Involuntary Patients in General Hospitals: A Positive View

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Recently, the admission of involuntary patients to open, general hospital psychiatric units has become a controversial issue. This article suggests that the admission of involuntary patients to open psychiatric units in general hospitals is perfectly feasible, without negative consequences, and is congruent with the goal of community treatment. This viewpoint will be supported with data obtained from a university hospital that has accepted involuntary patients on an open psychiatric unit for its entire nine-year history without negative consequences.

Leeman[1,2] raises a number of concerns about involuntary patients in general hospital units. He asserts such patients are hard to manage, difficult to control, and dangerous. He states that involuntary patients may disturb a milieu therapy oriented unit. He cites such patients' lack of motivation, need for seclusion, and locked doors as potential problems in a milieu. He further contends that unusually long lengths of stay in this patient population may cause problems with utilization review. Such patients are said to be indigent, to generate little revenue, and to require special attention given to patient rights. Leeman asserts the image of a general hospital may be destroyed by admitting such patients, in view of the past difficulty in establishing psychiatric services in general hospitals.

Most of what has been written on the subject of involuntary patients in open treatment is of recent vintage and negative in tone. Flamm[3] suggests the need to "guard against some growing efforts to convert general hospital units into miniature state hospitals." Gove[4] found that committed patients are poor, more often single, more often male, more seriously ill, and more difficult to manage than similar voluntary patients. However, Gove's study also found a slightly greater improvement in committed patients as compared to voluntary patients. Other studies have tended to find higher incidences of schizophrenia[5] and belligerence or aggression in committed patients as compared to voluntary patients. Lin and others[6] assert committed criminal patients are manipulative, have long stays, are difficult to manage, and experience secondary gains for staying "sick."

There are those whose perceptions of committed patients are not so grim. Mueller[7] describes 20 "criminally insane" patients transferred to open units from closed settings. Nineteen of these individuals went on to do well in aftercare settings outside the hospital and presented little in the way of difficulties in open settings. Only one failed secondary to recidivism. Crowder,[8] in a paper published at the same time as Leeman's, argues for

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admitting involuntary patients to general hospitals addressing with positive arguments many of the potential problems raised by Leeman.

Arizona Study

The Arizona Health Sciences Center is a 300-bed medical school teaching hospital with a single, 22-bed, unlocked psychiatric inpatient service. Since the hospital opened in September of 1971, it has been the policy of the inpatient service to accept all comers. The unit is a circular module with rooms opening off a central day room as spokes from the hub of a wheel. This design is similar to other inpatient units in the hospital except that the central open area is usually occupied with a nursing station. In our unit, the nursing station is near the entrance to the unit and access is controlled this way. The unit is staffed by approximately 30 full-time-equivalent nursing staff, two registered occupational therapists, and a variety of others including residents and a recreational therapist. Two seclusion rooms with lightly rubberized floors and walls and recessed fixtures are a part of the treatment unit. The treatment program includes occupational, group, and individual therapy as well as chemotherapy, family therapy, and other therapeutic modalities. The patient's day during the work week is heavily scheduled.

Since 1974, Arizona has had one of the nation's most restrictive patients'-rights oriented commitment laws.[9] Essentially, patients can be admitted involuntarily for a 72-hour evaluation if they are a danger to themselves, others, or gravely disabled. Arizona has no "need-for-treatment" criterion for involuntary hospitalization. Patients have the option of becoming voluntary patients at any time during their evaluation and/or court-ordered treatment. All patients who continue to be involuntary have a hearing in superior court within a week of admission. They then may receive court-ordered treatment for a maximum of 180 days (danger to others) before mandatory judicial review. Those who are a danger to themselves may be hospitalized for a maximum of two months prior to rehearing. The average length of stay on the psychiatric unit for all patients varies between 14 and 21 days, although the range is quite large with stays as short as a few hours up to four or five months.

Involuntary patients come to the University Hospital from the emergency room and also from the community when evaluation proceedings are instituted at one of the local mental health centers. County government pays for such evaluations, and patient distribution is managed through the local county hospital. Occasionally such patients are transferred to the county hospital to lower the county's indirect health care costs; however, this is rare due to the lack of bed space. Court-ordered treatment is usually carried out at a local hospital since Arizona law precludes commitment to the State Hospital unless no other treatment alternative exists. While fiscal considerations may play a part in the selection of a local hospital, indigency does not preclude local treatment or necessitate state hospital admission.

Methods

All involuntary patients admitted from September of 1979 through February of 1980 were identified. This period was selected because there were slight changes in the Arizona commitment law in July of 1979. This time was also considered to have less bias in admission practices due to resident inexperience. Once the patients were identified, lengths of stay, grounds for petition, and diagnoses were established. An attempt was made to establish which patients had received court-ordered treatment, which patients had converted to voluntary status, and which patients had been found not to meet criteria for involuntary hospitalization and had elected to leave the hospital.

Reports of unusual occurrences or incidents were reviewed for this period. Such reports are a formal document prepared at any time when an incident occurs that may be detrimental to a patient either by accident or by design. Suicide attempts, for example, would be considered unusual incidents. All reports of injuries to staff were reviewed as well. An attempt was made through this process to determine episodes of elopement, suicide attempts, and violent behavior among the patient population.

Results

A total of 42 patients were involuntarily hospitalized on the psychiatric service during a six-month period (Table). They ranged in age from 16 to 80 years old. Half were considered to be a danger to themselves. The remainder were equally divided between patients who are dangerous to others and those who were gravely disabled. The predominant diagnosis was schizophrenia, the next most common category being affective illness. Only nine of the sample were ordered to undergo further treatment. Ten patients

Table. Sex, Diagnoses, and Legal Status of Voluntary and Involuntary Patients

	Involuntary Patients N=42		Voluntary Patients N=178	
Sex	No.	%	No.	%
Male	17	40	59	33
Female	25	60	119	67
Diagnosis				
Schizophrenia	14	33	53	30
Organic brain syndrome	6	14	18	10
Affective disorder	8	20	71	40
Adjustment disorder	4	9	18	10
Miscellaneous	10	24	18	10
Legal Status				
Court ordered treatment	9	21		NA
Voluntary	10	24		NA
Discharged (AMA)	14	33		NA
*Transferred	11	26		NA

* Some overlap with other categories.

became voluntary at their request and proceedings were dropped. Another 14 were discharged after they failed to meet the criteria for further involuntary hospitalization. It should be noted in interpreting the data regarding status that there are some overlaps. Two patients who were transferred had received court-ordered treatment prior to transfer, the rest had not had hearings.

There was a total of four unusual incidents including a patient drinking shampoo, a patient hitting his head against the wall in seclusion, and a patient who scratched his wrist with broken glass. One patient eloped and was later returned to the hospital. There were two injuries to staff by patients during this period. One involved a staff member receiving a twisted thumb, another involved a patient smearing fecal material in a staff member's eye. Neither injury resulted in complications or claim.

The average length of stay for the total involuntary group was 13 days with an average length of stay of 30 days for the group receiving court-ordered treatment. The average length of stay for all patients was approximately 21 days. This average may fluctuate between 14 and 30 days.

During the period of time reviewed, 13 (31 percent) of the involuntary patients required seclusion. No single episode of seclusion lasted longer than 24 hours. During the same period, 16 (9 percent) of the voluntary patients were secluded for relatively short periods of time.

Discussion

A number of assumptions referred to earlier about the difficulty of caring for involuntary patients on open psychiatric units are challenged by the data presented. These data tend to show that such patients are no more violent, dangerous, or difficult to manage than voluntary patients except for a greater use of seclusion with the involuntary group. The average length of stay for the total group was short, which is accounted for by the fact that some of these patients were discharged after it was determined they could not be held involuntarily. However, even patients who received court-ordered treatment had lengths of stay on the average only one week longer than that of the general patient population.

One might ask how such findings can be accounted for, especially in the light of the reports of others. A number of possible explanations can be offered for our relatively positive experience.

Certainly, the high staff/patient ratio on the unit described is an important factor. There was adequate supervision of this relatively small group of patients at all times with the number of registered nurses (as opposed to psychiatric technicians) being approximately equal on most occasions. There is adequate staff to seclude and restrain patients when necessary. The mere presence of large numbers of staff may decrease incidents of elopement, violence, attempted suicide, and other unwanted behavior. The attitudes of staff are also important. Since the institution traditionally has dealt with involuntary patients, ward staff were familiar with such patients. It is possible that those who choose to work in this setting are aware of the

types of patients they will be dealing with when they are hired and are self-selected for a higher tolerance for deviance. Staff morale, feelings of security, and support may also relate to the relative lack of problems with involuntary patients. The fact that staff attitudes, conflicts, and low morale contribute to patient distress is well known.[10]

Another explanation for our experience may be that there is little difference between involuntary and voluntary patients. It should be recalled that patients who are a danger to themselves or others or gravely disabled may be voluntarily admitted to psychiatric facilities. Patients with the types of behaviors referred to may automatically be placed on involuntary status in other localities, but this is not the case in Arizona. Each patient essentially decides whether he or she will volunteer for treatment, thus aborting a hearing. What really separates involuntary patients from voluntary patients is their willingness or lack thereof to undergo evaluation and treatment. Lack of desire for treatment may stem from lack of insight into the fact of a mental disorder or from the patient's assumption that psychiatric hospitalization may not be the treatment of choice. As our results show, desire or willingness for treatment may change as reflected by the number of people who became voluntary patients out of the involuntary group.

Involuntary patients' relative ability to pay is an issue of real concern. It is well known that the incidence of severe psychiatric illness tends to be higher among the poor. Medicaid, Medicare, and other public sources of support for the care of involuntary patients may lighten the burden their indigency may present. In Arizona, the state has mandated that the counties will pay for the psychiatric evaluation of involuntary patients. When a system such as this is in effect, it may be advantageous for an institution to accept involuntary patients from a fiscal standpoint.

The idea that special attention must be paid to patients' rights[1] deserves careful consideration. It can be argued that the rights of all patients demand special attention. The impetus for the increasing body of case law and consequent changes in civil commitment law has been a common disregard for patients' rights.[11] Disregard of patients' rights, whether the patient is voluntary or involuntary, has potentially serious consequences for physician and hospital. Careful attention to patients' rights may prevent overzealous and restrictive legislation designed to correct abuses. Various lists of rights have been suggested. Those embodied in Arizona law include the right to privacy, the right to examine medical records, the right to one's clothing and personal belongings, the right to use the telephone and the mail, and the right to worship freely. Voluntary and involuntary patients are guaranteed their rights.

In summary, our data indicate that involuntary patients can be effectively treated on an open, general hospital psychiatric unit.

References

1. Leeman CP: Involuntary admissions to general hospitals: progress or threat? Hosp Community Psychiatry 31:315-318, 1980

2. Leeman CP and Berger HS: The Massachusetts Psychiatric Society's position paper on involuntary psychiatric admissions to general hospitals. Hosp Community Psychiatry 31:318-324, 1980
3. Flamm GH: The expanding roles of general hospital psychiatry. Hosp Community Psychiatry 30:190-192, 1979
4. Gove WR and Fain T: A comparison of voluntary and committed psychiatric patients. Arch Gen Psychiatry 34:669-676, 1977
5. Sata LS and Goldenberg EE: A study of involuntary patients in Seattle. Hosp Community Psychiatry 28:834-837, 1977
6. Liss R and Frances A: Court mandated treatment: Dilemmas for hospital psychiatry. Am J Psychiatry 132:924-927, 1975
7. Mueller RA and Fossi CM: Placement of long-term criminally insane patients in open settings. Hosp Community Psychiatry 26:160-162, 1975
8. Crowder JE and Klatte EW: Voluntary admissions to general hospitals: Legal status is not the issue. Hosp Community Psychiatry 31:325-327, 1980
9. Chap 5, Sec 501-550.8, Title 36 Arizona Revised Statutes.Western Publication Company, 1979
10. Stanton AH and Schwartz MS: The Mental Hospital. New York, Basic Books, 1954
11. Ennis BJ: Prisoners of Psychiatry. New York, Harcourt, Brace and Jovanovich, 1972 □