THE EFFECTS OF RESTRICTED HOSPITAL ADMISSION ON PATIENT DANGEROUSNESS

by

Lisa Schroff, RN, BSN

A Thesis

Presented to
Oregon Health Sciences University
School of Nursing
in partial fulfillment
of the requirements for the degree of
Master of Nursing

December 1988

APPROVED:

[redacted]

Florence F. Hardesty, Ph.D., Associate Professor, Thesis Advisor

[redacted]

Douglas A. Bigelow, Ph.D., Adjunct Assistant Professor, First Reader

[redacted]

Janet M. Mathews, P.M.H.N.P., Clinical Faculty, Second Reader

[redacted]

Carol A. Lindeman, R.N., Ph.D., Dean, School of Nursing

This study was supported by a National Institute of Mental Health Clinical Traineeship from Grant Number 5 T01 MH18671

ACKNOWLEDGEMENTS

I would like to thank the members of my committee, all of whom were understanding of and accomodating to, my frequently erratic schedule and trips around the world. To Florence Hardesty, thanks for your guidance and your help with writing and for not making me take things too seriously. To Doug Bigelow, for your help with everything and for making me take things more seriously. To Janet Mathews, thanks for your interest and encouragement and your insights into the chronically mentally ill, with whom you work so well and with such compassion.

Thanks to Dammasch State Hospital for granting me the permission to pursue this study, and the staff of medical records, especially Marsha Bell, for their assistance during data collection.

Thanks to Debbie Young, Faith Yang, and the rest of the staff at Mt. Hood Mental Health who make it such a great place to work. You have all helped me through the entire experience of graduate school, and even made it fun.

To my parents. What can I say? Thanks for teaching me the value of education and a fine sense of humor. Thanks for always and forever being around, even long-distance. Thanks for your expressions of interest, even when it was only me and not the topic in which you were interested. Thanks for giving me two of the finest role models I can ever hope to have.

To Andrew, thanks for continuing to be loving and supportive and listen to me pout when you were having a worse time than I was. Here's to better times in Baltimore!

TABLE OF CONTENTS

LIST OF TABLES

LIST OF APPENDICES

CHAPTER I

INTRODUCTION

Civil commitment policy has been a long-debated issue among psychiatric, legal, and civil liberty groups. On one side, the debate about civil commitment is concerned with: 1) the effects of going without treatment on those mentally ill people who need, but do not wish to accept, treatment and, 2) the effects of a person's untreated mental illness on others. The other side of the debate is concerned first with the deprivation of a person's civil rights and secondly with the potential for adverse effects of commitment, per se, on the mentally ill. Dangerousness has become the criterion on which all parties could agree. But "dangerousness" as an eligibility criterion for mental health treatment has had some serious negative consequences for patient pathology.

In 1976, Oregon narrowed its civil commitment law to restrict commitment to persons who, "because of a mental disorder, are dangerous to themselves or others, or unable to care for their basic needs" (ORS

426.07). This has continued to be the criteria for involuntary commitment since that time. In January, 1988, this criteria was expanded to include any person with two commitments in the previous three years.

Many seriously and persistently mentally ill people do not get the psychiatric services they need for a variety of reasons, including scarcity of services. There have always been mentally ill people who have gone without treatment because they choose not to accept it. As a result of the restricted commitment law, there are even more mentally ill persons who do not receive treatment because they choose to go without, and they do not meet the commitment criteria.

In June, 1986, in response to overcrowding, a decision was made to ration services by closing the largest state hospital in Oregon to all admissions except involuntary commitments. Suddenly, a much larger group of people needing mental health treatment, now including those who were willing to accept it, were not receiving treatment. This unmet need has had consequences. The purpose of this study is to examine some results of the restricted admission policy upon the characteristics of patients who had formerly accepted treatment voluntarily.

Chronic mental illness is stigmatizing, debilitating, and marked by periods of exacerbation and remission. The most common diagnosis among persons with chronic mental illness is schizophrenia. Of people who are afflicted with schizophrenia, only 33% recover completely; the remaining 67% require some level of continuing care throughout their lifetime (Torrey, 1984). Repeated hospitalizations over the course of mental illness are common.

History of Community Mental Health

In the 19th century, state mental institutions were created in response to insufficient and inhumane community services for the mentally ill. In the mid-20th century, psychiatric care for major, debilitating mental illness was almost entirely custodial and took place in long-term, inpatient hospital settings. By the mid 1950's hospital census was rising rapidly and there was a severe shortage of mental hospital capacity.

In the 1940's several social, political, economic, and treatment factors contributed to the belief that the chronically mentally ill would be more humanely and efficiently treated in the community. These factors also provided the impetus for federal

legislation in mental health and led to the deinstitutionalization movement of the early 60's. After World War II, there was an increased public awareness of mental illness and its treatment and, at the same time, there was a decrease in financial resources to state hospitals (Flaskerud & Servellen, 1985). Partly in response to these conditions, in 1946, Congress enacted the National Mental Health Act. This legislation created the National Institute of Mental Health (NIMH), and provided monies for states to develop programs outside of the severely overcrowded state hospitals.

Following the National Mental Health Act, in 1955, Congress enacted the Mental Health Study Act, authorizing a five year analysis of mental illness and its treatment in the United States. The result of this study was a documentation of the need for mental health services and recommendations for meeting that need (Joint Commission on Mental Illness and Health, 1961). The Commission which conducted the study endorsed community-based care, and presented its recommendations to President Kennedy in 1962. The President, in turn, delivered these findings to Congress and proposed a national mental health program

that focused on comprehensive treatment of the mentally ill within the community.

Subsequently, Congress enacted the Community Mental Health Centers Act of 1963, which authorized matching federal funds for the construction of community mental health centers (CMHC). The Act also designated the elements of service that would be considered essential for these CMHC's to provide. This Act, which carried with it the underlying philosophy of prevention at all levels, became the legal basis for community-based treatment of mental illness in the United States.

Federal support for this Act continued until 1977, when President Carter ordered a new Commission to study the mental health needs of the country. This Commission reported both the progress and the deficiencies of the CMHC's, and set new goals for the community mental health movement. The recommendations became the Mental Health Systems Act of 1980, which was only partially enacted due to the succeeding President Reagan's veto.

Had the Mental Health Systems Act been thoroughly implemented, services and their impact on clients might have been very different today. However, the Mental Health Systems Act was replaced by block grants

for all social services. At a time of economic recession there has been competition among agencies for funds, and mental health funding is insufficient to meet the commonly recognized need.

Deinstitutionalization

At the same time that awareness of mental illness was resulting in legislative action, the social consciousness of America was raised. The civil rights movement stressed individual rights, and argued that the mentally ill were being incarcerated without treatment, an unconstitutional deprivation of civil rights. Arguments were also made that long-term hospitalization promoted "institutionalization" (i.e., helplessness, dependency, chronicity), and the expense was unreasonable (Gralnick, 1985). In the early 1950's new pharmacologic agents made mental illness more treatable.

These factors resulted in a movement of patients out of the hospitals into the communities before appropriate and sufficient alternative treatments and supports were actually available. Deinstitutionalization began with more philosophy than planning and research, and the results have been less than expected. It was expected that incidence,

duration, social consequences, and especially costs of mental illness would decrease. Rather than reducing the incidence and duration of chronic mental illness, deinstitutionalization simply relocated the chronically mentally ill into unstructured situations where treatment was unavailable or inconsistent (Lamb, 1982), and costs continued to rise. As standards of care in mental hospitals improved, costs per patient day escalated and savings in hospital budgets were not often realized.

Because of the policies set forth during this era of deinstitutionalization, exactly which chronically mentally ill person (CMI) would be cared for in the community and which would be hospitalized became as much a socioeconomic and social control issue as a treatment issue. Patients with means (i.e., private insurance, Title XIX) went to private hospitals and community clinics. Indigent patients were generally admitted (often re-admitted) to state facilities, both on a voluntary basis and through the involuntary commitment process.

Originally, involuntary hospitalization was devised as a mechanism for providing mental health services to those who resisted because denial of

illness and refusal of treatment is very common in episodes of florid psychosis. Reforms in state laws, however, limited that imposition on a person's liberties to mentally ill persons who are dangerous to themselves or others. In 36 of 50 states, including Oregon, involuntary commitment laws require that persons be both mentally ill and dangerous to themselves or others to be hospitalized against their will (Shah, 1986). This requirement increases the tendency of the hospital to be primarily concerned with the social control of deviants rather than the treatment of mentally ill patients. Private citizens, law enforcement agencies, and other agencies often tend to see and use state hospitals for social control.

The use of "dangerousness" as a primary criterion also sets the stage for using involuntary commitment as a device for triage and for controlling the growth and costs of mental health services. This rationing, triage process leaves the mentally ill patient without services unless he/she can demonstrate dangerousness.

The course of chronic mental illness, however, is one of remissions and exacerbations. In an analysis of 25 studies in which schizophrenics were followed for an average of at least ten years, Stephens (1978)

concluded that 29% of these patients recovered. One-third of the patients were unimproved, and another third were improved but not recovered. Of this latter two-thirds, the later stages of the disease are quite characteristic (Torrey, 1984). When a sudden worsening of the clinical state occurs treatment is required, which often means the patient must be hospitalized. However, people with psychotic thought processes and impaired judgement typical of schizophrenia will frequently deny their illness and the need for treatment. It is this quality of resistance which leads to the need for civil commitment.

Policy to Restrict Admissions

Dammasch State Hospital (DSH) is a 350 bed capacity psychiatric hospital located in northwestern Oregon, serving a population of approximately 2.5 million. In June, 1986, an administrative decision was made to limit admissions to this facility to only those patients who were involuntarily committed.

The forces behind this decision were primarily economic. In 1980, a recession and changes in the financial priorities of the federal government resulted in cuts in social services. Without a

critical mass of community services available, more people were being hospitalized for longer periods, and DSH became severely overcrowded. The overcrowded, understaffed DSH lost its accreditation and, consequently, a large portion of its funding. The cost of hospitalization (approximately $130/day/patient) was borne entirely by the state general fund. In order to regain accreditation without a substantial increase in staffing, it was necessary to reduce the census.

In Oregon, the Mental Health Division (MHD) has authority over all mental health programs in the state. The state MHD contracts with the counties to provide mental health services, which in turn sub-contract with community mental health centers (CMHC).

Within the economic constraints of the state system, different strategies have been devised to ration limited mental health services. These rationing strategies were designed to do two things: first, to provide services to people who most needed them, who were, in fact, unable to manage without services. This has included a substantial improvement in community mental health services for chronically

mentally ill people, especially in the form of "community support units". The second intent was to reduce the pressure on state hospitals so that the major mental health program focus could be in the community. The strategies to accomplish these intents include a prioritization system, in which the question is not "who needs mental health services?", but "who needs mental health services badly?"

Restriction of hospital admissions to involuntarily committed persons was simply an extension of this long-standing rationing strategy. If the restricted admissions policy was a more extreme version of the rationing strategy, it was because of the "leveraging" power of federal funds: loss of accreditation threatened the entire mental health system. Also, restricting admissions to an Oregon state hospital is not a new strategy. It has, for example, been used to slow the growth of the Forensic Psychiatric Services Program at Oregon State Hospital (Carlson, 1987).

Until June 1986, DSH admitted patients in three groups: involuntary only, voluntary only, and those patients who were readmitted over time in both of these categories. The rationing admissions policy

assumed that at least one of these patient groups (the voluntary only) would be eliminated, thus lowering census. Similar policies had seemed to have that effect in the past (Carlson, 1987).

Contrary to their original intent, however, the restrictive hospital admission policy failed to reduce census (Figure 1). Further, it does not appear that this strategy provided a critical mass of mental health services, even to the narrowly defined target population of chronically mentally ill with social disabilities and periodic need for hospitalization.

Not only did restriction of admissions fail to reduce census and provide alternative services, it may have led to criminalization of the mentally ill by requiring them to be dangerous in order to obtain treatment, as well as by exposing them to, or failing to protect them from, a variety of criminalizing influences while in a decompensated state in the community.

The purpose of this study was to test the hypothesis that, when low- or no-cost voluntary hospitalization ceased to be a treatment option for indigent patients, some of those patients will begin to demonstrate behavior (i.e. dangerousness) that

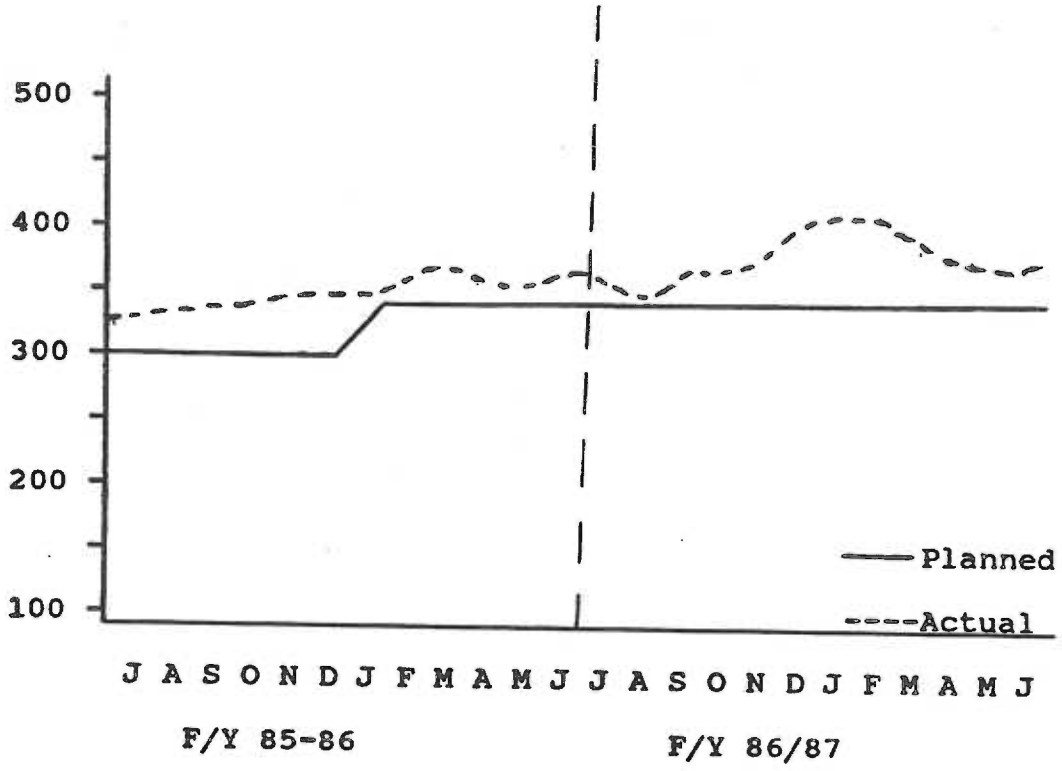

Figure 1. Dammmasch State Hospital Total Average Daily Population.

will qualify them for involuntary treatment. Beyond merely demonstrating dangerous behavior, some of these chronically mentally ill people actually became "criminalized" before they gained treatment for their mental disorder. The focus was on patients who at one time entered this institution voluntarily, whose status changed to involuntary after the new policy was implemented.

Review of Literature

Chronically mentally ill people are no more prone to dangerous or violent behavior than the general population (Shah, 1975). In fact, Steadman & Keveles (1972) found that mentally ill people are more likely to be victims of violence than perpetrators. Although not especially violent, severely mentally ill people can be a burden and nuisance, to both their families and society (Lefly, 1985). Some of that burden and nuisance very closely approach real dangerousness and criminal behavior.

When dangerousness does exist, it is a primary concern for relatives, caregivers, law enforcement personnel, and legislators. Therefore, dangerousness has always been a compelling reason for admission for those few who ordinarily become dangerous as well as

needing treatment for their mental illness. Now, however, under extreme rationing, dangerousness is not only compelling, it is the only reason for granting access to inpatient treatment for mental illness. To become "dangerous", a person may break into their parent's home, steal food, get into fights, and participate in illicit aspects of street life. Acquiring these behaviors is a process of "criminalization".

Substantive changes in the civil commitment laws have contributed to problems experienced by the mentally ill. Lamb & Mills (1986) stated that "these problems include widespread homelessness, criminalization, and the chaotic lives of many chronically mentally ill persons in the community". Although they have clearly identified criminalization as an issue related to civil commitment in the mental health field, they have failed to cite any research in support of this issue. This is indicative not only of the lack of empirical study on criminalization, but of the need for further study.

One aspect of a study of how changes in the mental health system affected civil commitment (Faulkner, Bloom, McFarland, & Stern, 1985) examined characteristics of patients before and during a period

of change. Patient groups studied before and during the mental health system change were similar diagnostically, demographically, and historically. There was a significant difference in the latter group in one respect; the reason the patient entered into the commitment process in the first place. Before the change, 21 percent of the persons in the study required an investigation because they were felt to be dangerous to others. During the changes, however, 42 percent of the subjects were investigated for that reason. This represents a 100 percent increase in dangerousness to others in groups that were otherwise similar. Faulkner, etal., do not elaborate this finding, as it was not the purpose of their study. For example, they did not show whether admissions had shifted to a new group of dangerous persons, or whether the <u>same group were becoming more dangerous</u>.

Bonovitz & Guy (1979) chose to assess the impact of restrictive civil commitment procedures by studying the population of a prison psychiatric unit before and after the procedures were implemented. The study took place in a state where the commitment law was changed to require that the person be dangerous to himself or others. The authors compared records in a prison 12

months prior to the implementation of the new regulations, then 12 months after the regulation change.

Bonovitz & Guy (1979) found that requests for psychiatric consultation on mentally ill prisoners rose substantially after the law was implemented. There was also an increase in the number of admissions to the forensic unit for mentally ill prisoners. These findings, though not conclusive, suggest that when it is difficult to use the option of involuntary hospitalization, arrest and imprisonment may be used to remove mentally ill people from the community. It seems unlikely that all patients were completely diverted into prisons, but those who were most certainly were exposed to criminalizing influences. Meanwhile, it is quite possible that others who were not sent to prison never the less came into contact with criminalizing influences before eventually getting back into mental hospitals.

Conceptual Framework

Much of the literature and public policy used a systems perspective to explain the movement of whole classes of patients (from hospitals to jails) or statuses (voluntary to involuntary). It would be helpful to understand how individuals act, choose, and

change under these conditions. There is a theory which would explain how previously voluntary patients become criminalized in response to restrictive admissions. Rotter's social learning theory (1954) suggests that people will achieve their most desired goal through the opportunities most available to them. To the CMI person experiencing acute positive symptoms or even overwhelming negative symptoms, and to their families, the most desired goal is hospitalization and treatment. In Oregon, the only means available for achieving this goal is through a civil commitment process. Thus, in order to acquire inpatient treatment, a CMI person must be deemed dangerous or unable to care for himself. The current mental health care system has created a major incentive for becoming or manifesting or emphasizing dangerousness, resulting in a behavioral and societal change of the most undesirable sort.

Hypotheses

Prior to June 1986 recidivist patients were admitted to DSH in one of three sub-groups over time (voluntary only, involuntary only, and a combination of both). MHD expected to lower census by eliminating the voluntarily admitted group altogether, assuming

that this group was not as sick or dangerous as those patients admitted involuntarily all along. Many of those voluntary patients did cease to be admitted to DSH, and are presumably receiving mental health services in the community. However, it is one speculation of this study that a number of these patients continued to be admitted to DSH on an involuntary basis after June 1986.

There are three possible explanations for the change in patients from voluntary to involuntary status. The first explanation is that this change happened at this particular time by coincidence only. If a patient has a history of only voluntary admissions and no previous criminal activity, this explanation is unlikely.

A second explanation for this change is that the patients actually decompensated further than previously, to the point that they were unable to care for themselves and refused treatment. This is plausible, but may be unlikely for patients who had never before refused treatment.

An alternative explanation for this conversion from voluntary to involuntary status is that the patients were criminalized. The restricted admission

policy of DSH forced a change in patient behavior in order to continue getting treatment for a mental illness. This study will test this alternative hypothesis by reviewing admission and other records for clinical detection of the emergence of dangerousness and other patient changes in response to the policy.

CHAPTER II

METHODOLOGY

Design

This exploratory study used a multiple case design. There were two data collection procedures. The first procedure was obtaining the sample to be studied, and second was reviewing the records of that sample. The steps in data collection were:

1. Listing all admissions from Multnomah County to DSH from June 1980 to May 1981. This was done at the Mental Health Division in Salem, using the FOCUS Report program against the Mental Health Information System (MHIS)/Patient Care System (PCS) data base. This list included a patient name, age, admission status, and other demographic variables.
2. Listing all admissions for every patient obtained in step 1 for the time period June 1981 to May 1987.
3. Dividing the list into groups of four possible treatment histories:

   a. Those patients admitted only involuntarily throughout the time period June 1980 to May 1987.

b. Those patients admitted both voluntarily and involuntarily throughout the time period June 1980 to May 1987.

c. Those patients admitted only voluntarily from June 1980 to May 1986, with no more admissions after the policy change of June 1986.

d. Those patients admitted only voluntarily at least three times from June 1980 to May 1986, who were admitted at least once on an involuntary basis in the year (June 1986 to May 1987) following the policy change (n=47).

4. Patient charts at DSH for all 47 subjects were reviewed. Specifically, the admission notes and social service histories for at least three voluntary admissions and for the first involuntary admission were reviewed. In the record of the involuntary admissions, the Notification of Mental Illness, the investigator's hearing recommendation, and the court's decision to commit were also reviewed. Data were extracted per protocol (Appendix A).

5. The 47 patients were further segrated into four groups depending upon clinical characteristics manifest during their voluntary hospital histories, June 1980 to May 1986.

Protection of Human Subjects

For the purpose of this study, the researcher had no direct contact with any patients. Individual data were collected from charts and records already in existence, and reported only in group statistics with a sample size large enough or in case reports with facts regarding individual cases deleted so that individuals are not identifiable. Approval for the data collection was obtained from the Administrator of DSH. Refer to Appendix B for a copy of the agreement to conduct archival research and the conditions to be applied to protect the privacy of the patients and the agencies involved. The researcher was guided in all practices by the Ethical Principles in the Conduct of Research with Human Participants published by the American Psychological Association (1982).

CHAPTER III

RESULTS

For the purposes of analysis, subjects with a history of voluntary hospitalization before June 1986 are divided into clinically homogeneous groups. Then the change in clinical characteristics of each group after June 1986 is described. Finally, the change in utilization of hospital services is described for each group. The results include descriptions of patient behaviors as charted by hospital staff. Statistics regarding length of time spent in the hospital are presented in summary tables.

Subjects

An initial review was made of each of 47 subjects' DSH records. Three subjects were disqualified from the study: one, an escapee from a California hospital, was immediately transferred back; another was transferred from a state penal institution and not considered voluntary; a third was mistakenly entered as being voluntarily admitted when in fact he was court committed.

The social service history and discharge summary for each of the remaining 44 subjects' admissions from 1981-1987 were reviewed, as well as the court documents from June 1986-May 1987.

When the data was examined, it became obvious that the subjects fell into well defined sub-groups, and the decision was made to divide them as follows:

1. those who had been "institutionalized" since an early age;
2. those who became more symptomatic after the policy change than they had been when voluntary;
3. those who deliberately manipulated the system to gain admission;
4. those who did not clearly fit into any one of the other sub-groups.

The characteristics of each sub-group before the policy change will be described in detail.

Institutionalized Group (GI). The institutionalized group (GI) consisted of 10 subjects, nine male and one female. Their history is characterized by early onset of illness, with the average age at first hospitalization being 16 years 2 months. They have spent long periods of time in the

hospital (Tables 1, 2, and 3) with multiple attempts at community placement, often with intensive CMHC involvement.

Without exception, these subjects have extensive records at DSH indicating that they have a poor ability to maintain in the community. They are unable to manage without the almost continuous supervision and structure of the hospital. They tend to act out against their caretakers and environment even in foster care homes. They are also much more comfortable in the hospital environment. To illustrate the characteristics of the institutionalized group, three typical case examples are presented below.

Subject 5 is a male first hospitalized at the age of 14 for rage outbursts, difficulty concentrating, and unmanageable behavior at home. He has been in the hospital almost continually since that time, with his shortest length of stay being nine months. While still a teenager, attempts were made to return him to his family or to foster homes without success. He was able to go on passes with family members without problems, but when discharged from the hospital, his violent behavior returned. As an adult, he was placed

Table 2

Average Number of Bed Days Used for Fiscal Year '86-87; Showing Change from Previous 5 Years

Group	86-87	Change from 81-86
GI	156.3	no change
GE	83.6	49.6% increase
GM	45.9	16.4% decrease
GU	107.4	22.1% increase

Table 3

Average Number of Bed Days Used per Admission

Group	Jun81-May86	Jun86-May87	Change
Institutionalized			
Range	3-857	27-365+	
Mean	111.3	196.7	76.7% increase
Median	27	97	
Mode(s)	11,14,23	-	
Early Hospitalization			
Range	3-153	32-235	
Mean	30.0	92.7	209% increase
Median	22	72.5	
Mode(s)	24	-	
Unclear			
Range	4-514	36-168	
Mean	63.5	92.3	45.4% increase
Median	28	50.5	
Mode(s)	23,24,72	-	
Manipulators			
Range	2-94	16-75	
Mean	25.6	39.9	55.9% increase
Median	21.5	39.0	

in residential care facilities with case management by the CMHC, but invariably attacked staff or destroyed property and was returned voluntarily to DSH. While in the hospital, his behavior is described as "docile...silly but compliant...requiring direction to perform ADL's...sometimes tantrums when he doesn't get his way". His longest continuous time in the hospital was approximately 2.5 years. His longest continuous time out of the hospital was approximately three months.

Subject 38 is a male first hospitalized at age 17 with impaired judgement, bizarre behavior, and auditory hallucinations telling him to harm himself. In response to these command hallucinations, he frequently cut or burned himself or took overdoses of medication. His voluntary hospitalizations generally lasted three to six months, during which time he would often elope for a few hours or days. His primary treatment when hospitalized was to restart medications, and his records indicate that "overt symptoms were suppressed, but [he] never showed much initiative for independent function...[he] seemed to like the institutional setting and said so". He was discharged from DSH to live in residential care or

room and board facilities, with case management, but invariably stopped medication and returned to his self-destructive behaviors.

Subject 7 is a male first hospitalized at age 17 with disorganized thinking, delusions, and paranoia. He has a history of several hospitalizations per year, each lasting one to two months. His behavior prior to hospitalizations ranged from "mild disorganization and agitation" to property vandalism and self-mutilation. Since 1980, he has had intensive case management, living across the street from the CMHC, with daily contact with his case manager, including having his medications dispensed daily from the clinic. However, he frequently stated that he "likes the hospital" and felt "too pressured" in the community. While hospitalized he was "calmer and quieter, with less expressed delusions...adjusted to hospital environment rapidly...cooperative and at ease".

These case examples are representative of the institutionalized group as a whole. As a group, their diagnoses are; schizophrenic disorders (7), organic disorders (2), and bipolar depressed (1).

Early Hospitalization Group (GE). There are 13 subjects in this group, including nine men and four women. Before the policy change, this group of subjects would typically present to DSH for admission, either alone or with family members, verbalizing symptoms that were distressing to them. They all had some level of insight into their need for treatment and requested hospitalization. Appropriate early hospitalization took place, and the person spent an average of 30 days per admission (Table 3), or 55.9 days per fiscal year (Table 1). Examples of subjects' presenting complaints at the time of voluntary admission include:

Subject 28. "Voices are calling me obscene names and I can't get any sleep."

Subject 2. "My head is crazy again and I can't think anymore."

Subject 37. "I am extremely depressed and staying in bed all the time, I am not coping with my housework or my son."

Subject 22. Brought in by family, admitting "not sleeping for 2-3 weeks, having faster thoughts, and feeling very good."

These quotes from hospital records are typical of the records of all these subjects. Their diagnoses as a group were schizophrenic disorders (10), and bipolar, manic (3).

Manipulators (GM). There was a group of 13 subjects (eight male, five female) whose records clearly indicate that they deliberately manipulated the system in order to gain hospital admission. Prior to the policy change, this group tended to use the hospital for multiple, relatively brief stays, as something of a respite from community stressors. They most often presented with complaints of dysphoria, vague suicidal ideation, and occassionally vague threats of harm to others. For example, subject 26 would frequently go to the hospital with complaints of "recently hearing voices and feeling paranoid...I have nowhere to go and no money, and came here for you to help me...I was thinking about trying to kill myself because I had a fight with my boyfriend".

The diagnoses of the subjects in this group were almost entirely personality disorders, with the exception of two diagnosed with depression.

Mixed Group (GU). The final eight subjects (four male, four female) did not clearly fit into any of the previously described sub-groups. They had a history of doing dangerous things, such as fire-setting and making suicidal gestures, yet could not be classified with the Institutionalized Group because of their different age and hospitalization histories. Their illnesses seemed to be characterized by poor impulse control and poor judgement, and often included drug and/or alcohol abuse. A typical example is subject 29, who had made frequent suicidal gestures when faced with disappointments, such as being denied SSI benefits or a sex change operation. Descriptive statements from voluntary records include "[he] again presents at the hospital depressed with suicidal ideation and paranoia...he relates strong feelings of wanting to hurt others and is delusional."

The diagnoses of this group were; bipolar (2), schizophrenic disorders (3), amphetamine delusional disorder (1), borderline intellectual functioning (1), and transexualism (1).

To reiterate, all 44 subjects had a history of at least four voluntary admissions to DSH immediately prior to the policy change which restricted

admission. Their differing clinical characteristics led to a division of the subjects into 4 distinct sub-groups. The post-policy change records were reviewed to determine if groups responded differently to the restricted admission.

Response to Restricted Admission

Rotter's social learning theory (1954) was used as a conceptual framework for this research. Simply stated, this theory states that people attempt to achieve their most desired goals by the most available means. This theory has been used to explain the adoption of abnormal behavior patterns (Jessor, R., Graves, T., Hanson, R., and Jessor, S., 1968). In this case, the desired goal is hospitalization. A previous, acceptable means of achieving this goal, voluntary admission, is no longer available. The new means of achieving this goal, civil commitment, requires the person to be dangerous or unable to care for his basic needs. The hypothesis was that some previously voluntary people would, in fact, adopt these behaviors, or the appearance of these behaviors, in order to gain hospitalization. The use of this framework clarified the difference between patients who went to the hospital because they wanted to be

there for "inappropriate" reasons, and those who went because they needed to be there. It was hypothesized that these different groups of patients would experience different clinical changes when admission became restricted.

The strongest form of the primary hypothesis of this research was that patients would become criminalized in response to the restricted admission policy. Analysis of the data collected did not support this first hypothesis. There were patients who were involved in misdemeanor crimes (i.e., shoplifting and trespassing) and became committed. However, these patients had engaged in the same activities prior to the policy change, so this did not represent a behavioral change for them. In terms of involvement in criminal activity, these subjects did not appear to become more dangerous in response to the restrictive admission policy. They did, however, demonstrate other clinical and behavioral changes which are of great importance. A description of each group after the policy change is presented below.

Institutionalized Group (GI). As previously described, the subjects in the institutionalized group have an extensive history of being difficult to

maintain in the community. Their clinical picture has always included acting-out in a somewhat dangerous fashion, such as self-mutilation or attacking others. They would have been eligible for commitment before the policy change. This group showed virtually no change in their illness or behavior after the policy change was effected. Only their status was changed, from voluntary to committed, and their average length of stay per admission was increased (Table 3). Four of these subjects were committed for dangerousness to self or others, six for inability to care for basic needs.

Early Hospitalization Group (GE). This group would not have been eligible for commitment at the time of previous voluntary admission. However, their records indicate a dramatic increase in psychotic symptomatology after the policy change. Upon admission by commitment, they were acutely distressed by, yet unable to verbalize, their symptoms coherently, and had lost all insight into their illness and need for treatment. Examples of statements made in the hospital record, using the same subjects as cited earlier, include:

Subject 28: "He is delusional and grandiose, claiming that we [hospital personnel] are aliens and have devoured 1/2 million people and will do the same to him."

Subject 2: "He presents with garbled, unintelligible speech and gesticulating mannerisms, harassing and showing his fists."

Subject 37: "She is psychotic and illogical to the point that she is not able to care for herself and is not caring for her pregnancy...she is talking incessantly and hallucinating."

Subject 22: "She is very confused and has been walking around in public naked...she is glassy-eyed, with latencies of 30-90 seconds, and unable to tell why she came to the hospital or answer questions."

These descriptions were typical of the clinical changes presented by this group. With one exception, the court's decision to commit these subjects was based on an inability to care for their own basic needs. The average length of hospitalization required before the subject regained their previous level of functioning was three times greater after court commitment than it had been when the person was voluntary.

Manipulators. After the policy change, this group continued efforts to manipulate the system, even to the extent of going to DSH to be voluntarily admitted. When turned away, they simply "upped the ante" by first verbalizing clear and specific suicidal or homicidal plans, and if still unsuccessful, acting on those plans in a non-lethal way. Examples of statements from these subjects' records include: "the patient said he wanted to come to DSH and if he could not he would jump off a bridge" (#23); "it was the feeling of the staff that the patient would present to the court in order to obtain the outcome that he desired, that being commitment to DSH" (#19); "When [voluntary] admission was denied, the patient took a sizeable overdose of Cogentin which produced a delirium which subsided within 24 hours, thereby forcing the patient's admission, and on this account he was court committed" (#32).

It was clearly not the opinion of the hospital staff that these subjects represented a true danger in most cases. However, the court's decisions to commit all of these subjects was based on danger to self and/or others. Since the policy change, this group uses more bed-days per each admission than they did

when voluntary (Table 3), but is admitted fewer times, thus using fewer bed-days per fiscal year (Tables 1 and 2).

Unclear Group (GU). The symptoms and behaviors of this group were described in the records essentially the same both before and after the policy change. It was unclear from the records whether these subjects wanted to be hospitalized and acted out to achieve that goal, or whether their illnesses became more symptomatic. Because of their clinical characteristics, they most likely acted out impulsively without considering hospitalization beforehand.

As a whole, this group had the smallest increase in the average number of bed days used per admission after the policy change (Table 3). The court's decisions to commit these subjects were based on inability to care (5) and danger to others (3). It is interesting to note that none of the commitments were made based on danger to self.

The groups showing the most change after the restrictive admission policy was implemented were the early hospitalization group (GE) and the manipulators (GM). The other two groups, the institutionalized

(GI) and the unclear group (GU), actually showed little or no behavioral or clinical change.

An analysis of the data showed that, on the average, each subject had longer hospitalizations when committed than when voluntary (Table 3). In terms of bed-days used per fiscal year, the subjects varied (Tables 1 and 2). The group characterized as institutionalized showed no change whatsoever in this regard. Two other groups, those with increased symptoms (GE) and the unclear group (GU) had a significant increase in the total number of bed days they used during a fiscal year. The manipulators (GM), however, showed a slight decrease in the number of bed days used per fiscal year, indicating that they are admitted less often than they had been when voluntary. The implications of these data will be explored in the discussion and conclusions section.

CHAPTER IV

DISCUSSION

The change to a policy which accepts only committed patients at DSH had multiple impacts. Though patients were not criminalized, they were affected significantly by the policy change. Also affected were the mental health system, in general, and the economics of mental health care. Discussions of each of these issues are presented below.

Why Not Criminalized?

The primary hypothesis of this study, that voluntary patients would become criminalized in response to the restrictive admission policy of DSH, was not supported. This is probably due to the fact that there are easier ways to get into the hospital than committing a crime, particularly when the court is involved. Furthermore, the delay in getting hospitalized may not have been sufficient for the process of criminalization to take place.

Judges generally do not have, nor are they expected to have, the clinical expertise necessary to distinguish someone who is genuinely dangerous from someone who is manipulating the system. Even if the distinction is obvious, the judge must take statements of the person at face value. If a person says, in effect, to a judge, "if you release me today I will kill myself and take someone with me", the judge is left with no alternative but to commit that person. The safety of society and its members are of primary concern to the court, versus the treatment and budgetary issues addressed by the hospital.

Though the subjects did not appear to be criminalized as a result of the policy change, there were other serious changes in their course of illness.

Impact on Subjects

The intended foci of this study are issues of patient care and the effect the "commitment only" policy has on their illness. One sub-group in particular, GE, showed a drastic increase not only in the number of bed days they used per admission, but also the number of bed days they used per fiscal year. As stated previously, these subjects became more symptomatic before being hospitalized, to the

point that they were unable to meet even their basic personal needs. One possible explanation for this is that it would have happened anyway, regardless of the policy. This explanation, however, is not very plausible because of these patients' records of voluntary admission. Another explanation would be that it is the natural course of mental illness to get worse over time without treatment. This argument is refuted by the literature (Harding, Zukin, and Strauss, 1987; Strauss, Hakes, Libermann, and Harding, 1985), which shows that symptoms of mental illness, particularly schizophrenia (which afflicts the majority of this group), tend to lessen over time.

A more logical explanation is that prior to 1986 the patients and/or their families recognized the signs of an impending acute phase and sought voluntary admission early. After the new policy was implemented, admission was necessarily delayed until commitment was required. The most plausible explanation seems to be that the effect of the policy on this group has been profound. They have become more severely debilitated, then spend a much longer time in the hospital to recover their previous level of functioning. At the same time, the patient must suffer the torturous symptoms of mental illness in the extreme.

The manipulative group (GM) was another whose behavior seemed to be affected by the policy change. Since the policy change, these subjects are admitted fewer times, but are staying longer when they are admitted (committed). Their manipulative efforts are also being rewarded, which may increase their manipulation further. This makes them even more difficult to deal with in the community, where treatment efforts are generally directed at decreasing manipulation. These subjects can probably be generally classified as system abusers.

The institutionalized group (GI) appears to have been the least affected behaviorally by the policy change. Their behavior and symptoms showed little, if any, change; only labelling by the system changed. However, this does not mean that there is no effect in other, not so obvious, ways. A major treatment goal for these patients is to get them to lessen their labels and dependencies. The already problematic stigma of mental illness is only increased by the status of legal commitment.

Oregon law (ORS 426.005), effective January 1988, specifies that a person who has been committed twice within the past three years is considered, by legal

definition, a "chronically mentally ill person", and may be committed again for any behavior similar to that which preceded one of the previous commitments. This law, in conjunction with the involuntary admission policy, further erodes the civil liberties of severely and persistently (i.e., chronically) mentally ill patients. As the policy now exists, a person needing hospital care has no choice except to be committed. The patient has now been legally, as well as clinically, defined and categorized. In the future, this patient may be more readily hospitalized, even if he/she does not want to be hospitalized. He/she can be committed again, even if not currently dangerous or unable to care, because of their commitments under the existing admission policy.

All the subjects in this study were adversely affected by the restrictive admission policy to some extent. By extrapolation, it is therefore presumed that most, if not all, mentally ill people who require hospitalization periodically were also adversely affected.

Impact on Mental Health System

One of the goals of the admissions policy change was to decrease the census. The theory was that previously voluntary episodes of hospitalization would simply cease to occur, leaving only previously involuntary episodes to deal with. This was a simplistic solution to a seemingly simple problem.

The census did not, in fact, decrease. One reason is that some previously voluntarily admitted patients became involuntarily admitted after the policy change. Another is the longer length-of-stays resulted from commitments.

The initial analysis revealed that, on average, subjects (regardless of sub-group) stayed in the hospital longer when committed than when they had been admitted voluntarily. One conclusion that can be drawn from this is that the subjects were more ill than they had been in the past, thus requiring a longer period of treatment before regaining the same level of functioning. It is also possible that the hospital staff tends to be more cautious with committed patients, keeping them longer to ensure, with a greater degree of certainty, that they are able to provide for their own needs or are no longer dangerous. This, however, seems an unlikely

explanation, given that the hospital is chronically over census.

Systems researchers can draw from this study the principle that when policies are changed to cope with problems, problems will change to cope with new policies. Neither policy change nor reorganization has beneficial effect unless the underlying problem is addressed. The primary underlying problem in this case is the gross lack of community and hospital resources for the mentally ill.

State hospitals in general and DSH specifically are frequently the treatment resource of last resort and the subject of much scrutiny and criticism. The tasks of the hospital are compounded when policy requires that only the sickest and most difficult-to-manage patients are admitted. In addition, the staff is then charged with the task of treating them as quickly as possible so that they may be discharged to make room for more. To the extent that community support services are limited in the number and severity of persons they are able to serve, to that extent chronically mentally ill persons will not be able to gain the type of help they need to remain stable in the community. The state hospital

then falls heir to these patients in a deteriorated condition. The extent of deterioration is dependent on the lack of help in the community and the delay in getting into the hospital. Only more and quicker help will alleviate this condition...not screening and denied admission.

Economic Impact

Although the economics of admission policies was not the focus of this study, it is an issue that demands discussion. Whatever the reasons for the longer stay per admission, the fact is that commitment is substantially more expensive for the community than is voluntary hospitalization. Before a commitment hearing, the patient is generally lodged in a local, sometimes private, hospital on a police or two-physician hold. Few patients have insurance. Therefore, the county must bear the expense of hospitalization. In addition, there is the expense of the legal proceedings, which involve a judge, a deputy district attorney, a public defender, two examiners, an investigator, detention staff (who arrange for and provide transportation and safety), and often police witnesses. This is in addition to the cost of hospitalization once the patient is committed.

Implications for Nursing

The policies and procedures which govern any health care system determine which patients are treated and how that treatment is provided. Nurses are often in a position of providing primary care, in both the community and in-patient settings. Thus, policy dictates how nurses get their "customers". Mental health nurses in the community are faced with a shortage of resources and the task of keeping a mentally ill client out of the hospital. Once that person is hospitalized, the hospital nurses play a significant role in their treatment. The severity of the patients' illnesses and the level of treatment they require defines the nurses' task. If policies are less than optimal, the nurses (and other line staff) bear the brunt.

Too often, policy decisions which affect nurses are made without nursing representation. Too often, nurses do not thoroughly understand the problems which policies are intended to solve. In this case, the policy created an increased burden for both community mental health nurses and the DSH nurses, as well as the rest of the DSH staff. Nurses have a responsibility to be aware of and, as much as

possible, to participate in determining policies which so greatly affect their livelihood and the treatment of their patients.

CHAPTER V

RECOMMENDATIONS AND CONCLUSION

The generalizability of this study is limited by use of a single site, and the sampling method and sample size. A replication of the study with another sample from a different geographical location woul increase the generalizability. Nevertheless, some general recommendations based on the results of this research are offered.

System Recommendations

As stated earlier, an underlying problem is a lack of mental health resources in the community. A certain amount of the money now being spent on legal proceedings and longer hospitalizations could be diverted into developing community resources. Different types of treatment resources are needed for the different types of patients being treated.

A problem for any system is a group that takes advantage of and abuses that system. However, this group is not going to go away, and more effective means of dealing with such patients need to be developed. These patients are, in general, personality disordered, for which the treatment of

choice is long-term therapy with a consistent therapist. There are very few low-cost resources that provide this type of treatment, and the ones available are limited in the number of people they can serve. These patients also tend to have frequent crises in their lives, from which they seek respite by going to the hospital. The development of treatment programs to serve this group, including respite facilities short of hospitalization, could potentially decrease the treatment and economic burden they are now placing on the mental health system.

A group with different treatment needs are those characterized as "institutionalized". These people have required some level of care and custody for a mental illness since adolescence. Much of the "treatment" they require involves maintaining a status quo, including administration of medication and almost continuous supervision. The hospital's role with these patients is largely custodial, a role that could be filled in the community given the proper resources. Although there are facilities of this type existing, there are not enough and the atmosphere and staffing are generally poor. More money spent on developing other facilities and better staff training

could potentially free some beds at DSH which are badly needed to provide treatment.

Many subjects of this research were involved with the abuse of alcohol and other substances, though it was not a problem area specifically addressed by design. DSH does not have a program for the treatment of chemical abuse or dependence, and is therefore not an appropriate placement for patients with that as a primary diagnosis. Though the use of substances continues to increase, there is a gross lack of community treatment resources for indigent patients. These people then frequently get placed at DSH, which can only serve as a "drying-out" facility in these cases, again using bed space more appropriate for other patients. This will continue to happen until more substance abuse programs, both in-patient and out-patient, are developed to serve indigent patients.

In summary, there are many people who need mental health treatment who cannot be adequately served by the existing resources. Though there are creative efforts being made by communities to address some of these problems, there simply is not enough money or manpower allocated for these endeavors. Shifting some of the monies now required for the involuntary

commitment of all patients into the community may be a beginning to alleviate some of the problems facing the mental health system. Shifting money into commitment does not seem to have helped.

Suggestions for Further Research

Throughout the course of this study, many interesting questions were raised, yet not dealt with because of the limitations of this research. The following questions are the ones which seem most important. The answers may be obtained in further research.

1. There were patients who had a history of voluntary admission to DSH prior to the policy change who were no longer admitted after the change. What happened to those patients? What services, if any, are they receiving in the community? What effect did lack of hospitalization have among these patients and their families?
2. In spite of a policy which would seemingly limit the number of admissions to DSH, the census has increased or remained the same over time. What are the factors which might explain this phenomena? What new patients were hospitalized to take the place of those diverted or denied? What are their characteristics?

3. State hospitals have persistently had morale problems among staff because of the adverse conditions under which they must work. Has the policy of accepting only committed patients affected the morale of the staff at DSH and their treatment of patients?
4. Is the treatment of patients committed for dangerousness different from that of patients committed for basic needs. Is "dangerousness" an aspect of more severe mental illness, or is it a separate problem? Are hospitals more directed to protection of society via incarceration than to treatment of mental illness?
5. Do patients from rural areas have similar histories and are they similarly effected by the policy, or are they different from those in highly populated areas? If so, what are the differences?
6. What systems are available to link the hospital and the community? Do staff of both the hospital and CMHC's depend on family members to coordinate the care? If not, how does it occur?
7. This paper has examined how one group of patients has been affected by a public policy. How have communities been affected? How have the families of the mentally ill been affected? How has the treatment system been affected?

8. Although the economic issues have been briefly addressed, it would be interesting and useful to have a thorough study to support (or refute) the conclusion that a commitment-only policy is more expensive than accepting voluntary admissions. What is the difference in actual dollars before and after? What is the source of funding?
9. Finally, what sorts of programs are needed in the community, to complement already existing programs, to relieve some of the burden placed on the state hospital and provide more and better care for the chronically mentally ill?

Conclusion

In many ways, the decision to admit only committed patients to DSH has been a failure. The immediate answer would appear to be to reverse the policy and again accept voluntary admissions. To do so, however, would simply repeat one of the mistakes of the restrictive policy; that is, making a change to cope with a problem, without addressing the underlying issues creating that problem. Such policy decisions have a limited ability to achieve their goal, and potentially negative consequences for all involved. In this case, the hospital census was not lowered, and the hospital staff continue to be overburdened with difficult patients. The economic strain has limited the financial resources available for community treatment of the mentally ill. It is the mentally ill patients themselves, though, who appear to have been the most adversely affected by the restricted admission policy.

REFERENCES

American Psychological Association. (1982). Ethical principles in the conduct of research with human participants. Menasha, WI: Banta.

Bonovitz, J.C., & Guy, E. B., (1979). Impact of restrictive civil commitment procedures on a prison psychiatric service. American Journal of Psychiatry, 136(8), 1045-1048.

Carlson, J.I. (1987). Forensic psychiatry program. Salem, OR: Mental Health Division.

Ciompi, L. (1980). The natural history of schizophrenia in the long term. British Journal of Psychiatry, 136, 413-420.

Faulkner, L.R., Bloom, J.D., McFarland, B.H., & Stern, T.O., (1985). The effect of mental health system changes on civil commitment. Bulletin of the American Academy of Psychiatry and Law, 13(4), 345-357.

Gralnick, A., (1985). Build a better state hospital: Deinstitutionalization has failed. Hospital and Community Psychiatry, 36(7), 738-741.

Hoaken, P.C.S. (1986). Psychiatry, civil liberty, and involuntary treatment. Canadian Journal of Psychiatry, 31(4), 222-226.

Huber, B., Gross, G. Schuttler, R., and Linz, M. (1980). Longitudinal studies of schizophrenic patients. Schizophrenia Bulletin, 6(4), 592-605.

Jessor, R., Graves, T., Hanson, R., and Jessor, S. (1968). Society, personality, and deviant behavior. New York: Holt, Rinehart, and Winston, Inc.

Lamb, H. R., (1982). Treating the long-term mentally ill. San Francisco: Jossey-Bass, Inc.

Lamb, H.R., & Mills, M.J., (1986). Needed changes in law and procedure for the chronically mentally ill. Hospital and Community Psychiatry, 37(5), 475-480.

Lefly, H.P., (1987). Aging parents as caregivers of mentally ill adult children: An emerging social problem. Hospital and Community Psychiatry, 38(10), 1063-1070.

Rotter, J.B. (1954). Social learning and clinical psychology. Englewood Cliffs, NY: Prentice-Hall.

Shah, S.A. (1975). Dangerousness and civil commitment of the mentally ill: some public policy considerations. American Journal of Psychiatry, 132(5), 501-505.

Steadman, H.J., & Keveles, G. (1972). The community adjustment and criminal activity of the Baxstrom patients: 1966-1970. American Journal of Psychiatry, 129(3), 304-311.

Stephens, J.H., (1978). Long-term prognosis and follow-up in schizophrenia. Schizophrenia Bulletin, 4, 25-47.

Strauss, J.S. & Carpenter, W. T. (1977). The prediction of outcome in schizophrenia. III. Five-year outcome and its predictors. Archives of General Psychiatry, 34, 159-63.

Torrey, E.F., (1983). Surviving schizophrenia; a family manual. New York: Harper & Row.

APPENDIX A

PROTOCOL FOR DATA COLLECTION

Protocol for Data Collection
First Involuntary Admission

Subject #:____ Age:_____ Sex:_____ LOS:_____
Diagnosis:_____

Source of financial support:_____

Living arrangement at time of hospitalization:
1. with family or friends
2. in group home or residential care facility
3. SRO hotel
4. alone in apartment or house
5. transient
6. other (describe) _____

Type of Notification of Mental Illness (NMI):
1. police officer
2. 2-physician
3. 2-party

Nature of complaint in NMI:_____

_____

_____

Reason for hearing recommendation:_____

_____

_____

Reason for Commitment:
1. dangerous to self
2. dangerous to others
3. unable to care for basic needs

Brief behavioral description on admission:_____

_____

_____

Course of treatment:_____

_____

_____

Discharge Plan:_____

APPENDIX B

AGREEMENT TO CONDUCT ARCHIVAL RESEARCH

Agreement to Conduct Archival Research

In order to protect the privacy of DSH and Multnomah County, the following terms and conditions are agreed to regarding records research:

1. Recorded data extracted from patient files may never be attached to any patient's name or other identifying information.

2. Data must be coded for research and statistical purposes in such a way that individual elements may not be traced back to any specific patient or patient's chart.

3. Data must be grouped and summarized in such a way, and with a sufficiently large sample size, that individual's contributions to the data pool may not be isolated or identified.

4. The researcher shall hold in the strictest professional confidence any information learned about any individual patient, and shall refrain from ever discussing or divulging such information about individuals.

5. The researcher <u>shall not</u> review any patient file wherein the name(s) of a patient is in any personal way known to the researcher.

6. The study will be conducted and results utilized only in the ways specified in advance in the research proposal, and for no other purposes.

7. DSH and Multnomah County retain the right to fully monitor the project and its operations, to discontinue the project at any time and for any reason, and to completely review and screen any information or results prior to their release to any third party or for preparation of a manuscript.

AN ABSTRACT OF THE THESIS OF

LISA SCHROFF

For the MASTER OF SCIENCE IN NURSING

Date Receiving this Degree: December 16, 1988

Title: THE EFFECTS OF RESTRICTED HOSPITAL ADMISSION ON PATIENT DANGEROUSNESS

Approved: _____

Florence Hardesty, RN, Ph.D., Thesis Advisor

From time to time, administrators are forced to make policies rationing mental health services when demand exceeds supply. In 1986, the Oregon Mental Health Division was faced with a census crisis at Dammasch State Hospital (DSH). A decision was made to restrict admissions to involuntarily committed patients only, the priority population. The question is, what impact has this policy had on patients previously admitted voluntarily?

An hypothesis was derived from Rotter's Social Learning Theory, which predicted that patients would meet the criteria for involuntary commitment in order to be hospitalized. Specifically, it was predicted that patients would become more dangerous, or criminalized, in response

to the restricted admissions policy.

All admissions to DSH from Multnomah County from 1981 to 1987 were examined. Those with four or more voluntary admissions prior to the policy and at least one commitment after the policy were selected. Hospital admission records for these subjects were reviewed with a protocol to determine if there had been any change in patient behavior after the policy was implemented. Court records for the involuntary commitments were also reviewed.

Based on the review of records, four patient groups were formed; an early hospitalization group, an institutionalized group, a manipulative group, and a mixed group. The length of stay per admission and per year for all groups was greater after the implementation of the policy, except for the manipulative group. The latter used fewer bed days per year. There was no evidence found that any of the groups were criminalized.

For the institutionalized group and the mixed group, only their admission status changed from voluntary to involuntary. The manipulative group became more threatening. The early hospitalization group was most affected by the policy. They experienced a dramatic increase in psychotic symptomatology, and lost all insight into their need for treatment.

It was concluded that these patients did not become criminalized because there are easier ways to get into the hospital than committing a crime. Manipulation was

rewarded, making this group more difficult to deal with. The institutionalized and mixed groups were more stigmatized. The early hospitalization group suffered to a greater extent. In short, all groups were adversely affected, as was the mental health system itself.