Lisa Dixon (00:07):

Welcome to our podcast, Psychiatric Services from Pages to Practice. In this podcast, we highlight new research or columns published this month in the Journal Psychiatric Services. I'm Lisa Dixon, Editor of Psychiatric Services, and I'm here with Podcast editor and my co-host, Josh Berezin. Hi Josh.

Josh Berezin (00:26):

Hi, Lisa.

Lisa Dixon (00:27):

Today we're going to discuss an article that gets us thinking about what we know and don't know about involuntary psychiatric hospitalization.

Josh Berezin (00:36):

So we're very happy to have Dr. Ned Morris, who's an Assistant Professor of Clinical Psychiatry at UCSF on here to talk about his open forum. Taking an evidence-based approach to involuntary psychiatric hospitalization. Dr. Morris, thanks so much for joining us.

Dr. Ned Morris (00:49):

Thanks so much for having me.

Josh Berezin (00:51):

We always start off the podcast with a question about how people got interested in this particular topic or the paper we're talking about represents. So what was the pathway to this area of interest for you?

Dr. Ned Morris (01:02):

I think in a few ways. First, when I was a medical student and I remember seeing an inpatient psychiatric unit for the first time. It was really jarring to me how we would literally confine people behind locked doors as part of their medical treatment. And it broadly made sense to me in terms of people are suicidal, or potentially dangerous, or maybe they have to be held briefly for safety purposes. But I wondered where did those policies come from? How are these developed.

(01:26):

And the second part was really during my residency training. And again and again, I would get these questions from patients or families and it would be about involuntary hospitalization. I often couldn't answer what were often pretty straightforward, not super complex. These were, "How often does someone get readmitted?" Or if they were going into a civil commitment hearing, "How often does someone prevail in these and get released?" And I wouldn't have answers for them. I wouldn't know, and I would try to look that up and it wouldn't exist.

(01:54):

So that shocked me that one of the most coercive, controversial, but also potentially lifesaving interventions that we do in medicine, we really didn't have much information about. And so that really seemed like an important issue that I really wanted to look into more.

Josh Berezin (02:09):

So I think you touched on some of this in the paper, but that original question that you had as a medical student, how did this evolve? Where did this come from? Have you found an answer that you could now talk to a family member about and say, "Well, actually this is how we got to where we are?"

Dr. Ned Morris (02:28):

Yeah. There's the academic answer, which I'm sure as you both know, we could talk about for hours about the history of civil commitment in the United States. One, sometimes I'll talk... I can get to patients and families, but at least with trainees, we'll often actually, not to... I work in California, not to be like California-centric, but there was a law that was passed in the sixties called the Lanterman-Petris-Short Act. And that was, at least many people have looked at is, or it's even been referred to as the Magna Carta of the mentally ill. It was a really important law passed in the sixties where basically, and I'll sometimes even talk about this with patients and families, is before then is what you often will see in media or magazines about the concerns of people getting thrown in asylums for decades.

(03:04):

And there wasn't really loose oversight. And that law, in the sixties, introduced really two important things. The first is specific criteria, so danger to self, danger to others. Something called Grave Disability, which is the inability to take care of yourself for food, clothing, or shelter. And the second is really firm time limits. So timed checkpoints when somebody is put in the hospital. And that has been thought to influence practices really across the country.

(03:30):

Over the last several decades there's really often been this very stringent focus. One, on largely dangerousness in the United States. And then two, is this timed checkpoint. And what I'll say to patients often in my discussions with them is, on the one hand, these can be really, really important protections. If I was put in the hospital, I would want to have there to be criteria and time limits. And that makes sense, right?

(03:50):

On the other hand, it can be really challenging with the legals things that come up where it often will put doctors and patients in situations where they seem against one another. And so I'll actually talk about what that's like with patients, "Hey, here's what a hearing is going to happen, here's what goes on in then. Here's what might happen after that." And trying to educate them as best you can. And so that's a very brief overview of decades of far more complex issues than I think we can get into right now.

Josh Berezin (04:13):

Yeah, for sure. One of the interesting things is that these are state laws right across the country that are regulated state by state. But whenever I do hear about... I'm most familiar with the laws in New York. But whenever I do hear about pieces or just examples from other states, it's always that same frame that you're talking about there where it's danger to self or others, and a timeframe, and then a legal process around it too. It seems like everyone has coalesced around the same framework. Well, I don't know about everyone, the limited number of states that at least I know about.

Dr. Ned Morris (04:46):

And I'd say, yes and no, to that. So yes, absolutely. Most states across the country have now developed specific criteria, often really focusing on dangerousness and then those time limits. On the other hand, just by devil's advocate, it's very, very different according to what state you practice in. And so I'll have patients who only by having heard this over time or knowing... they'll say, "Yeah, I was section twelved."

And only because I went to medical school in Massachusetts do I know that that's part of their practices there.

(05:11):

Or a patient will be like, "Well. That was my third Baker Act." And you're like, "Wait." And you Google that, and that's in Florida. And so even as practicing clinicians having been in this space for years, you may have no idea what a patient's talking about from Wisconsin, Texas, other places because it tends to vary so much. Even though, yes, as you mentioned, the basic framework is pretty similar.

Josh Berezin (05:30):

I think the background section to a lot of papers are, and the introductions to our podcast are often like, "Well, okay, so what do we know about the evidence behind this particular intervention?" And it seems like more appropriate here to ask what don't we know about the evidence behind involuntary psychiatric hospitalization?

Dr. Ned Morris (05:46):

Yeah, that's a great point. How I might answer that is, its complicated, is basically, there is a lot of literature on civil commitment. One thing we were very hesitant about writing this paper is in no way did we want to imply, no one's ever thought about this before. No one's ever... There are dozens and dozens of papers that have been written about civil commitment. You can drown yourself in the amount of data and papers that have been written. But, and here's the big but, when you look at most of these papers, they're at very, very specific details. So seclusion, involuntary medications, how often might people win a legal hearing or not? And so it'll go through all of these details. And what you realize over time is that if you take a broader view and step back the question, does this intervention actually work?

(06:29):

Does it prevent suicide or violence? Does it improve people's lives? We really don't have a lot of data on that. And so one comparison I might make is, it's similar for chemotherapy, we had dozens and dozens and dozens of studies about how it affects tumor size, how it has side effects, who can afford to have it, who's selected for chemotherapy? But we didn't know, do people live longer when they get chemotherapy? That would be a comparison I make for the current status.

(06:55):

And there's obviously, as we talk about in the paper, a lot of challenges for civil commitment research. But that I think is the important element is that someone could go to PubMed right now or Google Scholar or whatever and say, "What are they talking about? There're tons of studies on civil commitment." But the problem is the broader questions of does it actually work long term? That is something that is really challenging to study and that there's really not a lot of information out there about.

Josh Berezin (07:17):

What are some of the challenges behind doing some of the studies that would provide some evidence base for involuntary hospitalizations. Why are we in this, both setting of tons of information about the intervention and not so much about the actual outcomes?

Dr. Ned Morris (07:32):

The short answer is that basically civil commitment or involuntary psychiatric hospitalization is a very high stake situation. And because it's a very high stake situation, there are a lot of ethical challenges to

the research. The medical community is often almost, to an obsession, focused on randomized controlled trials. And that's another thing we really, really wanted to be careful with in writing this paper, is not to just say, "Well, we should have randomized trials for... If that doesn't exist." And we were thinking about, there's those tongue in cheek papers you can find about, "Why aren't there randomized trials for parachutes?" And so there're some interventions that are obvious.

(08:07):

So you might look and just say, it's obvious if someone is suicidal and they're saying they are going to kill themselves, you need to have them in the hospital until that person is better and can be safely in the community. That might seem like an obvious answer. But again, if you take a step back and you actually think at a population level. Well, we don't know how many people actually would hurt themselves if they're outside the hospital and being locked in a hospital unit can be really traumatic and distressing for people. They might lose their jobs, they're separated from their families, they might lose their housing.

(08:36):

Are there situations where people get worse? So, that's a really big challenge. To answer your question, "Why don't we have these types of studies?" If you just think about the logistics, if someone walks into an emergency department and is hallucinating and has a command hallucinations to kill someone, can you then send that person into the community and randomize them to go home? That's like a really tricky question. If somebody comes in and says, "I'm going to hurt myself." And can you randomize that person to go home? What IRB is going to approve that?

(09:03):

So we explore some of these challenges in the paper. Are there observational studies we can do? We talk about other solutions. There are ways you could think about randomizing such as crisis residential units are not just send people home, have step down levels of care. But at the end of the day, there's really, really challenging questions if you're going to run these types of big trials of, if this were to work long term, when you're dealing with really high stakes incidents like suicide, violence, things like that.

Josh Berezin (09:27):

And Lisa, when you, not to put you on the spot, but when you hear about this sort of research challenge, do you have something that comes to mind as this is very similar to the challenge in studying X and here's how they dealt with it? Or does this seem more a unique set of challenges?

Lisa Dixon (09:49):

I do think there have been alternatives to hospitalization that have been developed and are used, for example, the old Loren Mosher Soteria House and I know some colleagues in Israel that are trying to develop some comparable types of settings where there's care, and observation, and support. But not the extreme, if you will, just taking that position of involuntary hospitalization. And in answering the question, I do have to acknowledge that there's a difference between hospitalization and involuntary hospitalization.

(10:29):

And perhaps we need to understand more about what the source of the involuntariness is, if you will. So in other words, if I could imagine many different types of involuntariness. So let's take the example, and we were discussing this earlier, we know that people of color, probably Black men more than any other group, are disproportionately subjected to involuntary hospitalization and involuntary treatment. I don't have the exact data, but I think that's something that is known. So why might those individuals... A, it

raises the specter that there's not an objective judgment being made necessarily. And also perhaps individuals who don't trust the system, who don't trust the processes might be extremely reluctant to participate in and maybe that's something we can do something about.

Josh Berezin (11:27):

Do you think that some of the challenges of studying this is that, you have these laws that are very neat in some ways, and then all these decisions. Every single one is a subjective decision that's made individually by a clinician who has their own idiosyncrasies in terms of their background, training, viewpoint, understanding of the law, setting resources, all of these things. So it's-

Lisa Dixon (11:54):

Biases.

Josh Berezin (11:54):

... biases.

Dr. Ned Morris (11:55):

Absolutely. That's a fundamental aspect of what we're looking at here of where if there's not evidence, if there's not data, one thing we talk about is we don't even know how often people across the country are placed on these holds. Whereas there's pretty clear evidence in a lot of the literature about disproportionate diagnoses of psychotic disorders, what racial groups or people are more likely to be subjected to emergent medications or seclusion practices. These are really important things to think about at hospitals across the country. Some of the most, as Lisa was getting to, coercive things that we're doing to people and how do our own biases affect? And so that's a really important thing where you're totally right, danger to self. If somebody says, "I'm going to hurt myself right now," versus, "I'm going to hurt myself in seven days," versus, "I'm going to do that in a month."

(12:38):

These are often really subjective calls that happen in the emergency department or elsewhere. And that's a really important thing to think about if we have these laws that can... Subjectivity becomes quite important when they lead to really, really potentially life saving, but also potentially really distressing interventions where we're doing involuntary things to people. And we included a quote from Paul Applebaum, the article, really adding where another challenge to the research here is it's not just health outcomes.

(13:06):

We're not just... The Chemotherapy comparisons a little unfair because we're not just looking at tumor size and mortality benefit. But also there's these other tangible aspects of freedom, autonomy. How do you measure that in an RCT? How voluntariness, as Lisa was getting at. These are really other challenging notions that are really hard to just measure in a research study. But at the same time are really important to think about how does mistrust, how does bias, social determinants of health, poverty, homelessness, how do those factor in? And those are really profound questions I think we need to think about.

Josh Berezin (13:38):

After having looked at all this, if you could maybe not design, but think of two kinds of studies that would really advance our understanding of whether or not this intervention works or not. On a

fundamental level, or how it works, or when it works? What would be some things that you think are actually doable? You're not going to design a randomized control trial. So what are a couple things that you think we could actually get at, given our current research framework that we have?

Dr. Ned Morris (14:12):

We lay out three approaches in the paper of how we think... I'll expand two to three if that's okay with you, just to add those. We lay three in the paper that I think are really, really important for addressing those questions. There're limitations to RCTs, to observational studies, but lots of different research has limitations in different fields. And so the first is what we talked about earlier is literally just generating basic data. If the state is authorizing us to literally put people on locked units and potentially medicate them against their will, that should be tracked. That should be, I think, tracked at the state level, where basically how often are these holds being used? How often are people on them? Et cetera.

(14:47):

The second is, to Josh's question earlier, is think about long term outcomes. We should be tracking how often are people readmitted? What are their long term health statuses? And one thing I was thinking about as we wrote this paper is surgeons are often tracked on their complication rates. They know quite well often how often they have complications when they're applying to hospitals. Hospitals advertised based on that kind of stuff. But as a psychiatrist, I don't know about either of you, I have no idea how many of my patients have been readmitted. I don't know what percentage of them have had adverse outcomes. And how can you be doing one of the most coercive things we do in medicine, locking people against their will, when there's no tracking as to who does that more often than other people, who has better outcomes with their patients. I'm sure there're issues about patient populations and where you live and confounding variables, but at the end of the day, why do other medical specialties look at their interventions and long-term outcomes and we don't. So I think that's the second part is thinking about the outcomes.

(15:41):

And the last thing, I'll just add, the third to Josh's point about what can we do from a research standpoint to better understand these practices, is you can take either extreme of, "Involuntary hospitalization is terrible and awful and evil," or you can take, "Wow, it's really life saving and incredible and this is something we need to do." But I think pretty much everybody in that debate, can't speak for everyone, but I think most people would agree that, "Hey, it should be used as a last resort when everything else has failed." And I think most people agree on that.

(16:06):

So what is the research we can do to study ways to avoid involuntary hospitalization? And there's already, we put in the paper promising research on psychiatric advanced directives, intensive home services. There're other alternatives as Lisa was mentioning earlier, where I do think, even though it's a contentious debate, both people, or both sides, can come in the middle and say, "Yeah, there is a middle path of..." I don't think even psychiatrists enjoy putting people... locking them in units or giving involuntary medications. It's a very distressing experience. And what are ways we can reduce the use where it's not necessary?

Lisa Dixon (16:37):

This brings me back to working on an ACT team, which I know it has its own history, but way back when in the nineties when I was a part of a team. It really allowed us to build relationships with people. It allowed the time, the space to go out into the community to go where people were, this particular

program focused on homeless adults with serious mental illness. And that costs money. Those kind of services are... they won't be available if they're not funded. But I do think that that investment can really help. And maybe we don't have a lot of data on this, but it just seems really to make sense by building relationships with people where they are you can avoid at least some involuntary hospitalizations.

Dr. Ned Morris (17:33):

I absolutely agree. There are costs and there are thinking of how we place resources. But in my training, I have worked at places where they were charging something like 10 or $20,000 a night on involuntary hospitalization units. And so we think about how in medicine, often we will, insurance or whatever, will pay for the liver transplant but won't pay years earlier for the Uber ride for the person to go to the AA meeting. And so how we think about what are our priorities, and I absolutely agree what you're mentioning about.

(18:02):

That's an example of potentially avoiding hospitalizations. If I'm in the emergency department and I have somebody who is telling me that they are suicidal and suddenly their case manager appears and says, "This is Mr. Smith, we know him very well. Sometimes this happens when X, Y and Z happens. We have a van outside, we're taking him to his appointment tomorrow, he has his Medicaid..." I'm way more likely to discharge that person and keep them out of the hospital than the person who has nowhere to go, has no supports, has... the psychiatrist wait list is six months. I absolutely agree. I think the question is where do we want to prioritize those resources? And I think that's a great example of looking upstream to avoid these things.

Josh Berezin (18:37):

One thing that I think is really interesting about the conversation as a whole is this is all based on laws which are written by legislators who are elected officials. And I just always wonder if the general public understands what inpatient psychiatric hospitalization is? What happens on inpatients, what is the process like? Who gets hospitalized, who doesn't? And what happens during that in particularly involuntary situations? What happens there? And I think this question of, is it effective? Is very important in informing of the whole ideas we have around, not just from a medical perspective, but also around a public policy perspective as well.

Dr. Ned Morris (19:27):

Fantastic point. And of course there's a spectrum. There are people who are very, very familiar with involuntary hospitalization, people who are advocates, who go to policy makers, and whether they are for or against there are people who have never heard of it. And then I think your point's important is what is public understanding of these policies when we don't even know how many people are being placed on these holds? And if we think about how does that affect, from a public health standpoint, for example, 988 rolling out.

(19:51):

How many people are out there who are not calling that phone number? Because they don't know where that leads. They're afraid, they've heard of "Involuntary hospitalization." And, "If I call this number, is someone going to kick in my door and drag me into a hospital setting?" That's a really scary thing for someone to think about. And I'll take the other standpoint, which is I've been fortunate, I've given some talks at law schools where you come in and the law students there who, as you mentioned, these are the people who are often going to be designing these policies.

(20:15):

They're going to be becoming policy makers, legislators, lawyers. And there's such a different perspective, in many ways, good from clinicians, where our focus is safety of the patient, safety of the public, what can we do to help this person? And from many of the law students' perspectives is deprivation of liberty and they're very intense on that. And so what I'll often do in these talks is I'll walk through the basic decision making that happens in an emergency department. Which is somebody walks in and says, "When I leave here, I'm going to kill myself."

(20:42):

What do you do with that person? And often some students will say, "Well, give them medication so they don't say that." And I say, "Those don't really exist." Maybe ketamine and stuff is coming out, but that often does not exist, or is not an option, or the person still says they're going to harm themselves, what do you do? And so you lead them down the pathway where often a lot of these laws are really developed out of necessity of what do you do in that situation?

(21:03):

And I think that's a really great point about not necessarily public messaging, but again, just a reflection of the lack of public data or awareness of one of the most important, in my view, policies that we have from a mental health system standpoint, that a lot of people don't know about it. They don't know how it works, they don't know how it functions. And how should we, as psychiatrist, be participating in that. Whether it's collecting data, writing about it, advocacy, working with legislatures. I think that's a great point you bring up.

Lisa Dixon (21:30):

So just for the listeners, this article is an open forum and an open forum is like a conceptual, scholarly essay. And I love these and yours is so coherent and well argued. And again, one of your main points is that there needs to be, if not researched, there needs to be empirical investigations so that we can make evidence based decisions. So what's the first thing? You've been in this space, how are we going to do it? You're in California, how should the various psychiatric organizations, clinical, forensic, whatever, what should we be advocating for? How can we do it? How can we get there and get out of the gate?

Dr. Ned Morris (22:15):

One thing we had talked about earlier is really the lack of awareness or even just basic understanding of how this system functions. And I'm a pretty big advocate that we can't design solutions to problems that we don't understand. And so at a minimum, if I were to say one thing that I think clinicians, psychiatric organizations, medical organizations should be advocating for is really public tracking of these policies. These policies to many people, as Josh brought up earlier, whether we like it or not, are often the face of psychiatric care of mental health services.

Lisa Dixon (22:46):

So what does public tracking mean? What does that mean?

Dr. Ned Morris (22:50):

So in my view, basically every state across the country and ideally with federal coordination of this should be tracking how often are these holds happening? How long are they occurring for? How many people are placed on them? We need to, if we have laws that are authorizing, locking people in hospital units for treatment, which in many ways again, I find can be often life saving, how is that being used?

Lisa Dixon (23:10):

So who should be in charge of that tracking? Is it a governmental responsibility?

Dr. Ned Morris (23:17):

Sure.

Lisa Dixon (23:19):

Should some person or agency in the federal government be tracking all of these activities at the state level?

Dr. Ned Morris (23:25):

Yeah. So one potential comparison you could make is, as I was mentioning earlier with jails and prisons, the Bureau of Justice Statistics. There are jails and prisons across the country that's incredibly complicated to monitor how many people are behind bars. But they're able to at least, and again, I'm not saying their estimates are perfect, but they're able to come up with national estimates of how many people are behind bars, age, charges, they face, ethnicity. And I do think we should have something similar to that across the United States to better understand our system of civil commitment.

Lisa Dixon (23:52):

Thanks.

Josh Berezin (23:52):

So we've got all of our state and federal agencies getting ready to go.

Lisa Dixon (23:58):

Well, I mean, come on. Now, this is the main point. This is your marching orders, so to speak. How can we manage this if we don't even know anything about the practice across this country?

Dr. Ned Morris (24:12):

And I love your point of thinking, "Well, how does this practically happen?" Because one of my favorite things I once read was, "It's very easy to write in an academic essay. Two words. Policy makers should..." But the question is, who is reading that? Who's doing that? And really at the end of the day, you're bringing up fantastic points of on the ground logistically, what does that look like? And so yes, I do think that every state, if they're authorizing these policies, should have a central agency that is collecting data. Basically anytime these are filed, that should be going to that central agency. And then there should be federal coordination that's monitoring across states.

(24:45):

That, in my view, would be an ideal way to start the process where we at least understand how often is this occurring. And there's so much other stuff that we could look into that we've talked about today.

Lisa Dixon (24:55):

And then from there we can start to understand, make change, perhaps even do research, try to understand what works and what doesn't.

Dr. Ned Morris (25:06):

Absolutely. Yeah.

Josh Berezin (25:06):

Well, that's probably a good place to stop. Thank you so much for joining. We had a fantastic conversation. And I think it's a, as you said here and said it in the paper, it's a controversial topic, but I think that you present it both very even handedly and also in a way that everybody should want to at least understand where we are right now. We're not going to be able to make any good decisions without doing that. So thank you so much. We really encourage everyone to read the article. We look forward to hearing how your coordination of all the states and federal agencies go in the next couple weeks.

Dr. Ned Morris (25:40):

My co-author, Rob, he'll be the one doing that.

Josh Berezin (25:42):

Perfect. Well, we'll have him on in a couple weeks to hear how it goes.

Lisa Dixon (25:46):

Yeah, it's great. Thank you so much.

Josh Berezin (25:47):

Thanks.

Dr. Ned Morris (25:47):

Thanks for having me.

Lisa Dixon (25:49):

That's it for today. We invite you to visit our website ps.psychiatryonline.org to read the article we discussed in this episode as well as other great research. We also welcome your feedback. Please email us at psjournal@psych.org. I'm Lisa Dixon.

Josh Berezin (26:06):

I'm Josh Berezin.

Lisa Dixon (26:07):

Thank you for listening. We'll talk with you next time.

Speaker 4 (26:11):

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