# TESTIMONY OF MARY L. DURHAM BEFORE THE TASK FORCE ON MENTAL HEALTH PROCEDURES ACT AND THE MENTAL HEALTH SYSTEM,

## STATE OF PENNSYLVANIA

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My name is Mary L. Durham and I am an associate professor at the University of Washington, School of Public Health and Community Medicine in Seattle. I am Associate Director of the Center for Health Studies, the research component of Group Health Cooperative of Puget Sound, the largest consumer-owned health maintenance organization in the United States. I am also appearing on behalf of my colleague, John Q. La Fond who is a Professor of Law on the faculty of the University of Puget Sound School of Law in Tacoma, Washington. We have co-authored an article entitled "The Empirical Consequences and Policy Implications of Broadening the Statutory Criteria for Involuntary Civil Commitment" which was recently published in 3 *Yale Law and Policy Review* 395 (1985). We have provided staff with copies of the article. That article reports the major findings of a five year study, funded by the National Institute of Mental Health, of the effects of 1979 amendments to Washington's Involuntary Treatment Act (ITA).

Washington's Involuntary Treatment Act was revised in 1979 to make it easier to commit persons considered by mental health professionals to be mentally ill and in need of treatment. That was accomplished primarily by expanding the definition of "gravely disabled" to permit commitment of any person considered mentally ill and who "manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety". With minor exceptions, the 1979 ITA did not make significant changes in commitment procedures. Our research showed what effects the change in the law had on actual commitments for 72 hours or longer and on requests for detentions which came from the community (e.g., police, treatment personnel, families, etc.).

OUR WORK SHOWED:

- **Broadening involuntary commitment laws did *not* protect the community from dangerous people, it did *not* solve problems of homelessness, it *wasted* precious resources and it created a dependency on the involuntary commitment system that brought people back to it again and again.**

- Expansion of the commitment law brought a very large number of new people into the involuntary commitment system. Washington experienced a 91% increase in state hospital admissions during the first year following the 1979 expansion of commitment authority.

- Rapid expansion of the commitment system resulted in the following:

VOLUNTARY PATIENTS DISAPPEARED: Voluntary patients virtually disappeared from the treatment system. These are the patients for whom the most good can be done because of their willingness to be treated.

RESOURCE DEMANDS EXPLODED: System costs surpassed even the most generous predictions. Washington State saw a 62% increase in the administrative costs alone (e.g., investigation time, court time, transportation, etc) and enormous increases in hospital (clinical) costs associated with commitment. That expansion of the commitment system will be permanent, overwhelming the budget and treatment capacities.

The Washington State hospital system now represents the worst of both worlds: it excludes from inpatient treatment patients who voluntarily seek treatment and provides inadequate treatment for those patients who are committed for treatment against their will because funding and therapeutic resources are spread too thin.

LEGAL PROBLEMS DEVELOPED: Increased involuntary commitment caseload requires increased public attorney staffing, more petitions, more informal and formal hearings, and more judges.

-- OVERCROWDING: Washington State's largest hospital became so crowded that people were (and still are) being housed in crowded rooms and in hallways. Conditions are ripe for patient lawsuits demanding treatment for which people have been involuntary

detained. Pennsylvania also has a right to treatment statute.

-- LAWSUITS: Overcrowding at the major Washington State hospital was so severe that the hospital established a "cap" on admissions at 90% of their bed capacity. The cap frustrated Washington's county-based mental health officials who could no longer send committed patients to the State hospital; they sued and won an injunction that forced the state hospital to take all involuntary patients sent by the counties, *regardless of the available bed space.*

-- LIABILITY FOR RELEASE: Expanded commitment authority means increased exposure to civil liability for clinicians, hospitals and the state which likely will result in higher insurance premiums and additional lawsuits and judgements. The Washington Supreme Court held (in Peterson v. State, 100 Wn.2d. 421, 671 P.2d 230), that the state and its mental health professionals can be held financially responsible if they are grossly negligent in releasing or failing to commit someone who is mentally ill and dangerous and then harms anybody. [The award for Peterson was $250,000 for injuries received by the plaintiff in an automobile accident.] This important case emphasizes the RISK OF LIABILITY that may be imposed on public institutions when they release a person from state authority who goes on to commit a crime, or otherwise causes harm. Expanded commitment

laws make commitment easier, while cases such as Peterson make release risky, thus ballooning hospital caseloads.

PEOPLE BECAME MORE DEPENDENT ON HOSPITALIZATION: *All systems make mistakes;* a more inclusive system doesn't insure against mistakes. In Washington, expanded commitment authority made people dependent on hospitalization who had never been hospitalized before, creating a new population of "chronically mentally ill" people.

Beyond the empirical findings in Washington, DANGEROUSNESS CANNOT BE PREDICTED RELIABLY: Psychiatrists and other mental health professionals CANNOT reliably predict dangerousness. Expanding civil commitment laws increases costs without assuring prevention of tragedies like the Sylvia Seegrist incident. **TOUGH CASES MAKE BAD LAW.** The best system in the world won't reach everyone. The question is, "How do we make a law that *helps as many people as possible within the budget constraints that will remain with us into the future?*"

RECOMMENDATIONS:

- Do **not** expand involuntarily commitment. Work within the involuntary commitment law that you have to provide community-based services that have been shown to be as effective and less costly than hospital-based care.

- Provide better training for mental health professionals (including the police) on commitment laws, when and <u>how</u> to use them, and when and where to locate resources other than hospitals.

- Consider the possibility that you do not need a new law but you need to improve the implementation of your current law.