Involuntary and Voluntary Psychiatric Patients:
A Pilot Study of Resource Consumption

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Abstract: This pilot study compares the resources utilized caring for "voluntary" and "involuntary" patients in a community hospital inpatient psychiatric unit. "Voluntary" patients committed less episodes of violence. "Emergency involuntaries" experienced more episodes of restraint and were involved in more violent episodes than "other involuntaries". A critical predictor of behavior was whether patients were brought to the hospital by police. Implications for public policy and psychiatric DRGs (diagnosis related groups) are discussed. (Am J Public Health 1988; 78:1347-1348)

Introduction

An expectation exists that the treatment of involuntary psychiatric patients requires vastly greater consumption of resources than the treatment of voluntary patients. This expectation may explain part of the reluctance of many psychiatric units in general hospitals to accept such patients. Three sections of the Mental Hygiene Laws of New York State delineate the standards under which psychiatric patients may be involuntarily committed.1 Admissions under Section 9.39 are reserved for "emergency" admission of those who are demonstrably homicidal or suicidal and is governed by the narrowest standard. These patients are most often brought to hospital by the police who tend to intervene in situations involving violent rather than less threatening behaviors.2 Other involuntary commitment mechanisms are defined under Sections 9.27, requiring a two physician certification, and 9.37, requiring a one physician certificate which can be initiated by a director of community services; these hold to a less stringent legal standard. The following pilot study was conducted to ascertain differences in resource requirements in caring for patients admitted under involuntary as contrasted to voluntary statuses.

Method

This retrospective study included all involuntary admissions to the psychiatric unit of an urban community hospital in 1983. They were contrasted to a comparable group of voluntary patients admitted to the same unit. The groups were similar with respect to age, sex, and DSM III3 diagnostic categories. The sample consisted of 49 involuntary and 48 voluntary admissions.

Results

Differences of varying magnitude between voluntary and involuntary patients and between different groups of involuntary patients were found for episodes of violence, episodes of restraint and seclusion, and incidents of medication refusal (Table 1).

Table 2 displays data derived from an analysis contrasting patients brought to the hospital by the police versus all other patients, regardless of legal status; a number of differences were found between these groups.

Analysis revealed no association between length of stay and legal status; both groups remained in hospital for about 15 days. It was also noted that the same proportion of voluntary (22 per cent) as involuntaries (21 per cent) were brought to the hospital by the police.

Discussion

The data presented in this paper suggest that general hospital inpatient psychiatric units will expend resources differently depending on the patient population accepted for admission. For the purposes of this paper, resources are equated with demands made on unit staff in providing care.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Involuntary (N = 49)</th>
<th>Voluntary (N = 48)</th>
<th>P-Value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean number of discrete episodes of seclusion</td>
<td>.9</td>
<td>1.5</td>
<td>&gt;.05</td>
</tr>
<tr>
<td>Mean number of episodes of violence against people</td>
<td>.53</td>
<td>.35</td>
<td>.02</td>
</tr>
<tr>
<td>Mean number of episodes of violence against things</td>
<td>.27</td>
<td>.15</td>
<td>.06</td>
</tr>
<tr>
<td>Mean number of times patients refused medication</td>
<td>3.3</td>
<td>9.39 (Emergency Involuntary)</td>
<td>.6</td>
</tr>
<tr>
<td>Mean number of discrete episodes of restraint</td>
<td>.96</td>
<td>1</td>
<td>.03</td>
</tr>
<tr>
<td>Mean number of hours of restraint</td>
<td>7.46</td>
<td>.38</td>
<td>.03</td>
</tr>
</tbody>
</table>

a) Wilcoxon test
Each variable examined may be translated into terms of resources consumed and, consequently, differences noted in the comparison of groups reflect differences in the cost of caring for the patients comprising the various groups.

Although the same number of voluntary and involuntary patients were brought to the hospital by the police, voluntarily were involved in significantly fewer episodes of violence against people and things. It would be reasonable to expect that the cost of caring for involuntaries would be greater than that of voluntaries. Among the involuntary group, the 9.39 (emergency) admissions are involved in a significantly greater number of acts of violence against people and spent more time in restraint and seclusion. Addressing the issue of resource utilization from another vantage point reveals that, independent of legal status, patients brought to the hospital by the police consumed more staff time than other patients.

It is our impression that admitting involuntary patients to general hospital psychiatric units would not pose a burden so great in additional resource consumption that hospitals could not be compensated by reasonable governmental subsidies or higher reimbursement rates. For example, it would seem important that units admitting involuntary patients, and particularly on "emergency" statuses, would need seclusion rooms as well as a psychiatrist in the hospital at all times to provide care in the emergency room and on the unit. Finally, the data presented again underscore the inapplicability of the current approach to diagnosis related groups (DRGs) for inpatient psychiatric units where the cost of care is clearly not reflected in the length of stay.

REFERENCES

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### AIDS Reference Service at National Library of Medicine

The National Library of Medicine (NLM) and the NIH Office of AIDS Research recently announced to the medical research community a new database containing some 13,000 references to scientific articles about AIDS. AIDSLINE joins the family of databases made available widely through the NLM’s online network.

The references in AIDSLINE cover the clinical and research aspects of the disease, epidemiology, and health policy issues. Many of the records include an abstract in English. The articles cover the period 1980 to present, and the database is updated twice each month with the addition of 200–300 records.

Health professionals who wish to have access to AIDSLINE may join the NLM network by requesting a user code. To make online searching easier and more efficient, the Library offers GRATEFUL MED®, a microcomputer-based software that provides a user-friendly interface to most NLM databases. This software can be adapted by the user to access AIDSLINE. Using GRATEFUL MED an average search costs less than $5, including all communication and other charges. The software may be purchased from the National Technical Information Service, 5285 Port Royal Road, Springfield, VA 22161 for $29.95 (plus $3 per order for shipping).

Telephone inquiries about AIDSLINE, GRATEFUL MED, and user codes, may be made to NLM’s MEDLARS Management Section 301-496-6193 (toll free: 800-638-8480).

The National Library of Medicine also publishes a quarterly AIDS Bibliography that lists references by sub-topics. Subscriptions ($12; $15 foreign) may be sent to the Superintendent of Documents, US Government Printing Office, Washington, DC 20402.