Legal and Ethical Considerations in Psychiatric Emergencies

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KEYWORDS

• Individual rights • Custody • Malingering

KEY POINTS

- Individual rights can be limited in the context of psychiatric emergencies.
- Mental health emergencies present unique dilemmas of care and disposition that are informed by both standard of care and local statute.
- Patients in custody present alternative options for disposition from the emergency department.

INTRODUCTION

This article addresses legal and ethical considerations in the practice of emergency medicine. Allen and colleagues[1] ably considered capacity and consent, privacy and confidentiality, and involuntary treatment. The authors consider a patient presenting to the emergency department (ED) with depression and suicidality, a patient with psychosis and homicidal ideation, and a patient with anxiety and malingering, to further examine patient rights, in-custody issues, and what to do when it appears a patient is attempting to escape a trial appearance.

Mental health statutes vary widely in their scope and application. In addition to other sections of this issue, the reader is advised to refer to state medical associations for guidance with regard to specific practice surrounding individuals' rights in the context of custody issues or incapacity during mental health emergencies. The general discussion offered in this article is offered as a foundation for reviewing similar situations in American emergency medicine practice.

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CASE 1

An 18-year-old woman presents to the ED complaining of suicidal ideations after overdosing on pills. She is medically cleared, seen by the psychiatry consultation service, and deemed to require an admission. She is willing to sign a voluntary application; however, there are no beds available. She remains a boarder in the ED awaiting psychiatric bed placement. What rights does she have?

PATIENT RIGHTS

Patients who present to the ED with suicidality are entitled to a medical screening and mental health screening process that protects their human dignity while balancing their autonomy with the beneficence of caring for them. Emergency physicians (EPs) and other providers also must observe the duty to follow laws applicable to self-harm.

Autonomy

A competent patient with decision-making capacity has the autonomy to make their own health care decisions unless they are deemed a risk to themselves or others. A patient who expresses current suicidality is a risk to themselves, and it is therefore a right of the physician to overrule their autonomy for the patient's benefit. Many states distinguish between voluntary and involuntary placements in a conditional manner. Patients may volunteer to be admitted for treatment without activating statutes of involuntary holds, but occasionally patients at risk of self-harm may change their minds in the same visit and then are no longer voluntary. At this point, the legal mechanisms of detainment are activated.

Physician-Patient Relationship

An EP cannot override a patient's autonomy until they have a relationship with the patient. This relationship is established upon arrival to the ED.

Obtaining Nonconsensual Collateral Information

HIPAA expressly permits collateral information to be obtained without patient consent.[2] In *Jablonski v United States*, a psychiatrist was held liable for not doing so.[3] Although HIPAA does not explicitly discuss reviewing publicly available information, an EP may obtain patient information that is publicly available. Data sources may include court dockets, news sources, social media, mapping software, employment-related content, videos, and photographs. Suicide notes can include text messages, e-mails, or social media posts.[4]

Medical Screening

The American College of Emergency Physicians (ACEP) clinical policy offers recommendations with regard to medical screening (**Table 1**).[5] This includes recommendations for laboratories and especially the role of urine drug screens and blood-ethanol levels.

Voluntary Hospitalization

A great way to enhance a patient's sense of autonomy is to offer voluntary hospitalization to competent patients who have decision-making capacity. The American Psychiatric Association Task Force on Consent to Voluntary Hospitalization recognizes the many advantages of a voluntary admission over an involuntary admission. It maintains the patient's autonomy, maximizes the patient's rights, reduces stigma, broadens access to inpatient care as many patients do not meet the criteria for involuntary

Table 1
American College of Emergency Physicians recommendations for medical screening

Patient Management Recommendations	Level A	Level B	Level C
What testing is necessary in order to determine medical stability in alert, cooperative patients with normal vital signs, a noncontributory history and physical examination, and psychiatric symptoms?	None specified	In adult ED patients with primary psychiatric complaints, diagnostic evaluation should be directed by the history and physical examination. Routine laboratory testing of all patients is of very low yield and need not be performed as part of the ED assessment	None specified
Do the results of a urine drug screen for drugs of abuse affect management in alert, cooperative patients with normal vital signs, a noncontributory history and physical examination, and a psychiatric complaint?	None specified	None specified	1. Routine urine toxicologic screens for drugs of abuse in alert, awake, cooperative patients do not affect ED management and need not be performed as part of the ED assessment 2. Urine toxicologic screens for drugs of abuse obtained in the ED for the use of the receiving psychiatric facility or service should not delay patient evaluation or transfer
Does an elevated alcohol level preclude the initiation of a psychiatric evaluation in alert, cooperative patients with normal vital signs and a noncontributory history and physical examination?	None specified	None specified	1. The patient's cognitive abilities, rather than a specific blood-alcohol level, should be the basis on which clinicians begin the psychiatric assessment 2. Consider using a period of observation to determine if psychiatric symptoms resolve as the episode of intoxication resolves

Lukens, TW et al. "Clinical Policy: Critical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department." Annals of Emergency Medicine. Vol. 47. No. 1. Pages 79 to 99. January 2006.

admission, may allow for earlier treatment initiation before patients are more deteriorated, enhances the collaborative treatment relationship, may lead to more favorable outcome, and avoids increased costs for the mental health system and the courts that are incurred by involuntary admission processes.[6]

(In-)Justice of Scarce Resources

With mental health resources taxed beyond capacity in most jurisdictions, the contrast between ideal treatment and the typical practice is stark. Although a patient seeking help for an emergency presentation with suicidal thoughts should receive prompt clearance, expedient mental health evaluation, and straight-forward behavioral health admission, they typically experience days of emergency boarding until definitive care is arranged. It is not surprising that this suboptimal care could lead to voluntary decisions for hospitalization to escalate to involuntary interventions. Health systems everywhere are faced with the scarce resources of mental health practitioners and inpatient behavioral health beds, leaving EDs to aspire to provide the most humane care within circumstances that challenge privacy and mental health standard of care, and statutes (such as a 72-hour hold) requiring expedient care.

CASE 2

A 36-year-old man in police custody presents to the ED complaining of demonic voices telling him to strip naked and run down city streets and loot stores while attacking anyone in his way. He is medically cleared with the exception of screening positive for cannabinoids. The psychiatry consultation service recommends involuntary admission. An alternative option offered by law enforcement is that he be brought to jail, where he may receive psychiatric care via telemedicine. What should you do?

IN-CUSTODY ISSUES

Patients brought into the ED in custody have limited rights because of either being incarcerated or being under arrest. They may have further infringements on their rights if they are deemed a risk to themselves or others. Incarcerated patients may have in-person or remote psychiatry care available to them in prison; however, patients who are in custody pending arraignment may have limited access to such services. Nonetheless, law enforcement officials have jurisdiction over a patient's disposition if that disposition is prison or jail once medical screening is complete. If the patient is going to receive only a ticket for an appearance in court rather than being brought to jail, then the patient may receive mental health care in the hospital. Of course, it is possible that the patient who is acutely psychotic may become agitated when the EP recommends admission and require additional medical intervention.

Humane Agitation Management

When a patient is agitated, an EP can attempt verbal de-escalation. If this fails, chemical and even mechanical restraint may become necessary to protect the patient and staff from injury. Every effort should be made, however, to limit the power differential between the EP and patient in order to preserve the therapeutic relationship. Here is some specific guidance that may help to do this while in the ED.

- Clearly communicate that interventions are "for protection and prevention, and not punishment."
- Minimize confrontation with communication that intends to save face for all parties.

Table 2
American College of Emergency Physicians recommendations for sedation

Patient Management Recommendations	Level A	Level B	Level C
What is the most effective pharmacologic treatment for the acutely agitated patient in the ED?	None specified	1. Use a benzodiazepine (lorazepam or midazolam) or a conventional antipsychotic (droperidol or haloperidol) as effective monotherapy for the initial drug treatment of the acutely agitated undifferentiated patient in the ED 2. If rapid sedation is required, consider droperidol instead of haloperidol 3. Use an antipsychotic (typical or atypical) as effective monotherapy for both management of agitation and initial drug therapy for the patient with known psychiatric illness for which antipsychotics are indicated 4. Use a combination of an oral benzodiazepine (lorazepam) and an oral antipsychotic (risperidone) for agitated but cooperative patients	The combination of a parenteral benzodiazepine and haloperidol may produce more rapid sedation than monotherapy in the acutely agitated psychiatric patient in the ED

Lukens, TW et al. "Clinical Policy: Critical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department." Annals of Emergency Medicine. Vol. 47. No. 1. Pages 79 to 99. January 2006.

- Maintain open posture (do not cross arms or clench fists).
- Coach patients on how to stay in control and clarify behavioral expectations.
- Verbalize respect and empathy.
- Position self at a 45° angle (directly in front of the patient can seem confrontational).
- Avoid sounding punitive or accusatory, as well as posturing to challenge.
- Give choices and encourage patient responsibility.
- Avoid confronting; rather, explore misconceptions.
- De-escalate security's show of force (if possible).[7]

If medication is deemed necessary for sedation, the ACEP clinical policy offers a recommendation for benzodiazepines or antipsychotics (Table 2).[5]

Involuntary Holds

Involuntary hospitalization occurs when the patient's risk to self or others, owing to mental illness, renders the hospitalization necessary to prevent harm.[6] Different jurisdictions have varied statutory approaches to how EPs go about holding patients. ACEP encourages EPs to be familiar with their state laws; however, there are some trends worth considering. For example, the duration of an emergency hold varies between 23 hours and 10 days (Table 3). Who can initiate a hold varies from any interested person to a guardian (Table 4). Reasons to hold can vary from danger to self to grave disability, including substance use disorder (Table 5). Furthermore, states vary with regard to judicial involvement before a hold (Fig. 1).

Warning and Protecting Third Parties

If a patient were to make a direct threat to harm another individual, then the EP has a duty to warn and protect that individual. Involuntary admission of the patient is sufficient to meet that duty to protect. If the patient is discharged and has made a clear and direct threat, then it is incumbent upon the EP to warn law enforcement. The landmark legal case in California of *Tarasoff v Regents of University of California* established California case law placing accountability on psychiatrists to prevent harm to third parties when a patient shares intention to harm them.[8] The 1974 decision regarding this case

Table 3
Duration of emergency holds and states' ability to extend holds without a court order

Duration	No Court Order Required	Court Order Required
23 h		ND
24 h		AZ, DE, IL, ME, MI, MT, NC, SC, UT
30 h		MD
48 h	GA, HI, IA	DC, TX
72 h	LA, NY, TN, VT, WA	AK, AR, CA, CO, CT, FL, IN, KY, MA, MN, MS, NJ, NV, OR, VA, WI, WY
96 h		MO, OH
5 d		ID, OK, PA, SD
7 d		AL, NM
10 d		NH, RI

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Table 4
Who can initiate emergency commitment and judicial review requirements, by state

Initiator	No Requirement	Predetention Ex Parte Hearing	Postdetention Ex Parte Hearing
Any interested person	AZ, DE, LA, MA, MN, MO, NC, SD, UT, WV	AR, CO, MD, MS, VA, VT	IA, IN, ME, NH, TX
Relative	AZ, OK	MS, NY	NV
Friend	AZ		
Police officer	AL, CT, DE, FL, HI, LA, MA, MO, MT, OH, RI, WI	NY	KS, NV, TN, WY
Peace officer	AK, AZ, CA, CO, DE, IL, KY, LA, MD, MI, MT, NE, NM, OK, OR, PA, SD, TX, UT	NY	ME, MI, NH
Parole officer	OH		
Physician	AK, AZ, CT, DE, FL, GA, HI, KY, LA, MA, MD, MO, MN, NC, NJ, OH, OR, PA, RI, UT	NV	DC, ND, NH, NV, TN, WY
Nurse	AZ, MA, MO, NJ, RI	CO, FL, NY	ND
Advanced practice registered nurse	CT, GA, HI, LA, MD, MN		NH, WY
Physician assistant	HI, MN		WY
Psychologist	AK, CT, DE, GA, HI, LA, MA, MD, MN, MO, NC, NJ, OH, RI	FL, NY	DC, ND, NV, TN, WY
Psychiatrist	AK, AZ, DE, HI, MO, NJ, OH, RI, UT	VA	ND, NV, WY
Mental health professional	AL, CA, CO, DE, GA, HI, MA, MD, MN, MO, NE, RI, UT, WA	FL, KY	DC, ME, ND, NV, WY
Medical directors	CA, OR		
Hospital staff			ID
Attorney	HI	MS	
Judge	HI, IL, NJ	FL, VA	
Social worker	CT, GA, IL, HI, MA, MN, NJ, RI	CO, FL, NY	ND, NV, WY
Clergy	HI		
Government employee	DE, HI		
County-appointed professional	HI, MD, MS, PA		TN
Mental health program	MO, NJ		
Guardian	ID, OK	MS, NY	NV, TX

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Table 5
Reasons for emergency commitment, by state

State	Danger to Self	Danger to Others	Mentally Ill	Danger to Self due to Mental Illness	Danger to Others due to Mental Illness	Recently Attempted Suicide	Gravely Disabled	Unable to Meet Basic Needs
AK				✓	✓		✓	
AL				✓	✓			
AR	✓	✓						
AZ				✓	✓			
CA				✓	✓		✓	
CO				✓	✓		✓	
CT				✓	✓		✓	
DC				✓	✓			
DE				✓	✓			
FL				✓	✓			✓
GA			✓					
HI	✓	✓						
IA				✓	✓			
ID				✓	✓		✓	
IL	✓	✓						
IN				✓	✓			
KS				✓	✓			✓
KY				✓	✓			
LA				✓	✓		✓	
MA				✓	✓			
MD	✓	✓						
ME				✓	✓			
MI				✓	✓			✓

MN			✓	✓		✓		
MO			✓	✓	✓		✓	
MS			✓	✓				
MT			✓	✓			✓	
NC			✓	✓	✓		✓	
ND			✓	✓			✓	
NE			✓	✓				
NH			✓	✓	✓		✓	
NJ			✓	✓				
NM			✓	✓	✓			
NV			✓	✓				
NY	✓	✓						
OH			✓	✓				
OK			✓	✓				
OR			✓	✓				
PA			✓	✓	✓	✓		
RI			✓	✓				
SC			✓	✓				
SD			✓	✓				
TN			✓	✓				
TX			✓	✓				
UT			✓	✓				
VA			✓	✓			✓	
VT			✓	✓				
WA			✓	✓		✓		
WI			✓	✓			✓	
WV			✓	✓				
WY			✓	✓				

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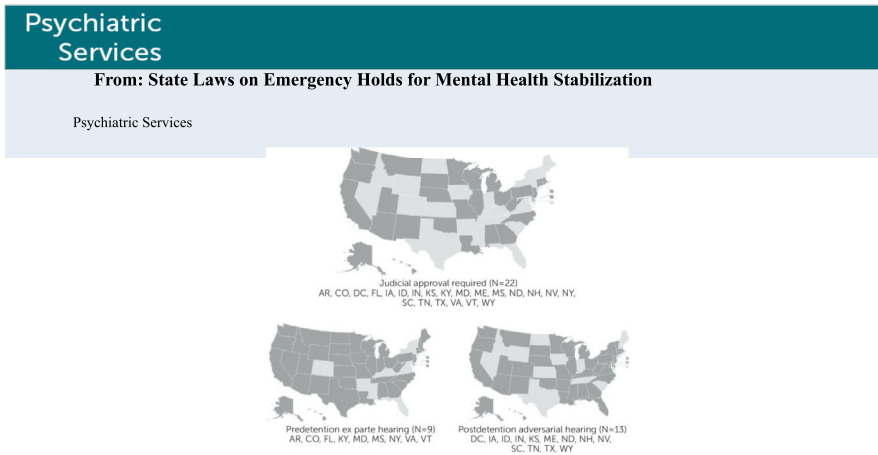

Fig. 1. State variation in requiring judicial approval before emergency holds. (Reprinted with permission from Psychiatric Services, Volume 67, Issue 5, "State Laws on Emergency Holds for Mental Health Stabilization," Hedman et al., p. 533 (Copyright © 2016). American Psychiatric Association. All Rights Reserved.)

codified a *duty to warn* third parties; however, the California Supreme Court's 1976 decision escalated this obligation to *duty to protect.*[9]

CASE 3

A 27-year-old nonbinary person presents to the ED complaining of anxiety. They state that they need to be admitted to the hospital. The psychiatry consultation service suspects malingering, as they have an outstanding warrant for arrest and are due to appear in court later this day. What should you do?

ESCAPING A TRIAL APPEARANCE

Patients presenting to the ED with anxiety or other mental health complaints may, in fact, be malingering. Most EPs are hesitant to make this diagnosis for fear of ignoring or dismissing a legitimate mental health concern. This is for good reason. One study found that ~75% of patients diagnosed with malingering were found to have a psychiatric diagnosis other than malingering. Furthermore, these patients were found to more likely be men, over the age of 45, black, homeless, and high utilizers.[10] Concerns about justice in diagnosis are well-founded based on the demographics described. The *Diagnostic and Statistical Manual of Mental Disorders* (Fifth Edition) defines malingering as intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives.[11] There are some pointed observations required before diagnosing malingering, including the following.

- Lack of cooperation during examination
- Historical evidence
- Exaggerated symptoms
- Evidence of antisocial personality disorder
- Conditional suicidality/homicidality
- Violence toward staff
- Under arrest/in police custody

SUMMARY

Patients presenting to the ED with mental health complaints deserve the same ethical treatment that would be afforded to the general population and typically require extra attention to concerns of autonomy, justice, and statutory frameworks. The voluntariness of suicidal patients is an important foundation for the approach to behavioral health treatment and should both be addressed by the EP early in the patient evaluation and nurtured even in the context of less-than-ideal patient boarding situations. When involuntary detainment is needed, solid understanding of local law and practice is needed to provide expedient psychiatric care. The authors recommend careful consideration of the context, timing, and motivation for patients presenting immediately before court appearances, but that patients' concerns should not be ignored out of hand, because pending legal action can be a valid trigger for mental health decompensation.

CLINICS CARE POINTS

- A familiarity with state laws surrounding involuntary holds will prepare you for more complicated ethical and legal dilemmas regarding involuntary detention for psychiatric reasons.
- Emergency physicians are well-qualified to medically screen patients complaining of mental health concerns and to lead efforts to de-escalate situations involving agitated patients.
- If malingering to avoid court appearance is identified, it can be directly addressed in the emergency department.

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