Indochinese Patients in the Civil Commitment Process

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This paper examines in detail the involvement of a group of Indochinese patients in the Oregon Civil Commitment process in the calendar years of 1985 and 1986. The authors found that there was no apparent difference in the rate of commitment as contrasted to the overall commitment rate of the general population. The results also indicated that there was heavy reliance on the Indochinese Psychiatric Program and staff to divert the involuntary Indochinese patients out of the commitment process. Furthermore, comparing the involuntary Indochinese patients to a randomly selected cohort of Indochinese patients hospitalized in the same period revealed no differences in demographic data, diagnosis, and treatment history except that the involuntary group was significantly younger and predominantly male. Finally, the follow-up study of the two cohorts showed high rates of hospitalization, noncompliance, and treatment drop-out.

Despite the fate that a great deal of research on various aspects of civil commitment has been done in recent years,[1-9] only a few studies have examined the effect of the civil commitment process on ethnic minority individuals.[1,2] In a New Zealand study,[1] it was found that Pacific Islanders were underrepresented in total psychiatric admissions, yet overrepresented in commitments. The authors concluded that the civil commitment process led to hospitalization of members of this ethnic minority group who would not seek voluntary treatment. The authors of another paper noted a difference in the rates of involuntary commitment for blacks and whites, but found no evidence to support the hypothesis that racial bias in the commitment and detention processes accounted for the disparity.[2]

The main objective of this paper is to examine in detail the involvement of a group of Indochinese patients in the civil commitment process in Oregon during calendar years 1985 and 1986. We begin with a brief description of Oregon's commitment process and present an overview of the Indochinese patients cared

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for in our system. We then present the data concerning our study and conclude with a discussion of the results and their programmatic and research implications.

The Civil Commitment Process in Oregon

Oregon's civil commitment statues have evolved through several stages. Their content and process have been described previously in detail[3-9] and will be reviewed only briefly here (Fig. 1). At the time of our study, a person could enter the civil commitment process at the local level as a result of a petition filed by two persons or by an emergency "hold" initiated by a peace officer or by two physicians. Subsequently, a mental health professional from the local community mental health program would conduct an investigation and make a recommendation to the judge concerning whether or not there was probable cause that the detained person was "mentally ill." Oregon statutes state that a "mentally ill" person is "a person who, because of a mental disorder, is either (a) dangerous to himself or others or (b) unable to provide for his basic personal needs and is not receiving such care as is necessary for his health or safety."[10] If the judge believed that probable cause of mental illness existed, the person was scheduled for a commitment hearing. If the judge at the hearing believed that clear and convincing evidence of mental illness existed, the person could be referred to voluntary treatment, placed on conditional release, or committed to the Oregon Mental Health Division (OMHD) for 180 days. If committed to the OMHD, the person could be placed in an Oregon state hospital or referred to another hospital or nonhospital community program at the discretion of the OMHD.

For non-English speaking persons, every attempt was made to provide the service of a bilingual and bicultural interpreter throughout the process. In the court hearing the interpreter was often required to perform verbatim translation during cross-examination.

Indochinese Patients in Oregon

The Indochinese are a diverse group of southeast Asians from the old French colony, Indochina. They include Vietnamese, ethnic Chinese, Cambodians (Khmer), Laotians, Hmong, and Mien. As a result of the Vietnam conflict, these people came to the United States as refugees and have been identified as a group. Since 1975, more than 800,000 Indochinese have resettled in the United States. From the beginning of this immigration Oregon has been one of the 10 states with the highest Indochinese population.

Several authors have described in detail the social adaptation, effect on health and mental health, and treatment issues of the Indochinese.[12-14] In 1978 the Indochinese Psychiatry Program was established within the Department of Psychiatry at Oregon Health Sciences University to provide mental health care to the Indochinese patients. Its development has been reported elsewhere.[15, 16] Currently the program serves about 95 percent of the Indochinese psychiatric patients in the Oregon public system and regularly receives referrals from the

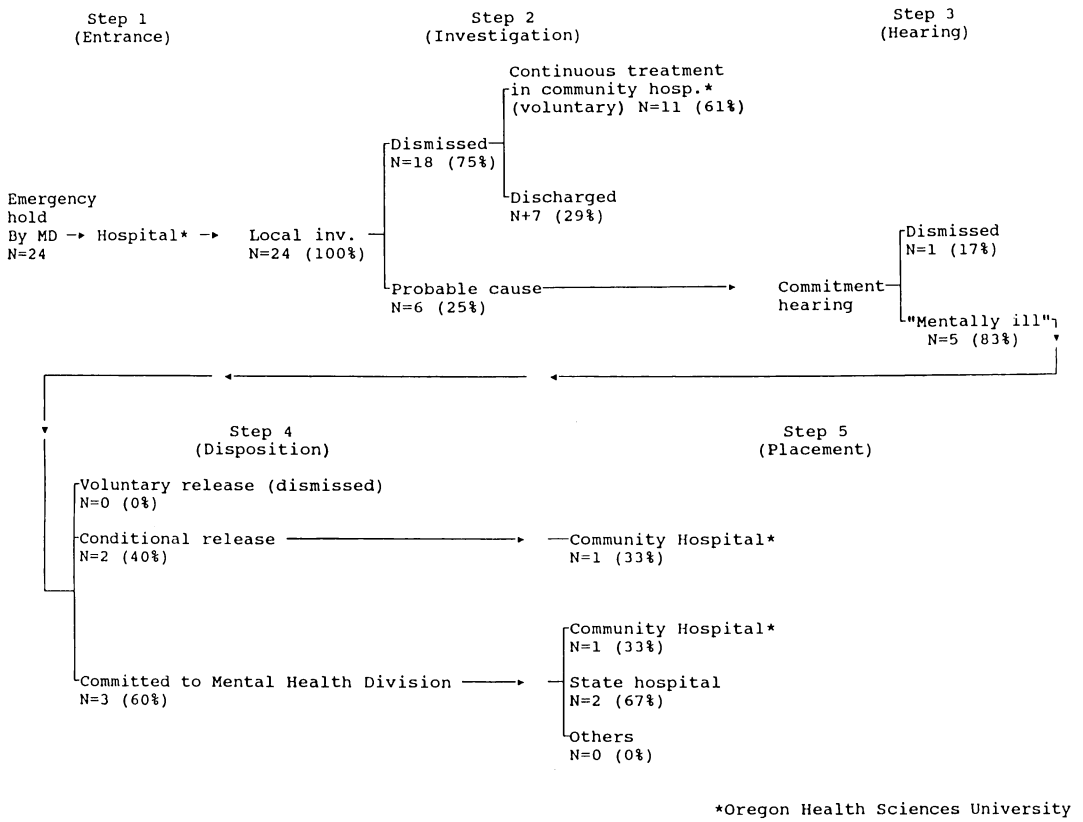

Figure 1. Indochinese patients in the civil commitment process.

southwestern region of the state of Washington. The program has an active case load of 360 outpatients. In addition, the psychiatric emergency room and inpatient services are readily available at Oregon Health Sciences University to provide care for these patients.

Methodology

The methodology employed in this study consisted of three components. First, all inpatient admissions of Indochinese patients to Oregon Health Sciences University for the calendar years of 1985 and 1986 were reviewed and involuntary admissions were identified. We then followed these involuntary subjects through the steps in the civil commitment process, tabulating the numbers of cases released from each step. We also contrasted the rates of hearings and commitments for the Indochinese patients to those for the general population of county M, where most of the studied

Indochinese resided. The data for fiscal years 1985 and 1986 for the general population were available through the mental health department of county M. Second, demographic data, past treatment history, and past involvement in the civil commitment process were collected for the involuntary subjects by means of a detailed review of hospital charts. These data were compared with the same information collected for a group of Indochinese patients who were admitted voluntarily to the same inpatient services during the study period. This group was selected according to a table of random numbers. Third, in January 1989, after an average of about 36 months since the index hospitalization, follow-up data were collected and compared for the two study groups concerning mental health treatment, hospital readmission, and involvement in the commitment process subsequent to the index admission. These data were gathered through a review of the hospital records as well as the charts available at the Indochinese Psychiatric Program at Oregon Health Sciences University where most Indochinese patients receive their post-hospitalization care. Chi-square (χ^2) and *)t* test statistical methods were used to test the significance of any differences in the data for the study groups.

Results

During calendar years 1985 and 1986 there were 98 admissions of Indochinese patients to Oregon Health Sciences University. Twenty-four (24%) of these admissions were involuntary. These 24 admissions represented 22 individual subjects, since one person was admitted involuntarily three times during the 24-month study period. As it happens, all of the involuntary admissions were of the physician hold type.

Figure 1 illustrates what happened to the 24 involuntary admissions as they proceeded through the commitment process. Step 1 represents the entrance into the civil commitment process, and shows that all 24 involuntary admissions were initiated by physicians screening the patients at the emergency room or in the Indochinese Psychiatric Program clinic at Oregon Health Sciences University. Police are often reluctant to initiate a "hold" on Indochinese patients, since the language barrier prevents an accurate assessment of the patient. At the emergency room, however, ethnic mental health counselors or interpreters are available to help with the interviewing process, often facilitating emergency physician holds. Local investigators have regularly utilized the same cultural and language aids when they perform their investigations of patients held involuntarily on our inpatient services. As reflected in Figure 1, 75 percent of the investigations for probable cause of mental illness resulted in dismissal on the grounds that the subjects did not demonstrate a probable cause of "mental illness." Of these 18 involuntary admissions dismissed at the investigation step, 11 (61%) consented to remain in our inpatient facilities to continue receiving treatment. Of the six (25%) subjects referred on to a commitment hearing, five (83%) were believed by the

judge to demonstrate clear and convincing evidence of "mental illness" as defined under the Oregon statutes.[10] Two (40%) of these five subjects were then released, with the condition that they would continue to receive inpatient treatment at Oregon Health Sciences University, and three (60%) were committed to the Mental Health Division. One (33%) of these subjects was assigned to Oregon Health Sciences University for inpatient treatment and two (67%) were sent to the state hospital. All in all then, 14 (58%) of the 24 involuntary admissions resulted in treatment at Oregon Health Sciences University and only two (8%) led to state hospital placements. During the study years of 1985 and 1986, 4,249 persons in county M were investigated for probable cause of mental illness, 1,294 (33%) were referred on to a commitment hearing, and 859 (66%) were committed. These rates for hearings ($\chi^2 = 0.125$, df = 1, p = ns) and commitments ($\chi^2 = 0.197$, df = 1, p = ns) are similar to those observed in Figure 1 for the Indochinese patients.

Table 1 presents the results of the comparison of the data for the 22 Indochinese patients involved in the civil commitment process with that for a randomly selected group of 20 Indochinese patients who were hospitalized voluntarily during the same period. The findings were significant for age and sex only. The involuntary group was significantly younger and was comprised of far more males than the voluntary group. There were no significant differences between the groups in their length of time in the United States, length of index hospitalization, ethnicity, marital status, education, source of financial support, living arrangements, treatment history, past involvement in civil commitment, or diagnosis. The typical involuntary subject was a relatively young, single, Vietnamese male with limited education who had a diagnosis of schizophrenia, was on welfare, lived with his family, was known to the Indochinese Psychiatry Program, had not been hospitalized, and had no history of involvement in civil commitment.

In January 1989, we collected follow-up data on the two study groups of subjects. The results and comparisons are presented in Table 2. There were no significant differences between the two study groups on follow-up with respect to investigations, involvement in treatment, or hospitalizations.

At the time the follow-up data were gathered (at least 24 months after the index hospitalization), about 40 percent of both groups were still actively participating in treatment in the Indochinese Psychiatric Program. During the follow-up period, about half of the subjects in both groups required readmission to the hospital for treatment of their psychiatric disorders. About one-third of each group, however, did not receive any treatment during the follow-up period. There were no deaths in either cohort during the follow-up period.

During this time 59 percent (n = 13) of the involuntary group were not actively in treatment with the Indochinese Psychiatric Program. We made a thorough inquiry into the current location of these patients by contacting the pa-

Table 1
Comparison of Demographic Characteristics, Diagnoses, and Treatment History for Involuntary and Voluntary Indochinese Subjects

	Involuntary Subjects (N = 22)	Voluntary Subjects (N = 20)	Independent *t* Test	df	*p*
Age					
Mean	28.09	37.80	−2.52	40	0.01
SD	9.59	14.99			0.02
Years in U.S.					
Mean	3.81	5.08	−1.13	40	0.15
SD	3.49	3.85			0.30
Length of stay					
Mean	13.45	10.65	1.02	40	1.20
SD	10.43	6.73			0.40

	Involuntary Subjects (N = 22)		Voluntary Subjects (N = 22)		χ^2	df	*p*
	N	%	N	%			
Sex							
Male	17	77	6	30	9.634	1	0.01
Female	5	23	14	70			
Ethnicity							
Vietnamese	14	64	15	75	0.734	1	0.90
Cambodian	5	23	3	15			
Laotian	1	4.5	1	5			
Mien	1	4.5	0	0			
Others	1	4.5	1	5			
Marital status							
Single	15	68	11	55	1.04	2	0.70
Married	4	18	4	20			
Others	3	14	5	25			
Education							
High School	11	50	9	45	0.096	1	0.80
No High School	11	50	11	55			
Socioeconomic status							
Employed	4	18	2	10	5.534	2	0.10
Welfare	14	63	11	55			
SSI	1	4.5	7	35			
Not known	3	14.5	0	0			
Living arrangements							
Family	10	45	11	55	1.071	3	0.80
Friend	5	23	5	25			
Alone	4	18	3	15			
Others	3	14	5	25			
Treatment history							
Current patient	11	50	12	60	2.781	2	0.30
Past patient	5	23	0	0			
New patient	6	27	8	40			
Hospitalization							
Yes	10	45.5	6	30	1.036	1	0.50
No	12	55.5	14	70			
Past investigation							
Yes	4	18	3	15	1.062	1	0.90
No	18	82	17	85			
Diagnosis							
Schizophrenia	10	45.5	8	40	6.931	4	0.20
Affective	5	23	10	50			
Substance Abuse	1	4.5	3	15			
PTSD	1	4.5	2	10			
OHSU	6	27	1	5			

Table 2
Comparison of Follow-up Data for Involuntar and Voluntary Indochinese Subjects

	Involuntary subjects (N = 22)		Voluntary subjects (N = 20)		χ^2	df	*p*
	N	%	N	%			
Investigation							
No	18	82	18	90	0.631	1	0.90
Yes	4	18	2	10			
Hospitalization							
No	9	41	7	35	0.146	2	0.50
Yes	11	50	11	55			
Unknown	2	9	2	10			
In treatment at follow-up*							
Yes	9	41	8	40			
No	13	59	12	60	0.064	1	0.80
Post-hospital treatment							
Yes	17	77	13	65	0.289	1	0.59
No	5	23	7	35			

* In treatment at the Indochinese Psychiatry Program.

tients and their families and by telephone interviews with friends or with case workers at public agencies. To the best of our knowledge, seven (54%) had moved to California to rejoin their families, three (23%) had sought treatment elsewhere, and three (23%) were judged well enough to be discharged from treatment.

Discussion

There are several observations that can be made from our study. First, it is important to recognize the methodological limitations of our investigation. The numbers of patients in the two cohorts are small, making the identification of statistical differences difficult. Our ability to gather information about patients was limited. This is especially true for those patients who were "lost to follow-up" by the Indochinese Psychiatry Program. Most of the information concerning these subjects was obtained from reports volunteered by other patients, from information provided by other human services providers in various ethnic communities, and from the limited documentation in the chart at the time of termination of their treatment. These issues should be kept in mind when drawing conclusions from our data.

Second, the reason the involuntary group was younger and contained more males than the voluntary group is unclear, but these characteristics are similar to those described for involuntary patients in other studies in the literature.[8, 9] As in the general population, it appears that many young Indochinese men are resistant to treatment. While it remains to be substantiated, we suspect that this resistance will also place these patients at subsequent risk for destabilization and relapse.

Third, the fact that nearly half (45.5%) of the Indochinese involuntary patients lived with their families indicates that

many of these people belong to a relatively rich social network that can be a source of significant support. It also points out the importance of including the families in the decision-making process about civil commitment where they might well affect its initiation, progress, and outcome.

Fourth, the similarity in the rates of commitment for the Indochinese patients (20.8%) to that for the general population (20.2%) in the study county suggests that the Indochinese patients were not overcommitted. We believe the willingness of investigators and judges to secure the assistance of experienced ethnic mental health interpreters has helped to ensure that the Indochinese patients are treated equitably throughout the commitment process.

Fifth, our data underscore the heavy reliance of the commitment process for Indochinese patients on the Indochinese Program at Oregon Health Sciences University. This program serves as a treatment resource for patients dismissed from the investigative step as well as for those who are conditionally released or committed at a hearing. In previous research we have demonstrated that the outcome of civil commitment depends upon the characteristics of the mental system in which it occurs.[8,9] We believe the presence of the Indochinese Psychiatry Program illustrates this fact. Without such a local program committed to the the mental health care of these non-English speaking minorities the majority of those entering the civil commitment process would most likely end up committed to the state hospital simply because of the lack of any alternative resources for placement.

Sixth, the similarities in the follow-up data for the two cohorts demonstrate that involvement of Indochinese patients in civil commitment processes does not necessarily result in a more negative future course than voluntary treatment. Rather, the data suggest that the courses of both groups are characterized by rehospitalization, noncompliance, and high rates of treatment dropout from even a program specially designed to reach out to these patients. These data are consistent with that reported for other commitment cohorts.[17,18] They provide further evidence to support the need for extremely vigorous community treatment efforts following hospitalization.

Finally, we believe our study has implications for further research. We are aware of no other study of Indochinese patients in the civil commitment process. Our results should be viewed as preliminary and they need to be substantiated by other research. Much more work needs to be done to identify the factors that contribute to the involvement of these patients in civil commitment processes and those that result in successful aftercare.

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