Comp. by: Balasubramanian Stage: Proof Chapter No.: 10 Title Name: CHANMUGAMand-TRIPLETTandKELEN
Date:15/11/12 Time:07:29:36 Page Number: 165

Chapter 10

Legal issues in the care of psychiatric patients in the emergency department

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Care for patients with active psychiatric problems in the emergency department (ED) requires an understanding of the complex intersection of emergency medicine, psychiatry, and law. The ED is frequently a site of concentrated risk and sometimes without the commensurate resources to address the complexity of patient presentations. Decisions must be made in an expeditious manner often without complete information, adequate time, or access to legal counsel. Although the old adage, "Think like a doctor first and like a lawyer second" is appropriate in emergency psychiatry, the well-informed clinician should have a working knowledge of the potential legal issues that are involved in providing care in this setting. A review of some the key issues is below.

Presentation to EDs

Although some patients present themselves voluntarily to the ED to seek treatment, others may be brought to the ED involuntarily. The process by which patients may be brought involuntarily for emergency psychiatric evaluations varies from state to state and is most usually codified in state law. Because state laws vary, clinicians should be familiar with the legal requirements in the local jurisdiction in which they are practicing. Particular attention should be paid to ensure that the correct procedures (including transport) are followed when a patient is brought to the ED and that the timelines for evaluation and decisions regarding admission or release are followed.

Some states allow citizens to petition a court to authorize police to detain and bring persons with potentially dangerous behaviors to an ED for emergency evaluation. Most states use the "probable cause" standard when determining if a patient poses a sufficient danger to self or others or whether the patient demonstrates grave disability. States also vary with regard to who may file a petition or who may issue a temporary hold allowing for psychiatric evaluations. Some states have statutes that assume an evaluation will be done in an ED before release or voluntary or involuntary admission to a psychiatric unit. Other states allow a short period of time (typically less than 72 hours) during which a patient may be evaluated on an involuntary admission basis before determining the necessity of subsequent steps in the civil commitment process.

In Maryland, for example, emergency petitions (EPs) constitute the means by which an emergency evaluation is started. EPs may be initiated and executed by law enforcement officers (peace officers) if the officers document that an individual's behavior "present[s] a

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Date:15/11/12 Time:07:29:36 Page Number: 166

danger to the life or safety of themselves or others." Licensed physicians, psychologists, social workers, or nurse practitioners who have examined the patient may endorse an EP for a peace officer to act upon without a judge's order.

Other citizens, including family members or loved ones, have the right to petition that an individual be psychiatrically evaluated on an emergency basis. Although states vary in the methods by which this is accomplished, most require that a judge or commissioner authorize such an evaluation. Many states provide access for the authorization of these kinds of evaluations on a 24 hours a day, seven days a week basis. Typically, a judicial overseer uses a probable cause standard to determine whether an individual requires an emergency evaluation.

In Maryland, the statute authorizing emergency petitions requires that the petitioner or "lay person" have "reason to believe" that the individual presents a danger to the life or safety of themselves or others. This includes endangering oneself by not eating or drinking, not recognizing actions that could lead to dangerous consequences, and neglecting serious or life-threatening medical conditions. If the judge approves the petition, a law enforcement officer will be authorized to pick up the evaluee and transport them to the nearest ED for evaluation. If the judge does not sign the petition, it is denied, and no further action may be taken.

Admission to an inpatient psychiatric unit

Following assessment and possible treatment in the ED, patients will be either released or admitted to an inpatient unit. When admission is to an inpatient psychiatric unit, it may be on a voluntary or involuntary basis.

When the determination is made by an evaluating clinician that a patient is in need of inpatient psychiatric hospitalization, the patient will be offered admission as a voluntary patient. Most jurisdictions require that a voluntarily-admitted patient sign a voluntary admission agreement, which may also be signed by the physician seeking the patient's admission. The majority of states require that a patient give an acknowledgement or assent to their voluntary admission.

In Maryland, for example, an individual may request voluntary admission through either an informal (not requiring a signed application by the individual) or formal procedure. Under either procedure, the individual must meet the following criteria: (1) the individual has a mental disorder; (2) the mental disorder is susceptible to care or treatment; (3) the individual understands the nature of the request for admission; (4) the individual is able to give continuous *assent* to retention by the facility; and (5) the individual is able to ask for release (emphasis added).

A minority of states require that a patient give informed consent to a voluntary admission. A pivotal landmark case in this area is *Zinermon v Burch*. Under Florida law at the time, voluntary admission required "application by express and informed consent." Zinermon alleged that his procedural due process rights had been violated when he was admitted voluntarily to a Florida psychiatric hospital because, he argued, he was unable to provide informed consent for his admission. Although not directly answering the question of whether voluntarily-admitted patients must provide informed consent for admission, the U.S. Supreme Court did find that Florida should have procedures in place to exclude those not able to give informed consent. States have adopted various methods to screen for incompetent patients following the *Zinermon* decision.

Comp. by: Balasubramanian Stage: Proof Chapter No.: 10 Title Name: CHANMUGAMand-TRIPLETTandKELEN
Date:15/11/12 Time:07:29:36 Page Number: 167

Decision-making capacity and informed consent

Competent patients, as a pre-requisite, must have decision-making capacity. Competence is a legal determination whereas capacity is a medical determination that may be made in the ED. A patient must have capacity in order to give informed consent. As alluded to above, an assessment of capacity may be prudent before a patient is voluntarily admitted to a psychiatric unit. Further, a capacity assessment is even more important before a patient can be allowed to leave against medical advice or refuse care. This may be an issue for psychiatric patients who are not candidates for involuntary admission, but still require medical evaluation and treatment. Before such a patient or any other patient may be allowed to leave against medical advice, decision-making capacity must be assessed by a provider. Once decision-making capacity is verified, the patient can then be provided informed consent about the risks and benefits of leaving against medical advice and opt to leave AMA.

The informed consent standard has its roots in the common law of both England and the United States. Treatment of patients without such consent was and is considered a battery. In 1914, Justice Cardozo, in the oft-cited case of *Schloendorff v. Soc'y of New York Hospital*, stated that, "Every human being of adult years and sound mind has a right to determine what shall be done with his own body: and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable." This rule governing consent remains in the American and English common law today.

Similar to the law, modern bioethics supports the concept of informed consent. Respect for autonomy can be traced back to the Nuremberg Code, the Belmont report, and principlism. Autonomous decisions require three basic elements: (1) disclosure of information; (2) comprehension; and (3) voluntariness. A patient must be informed of the risks, benefits, and alternatives of a procedure and a clinician must ensure that the patient understands this information. Further, a patient's decision must be voluntary. Only decisions that are substantially informed and free of duress are considered autonomous.

Decision-making capacity

A pre-requisite to informed consent is a patient's intact capacity to make decisions. Evaluation of such capacity is a decision-specific determination that focuses on the patient's ability to understand and communicate a rational decision. The key considerations in an assessment of decision-making capacity are:

1. **Ability to express a choice:** The person must be able to express his or her choice and communicate that choice.
2. **Ability to understand relevant information:** The person must be able to understand information about the purpose of treatment, remember the information, and show that he or she can be part of the decision-making process.
3. **Ability to appreciate the significance of the information and its consequences:** The person must understand the consequences of treatment refusal and the risks and benefits of accepting or refusing treatment.
4. **Ability to manipulate information:** The person must be able to engage in reasoning as it applies to making treatment decisions (e.g., use logical processes, weigh treatment decisions, and manipulate information about treatment decisions).

PROOF

Comp. by: Balasubramanian Stage: Proof Chapter No.: 10 Title Name: CHANMUGAMand-TRIPLETTandKELEN
Date:15/11/12 Time:07:29:36 Page Number: 168

It is usually inappropriate to assume that a patient with mental pathology, sedation, or cognitive deficit lacks decision-making capacity. Instead, a formal evaluation is necessary. As noted above, capacity is different from competence. Competence is determined by a court of law and uses issues of capacity in evaluating the legal ability to contract, write wills, or conduct one's affairs. As the standard of competence varies by jurisdiction, an exhaustive discussion of competence is beyond the scope of this chapter.

Involuntary admissions

Emergent psychiatric assessment may be the first in a series of events that leads to an involuntary hospitalization and potential civil commitment. Involuntary commitment is the act of placing an individual in a psychiatric ward or hospital against his or her will. This commitment is usually time-limited and requires periodic re-evaluation. Certain statutory mandates regarding criteria, which vary from state to state, must be met in order for an individual to be involuntarily committed. Licensed physicians, psychiatrists, and some mental health professionals have the ability to initiate the involuntary commitment of a patient. While procedures vary from state to state, the informed clinician will be familiar with the legal parameters around such involuntary admission so as not to have the patient released from a civil commitment hearing because procedural issues were not followed according to law. Ultimately, the commitment decision is made by a court or by a mental health commission.

State statutes differ in the exact wording of civil commitment laws. Nonetheless, there are three general criteria that are usually considered around the civil commitment process:

(1) The individual must be mentally ill, which loosely defined means they must be suffering from a mental illness which substantially impairs their mental health;
(2) They must be deemed a danger to themselves or others; and/or
(3) They must be unable to provide for their basic needs because of their impaired mental state.

In addition to the main criteria above, other factors may be considered in determining that an individual is in need of an involuntary psychiatric hospitalization. Grave disability rendering persons unable to care for themselves to the point of probable self harm may allow for civil commitment in some jurisdictions. Still others may allow persons who are in need of hospitalization but who refuse it to be considered for civil commitment. Individuals displaying a danger to property, individuals who lack capacity (see above) to make rational treatment decisions, and individuals for whom hospitalization represents the least restrictive environment may meet criteria for involuntary admission.

Once individuals are involuntarily admitted to a psychiatric hospital, they will be afforded legal representation to appear before a judge or other designated representative to determine whether procedures have been followed appropriately and whether they meet the civil commitment criteria for further hospitalizations and treatment. At that time, clinicians may present information related to the need for ongoing involuntary admission and treatment. A judge will determine whether the facility/treatment team has met the "minimum standard of proof" constitutionally required for continued long-term commitment of the individual. In *Addington v. Texas*, the U.S. Supreme Court held that the standard of proof required in a civil commitment proceeding was "clear and convincing evidence." This standard of proof is less than the standard of "beyond a reasonable doubt"

PROOF

Comp. by: Balasubramanian Stage: Proof Chapter No.: 10 Title Name: CHANMUGAMand-TRIPLETTandKELEN
Date:15/11/12 Time:07:29:36 Page Number: 169

required in criminal proceedings but more than the required "preponderance of the evidence" standard used in most civil cases.

When an individual continues to meet criteria for involuntary commitment, the case is generally reviewed by the court or judicial body that conducted the initial hearing every 3, 6, or 12 months, according to the specific state statute. Psychiatrists also have the ability to release patients when they believe the patient no longer meets commitment criteria.

Psychiatric hospitalization of minors

As with other topics discussed in this chapter, states differ in their statutes outlining the guidelines for the psychiatric hospitalization of minor children. Generally, children are considered to be those 18 years and younger. The American Psychiatric Association's Task Force on the Commitment of Minors published guidelines to ensure that children in need of mental health care would be protected against needless hospitalization and deprivations of liberty. In these guidelines, the Task Force recognized the importance of parents' authority to make medical decisions for their children and the need for "medical decisions to be made in response to clinical needs and in accordance with sound psychiatric judgment."

Under these guidelines, children under the age of 16 can be admitted without their consent to a psychiatric hospital but with the consent of their parents, if a treating or admitting physician determines that the child is in need of psychiatric hospitalization. Children aged 16 and over have the right to contest the admission. States vary on the exact mechanisms put in place for a child over the age of 16 to contest the admission. The treating physician has the ability to move forward with involuntary commitment of a child aged 16 and over who refuses psychiatric hospitalization but meets involuntary commitment criteria. Also, children age 16 and over have the ability to admit themselves, without the consent of their parent or guardian, if the treating or admitting physician agrees that psychiatric hospitalization is indicated. Parents do have the right to be notified immediately in the event that their child age 16 and over is self-admitted to a psychiatric hospital.

Tarasoff issues

The concepts of duty to warn and duty to protect arose in the context of two court decisions from the Supreme Court of California in the 1970s. Both decisions sprung from the same set of facts and legal case. *Tarasoff v. Regents of the University of California* was a civil suit filed by the surviving parents of a college-age woman who had been killed by a student being treated by the university psychologist.

In this case, a University of California student (Prosenjit Poddar) disclosed to his student health center psychologist that he planned on harming his former girlfriend, Tatiana Tarasoff. The psychologist notified campus police, who questioned Poddar, found him to be rational, and made him promise to stay away from Tarasoff. Two months later, Poddar killed Tarasoff, which led to a suit brought by the parents of Tatiana Tarasoff against the University of California, the university health center, and the police. At trial, the case was dismissed on the grounds that, because of confidentiality between a doctor and patient, the physician has a duty only to the patient and not to third parties.

The family appealed to the Supreme Court of California. They asserted that the defendants had a duty to warn Tatiana or her family of Poddar's threat and that steps should have been taken to ensure his confinement. The Supreme Court of California

PROOF

Comp. by: Balasubramanian Stage: Proof Chapter No.: 10 Title Name: CHANMUGAMand-TRIPLETTandKELEN
Date:15/11/12 Time:07:29:36 Page Number: 170

reversed the trial court's decision and stated that a "therapist bears a duty to use reasonable care to give threatened persons warnings as are essential to avert forseeable danger." (*Tarasoff I*). Following the *Tarasoff I* ruling, there was discontent among the mental health and police communities, and the court took the unusual step of hearing the case again.

In 1976 (*Tarasoff II*), the Supreme Court of California held: "When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more of various steps. Thus, it may call for him to warn the intended victim, to notify the police, or to take whatever steps are reasonably necessary under the circumstances."

This case illustrates that confidentiality no longer takes precedence when there is a direct threat of imminent danger or harm toward a third party. States differ in their interpretation of *Tarasoff*, and clinicians should consult their state's laws as they pertain to the duty to warn.

EMTALA

EMTALA was passed in 1986 as part of the Consolidated Omnibus Budget and Reconciliatory Act (COBRA). The term EMTALA now commonly refers both to the statute and the regulations enacted and amended to enforce the statute. Sometimes referred to as an "anti-dumping law," EMTALA requires hospitals with an ED to provide an appropriate medical screening examination "within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists."

The US government defines an "emergency department" as a "specially equipped and staffed area of the hospital used a significant portion of the time for initial evaluation and treatment of outpatients for emergency medical conditions." An "emergency medical condition" is defined as "a condition manifesting itself by acute symptoms of sufficient severity such that absence of immediate medical attention could reasonably be expected to result in placing the individual's health (or health of an unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs."

EMTALA applies to "participating hospitals," which are those that accept payment from the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) under the Medicare program. However, EMTALA's provisions apply to all patients and not just Medicare patients.

Hospitals have three main obligations under EMTALA. First, a hospital must determine whether an emergency medical condition exists for any individual who comes and requests a medical screening. Second, treatment must be provided until the medical condition is resolved or stabilized or the hospital must transfer the patient to another hospital that can appropriately treat the patient. Lastly, hospitals with specialized capabilities must accept transfers from other hospitals and may not discharge a patient until the condition is resolved and the patient is able to provide self-care or is transferred to another facility.

There are penalties for violating EMTALA, which is enforced by CMS and the Office of the Inspector General (OIG). The most severe of these penalties can include termination of the hospital or physician's Medicare provider agreement. Hospitals can be fined up to $25,000 if they have less than 100 beds and up to $50,000 if they have more than 100 beds.

PROOF

Comp. by: Balasubramanian Stage: Proof Chapter No.: 10 Title Name: CHANMUGAMand-TRIPLETTandKELEN
Date:15/11/12 Time:07:29:36 Page Number: 171

Physicians, including "on call" physicians, can be fined up to $50,000. Patients may bring personal injury suits against hospitals, and a receiving hospital or facility can file a suit to recover damages if it suffered a financial loss as a result of another hospital's EMTALA violation.

There are myriad issues that can come up when trying to apply EMTALA to psychiatric patients or patients who are suspected of having a mental illness. An "emergency medical condition" as it pertains to psychiatric patients requires the patient to be determined "dangerous to self or others." Guidelines to the federal regulations make it clear that simply expressing the intent to harm oneself or others by itself is not necessarily sufficient to create an emergency medical condition for the purpose of EMTALA. The expressed intent would require the examining physician to assess the dangerousness and seriousness of the threat. Once the individual is assessed at being "dangerous to self or others," EMTALA would apply, and it would be the duty of the treating physician or mental health professional to stabilize and treat the condition or to transfer to a facility that has the capabilities of treating the patient.

EMTALA does not require forcible detention or treatment. EMTALA does not preempt state statutes or regulations requiring that informed consent be obtained before treatment is provided, nor does it preempt state emergency commitment statutes.

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law passed in 1996 by Congress. There are several provisions and titles under HIPAA that address different issues including: protecting health insurance coverage for workers and their families when they change or lose their jobs; the Administrative Simplification Provision that requires the establishment of national standards for electronic health care transactions; and national identifiers for providers, health insurance plans, and employers. There is also a federal privacy rule that is a component of HIPAA, which is aimed at protecting a patient's health care information.

The component of HIPAA aimed at protecting a patient's health care information can have significant impact on the treatment of psychiatrically ill individuals in an emergency setting. The federal privacy rule of HIPAA attempts to help patients maintain their medical history and retain control of how that information will be used and disseminated. The privacy rule allows for patients to see and make corrections in their medical record and requires that patients authorize the release of their medical information.

The concept of confidentiality requires that information given in confidence to a physician will be kept secret and revealed to others only with permission. In psychiatric emergency settings, other interests may take priority and lead to a permissible breach of confidentiality. In these situations where confidentiality must be breached, the clinician should be careful to consider what information will be disclosed and documentation should support why confidentiality is being broken. An emergency situation is usually sufficient grounds to reveal health information without a patient's consent if the information obtained will help with emergency treatment. Another situation where a patient's confidentiality can be breached is when there may be risk to a third party. Clinicians may also have to breach confidentiality when they are concerned about potential child or elder abuse.

Patients who believe their rights have been violated under HIPAA can file a complaint with the Secretary of Health and Human Services (HHS) within 180 days of the date of the

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Comp. by: Balasubramanian Stage: Proof Chapter No.: 10 Title Name: CHANMUGAMand-TRIPLETTandKELEN
Date:15/11/12 Time:07:29:36 Page Number: 172

violation. HHS can then refer complaints to the Department of Justice for criminal prosecution and penalties.

Seclusion and restraint

Although there has been a national focus on reducing the use of seclusion and restraint, in the emergency setting such use may be necessary at times. In the United States, the Centers for Medicare & Medicaid Services (CMS) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) set standards and regulate the use of seclusion and restraints. Providers should be familiar with specific state laws or regulations that impact providing care for patients requiring seclusion or restraint.

Summary

Patients with psychiatric disorders who need emergency treatment pose a number of unique challenges. The assurance of safety and provision of appropriate care must be the primary goal. Knowledge of applicable federal, state, and local regulations is critical as care is delivered in the ED and a plan of care is created. The intersection of psychiatry, emergency medicine, and law commonly involves the process of involuntary referral and assessment, informed consent, involuntary commitment, decision-making capacity, duty to warn, HIPAA, EMTALA, and seclusion and restraints. Familiarity with these issues in advance of actual patient presentations can help providers create a more efficient and effective treatment system of care.

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