SPEAKER NOTES

Involuntary Hospitalization—What's It All About?

Summarized by Thomas T. Thomas

Involuntary hospitalization, the process of calling the police or mobile crisis team and having a distressed family member hospitalized under Welfare & Institutions Code 5150, [1] is an anguished decision that usually comes at the end of hours, days, or weeks of crisis. At our September 23 meeting, we had the opportunity to discuss this process with three local professionals: **Francesca Tenenbaum,** Program Director, Patients' Rights Advocates, who counsels clients on the ward and their families about legal rights and participates in the legal hearings that are part of hospitalization; **Beverly Bergman,** Family Advocate through the Mental Health Association, who spends several evenings a week at the John George Pavilion's Psychiatric Emergency Services counseling and supporting families; and **Eva McRae,** who works to redress complaints from consumers and family members through the Complaint Assistance process.

FRANCESCA TENENBAUM

"We work collaboratively to solve the problems that come up in the system," Francesca Tenenbaum said. "If you reach any of our programs and it's not the right one, we'll make sure you get to the person who can help you."

Basically, all three women deal with complaints. Eva McRae deals with people who are entitled to specific services from Alameda County Behavioral Health Care. Most of these consumers are on MediCal, and they are entitled to quality services. When people aren't getting what they're entitled to, McRae processes a grievance. On the other hand, Tenenbaum and Bergman deal with violations of people's rights—issues of abuse and neglect, violations of due process and civil rights when people are being treated on an involuntary basis. Tenenbaum and Bergman are on the units every day, watching what goes on, and spend a lot of time at John George Psychiatric Pavilion.

During the meeting the three women spoke as a team to address some of the issues that come up with an involuntary hospitalization.

Most people are nervous about calling the police when a family member is in crisis because they don't know what to expect. "The person is in the waiting room until a nurse comes out to take him back to the Psychiatric Emergency Department," Beverly Bergman said. "Then they do a blood pressure reading and begin the interview to find out what's going on. If the patient becomes severely

[1] Under Welfare & Institutions Code Section 5150, a person is held involuntarily if he or she is a danger to self or others or is gravely disabled.

agitated, they can offer an oral dose of Haldol or Ativan. If the person is dangerous, they may give the medication by injection."

"What we're working toward," said Francesca Tenenbaum, "is for the staff to offer people food, something good to eat. We've actually suggested that chocolate be allowed at John George."

BEVERLY BERGMAN

"We also suggest that the staff talk to people," said Bergman. "The screaming people get the attention, but the ones who are waiting quietly may be suicidal. The staff are now paying more attention to the quiet ones."

As to the amount of wait time involved, Tenenbaum pointed out that the law says a patient must be assessed within 24 hours—and it usually takes that long. "We're talking to the staff about improving their triage system to determine who is the most acute and have them seen by a doctor faster." Unfortunately, in a situation with a limited number of hospital beds, sometimes people who are not quite ready for release are moved out early to make room for incoming patients who are worse off than they are.

An alternative to 72-hour involuntary hospitalization is a voluntary stay at Villa Short Stay, a facility at Villa Fairmont—the same campus that houses John George. Referrals to this facility are through John George and through Sausal Creek, which is a crisis stabilization center in East Oakland.

During the admission process, the patient is asked to sign a number of consent forms. This includes the consent allowing staff to talk to family members while the patient is in the hospital. "We suspect they roll right over this with a million other questions," Tenenbaum said. "What we'd like them to say is, 'Is there anyone you want us to talk to?' That would isolate the question. In most cases, the patient is not unwilling to have their family members talked to."

"When people are brought in, they're not in the best of shape," Bergman said. "They may be agitated or depressed and not communicative. We don't know that the facility is going back every day and asking them to sign the consent form."

EVA MCRAE

Eva McRae noted that families can fill out an "AB 1424 form." This is a form mandated under California Assembly Bill 1424 in 2001 that made changes to the Welfare & Institutions Code 5150 relating to involuntary hospitalization. The law requires anyone making a decision about holding a person involuntarily to take into account recent, relevant historical information. Family members, friends and case workers are sources of such information, which might include helpful observations about compliance with medication, symptoms and recent behaviors. The form includes a check box where families can request that the staff ask the patient to sign the consent form.

If a person stays in the hospital involuntarily longer than 72 hours, there will be a hearing. If the patient's records include an AB 1424 form or a letter from a family member, the staff is obligated to present that information in court.

One of the questions that arises while the person is being held is whether family members can bring in food. "Sometimes the family has brought a favorite food of the patient's only to discover that it's not being handed out," McRae said. "Sometimes the staff uses this as a punishment for rude or noncompliant behavior. But patients do have a right to their own food—unless they are on a special diet, and then it's a quality-of-care issue." McRae can find out what the patient's diet should be and, if food is being inappropriately withheld, help the family file a grievance.

"Many patients have had such terrible experiences with treatment providers," Tenenbaum said, "that they might feel they deserve some of the negative treatment they get. That they deserve to be punished for behavior they have no control over. But family members can recognize when a loved one is not being treated with dignity and respect. Family members can identify unusual injuries and other things that are not right. It's important that we hear from you. You can express yourselves in ways that many consumers can't."

Another issue is lost property, a subject of frequent grievances. Personal items like dentures and contact lenses disappear while the patient is hospitalized. Often this is due to forgetfulness: the patient takes out bridgework while eating and sets it on the food tray, then forgets and the tray goes back to the kitchen. Others are lost when bedding goes to the laundry. "It's hard to prove that the item is lost if it doesn't appear on the personal inventory that's taken when the patient is admitted," McRae said. "Many people forget they wear dentures or contacts, and so the property sheet does not show these items, and then the claim is denied." McRae said she can sometimes prove the prior existence of the item—for example using the patient's dietary instructions relating to soft food as evidence of dentures and bridgework.

When the patient is ready for discharge, it's important that family members check through his or her belongings to make sure all property is returned, or even that it's the right property envelope. "We're working on a procedure to inventory belongings to make sure it's in compliance with codes and regulations," Francesca Tenenbaum said.

"Sometimes the hospital will have the patient sign all the forms, including the property receipt form, before they've actually received their property," Beverly Bergman said. "So make sure your family member looks through it before he or she signs. And you have the right to make a correction."

Having a discharge plan and calling family members to pick up the patient, if they are available, is a continuity of care issue. If a patient who is unable to take care of him- or herself is released and comes to harm, is the hospital liable? "Not if the hospital has followed the regulations and documented their actions," Tenenbaum said. "There are a lot of protections for hospitals in the law. And some adult patients have stated they don't want a family member present or they don't have anyone to meet them."

If there are parents but it's clear they are not providing housing, will the hospital check to make sure the patient has somewhere to go? "Not always," she said, "although it's different with patients who have been 5150ed frequently. Then the hospital will hold them longer and look for housing, because they are 'gravely

disabled.' Then someone is so ill that it interferes with his or her basic survival needs—a passive danger to self."

Many hospital staff and professional members hold the old-fashioned view that patients are a product of dysfunctional families, and so they tend to dismiss family members and don't listen to their questions and concerns. "Patient Rights Advocates are talking to staff and trying to educate them about the benefits of working with families," Francesca Tenenbaum said. "Family members are the voice of patients who are too ill to make a phone call, keep an appointment, describe their symptoms adequately, or even describe their medications.

"Family members help people get better. Inclusion of family members can help reduce hospitalizations. That's an incentive for the county to educate the staff about being more open to families."