Involuntary Psychiatric Hospitalization

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INDETERMINATE COMMITMENT of the mentally ill was abolished in California July 1, 1969. In its place, a variety of procedures were established for time-limited involuntary detention of certain mentally disordered persons. This system now has been in use long enough to permit an early appraisal of some of the effects.

For a number of years, mentally ill citizens of California could be committed to a mental hospital if they were dangerous to themselves or to the person or property of others, *or if* they were in need of care, supervision, treatment or restraint. The latter provision could be construed to permit wide latitude in its aplication. Examining physicians appointed by the Superior Court were the determiners of the person's need for care, supervision, treatment or restraint, and the criteria they used might vary from county to county and circumstance to circumstance. Counties that had a variety of community facilities that could serve mentally disordered people used the commitment laws and the state hospitals less than other counties which had fewer such facilities. There were considerable variations from one part of the state to another in the utilization of state hospital beds for elderly senile persons who were mentally disordered on the basis of organic disease of the central nervous system. Some of the counties preferentially placed such persons in the state hospital, while other counties rarely used state hospitals for them, utilizing local nursing facilities instead.

In some counties the court review procedures in commitment cases were perfunctory; in others there were agencies which screened proposals for commitment with considerably more care.

A person committed to a state hospital forfeited a variety of civil rights—voting rights, driver's license, and professional licensure, to mention the most important. Apart from the court procedures which dealt chiefly with public hospitalization, it was possible for a person to be hospitalized in a private psychiatric hospital for a period up to 90 days solely on the basis of medical certification. Such hospitalization did not entail forfeiture of civil rights, however.

A subcommittee of the California Assembly Ways and Means Committee had been formed to deal with the general subject of mental health. This subcommittee undertook to examine the laws and procedures related to involuntary hospitalization of the mentally ill. In 1967, a preliminary document was issued by the subcommittee, entitled *The Dilemma of Mental Commitments in California.* This report condemned involuntary hospitalization procedures then in use and criticized psychiatrists and the courts alike for their participation in them. The chairman of the mental health subcommittee subsequently sponsored legislation which undertook a total reconstruction of the procedures for involuntary hospitalization. There was much debate on the underlying philosophy of the new law, as well as on the specific procedures proposed. The matter carried through two sessions in the state legislature, ending with the Mental Health Act of 1967.

The new law, as it finally emerged, besides

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setting procedures for involuntary hospitalization, included a broad revision of the state's community mental health services program which had been in effect since 1957. Even before the new law went into effect, an interim measure had been pased in the legislative session of 1967, providing that court commitment for mental disorder might be made only on the basis of dangerousness *and* the need for care, supervision and treatment, rather than on the basis of one *or* the other of these conditions.

The California Mental Health Act of 1967

As had the previous laws, the new law, known as the Lanterman-Petris-Short Act, provided for emergency detention for treatment and evaluation for 72 hours in cases where a mentally disordered person was in need of immediate detention. It also allowed petitions alleging mental disorder to be filed by relatives, friends or others. However, such petitions under the new law did not eventuate in indeterminate commitment, but only in a court order for 72-hour detention for treatment and evaluation. In other words, all involuntary hospitalization for mental disorder would now begin with the 72-hour evaluation process. This process was only justified, however, where the mentally ill person was judged to be a danger to himself or to others, or where he was judged to be gravely disabled. Grave disablement, a condition specified by the new law to cover those non-dangerous persons who were so incapacitated as to require involuntary detention, was defined as inability to provide for one's basic needs of food, clothing or shelter.

"Grave disablement" has been the thorniest aspect of the new mental health law, since its interpretation was so imprecise as to permit wide variations from area to area in its application. In some counties it has been taken to mean that the person must be so incapacitated as literally to be unable to feed, shelter or dress himself. In others it has been construed as meaning that the person is unable to carry out his normal life activities, to work at a job or to manage a household.

Once admitted for the 72-hour period of treatment and evaluation, the person may elect to remain in hospital for further treatment if he wishes to. If not, unless the preliminary evaluation confirms the judgment of dangerousness or grave disablement, he must be discharged by the end of that period. If he is judged to be dangerous or gravely disabled, he may be placed in a facility for intensive treatment for a period not to exceed 14 days on the basis of medical certification and without a court procedure. However, since he then is being detained longer than the 72-hour emergency period without due process of law, he has to be informed of his right to contest the medical certification and to have legal assistance if he wishes to do so. If he does not contest the certification, or if he does and it is upheld, he may be held for the 14 days, for treatment.

By the end of the 14 days, if he is not discharged and does not elect to remain voluntarily, further detention in hospital can be justified in three different ways, depending on whether he is considered dangerous to himself, dangerous to others, or gravely disabled. If dangerous to himself, he may be certified *once more only* for an additional 14 days. If he is considered dangerous to others, the facility treating him may apply to the court for post-certification treatment for a period not to exceed 90 days in a facility designated for that purpose. This procedure requires a formal court hearing, and it has been very little used since the law went into effect. If the person is felt to be gravely disabled, a recommendation may be made for the establishment of a conservatorship of his person or of his person and property. This also requires a court procedure, and it is also time-limited, being for a maximum of one year. In case of dangerousness to others, both the post-certification treatment and the conservatorship can be renewed if justified, but each renewal requires a further court procedure. The intent of all this was to avoid indeterminate detention of any kind.

The looseness of the concept of "grave disablement," referred to above, has been illustrated in a practical sense by some follow-up studies done in two California counties.[1,2] In one county, there were 345 recommendations for conservatorship during the first seven months under the new law, and 186 of the 345 recommendations eventuated in establishment of conservatorships. In the other county, only 34 recommendations were made and only 11 granted in the same period. Although the first of these counties had almost twice the population of the second, the rate

of recommendations for conservatorship per 100,000 population was almost six times as high in the first county as in the second, and the rate of granting of conservatorship was almost ten times as high. This data illustrates well the point made by Glass[3] that admission procedures are determined less by laws than by philosophies.

Philosophies Regarding Involuntary Hospitalization

The issue of involuntary hospitalization of the mentally ill has been a matter of sharp disagreement and debate for many years. The motives for such involuntary detention vary from protection of the community, to protection of the ill person, to detention for the purpose of treatment; and these varying motivations are often blurred and mixed with each other. A scholarly review by Curran of commitment laws in the United States[4] traces the history of the varying philosophies which have marked such procedures. Largely owing to the persistent efforts of Mrs. E.P.W. Packard, commitment laws in the 19th century were developed on the model of criminal procedures. Curran refers to this as the period of the "romance with the criminal law." Mrs. Packard promoted laws which were often referred to as a "bill of rights for the mentally ill." This was an interesting misnomer, since these bills were most often established to prevent the committing of persons who were not mentally ill, and they were really concerned with "innocent" people who someone might wrongly wish to have put away, rather than with those who were actually mentally ill. Curran points out that this emphasis led to a lack of concern for the treatment accorded to the mentally ill, since the only matter of concern was whether a well person might be committed. Once a person was judged to be actually ill, he might well end up in a hospital whose atmosphere was more like jail.

Moreover, this focus on procedures akin to those of the criminal law tended to cast the mentally ill into the role of wrongdoers. The reaction to this state of affairs led to what Curran calls the "romance with psychiatry" in the late 1940's and the 1950's. This reaction culminated in the 1952 Draft Act Governing Hospitalization of the Mentally Ill, which was prepared by the Federal Security Agency as a model for state laws. It provided for informal admissions to hospitals, but it removed the legal safeguards of the earlier period, leading to a backlash from those who were concerned lest commitment laws be used for political purposes. By the mid-1960's came what Curran calls the "period of disenchantment," in which attention was paid more to what kind of treatment patients received in hospitals and to the difficulties in getting out of hospitals, rather than to the problems of getting into them.

Goffman's work[5] provided graphic illustration of the ways in which mental hospitals were much like jails, as patients would experience them. In a less accusatory way, Smith[6] pointed out how the logic of a custodial organization would differ from that of an organization oriented to treatment and return to the community. She suggested that involuntary hospitalization implies a kind of parent-like guardianship over the patient. The staff in a custodial institution comes to be concerned less with what is *likely* to happen as a result of some policy, and more with what might *possibly* happen. Such a focus leads to conservatism and an avoidance of risk-taking which prolongs the stay in hospital and further fosters dependency and institutionalism.

Szasz[7,8] is more sharply critical of involuntary procedures for hospitalization of mentally disordered people, and holds that the idea of mental illness is a myth, rather than a reality. He and, more recently, Leifer[9] suggest that our society needs to avoid admitting that it wishes to use mental hospitals to control the deviant behavior of its citizens and to preserve social order. The medical model is seen as a subterfuge to avoid that admission. Few psychiatrists would subscribe to Szasz's and Leifer's arguments in precisely the form in which they state them. However, many psychiatrists would agree that over the years the mental hospitals in the United States came to be used as custodial institutions for sequestering disturbed people, rather than as hospitals in the usual sense of medical facilities for the intensive treatment of the ill.

Roemer[10] takes a more moderate position in speaking of the need to balance the patient's right to free choice with society's right to improved mental health and functioning of its citizens. She holds that the proper question is, "Under what circumstances is compulsory hospitalization justified?"

It is common for those who are opposed to compulsory hospitalization to argue that such procedures are not necessary in the case of physical illness and that they should, therefore, not be necessary in mental illness. Such arguments seem to ignore an essential difference between physical and mental illnesses: physical illnesses do not generally impair the mental functions by which a person determines a course of action. A man with a broken arm may choose not to go to the doctor. Others may deplore his decision but will generally not use other means than persuasion to change his mind. He may have a variety of reasons, sound or unsound, for his decision; but there is no thought that the fracture impairs his mental functioning or makes him unable to choose in his own best interest. In cases where organic illness impairs judgment, as where a toxic state due to organic disease causes mental confusion and judgment, what usually happens is that the confusion itself makes the person more easily persuaded to sign a voluntary hospitalization form. In such cases, no one asks whether he is mentally clear enough to know what he is doing, as would be asked in the analogous case of a confused person signing himself into a mental hospital. If a person's mental functioning is impaired by physical illness but he is not confused enough to be coaxed into signing for voluntary treatment, he is automatically placed in the category of having a mental illness due to organic brain disorder, and this places him in the category of "other" mental patients. In point of fact, many people with physical diseases who are unwilling to be treated as their doctors wish, are coaxed, bullied or frightened into "voluntarily" agreeing to be treated for their illness. Yet such coerced volunteering never seems to arouse the same concern that coercion in the case of mental illness does.

Minors, the mentally retarded and persons with senile impairment who have had guardians or conservators appointed for them are denied the right to determine whether they will be treated or not. Their parents or guardians are permitted to make that decision for them. Thus, it is clearly accepted in our society that not every person may determine whether he will be treated or not. The basis for denying a person that right is the determination on one ground or another that he is not capable of using normal adult judgment in planning for himself. It does not seem to be so alien a concept that a person whose illness impairs his ability to make rational judgments might be as much unable to determine whether he will be treated as might a person too young, too lacking in intelligence or otherwise too impaired to do so. If mental disorders were as susceptible to cure or remission as some physical disorders, there would be far less concern about involuntary psychiatric hospitalization. It seems evident to the authors that the great concern about the matter relates to the fact that people have been involuntarily hospitalized in mental hospitals over the years without being effectively treated or returned to their homes and communities. It is the custodial atmosphere of the old state mental hospitals and the chronic incarceration of patients which makes such concerns understandable. The current focus on rapid treatment and return of such patients should lessen the concern about involuntary hospitalization.

Recent developments in England and in some other states of this country have focused on promoting informal voluntary hospitalization and establishing procedures whereby patients might protest against involuntary detention. The English Mental Health Act of 1959 replaced or modified over 50 previous acts. Laughlin[11] reports it is estimated that 95 percent of all patients who enter medical hospitals in England do so informally. However, Barton and Haider[12] reviewed the admissions to one English hospital in the period 1961 to 1964, and reported that 182 out of 1560 total admissions were made under a section of the law providing involuntary hospitalization in emergencies. They concluded from their review that in only 73 of the 182 cases did the record demonstrate justification for admission under the terms of that provision.

Curran[4] reports that New York, Illinois and the District of Columbia all passed laws in 1964 and 1965 emphasizing voluntary admission and abolishing civil disabilities. However, the evanescent nature of "voluntariness" is illustrated by Glass's comment[3] that patients on one kind of "voluntary" admission must give 15 days' notice before leaving against medical advice, while those on another kind of "voluntary" admission must give 60 days' notice. The New York law in 1964 provided for a kind of informal admis-

sion in which a patient might leave at any time, with no coercive alternative available to the hospital. McGarry points out[13] that Dr. Walter Barton established a similar procedure in Massachusetts in 1959, at Boston State Hospital. However, it was little used until the mid-1960's, according to McGarry.

Another feature of the New York law was the establishment of a Mental Health Information Service, which acted as a sort of ombudsman for hospitalized patients, informing them of their rights to review of their admission. Bigelow was critical of the New York law[14] and especially of the provision which required the hospital physician to take the responsibility for the decision to admit the patient. This latter is, incidentally, a feature of the California law: and it was one of which many California psychiatrists were critical, since it made the hospital physician into an adversary of the unwilling patient, and was expected to make his subsequent treatment of the patient more difficult. Bigelow's estimate was that about 20 percent of patients should not be admitted on a voluntary basis. This is at some variance with the experience in England. It may represent a more conservative view on Bigelow's part, or may reflect a social difference betwen the two countries.

Greenland compares[15] the provisions for appeal against commitment in England, Canada and the United States, indicating that a relatively small proportion of involuntarily detained patients actually pressed such appeals, and an even smaller number were ordered to be discharged as a result of such action.

Impact of the California Law

The senior author of this paper became chief of the adult inpatient service of Orange County Medical Center, the only county hospital for a county of 1.4 million people, in September 1969, two months after the new law became effective. In an attempt to monitor the effects of the law, data were collected for the month of October, 1969, and also for October, 1968. The data for the two years had been reported in differing form, making comparisons only partially feasible. It is planned to conduct a continuing study of the nature of admissions and subsequent legal status of patients in Orange County, in order to secure a sequential record of the change in legal status of patients. In future years, more complete comparisons will be possible. For purposes of this comparison, it is planned to collect data on all admissions to the hospital in October of each year. October was chosen primarily because the patients at the Medical Center are cared for by psychiatric residents, and the residents begin their training year in July. It is anticipated that by October they will have become reasonably familiar with hospital and legal procedures and will be functioning effectively.

TABLE 1.—*Comparison of Legal Status of Psychiatric Patients at time of Admission to Hospital, before and after Lanterman-Petris-Short (LPS) Act*

Legal Status	*Pre-LPS*	*Post-LPS*
Voluntary	13.3%	31%
Involuntary	61.1%	65.1%
Other	25.6%	3.9%

The present paper will present preliminary data whose importance is that they represent the effect of the changes in the law for the first year under it.

Method

There were 293 admissions to the adult inpatient service in October 1968, and 235 in October 1969. The October 1968 sample will be called the "pre-LPS" (Lanterman-Petris-Short) group and the October 1969 sample will be called the "post-LPS" group.

The variables to be compared are *legal status* (that is, voluntary and involuntary), *diagnosis* and *length of stay*. These were tabulated from the Department of Mental Hygiene, Bureau of Biostatistics. Individual Patient Summary Forms 1794 and MH 1580, for the 1968 and 1969 samples respectively.

Results

Table 1 shows that the proportion of involuntary admissions did not change significantly from 1968 to 1969 but the proportion of voluntary admissions more than doubled. The change in proportion of voluntary admissions was at the expense of a category designated "other." Such admissions were not involuntary in a formal sense, but included informally "pressured" admissions such as hospital admission as a condition of probation. There is at present no way of

determining exactly how voluntary the "other" admissions were in the pre-LPS sample. For this reason, the data presented in Table 1 do not permit any firm conclusions to be drawn as to the impact of the law on legal status.

There is one other fact worth commenting on: The 1969 data permit recording of change in legal status from voluntary to involuntary and from involuntary to voluntary. Such changes were not recorded in the statistics for 1968 and the two samples cannot, therefore, be compared in this regard. In the post-LPS group, only two patients who entered voluntarily were changed to involuntary status during hospitalization. On the other hand, 35 who entered involuntarily were changed to voluntary status while they were in hospital. As to legal status at the time of discharge for the 1969 sample (post-LPS), 44.3 percent were on voluntary and 55.7 percent on involuntary status. Again, this finding cannot be compared with the 1968 sample (pre-LPS) because data of that kind were not recorded on the statistical summary sheets used in 1968.

Table 2 shows data on length of stay as related to legal status. Involuntary patients stayed for a shorter time than voluntary patients in both the pre-LPS and the post-LPS groups. Length of stay was shorter for the post-LPS group than for the pre-LPS group, both for involuntary and for voluntary patients. More than half of the post-LPS voluntary patients stayed for six days or less, compared with less than one-third of the pre-LPS voluntary patients. In comparing involuntary patients, the proportion of those who stayed less than six days rose from 56.25 percent pre-LPS to 95.5 percent post-LPS. This finding is significant at the 0.05 level of confidence.

Length of stay in relation to diagnosis (the five major diagnostic categories) is shown in Table 3. The shift to shorter hospital stays post-LPS was noted in all categories, except transient situational reactions. In that category there appeared to be no significant change from pre-LPS to post-LPS. The most striking shifts in duration of stay from pre-LPS to post-LPS were in the schizophrenia and neurosis groups.

TABLE 2.—*Length of Hospital Stay for Voluntary and Involuntary Psychiatric Patients before and after Lanterman-Petris-Short Act*

	Voluntary		*Involuntary*	
Number of days in hospital	*Pre-LPS*	*Post-LPS*	*Pre-LPS*	*Post-LPS*
6 or less	30.8%	54.75%	56.25%	95.5%*
7 to 15	38.5%	23.7%	29.8%	3.9%
16 or more	30.7%	21.55%	13.95%	0.6%

* Significant at the 0.05 level.

Conclusions

Only limited conclusions can be drawn from this first study. They are limited in part by the fact that the forms on which data were collected changed from pre-LPS to post-LPS, making comparisons uncertain. Even so, the data appear to show that the major effect of the change in the law for the first year in Orange County was to shorten the length of hospital stay for patients, and especially for involuntary patients. This change held for all the most frequent diagnostic groups except for patients with transient situational disturbances. Patients in this group stayed a relatively short time pre-LPS *and* post-LPS.

The data show a clear increase in the proportion of patients who were unequivocally voluntary, but this change was not accompanied by a decrease in the proportion of patients who were unequivocally involuntary. Rather, the shift appeared to be one in which fewer patients were hospitalized in categories other than clearly voluntary or clearly involuntary, and the decrease in this category was accompanied by the increase in clearly voluntary admissions.

TABLE 3.—*Length of Stay in Hospital for Psychiatric Patients of Major Diagnostic Categories, before and after Lanterman-Petris-Short Act*

	Schizophrenia		*Transient Situational Disturbance*		*Neurosis*		*Personality Disorders*		*Drug Dependence*	
Number of days in hospital	*Pre-LPS*	*Post-LPS*	*Pre-LPS*	*Post-LPS*	*Pre-LPS*	*Post-LPS*	*Pre-LPS*	*Post-LPS*	*Pre-LPS*	*Post-LPS*
6 days or less	27%	72.5%	75.1%	72.3%	26%	83%	45%	74.5%	57%	73.3%
7-15 days	52.5%	9.5%	6.6%	15.3%	42.5%	8.5%	34%	14.5%	4.3%	20.8%
16 days or more	20.5%	18%	18.3%	12.4%	31.5%	8.5%	21%	11%	38.7%	5.9%

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