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David C. Stone

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HOLLYWOOD ON THE SCREEN AND ON THE STREETS: THE CUCKOO'S NEST OF LPS

*David C. Stone, M.D.**

It seems that I am the last speaker on a long day of difficult and academic topics. That being the case I should congratulate all of you who have stayed, and I'll try to reward us all by my making my remarks as concise as possible. Today, from the "Ivory Towers," we have entertained a largely academic dialogue concerning new legal directions in mental health law. In this last hour, I hope to convey some of the "street level" impact of current mental health law, as I draw from personal experience and from my own research. Be forewarned that I may poke fun at some of us along the way, and I may even tell some disturbing stories. By the end, though, I hope we will all leave thinking about those patients and clients whom we, as physicians, advocates, and policy makers, sometimes fail.

I'd like to thank Professor Jan Costello for giving me the opportunity to participate on this panel devoted to therapeutic jurisprudence, and also for the chance to present some of my research in the area of California civil commitment law, which is known in California by its abbreviated name "LPS."¹ I've decided to entitle my portion of the panel "Hollywood on the Screen and on the Street: The Cuckoo's Nest of LPS."

In July of this year I completed my four years of residency training in psychiatry at Harbor-UCLA Medical Center. Before I go any further, I should disclose one bias: as a physician whose work is primarily clinical, I believe that the medical discipline we call psychiatry helps people. A small disclosure, perhaps, but one that conforms with the point of view that, when people who need psychiatric care actually get that care, good things happen. When they don't get the care they need, bad things happen.

* Princeton University, A.B.; U. Texas, San Antonio, M.D.; Residency in Psychiatry, Harbor-UCLA Medical Center; Forensic Fellowship, UCLA.

1. Lanterman-Petris-Short Act, CAL. WELF. & INST. CODE §§ 5000-5575 (West 1984 & Supp. 1998).

That being disclosed, I would like to share with you a few anecdotes taken from the past four years of my training. Later, I will share some of my research regarding what happens when psychiatric patients don't get the treatment they require.

The psychiatric emergency service at Harbor-UCLA is staffed twenty-four hours a day by no less than three psychiatrists at any time in order to evaluate roughly 500 patients per month, totaling over 6000 patients a year. During their four years of training, residents spend between 250 and 300 nights staffing the psychiatric emergency service, and up to three months total staffing the psychiatric emergency room by day.

Sometimes our patients are brought to us by concerned family members or are transferred to us from the medical emergency room. However, more often than not, they are brought to us by the police on seventy-two-hour holds for emergency psychiatric evaluation. Some of them are drunk, some of them are high, but a good portion are simply mentally ill and homeless.

Of these 6000 patients each year, only a very select few are admitted to our thirty-six psychiatric inpatient beds. Once admitted, their average length of stay is 9.1 days. Some patients are there voluntarily, but most are there on involuntary fourteen-day commitments.

Having presented those background statistics, let me stop and pose a question to the audience. I'd like you to imagine that as you walk out of this conference room, you encounter not one door but three, each guarded by an evil psychiatrist. You are allowed to pass through only one door. Through the first door, the evil psychiatrist will lead you to fourteen days of involuntary psychiatric treatment. Through the second door, the evil psychiatrist will lead you to the Los Angeles County Jail where you will stay for thirty days, but with minimal psychiatric treatment. Through the third door, you will go completely free, but with time, you will begin to suspect and fear others. You may begin to hear voices that frighten you or command you to harm yourself or others. You may experience violent and unpredictable mood swings. Regardless of your symptoms, your mental faculties will dull until you are no longer able to perform your duties as a lawyer. Which of these fates would you choose? While you consider your choices, let me continue with a true story from the trenches.

Over the four years I was on call in the Emergency Room, I was visited no less than four times—approximately one per year—by

young aspiring UCLA or USC Film School Graduate Students. Their stated goal was, in every case, to do research for their new film. They each hoped that their film would be the next blockbuster psychiatric-suspense-mystery thriller.

Invariably, their pitch went like this: "Well, Doc, I have this idea for a movie There's this crazed psychiatrist, and he's got this patient of his locked up for good, and then she gets out, and he starts to chase her all over the country, but she's not crazy, *he* is, and he's trying to lock her up against her will . . . etc., etc."

By the fourth film student—and it was indeed the same plotline—I began to savor, just for one moment, the irony of putting that young student on a psychiatric hold. Of course, I didn't.

However, these students did cause me to think a lot about archetypes, stereotypes, and how artists can tweak our fears of psychiatrists, the mentally ill, and the legal profession. Who among us is not frightened by the thought of being detained against our will, losing our autonomy? Who among us is not deeply frightened by the thought of losing their mind? As a culture, we relieve the collective dread of Alzheimer's disease when we exchange the most recent Alzheimer's joke. But we fear we might be the disease's next victim.

In mental health law, we see the tips of that fear surface when Justices refer to state of the art medicines as "mind altering" drugs.² What, then, are the dark archaic fears that charge public policy on the mentally ill? In case law we read arguments that compare one legal standard of proof to another as they apply to civil commitment law. We speak of weighing the interests of state and individual.³ Beyond the rational assessment, what is more terrifying for us: to be wrongfully sent to jail for life, or to go insane for life? To be mentally ill and forced into treatment, or to be mentally ill and deprived of treatment? Who fears they might become so mentally ill as to resist all forms of therapeutic intervention, even though a younger saner self might have known they needed that treatment?

As it turns out, my training program, like most, was set up so that the young resident received training in emergency, inpatient and outpatient psychiatry. Often, we got this all on the same day. Therefore, if one of our patients was released from inpatient care and relapsed back into the emergency room within one or two days, we inevitably found out about it. For many of us, it became a topic of

2. See *Riese v. St. Mary's Hospital*, 209 Cal. App. 3d 1303, 1324, 271 Cal. Rptr. 199, 212-13 (1987).

3. See *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 280-85 (1990).

interest to determine what factors made patients relapse back into the Emergency Room. Collectively, and anecdotally, we began to suspect that the law itself, albeit well-intentioned, was sometimes the reason for the relapse. From this presumption, we set out to test our hypothesis.

In California, patients placed on an additional fourteen days of involuntary treatment after their original seventy-two-hour certification, are entitled to a judicial review of their confinement.⁴ Other jurisdictions have developed other methods of review. Dr. Behnke, for instance, has related to me that patients in Massachusetts can be held for up to ten days without judicial review.⁵

In the 1979 case of *Doe v. Gallinot*,⁶ District Court Judge Warren J. Ferguson lauded the Lanterman-Petris-Short Act as "among the most thoughtful and progressive in the country," while asserting that there was a "substantial risk of erroneous application" of the grave disability standard.⁷ As a result of Judge Ferguson's opinion and the Ninth Circuit Court's affirmation on appeal,⁸ probable cause hearings were created that should in no event "occur later than the seventh day of confinement."⁹ Appellants in the case argued that mandatory probable cause hearings would "have a direct effect on the ability of psychiatric hospitals and facilities to provide the maximum amount of treatment to individuals in need of it."¹⁰ They went on to argue that "[e]very hour spent by a psychiatrist or physician testifying at a probable cause hearing is an hour which could have been spent in diagnosis and treatment of mentally ill persons."¹¹

On appeal, Judge Dorothy W. Nelson cited the "massive curtailment of liberty"¹² and the "adverse social consequences" resulting from commitment.¹³ But neither judge nor psychiatrist in this case seemed to have appealed to arguments addressing the possible personal and social consequences to the patient if treatment were curtailed as a result of the hearing.¹⁴ That is to say, by requiring manda-

4. See CAL. WELF. & INST. CODE §§ 5000-5575 (West 1984); *Doe v. Gallinot*, 486 F. Supp. 983, 985-86 (C.D. Cal. 1979).

5. See MASS. GEN. LAWS ANN. ch. 123, § 12 (West 1997).

6. 486 F. Supp. 983 (C.D. Cal. 1979).

7. *Id.* at 992.

8. See *Doe v. Gallinot*, 657 F.2d 1017, 1019 (9th Cir. 1981).

9. *Gallinot*, 486 F. Supp. at 994.

10. *Gallinot*, 657 F.2d at 1023.

11. *Id.*

12. *Id.* at 1021 (quoting *Humphrey v. Cady*, 405 U.S. 504, 509 (1972)).

13. *Id.* at 1022 (quoting *Addington v. Texas*, 441 U.S. 418, 425-26 (1979)).

14. *Id.* at 1022-23.

tory probable cause hearings within seven days for every case of fourteen-day confinement the court assured that at least some of the patients reviewed would be released before receiving adequate treatment. Thus the court, in following very sound and reasonable legal logic regarding due process, put in motion a substantial social experiment. This action necessarily altered the potential length of stay, and therefore length of treatment, of the individuals detained. As stated previously, psychiatrists tend to believe that psychiatric treatment benefits those in need of it. Consequently, we may ask how patients, denied treatment by the *Gallinot* probable cause hearing, fare in the long run compared to those who are allowed to continue treatment.

Though most psychiatric residents may not know the details of *Gallinot*, residents at Harbor will always remember the case of Mr. R. Mr. R. was brought to our emergency service by the police department of a wealthy municipality in west Los Angeles. They had received numerous calls by neighbors regarding the stench emanating from Mr. R.'s condominium. Neighbors later confirmed that rats and roaches had taken up residence for the first time in their otherwise clean, upper-class building. Officers arrived on the scene and were greeted at the door by Mr. R., who appeared to be disheveled and disorganized in thought but otherwise not bothered terribly by the incredible odor of decay coming from his condo. The officers entered to find the windows coated yellow from the smoke residue of continuously smoked cigarettes. Stacks of trash lay everywhere, and piles of barely eaten rotted food—some the recent delight of vermin, had filled the kitchen. In the sitting room—the officers met Mr. R.'s elderly mother, who seemed to have nodded off in the reclining chair.

The officers estimated that Mr. R.'s mother was at least one week deceased at the time they met her. The rats in the apartment had eaten the mother's toes and fingers. The remainder of her body was in advanced decay. A substantial portion of the mother's facial skin, with the help of rodent bites, had begun to fall away from her skull. When asked about this situation, Mr. R. replied that his mother had instructed him to tell anyone who called that she was napping.

Mr. R. was released from his probable cause hearing after only five days of treatment for chronic paranoid schizophrenia. Because he had a condo, money in his bank account, and some food in his refrigerator, he did not meet criteria for grave disability. This was exactly the imprecise standard which Judge Ferguson feared would be

erroneously applied by mental health professionals.¹⁵ Mr. R. returned home where police found him again trying to figure out how to get into his condo. Again he was brought to us; this time the police department supplied photographs of the patient's mother for evidence in the next round of probable cause hearings.

In 1995 I began to collaborate with my colleagues Dr. Rebecca Crandall and Dr. Kyle Boone. We performed a search of the literature to determine what sort of studies existed regarding civil commitment law. The majority of these studies have been recently summarized in Dr. Paul Appelbaum's book *Almost A Revolution: Mental Health Law and the Limits of Change*.¹⁶ We discovered that almost all studies to date had assessed the impact of changes in mental health law on admission rates and censuses, comparing data before and after the institution of the new commitment laws. To our surprise, we found that no one had published an outcomes study comparing the fates of patients who complete treatment versus those who do not complete treatment because of premature release on legal grounds. Using a prospective design, we began to accumulate data on over 250 consecutive patients who entered psychiatric treatment at Harbor-UCLA. Along with numerous demographic, ethnic, social, diagnostic, psychiatric and medical variables, we included variables regarding completion of treatment—yes/no—and source of discharge.

After one year, we measured these patients' progress using data from the clinical database that tracks admissions and treatment for psychiatric patients in the Los Angeles County system. We looked at the following variables following discharge: time to first relapse; time to enter outpatient treatment; total time spent in acute treatment over the ensuing year; and total time spent in psychiatric treatment in the Los Angeles County Jail over the ensuing year. This being a pilot project, we defined significance as p-value less than .05, but a trend as a p-value less than .20. The following are our initial results:

(1) When all patients studied were analyzed together, the patients released by their doctor versus those released by the referee differed significantly only in length of stay and income. Patients kept had an average length of stay in the hospital of 11.28 days versus 7.35 days. Conversely, patients released by the referee had a significantly higher income, suggesting some correlation with the issue of grave disability. The groups did not differ in age, education, age of first

15. See Gallinot, 486 F. Supp. at 992.

16. PAUL S. APPELBAUM, *ALMOST A REVOLUTION: MENTAL HEALTH LAW AND THE LIMITS OF CHANGE* (1994).

hospitalization, number of previous hospitalizations, number of med doses refused, days to relapse, or days to outpatient therapy. Over the follow-up year the groups did not differ in total number of hospital days or total number of jail days.

(2) We suspected that the patients might behave differently by diagnostic subgroup; this concept is supported by the outcomes literature in other areas of psychiatry.¹⁷ Therefore, we compared completers and non-completers by each diagnosis.

(3) Patients with depression differed significantly on the days it took to get into outpatient treatment. Those kept by the referees entered outpatient treatment within twenty-four days of discharge, whereas those released by the referees took an average of one hundred seventy-three days to find their way into outpatient treatment. Second, there was a near significant trend— $p=0.074$ —that released patients spent more time back in the hospital during the follow-up year than those who were kept. Thus patients who completed treatment had only an additional 1.55 average inpatient days over the ensuing year, whereas those released by the probable cause hearing spent an average of 14.25 days in inpatient treatment over the next year.

In “patients with depression,” then, arguments appealing to the “least restrictive alternative” treatment and against “massive curtailment of liberty” begin to falter. Deprived of necessary treatment, patients in this group took almost half a year to get into outpatient treatment—the less restrictive setting—subsequently relapsing, and requiring almost another two weeks average of internment.

(4) When we turn to the patient with bipolar disorder we see even more interesting results. Mental law practitioners whose clients include those with bipolar disorder know that manic depression is, by nature, a relapsing-remitting illness.¹⁸ It is episodic. What is very clear from the accumulated literature on bipolar disorder is that, when left untreated, the natural course of bipolar illness reveals subsequent episodes to be longer and more intense, while the interepi-sodic periods of mood stability tend to shorten.¹⁹ Because the aver-

17. See Bruce J. Winick, *The MacArthur Treatment Competence Study: Legal and Therapeutic Implications*, 2 PSYCHOL. PUB. POL'Y & L. 137, 142 (1996).

18. See Rebecca Dresser, *Ulysses and the Psychiatrists: A Legal and Policy Analysis of the Voluntary Commitment Contract*, 16 HARV. C.R.-CL. L. REV. 777, 806 (1992).

19. Kraepelin was among the first to recognize this possibility. See EMIL KRAEPELIN, *MANIC-DEPRESSIVE INSANITY AND PARANOIA* (1921).

age untreated manic episode lasts about three months,²⁰ clinical wisdom dictates that the clinician should not discontinue drugs before that time.²¹

Anecdotally, we have seen a trend for patients with bipolar disorder to reconstitute quickly and adequately enough to "look good" at the probable cause hearing, even though continued treatment is clearly necessary. We predicted, therefore, that such patients, if released from treatment, should relapse sooner and spend more time back in the hospital than their counterparts who continued treatment.

Surprisingly, the "released" and the "kept" did not differ significantly on total subsequent in-patient days in our sample. However, they differed significantly on the time to relapse, as predicted. Released patients relapsed within eighteen days, while those who were allowed to complete their treatment did not relapse for an average of sixty-five days. There was also a near significant trend that released patients took longer to get into therapy—33.23 days versus 1.44 days. Not surprising, but disturbing nonetheless, was the final trend for this group: released patients tended to spend a greater number of identified days receiving psychiatric care in jail. Indeed, bipolar patients who completed their treatment did not spend any days in jail over the following year.

As in the depressive cases, it becomes harder to make appeals to the social consequences and stigma of psychiatric hospitalization, to least restrictive alternatives, or even to deprivation of personal liberties, when deprivation of *treatment* leads to their repeat hospitalization and/or incarceration. As psychiatrists, we are drawn to ask: What is so terrible about getting it right the first time?

(5) Patients with schizophrenia have the unfortunate burden of having the worst disease of the three diagnoses mentioned here. As it turns out, they do not fare so well under LPS intervention either.

In our clinical experience, it is easiest to prove grave disability in this diagnostic category, and statistically, these seem to be among the patients most likely to be kept. However, the few who are released by the probable cause officer clearly experience a worse course compared to their fellow patients who complete treatment. The total number of days the released group spends in the hospital over the

20. Rennie studied 208 bipolar patients admitted to the Phipps Psychiatric Clinic and described their prognosis. See Thomas Rennie, *Prognosis in Manic-Depressive Psychoses*, AM. J. OF PSYCHIATRY 801 (1942).

21. See H. KAPLAN & B. SADOCK, SYNOPSIS OF BEHAVIORAL PSYCHIATRY 539 (1994).

following year was significantly greater, as was the total number of days they spent in jail. Patients with schizophrenia for whom probable cause was found spent an average of only 0.63 days in jail over the following year. In contrast, those released prematurely averaged twenty-eight days—almost a month—in jail. As is the case with the bipolar patients, this number likely represents an underestimate of the total time spent in jail, since we were only able to measure days of psychiatric treatment in jail.

I. PATIENT OUTCOMES: PREMATURE RELEASE OR INADEQUATE PRIOR CARE?

First, a reasonable question to raise is: Is it just the fact that the patients were released that contributes to their worse outcome, or are there other factors, like concurrent outpatient treatment, or how well the system connects them to outpatient therapy, that predict outcome? I believe there are three areas of evidence to suggest that the release of patients on legal grounds instead of clinical grounds results in their worsened outcomes. Furthermore, premature release is more strongly correlated than any other factor with poor outcome.

The first of these areas of evidence is anecdotal. While patients may suffer from an illness that affects certain domains of neuropsychiatric function—for example, perception-reality testing—there often are other functions that remain unimpaired, including basic cognitive functions. As a result of selectively impaired domains, some patients may be too disorganized to function independently in the community, but their ability to learn new skills remains intact. One of these skills may be the ability to learn what is necessary to say in order to get out of treatment at the probable cause hearing. I have had several patients who declared, “I know what I have to say to get out of here.” Indeed, the probable cause hearing often proves them correct.

The most shocking example I have seen was the case of a young man briefly under my care. He was brought to Harbor General by a South Bay police department after he had assaulted two elementary school teachers in the midst of an intense manic episode. As a result, he had criminal charges pending his release from treatment.

We learned from his parents that he had his first break of mania three years prior while in his last year of law school. Be assured, this man knew his rights as a patient. Moreover, annointed with manic grandiosity, he was in no mood to heed the advice of his treating physicians.

In fact, he knew his rights so well that he had been admitted no less than thirty times over the prior two years. From the record his parents kept, it became apparent that at no time was his confinement greater than seven days. He always knew what he had to do and say to escape treatment. As is the case for many patients with mania, he enjoyed his manic episodes, while remaining inattentive to the havoc they wreaked on his life. In the past years, he had exhausted his HMO insurance benefits, and nearly exhausted his life savings on manic spending sprees. Now his disease had progressed to such intensity that it had become the direct cause of the criminal charges now pending. With each premature release, he had been deprived of the treatment crucial to aborting his manic episodes. For this particular patient, outpatient treatment had been inadequate to maintain him and would continue to be inadequate until he received intense, and perhaps lengthy, acute care in order to lyse the manic episode.

The second area of evidence that leads me to believe that a worse outcome is related to premature discharge in these patients derives from the hospital's referral policy itself. Namely, all patients are given appropriate outpatient referral at the time of discharge regardless of whether they are discharged by a physician or the court. In both groups, follow-up appointments are made for the patient prior to his or her release.

In the patients with bipolar disorder, for example, we noted both the significantly shortened time to first relapse for those discharged by the probable cause hearing, as well as the trend to enter outpatient treatment later. One may argue that the delay to enter outpatient treatment in the discharged group may be a statistical effect of those same patients relapsing into the acute setting, thus preventing them from keeping their outpatient appointment. Regardless, the resulting combination is telling. Mental health law has striven to promote the least restrictive treatment alternative for patients, to increase community tenure through outpatient treatment, and to avoid the more restrictive alternative of involuntary inpatient care. That the group of bipolar patients discharged by legal intervention fared worse in all these regards compared to those ultimately released on *clinical* grounds is, at the very least, ironic.

The final and strongest reason I believe that patient outcomes in this particular sample are more affected by premature release than by inadequate community-based care derives from statistical evaluation of the data itself. Having previously compared the two groups on continuous outcome variables—for example, number of days to re-

lapse, total number of days in acute treatment, etc.—we returned to the data to look simply at whether patients relapsed or not, and if so, why they relapsed. Using chi-squared analysis we investigated the following relations: outpatient treatment to relapse; discharge source to relapse; outpatient treatment to jail contact; and discharge source to jail contact. For patients with bipolar disease or schizophrenia, relapse to acute care and jail contact was strongly correlated with the source of discharge—either physician or court—achieving p-values of 0.001 in many cases. By contrast, concurrent outpatient therapy correlated weakly or moderately with acute relapse or jail contact, achieving near significance only in the bipolar category. For this study group, then, premature discontinuation of treatment is far more strongly related to relapse and jail contact than prior outpatient care is related to prevention of relapse.

II. CONCLUSION

Mental health professionals share with mental health advocates the goal of increasing the availability and quality of outpatient psychiatric care, with a view towards increasing community tenure and quality of life. In agreement with principles of therapeutic jurisprudence, mental health professionals have long recognized the potential therapeutic impact of mental health law as well as the need to “audit the law’s success or failure” in the area of mental health.²² This study conforms with the proposition that mental health law, following sound legal principles, may sometimes inflict a paradoxical or antitherapeutic effect. Furthermore, a uniform mental health law may not appreciate and respond to the different needs imposed on the patient by different diagnoses.

22. David B. Wexler & Bruce J. Winick, *Therapeutic Jurisprudence and Criminal Justice Mental Health Issues*, 16 MENTAL AND PHYSICAL DISABILITY L. RPTR., Mar.-Apr. 1992, at 226.

