# B. Patients Rights

## Indexing Civil Commitment Criteria in Psychiatric Emergency Rooms[1]

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The civil commitment of the mentally ill is a major dilemma for mental health professionals throughout the United States and the world. Given persistent ambiguities in commitment statutes and the difficulty inherent in predicting behavior, clinicians must make commitment decisions which may, on the one hand, violate individual rights or, on the other, result in the neglect of community safety or of individuals who need care. While it is generally agreed that commitment is necessary in some cases, there is widespread concern that the commitment process is irrational, arbitrary, and discriminatory [4, 14]. Further, is has been seriously questioned by the courts [3, 9, 15].

Most efforts to prevent the improper use of commitment have focused on procedural safeguards to insure the protections of due process [6]. Due process implies the existence of a standard which is thoroughly and consistently applied in all cases. To date, the courts and legislatures have left the assessment of the substance of commitment criteria to professional discretion. They have assumed that in the absence of predictive accuracy there are professional standards to be consistently applied. In view of this assumption, it is surprising to find that few studies [2, 7, 19] have examined clinical reasons for admission decisions and that none of these attempted to describe the clinical application of legal or statutory criteria.

According to Schwitzgebel [17], most states in the United States specify two or three criteria for involuntary commitment. Criteria of danger to self or others or likelihood of serious harm to self or others are usually combined with a criterion similar to California's grave disability standard. While state statutes vary in the degree of restrictiveness implied by their wording, "the trend has been to narrow the population of those who may be committed" [10, p. 84]. As the California statute was a harbinger of this trend when first implemented in 1969, information about its application by clinicians may be presumed also to be relevant to most other states and countries with similar laws or conditions.

Criteria for civil commitment in California were established by the Lanterman-Petris-Short Act (LPS), but the low provides very little definition of these standards. The commitment process begins with a 72-hour emergency detention for observation and treatment. While a variety of mental health and law enforcement officials

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are authorized to begin this process, the critical decision about hospitalization is made by personnel in the psychiatric emergency rooms of general hospitals. There are no data to indicate how these clinicians apply legal commitment criteria.

According to LPS, involuntary hospitalization requires that

- due to a mental disorder for which the facility can offer treatment, the person must be
- dangerous to himself, dangerous to others, or gravely disabled, and that
- the person must be unable or unwilling to agree to the necessary treatment.

Thus the law requires that three separate assessments be made with almost no statutory guidance. In failing to specify the meaning of these criteria, the legislature clearly intended that these determinations be guided by clinical judgment.

The criteria that have been the focus of greatest concern are those of dangerousness and grave disability. In a statewide evaluation of California involuntary treatment procedures, Schwitzgebel and Swenson [18, pp. 38-39] noted that there is:

> Need for clarification of the criteria to be used in the detention of patients under the three LPS standards.... Consistently applied interpretations have been lacking. Facility staff members frequently seem to want information or suggestions about the detention or commitment criteria. Ambiguity of interpretation allows an unnecessary and unintended abuse of liberties. The preparation of regulations or guidelines describing involuntary detention criteria might, with suitable inservice training, reduce considerably the present diversity in the application of LPS standards.

Uncertainty among clinicians about how the involuntary commitment law should be interpreted and corresponding inconsistency in its application do not refute the assumption of a body of relevant clinical opinion, nor do they tell us in what particulars and to what extent its application is inconsistent. Moreover, most previous studies of determinants of admission decisions are seriously flawed. The conclusions of these studies are valid only to the extent that all significant variables that influence the admission decision were included in the analysis. Studies of the environmental determinants of admission decisions [5, 11, 16] have not considered the influence of legal commitment criteria as they are clinically construed. Indeed, only one study [8] included as an independent variable a clinical assessment of the state of the patient with regard to a legal criterion for commitment.

In short, it is too soon to conclude that mental health professionals need administrative guidelines in order to achieve substantial agreement and consistency in applying involuntary admission criteria. Further effort is warranted to establish (a) the extent to which there is already agreement among clinicians as to the meaning of the criteria, and (b) the extent to which there is consistency in their application. Note that the question being addressed here is not the predictive validity of emergency psychiatric assessments, but rather the prior question whether clinicians respond to similar cases with similar judgments. In this chapter we report the preliminary results of the development of a tool to reflect the application of legal commitment criteria in psychiatric emergency rooms.

## Method

In an attempt to reflect the way clinicians in psychiatric emergency rooms interpret and apply the legal criteria of dangerousness and grave disability, we developed a prototype index entitled "Three Ratings of Involuntary Admissibility" (TRIAD). The instrument was developed through an iterative process which included literature review, observation of actual cases, and debriefing of clinicians. This iterative process resulted in the identification and ranking of patterns of behavior and circumstance more and less likely to lead to a determination that a patient is involuntarily admissible by LPS standards.

We theorized that through professional training and experience clinicians are sensitized to clusters or patterns of behavior and circumstance that are associated with danger of self, danger to others, and grave disability, and that they internalize scales by which they weigh or rank these patterns. (Several patterns are of equivalent rank.) Thus clinicians will react to some patterns as unambiguously dangerous or not dangerous, and they will consistently respond to these patterns with decisions that a person is admissible or not admissible under commitment criteria. Admission decisions will therefore be highly consistent in cases involving these unambiguous patterns. Other patterns will be experienced as more ambiguous, and this ambiguity will lead to a greater variation in the outcome of the decision-making process.

Expecting that many patients would present complaints or behavior related to more than one of the legal criteria, we further hypothesized that an ambiguous presentation on any one criterion would be more likely to lead to a decision that the person was admissible if it was accompanied by at least a low-level presentation on another criterion. For example, a person who presented some moderate threat to the safety of others would be more likely to be judged admissible if he also seemed to present a moderate or mild potential for harming himself. Thus we expected that in these cases a total score across all three criteria on TRIAD would also predict the clinician's judgment.

### *Observations*

After creating the first draft of TRIAD, we observed evaluation interviews in the Psychiatric Emergency Service (PES) of San Francisco General Hospital and Highland General Hospital, Oakland. These are the major emergency evaluation units for the two largest San Francisco Bay Area counties. Eighty-nine patients were chosen on the basis of their availability at a time when an observer was free to follow a new case. Observers followed a patient and the assigned clinician as long as the patient remained in the PES, usually for a period of several hours. TRIAD was scored when a disposition decision had been reached. The clinician handling the case was not involved in the scoring process.

### *Description of TRIAD*

The result was an easily scored instrument consisting of three scales. The three scales, organized as checklists, consist of a total of 84 numbered items which can be combined to yield 146 patterns of behavior and circumstance relevant to the clinical prediction of violence and suicide and the assessment of grave disability. On each of the scales, a number of patterns are assigned to the highest score, a number are assigned to the next highest score, and so on.

No pattern combines more than nine items, and most involve two, three, or four items. For example, "threatened to harm another" is one item which, by itself, scores at a low level (= 1) on the danger to others scale. However, such a threat may yield the highest score (= 4) if it occurs in combination with three other particular items. The first additional item has to do with provocation or lack thereof. The others involve indications of having a concrete plan and/or weapon, and/or being in a volatile or unpredictable or enraged state, and/or having a history of assault. According to our hypothesis, if such a presenting picture is accompanied by a mental disorder, the evaluating clinician will determine than the patient is clearly admissible by LPS standards. In order to prevent hospitalization, he may attempt to bring about some change in the picture through crisis intervention or medication in the emergency room, but if these efforts fail, admission will follow. If the efforts succeed, the danger to others score will be lower than it would have been otherwise. Other patterns seem equally clear, but some are more ambiguous and yield intermediate scores.

TRIAD is scored at the time of disposition by simply checking off items applicable at that time and finding the standard pattern that includes the numbers of the checked items and yields the highest score.

## Results

### *Inter Rater Reliability*

Three pairs of observers rated ten cases each and achieved interrater reliability coefficients (Pearson's $r$) of 0.94, danger to self score; 0.89, danger to others score; 0.77, grave disability score; and 0.89, total admissibility score. The results demonstrate that it is possible to use this instrument reliably to rate psychiatric emergency cases.

### *Patient Characteristics*

Table 1 summarizes some of the demographic and diagnostic characteristics of the sample of 89 patients observed in both hospital emergency rooms. On the basis of data for most of the sample we are able to describe what we believe to be the "typical" patient. This typical patient was a white male, aged 26-44, born in the United States, and fluent in English. The patient had never been married, had had 10-12 years of education, and was out of the job market as a result of disability, for

which he was receiving Supplemental Security Income. He was more likely to receive a diagnosis of psychosis than a non psychotic diagnosis.

**Table 1.** Patient characteristics (%, adjusted for missing data) ($n = 89$)

| | |
|---|---|
| Sex | |
| Male | 69.3 |
| Female | 30.7 |
| Age (years) | |
| 14-25 | 12 |
| 26-44 | 65 |
| 45-87 | 23 |
| Ethnicity | |
| White | 61.7 |
| Black | 24.7 |
| Spanish surname | 8.6 |
| Other | 4.9 |
| Birthplace | |
| United States | 86.5 |
| Other | 13.5 |
| Marital status | |
| Single | 46.6 |
| Married | 25.9 |
| Divorced/separated | 25.8 |
| Widowed | 1.7 |
| Education | |
| < 10 years | 16.7 |
| 10-12 years | 62.5 |
| 13-17 years | 21 |
| Employment | |
| Full- or part-time | 5.6 |
| Unemployed | 8.5 |
| NA/disabled | 70.4 |
| Other | 15.4 |
| Source of income | |
| None | 10.5 |
| Family/friends | 12.3 |
| Employment | 10.5 |
| Disability | 54.4 |
| Other | 12.4 |
| Living arrangements | |
| No address | 30 |
| Alone | 23 |
| With others | 32 |
| Sheltered care | 8 |
| Other | 7 |
| No. of previous PES visits | |
| None | 52.9 |
| 1-5 | 24.2 |
| > 6 or unclear | 22.9 |
| No. of previous hospitalizations | |
| None | 14.3 |
| Multiple (no. unknown) | 49.2 |
| 1-5 | 25.4 |
| 7-13 | 11.2 |

**Table 1.** (continued)

| | |
|---|---|
| Previous diagnoses | |
| Major affective disorder ± schiz. | 44.2 |
| Schiz. ± substance abuse | 27.9 |
| Substance abuse only | 11.6 |
| Organic psychosis | 4.7 |
| Acute or atypical psychosis | 4.7 |
| Adjustment, reactive or anxiety disorder | 7 |
| Current diagnosis (Axis I) | |
| Psychotic | |
| Schiz. or schiz. affective disorder | 33 |
| Major affective disorder | 19 |
| Organic psychotic disorder | 6 |
| Other psychotic disorder | 8 |
| Nonpsychotic | |
| Adjustment or anxiety disorder | 13 |
| Acute organic/substance abuse disorder | 6 |
| Other | 8 |
| No MDO or deferred | 7 |

Fifty-five percent of the cases were evaluated by psychiatrists, 18% by nurses, 18% by social workers, and 7.5% by other professionals, paraprofessionals, or unlicensed professionals in training. Clinical experience of evaluators ranged from 2 to 23 years, and the emergency psychiatric experience of the clinicians ranged from less than 6 months to 13 years. Of the patients observed, 93% were examined by clinicians with 2 years of PES experience or more.

The number of patients evaluated in the emergency service on the day of our observations ranged from 14 to 32, and in most cases was 20–26. If admitted to a ward following the emergency evaluation, the patient was most likely to remain for 7–9 days (30%) or for 15–17 days (25%). Average occupancy rates for the inpatient wards at the two hospitals during the study period were 94% and 91%.

### *Severity of Presenting Problem*

Our observations led us to believe that when a patient comes into the emergency room the clinician focuses his assessment on the area suggested by the patient's major presenting behavioral problem. For example, a suicide threat will lead to an assessment of danger to self rather than grave disability or danger to others. These areas will be explored secondarily, as a result of information that comes to light in the assessment of danger to self. If the patient does not present a strong picture of admissibility on any one criterion, the overall picture becomes most relevant to the disposition. In our analysis, therefore, we attended not only to the patient's presentation on individual criteria but also to the overall presentation. Table 2 shows how scores are combined at different severity levels given a range of 0–4 on the danger to self (DSS) and danger to others (DOS) scales and a range of 0–3 on the grave disability (GDS) scale. The distribution of the 89 patients we observed across severity levels was: 69.7% at the highest severity level, 4; 2.2% at level 3; 10.1% at level 2; and 18.0% at level 1, the lowest level.

### *Disposition*

Disposition was consistent with TRIAD severity scores in 82% of the cases (gamma = 0.82; see Table 2), and agreement was roughly equivalent for both hospitals. After the initial evaluation 58 patients were retained.

**Table 2.** Disposition of case by severity level ($n = 89$)

| Severity level | Released | Retained voluntarily | Retained involuntarily | Totals |
|---|---|---|---|---|
| 1 (DSS, DOS, GDS = 0 or 1; total = 3 or less) | 13 (81%) | 0 | 3 (19%) | 16 (100%) |
| 2 (DSS, DOS, GDS = 2; total = 2) | 7 (78%) | 0 | 2 (22%) | 9 (100%) |
| 3 (DSS, DOS, GDS = 2); total = 3) | 1 (50%) | 0 | 1 (50%) | 2 (100%) |
| 4 (DSS, DOS, GDS = 3 or 4 or total = 4 or more) | 10 (16%) | 4 (7%) | 48 (77%) | 62 (100%) |

As expected, the most and least severe presentations were most predictive of disposition (84% and 81% predictions respectively). The high scorers who were retained and the low scorers who were released are the true positives and true negatives. False positives and false negatives are identified by heavily lined boxes in Table 2. False negatives are patients who scored low on TRIAD but were retained by the clinician; false positives are the high scorers who were released by the clinician.

Severity levels 2 and 3 represent the hypothesized ambiguous range on TRIAD. However, severity level 2 also turned out to be quite discriminating, with 78% of patients being released. At severity level 2, the picture presented by the patients was ambiguous, but at this level of severity clinicians were inclined to let the patient go. The least predictive score configuration represents the situation in which the patient presents only a moderate degree of concern on any one criterion but raises one other issue at a low level (severity = 3). With only two cases at this level, the figure of 50% released and 50% admitted is far from conclusive. However, the difference between severity levels 2 and 3 does suggest that the index is capable of representing salient dimensions of the decision-making process at a fine level. Future observations will be necessary to test our hypothesis that severity level 3 represents more ambiguous situations that provide wider latitude for clinical discretion.

Most (69.7%) of the 89 patients scored at the highest level of severity. Table 3 describes the disposition of patients at severity level 4 according to whether their high score resulted from danger to self (8%), danger to others (35%), grave disability (38%), or a combination (2%). Thirteen percent ($n = 12$) scored at the highest level on two scales.

**Table 3.** Disposition of cases at severity level 4[a] by scale/Total score

| Score qualifying case for severity level 4 | Released | Retained voluntarily | Retained involuntarily | Totals |
|---|---|---|---|---|
| Danger to self = 3 or 4 | 5 (71%) | 0 | 2 (29%) | 7 (100%) |
| Danger to others = 3 or 4 | 4 (13%) | 2 (6%) | 25 (81%) | 31 (100%) |
| Grave disability = 3 | 1 (3%) | 2 (6%) | 31 (91%) | 34 (100%) |
| Total score = 4 or more but no scale score = 3 or | 0 | 0 | 2 (100%) | 2 (100%) |

[a] $n = 62$ (12 cases scored at highest level on two scales)

Of the patients whose scores on danger to others and grave disability but them into the highest severity level, 87% and 97% respectively were retained. Of those who attained the highest severity level by reason of a high danger to self score, 71.4% were released, contrary to our expectation, and 28.6 were retained.

### *Diagnosis*

Disposition may legitimately be influenced by legal and clinical considerations in addition to dangerousness and grave disability. The presence or absence of a mental disorder and the severity of the disorder are major criteria. To the extent that the presence or absence of psychosis captures these concerns, we are able to report their influence on disposition.

To facilitate analysis, DSM-III [1] Axis- I diagnoses were categorized as psychotic and nonpsychotic. While the presence of psychosis was moderately related to severity of presentation on TRIAD (gamma = 0.53), it was strongly related to disposition (gamma = 0.79), although not as strongly as TRIAD severity (gamma = 0.82). Thus it appears that severity of dangerousness and disability, on the one hand, and presence or absence of psychosis, on the other, make partially independent contributions to the explanation of disposition. Not surprisingly, the relationship between disposition and TRIAD severity was stronger for nonpsychotic patients (gamma = 0.89) than for psychotic patients (gamma = 0.74). Presence or absence of psychosis is helpful in explaining dispositions that differ from those predicted by the TRIAD score.

### *Discrepant Cases*

It appears that the best explanation for the discrepancy between TRIAD scores and disposition in the false positive cases is the clinician's judgment in each case that admission was not clinically indicated - i.e., slight degree of mental disorder (insofar as it is reflected by diagnosis), the availability of treatment alternatives, and the

judgment that patients would not benefit from hospital care appear to have been the critical factors. At least two cases appear, however, to have been influenced by obviously non clinical considerations - one case a false positive and the other a false negative.

## Comment

The results of this study strongly suggest that psychiatric emergency room clinicians employ shared constructs of danger to self, danger to others, and grave disability; that these constructs are reliably applied in actual cases; and that most involuntary admissions are predictable from the severity of the patient's status with respect to these criteria. Further, it seems that these shared constructs can be operationalized to provide a behavioral description of how a patient comes to be seen as admissible under one or more involuntary admission standards.

The study provides a test of TRIAD as an instrument which describes the process and content of clinicians' judgments as to whether a patient meets legal standards for involuntary admission. In this instance, the concurrent measure was disposition. By this criterion, the construct validity of the DOS and GDS was supported. Also supported was the validity of the total TRIAD score as a measure of the construct "involuntary admissibility." However, the validity of the DSS has yet to be established.

While disposition proved a useful concurrent measure of the construct validity of TRIAD, it is obviously limited by the fact that variables beyond the clinician's assessment of dangerousness and disability appropriately influence these decisions. We are currently proceeding with other ways to test the validity of TRIAD as a measure of clinicians's constructs of danger to self and others and grave disability.

If these procedures establish that TRIAD reflects the way clinicians interpret and apply legal criteria in most instances, and if, in addition, TRIAD predicts disposition, the discussion of emergency involuntary commitment criteria and procedures should be greatly facilitated. TRIAD could then provide a very useful description of the state of patients being held involuntarily, as well as assurance that legal criteria are applied consistently and equitably.

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