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The Impact of a Change in Commitment Procedures on the Character of Involuntary Psychiatric Patients

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ABSTRACT: The statutory requirements for involuntary civil psychiatric confinement have become increasingly restrictive. In the jurisdiction under investigation, patients were originally admitted under an Order to Apprehend (OTA) procedure simply on the petition of two affiants who indicated the patient was in need of care. A newly elected judge instituted changes requiring affiants to claim the subject was "dangerous" to self or others and asking for a clinical assessment and recommendation before signing the petitioned request for involuntary confinement. It might be expected that the more restrictive procedures would have produced a population of more assaultive patients. A study of petitions signed under in the earlier ($N = 133$) and later, more restrictive ($N = 218$) procedures indicated that the proportion of assaultive or dangerous patients was virtually identical. Further investigation, using hospital data an OTA patients from this area in both time periods, suggested that while patients were not more assaultive, they appeared to be more seriously ill or psychiatrically impaired. Apparently, movement to a dangerousness standard that allows clinical discretion in interpreting its presence may result in involuntary commitments for more seriously ill, although not necessarily more assaultive, patients.

KEYWORDS: psychiatry, jurisprudence, mental illness

The history of psychiatric hospitalization has witnessed an enduring tension between the professions of law and medicine over justifications for involuntary commitment [*1,2*]. In the past two decades the statutes governing civil psychiatric commitment have become increasingly restrictive. Stimulated by the civil rights movement's emphasis on individual rights, a growing critical literature on the fallibility of psychiatric diagnosis and prediction, the campaign for the treatment of the mentally ill in the community, and the rise of the mental health bar, medical commitments have been challenged, resulting in a move toward the establishment of judicial standards and procedures [*2,3*]. An expanding set of review procedures involving lay participants (judge, legal, counsel, jury, and so on), the centrality of the dangerousness criterion, and a higher standard of evidence for dangerousness have been instituted as reforms to the involuntary civil psychiatric commitment process.

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Despite the more carefully defined and restrictive criteria governing civil psychiatric commitment, some have been skeptical about their actual impact. For example, those admitted as dangerous to self or others have been found far less assaultive or suicidal than alleged [*4–6*]. Hearings arranged to assess patients' suitability for civil commitment have been found somewhat superficial and brief [*7–9*]. Indeed, Brooks [*10*] argues that psychiatric evaluators often use whatever statutory language is required to gain admission for patients they deem sick and in need of care. Pfohl's [*11*] observations provide partial support as psychiatric staff look for rationale in the statutory language to justify the confinement of those believed to be in need of treatment. Further, several studies have reported that changes in mental health statutes did not produce anticipated outcomes in the nature and number of involuntary commitments [*12–17*]. Thus, more restrictive commitment procedures, particularly those requiring patients to be "dangerous," may not have the anticipated impact on who is admitted to mental hospitals. If mental health clinicians continue to play a major role in commitment decisions, then the outcome should reflect their priorities of forcing the patient into care when serious pathology is believed to exist. Hence, the population of civil psychiatric patients might not be any more assaultive or suicidal, regardless of the change in statutory language or procedures.

The present study examines the consequences of moving to a restrictive involuntary commitment procedure in a large, metropolitan county in the southeastern United States. A newly elected judge of the County Probate Court altered the procedures and criteria for obtaining a petitioned emergency psychiatric evaluation in the county, even though state laws remained unchanged. The procedure is termed an "order to apprehend" (OTA), which instructs the sheriff to pick up an individual for an emergency evaluation, where he/she could be held for up to 24 h. On recommendation of two physicians, the patient can be retained for an additional five-day evaluation period. If treatment is deemed necessary beyond the five-day evaluation period, another petition may be filed by the medical personnel with the option of a hearing open to the patient. The OTA petition process at the Probate Court applies only to the initial 24-h evaluation period.

Previously, any two citizens (usually relatives) could petition the court as affiants for an emergency evaluation. The clerks rarely questioned affiants when they came into Probate Court offices. Petitioners were required to indicate, by checking a line on the petition, that the client was "mentally ill and dangerous to self or others or incapable of caring for self" and describe patient behavior that led them to make that assessment. Petitions were routinely signed and sent to the sheriff for action at the end of the day.

With the new administration of January 1977, a different set of procedures were introduced, reflecting the new judge's interpretation of the existing law. Upon petition, affiants were first referred to a community mental health facility to discuss the problem with their staff. The mental health personnel were expected to determine whether the OTA was necessary or the case could be handled by some alternative method. After that interview, if the mental health center and affiants both thought that the patient should be evaluated under an OTA provision, the judge usually signed the petition. (In more than 95% of the cases, the judge signed petitions on recommendation from the mental health services and did not sign when they recommended the opposite.) In determining suitability for an OTA, the mental health evaluators and affiants were asked to focus on the client's potential "dangerousness." The petition language was also changed, requiring the affiants to declare the patient was "likely to injure self or others"; the criterion "incapable of caring for self" was dropped. The judge also suggested that evaluators push for evidence of assaultiveness and concern themselves less with the damage of the psychopathology itself, unless it was likely to be life-threatening.

Given the procedural and substantive changes, one might expect the second OTA population to contain a greater proportion of assaultive or "dangerous" individuals. However, because clinicians are essentially given the power to make commitment decisions, working with

the relatively undefined concept of dangerousness, the outcome could reflect the orientation of mental health professionals. As the previously cited anecdotal observations indicate, patients might not be more assaultive but could give evidence of more serious psychopathology. It is therefore of interest to examine the outcome of a change instituted by a "gatekeeper" from the legal system when mental health clinicians are accorded considerable power in the decision-making process.

Methods

Information was taken from all petitions filed for an Order to Apprehend in the County Probate Court in a six-month period before the change in administration during 1974 and 1975 ($N = 133$). A second set of petitions, filed in a 16-month period after the procedural changes (January 1977 to April 1978), was also used ($N = 218$). Petitions provided both background information on the subjects of OTAs and descriptions of the behavior that led petitioners to believe they were "dangerous." Additional data on admission rates and length of stay were provided by the county-supported psychiatric hospital that served as the evaluation facility for all county OTA patients. Information was provided on all county OTAs evaluated during 1976 (before the change, $N = 269$) and 1977 (after the change, $N = 137$). It was not possible to link cases in a combination of the two data sets because there was no identification of individual subjects.

Petitions contained a limited amount of information on the background of OTA clients. While there is no information on social status-related variables in the petitions, the patient population is known to be primarily from low-income families; a large proportion are medically indigent. Males predominated as clients in both groups (61.7% in 1974-75; 59% in 1977-78). The nonwhite proportion was 42.1% in 1974-75 and 60.3% in 1977-78. The ages ranged from 15 to 90, with a mean age of 40 in 1974-75 and 39 in 1977-78. Thirty-six percent of those in 1974-75 had been previously hospitalized for a psychiatric problem, while in 1977-78 that proportion was 52%.

To examine changes in levels of dangerousness, two operationalizations of the concept were constructed. A "narrow definition" included clients whose prepetition behavior included actual assault against others, attempted suicide, or actual destruction of property (setting a fire, for examine). A "broad definition" of dangerousness included not only those who were actually assaultive, but individuals said by affiants to seriously threaten harm to self or others. The classification of coding was more than 90% reliable [5].

Findings

It was predicted that with the change of OTA procedures committed patients would not be more "dangerous," but would give evidence of being more seriously ill. Table 1 displays the proportion of OTA patients categorized as "dangerous" before and after the change in procedures. As predicted, before-after differences were negligible, regardless of how "dangerousness" was operationalized.

It is possible that real differences were masked by changes in other characteristics of the patient population. To test for interactions between potentially confounding changes in patient characteristics and the proportion declared "dangerous" at each time, an analysis of variance was performed on the data, with the proportion of patients judged dangerous or nondangerous as the dependent variable. Tables 2 (narrow definition) and 3 (broad definition) reveal that there were no significant main effects and no significant interactions between time and patient characteristics of age (trichotomized), race, sex, or whether or not the patient was previously hospitalized for a psychiatric problem. Even with a more restrictive procedure, there was no increase in patient "dangerousness," nearly 50% were admitted without overt expressions of assaultiveness.

TABLE 1—*Proportion of "dangerous" patients.*[a]

Dangerousness	1974-75 (N = 133)	1977-78 (N = 218)
Narrow (actual assault)	54.1	54.6
Broad (actual or threat)	78.9	82.6

[a]Admitted under "order to apprehend" procedure before (1974-75) and after (1977-78) change in the court evolution process.

TABLE 2—*Analysis of variance for narrow definition of dangerousness.*[a]

Variable	Sum of Squares	Degrees of Freedom	Mean Square	F
F	0.00249	1	0.00249	0.23
S	0.15792	1	0.15792	14.71
R	0.01304	1	0.01304	1.21
A	0.00020	1	0.00020	0.02
T	0.04019	1	0.04019	3.74
FS	0.00505	1	0.00505	0.47
FR	0.11329	1	0.11329	10.55
SR	0.01684	1	0.01684	1.57
FA	0.00600	1	0.00600	0.56
SA	0.00451	1	0.00451	0.42
RA	0.00002	1	0.00002	0.00
FT	0.02645	1	0.02645	2.46
ST	0.05528	1	0.05528	5.15
RT	0.00353	1	0.00353	0.33
AT	0.00006	1	0.00006	0.01
All three-way interactions	0.25271	10	0.02527	2.36
All four-way interactions	0.15841	5	0.03168	2.95
Error	0.01073	1	0.01073	...
Total	0.86672	31	...	...

[a]F = former patient, S = sex of client, R = race of client, A = age of client, and T = time of petition.

Information provided by the hospital psychiatric evaluation facility on County OTAs admitted in 1976 and 1977 allows some measure of change in the perceived seriousness of patient pathology before and after the procedural change. It is not surprising to learn from Table 4 that the proportion of County OTAs processed was reduced in half from 269 in 1976 to 137 in 1977. The change was not the result of alterations in hospital policy or police procedures, and it is unlikely that there was a general improvement in the mental health of the community at this time. (If so, it was not reflected in a reduction of the overall hospital psychiatric patient census). It appears that the change in Probate Court procedures had the effect of reducing the number of OTAs. Mental health clinicians effectively screened those presented as mentally ill, but apparently focused on something other than assaultive behavior.

The other two sets of figures in Table 4 suggest that patients brought to the hospital under the OTA provisions in 1977 were perceived to be more seriously ill than those appearing in 1976. Of those evaluated at the hospital, the proportion admitted to inpatient evaluation or

TABLE 3—*Analysis of variance for broad definition of dangerousness.*[a]

Variable	Sum of Squares	Degrees of Freedom	Mean Square	F
F	0.00602	1	0.00602	0.26
S	0.36786	1	0.36786	15.95
R	0.01936	1	0.01936	0.84
A	0.00359	1	0.00359	0.16
T	0.10730	1	0.10730	4.65
FS	0.00050	1	0.00050	0.02
FR	0.05925	1	0.05925	2.57
SR	0.18681	1	0.18681	8.10
FA	0.04448	1	0.04448	1.93
SA	0.00200	1	0.00020	0.09
RA	0.19798	1	0.19798	8.58
FT	0.00004	1	0.00004	0.00
ST	0.01819	1	0.01819	0.79
RT	0.00000	1	0.00000	0.00
AT	0.00050	1	0.00050	0.02
All three-way interactions	0.37497	10	0.03750	1.63
All four-way interactions	0.10336	5	0.02067	0.90
Error	0.01073	1	0.01073	...
Total	1.50294	31	...	...

[a]F = former patient, S = sex of client, R = race of client, A = age of client, and T = time of petition.

TABLE 4—*Psychiatric hospital data.*[a]

Variable	1976[b]	1977[c]
Number of involuntary admitted OTAs by county	269	137
Proportion of total OTAs admitted by county receiving in-patient evaluation or treatment[d]	64.3%	72.9%
Average length of stay (days) of OTAs receiving some inpatient hospitalization for evaluation or treatment	6.9	10.3

[a]The numbers of patients for the hospital are not identical to those provided by the Probate Court, since hospital data reflect the total number of OTAs from the county in 1976 and 1977, while Probate Court petitions were available for 6 months in 1974-75 and a 16-month period in 1977-78.
[b]January 1 to December 31, before the change in court procedures.
[c]January 1 to December 31, after the change in court procedures.
[d]$Z = 2.29$; $P = 0.0107$.

treatment increased from 64.3% in 1976 to 72.9% in 1977. Further, the average length of stay for evaluation and treatment of those admitted OTAs increased from 6.9 to 10.3 days. According to the administrators and staff interviewed, the increases in length of stay and admission cannot be attributed to changes in hospital policy or greater availability of space. Other categories of patients did not show an increase in days hospitalized. Because OTAs comprise a very small proportion of the total population evaluated by the hospital (less than 5%), it is unlikely that their reduction in numbers caused added resources to be available for the longer stays. Indeed, the overall psychiatric patient population using this hospital has not changed significantly over the years. Finally, informally interviewed hospital personnel

were themselves under the impression that the OTAs being sent from County were "sicker" than those in the past. One possible inference from the findings is that the judge's changes resulted in screening for more severly impaired, not more assaultive, individuals. Once the OTAs were at the hospital, a second set of mental health clinicians were then more likely to admit them as patients.

Discussion and Conclusions

The findings suggest that movement to more restrictive commitment procedures (use of the dangerousness standard and requiring clinical evaluations) does not necessarily produce a larger proportion of assaultive patients among those admitted. However, it may lead to more carefully considered judgments and confinement of patients perceived to be more seriously ill.

The process described by Brooks [*10*], in which clinicians use the available statutory language to justify admissions of those considered seriously ill and in need of treatment, appears to be supported by the data. Thus laws that require dangerousness as a standard but leave its determination to the discretion of mental health clinicians may not produce a more assaultive group of patients, the outcome intended by the reforms (which are designed to ensure that only the assaultive are involuntarily confined). While this may imply that clinicians do not take the dangerousness standard seriously, it could be that they simply have a different conception of what "dangerousness" means. For mental health professionals, it could be a quality of impaired psychic functioning rather than previously demonstrated behavior. For them, the behavior may be insufficient, or even irrelevant, indicators of patient "dangerousness." The dynamic may resemble that described by Warren [*17*], in which legal and medical experts collaborate within the broad framework of the law to obtain hospitalization for those seen to be in need.

Unfortunately, too many pieces of information are missing for us to be confident of these interpretations and provide a more complete picture of the changing commitment process. Additional weaknesses derive from the particular sample. The population of OTAs may not be representative of the larger body of involuntarily committed civil patients. They are a special set whose friends and relatives sought court and police action to apprehend and bring them into a psychiatric facility for evaluation and treatment. Further, we have no way to assess the accuracy of the information contained on the petitions. As Hiday [*9*] cautions, petition reports may exaggerate the degree of assaultiveness. Affiants who are clearly motivated to seek hospitalization are encouraged by the procedures to make the patient look "dangerous," particularly under the more restrictive procedures. However, this makes it all the more remarkable that nearly half of those admitted had no reported prepetition acts of assault and that the proportion of assaultive patients remained virtually identical at each point.

Ideally, one would present comparable statistics for OTA patients from a county that did not undergo procedural changes (that is, a comparison group). Unfortunately, there were no other counties in the state that admitted all its OTAs to a single facility that could then produce comparable data for that particular population.

While this study investigates the move to an unspecified standard of dangerousness, more recent changes have resulted in statutes calling for "imminent dangerousness" as evidenced by "overt assaultive acts" [*18*]. This is part of a trend in which statutes have been pushing for more objective, less subjective definitions [*2*]. As such, considerable discretion (and hence power) is removed from the clinicians, making the decision one that can comfortably be made by any lay person or nonclinical participant in the judicial process. Clinical expertise in predicting dangerousness, which may have been illusory in the first place [*19*], is less essential with objective standards. Such a change could well produce a greater proportion of

assaultive patients among patients hospitalized under involuntary civil procedures, a phenomenon reported in some states [*20,21*]. Mental health clinicians finding it difficult to obtain confinement for patients perceived to be seriously ill (because they have not demonstrated dangerousness through their actions) are likely to express increasing frustration and continue to push for the kind of procedures that they feel will better balance the rights of their patients with a need for treatment.

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