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A Comparison of Commitment and Recommitment Hearings:

Legal and Policy Implications

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Introduction

The changes in civil commitment law that took place in the late 1960s and early 1970s stimulated much empirical research. The resulting studies have provided a detailed description of respondents in commitment hearings and of the commitment process itself. With few exceptions (Hiday, 1981a; Peters, Miller, Schmidt, & Meeter, 1987), this research has demonstrated that the procedural and statutory requirements of state civil commitment laws are rarely met in practice.

Studies have reported that attorneys have limited experience in mental health law and are inadequately prepared for hearings (Hiday, 1982; Koch, Mann, & Vogel, 1987). Furthermore, many defer to the opinions and recommendations of mental health professionals and function as guardians *ad litem* or as mere bystanders (Ehrenreich, Roddy, & Baxa, 1982; Hiday, 1982, 1983). Attorneys rarely call witnesses, object to evidence, cross-examine clinicians, or explore the use of less restrictive alternatives (LRAs) to involuntary hospitalization (Hiday, 1982; Lelos, 1981; Lipsitt & Lelos, 1981).

The performance of judges in commitment hearings has also been found to be deficient. Judges often conduct commitment hearings in an informal manner and routinely neglect to inform respondents of many of their rights (Ehrenreich et al., 1982; Koch et al., 1987). Judges sometimes discourage attorneys from actively representing their clients and may usurp attorneys' role by questioning respondents and witnesses (Hiday, 1981a, 1982; Shar, 1981). In addition, judges fail to fulfill the statutory requirement to consider treatment in the least restrictive environment in as many as 55% of hearings (Ehrenreich et al., 1982; Grouse, Avellar, & Biskin, 1982). When LRAs are considered they are used infrequently (Hiday, 1981b; Hiday & Goodman, 1982).

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The behavior of clinicians also contributes to the gap between the letter and practice of the law in commitment hearings. For example, many clinical examiners do not interview respondents prior to hearings, and provide only a perfunctory evaluation of a respondent's mental status during the hearing (Ehrenreich et al., 1982). Furthermore, there is evidence to suggest that nonlegal factors exert considerable influence on the recommendations of clinicians in commitment hearings (Thompson & Ager, 1988). These factors, coupled with the already tenuous ability of clinicians to predict dangerousness (Monahan, 1978), can lead judges to prescribe involuntary hospitalization without adequate validation of the substantive criteria for commitment (Bursztajn, Gutheil, Mills, Hamm, & Brodsky, 1986; Hiday, 1977, 1988).

This body of research has served a quality assurance function by informing policymakers where modifications in civil commitment statutes and mental health regulations are needed (e.g., National Task Force on Guidelines for Involuntary Civil Commitment, 1986). Empirical research has also informed psychological, psychiatric, and legal theory regarding civil commitment. A major shortcoming of this research, however, is that it has been limited to initial commitments, that begin or reinitiate a patient's involuntary participation in the mental health system. Recommitments, which are necessary to continue involuntary treatment for patients whose initial commitment order has expired, have often been ignored. At best, recommitment has been included as an adjunct to research primarily concerned with initial commitments (e.g., Ehrenreich et al., 1982; Hiday, 1983a; Hiday & Goodman, 1982).

The recommitment process has also been given inadequate theoretical consideration. The National Center for State Courts (1986) for example, in its extensive Guidelines for Involuntary Civil Commitment, gives scant attention (1 out of 105 pages) to recommitments. Only slightly more attention is given to recommitments in the model civil commitment statutes of the American Psychiatric Association and the Mental Health Law Project (Parry, 1986; Stromberg & Stone, 1983).

The lack of attention to recommitments is difficult to justify, since recommitments account for approximately one third of the more than 500,000 hearings that take place in the United States each year (Goldman & Manderscheid, 1987; Rosenstein, Milazzo-Sayre, MacAskill, & Manderscheid, 1987). Ethically, recommitment hearings are especially important because they serve as a case review for persons who have already been deprived of their liberty for months or even years (Van Duizend, McGraw, & Keilitz, 1984).

The limited evidence that is available suggests that there may be substantial differences between initial and recommitment patients, and in the conduct of the hearings. Ehrenreich and associates (1982), in a study of 75 commitment hearings in 4 jurisdictions, found that recommitment hearings were shorter than initial hearings, that voluntary hospitalization was mentioned less often, and that attorneys were much less likely to confer with the respondent. Initial and recommitment hearings also differed substantially in outcome: 56.3% of initial hearings resulted in involuntary hospitalization, whereas the corresponding percentage for recommitment hearings was 97.2%. Koch and associates (1987) observed 29 recommitment hearings and reviewed patient records. They found that respondents were not always informed of their legal rights; that judges sometimes inquired about the status of respondents prior to the hearing

and out of the presence of the respondent or the attorney; that hearings were of short duration (6–8 min); and that attorneys were poorly prepared for the hearings and typically did not conduct a rigorous defense. They also noted that an extremely high proportion of hearings resulted in involuntary hospitalization (28/29).

Neither of these unpublished studies, however, were specifically designed to examine the difference between initial and recommitment hearings. In Ehrenreich et al. (1982) data from recommitments were usually combined with initials, and the two kinds of hearings were only compared on a few variables. The Koch et al. (1987) study did not include initial commitments, and was based on a sample of convenience acquired during a one-day visit to six state hospitals. The small samples in both studies precluded detailed statistical analysis.

The current study was undertaken to examine whether due consideration of the recommitment process mandates changes to theory and policy regarding civil commitment. In particular, it was designed to compare initial and recommitment hearings; to assess whether there is a greater relative gap between the letter and practice of the law in recommitment hearings; and to identify possible improvements to the current application of civil commitment statutes.

Methods

Setting

In Virginia, involuntary commitment begins with the issuance of a Temporary Detention Order (TDO) requiring the respondent to appear in court for a hearing within 48 hours. A community services board (CSB) is required to provide a prescreening report indicating the need for hospitalization. At a preliminary hearing, an assessment is made of whether the respondent is capable of seeking voluntary hospitalization. If not, the court proceeds with an involuntary commitment and may commit the respondent to involuntary inpatient treatment for a period not exceeding 180 days. The standards for involuntary commitment require a finding of mental illness, evidence of danger to self (DS) or danger to others (DO), or inability to care for self (ICS), and the absence of a LRA. During these hearings, the respondent is afforded a number of procedural rights, such as the right to counsel and the right to appeal. If the patient is still in the hospital after the expiration of the initial commitment order, a new hearing, with the same requirements, is needed to initiate another 180-day commitment.

Subjects

There were two categories of subjects in this study: respondents who had civil commitment hearings during June, July, and August 1988 at Western State Hospital (WSH) in Virginia, and judges, attorneys, and clinical examiners involved in the commitment process. WSH can accommodate approximately 630 patients and covers a catchment area of over 2,000,000 in 13 counties in western and northern Virginia.

Respondents in Civil Commitment Hearings. The sample included all 374 adults who had initial or recommitment hearings during June, July, and August of 1988. Just over half (190/374) were respondents in initial commitment hearings (termed "Initials"). There were 184 respondents observed in recommitment hearings (termed "Recommitments"). The average duration of their most recent admission was 7.8 years ($SD = 11.1$).

Attorneys, Judges, and Clinical Examiners. In all 374 hearings the position of judge was filled by one of two special justices appointed by the local Circuit Court. One attorney from a pool of six was selected to represent all respondents on a given day. Only 2 of 374 respondents were represented by private attorneys. An external clinical examiner was likewise selected from a pool of four to examine all respondents on each day. The clinical examiners included one psychiatrist, one general physician, and two clinical psychologists.

Apparatus

A checklist was constructed to facilitate the recording of information during the hearing. Interrater reliability of the items on the checklist was assessed in a pilot study of 28 hearings. Some items with very low reliability were dropped from the main study; others were reviewed, and specific scoring criteria developed. Forty-four percent of the items retained in the final checklist had kappa coefficients above .80, and 80% were above .40, indicating a reasonable agreement beyond chance for all but 20% of the items (Fleiss, 1981, p. 218). The average percent agreement for the items with kappa's below .40 was 87.5%, indicating that the low kappa's were the result of highly skewed responses on these items.

Procedure

During June, July, and August of 1988, every civil commitment hearing held in WSH was observed. The only hearings omitted were those involving a primary diagnosis of substance abuse. Information was recorded during the hearing by one or both of the observers.

Results

Initial and recommitments hearings were compared using chi-square tests of association or *t*-tests for independent samples (Tables 1–6). Because of the large number of univariate comparisons, only relationships with $p < .01$ will be reported as significant.

Clinical Examiner Behavior

The behavior of the clinical examiner was markedly different in the two kinds of hearings (Table 1). For example, in recommitment hearings, clinical examiners were less likely to overtly examine respondents or ask them about general mental health issues, suicidal plans, ability to care for themselves,

TABLE 1
Clinical Examiner Behavior

	(*N* = 190) Initials %	(*N* = 184) Recommitments %	(*N* = 374) Total %
Does not review respondents file[a]	0.5	1.6	1.1
No overt examination*	1.1	10.3	5.6
Does not question respondent*	1.6	18.5	9.9
Does not ask respondent about mental health issues*	4.7	27.7	16.0
Does not ask respondent about ability to care for self*	32.6	65.2	48.7
Does not ask respondent about physical problems*	55.3	78.3	66.6
Does not ask respondent about treatment*	31.6	64.1	47.6
Does not ask respondent whether they wish to stay*	57.4	77.7	67.4
Does not ask respondent if they need psychiatric help*	77.9	97.3	87.4
Does not question witnesses*	80.0	45.7	63.1
Does not question respondent about suicidal plans*	81.6	97.8	89.6
Does not mention that LRAs might be suitable	92.6	94.0	93.3
Does not mention that LRAs would be unsuitable*	90.5	80.4	85.6
Recommendation*			
Involuntary inpatient	70.0	98.9	84.2
Voluntary inpatient	5.8	0.0	2.9
Release	13.2	0.5	7.0
Other[b]	11.0	0.5	5.9

*$p < 0.01$.
[a]Unable to test because of low expected cell frequencies.
[b]Includes involuntary outpatient care or short-term treatment in a drug/alcohol rehabilitation program.

physical problems, treatment they have been receiving, whether they wished to stay in the hospital, or whether they needed help. However, they were more likely to question other witnesses, and to point out the unsuitability of less restrictive placements. Clinical examiners' recommendations to the judge also differed as a function of the type of hearing. In only 1% of recommitment hearings did clinical examiners recommend a disposition other than involuntary commitment, in contrast with 30% for initial commitment hearings.

Attorney Behavior

Attorneys did not confer with their client either before or during 81.5% of recommitment hearings, compared with 46.3% for initial commitment hear-

ings (Table 2). In comparison with initial commitment hearings, attorneys were less likely to question respondents in recommitment hearings, to ask them whether they wished to stay in the hospital, or to question the clinical examiner's conclusions. Activity level of attorneys was low in both initial and recommitment hearings, with a lower level of attorney activity noted in recommitment hearings.

No differences between initial and recommitment hearings were found on variables assessing whether the attorney reviewed the respondent's file during the hearing, whether they drew attention to the issue of "imminence" of dan-

TABLE 2
Attorney Behavior

	(*N* = 190) Initials %	(*N* = 184) Recommitments %	(*N* = 374) Total %
Does not review respondent's file	62.1	63.6	62.8
Does not question respondent*	55.3	82.1	68.4
Does not ask respondent re mental health issues	92.7	94.0	90.4
Does not asks respondent re ability to care for self	90.0	96.2	93.0
Does not ask respondents re treatment	93.2	98.4	95.7
Does not ask respondents if they wish to stay*	82.6	92.9	87.7
Does not question other witnesses	96.8	91.9	94.4
Does not question clinical examiner's conclusions*	89.5	96.7	93.0
Does not question the admissibility of evidence[a]	97.4	98.9	98.1
Does not draw attention to the issue of "imminence"	95.3	97.8	96.5
Does not mention suitability of LRAs	91.6	90.8	92.2
Does not mention capacity of respondent to live in outpatient setting	94.7	98.4	96.5
Manner in which they conferred with respondent*			
Does not confer	46.3	81.5	63.6
Respondent rejected attempt	4.2	3.3	3.7
Conferred	49.5	15.2	32.6
Activity level*			
Low	60.5	85.3	72.7
Moderate	29.5	12.5	21.1
High	10.0	2.2	6.2

*$p < 0.01$.
[a]Unable to test because of low expected cell frequencies.

gerousness, or whether they mentioned the suitability of less restrictive community alternatives.

Judges' Behavior

Judges were less likely to mention respondents' right to be represented by a private attorney, to be admitted voluntarily, or to appeal the outcome of the hearing in recommitment hearings (Table 3). The hearings did not differ in whether the judge reviewed the respondent's file, questioned respondents in general or asked them about their ability to care for themselves or their desire to stay at the hospital, or mentioned the suitability of less restrictive alternatives in the community. Judges were, however, more likely to encourage the hospital staff to look into less restrictive placements in recommitment hearings.

Presentation of Evidence

In both kinds of hearings evidence was presented by hearing participants to substantiate claims of mental illness, imminent danger to self or others, or

TABLE 3
Judge Behavior

	(*N* = 190) Initials %	(*N* = 184) Recommitments %	(*N* = 374) Total %
Right to appeal not mentioned*	67.9	91.9	79.7
No mention of possibility of voluntary admission*	79.0	93.5	86.1
No mention of right to own attorney*	67.9	94.6	81.0
Does not review respondent's file	79.5	78.3	78.9
Witnesses do not testify under oath[a]	97.4	99.5	98.4
Does not question respondent	54.7	56.0	55.4
Does not ask respondent re mental health issues	77.4	85.9	81.6
Does not ask respondent re inability to care for self	95.8	96.7	96.3
Does not ask respondents if they wish to stay	92.6	91.3	92.0
Does not question other witnesses	86.8	77.7	82.3
Does not mention suitability of LRAs	96.8	94.0	95.4
Requests hospital staff to perform certain actions within the next commitment period*	0.5	7.1	3.7

*$p < 0.01$.
[a]Unable to test because of low expected cell frequencies.

substantial inability to care for self (Table 4). Some evidence relating to the presence of mental illness was presented in all 374 commitment hearings. Initial and recommitment hearings did not differ in how often the respondent was described as having a diagnosed psychiatric condition. However, the topic of previous hospitalization was more likely to be brought up in initial commitment hearings, while the issue of the respondents annoying others and being uncooperative was more likely to be mentioned in recommitment hearings.

Evidence relating to DS was less likely to be presented in recommitment than in initial hearings. In contrast, no differences between the two groups were found on any of the variables measuring danger to others or property. Evidence relating to respondents' problems with taking medication, financial difficulties, or unemployment was more likely to be presented in initial com-

TABLE 4
Presentation of Evidence

	(*N* = 190) Initials %	(*N* = 184) Recommitments %	(*N* = 374) Total %
Evidence of mental illness			
In general	100.0	100.0	100.0
Previous hospitalization* for mental disorder	67.9	39.7	54.0
Annoys others/uncooperative*	8.4	37.5	22.7
Has a diagnosed psychiatric condition	24.7	27.7	26.2
Other evidence presented	64.7	67.4	66.0
Evidence of danger to self			
In general[a]	65.3	17.4	41.7
Suicidal*	42.1	4.9	23.8
Substance abuse*	43.2	12.5	28.1
Other evidence presented	4.2	2.2	3.2
Evidence of danger to others/property			
In general[a]	35.8	38.6	37.2
Assaultive	26.3	27.2	26.7
Property damage	6.3	7.1	6.7
Other evidence presented	10.0	10.9	10.4
Evidence of inability to care for self			
In general[a]	61.0	49.5	55.4
Problem with taking medication*	21.6	8.7	15.2
Denial of mental illness	8.4	9.2	8.8
No job/financial problems*	33.7	3.8	19.0
No adequate place to stay	16.3	18.5	17.4
Other evidence presented*	12.1	25.0	18.4

*$p < 0.01$.
[a]Composite of the subscales.

mitment hearings, while more evidence of "other" issues relating to inability to care for self, such as the need for assistance with activities of daily living, was presented in recommitment hearings. No differences were found on other variables relating to substantial inability to care for self, such as homelessness or the respondent's denial of illness.

Hearing Outcome

Initial and recommitment hearings had significantly different outcomes (Table 5). The respondent was released unconditionally in only 1 of 184 recommitment hearings. This was one of the two hearings in which a respondent retained a private attorney. In contrast, 22 respondents in initial commitment hearings were released, in addition to those who were returned to jail (1), ordered to undergo outpatient treatment (7), or ordered to undergo detoxification or encouraged to sign into such a program voluntarily (16). Furthermore, of the 14 cases in which the judge allowed the respondent to sign a voluntary admission to the hospital, only 2 were Recommitments. Important distinctions were noted between the commitment criteria that were applied in the two types of hearings. In both types, ICS was by far the most frequent criterion for commitment. In 77.7% of initial commitments, and 93.7% of recommitments it was the only criterion that was indicated (difference $p < .01$). ICS was

TABLE 5
Hearing Outcome

	(N = 190) Initials %	(N = 184) Recommitments %	(N = 374) Total %
Judge's disposition*			
Involuntary inpatient	69.5	98.4	83.7
Voluntary inpatient	6.3	1.1	3.7
Release	11.6	0.5	6.1
Other[b]	12.6	0.0	6.4
Actual/implied recommendation of hospital staff*			
Inpatient tx.	84.2	98.4	91.2
Other	15.8	1.6	8.8
Length of commitment	(N = 131)	(N = 180)	
< 180 days	7.6	3.9	5.5
180 days	92.4	96.1	94.5
Basis for commitment[a]	(N = 132)	(N = 181)	(N = 313)
DS*	15.9	2.8	8.3
DO	8.3	5.0	6.4
ICS	92.4	96.7	94.9

*$p < 0.01$.

[a]Not tested for significance as the categories are not mutually exclusive.

[b]Other includes involuntary outpatient care or short-term treatment in a drug/alcohol rehabilitation program.

applied either alone or in combination with another criterion in 92.4% of initial commitments, and 96.7% of recommitments (Not Significant [NS]). Dangerousness standards were used much less frequently. Only 3.8% of initial commitments were on the basis of DS alone, and 1.5% DO alone. No Recommitments were committed on the basis of DS or DO alone. Recommitments were less likely than Initials to be committed as DS ($p < .01$). No differences were found on the other two bases for commitment.

The bases under which respondents were committed were not consistently related to evidence presented during the hearing. Of 343 criteria that formed the basis of the commitments, in 139 (40.5%) no explicit evidence was presented during the hearing. Failure to present evidence did not occur significantly more often in recommitment (91/189) than initial hearings (48/154), but was much more prevalent in the case of the ICS standard (44.1%) than for the DS (15.4%) or DO standards (20.0%).

Miscellaneous Variables

Contrary to the requirements of the Code of Virginia, 4.1% of Initials and 100% of Recommitments were not prescreened prior to the commitment hearing (Table 6). Recommitment hearings were shorter than initial commitment hearings ($p < .0001$). The mean duration of recommitment hearings was 10.5 minutes with a median of just under 8 minutes. In contrast, initial commitment hearings lasted on average 16.7 minutes, with a median of just over 14 minutes. Respondents in recommitment hearings were rated as more impaired than Initials in physical appearance, English language ability, and appropriateness of behavior. Clinical and demographic characteristics of the patients are described elsewhere (Parry, Turkheimer, Hundley, & Creskoff, 1991).

Multivariate Relationships

An assessment of the multivariate relationships among hearing process variables and hearing type was performed using discriminant analysis. The main purpose of this statistical procedure is to predict group membership on the basis of several predictor variables (Klecka, 1980). The procedure results in the linear combination of predictor variables, which maximizes differences between groups, in this case between initial and recommitment hearings (Tabachnick & Fidell, 1983). To minimize the effects of violations of the assumption of the linearity of relationship between predictor variables, discrete variables were recoded into 0/1 dummy variables (Klecka, 1980; Tabachnick & Fidell, 1983). Variables showing a significant chi-square association ($p < 0.01$) with hearing type were selected for inclusion. Thirty-six variables were chosen for further analysis.

A stepwise discriminant analysis was performed to select the most useful subset of variables for discriminating between Initials and Recommitments. Only two thirds of the observations ($N = 247$) were used, with the remaining third held for a cross-validation study. The 16 variables retained by the stepwise analysis, together with Univariate F and Wilks Lambda values, are given in Table 7.

TABLE 6
Miscellaneous Variables

	(*N* = 190) Initials %	(*N* = 184) Recommitments %	(*N* = 374) Total %
Hearing petitioner is hospital staff*	15.8	94.0	54.3
Prescreening not filled in[a]	4.1	100.0	52.7
Presence of hospital mental health professional*	86.3	70.1	21.7
Presence of hospital aides*	14.2	50.0	31.8
Presence of family	13.7	4.3	9.1
Place of hearing			
Hearing room	51.6	39.7	45.7
On ward	48.4	60.3	54.3
Number of persons present in the hearing,* excluding the special justice, clinical examiner, and respondent			
0	54.6	23.4	39.1
1	25.7	51.6	38.5
More than 1	19.8	25.0	22.4
Length of hearing*			
1–15 min	53.4	89.0	70.9
16–30 min	39.1	8.2	24.0
GT 30 min	7.4	2.8	5.1
Respondent's physical appearance*			
Very poor	2.6	15.2	8.8
Impaired	33.7	48.9	41.2
Normal	63.7	35.9	50.0
Respondent's English language ability*			
Very poor	3.2	27.3	15.1
Impaired	22.8	33.9	28.2
Normal	74.1	38.8	56.7
Appropriateness of respondent's behavior*			
Inappropriate	4.2	28.8	16.3
Impaired	26.3	39.1	32.6
Normal	69.5	32.1	51.1

*$p < 0.01$.
[a]Unable to test because of low expected cell frequencies.

A direct discriminant function analysis was then performed on this subset of variables. One discriminant function was calculated, with $F(16, 230) = 26.32$, $p < 0.0001$. The discriminant function accounted for 65% of the between-group variability. A plot of discriminant function scores for Initials and Recommitments is presented in Figure 1. A cross-validation was performed to assess the ability of the discriminant function to classify the 124 hearings that were not included in the original analysis. Overall there was a 81% correct classification rate.

TABLE 7
Results of Discriminant Function Analysis of Hearing Process Variables: Prediction of Commitment Status

Predictor Variable	Correlation with Discriminant Function	Univariate $F(1, 245)$	Wilks Lambda
Respondent variables			
Suicidal ideation	0.55	60.64	0.80
Job or financial troubles	0.50	47.31	0.54
Annoys or uncooperative	−0.38	25.80	0.37
Previous hospitalization	0.28	12.61	0.36
Problems with taking medications	0.25	10.05	0.39
Clinical examiner (CE) variables			
No overt clinical examination	−0.28	13.20	0.35
CE asks about mental health	0.46	40.06	0.35
CE questions witnesses	−0.40	28.15	0.46
CE asks about needing help	0.43	33.57	0.43
CE asks about treatment	0.54	56.37	0.69
CE asks about staying	0.32	17.38	0.41
CE recommends involuntary hospitalization	−0.50	47.66	0.50
Attorney (AT) variables			
AT does not confer	−0.49	45.26	0.60
AT questions client	0.41	30.23	0.37
Judge variables			
Staff to look for an alternative place	−0.20	6.18	0.38
Hospital variables			
Presence of staff professionals	−0.20	6.54	0.40
Canonical R	0.80		
Eigenvalue	1.83		

Correlations between predictor variables and the discriminant function are given in Table 7. Positive correlations indicate that the variable is characteristic of initial commitments. Recommitment hearings were characterized by absence of evidence about suicidality or financial difficulties, previous hospitalizations and problems with medication compliance, whereas evidence was presented about annoying and uncooperative behavior. Attorneys were less likely to question or confer with respondents in recommitment hearings. Clinicians were less likely to question the respondent, more likely to question witnesses, and more likely to recommend involuntary hospitalization. The judge was more likely to instruct hospital staff to seek alternative placements in recommitment hearings.

Discussion

Initial and recommitment hearings differed on several dimensions, including the behavior of all participants, the substance of the evidence presented, and

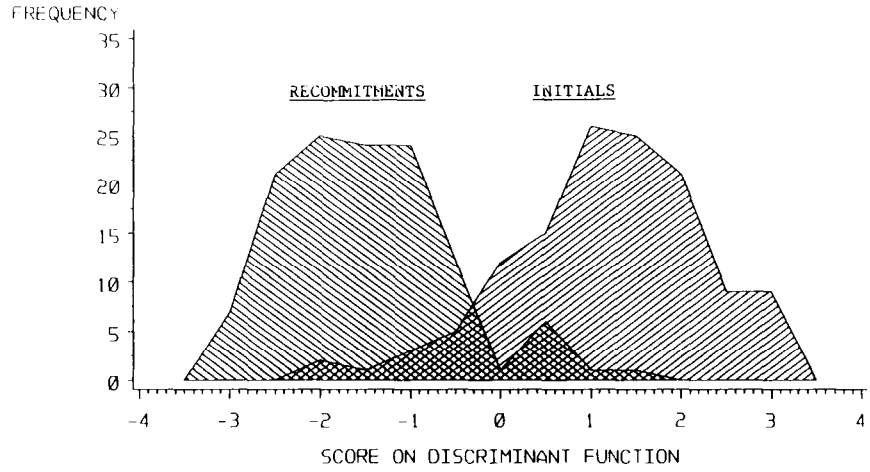

FIGURE 1. Frequency distribution of scores on discriminant function for subjects in initial and recommitment hearings.

in outcome. Furthermore, as previous studies have documented, there was a considerable gap between the letter and practice of the law (Grouse et al., 1982; Hiday, 1977; Lipsitt & Lelos, 1981; Warren, 1977). The unique contribution of this study has been to demonstrate that the gap was significantly more pronounced in recommitment hearings.

Since in Virginia, as in most states, statutory requirements for commitment and recommitment hearings are virtually identical (Van Duizend et al., 1984), the differences between them must reflect clinical, institutional, and policy-based influences on the commitment process, which are not explicit in the statute. In an earlier paper (Parry et al., 1991), we have shown that respondents in recommitment hearings are older than those in initial commitments, and exhibit symptoms of chronic deteriorating psychopathology, especially organic conditions and schizophrenia. Very few were dangerous to themselves or others at the time of the hearing, but most had severe medical problems. Respondents in initial commitment hearings, in contrast, displayed signs of acute mental illness, including dangerous and bizarre behavior—precisely those issues that commitment hearings are designed to address.

The differences between initial and recommitment hearings also reflect explicit and implicit institutional pressures on judges, clinical examiners, and attorneys from both the mental health and judicial systems. These pressures are likely to be heightened in recommitment hearings. Attorneys and clinical examiners may feel that the hospital would have discharged respondents in recommitment hearings if it were appropriate, and that vigorous attempts at obtaining release might result in denial of treatment to needy patients (Engum & Cuneo, 1981; Hiday, 1983b; Shuman & Hawkins, 1980). Many judges view commitment decisions as medical, and give covert suggestions to expedite the proceedings (Ehrenreich et al., 1982; Hiday, 1982, 1983b; Litwack, 1974). In Virginia this is exacerbated because attorneys and clinical examiners are

appointed on a *per diem* basis by the court, and are paid a flat fee for each case. Furthermore, participants are paid less for recommitment hearings.

Local, state, and national level mental health policies also affect the civil commitment process. In particular, the current *de facto* national mental health policy of institutionalization through federal programs such as Medicaid and Medicare has fostered a climate which has restricted the development and availability of LRAs to inpatient treatment (Kiesler & Sibulkin, 1987; Mechanic, 1987; Sharfstein, 1987). In civil commitment hearings the lack of availability of LRAs is reflected in the court's routine neglect of LRAs to involuntary hospitalization and CSBs lack of involvement in recommitment hearings. Local zoning regulations and restrictive covenants (which control the number of nonrelated persons who may reside within a residence) also constrain the housing options open to persons discharged from state mental facilities (Drinan, 1983). These governmental policies are likely to have a greater impact on the outcome of recommitment hearings because respondents in these hearings often display symptoms of chronic (as opposed to acute) psychopathology, which could almost always be treated within a less restrictive setting than the state hospital (Parry et al., 1991).

Although further research is needed to establish a causal relationship between the diverse clinical, institutional, and policy-based influences identified above, and the greater relative gap between the letter and practice of the law in recommitment hearings, the hypothesis appears warranted at this time. Respondents in recommitment hearings are precisely those who are most difficult to place in an overburdened community mental health system. Participants in hearings are faced with a choice between releasing nondangerous patients into a community that is ill-prepared to treat them, or maintaining them in the hospital using the ICS criterion for commitment. The major shortcomings of the recommitment process—cursory and nonadversarial hearings, inactive clinical examiners, and deferential attorneys—all reflect a desire to hold patients on a "need for treatment" standard when they are obviously ill and no alternative treatments are available.

Further research is also needed to replicate the findings reported in this study in other jurisdictions. This is essential because the findings could have been biased by the fact that subjects were selected for inclusion in the study because of residence in a state hospital, and because the present study involved a single hospital in a single state. In addition, the effect of national mental health policy on the civil commitment process needs to be studied in greater detail. Of particular interest, will be the clinical and demographic characteristics of long-term involuntarily committed patients who have derived maximum benefit from hospital care, as well as the community services that can be developed to care for such patients in a less restrictive environment. This is especially important given the high percentage of long-term residents in state hospitals who could safely be treated in the community or who are currently awaiting placement (Bigelow, Cutler, McCoomb, & Leung, 1988; Department of Mental Health and Mental Retardation, Commonwealth of Virginia, 1985; Kiesler, 1980).

The findings reported in this study have a number of theoretical and policy implications. First, they serve to establish the subject of recommitment hear-

ings as an important, and previously neglected focus of future research and policy-making efforts in the area of civil commitment. Second, they question the wisdom of the current policy practice of having initial and recommitment hearings governed by similar statutory and procedural criteria. While it is possible that current state civil commitment statutes are well suited to the exigencies of recommitment hearings, and that the hearing participants are merely negligent in their application of the law in these situations, it is more likely that current civil commitment statutes are poorly suited to the demands of recommitment hearings. In either case, changes are needed so that the recommitment process does not purport to be a system for legally based dangerousness commitments when, in fact, it is not.

There is currently some consensus in the medical profession that there is a need to return to some variant of the "need-for-treatment" approach, while still retaining the dangerousness standard and the procedural safeguards, which accompanied the legal model of civil commitment (Appelbaum, 1984). Suggestions for statutory and procedural change are contained in American Psychiatric Association's (APA) model state law for civil commitment of the mentally ill (Stromberg & Stone, 1983; Zusman, 1985). Implementation of the APA model would decrease the gap between the letter and practice of the law caused by having recommitment orders based on insufficient evidence of dangerousness or inability to care for self. Expanding commitment criteria would not, however, eliminate many of the problems outlined above, such as the low activity level of attorneys.

The findings of the current study suggest a need for better training of attorneys, external clinical examiners (where applicable), and judges. All three require training in mental health law and the roles and responsibilities of hearing participants; judges and attorneys may require additional training in mental health, illness, and LRAs. Attorneys and clinical examiners also need independence from the judicial system, especially in jurisdictions in which they are appointed by the court.

One approach to reform the civil commitment process would involve ongoing institutional evaluation of civil commitment hearings. Attorneys representing respondents in civil commitment hearings would be explicitly evaluated in terms of their preparation for the hearing, their cross-examination of witnesses, and their efforts in ensuring consideration by the court of the need for treatment in the least restrictive alternative. Judges' records of committing and releasing patients would be scrutinized to guard against deference to clinical opinion or unwarranted release of committable patients, and clinical examiners would be evaluated for thoroughness in their examinations. Encouraging attendance of hospital staff, patient advocates, Community Mental Health Center representatives, and members of patients' families would also enhance accountability and public confidence.

Another alternative would be for policymakers to completely overhaul the statutory criteria to meet the specific exigencies of recommitment hearings. Appelbaum (1982) has proposed reducing the legal emphasis of the commitment process and returning control to physicians through a case-conference model. Others (e.g., Hoffman & Dunn, 1975) have discussed compromises that would still allow for input from attorneys and judicial appeal. Whatever

statutory changes are implemented, it will be important to ensure that respondents in recommitment hearings are afforded due process, that recommitment hearings are not conducted in a *pro forma* manner, and that cognizance is taken of the effect of national mental health policy on the civil commitment process.

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