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Involuntary Hospitalization & Treatability: Observations From the District of Columbia Experience

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There is abroad today a strong current of feeling that involuntary hospitalization for mental illness is an oppressive procedure based on specious criteria which cannot be justified on the basis of evidence of its value or morality, and which may be malevolently directed against the creative activity of minority and dissident elements of our society.¹ Yet, though under attack, it goes on. An involuntary hospitalization occurs about six times a day in the District of Columbia and about 1,000 times a day in the United States.² Dealing with those presumed to be mentally ill in this way has been a common practice for many years and in many societies. Is it possible that rather than being a disappearing anachronism it fills a real need and that it has positive aspects as well as the negative ones put forth by civil liberties advocates and the new breed of antipsychiatrists? If this is so, and

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1. See T. SZASZ, *LAW, LIBERTY AND PSYCHIATRY* (1963); *MYTH OF MENTAL ILLNESS* (1961); Anderson, *Breaking Out of the Establishment Vise*, *HUMAN BEHAVIOR*, 11-16 (1973); Dershowitz, *Psychiatry in the Legal Process: A Knife that Cuts Both Ways*, 5 *JUDICATURE* 370-77 (1963); Llado, *Involuntary Psychiatric Treatment*, *THE HUMANIST*, 44 (1972); Rubin, *Prediction of Dangerousness in Mentally Ill Criminals*, 27 *ARCHIVES OF GENERAL PSYCHIATRY* 397-407 (1972); Szasz, *Commitment of the Mentally Ill: Treatment or Social Restraint?*, 125 *JOURNAL OF NERVOUS AND MENTAL DISEASE* 293-307 (1957); *Science and Public Policy: The Crime of Involuntary Hospitalization*, 4 *MEDICAL OPINION AND REVIEW* 25-35 (1963).

2. See H. SILVERBURG, *PERSONAL COMMUNICATION* (1974); N. Chayet, *Should You Sign that Commitment Order?* *MEDICAL ECONOMICS* 130-53 (1971).

if the thousands of people who initiate the process believe that they are doing something useful and necessary, it seems odd that so little has appeared in print in support of involuntary hospitalization. It will be the purpose of this paper to attempt to make the case for involuntary hospitalization, to explore some of the reasons why we believe it should not be phased out, and to advance suggestions about criteria which will allow psychiatrists to exercise the skills for which they have been trained in the service of patients whose illnesses have deprived them of the ability to make rational judgments about their best interests.

The Current Legal Anomaly

First we need to describe involuntary hospitalization. In the District of Columbia, it comes about as the result of a sequence of events beginning with a concerned citizen, police or mental health professional who initiates a procedure that involves two independent evaluations of whether an individual meets the criteria of being both mentally ill and likely to injure himself or others. If these criteria are met, the person is transported to D.C. General Hospital or Saint Elizabeth's Hospital. Ordinarily, he will be in a ward with fifteen or forty other patients, but if he is too disturbed for the ward community he is placed in a room by himself. Initially the patient has no freedom to leave the ward although this restriction may be lifted in as little as a week's time. Therapy consists primarily of medication, psychotherapy and other forms of interactions with the staff. Electric shock is used when prescribed but in practice is infrequent and—to our knowledge—psychosurgery has not been used on any emergency patients in the last year and has been extremely rare in any event for the past twenty years. For the patient, there are many unpleasant aspects to involuntary hospitalization. The displacement from community to institution, the intrusions into one's personal life by strangers, the initial sense of isolation experienced by many, the regimentation of ward life, the sense of shame and guilt and failure, the psychological discomforts which may go along with psychotherapy, and the physical discomforts of psychopharmacology—all these are undeniable discomforts which can be diminished but not eliminated. For most patients, this experience lasts several weeks, although a few stay only for a day or two and a very small number—maybe one in a thousand—remain for many years. Less than one percent are changed from emergency to committed status (this occurs after thirty days in the hospital—when it occurs) whereas more than 99 per cent are discharged or changed to voluntary status.³

3. See H. SILVERBURG, *supra* note 2.

Granted that an involuntary hospitalization is at least an unpleasant experience for many patients, are there any positive results for them and for the public? An exact answer is not available since there are no controlled experiments that would clarify what would happen if psychiatric involuntary hospitalization were not available. No one maintains that in each instance disastrous results would have ensued if the patient had remained at liberty. Undoubtedly there is substance to the charges that psychiatrists are prone to over-predict dangerousness directed towards other persons. There is also little reason to question that at least some homicides and severe assaults have been avoided by involuntary hospitalization. It should be pointed out, however, that the thrust of the criticism that psychiatrists lack exceptional ability in predicting dangerousness is blunted by the fact that two-thirds of the patients are not hospitalized because of dangerousness to others but rather on the basis of the threat they pose to themselves.⁴ We do not hear charges that over-prediction of a suicidal danger is a problem in the way that prediction of dangerousness to others is. Taking into account all of the probabilities and uncertainties, we believe it can be stated positively that a certain amount of physical harm to the patient himself and to other people is prevented by involuntary hospitalization. In the case of self damage this includes not only potential suicides but also the larger group of patients with symptoms of mental disorders accompanying physical disease, such as intoxications due to various agents, particularly alcohol.

It is our belief, however, that the case for involuntary hospitalization does not depend only on avoidance of physical damage. It may be a beneficial experience in ways which go beyond the saving of the patient's own life or the lives of others. An indication that patients also feel this way is the fact that about 50 per cent of readmissions of patients previously hospitalized involuntarily are on a voluntary basis.⁵ We also point out the problems, sometimes passed over too lightly, of turning over the responsibility for disturbed people to inadequately prepared relatives, friends and community. Anyone who believes that placement in the community is always a satisfactory answer is ignoring present reality.

We do not intend to suggest by any means that involuntary hospitalization is a panacea. Sometimes it does not work either for the patient or for the community: this may be the fault of the constraints presented by the present criteria which allow for continued involuntary hospitalization only on the basis of dangerousness. For example, a man is involuntarily hospitalized

4. This figure was obtained from patient flow files kept by Mr. Idella von Loetzen of the Area D CMHC, St. Elizabeth's Hospital, Washington, D.C.

5. *Id.*

for the reason that he is both mentally ill and dangerous to others. After a week or two of observation, the staff comes to the decision that he is certainly mentally ill but cannot be considered dangerous. Under present law he must be released even though there has been no alteration in his mental status and—as far as anyone can tell—he is not better for the experience. A possible remedy for this kind of situation, which occurs in less than 5 per cent of emergency hospitalizations,⁶ will be discussed later. Another and larger group for which hospitalization is of questionable value includes patients who were hospitalized as dangerous to themselves because of organic problems such as confusion and disorientation. Although their mental status may not have improved during hospitalization, it is possible that this period may have been indirectly beneficial to them by giving time for mobilization of resources for their care in the community through the efforts of the hospital, relatives, or the public defender. We would submit that patients in this category were well served by involuntary hospitalization even though the patient's own ability to function was unchanged. Parenthetically, sometimes the major benefit a person obtains from involuntary hospitalization is in the form of legal services that would not have otherwise come his way.

Although there are of course patients who simply do not benefit in any way from being hospitalized, it is our impression that three out of four patients who are involuntarily hospitalized in the District of Columbia have improved in one way or another in their ability to live in the community as a result of their hospital experience.⁷ In spite of this evidence of beneficial results, pressure has been growing to narrow even further the criteria for involuntary hospitalization. We suggest that this is unwise, and that the inability to bring about involuntary hospitalization of certain individuals is responsible for needless suffering by themselves and their families.

As an example, we cite the case widely publicized last year of a woman in her twenties who was attempting to live at Union Station supporting herself on handouts from strangers. She was interviewed by the police and was befriended by a reporter who took her to a hospital for an evaluation. Everyone concerned, including a psychiatrist who examined her, agreed that she was mentally ill. However, the decision was made that she was not dangerous to herself or to others. She was not admitted. Several days later she was found stabbed to death. Dead, she was not able to enjoy the liberty given her by current statutes and current prejudice against involuntary hos-

6. *Id.*

7. *Id.*

pitalization. She "died with her rights on."⁸ Subsequent discussion in the psychiatric profession and in the press focused on whether she could have been considered likely to injure herself. That she was sick and could have been helped was never in doubt, but this was not the question being debated.

Another example is a delusional divorced mother of three children, living in a row house, who has come to believe that she is the reincarnation of Cleopatra. She accuses neighbors of trying to make her stink, leaves garbage in the front of her house, confronts neighbors and passers-by. However, she is "not dangerous." According to some her behavior should be characterized only as an "annoyance," to be either tolerated or dealt with as a breach of the peace. Is it in her real best interests to take the latter road and deal with her on the basis of her misdemeanors, or to take what we regard in this case as the humanitarian road which involves hospitalizing her, against her will if this cannot be avoided, so that she can have the treatment which we have every confidence will help her to function more adequately for herself and her children?

A third example is the manic-depressive who on one of his swings into mania can wipe out his financial resources, his family's security, and his own dignity in a few weeks of frantic overactivity, but yet cannot be considered likely to injure himself or others. Would legal means to check his destructive behavior be as effective as hospitalizing him, again, whether he agrees or not, so that he can be treated? Mania is one of the illnesses for which rapid and effective treatment is available. What is humane in not insisting on treatment?

In all the above instances, effective treatments are available. It is a perversion and a travesty to deprive these needy and suffering people of treatment in order to preserve a liberty which is in actuality so destructive as to constitute another form of imprisonment.

In our opinion, the change in attitudes toward involuntary hospitalization has gone so far in the direction of rectifying abuses against personal liberty that there is now a danger of neglect of the real best interests of both the patient and the public. We will attempt a brief survey of some currents in psychiatry that are contributing to the present adverse climate of opinion about involuntary hospitalization.

8. See Treffert, *Dying With One's Rights On*, 224 AMERICAN MEDICAL ASSOCIATION JOURNAL 1649 (1973); Treffert, *Dying With Their Rights On*, PRISM 47-52 (1974).

The Institutionalization Concept

At the beginning of the 19th century an idea arose that, on humanitarian grounds, the mentally ill should be placed in a kind and moral setting. Later, it was also noted that many of those who were so treated got better and could return home. Thus, there developed what has been called "moral treatment." For a variety of reasons this idea became twisted and institutions arose whose main purpose was to protect society from the patient, as well as to protect the patient from his mental illness. For a century, from the 1850's to the 1950's, mental institutions became bigger and bigger to the point where nearly 600,000 people were hospitalized at one time, most of them on an involuntary basis. Important changes in the 1950's reversed this trend. First, evidence accumulated that many patients remained hospitalized, not because of the natural course of their illness, but because of the effect the institution itself had on them. At the same time there were two developments which enabled hospitals to avoid this "institutionalization" as it was called: milieu therapy, and especially, the new psychopharmacological agents. These tools provided hospitals with the means to drastically shorten hospitalization—for many patients to only a matter of days—and they allowed the release of a considerable proportion of those admitted prior to the 1950's. It also became possible for a greater proportion of psychiatric care to move out of the public mental hospitals, into the private sector's general hospitals and physicians' offices, and the public sector's community clinics. These changes since the 1950's have contributed to a growing attitude among psychiatrists, sometimes open and sometimes subtle, that the purpose of one's work was to save the patient from that ultimate evil, the public mental hospital. Success bred some haughty attitudes. First England and later California announced that they were moving rapidly toward abolishing their mental hospitals. Both reversed themselves, in the case of California largely because of a significant degree of public protest generated by homicides by released patients.⁹ However, another consequence of this anti-hospital opinion within the psychiatric profession was increasing support of the movement to narrow the criteria needed to involuntarily hospitalize a patient.

Another historical current has been the humanization of the legal procedure for involuntary hospitalization, improvement sought and brought about primarily by psychiatrists. Prior to 1938 in the District of Columbia, commitment procedure was much like criminal procedure. The patient ap-

9. *Patients' Families Protest Liberal Laws on Commitments*, Psychiatric News, July 18, 1973; *Concern Rises for Patients Released Under California Law*, Psychiatric News, November 7, 1973.

peared in open court and in effect was charged with being insane. Doctors, friends, and relatives then had to "testify against" the patient. The reforms were not intended to make it easy to "put people away," but to provide hospital care without humiliation to his friends and relatives. In the process of stripping away much of this trauma and humiliation of the old procedures, the prosecuting attorney was removed. One result of this, surely unintended and unwelcome to the psychiatrist, was that he alone was left to represent the interest of the public. True, jury trials can still take place, but this happens in less than 1% of the cases.¹⁰ True, the present procedure allows the Mental Health Commission to invite concerned relatives, friends and the police to testify, but only a minority of cases ever get to full Mental Health Commission hearings.¹¹ In the event the case does go to the hearings, the actual process tends to require the patient's psychiatrist to compromise his role of concern for the patient by also having to take into account the effect of the patient's release on relatives, friends and the community at large.

Treatability as Admission Criterion

Clearly, psychiatrists are unhappy at being thrust into the position of advocate for the judge of public safety. Many of them find involuntary hospitalization an unattractive necessity, not only for the reasons stated above, but also because they share the general distaste for depriving an individual of his liberty against his will. They find the care of such patients much more burdensome than dealing with voluntary patients. Yet we are asking that the procedure not be abolished, and in fact that the present criteria be extended. We take this position because we believe, for the reasons we have given, that it is necessary, humane and life-saving in certain cases. We would also like to take away as much as possible the stigma attached to involuntary hospitalization. We believe that one way to do this is to add to the present criterion of dangerousness the criterion of need for care and treatment of patients who are so gravely disabled by their illness as to be unable to make rational judgments about their own best interests. If these criteria were employed, individuals would be deprived of their liberty not only to protect themselves and their family against physical harm, but also because they are in effect helpless, and need care and treatment for certain conditions we feel we often can do something about. Thus, we would like to have the need for care and treatment of those severely disabled by reason of mental illness included along with dangerousness as

10. See H. SILVERBURG, *supra* note 2.

11. *Id.*

a major factor in assessing whether or not a patient should be hospitalized. The main clinical groups in which these two criteria should interact are as follows:

1. Delusional patients who may be dangerous to others. Just because it is difficult to predict the likelihood of dangerous behavior does not change the fact that an element of danger may be present and that the admittedly inexact judgment of psychiatrists must be balanced against that danger.

2. Other schizophrenic patients who, while not dangerous, are so disabled in their social and interpersonal functioning as to be substantially helpless and subject to damage or mistreatment by others.

3. Manic patients who, while possibly not physically dangerous, are nevertheless sick and destructive of the security and dignity of themselves and their families.

4. Seriously depressed patients who may commit suicide not as a rational act or an existential protest, but as a consequence of mental illness.

5. Certain patients with acute organic brain disease who are unable to care for themselves.

Two other groups occur to us that might be considered. One group, including those afflicted with a chronic organic brain disease such as the senile brain syndrome, might regrettably have to be added to the list since there may be no other institution available to them. Another group that many would want to add includes those alcoholics and addicts who are in a tailspin of repeated, destructive episodes of overuse of alcohol or drugs.

Right to Treatment

Since we have spoken in favor of treatability as a criterion, we need to touch on the concept of "right to treatment." Advances in psychiatric treatment in the 1940's and 1950's spawned the "right to treatment" issue which emerged in the 1960's and has continued to the present time. So far, however, this issue has been of concern only in connection with the question of release of patients who have not been receiving adequate treatment. It has been, so to speak, a back door issue. We think it is also a front door issue which should be taken into account at the time of admission. Initially, the patient was admitted presumably because he was mentally ill and likely to injure himself or others. More recently this criterion has seemed to drop out, however, and the hospital is now told that it can hold the patient only if he is getting adequate treatment. If this is to be as important a test of whether the patient should remain in the hospital, why is it not equally important at the point when his admission is being considered? If treatabil-

ity were a consideration from the beginning, then there would be more pressure on the hospital to justify the hospitalization by providing such treatment. Some will say however that the terms "provide treatment" and "treatability" are not the same. In actuality they are the same. Treatments should be applied to the treatable, and treatability should be a factor that is considered in the decision to hospitalize involuntarily.

In one sense, treatability is already a covert criterion. In answering questions about whether the patient is mentally ill, concern about whether the patient's condition is going to be changed by treatment is sometimes an unspoken consideration. The educational system's failures can be dismissed, some medical specialties' failures can be buried, but psychiatry's failures may continue in the system for years, using up a hospital's resources and bringing down a staff's morale. We would suggest that bringing in a treatability criterion would open up communications between psychiatrists and the legal system and provide an increased candor that would be useful to all.

Often, of course, whether a patient is treatable is an issue that only can be resolved after trial. For this reason we would like to see frequent, thorough, periodic reviews of those who are involuntarily hospitalized, with treatability being one of the parameters to be considered in determining the continuation of involuntary hospitalization. However, we recognize that not all patients can be helped to a significant degree. For that reason we have included the need for care of the gravely psychiatrically ill within the need for treatment criterion.

Shifting the role of psychiatrist from that of a custodian of public safety to that of the physician treating his patients would not only be advantageous for the psychiatrist as a practitioner, but it would be a welcome change for him and for the public as well. We think the patient as well would be better off if his hospitalization depended more on the expectation that he was to benefit from the experience.

Finally, we want to respond to the objection to our proposed criterion usually voiced by those seriously and legitimately concerned about civil liberties, that it will be difficult to draw the line and that a powerful and potentially repressive weapon will be granted psychiatrists if they can put someone in the hospital against his will by declaring him mentally disabled and in need of treatment. This is the "*quis custodiet ipsos custodes*" issue, and we do not minimize its importance. One of us has recently published a paper on this very kind of abuse of psychiatry in the Soviet Union.¹² We

12. Chodoff, *Involuntary Hospitalization of Political Dissenters in the Soviet Union*, 11 *PSYCHIATRIC OPINION* 5-19 (1974).

do not maintain that American psychiatrists are any more inherently pure than their brethren of other lands, or that they can always be relied on to resist pressure.

Rather, our confidence that involuntary hospitalization of the mentally ill under the proposed criterion can be restricted to cases in which it is prescribed, necessary and potentially beneficial, rests in the American institutions of judicial review. We advocate the strengthening of these institutions by the following measures:

1. No patient shall be committed for involuntary hospitalization without being represented by a lawyer, either of his own choosing or retained through the public defender. Parenthetically, and somewhat hesitantly, we suggest that consideration be given to providing a legal representative of the public to represent its interest and to relieve the psychiatrist of this role.

2. No commitment should be for an indefinite period. Each case should be legally reviewed at stated intervals and the hospital should be required to justify continued involuntary hospitalization on each occasion.

3. Right to treatment cases should vigorously be pursued and should receive psychiatric support. As we have indicated, we believe a treatability criterion for involuntary hospitalization will aid efforts in this direction.

The authors of this paper are happy to see the decline in the number of cases in which commitment of the mentally ill is necessary, and we are of course in favor of patients entering psychiatric institutions voluntarily. We believe, however, that there will continue to be an irreducible minimum of cases where the former procedure is necessary and appropriate. In determining such cases we advocate the inclusion of a need for care criterion and consideration of the needs of the gravely disabled, in addition to the dangerousness criterion. With adequate safeguards of the kind described above, we believe that a proper balance can be struck between the right of a citizen to remain at liberty and the occasional instance when good sense and humanitarian considerations require that he be temporarily deprived of that liberty on behalf of his best interests, and those of the community.