community treatment" (p. 652).

> "The disgrace is that we know how to care for the mentally ill in the community, to assure that mentally ill individuals live in humane conditions, and to provide the care and treatment that will enable them to come closer to their full potential. But we have not made this knowledge a reality for too many of the seriously mentally ill" (Kennedy, 1990, p. 1238).

An educational framework will be proposed to attempt to bridge the gap between what is known and what occurs.

Educational Framework

The elements of the following framework are defined but not fully addressed as that would be outside the parameters of this study.

Priorities:

1) Determine (via quantitative analysis) the number, needs, and identified risks of those who will be served.

2) Identify a case manager who will accept responsibility for coordination and ongoing monitoring of needed services.

3) Develop programs designed to promote advocacy, treatment, rehabilitation, and ongoing support and monitoring. Treatment may include supportive psychotherapy, medications, social networks, vocational training, etc. The goal is to assist individuals to realize their maximum potential, as their risk for deterioration increases if they experience failure with goals they have set.

4) Provide adequate and necessary medical and mental health treatment. Create a system for ease with appointments (i.e. community support implies that the provider goes to the client via a home visit, hence the contact is made in the community) to increase client follow through and also for medication management and symptom monitoring.

5) Provide quality housing services (i.e. group homes and supervised apartments) so that continuous supervision is available if necessary.

6) Provide vocational training and support so that people with chronic mental illness can earn a wage, while at the same time, be productive members of society giving back to their community.

7) Provide a range of services (mental health support, respite care, etc.) to families or care providers to decrease the chances of burnout, and,

8) Broaden the civil commitment criteria to include a clinically-based need for treatment criteria that will serve as a vehicle for treating people with chronic mental illness sooner (in their cycle) so as to avoid inpatient psychiatric stabilization. (Some

concepts defined in the Educational Framework were taken from: Kennedy, 1990, p. 1238-1239, and Pepper, 1987, p. 455-456).

Wisconsin policymakers must be charged to create laws that are fair, equitable, and assure the care and treatment of the chronic mentally ill, thereby reducing false negative errors. Also built into the law must be safeguards to protect people from inappropriate civil commitments (false positive errors).

Recommendations for Further Study.

Further research should be conducted to assess the most effective approaches in providing community-based care for a person with chronic mental illness, while at the same time, respecting his or her civil rights to independently make choices and decisions. The exception is when a person's judgement is so impaired that he or she becomes a danger to self or others.

Other suggestions include: 1) day hospitals or day treatment, 2) housing, 3) employment, and 4) community education/awareness.

Day hospitals or day treatment. This option would provide treatment programming in a hospital setting or community-based drop-in center on a daily basis, participants would return home in the evening. Treatment programming may consist of the following components or combination thereof: group psycho-therapy, medication monitoring, occupational therapy, and training in daily living skills.

Housing. As the literature stated, 30% of the 500,000 homeless in 1990 were afflicted with a mental illness (Bassuk and Buckner, 1992, p. 330). Adequate and

affordable low income housing that addresses the needs of people with chronic mental illness is a critical issue. Housing that provides common gathering areas for peer support, congregate dining, shared household maintenance responsibilities and medication supervision may be beneficial in reducing the need for civil commitment due to the supportive stability that would be created.

Employment. Further research would be useful in assessing the feasibility of developing supported employment workshop opportunities in the community. These workshops would allow for the cyclical nature of chronic mental illness, a component currently lacking in most programs of similar nature. Failure to address this key factor results in frequent unemployment of people with chronic mental illness which ultimately may have a snowballing effect; loss of job, loss of income, loss of housing, etc.

A supported employment workshop would have the means to hold positions open when people with chronic mental illness were amidst cycles of their illness and unable to perform necessary tasks. Once stabilized, they would not be faced with the possible shame of having lost a job, nor would they be overwhelmed with having to look for new employment.

Community education and awareness. A final recommendation is to begin to educate communities about mental illness to reduce fear and decrease stigma. This can be accomplished by integrating clients into communities via vocational or social opportunities. Professional and client outreach into schools, churches and businesses can assist in the development of collaborative networks that may be useful in reaching common goals.

Summary

This study sought to explore the issues inherent in proposing a clinically-based need for treatment criteria to Wisconsin's civil commitment statutes, and to assess potential effectiveness in reducing false negative errors (people in need of treatment, but not receiving it) without increasing false positive errors (people not requiring treatment being committed). Legislators interviewed concluded that 'the pendulum has swung too far;' it has become more difficult to obtain civil commitment in Wisconsin and thus provide people with chronic mental illness with necessary treatment, ultimately preventatively.

If the legislative constituency via their legislators can be educated about mental illness in general, as well as the process of civil commitment, they may become a powerful strategic alliance with the community-based mental health service system and become instrumental in decreasing the fear and stigma attached to mental illness.

As one legislator interviewed stated, "What more rights than that do they need than to get needed treatment in a timely manner and be returned to their families, their community, their jobs, their life?"

APPENDIX A

Cover Letter

My name is Kathy Huston. I am a Master of Social Work student at Augsburg College in Minneapolis, MN. As part of my graduate work, I am interested in studying proposed legislation regarding a fifth standard of dangerousness to Wisconsin's civil commitment law - AB203.

The purpose of this research study is to analyze policy implications which seek to explore potential effectiveness of proposed fifth standard legislation. As part of this analysis, I will be soliciting several legislators viewpoints who were instrumental in this legislation.

Participation in this study is voluntary. If you choose to participate in this study, I would appreciate it if you, or an appointed representative from your office, could take approximately one-half hour of your time to discuss with me (via phone), your responses/reactions to the enclosed questions relevant to my research study. I am particularly interested in the mindset of your constituents. You may choose not to answer any question(s) that make you feel uncomfortable. You may also choose to end the interview at any time.

All data obtained from this interview will be kept confidential by the interviewer and only shared with her thesis advisor. Any published reports based on this study will not include information that could be used to identify you. All data

will be destroyed upon completion of the study.

I will attempt to contact you by phone the week of March 28, 1994. If you have any questions before, during, or after the interview, please feel free to ask me; my phone number is (715) 246-8400. I would be happy to share my findings and results of the study upon its completion.

Sincerely,

Kathy Huston, LSW

APPENDIX B

Interview Questions

1. Currently the standards of dangerousness as set forth by the statute (Chapter 51) allow for clients to significantly decompensate (mentally regress). What is your position on this?

2. What is the concern of your constituency regarding the need for treatment vs. inappropriate civil commitment?

3. How do you think the proposed fifth standard legislation will affect Wisconsin's residents' civil and constitutional rights?

4. What would you see as potential benefits/limitations of AB203?

5. What do you see would be indicators that people may need treatment more than their civil rights?

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