

A Reflection on Meteorological Considerations in Civil Commitment Evaluations

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A few winters ago, on a cold, clear night with the temperature dipping into the twenties, I worked a shift as the on-call psychiatric resident at a busy Crisis Response Center in the middle of a sprawling city. Midway through my shift, a homeless outreach team brought in a man for an involuntary psychiatric examination under the auspices of Code Blue, a city-wide humanitarian initiative triggered by freezing winter weather conditions. Each winter, Code Blue mobilizes outreach teams to find homeless men and women on the streets and bring them to shelters. Those who decline transportation to a shelter, such as the man I was asked to evaluate, are instead brought involuntarily by outreach workers or police to a Crisis Response Center under court-ordered transportation to shelter (also called a COTS or a Code Blue 302, the number reflecting the section in the state's statute that provides for involuntary mental health assessment), with the help of the city solicitor and Common Pleas Court judge on call. The rationale for this procedure is that persons so indifferent to obvious danger (e.g., freezing temperatures) may have a mental illness impairing their ability to make rational decisions, leading either to inability to care for self or active dangerousness to self. Either way, an emergency psychiatric evaluation is needed.

If, on psychiatric evaluation, there is a finding of mental illness and a finding of imminent danger, the person can then be involuntarily committed to a psychiatric facility. In the state where I practice, this initial commitment can last up to 120 hours, or five days, before a hearing occurs. Through this mechanism, the state exercises its *parens patriae* interests to provide care to its citizens who are unable to care for themselves.

According to this man's chart, he carried a diagnosis of schizophrenia and was chronically homeless. His chart reflected many previous involuntary psychiatric hospitalizations, several of which occurred in similar Code Blue scenarios.

He was frustrated with the situation. Outreach workers had apparently found him sleeping over a subway grate; the steam, he claimed, kept him warm. His experience told him that he would survive the night. He agreed with me that there was a chance that he might freeze, but he wished to manage his own risk. I asked him if he would be willing to accept shelter. He declined. He'd been to shelters before; they were not for him. He had gotten into fights in shelters and had had important possessions stolen from him in shelters. Why would he want to go to a shelter? I asked him if he would be willing to go to a hospital instead. He again declined. "I'm not sick!" Why would he want to go to a hospital? Apart from the circular reasoning that his indifference to danger was *per se* evidence of psychiatric illness, there was no indication that he was suffering from an exacerbation of schizophrenia or any other mental disorder. His

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sensorium was clear; he did not have any hallucinations or bizarre delusions, nor did he have the disorganized thoughts or jumbled speech characteristic of schizophrenia. He did not want to hurt anybody, least of all himself. It would have been disingenuous, I think, to have concluded that his decision to avoid shelters stemmed from paranoid delusions, in the same way that it is not delusional to avoid hot stoves after being burned. I did not believe that his decision-making that day was a product of schizophrenia or any other psychotic illness. I think that, if I were in his situation, I might have made the same decisions and arguments that he did.

In my residency training, I was encouraged to err on the side of parentalism and safety when evaluating persons brought into the Crisis Center on a Code Blue 302. Hospitalization was almost a predetermined outcome: instant commitment, just add a diagnosis. I can understand this reflexive parentalism: one attending psychiatrist described it euphemistically as a way to prevent “poor outcomes.” Indeed, any Internet search of the keywords “homelessness” and “freezing death” yields multiple local news articles reiterating just how dangerous it is to be homeless in the winter. Thus, despite believing that my patient was not acutely psychiatrically ill and was thinking and behaving rationally under his specific circumstances, I admitted him to the hospital. Apart from the medical credentials with which I signed the paperwork, the 302 evaluation could have been accomplished by a meteorologist or anyone with an outdoor thermometer. The patient spent the next few days mostly lying quietly in his room. He declined all medications, and, as he displayed no violent behaviors necessitating the use of involuntary medications, he received none. When the temperature climbed above 32 degrees Fahrenheit and the Code Blue was lifted, he was discharged from the hospital.

In the days after my encounter in the Crisis Center, I often pictured this man curled on top of a grate, the steam providing a small bit of refuge against the cold. These thoughts brought on many emotions, but the emotion subsuming all others was anger. I was angry because the city was failing its homeless citizens, especially those with chronic mental illnesses. I was angry because I had been roped into whitewashing deficiencies in public policy by medicalizing the problems of people who needed so much more: permanent housing or housing-first programs, social

welfare programs, employment opportunities, social trust, and acceptance. I was angry that to get a man out of the cold, I had to label him as sick and admit him to a hospital for treatment. I was angry at the ease with which his constitutional rights were suspended because I had labeled him as “sick.” I was angry at being made to feel like a warden, not a healer.

I think I felt so angry because feeling angry was more productive than feeling both angry and uncertain. Those reading this may sometimes feel, as I have often felt, that to do psychiatric work is to be steeped in uncertainty. This uncertainty ranges from the squishiness of psychiatric nosology and classification (what exactly am I treating?) to the shifting responsibilities of psychiatrists as stakeholders, decision-brokers, and advocates in mental health systems in addition to their traditional duties as clinician-healers (who am I and what is my responsibility to my patients, my profession, my community?).

Sometimes these uncertainties converge, as they did on that Code Blue night, in ways that threaten to obliterate my sense of professional purpose: that my work is true, good, or meaningful; or at least furthers or helps someone else achieve something true, good, or meaningful. At what point does a man’s seemingly rational reaction to a horrible situation (e.g., choosing to sleep over a grate instead of in a shelter after going through previous noxious experiences in shelters) become seen as irresponsible or irrational enough to cross the definitional threshold into mental illness? Where should I draw the boundary between “not sick” and “sick,” especially when the designation of “sick” has the power to deny someone his autonomy? The circular logic of Code Blue involuntary hospitalization reminds me of an exchange from Lewis Carroll’s *Alice’s Adventures in Wonderland*,¹ in which Alice seeks help from the Cheshire Cat, who is not very helpful:

“But I don’t want to go among mad people,” Alice remarked. “Oh, you can’t help that,” said the Cat: “We’re all mad here. I’m mad. You’re mad.” “How do you know I’m mad?” said Alice. “You must be,” said the Cat, “or you wouldn’t have come here” (Ref. 1, Chap. VI).

After my residency ended and I started my training in forensic psychiatry, I saw that the determination of violent, dangerous, or bizarre behavior as “sick” or “not sick” may have implications in adjudication of criminal responsibility. In these cases, what is at stake (including, among other things, privacy, property, social relationships, educational and employment

opportunities, liberty, dignity, and life) may encompass more than just autonomy.

These stakes highlight the incredible power that psychiatric diagnoses hold within medical or medico-legal systems. Given their power, psychiatric diagnoses are surprisingly malleable when they need to be. When COVID-19 first started to sweep into my state, psychiatric units scrambled to reconfigure themselves to minimize disease transmission. Double-occupancy rooms were converted to single occupancy, and new admission requests were rigorously screened for potential COVID-19 exposure (before rapid testing became widely available, it was exceedingly difficult to secure inpatient admission for homeless men and women, partly due to presumed exposure from shared living spaces where physical distancing was almost impossible to achieve). The result was that admissions dropped even as demand for inpatient psychiatric treatment held constant or increased. I was instructed to be more judicious when admitting patients from emergency rooms or Crisis Centers, implying a redrawing of the line between “sick” or “not sick.” Is a diagnosis still real when it changes with the weather, or with whether the hospitals in the area have single- or double-occupancy rooms? Does a diagnosis still carry the same meaning when the outcome (admission versus discharge) is largely predetermined by systems-level factors?

I do not yet have any satisfying resolutions to my uncertainties. Sometimes I even appreciate

uncertainty and feel that my love of psychiatry would diminish if the work were to become more certain. It is, for example, precisely because psychiatry concerns itself with people’s interiorized experiences, needs, and desires and tries to reconcile them with an external “objective” reality that we can have conversations about squishy topics like truth, power, agency, autonomy, and dignity in psychiatry and the law. I am not in favor of allowing homeless men and women to freeze “with their rights on.” Ideally, my patients would all be warm and stably housed, with their rights intact. Stopping short of concluding that “we’re all mad here,” I do believe that context matters as much as phenomenology in the assessment of mental illness and that the social aspects of mental health deserve more attention if we take the biopsychosocial model as seriously as we say we do. In our current systems, rational behavior *in extremis* can look like illness, but we can do better than to localize the illness to our patients.

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Reference

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