Information

Civil Commitment Considerations in California

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BEFORE THE Lanterman-Petris-Short Act, the state of California lacked adequate procedural guidelines for the involuntary care and treatment of the mentally ill. The previous body of laws, which afforded less protection for civil rights or provision of timely treatment, failed to deliver consistent and acceptable health care to a significant patient population. The Lanterman-Petris-Short Act was written with the following goals: to end indeterminate commitments, to ensure reasonably prompt evaluation of civilly committed persons, to enhance public safety and to safeguard the civil rights of the mentally ill. This legislation was first introduced in 1967 and implemented in 1969. The Lanterman-Petris-Short Act has proved both innovative and durable and has served as the prototype for mental health laws in many other states. There have been no radical changes in the outlined procedures since its inception. Yet, 15 years after enactment of the law, many clinicians and mental health workers are still not acquainted with civil commitment procedures, this despite a rather frequent utilization in California. For fiscal year 1983-1984, a total of 77,738 people were detained for 72-hour evaluation and treatment. Of those, 29,593 were placed on 14-day certifications, 217 were placed on 180-day certifications for danger to others, temporary conservatorships were obtained for 8,224 and permanent conservatorships were either renewed or granted for the first time for 12,758. Preliminary data from California's Department of Mental Health show an increase in the number of 72-hour and 14-day detentions between fiscal years 1983-1984 and 1984-1985. In fiscal year 1984-1985, the number of people detained for 72-hour evaluation and treatment rose to 86,777, and 33,034 persons were placed on 14-day certifications; 180-day certifications in fiscal year 1984-1985 numbered 15 fewer than in the previous year.

Section 5150 of the California Welfare and Institutions Code reads as follows:

> When any person, as a result of mental disorder, is a danger to others, or to himself or herself, or gravely disabled, a peace officer, member of attending staff, as defined by regulation, of an evaluation facility, designated members of a mobile crisis team, or other professional person designated by the county may, upon probable cause, take, or cause to be taken, the person into custody and place him or her in a facility designated by the county and approved by the State Department of Mental Health as a facility for 72-hour treatment and evaluation.[1]

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This quotation serves as the basis for starting civil commitment. It is the purpose of this article to use the prototypal guidelines of the Lanterman-Petris-Short Act to elucidate the legal concepts involved in evaluating a mentally ill person for initial involuntary psychiatric admission to hospital and to examine other pertinent civil commitment considerations.

Dangerous and Grave Disability

Is a person dangerous? This is the first question to answer before someone is committed. Most states have three criteria for commitment. One may be a danger to oneself, a danger to others or gravely disabled. Often a person may meet more than one of these criteria. The determination of dangerousness or grave disability calls for a judgment on the part of an evaluating physician. Accordingly, in evaluation one must take into account the requirement of civil commitment law that this danger be physical or behavioral in nature. People who are mentally ill and need treatment cannot be forced into treatment unless they present a risk of harm to themselves or others.

The most common danger to self is a planned or attempted suicide. In these cases, it is important to determine the risk factors for suicide. This will be the basis for the decision to release or commit a patient who was brought for evaluation. Risk factors that are associated with committed patients include recent or acute suicide gestures, definite suicide plans and a previous history of serious suicide attempt. In contrast, factors that are associated with patients who are not committed are passive rather than active death wishes, no suicidal plan, no previous attempts and being future oriented. A nonsuicidal person may also be a danger to himself. For example, a manic person may endanger himself through a delusion that it is his duty to direct traffic on a busy highway.

The concept of grave disability is frequently misunderstood and abused. It was intended to make it easier for mental health services to provide involuntary patient care for persons who clearly cannot take care of themselves. The inability to provide food, clothing or shelter for oneself is a demonstration of grave disability according to California Welfare and Institutions Code. Not all states have this criterion for civil commitment. New York, for example, lacks this standard. For all intents and purposes, grave disability is an extension of danger to self. Only in this case, the danger is not as imminent as say, threatening to jump off a bridge. Because gravely disabled behaviors are not spelled out in the law in New York, it is more difficult there to commit patients who are deteriorating but not imminently dangerous to themselves.

To document grave disability is sometimes difficult. Here are some more basic examples: a patient with agoraphobia who has become so phobic he can no longer leave his home to get any food, a manic patient who is so psychotic he insists on walking in public without clothes, a schizophrenic patient who is so disorganized he no longer uses the toilet, a patient with Alzheimer's disease who continually wanders from home and cannot get back. These examples of grave disability

do not include people who do not have clothes, do not have shelter or do not have money to buy food. In this day and age, there are enough social resources to provide these necessities of life to those who can figure out how to tap into these resources. Gravely disabled people are those who fail to make use of these social services even when given specific instructions. They cannot get through the basic activities of daily living without someone else's help. Documentation should be a clear description of behavior that avoids jargon. For example, a vague description of a gravely disabled schizophrenic person would be as follows: "the patient is so psychotic that he is gravely disabled." A better description would be as follows, "the patient believes that the next-door neighbors are spying on him and refuses to leave his house to buy food." This principle of using a clear description of behavior and avoiding the use of technical jargon also applies to describing patients who are a danger to themselves or others.

Danger to others may be indirect or direct. Direct dangers posed by mentally ill persons are usually in the form of a threat or a physical assault. Usually through history from witnesses or the patient, threats or homicidal gestures can be substantiated. What is more frequently missed are those patients who are significantly disturbed and whose impaired judgment makes them a danger to others. For example, an acutely psychotic schizophrenic person may not be homicidal but is an obvious danger to others if he insists he always has the right of way when he drives his car.

An onerous but necessary aspect of dangerousness to others is the requirement to warn named victims. Two landmark court cases defining physician liability are *Tarasoff versus UC Regents*[2] and *Jablonski versus the United States*.[3] The important points to remember are to

- Review all available records and document the effort.
- Document carefully the reasons for finding a patient dangerous or not dangerous to others.
- Document fully your effort to contact the named victim or, if unable to do so, to contact the respective law enforcement agency.

Mental Illness

Civil commitment requires that dangerous behavior be the result of a mental disorder. Persons who are found to be dangerous or gravely disabled but not as a result of a mental illness do not qualify for civil commitment. The Lanterman-Petris-Short Act defines a mental disorder by any diagnosis listed in the DSM-III (*Diagnostic and Statistical Manual of Mental Disorders*, third edition).[4] Schizophrenia, major depression, bipolar affective disorder and organic brain syndromes, especially drug and alcohol induced, are frequently found in patients placed on 72-hour holds. Other DSM-III diagnoses, such as personality disorders, adjustment disorders, psychosexual disorders, anxiety disorders, disorders of impulse and somatoform disorders are uncommon grounds for civil commitments, because the latter are less likely to disturb reality testing. Commitment requires a mental illness accompanied by behavior dangerous enough to warrant incarceration. Many persons with schizophrenia are part of the "street people" population and are often brought to hospital emergency rooms for involuntary commitment because of their bizarre behavior. If they are not grossly psychotic, admission to hospital is inappropriate. For legal purposes, significant psychotic processes or mental illnesses are those that cause dangerous behavior. Psychiatrists are frequently consulted when medical or surgical patients refuse life-saving treatment. These patients appear dangerous to themselves. Yet even in these situations, an involuntary hold should not be placed unless a mental disorder is definitely present and severe enough to impair the patient's ability to give informed consent. Civil commitment laws were not intended to provide involuntary medical care. If a patient is unable to give informed consent, a judicial review should precede the implementation of life-saving medical care in nonemergency situations. Commitment requires the presence of a mental illness severe enough to impair judgment and prevent the patient from making reasonable decisions or understanding the consequences of those decisions. The ambiguity here can make disposition difficult, but it is this ambiguity that gives the law flexibility.

Upon Probable Cause

Different standards of proof are used for evidence in making legal decisions. The law regarding an initial civil commitment in the California code uses a less restrictive standard than "beyond a reasonable doubt." California civil commitment law uses the term "upon probable cause." Some other states use the "clear and convincing" standard. What does this mean in a practical sense? In gathering data to evaluate a patient for civil commitment, direct observation of dangerous behavior is not required. For example, if a family reports that a relative has made a serious suicide attempt, even though he denies it, the patient may still be admitted involuntarily. In this and every case, besides the current history gathered from the patient and the patient's family, evaluation should include past psychiatric history, observations from a mental status examination, history from other observers and an estimate of the reliability of the sources of information. What would a reasonable physician do given the preceding list of information? This is the question to guide an evaluation and disposition for commitment. If in this example the patient had a history of past suicide attempts, recently suffered a severe psychosocial stressor and showed clinical signs of depression, psychiatric confinement is clearly indicated. Unfortunately, many cases are not that clear. Here is where experience, clinical intuition and consultation are valuable assets to reaching a decision. For the most part, physicians prefer to err on the conservative side and perhaps commit people who may not be imminently dangerous. The gathering of as much data as possible is of utmost importance, for it can only aid the evaluation process.

Alternate Dispositions

Just because a patient meets the requirements for civil commitment does not mean that that patient must be involuntarily committed. Civil commitment law gives the authority to commit "holdable" patients, but does not require it. There are commitable patients for whom alternate dispositions should be considered. For example, persons with chronic alcoholism are frequently brought into a hospital for gravely disabled behavior when inebriated. While intoxicated, they meet the criteria for grave disability. Simple intoxication, however, is not an appropriate indication for admission. A more appropriate disposition for these persons would be a

detoxification center, not a psychiatric or a medical ward. The county sheriff's "drunk tank" should also be considered for patients refractory to treatment. Hospitalizing alcoholic patients while drunk, then releasing them when they are dried out, is a disservice to both the patients and the hospital. This would be an example of holding a patient without giving needed treatment. Patients with character or personality disorders are another source of difficult disposition. For these patients, county jail may be a more appropriate place than a hospital. Sometimes social work services can be an alternate source of disposition rather than psychiatric services for gravely disabled elderly patients with primary degenerative dementia.

In general, it is appropriate to admit to psychiatric wards patients who are suicidal. Some patients who are a danger to others or gravely disabled should not be admitted via civil commitment, however, and alternate dispositions should be considered. In these cases, the best interests of the patient, hospital, family and community should be kept in mind. Sometimes looking at these other interests makes placement out of a hospital the best disposition for everyone, including the patient.

Summary

Here are the salient points to remember about commitment.

- Besides being mentally ill, a patient must also be at least one of the following: a danger to himself or herself or to others or gravely disabled to be committed. Need of psychiatric treatment is not enough to fulfill the requirements of the law.
- A patient can be both dangerous and mentally ill but still not meet the commitment standard. A patient's dangerous behavior or grave disability must be a result of a mental disorder.
- Gravely disabled persons are those who lack the ability to make use of food, clothing and shelter when they are available. Simply lacking food, clothing and shelter does not fulfill the gravely disabled criterion.
- Civil commitment law was not intended to be used to force medical or surgical treatment on patients who are competent to refuse life-saving treatment.
- In evaluating a patient for involuntary admission to a psychiatric hospital, the physician need not be an eyewitness to reliably reported dangerous or gravely disabled behavior.
- Probable cause or clear and convincing cause implies that a physician make a reasonable decision such as any other physician would make, given the information, past and present, about the particular patient and situation.
- Even if a patient meets all the commitment criteria, physicians are not required to admit a person involuntarily to a hospital. Furthermore, under some circumstances some of these patients should not be admitted. Sometimes other dispositions are more appropriate.

Evaluating patients for civil commitment is very difficult and precarious because of the unpredictable nature of mentally disordered patients. To evaluate without any idea of what legal considerations are involved is hazardous at best. When evaluating a patient for involuntary psychiatric treatment, considering the concepts of dangerousness, grave disability, mental disorder, probable cause and alternate disposition should help reduce the uncertainty surrounding this unpopular process.

REFERENCES

1. California Welfare and Institutions Code. Division 5. Community Mental Health Services, Part 1. The Lanterman-Petris-Short Act. Chapter 2. Involuntary Treatment, Article 1. Detention of Mentally Disordered Persons for Evaluation and Treatment, Section 5150. Sacramento, State of California Department of Mental Health, Jan 1, 1983

2. *Tarasoff v University of California Regents*, 131 Cal Rptr 14,551 P2d 334(Cal1976)

3. *Jablonski v United States*, 712 F2d 391 (9th Cir 1983)

4. Diagnostic and Statistical Manual of Mental Disorders, 3rd Ed. Washington, DC, American Psychiatric Association, 1980