Professional Stakeholder Survey on the Involuntary Psychiatric Commitment Process in Maryland

Analysis Prepared for NAMI, Maryland
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Executive Summary

Survey Method

246 professional stakeholders involved with the involuntary psychiatric commitment process in Maryland completed an anonymous 21-item online survey in late 2013. The survey asked respondents to rate their agreement to a number of statements regarding their perception of the process on a scale of 1 (strongly disagree), 2 (disagree), 3 (neutral), 4 (agree), and 5 (strongly agree). It also included options for open ended comments.

Respondents' Roles, Location, and Experience with Involuntary Psychiatric Commitment

- The majority of respondents were social workers, psychiatrists, other mental health professionals, counselors, and nurses.
- Participants came from all over Maryland; over a quarter (29.3%) served in multiple jurisdictions.
- Nearly three quarters (72.0%) of respondents recently involved in the process were involved at multiple points.
- The majority of respondents (71.9%) have been involved in the Petition for Psychiatric Evaluation process for more than five years.

Respondents Assessment of the Process

- The majority of participants felt that the process is somewhat or very effective in terms of protecting the safety of individuals (91.4%) and others (93.8%).
- Overall, respondents had a generally favorable view of the process in terms of maintenance of respect and dignity for the individual and related parties, the maintenance of safety of the individual and others, and the overall fairness of the process.
- Despite overall agreement on their assessment of the process, subgroups of respondents who held different professional roles or who were involved at different points in the process raised concerns about maintenance of dignity and respect of individuals and related parties as well as the effectiveness of the process in linking individuals to appropriate services (see below).

Criteria for Interpreting Legal Definitions and Standards

- Over a third of participants (36.0%) use multiple criteria for interpreting "mental disorder" and one third use multiple interpretations to determine danger to self and others.
- Over three quarters of participants (76.0%) include gravely disabled in their interpretation of presenting a danger, and nearly two thirds (65%) perceive others as including gravely disabled in their definition of danger.

Professional Role & Rating of the Process

- Nurses and psychiatrists had more favorable views of the process when compared to other professionals.
    - Specifically, nurses had higher ratings of agreement that the process maintained the dignity of the individual (4.00 vs. 3.39) and related parties (4.13 vs. 3.60), as well as maintained respect for the individual (4.20 vs. 3.56).
    - Psychiatrists had higher ratings of agreement that the process stabilized the individual (4.03 vs. 3.59) and linked the individual to appropriate services (4.00 vs. 3.39).
- Public defenders and counselors had less favorable views of the process when compared to other professionals.
    - Specifically, public defenders had lower rates of agreement that the process maintained dignity (2.29 vs. 3.49) and respect for the individual (2.71 vs. 3.65).

Stage of Involvement & Rating of the Process

- Those involved with identifying people in crisis had less favorable ratings of the process.
    - Specifically, this group had lower ratings of agreement that the process maintained the dignity of related parties (3.52 vs. 3.90) and maintained respect for related parties (3.59 vs. 4.03).
- Those involved in the inpatient assessment and care, discharge planning, and testifying at hearings had more favorable views of the process. Specifically:
    - Those who provided health screenings in the ER had higher rating of agreement that the process maintained the dignity of related parties (4.17 vs. 3.60).
    - Those who were involved with providing treatment in the psychiatric unit had higher agreement ratings that the safety of the individual was maintained (4.40 vs. 4.02), the process maintained the dignity of the individual (3.83 vs. 3.38) and related parties (3.97 vs. 3.54), and the process maintained respect for individuals (3.93 vs. 3.57) and related parties (4.00 vs. 3.64).
    - Those involved in diagnostic assessment in the psychiatric unit had higher ratings of agreement that the process resulted in the individual linking with appropriate services (3.89 vs. 3.45) and maintained the dignity of the individual (3.89 vs. 3.41).
    - Those who testified at hearings had rating of agreement that the process resulted in linking individuals to appropriate services (4.14 vs. 3.44).
    - Respondents involved in discharge planning had higher ratings of agreement that the process linked the individual to appropriate services (3.87 vs. 3.44) and maintained the safety of the individual (4.48 vs. 4.03).

Recommendations

- Include nurses and social workers in future surveys and focus groups.
- Changes to the standard to include gravely disabled may not have an impact as most respondents already include it in their interpretation of the law and perceive that others also do.
- The most commonly identified need was additional training and clarification and standardization of current laws.
- Meetings that allow for better collaboration and understanding the roles and responsibilities of different professionals and different stages of the process as well as risks and benefits of treatment options.
- There is a need for improvement to the mental health system more generally

Report

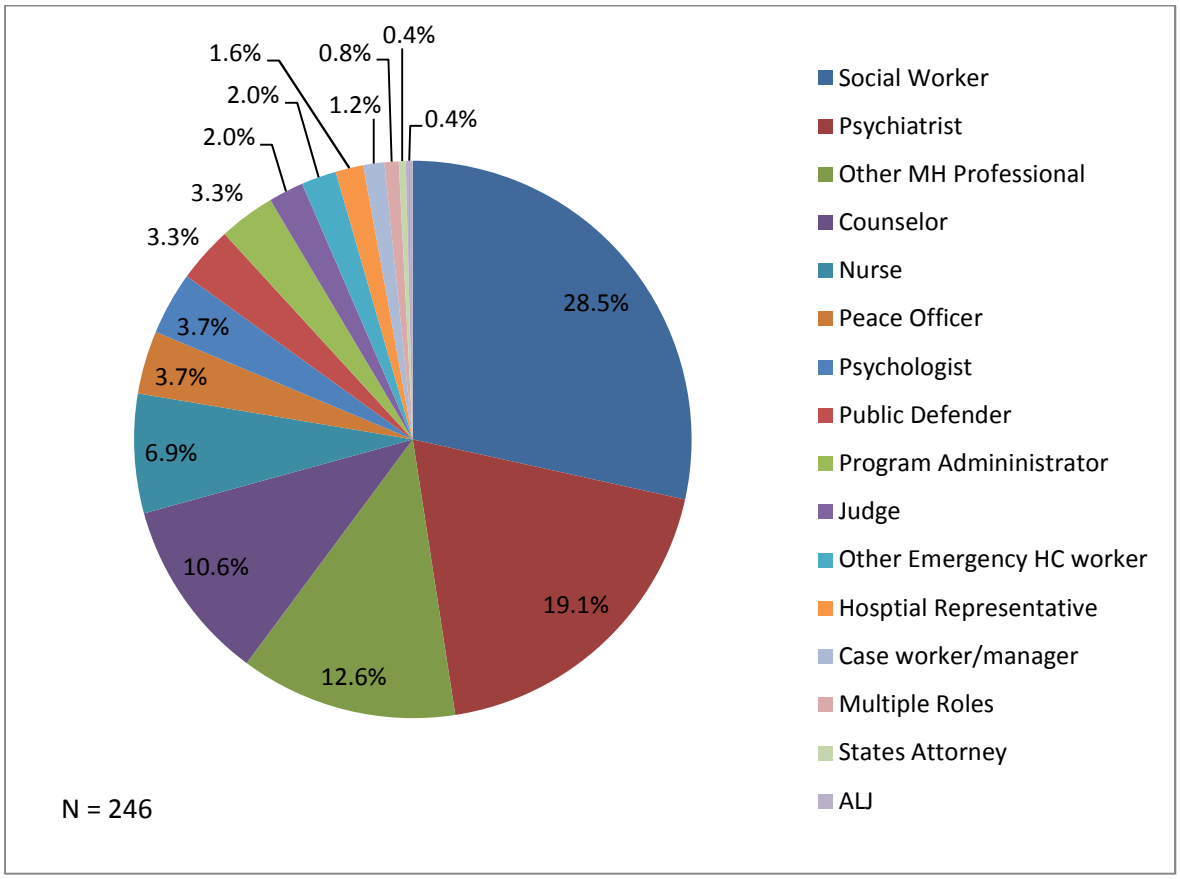
Survey Method

NAMI Maryland sent an invitation via email to complete a 21-item survey soliciting feedback on Maryland's Civil Involuntary Psychiatric Commitment Process on October 11, 2013. The email contained a link to the survey, which could be completed anonymously, with the option of providing NAMI Maryland with contact information regarding focus groups which NAMI intended to conduct in 2014. The survey closed on November 26, 2013. This report is based on analysis of the data.

Respondents' Roles, Location, and Experience with Involuntary Psychiatric Commitment

The survey was completed by 246 professional stakeholders,[1] with the breakdown provided in Figure 1, listed in order of percentage of the sample.

Figure 1: Professional Roles



The largest groups represented were social workers, psychiatrists, and other mental health professionals. Over forty percent[2] of the sample was professionals not listed among stakeholder roles. These included social workers

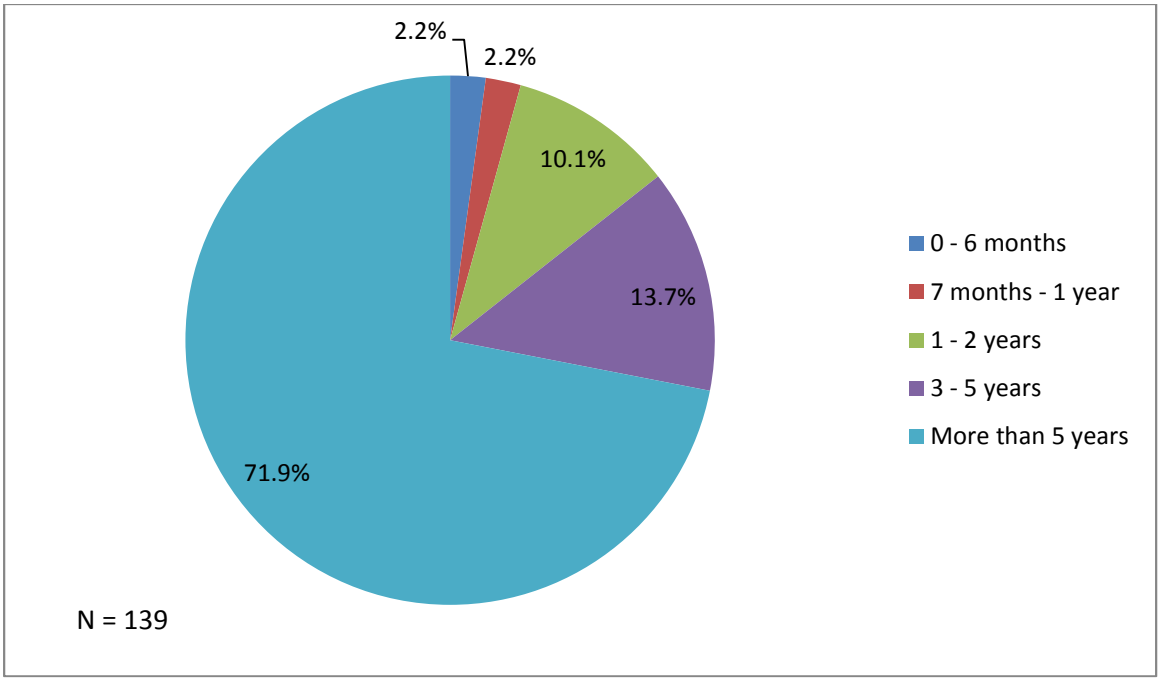
[1] Five of the 251 surveys were removed because respondents were not professional stakeholders.
[2] Not all respondents answered every question; percentages provided here are of those respondents who answered a particular question.

who made up the largest single professional group, nurses, and counselors.[3] Some noted the absence of their profession from the list. This indicates the need to pay closer attention to these professionals' roles and include them in future research. NAMI had hoped to obtain more responses from judges (including administrative law judges), however only five judges, including one administrative law judge, participated in the survey. NAMI may want to consider how to increase their participation for focus groups.

Study participants were from all counties in the state, with 29.3% of participants indicating that they served in multiple counties. The largest percentage of respondents (44.2%) was involved at the emergency petition stage and 25.0% were involved in multiple stages. Seventy two percent of the respondents who were recently involved in the civil involuntary admissions process were involved at multiple points, with most being involved in early stages such as identifying a person in crisis or filling out an emergency petition.

Nearly 72% had been involved in petitions for psychiatric for evaluation for over five years, with an additional 13.7% involved between 3-5 years (Figure 2). Fifty three percent of respondents were involved over 10 times in this process, and 70% were involved during the past year.

Figure 2: Length of Time Involved in Petition for Psychiatric Evaluation



[3] This group included anyone who identified as a counselor and consists primarily of licensed clinical and general professional counselors.

Respondents Understanding of the Process and Criteria

Eighty percent of respondents did not rely solely on one source for their understanding of their role and responsibilities in the involuntary psychiatric commitment process, but rather drew their knowledge from multiple sources. The source least often cited was a reading of the law, which 39.7% of the sample indicated, and the most often cited was professional training about the process, which was checked by 49% of respondents. All other categories were cited within this percentage range.

Respondents were asked to indicate how *they* interpreted criteria for involuntary treatment, as well as to assess how they believed that *others* involved in the process interpreted them. In Figures 3 and 4 we provide a by-side breakdown for each the criteria of "mental disorder" and "presents a danger to the life/safety of others."

Figure 3: Interpretation of "Mental Disorder"

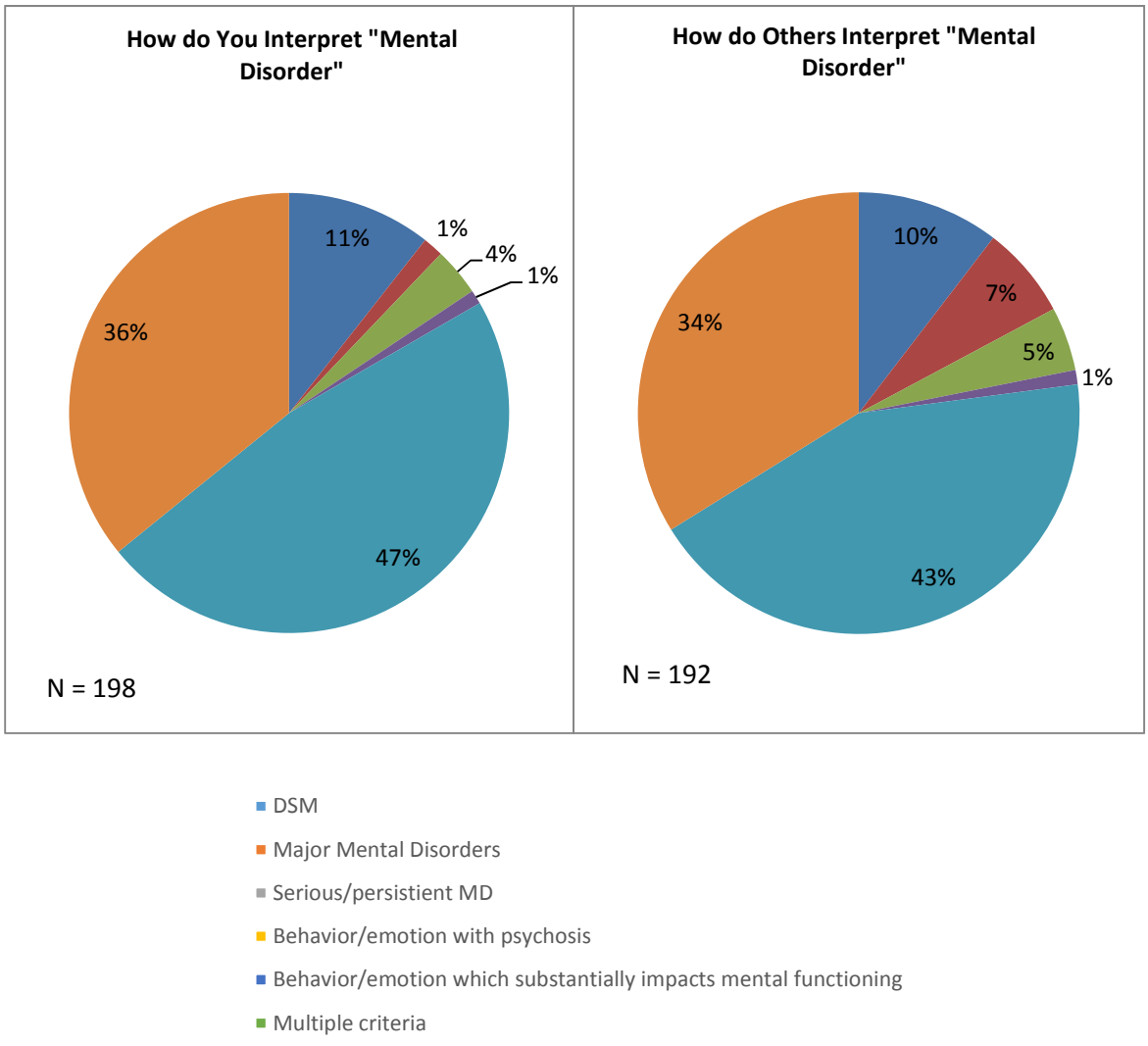
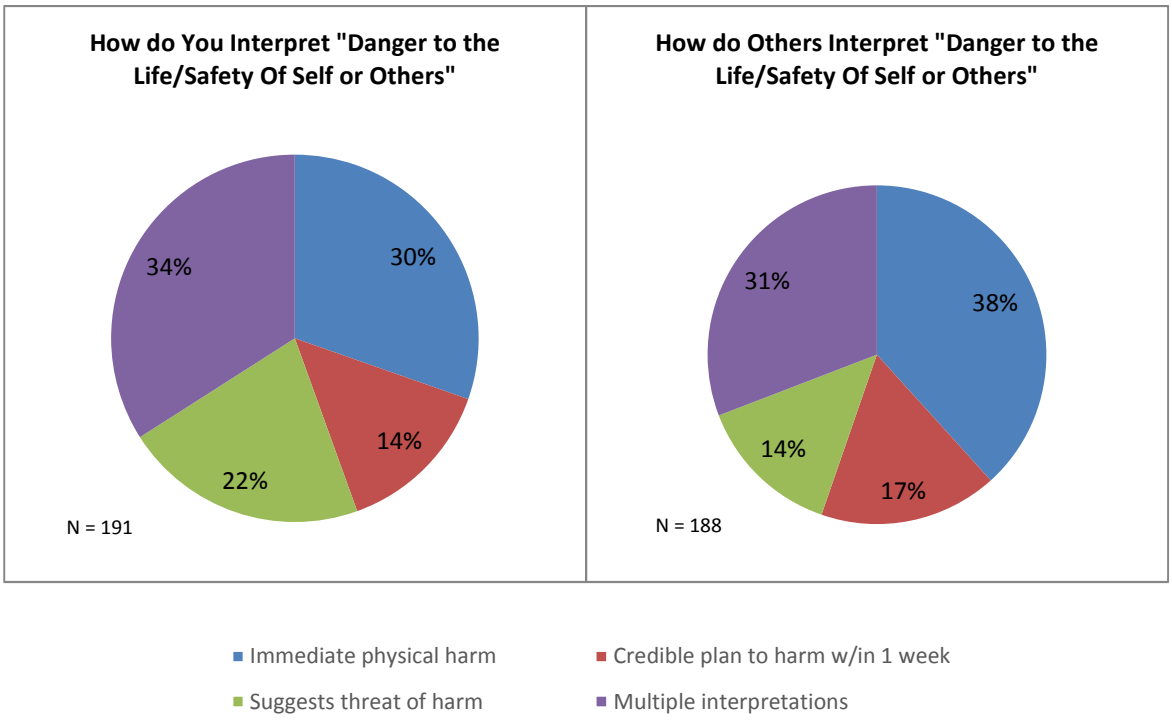
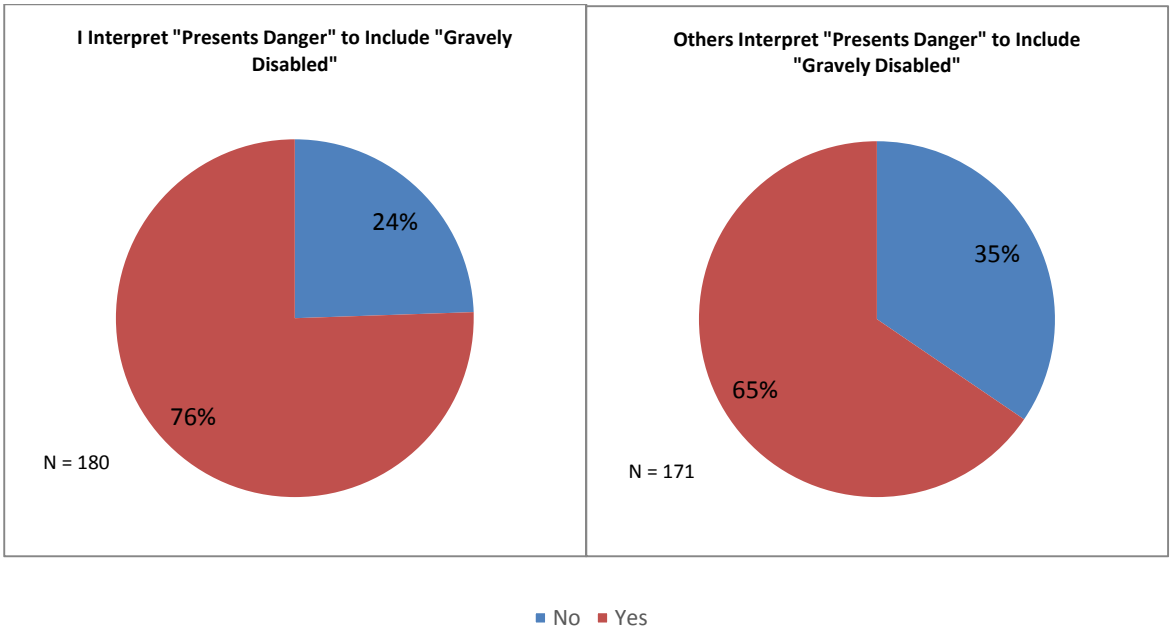


Figure 4: Interpretation of "Presents a Danger to the Life/Safety of Self or Others."



In further refining how respondents interpreted the concept of "presents danger", a large majority (76%) of respondents themselves included "gravely disabled" within their definition of "presents danger". A smaller majority (65%) believed that other professional included "gravely disabled" in their understanding of this criterion.

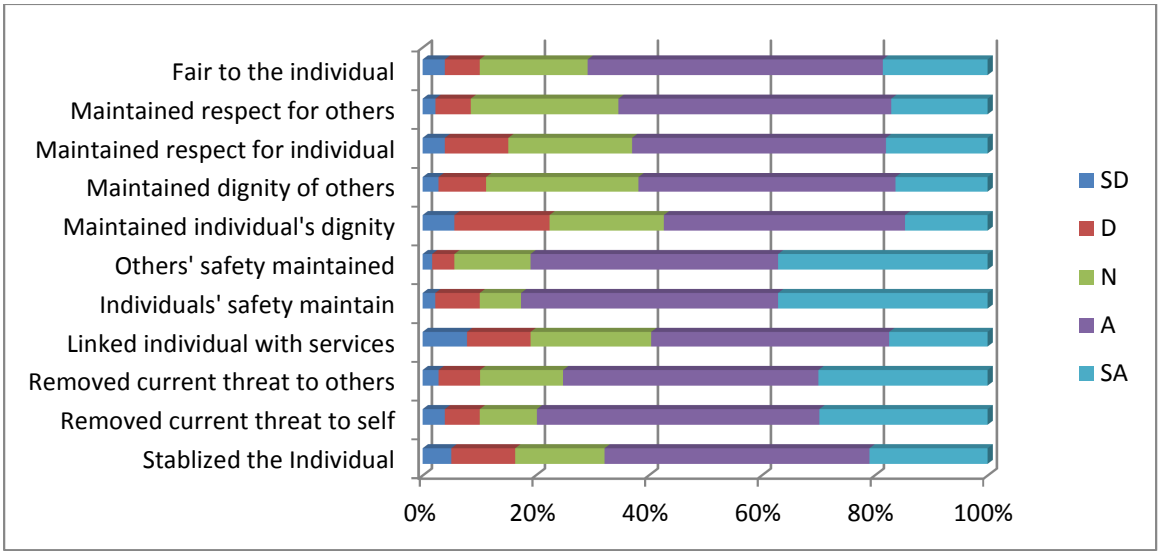
Figure 5: Interpretation of "Presents Danger" to Include "Gravely Disabled"



Study respondents were also asked whether the involuntary psychiatric commitment process in Maryland maintained the safety, dignity, respect, and fairness of the individual and of others. For each aspect of these, respondents rated their level of agreement using a five point Likert scale (1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, 5 = strongly disagree).

Figure 6 show that most respondents either agreed or strongly agreed that the process maintained dignity, safety, respect, and fairness for both individuals whose cases were reviewed as well as others. The largest percentage of respondents who raised concerns did so over maintenance of the dignity of the individual. Although this was the area of greatest concern, most respondents did not view this as a problem: 16.1% either strongly disagreed or disagreed with the statement that the process maintained the dignity of the individual, while 41.3% agreed or strongly agreed with the statement.

Figure 6: The Process – Safety, Dignity, Respect, & Fairness



Professional Role & Rating of the Process

We examined ratings along key variables to determine whether respondents' assessments of the involuntary psychiatric commitment process differed by their professional roles. We used a Likert scale to create scores ranging from 1 – 5 (see above) for each of the items and averaged these scores according to professional roles. We conducted a separate analysis for each professional group to compare that professional group to all other respondents in the survey. There were no statistically significant differences between social workers, peace officers, licensed psychologists, program administrators, and other mental health professionals in comparison to all other professionals in their assessment of the process. However, the ratings of psychiatrists, counselors, nurses, and public defenders differed significantly from the ratings of all other professionals.

Psychiatrists reported higher agreement that the process stabilized the individual in crisis in comparison to other professional groups (see Table 1). Not surprisingly, psychiatrists were also more likely to be involved with individuals while they were under inpatient psychiatric care. It is possible that the higher agreement regarding stabilization is a result of working with individuals while they are under care and are, therefore, more stable. Psychiatrists also indicated higher agreement with the statement that the process results in people receiving needed services, seeing the process as a "necessary evil". Like psychiatrists, as nurses are involved more in inpatient stages of the processes when individuals are by definition under psychiatric care, they are more likely

to be receiving services. The statement however, does not differentiate between psychiatric services and community-based services so without further clarification it is difficult to determine whether the stage of involvement mediates or is the reason for this assessment rather than or in addition to professional role.

Table 1

Psychiatrists vs. Other Professionals

Variable	*Psychiatrists (32)*	*Others*	*M*	*SD*
The process stabilized the individual in crisis.	4.03*	3.59*	3.67	1.08
The process resulted in linkage to appropriate services.	4.00**	3.39**	3.50	1.14

* Statistically significant at the p <.05

** Statistically significant at the p <.01

Conversely, counselors had lower ratings of agreement regarding linkage to services (see Table 2), potentially reflecting a difference in community versus psychiatric inpatient services. Indeed, one counselor indicated that the role of a counselor is to make sure "the individual is linked directly to mental health services, not just referred to them. If they could follow up on their own, they may not be in crisis".

Table 2

Counselors vs. Other Professionals

Variable	*Counselors (19)*	*Others*	*M*	*SD*
The process resulted in linkage to appropriate services.	3.00*	3.56*	3.50	1.14

* Statistically significant at the p <.05

** Statistically significant at the p <.01

Nurses reported higher agreement than all other professionals that the process maintained the dignity and respect of the individuals, as well as the dignity of related parties (see Table 3). Similar to psychiatrists, nurses were more likely to be involved while the individual was receiving services or assessment in the psychiatric unit, as well as during screening in the hospital and planning for discharge. Again, these are likely time points when the individual is more stable, but how this affects professionals' perceptions of dignity and respect is not entirely clear. Comments from nurses provided little elucidation on this issue and their different ratings on this item could be further explored in focus groups or future research.

Table 3

Nurses vs. Other Professionals

Variable	*Nurses (16)*	*Others*	*M*	*SD*
The process maintained the dignity of the individual.	4.00*	3.39*	3.44	1.10
The process maintained the dignity of related parties.	4.13*	3.60*	3.64	0.95
The process maintained respect for the individual.	4.20**	3.56**	3.62	1.03

* Statistically significant at the p <.05

** Statistically significant at the p <.01

With regard to the process maintaining individual's dignity and respect, public defenders had significantly lower levels of agreement than other professionals (see Table 4). This comports with professional values and norms for attorneys, especially public defenders, whose role it is to ensure that their clients' rights and procedural safeguards are upheld and whose professional ethics include zealous representation to further their clients' wishes. They may therefore be more attuned to real and perceived injustices and questions of dignity and respect.

In addition, public defenders are not involved in the process of identifying individuals in crisis, and may not interact with individuals when they are less stable, or may not be involved in crisis situations that spur commitment. For this reason, they may not be assessing involuntary commitment in the fuller context of the lives of individuals in crisis or as against other options nor would such balancing be appropriate given their role and professional ethics.

Table 4

Public Defenders vs. Other Professionals

Variable	*Public Def. (7)*	*Others*	*M*	*SD*
The process maintained the dignity of the individual.	2.29	3.49**	3.44	1.10
The process maintained respect for the individual.	2.71	3.65**	3.62	1.03

* Statistically significant at the p <.05

** Statistically significant at the p <.01

Stage of Involvement & Rating of the Process

Participants' levels of agreement with how the process affects individuals and families also differed by the stage of the process in which they were involved. Those who were involved in the process of identifying individuals in crisis had significantly lower agreement with the statements that the process maintained the dignity and respect of related parties (see Table 5). This may relate to families' struggles with navigating the mental health and civil commitment systems. It may also relate to the situations where treatment was contested and therefore enforced against the person's will, which inherently raise concerns around dignity and respect, even if professionals believe that the process was ultimately beneficial and that efforts were made to maintain dignity and respect to the extent possible.

Table 5

Involved in Identifying Individuals in Crisis

Variable	*Yes*	*No*	*M*	*SD*
The process maintained the dignity of related parties.	3.52*	3.90*	3.64	0.95
The process maintained respect for related parties.	3.59*	4.03*	3.72	0.90

* Statistically significant at the p <.05

Those who are involved with individuals in the emergency room and psychiatric unit were more likely to have higher levels of agreement that the process maintained dignity and respect of individuals and their families, as well as more likely to agree that the process stabilized individuals (see Tables 6 – 8). It is possible that these are stages when individuals are less likely to be at odds with mandated treatment either because they are more

stable or they have become resigned to their fate after determinations have been made. Assessment that the process maintained respect for related parties may come from the fact that these related parties may in fact be the ones referring individuals for involuntary commitment in the first place

Table 6

Involved in Providing Health Screening in ER

Variable	*Yes*	*No*	*M*	*SD*
The process maintained the dignity of related parties.	4.17*	3.60*	3.64	0.95

* Statistically significant at the *p* <.05

Table 7

Involved in Providing Treatment in Psychiatric Unit

Variable	*Yes*	*No*	*M*	*SD*
The safety of the individual in crisis was maintained.	4.40*	4.02*	4.07	0.98
The process maintained the dignity of the individual.	3.83*	3.38*	3.44	1.10
The process maintained the dignity of related parties.	3.97**	3.54**	3.64	0.95
The process maintained respect for the individual.	3.93*	3.57*	3.62	1.03
The process maintained respect for related parties.	4.00*	3.64*	3.72	0.90

* Statistically significant at the *p* <.05
** Statistically significant at the *p* <.01

Table 8

Involved in Diagnostic Assessment in Psychiatric Unit

Variable	*Yes*	*No*	*M*	*SD*
The process resulted in linkage to appropriate services.	3.89*	3.45*	3.50	1.14
The process maintained the dignity of the individual.	3.89*	3.41*	3.44	1.10

* Statistically significant at the *p* <.05

Table 9

Involved in Testifying at the Hearing

Variable	*Yes*	*No*	*M*	*SD*
The process resulted in linkage to appropriate services.	4.14**	3.44**	3.50	1.14

** Statistically significant at the *p* <.01

Those who are involved in discharge planning are also more likely to agree that the process maintained the safety of the individual, as well as linked them to needed services. It makes sense that they professionals working with individuals who have assessed them to be ready for discharge believe that they are safe. It also

makes sense that these individuals are more likely to agree that people are connected to appropriate services, especially if these are the professionals providing such services. Some respondents outside the discharge planning process expressed concerns regarding individuals' ability to access services after discharge and to prevent future commitment. One noted that many are "amenable to treatment but due to barriers (income, homelessness, race, education level, geographic location, substance abuse) are unable to access it" describing it as a "system is a patchwork of programs, difficult even for a savvy person to navigate".

Table 10

Involved in Providing Discharge Planning

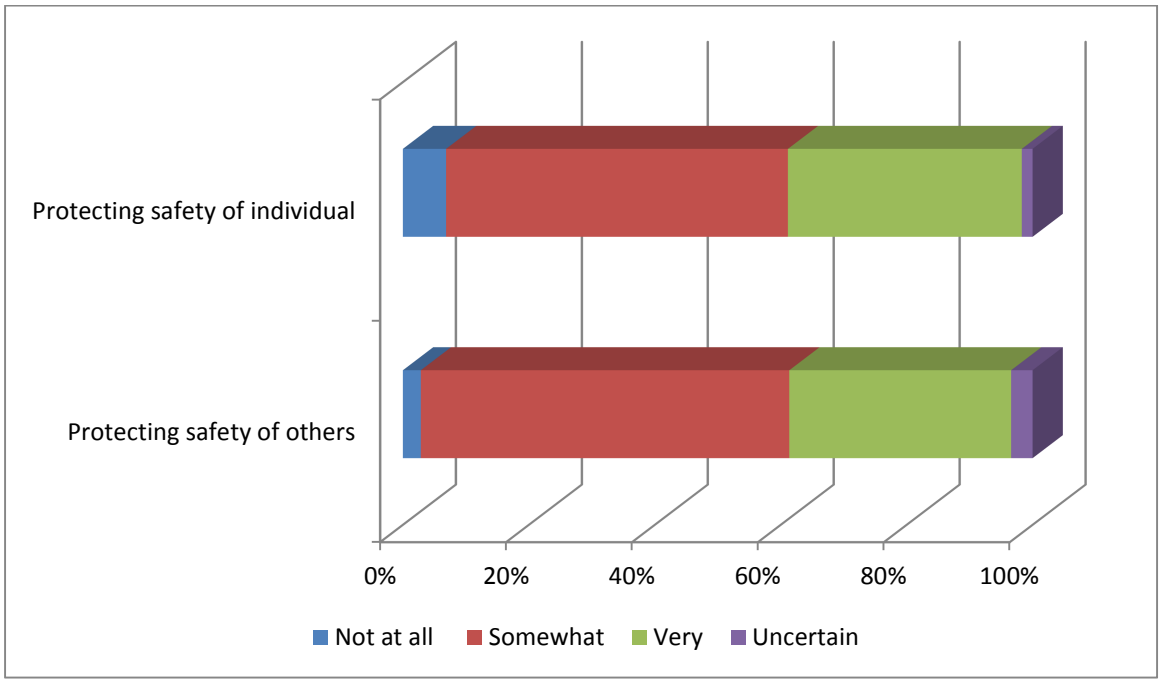
Variable	*Yes*	*No*	*M*	*SD*
The process resulted in linkage to appropriate services.	3.87*	3.44*	3.50	1.14
The safety of the individual in crisis was maintained.	4.48*	4.03*	4.07	0.98

* Statistically significant at the $p < .05$

Effectiveness of the Process

The overwhelming majority of respondents indicated (Figure 7) that they believed that involuntary psychiatric commitment was effective in protecting the safety of individuals as well as protecting the safety of others, with slightly more respondents expressing concern about protecting the safety of individuals than about the safety of others.

Figure 7: Effectiveness of the Process



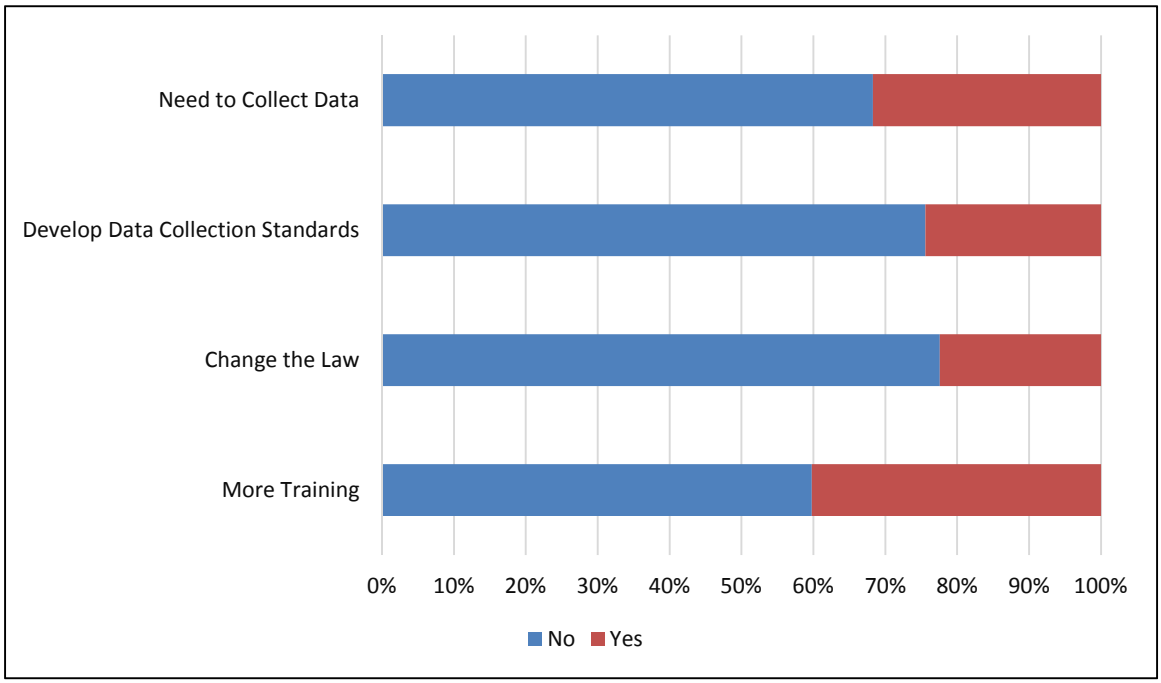
Despite relatively positive assessments of their own and others' understanding of Maryland's involuntary psychiatric commitment process and of its ability to safeguard individuals whose cases are heard as well as

others, 62.8% of respondents believed that changes are needed (see Figure 8). The most frequently cited change was a need for more training. Just over 59% indicated more than one needed change.

Thirty-one respondents suggested improvements to the emergency petition process or to mental health care generally. These included ten who wanted the option for lengthier hospital stays, either voluntary or involuntary; fourteen indicated the need for additional voluntary or involuntary outpatient treatment. Ten respondents called for better mental health services or general community services, often as a possible way to avoid reaching the stage where an emergency petition might be necessary. Still others called for alternatives to emergency petitions (N=7), such as adult protective services or outreach to family members; most of these respondents implied that emergency petitions are often used inappropriately because other services might not be available or because they are not pursued.

Eighteen respondents also suggested a need for some kind of standardization to the process. Nine of these thought that standardization would improve clarity of how and what needed to be done by whom, and under what conditions. Twelve of these respondents believed that standardization would improve consistency, noting different practices that varied across geographic region, institutions, individuals, and people with different professional roles.

Figure 8: Needed Changes to the Process



In their response to open ended prompts, some study participants described why they wanted changes. These responses came from study participants across roles. Most were explanations regarding changes to the standard for involuntary commitment and training.

Changing Standards

When asked about needed changes, 77.6% indicated that the current laws do not need to be changed. Thirty four respondents provided feedback in the open-ended response regarding changing the current standards. Of

those, 26 provided a clear rationale for their response. Of the twenty-one responses in support of changing the standards, the most common was either a desire to intervene at an earlier stage rather than waiting until an evaluee's mental state had deteriorated to the level that they perceived is required currently or for reasons of self-care and safety.

Far fewer of those respondents who indicated that the standard should not be changed provided us with feedback (N=6). One provided the most commonly cited concerns in the literature, which was the need to balance treatment and safety with the recognition that involuntary hospitalization is an extreme measure. Five of the respondents indicated that gravely disabled is already used. Interestingly, two of these five gave this as their reason *not* to change the standard due to lack of necessity and/or fear that moving it was a "slippery slope" while the other three saw the need to articulate a standard that was already in use for purposes of uniformity and clarity.

Training

Additionally, 40.2% of respondents indicated a need for more training. There were 62 comments regarding training. Twenty of the respondents either provided general comments regarding the need for more and/or better training for a variety of professionals involved in the process or provided comments that were somewhat ambiguous about the purpose for the training. Twenty four respondents called for training about the process and/or the roles and responsibilities of different professionals in the process. Eight respondents recommended training in order to preserve evaluees' dignity. One respondent decried stigmatized treatment of evaluees, but did not suggest that this could be improved through training.

Throughout the comments there was a common thread that law enforcement needing more training (N=31, including three law enforcement personnel). The training noted was in all areas, but focused primarily on the process. Three respondents specifically praised the improved training or exemplary performance of law enforcement.

Twelve respondents focused specifically on the need for training around standards. These were either in regards to initiating involuntary placement procedures or for decisionmakers charged with applying the standards at different points in the process. While some respondents believed that the emergency petition process was underutilized due to lack of training, others saw training as a way to reduce overutilization. Another reason respondents gave for standards training was to mitigate safety concerns for evaluees or for professionals involved in the process. Some of the respondents also thought that better training would bring about more uniformity in interpreting standards.

Recommendations

Our findings lead to a number of recommendations:

- Future research, outreach, and decision-making should include professionals not initially considered in the survey, but who made up a large portion of respondents, specifically social workers and nurses.

- The majority of respondents already include “gravely disabled” in their assessment of imminent danger and perceive that the majority of other mental health professionals also include this. This suggests that legal changes to the standard to include “gravely disabled” may not impact practice.
- We found a call for standardization of the process throughout the state. However, this was absent specific recommendations as to what, specifically, was concerning. This should be explored in greater detail in the focus groups or future research.
- Respondents indicated a need to better train those who come into contact with individuals in the community. Many specifically focused on additional training for police and first responders.
- Different perspectives shared by stakeholders with different roles or who are involved at different stages suggest that benefit of providing more comprehensive training of stakeholders regarding how people enter and move through treatment and where they go after discharge. This would better contextualize risks and benefits of different treatment options as well as expectations for treatment.
- Different assessments suggest that professional stakeholder may not have a sense of others’ roles in the process and how the stages and roles fit together. Meetings and education regarding these roles might allow for better collaboration and use of professional skills and expertise.
- Many of the comments suggest that the mental health system in which the commitment process is nested could use improvement, either to obviate the need for involuntary treatment, to improve it, or to ensure that gains are more long-lasting. This warrants a more comprehensive investigation. It also points to the limitations of what involuntary commitment can accomplish, particularly over the long term, given the present state of mental health resources, particularly in the community.