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Civil Commitment in the Psychiatric Emergency Room:

I. The Assessment of Dangerousness by Emergency Room Clinicians

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Abstract

Critics of the dangerousness standard for civil commitment contend that there is no professional standard for the evaluation of dangerousness. We used Three Ratings of Involuntary Admissibility, a reliable Index of behavioral indicators of danger to self, danger to others, and grave disability, and found that when combined into weighted patterns these indicators predicted disposition decisions of 70 clinicians in five psychiatric emergency rooms over 251 cases. A concurrent measure of perceived dangerousness, Clinician's Global Ratings of patients on these criteria, yielded similar results. We conclude that clinicians in California psychiatric emergency rooms apply a shared concept of dangerousness that can be described in behavioral terms.

In the past three decades, involuntary confinement of the mentally ill has been dramatically curtailed. Several factors, including concern for the civil rights of patients, converged to bring about a decrease in reliance on institutional care and a narrowing of the grounds for civil commitment. Most state commitment statutes today specify that patients may be involuntarily admitted to a hospital only on grounds of danger to self, danger to others, or (in many states) grave disability, and then only if the condition results from mental disorder. Judicial interpretations of these statutes indicate that the common denominator, ie, the only legitimate basis for civil commitment, is danger due to mental disorder.^{1–4}

In the view of many commentators,^{4,5} the adoption of the dangerousness standard constituted the most fundamental change brought about by commitment reform laws of the 1970s, laws modeled after California's Lanterman-Petris-Short (LPS) Act.⁶ This standard

has in turn become the focus of current criticism of civil commitment law by some of those concerned that the mentally ill are “dying with their rights on.”^{7–9} Many commentators advocate return to a standard focusing on the person’s illness and need for treatment^{10,11}

Some of these contemporary critics point out that there is no necessary relationship between dangerousness and mental disorder.⁴ Although they raise a broad and complex issue, its use in the current debate over civil commitment criteria is more focused. The implication is that many patients admitted under dangerousness criteria are “not really mentally ill”¹² or are at least not in need of, or are untreatable in, acute-care psychiatric facilities, and that they therefore constitute an inappropriate population for the mental health system.^{11,13}

Another concern expressed by advocates of return to an illness-focused standard, as well as advocates of restricting commitment even further, is that there is no professional standard for the clinical evaluation of dangerousness.⁴ “While there are consensually validated—professional—standards defining mental illness, such standards are not present with regard to dangerousness and so the concept remains overly elastic and unclear.”^{4(p36)}

Given their enormous potential ramifications, changes in commitment criteria that are based on testable assumptions should be guided by empirical knowledge. In light of the current push for change in the commitment criteria, “the production of data that might inform the decision-making process would appear to be an urgent priority.”¹⁴ Knowledge about how the present laws are being applied is the first priority.¹⁵

In this and two companion articles^{16, 17} we report our findings with regard to three of the questions raised by opponents of dangerousness criteria: (1) the extent to which clinicians employ a shared professional standard in evaluating patients’ dangerousness, (2) the relationship between mental disorder and perceived dangerousness in patients evaluated for hospital admission, and (3) the effect of this relationship on admission decisions and the character of the acute-care population.

In the era of community-based treatment, most initial evaluations for involuntary commitment are conducted in general hospital emergency rooms.¹⁸ Thus, we have focused our study on the emergency commitment procedure. This article will report our findings regarding the existence of a shared professional approach to the evaluation of dangerousness in the psychiatric emergency room.

STUDY METHOD

Procedures

Two hundred fifty-one cases were observed at five public psychiatric emergency rooms: four in the San Francisco Bay Area and one in California’s Central Valley. Two of the facilities were located in large Bay Area cities, two in smaller cities in primarily rural counties, and the fifth in a metropolitan suburban community. Two settings were emergency psychiatric services operating within medical emergency rooms, two were separate psychiatric emergency facilities within the hospital, and one was located approximately 200 yards from the hospital in a separate building.

Approximately 50 evaluations were observed at each emergency room. No formal sampling procedures were employed. Any patient was included in the sample who had not yet been seen by a clinician and was available when a researcher and a staff clinician were free to take a case. Evaluations were observed on all days of the week, during day and evening hours, and in one facility around the clock. Observation was refused in only ten cases (4% of 261 attempts).

Observations involved the independent assessment of a case by a researcher who accompanied the clinician and the patient through the psychiatric emergency evaluation of that case from the time of the patient's arrival until a disposition decision was made. With the researcher looking on, the clinician simply went about his or her business in the course of the evaluation, keeping the research observer informed as to any information he or she had received by phone. The observer also reviewed charts and other written material available to the clinician.

The observer coded the case on prestructured rating instruments on the basis of the information gathered by the clinician. Information was taken up to the point at which the clinician made a disposition decision on the case. The clinician made his or her ratings on the Clinician's Global Rating (CGR) form immediately after making the decision. The clinician was at no time aware of the contents of the researcher's own rating schedules, and the researcher did not see the clinician's ratings. Observers were clinical social workers with experience in assessing severely disturbed adults. They included senior staff, who had developed the instruments and a 150-page manual and had had extensive experience using them in previous studies. Two additional observers were trained by didactic instruction, practice coding of case vignettes, and experience in using the instruments and manual in vivo under close supervision. Each observer was tested for acceptable interrater reliability on key study instruments before beginning independent study observations.

Measures: Defining and Measuring Concepts of Dangerousness

California's civil commitment law, the LPS Act,⁶ permits involuntary detention on grounds that a person is either dangerous to himself or others, or gravely disabled, due to mental disorder. Despite the inclusion of the grave-disability criterion, the law is clear that to be involuntarily confined the person must be a "danger" to himself or herself or others. The relationship between dangerousness and grave disability was clarified in the landmark case of *Doe v Gallinot*,⁷ in which the court explained that "the threat of harm to oneself may be through neglect or inability to care for oneself," as specified in California's "gravely disabled" standard. Nevertheless, in comparison with states in which patients may be committed only when homicidal or suicidal, the inclusion of grave disability renders California's dangerousness standard relatively broad. "Gravely disabled" is defined for purposes of all provisions of the LPS Act⁶ as "a condition in which a person, as a result of a mental disorder, is unable to provide for his basic personal needs for food, clothing, or shelter" (§ 5008h).

TRIAD: An Index of Dangerousness Indicators.

In operationalizing the concept of dangerousness, Segal et al¹⁹ developed an index entitled Three Ratings of Involuntary Admissibility (TRIAD) to reflect the way clinicians in psychiatric emergency rooms interpret and apply the criteria “danger to self,” “danger to others,” and “grave disability” due to mental disorder (see Appendix: The TRIAD Assessment). In 1981, they observed 89 cases at two urban county hospital psychiatric emergency rooms in the San Francisco Bay Area, leading them to the following conclusions. (1) They had developed an index of indicators used by clinicians with interrater reliability coefficients (Pearson r) equal to .89, danger-to-self score; .94, danger-to-others score; .77, grave-disability score; .89, total TRIAD score. (2) TRIAD appeared to be a valid index of those aspects of a case to which clinicians respond, and the weights they assign various constellations of those aspects, in evaluating dangerousness and grave disability.

This tentative conclusion was drawn from the fact that TRIAD scores correctly predicted disposition, a concurrent measure of perceived dangerousness, in 82% of 89 cases observed in these two psychiatric emergency rooms. The results of this study further indicated that clinicians had employed shared constructs of danger to self, danger to others, and grave disability and that these constructs could be reliably applied in actual cases. These findings were replicated successfully in 1983 in a study of one new room and one of the original settings ($n = 101$).²⁰ TRIAD correctly predicted disposition in 78% of the cases. When comparable patient load was taken into account, correct predictions of case disposition increased from 81% to 86%.

The TRIAD instrument was therefore chosen as one of two instruments to operationalize the dangerousness criteria for the current study.

The TRIAD Simulation of Clinical Judgment.

TRIAD simulates clinical judgment by scoring patterns of behavior and circumstance as more or less dangerous. TRIAD was developed through an iterative process resulting in the identification and ranking of patterns of behavior and circumstance more or less likely to lead to the determination that a patient is involuntarily admissible by the standards of California’s LPS Act.⁶

TRIAD consists of three checklists with a total of 88 numbered items that can be combined to yield 149 patterns of behavior and circumstance relevant to the clinical prediction of violence and suicide and the assessment of grave disability. On each of the scales, several patterns are assigned the highest score, several are assigned the next highest score, and so on. No pattern combines more than nine items, and most involve two, three, or four items.

For example, “threatened to harm another” is one item that, by itself, scores at a moderate level (2) on the danger-to-others scale. However, such a threat may yield a higher score (4) if it occurs with three other particular items. The first additional item has to do with provocation or lack thereof. The others involve indications of a concrete plan and/or weapon, and/or being in a volatile or unpredictable or enraged state, and/or having a history of assault

According to the assumptions embodied in TRIAD, if a presenting picture that yields a score of 4 is accompanied by a mental disorder, the evaluating clinician will determine that the patient is clearly admissible by the LPS standards. To prevent hospitalization, the clinician may attempt to bring about some change in the picture through crisis intervention or medication in the emergency room, but if these efforts fail, admission will follow. If the efforts succeed, the danger-to-others score will be lower than it would otherwise have been. Some other patterns are equally straightforward; some are more ambiguous and yield intermediate scores. The TRIAD scale scores were computed by finding the standard pattern on each scale that included the items checked at the time of disposition. If more than one pattern applied, the one that yielded the highest score was chosen.

TRIAD Interrater Reliability.

A total of 30 cases, the last 30 of the 251 observed in the current study, were jointly observed as a conservative estimate of the interrater reliability of TRIAD. Three pairs of observers, using TRIAD, rated ten cases each and achieved interrater reliability coefficients (Pearson r) of .86 on the danger-to-self score; .79 on the danger-to-others score; .70 on the grave-disability score; and .83 on the total score.

The results replicate the TRIAD reliability assessments of Segal et al¹⁹ reported above. Though there was a significant reduction in interrater reliability of the danger-to-others scores ($P < .05$), no significant reductions were observed in the TRIAD total, danger-to-self, and grave-disability scores, and all reliability figures remain in a respectable range. The results demonstrate that it is possible to use this instrument reliably to rate actual cases in the psychiatric emergency room.

CGR of Dangerousness.

A second measure used to operationalize the dangerousness concept was the CGR of each patient. At the time the researcher scored TRIAD, the clinician was asked to provide an independent rating of the patient on global scales of danger to self, danger to others, and grave disability. These scales had ranges and points equivalent to the possible scores on the structured TRIAD instrument—for example, from 0, “not dangerous to self at this time,” to 4, “clearly dangerous to self at this time.”

RESULTS

Characteristics of Patients, Clinicians, Settings

Table 1 summarizes some of the demographic characteristics of the sample of 251 patients observed in the five hospital emergency rooms. The characteristics of the sample would appear to be those of a marginal group, one likely to be served at a public hospital and certainly one at high risk of involvement with systems of health care, social services, and regulation simply by virtue of lack of social integration.²¹

Most patients came to the emergency service voluntarily (53%); most involuntary patients were on emergency holds (80%), often with more than one of the three admission criteria cited as the reason for the hold (Table 1, bottom). Nearly 38% of patients had been placed on

a 72-hour emergency (LPS §5150 [Lanterxnan-Petris-Short Act]) hold by a police officer or mental health professional in another setting, 8% had another involuntary status (such as police custody for criminal charges or mental health conservatorship), and slightly less than 1% had been sent by courts for evaluation at the request of family.

Seventy clinicians evaluated the cases. Forty-five percent of the patients were evaluated by psychiatrists, 21% by psychiatric technicians, 13% by nurses, 8% by social workers, and 13% by other professionals, paraprofessionals, or unlicensed professionals in training. The clinical experience of evaluators ranged from none to 30 years; the emergency psychiatric experience of the clinicians ranged from none to 13 years (an average of four years). Of the patients observed, 78% were examined by clinicians with two years or more of psychiatric emergency service (PES) experience.

The number of patients evaluated in the emergency service on the days of the observations ranged from one to 35, and in most cases (73.8%) was eight to 24. If admitted to a ward following the emergency evaluation, the patient was most likely to remain for one to six days (60%) or for seven to 18 days (32%). Average occupancy rate for the inpatient wards at the five hospitals during the study period was 89%, ranging from 79% at one facility to 101% at another.

Applying the Dangerousness Measures

TRIAD Severity Level as a Dangerousness Analogue.—The overall severity of the patient's presentation on the three legal criteria was taken as a measure of how dangerous that person was perceived to be. The TRIAD severity score (as opposed to each subscale score or the sum of the subscale scores, ie, the total score) takes into account individual scale scores (danger to self, danger to others, and grave disability) as well as the sum of all three subscale scores. Its computation is illustrated in Table 2. The TRIAD severity score yielded an interrater reliability coefficient of $r = .65$ and is referred to below as the TRIAD “dangerousness” score.

CGR and Severity of Dangerousness.—Since the CGR was scored with ranges and points equivalent to TRIAD scores, it was possible to compute a CGR severity level—ie, a CGR “dangerousness” score equivalent to that computed from the TRIAD scores (Table 2)—that would directly reflect the clinician's view of the case and would be available for comparison with the TRIAD severity score. The CGR severity score will be referred to below as the CGR “dangerousness” score.

Validating TRIAD

As Table 2 indicates, most (58%) of the sample patients scored at the highest level of dangerousness (severity=4) and 31% scored at the lowest level (severity = 1), whereas 11% scored at moderate levels. For summary purposes, those case dispositions considered correctly predicted include cases in which patients scoring at severity level 4 were retained and patients scoring at severity levels 1 through 3 were released. The percentages reported below reflect this method of computing TRIAD accuracy. We consider this approach satisfactory for summarizing our findings, although it does not quite reflect the complexity

of our expectations for severity levels 2 and 3 and yields a somewhat conservative estimate of TRIAD accuracy. The γ statistic, on the other hand, enables us to reflect the ordinal character of the dangerousness score. Given that we assume the higher the dangerousness score is, the higher the probability of admission will be, the γ statistic will test this assumption and tell us the percentage of guessing errors eliminated by using our knowledge of the dangerousness score to predict whether or not a patient will be retained.

TRIAD predicted 76% of disposition decisions in 251 cases ($\gamma=.75$). As expected, level 4 patients were most likely to be retained (85%), and level 1 patients were least likely to be retained (30%), whereas disposition of moderately “dangerous” patients was less predictable (57% retained).

The accuracy of TRIAD predictions of disposition in the 5 facilities ranged from 72% in a rural county PES to 86% in a suburban county hospital PES. However, the rural county had the lowest inpatient occupancy rate and admitted the most voluntary patients from the PES. As the dangerousness criteria apply only to involuntary admissions, one would expect TRIAD to be more accurate in distinguishing involuntarily retained patients from those released. When patients admitted voluntarily were removed from the sample, the rate in the above-mentioned rural PES rose to 83%.

When voluntarily retained patients in all settings ($n = 22$) were removed from the analysis, the rate of correct predictions by TRIAD was 79% overall (229) and ranged from 71% in a busy urban PES to 89% in a suburban PES with a lower patient-staff ratio. (Removal of voluntary patients lowered the prediction rate in the two busy urban sites, as the few patients admitted voluntarily in those facilities scored as high as the bulk of involuntarily retained patients, and more low-scoring patients were retained involuntarily than in smaller facilities.)

Table 2 compares the distribution of the severity of perceived dangerousness as measured by TRIAD and the CGR. Severity of dangerousness combines scores on the danger-to-self, danger-to-others, and the grave-disability subscales of these two instruments to provide an overall perspective of the patient’s presentation on the dangerousness dimension. The distribution of TRIAD severity scores of the 251 observed patients closely parallels the distribution of the CGR severity scores.

Agreement between clinicians’ dangerousness ratings and the TRIAD dangerousness score is considerable ($\gamma = .66$), and the stability of this agreement is validated by the parallel relationship between these two scores and disposition. Differences were not explained after extensive exploratory multiple-regression analysis with a host of variables related to the patient’s social and psychiatric history, presenting symptoms, clinician discipline and experience, and the PES environment.

The average clinician ratings on danger to self and grave disability were significantly higher than the average TRIAD scores on those scales. Not surprisingly, disagreement between clinician ratings and TRIAD was greatest on discrepant cases, ie, cases in which patients were retained with a lower score on TRIAD or released with a higher score on TRIAD. Thirty-one percent of the variance in TRIAD/CGR disagreement was explained by those

cases. This may indicate that the clinician's rating was influenced by his or her disposition decision in the particular case. It is equally likely that relevant features of the case were not captured by TRIAD, and that these features explain both the clinician's rating and disposition. Disagreements between TRIAD and CGR scores may also be explained by the assignment of an inappropriate value by us to one or more of the 149 specific patterns. Thus, for example, an unprovoked physical attack is assigned a score of 4 on the TRIAD Danger to Others scale, yet may be seen as only moderately dangerous (2) by clinicians. Internal validation of individual TRIAD pattern scores is currently under way.

COMMENT

Consistency of Emergency Dangerousness Assessments

Both disposition of cases and CGRs of cases were used as measures to determine the concurrent validity of TRIAD as a description of the way clinicians think about the dangerousness criteria. As in previous studies, the concurrent validity of TRIAD was supported by its success in identifying the patients who were most likely to be retained and least likely to be retained, as well as those whose dispositions were least predictable. It was further supported by the fact that the CGR, a second measure of dangerousness, also discriminated among the cases in a parallel way. This success in predicting disposition decisions and clinician ratings on the basis of the behavioral indicators of dangerousness could not have been achieved in the absence of an underlying agreement among emergency clinicians as to the meaning of the dangerousness criteria and their applicability in particular cases. The study findings constitute an empirical demonstration that clinicians assess dangerousness consistently.

Note that the question addressed by the study was not whether emergency psychiatric assessments have predictive validity ie, predict future occurrences of dangerous behavior—but rather the prior question of whether clinicians respond to similar cases with similar judgments. Although there is some preliminary evidence of the accuracy of emergency room predictions of future dangerous behavior,^{22,23} a definitive test of their predictive validity would require experimental procedures involving possibly insurmountable legal and ethical problems. Thus, though the finding that clinicians respond consistently to a specific set of dangerousness indicators does not imply that all ought to follow the same decision rules, the data do demonstrate that the assessment is not idiosyncratic and that, right or wrong, there is an example to follow. Our methodology has produced substantial evidence that there is a consensus among clinicians across five settings as to the behavioral bases of clinical predictions or assessments of dangerousness.

Our findings are consistent with those of two other studies^{24,25} indicating that clinicians are in overwhelming agreement as to the applicability of the specific criteria to specific cases. Our findings take the idea of a professional consensus further, demonstrating that it can be described in behavioral terms.

Previous Contradictory Findings

Our sample was comparable with that of Monahan et al,²⁴ who reported on 589 emergency commitments. They found that in very few cases was only one criterion thought to be applicable to a patient. In fact, 14% of all patients in our sample scored at the highest level on more than one criterion. In many more cases, however, patients scored high on one criterion and low or moderate on one or more of the others. The idea, inherent in TRIAD, that there are degrees of danger to self or others or disability is important to keep in mind when interpreting findings bearing on the application of dangerousness criteria. If a number of patients present a severe picture on one criterion along with low-level indicators of other criteria that are also checked on the admission records, a study focusing on only one criterion is likely to yield findings that indicate inconsistency in its use. It might find, as Rubin and Mills¹⁵ did, for example, that individuals admitted as dangerous to others vary greatly in their potential for violence. However, in the less severely violent cases, the reason for admission may actually have been a severe presentation on grave disability or danger to self.

Similarly, patients in the Monahan et al²⁴ study on whom psychiatrists agreed regarding the applicability of the danger-to-self criterion but who were not rated as imminently in danger of physical harm may in fact have presented low or moderate degrees of danger to self but severe pictures on other criteria that were also cited and that actually explained the admission.

These variations in degree of perceived dangerousness do not depend entirely on differences in specific acts for which patients are brought in. As Yesavage points out²⁶ clinicians are not so much measuring the dangerousness of acts already committed as the likelihood that similar or even more dangerous actions will be taken in the future. Thus, variations in degree of perceived dangerousness may depend less on difference in specific acts committed before the evaluation than on the presence or absence of certain kinds of fairly concrete surrounding behaviors and circumstances. We believe that such conditions, which may have been beyond the scope of other studies of behaviors leading to commitment,^{15,27} are captured by TRIAD.

Generalizability of TRIAD

Two questions arise regarding the generalizability of TRIAD as a description of clinicians' concepts of dangerousness. The most obvious is the fact that some states do not permit commitment on the basis of grave disability. Presumably the danger-to-self and danger-to-others scales alone would be valid descriptors of the dangerousness criteria in those states. In our sample of clinicians, the three concepts were quite distinct. (The average coefficient of correlation between concepts as measured by TRIAD was [Pearson] $r=.06$ and for the CGR was $r=.2$.) However, it may be that clinicians in some states have incorporated some aspects of grave disability in their concepts of danger to self and others as a way of coping with the demand to treat patients whose ability to care for themselves has deteriorated severely. Replication of our study in those states would answer this question.

The second question is that of the effect of resources on the interpretation of the criteria. TRIAD was developed in settings in which demand for inpatient beds is high and the vacancy rate is low (less than 10%).¹⁹ Although bedspace did not account for disagreement between TRIAD and clinician ratings or TRIAD and disposition, we expected that clinicians might be less rigorous in their thinking about the criteria in settings in which bed space was not a problem. However, in the study reported herein, TRIAD held up equally well in settings with higher vacancy rates (up to 21%).

CONCLUSION

The fact that the dangerousness criteria can be reliably described in behavioral terms in several settings—at least in the geographic areas studied—counters one of the arguments made by their opponents—ie, the argument that the mental health professions have developed no standard for the evaluation of dangerousness and are forced to rely on concepts that are overly elastic and unclear.

Given reliable measures that reflect the way clinicians apply the dangerousness criteria, it is possible to test empirically two additional assumptions of critics of the dangerousness criteria: (1) that these criteria are unrelated to mental disorder, and (2) that they result in the preferential selection of less severely ill individuals into the acute-care system. Our findings on these questions follow in two companion articles^{16,17} and suggest caution in revising civil commitment policies. Such revisions should be based not on untested assumptions but on empirical findings about the impact of current and proposed standards.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Table 1.—

Characteristics of Patients Seen in Five PES, 1983 to 1984 (N=251)*

Characteristics	%
Sex	
M	56.6
F	43.4
Age, y	
15-24	20.8
25-34	34.8
35-44	25.2
45-54	8.0
55-64	4.8
65 +	6.4
Ethnicity	
White	67.7
Black	18.3
Spanish surname	10.4
Chinese	1.2
Other	2.0
Birthplace	
United States	88.0
Foreign	9.2
Unknown	2.8
Marital status	
Never married	47.8
Married	11.2
Divorced or separated	28.7
Widowed	6.4
Unknown	7.6
Education, y	
<10	9.6
10-12	34.3
13-20	16.8
Unknown	39.4
Employment	
Full- or part-time	9.6
Unemployed	16.0
Disabled	55.4
Other	10.8
Unknown	8.4
Income source	
None	11.6

Characteristics	%
Family or friends	12.4
Employment	9.6
Disability	37.1
Other	8.8
Unknown	20.7
Living arrangements	
With others	43.7
No address	15.9
Alone	20.4
Sheltered care	12.8
Other	6.8
Unknown	2.4
Legal status at entry to PES	
Voluntary	53.0
Involuntary	47.0
Status of involuntary patients at entry (n= 117)	
Emergency (LPS §5150) hold	80.0
Court-ordered evaluation	2.0
Other	18.0
Criteria cited for patients on LPS §5150 holds at entry (n=94) [†]	
Danger to self	60.0
Danger to others	49.0
Grave disability	32.0

* PES indicates psychiatric emergency service; LPS §5150, section of Lanterman-Petris-Short Act governing emergency 72-hour civil commitment. Percentages may not total 100% due to rounding.

[†] In nearly half the cases, 5150 forms cited more than one criterion.

Table 2.—

Severity Ratings of Dangerousness on TRIAD and CGR *

	Total Sample	Disposition	
		Released	Retained
TRIAD severity score			
Level 4, high	58	25	76
Levels 2 and 3, moderate	11	14	10
Level 1, low	31	61	14
Total (N = 261)	100	100 (n = 89)	100 (n = 162)
CGR severity score (n = 249)			
Level 4, high	62	21	85
Levels 2 and 3, moderate	11	12	10
Level 1, low	27	67	5
Total (n = 249)	100	100 (n = 88)	100 (n = 161)

* Values are percentages. TRIAD indicates Three Ratings of Involuntary Admissibility; CGR, Clinician's Global Rating; high score, danger to self (DSS), danger to others (DOS), or grave disability (GDS) score of 3 or 4, or total score of 4 or more; moderate score, DSS, DOS, or GDS score of 2, and total score of 2 or 3; low score, DSS, DOS, or GDS score of 0 or 1, and total score of 3 or less.