Modernization of a Mental Health Act:
I. Commitment Patterns

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Introduction

The involuntary commitment of psychiatrically ill patients remains a controversial subject. Arguments have been made that involuntary commitment is a form of "social control" and as such should be totally abolished.1 Others have argued that although involuntary commitments should be kept to a minimum, there is a small but significant portion of the population who are in great need of treatment that they would not get unless they are committed against their will.2,3 The American Psychiatric Association's Committee on Psychiatry and Law took this position:

Unfortunately a small percentage of patients who need hospitalization are unable because of their mental illness to make a free and informed decision to hospitalize themselves. Their need for and right to treatment in a hospital cannot be ignored. In addition, public policy demands that some form of involuntary hospitalization be available for those mentally ill patients who constitute a danger either to themselves or to others. In such cases, it is a public responsibility to guarantee the right to treatment and to due process.4

If one accepts the premise that there is a small sub-population of psychiatric patients who are in need of involuntary hospitalization, the question then raised is how does one identify the committable patients? "Civil liberties" lawyers have argued that the grounds for involuntary hospitalization should be strictly circumscribed around the issue of dangerousness to self or others.5 Furthermore, it has been argued that since psychiatrists are clearly poor predictors of dangerousness, and since past behavior is the best predictor of future behavior, then persons

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should be involuntarily committed only if there is "evidence of an overt act, attempt, or threat of a dangerous nature in the recent past." 6

The inadequacy of dangerousness as the sole basis for involuntary commitment has been argued convincingly by "the medical model psychiatrists." They believe a small proportion of mentally ill patients (not necessarily dangerous) are in need of treatment and if not involuntarily hospitalized would be unable to receive it. 5, 7, 8

The debate has not ended and has had a major impact on mental health legislation throughout the United States. Pennsylvania has been one of the states which has responded to the discussion by passing a new mental health law which went into effect in July, 1976. The new law was clearly influenced by the arguments of the "civil liberties lawyers." 11 It was more specific and restricted in terms of who could be committed than its predecessor. However, it was also influenced by the medical model psychiatrists.

Pennsylvania’s Mental Health and Mental Retardation Act of 1966 (Pa Stats Title 50 s4405) provided for involuntary commitment for emergency detention. The broad bases for the commitment were dangerousness and need for treatment: "Whenever a person appears by reason of his acts or threatened acts, to be so mentally disabled as to be dangerous to himself or others and in need of immediate care, he may be taken into custody for the purpose of examination. . . ." Once in custody, the patient is examined by a physician who may certify that the patient is in need of immediate emergency care. Patients committed in this way could be detained up to ten days. If it were felt after ten days that the patient required further involuntary treatment, then a civil court commitment hearing had to be held.

Of note in the 1966 law is the fact that dangerousness was really the sole criterion for commitment. Assessment of dangerousness was based on acts or threatened acts of harm to self or others. The specific basis for each patient’s commitment was described narratively by the petitioner.

In September, 1976, implementation of The Mental Health Procedures Act (P.L. 817 No. 148) was begun in Pennsylvania. This law provided for several changes from its 1966 predecessor. Involuntary emergency examination could be provided to persons severely mentally disabled and in need of immediate treatment. Severe mental disability was defined as being manifested by a clear and present danger of harm to self or others. Clear and present danger required the occurrence of an act within thirty days of the petition and the reasonable probability that such an act would be repeated. Specifically, in addition to a narrative describing the particular behavior on which the petition is based, the petitioner checks one of four bases for the petition (Figure 1).

Patients committed in this way could now be held for up to 72 hours pending a decision regarding the need for further involuntary treatment. The decision to admit for the 72 hour observation and emergency treatment period was the responsibility of the examining physician.
Of note in the 1976 law is the need for specific acts by the mentally ill patient to make him committable. Threats of harm to self or others were no longer acceptable. However, category B, although presumably also based on the concept of dangerousness actually seems to look more towards the concept of need for treatment.

Thus, the 1976 law appeared to have been influenced by both “liberal” legal concepts and “restrictive” medical philosophy. McGarry and Kaplan have commented on the importance of monitoring the impact of changes in mental health legislation. In this study we have attempted to assess how the adoption of Pennsylvania’s 1976 Mental Health Procedures Act affected the emergency involuntary admission of patients to our hospital. The answers to several questions were sought. Do real changes result, or do people simply find new ways to do what they did before within the framework of a different law? Can health care providers and citizens really be persuaded by legislation to give up their notions of providing care for the unwilling ill and focus only on a person’s clear and present dangerousness? The authors took advantage of this experiment in nature (or perhaps better stated, “experiment of legislature”) to investigate a number of these and related issues.

This report examines questions of who got committed, who filed the commitment request, and why the request was made. A retrospective analysis was also done on the accuracy and appropriateness of the commitment petition. Subsequent reports will focus on the outcome of committed patients before and after implementation of the new law and what effects, if any, the new law had on the general characteristics of patients in regard to the population served.

Method

Three groups of patients who were involuntary admitted (committed) to Western Psychiatric Institute and Clinic (WPIC) were studied. WPIC is the home of the Department of Psychiatry at the University of Pittsburgh School of Medicine. Its approximately 100 bed adult inpatient capacity serves as a university level referral center as well as having direct service responsibility for the 9C-1 catchment area of Allegheny County in Western Pennsylvania. The majority of in-patient admissions come from the 9C-1 area which includes several areas of metropolitan Pittsburgh.

Patients who had been brought to WPIC for involuntary evaluation were seen by a staff physician or psychiatric resident. A decision was then made as to the veracity of the petitioner’s information and whether the patient’s alleged behavior was the result of a mental illness. If both conditions were met (or a reasonable probability thereof), the patient could be admitted. After the 1976 Act became operational, patients were still allowed the option to sign voluntary admission forms and thus avoid commitment.

The first group (Group I) consisted of the last 50 patients committed to WPIC under the 1966 law between April 22 and September 5, 1976.
Group II consisted of the first 50 patients committed under section 302 of the 1976 law between September 7, 1976 and January 4, 1977. Group III were 50 consecutive involuntary admissions from July 5 to September 7, 1978.

Four sources of data were reviewed: the admission work-up, the commitment petition, records of the index inpatient stay, and available past and subsequent psychiatric records.

A diagnosis for each patient was determined by using the diagnostic criteria defined by Feighner, et al. All cases were reviewed by at least two of the three investigators before the diagnosis was decided upon. In cases where there was more than one diagnosis applicable, a “primary” diagnosis was chosen based on which psychiatric illness manifested itself first by history. Also, a judgment was made for each case as to the presence of form or content through disorder (“psychosis”) at the time of admission.

In Group I, the grounds for the commitment request were assigned to one of two categories (acts or threats) based on the petitioner’s narrative statement. For Groups II and III, the bases for the commitment requests were tabulated as indicated on the petition (Figure 1). There were a few cases (5) where no basis was checked. For those, the information available on the petition and the admission work-up was used to arrive at a consensus as to the most likely grounds for the commitment request. There were also eighteen cases where more than one basis was checked. Again, by reviewing the records, a consensus was reached as to the most likely single basis for the commitment request. For example, if a patient had hit someone (resulting in no injury) and then taken an overdose (serious), the latter was considered the basis if ambiguity on the petition was found.

An estimate of actual dangerousness was determined by the investigators for each case. Six categories of estimated actual dangerousness were defined (Figure 2). All of the available information was reviewed in an attempt to clarify ambiguities on the petition. The estimate was made independently of (but not blind to) the petitioner’s statement of dangerousness. If one of the authors had actually been the petitioner or examining psychiatrist, the other two decided the estimate of dangerousness.

The relationships of the petitioners to the patients were recorded. Petitioners were categorized as family, police, friend, health professional, or other. “Other” usually referred to a non-medical professional.

Statistical analyses were done using the chi square test with Yates’ correction for small numbers when appropriate.

Results

Demographic characteristics of the three groups are shown in Table 1. There were no significant differences among the three groups.

Table 2 shows the diagnostic breakdown for each group. Also indicated are the numbers of patients in each group judged to have evidence of
thought disorder (psychosis) on admission. There was a non-significant shift in the affective disorders from fewer to more depressives and more to fewer manics admitted involuntarily after the 1976 Act became operational (Group I vs. Groups II plus III). Besides the primary diagnoses listed, twelve patients had secondary diagnoses. Two also had more than two diagnoses. There were no significant differences in the numbers of

<table>
<thead>
<tr>
<th>TABLE I</th>
<th>DEMOGRAPHIC DATA</th>
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<tr>
<td>AGE (in years)</td>
<td>SEX</td>
</tr>
<tr>
<td>Group</td>
<td>Range</td>
</tr>
<tr>
<td>I</td>
<td>n=50</td>
</tr>
<tr>
<td>II</td>
<td>n=50</td>
</tr>
<tr>
<td>III</td>
<td>n=50</td>
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*There was one Oriental patient in Group III.

<table>
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<tr>
<th>TABLE II</th>
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<td>Diagnosis</td>
<td>Group I</td>
</tr>
<tr>
<td>Schizophrenia</td>
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<tr>
<td>Affective Disorder — Depressed</td>
<td>2</td>
</tr>
<tr>
<td>Affective Disorder — Manic</td>
<td>8</td>
</tr>
<tr>
<td>Alcoholism</td>
<td>3</td>
</tr>
<tr>
<td>Organic Brain Syndrome</td>
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</tr>
<tr>
<td>Antisocial Personality</td>
<td>3</td>
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<tr>
<td>Undiagnosed</td>
<td>13</td>
</tr>
<tr>
<td>Other</td>
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<td>Psychotic on Admission</td>
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<table>
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<th>TABLE III</th>
<th>PETITIONERS</th>
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<tbody>
<tr>
<td>Group</td>
<td>Family</td>
</tr>
<tr>
<td>I</td>
<td>17</td>
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<tr>
<td>II</td>
<td>27</td>
</tr>
<tr>
<td>III</td>
<td>25</td>
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*I vs. II p < .01
II vs. III p < .05

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<thead>
<tr>
<th>TABLE IV</th>
<th>PETITION BASIS</th>
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<tr>
<td>GROUP</td>
<td>Harm to Self†</td>
</tr>
<tr>
<td>I*</td>
<td>17</td>
</tr>
<tr>
<td>II</td>
<td>Suicide Attempt†</td>
</tr>
<tr>
<td></td>
<td>6</td>
</tr>
<tr>
<td>III</td>
<td>11</td>
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</table>

*One case in Group I had no basis for petition
†I vs. II plus III p < .05

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TABLE V
ESTIMATED DANGEROUSNESS

<table>
<thead>
<tr>
<th>Level of Dangerousness</th>
<th>Group I</th>
<th>Group II</th>
<th>Group III</th>
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</thead>
<tbody>
<tr>
<td>A. Dangerous Acts*</td>
<td>14</td>
<td>29</td>
<td>23</td>
</tr>
<tr>
<td>B. Non-Dangerous Acts†</td>
<td>13</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>C. Threats — No Act‡</td>
<td>13</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>D. Inference of Danger</td>
<td>4</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>E. Poor Self Care*</td>
<td>3</td>
<td>12</td>
<td>19</td>
</tr>
<tr>
<td>F. Unclear</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

* I vs. II plus III p < .01
† I vs. II plus III p < .05
‡ I vs. II plus III p < .001

FIGURE 1
1976 PENNSYLVANIA MENTAL HEALTH ACT:
BASES FOR INVOLUNTARY EVALUATION

IMPORTANT NOTICE
ANY PERSON WHO PROVIDES ANY FALSE INFORMATION ON PURPOSE
WHEN HE COMPLETES THIS FORM MAY BE SUBJECT TO CRIMINAL
PROSECUTION AND MAY FACE CRIMINAL PENALTIES INCLUDING
CONVICTION OF A MISDEMEANOR.

Part I
PETITION
I believe, based upon my personal observation, that (Patient's Name)
is severely mentally disabled in that: (Check and complete all applicable):

A. [ ] The patient inflicted or attempted to inflict serious bodily harm on another, and there is reasonable probability that such conduct will be repeated unless treatment is afforded.

B. [ ] The patient has acted in such manner as to evidence that he would be unable, without care, supervision and the continued assistance of others to satisfy his or her need for nourishment, personal or medical care, shelter, or self-protection and safety. I believe that there is reasonable probability that death, serious bodily injury or serious physical debilitation would ensue within 30 days unless treatment is afforded.

C. [ ] The patient has attempted suicide, and there is reasonable probability of another attempt at suicide unless treatment is afforded.

D. [ ] The patient has severely mutilated himself or herself or attempted to mutilate himself or herself, and there is reasonable probability of self-mutilation unless treatment is afforded.

(Describe in detail the specific behavior within the last 30 days which supports your beliefs.)

FIGURE 2
CRITERIA FOR ESTIMATION OF DANGEROUSNESS

A. Act was dangerous and warranted commitment
B. Act involved physical contact but not really dangerous
C. Threats only — no physical contact involved
D. Interferences of potential danger — no actual threats or acts
E. Patient not caring for self well, but not really felt to be at risk in 30 days
F. Other
psychotic patients among any of the groups.

The petitioners for involuntary examination of the probands are shown in Table 3. While there were overall differences before and after the law change (more family and fewer health professional petitioners), the only striking change was the sudden drop in health professional petitioners immediately after the implementation of the new law ($p < .01$). This corrected itself by the time the third group was examined.

The bases for the petitions are shown in Table 4. They were further lumped into "act" versus "non-act" groups because of the difficulty in comparing all of the specific criteria in the two laws. This was done also because, as mentioned above, one of the intents of the new law was to focus on specific dangerous acts. The "non-act" probands for Groups II and III correspond to petition criterion B (Figure 1). A gradual, but non-significant, increase in the number of "non-act" involuntary admissions is seen after the 1976 law became operable. Significantly fewer patients were committed on the basis of harm to themselves under the new law ($p < .05$).

The authors' estimates of actual dangerousness of the behaviors resulting in involuntary admission are shown in Table 5. Before and after (Group I vs. II plus III) increases in actual dangerous acts ($p < .01$) and decreases in threats ($p < .001$) or non-dangerous acts ($p < .05$) were found. Poor self care, which had increased as a petition basis ($p < .01$) was not as often felt by the authors to be as dangerous in retrospect as it was to the admitting physician.

**Discussion**

Implementation of the Pennsylvania Mental Health Act of 1976 did not result in any change in major demographic characteristics for the committed patients we studied. Our entire sample of 150 involuntary admissions showed absolutely even sex distribution and a stable predominance of white over black patients. Whether these demographic characteristics accurately reflected those of all WPIC admissions during the same periods is unclear at this point. The answer awaits collection and analysis of further data which will be reported by us in a future communication.

The three groups also looked alike diagnostically. The apparent (but not significant) drop in frequency of manics committed is of some interest. It was felt by some critics of the new law that this would be the group that would suffer most from too much freedom. It was argued that manics are at risk for, and need protection from, serious socio-economic harm which is not covered by the law. Our data cannot really address this since we only looked at those who were actually admitted. One of the manic patients in our series later was alleged to have committed a murder (eyewitness accounts seem convincing, but the case has not been tried yet). Whether this occurred immediately subsequent to a "failed" commitment is unknown. From reports, it would appear to have been a
highly impulsive act resulting from a spontaneous argument. The trend toward changes in rates for admission of patients with affective disorders is not explainable on the basis of the changing criteria for committability. Most of the manics and depressives had in fact been committed on the basis of dangerous acts.

There was a lower proportion of schizophrenia among our patients than in other reported series. This could possibly be explained by our use of fairly rigid diagnostic criteria. Our low frequency of schizophrenia is offset by the high incidence of undiagnosed psychiatric illnesses. Using similar diagnostic criteria, other studies suggest that about 20% of patients will be undiagnosed. It may be that one of the conditions adding to the necessity for commitment is diagnostic uncertainty which remains even when more information becomes available later.

The undiagnosed patients were not judged psychotic any more than the diagnosed patients, so that factor did not influence undiagnosed patient commitment disproportionately. At least two thirds of all the patients were psychotic, however, so this does seem to be another additive condition for commitment. Again, however, we do not know what the frequency of psychosis is among the voluntary WPIC admissions.

Besides the large number of undiagnosed patients, a considerable number of patients have more than one diagnosable psychiatric disorder. This again adds to the complexity of the cases which may be another determining factor in commitment.

Although patient characteristics did not change very much, there were some interesting changes in why and by whom patients were brought for consideration of involuntary admission. In Group II, when the 1976 law had just gone into effect, there was an immediate significant drop in health professionals serving as petitioners. We interpret this finding in light of the climate at that time. Health professionals were probably wary of taking responsibility for serving as petitioner and risking being accused of unfairly denying patients their rights to freedom. Family members (and to some extent police) were given more encouragement to take the initiative in petitioning, thus getting health professionals “off the hook.” On the other hand, some families may have been aggressive in pursuing commitment despite reluctance, or even discouragement, on the part of the health professionals. McGarry and Greenblatt have commented on the fact that families often place a great deal of pressure on hospitals to admit their sick relatives. By Group III (mid-1978), however, the concern over the apparent rigidity of the new law was diminished. Health professionals were again willing to serve as petitioners, and the pattern of petitioners had reverted to being the same as before the new law.

Despite the general impression that the 1976 law is more restrictive in its approach to involuntary commitment, our data suggests that in actual practice it may, in fact, be less restrictive from the petitioner’s standpoint. Although “threats” were eliminated as an acceptable basis for involuntary examination and admission, “need for treatment within thirty
days” was added as a new criterion (Figure 1). In Groups II and III where the category of “threats” no longer exist, we found over 40% (21/50 and 24/50) of patients being committed on the basis of need for treatment within 30 days (Table IV). This more than compensates for the number of patients in Group I admitted on the basis of threats (15/50). In addition, this seems to include some part of the patients in Group I admitted for acts against self. The overall effect of this was that fewer patients were committed in Groups II and III for dangerous acts than in Group I. Mentally ill people who had not committed or even threatened acts of harm to self or others were now being committed because they were felt to be badly in need of treatment which they would not receive voluntarily. Whether the drafters of the 1976 law intended this section to be used so freely is unclear.

What is clear is that clinicians at WPIC chose to make frequent use of this criterion for patients who may not have been overtly dangerous but whom they felt to be in need of treatment. We found no indication that false accounts were given in defense of the “need for treatment in thirty days” decision. We simply, in retrospect (a risky business at best), did not feel that the evidence was as compelling as apparently thought at the time of admission. On the other hand, in all cases we felt that the admission was clinically indicated. The same was true for the patients who were presumably committed for an act which we did not find, again in retrospect, was dangerous or, in some cases even occurred. Our usual conclusion was that, faced with an unclear story and an obviously ill patient, clinicians opted to err in favor of an inpatient evaluation. These cases occurred with equal frequency for Groups II and III suggesting that there is a steady incidence of such cases which will not be eliminated by experience in filling out the forms. This conclusion is supported by our own estimates of dangerousness (Table 5). Group I patients were admitted across the spectrum of clearly dangerous to mere inferences of danger. Groups II and III, however, separated into two main classes of behavior. There were those who had performed a clearly dangerous act, and those who were not caring for themselves well. As mentioned above, most of this latter group was not felt by us to be really at risk if not treated within thirty days. They probably represent, then, the obviously ill patients with unclear stories.

There have been reports on commitments based on incomplete evidence.16,17 Wohl and Palmer, in fact, found over half the patient charts which they reviewed had inadequate documentation of grounds for commitment.16 From the point of view of proper administrative procedure, we found a small but consistent proportion of commitment papers improperly filled out in all three groups. In Group I, one petition had no grounds for commitment whatsoever. Several Group II and III petitions were accepted without one of the four bases for commitment checked. The time of commitment was left out on several forms. Forms were often not supplied with the specifics of the act deemed dangerous.
What we do not know is whether the county administrator who approved these petitions was basing approval on this minimal information or whether more information was given verbally than was written. We suspect the latter is true and that this represents predictable errors in paper work rather than overt attempts to skirt the law.

Just after the collection of our Group III patients, the 1976 law was amended. The regulations for the amended law (55PA. CODE S7100) redefine the standards of clear and present danger. Threats of harm to self or others are again considered evidence of dangerousness if an act has been committed in "furtherance" of such threats. This move closer to accepting "threats" appears to be an indication that Pennsylvania lawmakers may be thinking that the old law was not so bad after all from that standpoint. The necessity for this change, however, seems less compelling in light of our data suggesting that the same patients were getting committed before and after the 1976 act.

Conclusion

This study examines clinical issues relevant to involuntary psychiatric hospitalizations before and after the implementation of a "modern" mental health law. This law was presumably designed to stress recent dangerous acts and therefore be more restrictive in terms of involuntary admission. Our data show that more attention was indeed paid to defining actual dangerous acts as required by the new law, but there was remarkably little, if any, change found in the clinical characteristics of the patients committed. Also, the clinicians responsible for making decisions regarding involuntary admission at WPIC seemed determined to not pass lightly over the patients whom they felt were in need of inpatient evaluation. Operating in good faith within the framework of each law, the clinicians seemed to have identified highly similar patients as needing involuntary admissions. Finally, even though the initial commitment period was designed primarily for evaluation purposes, a large amount of diagnostic uncertainty plagued this population. This uncertainty remained even after extensive further evaluation.

It appears that protection of civil liberties is not inconsistent with the provision of good clinical care. Definition of "clear and present danger" may be debated, but its clinical definition seems from this study to include the recognition that a clinically dangerous situation may more often than not be determined by uncertainties of diagnosis than by certainty of dangerousness.

References

17. Scheff TJ: The societal reaction to deviance: Ascriptive elements in the psychiatric screening of mental patients in a midwestern state. Social Prob 11:401-413, 1964