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## Ambivalence of PES patients toward hospitalization and factors in their disposition

Steven P. Segal<sup>a,\*</sup>, Theresa A. Laurie<sup>b</sup>, Perri Franskoviak<sup>c</sup>

<sup>a</sup>Professor and Director, Mental Health and Social Welfare Research Group, School of Social Welfare, University of California, 120 Haviland Hall (MC# 7400), Berkeley, CA 94720-7400, USA

<sup>b</sup>Assistant Professor, University of New England, UK

<sup>c</sup>Clinical Supervisor, Substance Abuse and Crime Prevention Act, Department of Public Health, San Francisco, USA

### 1. Introduction

The psychiatric emergency service (PES) in general hospitals in California is where most civil commitment evaluations are completed and where significant numbers of psychiatric inpatient stays are approved. The PES evaluation is an important component of the civil commitment process and is carried out under psychiatric supervision by professionals whose specific purpose and training is in the assessment of those who are dangerous to themselves or others, and/or gravely disabled due to a mental disorder (California Welfare and Institutions Code, Section 5150). As such, the PES setting is a critical entry point into the mental health system and sets the tone for the patient's view of the mental health treatment continuum. In response to the growing concerns about the coercive nature of the civil commitment process (Hiday, Swartz, Swanson, & Wagner, 1997; Hoge et al., 1997, 1998; Lidz, Mulvey, Arnold, Bennett, & Kirsch, 1993; Lidz et al., 1995), this study looks at those individuals who are ambivalent about hospitalization as a treatment choice at the close of their PES evaluation. These individuals are neither for nor against hospitalization, they are ambivalent about it. Such ambivalence has frequently been attributed to the patient's psychotic process (Kwapil, Raulin, & Midthun, 2000; Puskar et al., 1990; White, 1929) but may also derive from the patient's rational assessment that hospitalization for them is an inappropriate treatment disposition. In the latter situation, a sense of being coerced may be derived from having one's rational assessment acted on as if it were part of a psychotic process. To determine the most likely explanation for patient ambivalence, this study seeks to specify those factors that best distinguish ambivalent patients from other patients and investigates the disposition outcomes of such patients.

\* Corresponding author. Tel.: +1-510-642-3949; fax: +1-510-643-5138.

### *1.1. The PES evaluation, civil commitment, and coercion*

Civil commitment as an outcome of PES evaluations in general hospitals may be considered the result of a complex negotiation, in which the factors involved in patient attitudes toward disposition decisions are still not well understood. Previous research has determined that the civil commitment assessment that takes place in PES is reliable, and has concurrent and discriminant validity (Segal, Watson, Goldfinger, & Averbuck, 1988a, 1988b, 1988c). In the PES setting, dangerousness is clinically related to mental disorder (Segal et al., 1988a, 1988b, 1988c). Moreover, it has been determined that the civil commitment criteria—dangerousness and mental disorder—are the primary factors leading to a patient's involuntary hospitalization (Appelbaum, 1982; Segal, Laurie, & Segal, 2001; Wanck, 1984). Current researchers, however, have focused extensively on the patient's experience of being coerced in the PES setting, and have found that coercion or its absence does not necessarily conform to the patient's legal status. For instance, some researchers have found that PES staff and advocates, such as family members who are present during the assessment, unduly influence patients into signing voluntary hospitalization orders (Hoge et al., 1997; Lidz et al., 1995), or inappropriately pressure them into accepting an involuntary hospitalization (Cascardi, Poythress, & Ritterband, 1997; Hoge et al., 1998). Others have noted that patients who are hospitalized involuntarily do not necessarily report feeling coerced in the PES evaluation (Hiday et al., 1997). Such apparently conflicting findings may lead one to the conclusion that the feeling of coercion itself may not be the major factor involved in the patients' negative attitude toward hospitalization (Campbell & Schraiber, 1989). Perhaps coercion derives from the structural characteristics of the experience, that is, an overwhelming process that in some way is tainted by institutional constraints, social biases, or the absence of procedural justice, rather than the prospect of having one's liberties curtailed.

### *1.2. Civil commitment, coercion, and structural determinants*

It has been hypothesized that failure to strictly adhere to the legal standards in making civil commitment decisions may involve undue restrictions of liberty and possible abrogation of rights under the Fourteenth Amendment (Segal et al., 2001). Others, emphasizing the patient's fear of civil commitment, have warned that it may inhibit willingness to engage in future treatment (Campbell & Schraiber, 1989; Cascardi et al., 1997; Hiday et al., 1997; Lidz et al., 1995). This is because the care that is imposed may reduce the patient's sense of having a voice in their own treatment planning. It is unclear in these reports, however, whether fear of civil commitment derives from involuntary detention, or the patient's perception that such detention is unnecessary, counterproductive, and, more importantly, not the best way to address their problems. Additionally, managed-care plans in both the public and private sectors parsimoniously allocate inpatient psychiatric care, thus making civil commitment more desirable as a way to justify using this resource, as well as shifting the burden of longer term care to another provider (Petrla, 1995).

With these competing forces impinging upon the PES clinical encounter, we must be especially aware of those individuals who are ambivalent about treatment. Ambivalence may derive from that patient's clinical condition; it has been associated with schizophrenic behavior and the behavior of others with psychosis (Kwapil, Raulin, & Midthun, 2000; Puskar et al., 1990; White, 1929). Ambivalence may also result from a legitimate evaluation, on the patient's part, of the adequacy of treatment options. In the former case, such ambivalence may be an indicator of a need for treatment and support a decision to

retain the patient. In the later case, a decision to retain an ambivalent patient may be coercive in that it may result from structural deficits in the system. Determining those factors that contribute to a patient's ambivalence is important for understanding whether the use of hospitalization is an appropriate way to deal with clinically derived ambivalence or, no matter how benign its intent, an inappropriate therapeutic alternative compensating for system deficits. We therefore first explore possible inappropriate influences on civil commitment that may be associated with patient ambivalence toward hospitalization.

### *1.3. Civil commitment and inappropriate influences*

We all can be coerced. In fact, coercion is part of everyday life. For the sake of efficiency, modernity demands that we accept a certain amount of coercion in exchange for security and the expression of well-defined civil rights. One way in which inappropriate coercion is prevented is by creating a set of criteria to be used in determining when coercion may either be deployed or withheld for the greater good of individuals and the community. Civil commitment laws, from a clinical perspective, are a means of protecting individuals unable to appreciate their need for treatment; from a legal perspective, they are an example of a trade-off between individual rights and public interest. Because of its coercive character, it is important to better understand the civil commitment process to be assured that it proceeds without the influence of inappropriate or confounding issues that are unrelated to both the legal and clinical criteria, under which hospitalization is allowed. In making such a determination, three sets of issues should be considered. The first set of issues arises from the influence of institutional constraints, such as those attributed to the increasing use of managed-care strategies, to control inpatient admissions. These constraints include increasing workloads, treatment decisions based on cost factors such as whether the patient has insurance, and the use of difficult, inadequate, and unaccommodating work environments that place a greater burden on the practitioner and may lead to inappropriate release or retention decisions. The second set relates to procedural justice issues such as those that were highlighted during the civil rights movements of the 1960s and have been discussed in considerable detail in more recent literature (see Hoge et al., 1997, 1998; Lidz et al., 1993; Lined, Confer, & Early, 1990; Monahan et al., 1995; Poythress, Petrila, McGaha, & Boothroyd, 2002). In contemporary PES settings, the elements of advocacy, institutional processing and patient participation in the evaluation represent points where procedural justice may be distorted or overlooked altogether (Scheff, 1966). Finally, race and gender social bias may lead to inappropriate use of coercive powers (Commander, Cochrane, Sashidharan, Akilu, & Wildsmith, 1999; Whaley, 1997).

Mental disorder and dangerousness represent the prevailing legal admission criteria in most states. In several states such as California, these criteria may only be used to justify the decision to retain an individual in the hospital when there is an absence of a less restrictive alternative to hospitalization (*California Welfare and Institutions Code, Section 5150*). Advocates of the APA Model Law (Rubenstein, 1985; Stolberg & Stone, 1983) have proposed the addition of a "need for treatment criterion," to the states' civil commitment statutes, including treatability and ability to benefit from hospitalization.

On the other hand, mental disorder and dangerousness may also be construed as indicators of the patient's problematic interaction with society. Similarly, the indicators of treatability and ability to benefit from hospitalization, as well as the availability of a less restrictive alternative to inpatient care, would appear to be indicators of the patient's fit with the mental health system. In our increasingly penurious health care system, clinicians are often forced to prescribe, and patients forced to accept,

treatments that both know are less than desirable, ineffective, or even counter productive. In considering inappropriate and perhaps coercive influences on ambivalent patients, we will look at the lack of availability and clinical fit between system resources and patient need as reflected in the latter three criteria.

## **2. Methods**

### *2.1. Sample and procedures*

This study is part of a continuing investigation of civil commitment evaluation decision making and the factors that influence it. While the data are somewhat dated for evaluating the operations of a particular setting, the quality of the observations enable us to explore decision-making issues that are of general concern in the civil commitment process. Of 711 attempted observations of patients who had visited one of nine PESs between 1985 and 1986, 683 were used for this study. The refusal rate was 3.9% ( $n = 28$ ), meaning that these cases were not included in the analysis due to their own preference or the preference of their PES clinician. PES observations were obtained from seven San Francisco Bay Area hospitals, one Los Angeles hospital, and one California Central Valley hospital. All PESs are licensed sites for psychiatric evaluations. To insure narrow confidence intervals on validity estimates in dangerousness assessments, the primary purpose of the original study, a minimum of 50 observations were obtained from each PES. Sites outside the Bay Area were selected to expand the generalizability of the findings. Including Los Angeles and Fresno gave us the opportunity to look at differences between PES practices in areas that functioned under the same legal and clinical criteria, yet differed significantly in terms of sociocultural makeup.

Patients were chosen consecutively on entry to the PESs, and observations were completed around the clock, 7 days a week. As soon as one case was completed, the next one was assessed. No patient could be passed over for any other reason than the case's refusal to participate.

Patient evaluations were performed by PES clinicians and observed by mental health professionals-trained as clinical research observers and experienced in assessing severely disturbed behavior. The observer accompanied the patient and the PES clinician throughout the course of the assessment, witnessing all interactions including telephone contacts, and was privy to all information available to the clinician. The observer recorded the entire assessment process until a disposition decision was reached by the PES clinician. In addition to information about the patient that had been gathered by the clinician, the observer coded her/his own impressions about the patient and several aspects of the PES clinician's treatment of the patient. Information was ascertained and recorded on prestructured scales, as well as recorded in the form of process notes. Acceptable interrater reliability in the .75 to .9 range between observers on key study instruments was established before the independent observations were initiated. Human subject procedures were reviewed and approved by 11 committees.

The PES clinician was at no time aware of the contents of the instruments coded by the research observer. The Three Ratings of Involuntary Admissibility (TRIAD) dangerousness assessment is based on gathering specific units of information that are then constructed into validated patterns of dangerousness and disability via computer programs. Since the research observer is not privy to the coding schemes, he/she is effectively blind to the scoring, giving the study a double blind effect. Following the initial reliability checks, research observers became part of the routine staffing in the PES.

That no effort was made to impress them or attend to liability concerns was indicated by the unusual candor clinicians displayed regarding their opinions of patients during the evaluations.

### 3. Measures

#### 3.1. *Criterion variables*

We worked with two criterion variables. The first criterion was whether a patient was ambivalent toward a hospital disposition following PES evaluation. To define this subgroup of patients, we took account of the expressed wishes of the patient during their PES evaluation as to whether they wanted hospitalization. Patients who were unsure, unable to express an opinion, or expressed views that were ambiguous about whether hospitalization might or might not be beneficial for them were considered to be ambivalent toward the acceptance of hospitalization. This group is a distinct set of respondents, not a residual category of patients for whom no information is available regarding their opinions about disposition.

The second criterion variable we considered was disposition outcome, that is, release or retention within the ambivalent group.

#### 3.2. *Predictors*

##### 3.2.1. *Admission criteria/severity of the patient's condition*

Four affirmative admission criteria that are consistent with current and proposed legal requirements are analyzed as indicators of the severity of the patient's condition: (1) clinician-assigned *DSM III* diagnosis of a *Psychotic Disorder*, (2) the patient's likelihood of causing harm to self, harm to others, or being gravely disabled at the time of the PES evaluation, the *TRLAD Dangerousness Scale Score* (range 1–11, higher scores indicating increased dangerousness; across three replications, average interrater reliability was between .8 and .85 and scores correctly predicted 72–80% of PES dispositions; Segal, Eagley, Watson, & Goldfinger, 1995), (3) whether the psychiatric disorder was viewed as treatable by the clinician, the *Treatability Scale Score* (range 0–1, higher scores indicating greater Treatability; Segal, Eagley, Watson, Miller, & Goldfinger, 1998), and (4) the patient's ability to benefit from hospitalization, *Benefit from Hospitalization Scale Score* (range 0–1 higher scores indicating greater likelihood of benefiting from hospitalization; Segal et al., 1998). In addition, we included the presence of a less restrictive alternative placement as an obviating factor. The presence of such an alternative (defined as any supervised residential arrangement, including placement with a willing and responsible relative, crisis housing, nursing homes, and foster family care) was measured as a 1/0 variable with 80% interevaluator agreement.

##### 3.2.2. *Procedural justice*

More recent research on the psychology of procedural justice has broadened our understanding of the factors that influence this complex social phenomenon. Currently, the literature suggests that the “voice” effect is not limited to beliefs or expectations about the outcome of any given decision, but that it also extends to having input into the decision-making process as well (Lined et al., 1990; Tyler, 1989). Thus, any measure of procedural justice in a naturalistic study would look at the degree to which steps were

taken to include individuals in the decision-making process, and whether the decision made matched the participant's desired outcome. We chose three indicators of procedural justice that reflect this enhanced understanding, as discussed in the following sections.

*3.2.2.1. Involuntary legal status at PES entry.* Deviance theorists argue that civil commitment proceedings are lacking in procedural justice in that persons arriving at the PES are routinely processed and retained or released consistent with prior statuses or labels (Scheff, 1966). Under such circumstances, prediction of the patient's disposition would be strongly associated with legal status at entry to the PES. This assumption is testable by the inclusion of this indicator in our PES decision model as a predictor of disposition. Legal status at entry should not necessarily be a significant predictor of retention. This is because the clinical status of many patients will improve over the evaluation period in the PES. For example, suicidal patients may respond to crisis intervention and by the end of the evaluation are no longer a danger to self; individuals on methamphetamines may find the acuity of their amphetamine psychosis diminishes as they detoxify during the PES evaluation.

*3.2.2.2. The art of care scale.* The primary concern in assessing procedural justice is insuring that the process is conducted fairly (Tyler, 1992; Tyler & Lined, 1992). This can only be achieved when the patient has been given the chance to fully participate in the evaluation to the maximum extent possible (Hoge et al., 1997, 1998; Lidz et al., 1995; Monahan et al., 1995). The Art of Care Scale (Segal, Eagley, Watson, & Goldfinger, 1997) measures the extent and character of such participation. It includes the average of four items (scored 1 if present, 0 if absent), which address the clinician's attempt to engage in a collaborative interaction, elicit information from the patient, include the patient in planning appropriate to their functioning, and attend to the patient's feelings with empathy. Interrater agreement in coding the items from process notes averaged .75, and evidenced an internal consistency of  $\text{Alpha}=.69$ .

*3.2.2.3. Advocacy for and/or against hospitalization.* An additional concern in civil commitment evaluations has been the influence of advocates in the PES evaluation process. Undue influence on the part of others whose preference may dominate the evaluation could lead to inappropriate disposition decisions (Bloom & Asher, 1982; Lidz et al., 1993). Because ambivalent patients may be especially vulnerable to the influence of advocates, we sought to determine whether advocacy played a role in a particular outcome for these patients.

### *3.2.3. Institutional constraints*

Factors that might be considered institutional constraints on the clinician's disposition decision include (1) excessive *Clinician's Workload* (measured by a four-item factor score including patient–staff ratio in the PES [Factor weight=.257], the clinician's patient load [Factor weight=.683], and the total number of inpatient beds [Factor weight=–.132] and out of hospital beds [Factor weight=–.168] available at the time of the evaluation); (2) a *Difficult Setting*, in which the evaluation was completed (measured as a 1/0 rating based upon the observer's conclusion that the patient was assessed in a context including conditions of relentless noise, limited space, limited phone access, visual distractions, and/or other negative characterizations); and, (3) the absence of *Insurance Coverage* (measured as a 1/0 rating, where Medicaid and Medicare were included as a form of insurance).

### 3.2.4. *Social bias indicators*

Social bias indicators that might prejudice a clinician's action toward adopting a coercive disposition include demographic characteristics, which have conventional association with discrimination, that is, patient's gender (coded 0 = male and 1 = female) and ethnic minority status (coded 1 = African American and 0 = other).

### 3.2.5. *Other context controls*

We considered other context variables as controls in the analysis. These included the time of evaluation (9 a.m.–5 p.m. vs. other), hospital in which evaluation was completed (nine 0/1 dummy variables), technical quality of care received, (Segal et al., 1995, 1998), and whether the disposition was voluntary or involuntary.

## 3.3. *Analyses*

### 3.3.1. *Univariate/bivariate*

Demographic characteristics are reported along with bivariate analyses on all variables distinguishing ambivalent patients from others seen in the PES, as well as for those variables within the ambivalent group that distinguish patients retained or released following PES evaluation. Bivariate relationships are evaluated using *t* tests for differences in means and Chi square analyses for categorical variables.

### 3.3.2. *Multivariate*

We first completed a two-stage logit regression focused on those individual and contextual factors most likely to distinguish individuals in the ambivalent group. Second, working only with the ambivalent patients, a two-stage logistic regression model was constructed to predict patient disposition. Each model examines the relative importance and significance of admission criteria, procedural justice indicators, institutional constraints, and social biases. The first stage includes the aforementioned factors. In the second stage, a set of control factors was entered. The model was run three times: once with a block of controls involving quality of care issues measured by clinicians' experience and Gustofson's Technical Quality of Care Scale (Segal et al., 1995, 1998), a second time with a block of controls involving methods issues including the time of entry into the PES, the time the retention/release decision was made (both measured as a 0/1 variables of 9 a.m.–5 p.m. vs. other), and the hospital in which the decision was made (eight of nine possible 1/0 dummy variables), and a third time including a 1/0 dummy variable indicating whether the retention was voluntary or involuntary.

## 4. **Results**

Of the 683 cases investigated, 24% ( $n = 164$ ) were found to be ambivalent toward hospitalization. Ambivalent patients were more likely to be male (68%,  $X^2 = 9.854$ ,  $df = 1$ ,  $P < .002$ ) and younger (Mean = 32.48, S.D. 11.45;  $t = 2.937$ ,  $df = 516$ ,  $P < .003$ ) than other patients. No racial differences were found between the two groups. Of the 164 individuals who were ambivalent toward hospitalization, 78% ( $n = 128$ ) were retained and 22% ( $n = 36$ ) were released. Of those ambivalent patients who were retained, 53.6% ( $n = 88$ ) were retained involuntarily and 24% ( $n = 40$ ) voluntarily. Ambivalent patients were more likely to have been brought voluntarily to the PES than other patients ( $X^2 = 4.464$ ,  $df = 1$ ,  $P < .035$ );

57.3% entered PES with a voluntary legal status. They were also more likely to have been retained voluntarily than others ( $X^2=65.285$ ,  $df=1$ ,  $P<.000$ ). They accounted for 83% of all voluntary retentions.

With regard to the admission criteria, the average TRIAD Dangerous score for ambivalent patients was 3.51, making the average ambivalent patient (like the nonambivalent patients) severe enough to be civilly committed on any one of the three dangerous criteria: Danger to self, Danger to Others, or Gravely Disability. Among ambivalent patients, 69% were given a diagnosis of a psychotic disorder (schizophrenia, schizoaffective, bipolar, or brief psychotic episode). They were considered more treatable by their evaluating clinicians ( $t=-2.955$ ,  $df=436$ ,  $P<.003$ ), and were less likely to have an alternative placement to the hospital available to them ( $X^2=11.159$ ,  $df=1$ ,  $P<.001$ ).

With respect to procedural justice indicators, while 30.5% of the ambivalent patients ( $n=50$ ) had an advocate to participate in their hospitalization, than nonambivalent patients. Out of a total of 116 advocate responses on behalf of ambivalent patients, 21.6% came from patients' therapists or psychiatrists, 20.7% came from other relatives or friends, 13.8% from the case managers, and 12.9% from parents spouses and partners. The remainder of the advocacy responses were represented by neighbors or landlords, other acquaintances, patients' medical doctors, and other collateral contacts. Advocacy undertaken on behalf of ambivalent patients was most effective when the advocates fell into the categories of therapist and psychiatrist ( $X^2=22.00$ ,  $df=2$ ,  $P<.000$ ) and friend and relative ( $X^2=5.923$ ,  $df=1$ ,  $P<.015$ ). Apparently, parents, spouses, and partners did not have much influence on the decision to release or retain their loved ones.

On the Art of Care Scale (range 0–1), our measure of patient engagement, 41.3% of the ambivalent patients ( $n=59$ ), received the highest score, indicating that they, like other patients, were very much engaged in the process of the PES evaluation, to the extent that they were capable.

Finally, with respect to institutional constraints, almost a third (32.3%) of the ambivalent patients had no insurance, while 11.2% ( $n=16$ ) experienced their PES evaluation under conditions that were rated difficult. No differences were observed on the workload factor between the ambivalent and non-ambivalent groups of patients.

#### *4.1. Multivariate PES decision model*

Since neither the quality of care, retention on a voluntary basis, nor the controls related to site and time of assessment significantly added to either of the two models, findings are presented for single-stage logistic models including only those factors in our theoretical construction.

##### *4.1.1. Distinguishing ambivalent patients from others*

The model distinguishing ambivalent patients from others was significant ( $X^2=29.659$ ,  $df=14$ ,  $P<.0085$ ; see Table 1). However, ambivalent patients were distinguished from others only by matters pertaining to their fit within the mental health system. They were 42% more likely than others to be without a less restrictive alternative to hospitalization, 53% less likely than others to be seen as being able to benefit from hospitalization, and 322% more likely than others to be seen as



Table 1  
Factors predicting patient ambivalence toward hospitalization, a logistic regression ( $n=402$ )

Variable	B	P	Odds ratio
<i>Psychiatric admission criteria</i>			
Dangerousness	0.00	.9786	1.00
Less restrictive alternative available	−0.54	.0271	0.58
Psychosis	0.17	.4884	1.19
Benefit from hospital stay	−0.75	.0132	0.47
Treatability	1.17	.0252	3.22
<i>Institutional constraints</i>			
Difficult setting	0.10	.7711	1.11
No insurance	−0.12	.6171	0.88
Workload	−0.08	.1934	0.92
<i>Procedural justice indicators</i>			
Advocate for hospitalization	0.00	.9959	1.00
Advocate against hospitalization	−0.82	.1607	1.13
Involuntary entry to PES	0.01	.9784	0.99
Art of Care	−0.37	.3262	0.69
<i>Social bias issues</i>			
Female gender	−0.33	.1492	0.72
Client ethnicity	0.12	.7021	1.12

Model  $X^2=29.659$ ,  $df=14$ ,  $P<.0085$ .

treatable. Psychosis was not a significant factor in distinguishing ambivalent patients from other patients.

#### 4.1.2. Release versus retention of ambivalent cases

Five factors significantly predicted the release or retention following PES evaluation ( $X^2=69.1$ ,  $df=14$ ,  $P<.0000$ ,  $n=133$ ; see Table 2). Among the admission criteria, factors increasing the likelihood of retention of ambivalent patients were their having a psychotic diagnosis, and a three-point, clinically significant, increase in TRIAD dangerousness scores. The former group had a 554% greater chance of retention versus others in the sample, the latter a 468% higher probability of retention versus others in the sample. The availability of a less restrictive alternative to hospitalization reduced the probability of retention 92% versus others. Other factors influencing the retention of ambivalent patients were having no insurance and having an advocate in favor of hospitalization participation in the evaluation process; the former group had a 666% higher probability of retention versus others in the sample, the latter a 1540% higher probability of retention versus others in the sample.

The fact, observed in the bivariate analyses, that ambivalent patients were more likely to be retained voluntarily than others, and that advocacy for hospitalization was important in the decision to retain them, led us to hypothesize, following the literature (Hiday et al., 1997; Hoge et al., 1997, 1998), that patients may be coerced into accepting a voluntary status. To check the importance of this hypothesis, we reran the model with an additional variable—the interaction

Table 2  
 Predictive factors in disposition of patients ambivalent toward hospitalization, a logistic regression ( $n = 133$ )

Variable	B	P	Odds ratio
<i>Psychiatric admission criteria</i>			
Dangerousness	0.45	.0083	1.56
Less restrictive alternative available	2.57	.0007	0.08
Psychotic disorder	1.71	.0234	5.54
Benefit from hospital stay	0.23	.8012	1.25
Treatability	−3.17	.0547	0.04
<i>Institutional constraints</i>			
Difficult setting	−0.64	.5218	0.52
No insurance	1.90	.0238	6.66
Workload	0.18	.3781	1.2
<i>Procedural justice indicators</i>			
Advocate for hospitalization	2.73	.0047	15.40
Advocate against hospitalization	−8.71	.7370	0.00
Involuntary entry to PES	0.23	.7404	1.26
Art of Care	0.66	.5214	1.94
<i>Social bias issues</i>			
Female gender	0.68	.3306	1.98
Client ethnicity	−1.09	.3192	0.34

Model  $X^2 = 69.100$ ,  $df = 14$ ,  $P < .0000$ .

of advocacy for hospitalization and voluntary status. This was not found to be a significant addition to the model.

## 5. Discussion

Table 1 indicates that ambivalence toward hospitalization is a position adopted by patients, primarily in response to the options available to them at the time of disposition rather than one attributable to their psychosis. In fact, ambivalent patients are more likely to possess those characteristics that make them appear treatable, and are less likely to be viewed as able to benefit from hospitalization. They are also in the position of not having a less restrictive alternative placement to hospitalization available to them. These findings should lead one to the conclusion that hospitalization would be inappropriate for this group but for the lack of a critical alternative resource. While the clinician and the patient are aware of a more appropriate treatment modality, its unavailability at the time of the PES evaluation prevents its use by the patient.

The fact that advocacy for or against hospitalization was not significant in defining the ambivalent group would indicate that the ambivalence was not being created by some form of coercive influence by relatives or others taking part in the evaluation. While a significant and negatively signed *Art of Care* score might have indicated that a communication failure somehow accounted for the patient's ambivalence, this was also not found to be the case. The absence of the

latter relationships in the definition of the ambivalent group, as well as the fact that no other institutional constraints, social bias issues, or procedural justice indicators were significant, is further evidence that this is a resource issue involving lack of fit between patient need and available care.

Ambivalent patients, like other patients, were retained involuntarily in the hospital if they met the civil commitment standard of dangerousness due to mental disorder. Ambivalent patients were also more likely than other patients, however, to be retained voluntarily. What is troubling from the standpoint of understanding the experience of ambivalent patients in the PES is that the lack of a less restrictive placement seems to force the use of hospitalization. Given the treatability of the group and indications that they do not benefit from hospitalization, the retention disposition appears to be a less than appropriate choice of treatment. The latter observation may be the reason why ambivalent patients also required the participation of an advocate, primarily a mental health professional in favor of hospitalization, as well as the status of “no insurance,” to obtain hospitalization.

As long as patients must contend with a mental health system that does not have the range of treatment alternatives to hospital care to provide clinically appropriate treatment, they will undoubtedly feel coerced. The experience of coercion for the ambivalent patient, however, contrary to what is hypothesized in the literature, appears not to be the result of inappropriate advocacy, but rather derives from a lack of treatment options. Patients may perceive that their call for help is not heard because they end up in the hospital when they sense, and clinical criteria concur, that their progress toward well-being is more hopeful if served in an alternate way. It would not take many experiences like this before patients eventually stop seeking help altogether (Campbell & Schraiber, 1989), putting themselves at risk for unnecessary, and, not incidentally, expensive psychiatric decompensation. While the findings of this study may not be replicable in other jurisdictions, they do represent the practice in nine different counties in California. Since no significant cross-room effects were observed above and beyond those contributed by the model, we believe that the findings may be comfortably generalized to the rest of California, and, to a lesser extent, those other states using the dangerousness criteria as part of a crisis evaluation in the first phase of the civil commitment process. Furthermore, the situation with respect to the lack of availability of less restrictive alternatives is no better and perhaps worse than it was when the study was completed.

## **6. Conclusion**

Ambivalence toward hospital admission at the close of their PES evaluation among this sample of patients was related to deficits in treatment resources, specifically alternatives to hospitalization, matching patient need rather than being related to the patient’s psychosis. While the fact that such patients were more likely to sign in voluntarily may indicate that the clinician was able to engage what might clinically be seen as the help seeking part of the ambivalence (a fact consistent with the relatively high scores on the Art of Care Scale), the fact that the patient was likely to not benefit from hospitalization and was treatable in an alternative setting (should one have been available) is likely to create in the patient a sense of coercion. This coercion is derived from having to settle for hospitalization when there is agreement among both clinician and patient that alternatives are more appropriate.

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