Episode 061: Deciding for Others: Involuntary Holds and Decision Making Capacity

Katie Cho, D.O., Mark Ard, M.D., David Puder, M.D.

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There are no conflicts of interest for this episode.

This week on the Psychiatry and Psychotherapy Podcast, I am joined by Dr. Mark Ard, a chief resident physician at Loma Linda University's Psychiatry program, to talk about holds and capacity evaluations as it relates to medicine and psychiatry.

Why is this important for mental health professionals?

Medical ethics is an important component of healthcare, and oftentimes, physicians and family members have to make difficult decisions with insufficient information or time. As a psychiatrist, it is very common to be consulted on how to help patients who struggle to keep themselves safe, others safe, or are incapable of leading their best life. In regards to psychiatric detainment, there are specific laws in place protecting both physicians and patients.

Understanding the laws, regulations, and practices of involuntary treatment is important. Essentially, a determination is made that a patient is unable to make a rational decision for reasons that become apparent through the evaluation process; they are not able to display the capacity necessary to make the decision.

As a physician, you must justify these decisions to yourself and in documentation based on the evidence presented. Fully understanding the ethical underpinning of these holds with a capacity evaluation really puts it all together and helps with appreciating why it might be appropriate to hold somebody in a hospital setting.

Probate vs Lanterman Petris Short Act (LPS)

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Probate Conservatorship

- When a person is taken to court to present evidence that he/she cannot make decisions for themselves in broad areas, including medical and financial decisions, a family member or state representative can be granted legal authority to make such decisions on the person's behalf. This is the idea of probate conservatorship.
- Dementia powers are also granted at times, allowing a probate conservator to make the decision to admit the person into a locked dementia facility for protective reasons, ensuring patient safety and well-being.
- Persons under a probate conservator do not need a psychiatrist, though a psychiatrist's assessments may carry weight when the patient is taken to court.
- The process of obtaining a probate conservatorship is prolonged. It starts with a petition to the court and includes a long waiting list that can be extremely costly.

Lanterman–Petris–Short (LPS) in California

- When a person has a severe mental illness or chronic alcoholism that is gravely disabling, meaning the person is unable to make appropriate decisions to provide basic needs for themselves, a conservator may be assigned by the court to make all decisions in regards to housing, medications, hospitalizations, etc. on their behalf.
- Psychiatrists must initiate the process of obtaining a conservator on a patient's behalf, and legal proceedings take place in mental health court.

Holds

Much of what will be discussed are based on California laws. You should become familiar with the regulations and laws established in the state in which you practice.

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Definitions

Voluntary: The patient agrees and chooses to stay at a treatment facility for further assessment, evaluation and management.

Involuntary: The patient refuses the option of being assessed, evaluated, and managed at the treatment facility despite being a danger to themselves, to others, or unable to provide for themselves. Involuntary holds means that you the provider think that they must receive care under direct supervision, ultimately at a locked inpatient facility.

5150: Involuntary 72 Hour Hold

If the evaluator deems the patient, "…as a result of a mental health disorder, **is a danger to others, or to himself or herself, or gravely disabled**…[the patient may be held] up to 72 hours for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment in a facility designated by the county…if the person can be properly served without being detained, he or she shall be provided evaluation, crisis intervention, or other inpatient or outpatient services on a voluntary basis."

Patient diagnoses are often mistakenly used to justify a 5150 involuntary hold. However, diagnosis does NOT justify the detention, but rather the evidence of behavior or risk. **Of note: patients are allowed to refuse medications while hospitalized.** Involuntary administration of medications involves a completely separate court process.

Patients are often told incorrectly that they "are on a 72 hour hold" then they will be released. With treatment and evaluation, a patient may require hospitalization for shorter or longer than the 72 hour period. As the hold expires, the patient may choose to be voluntary or the hold may be extended, for example in a patient with catatonia, suicidal depression, or current mania to keep the person safe may take 1-2 weeks.

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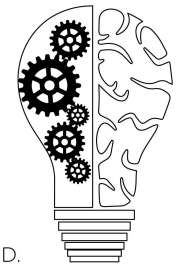

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5250: California's 14 day extension

After a patient on a 5150 hold "…has received an evaluation, he or she may be certified for not more than 14 days of intensive treatment related to the mental health disorder or impairment by chronic alcoholism."

Patients are kept longer for continued evaluation and treatment when their treating psychiatrist believes that the patient's mental health disorder has not resolved enough to where the patient demonstrates the capacity to be of no danger to themselves, others, or provide for themselves. The extension is up to 14 days. This allows for more patient protection with an automatic probable cause hearing for the patient so that the court can determine whether the psychiatrist has met a probable cause threshold. The patient also has a right to legal representation.

5300: 180 day extension for homicidal ideations

There can be an extension up to 180 days if a patient poses a significant danger to others as psychiatrists continue to evaluate and treat. This is very rare in my experience.

1799.111: California Law

There is a subsection of California law that addresses patients being treated in facilities that have not been designated as a psychiatric hospital. This law protects a medical doctor for detaining a patient against their will in a hospital facility **for up to 24 hours** if their mental disorder is presenting a danger to themselves, to others, or is deemed gravely disabling.

The biggest problem with this law is that it is often near impossible to find placement in a psychiatric hospital within 24 hours. It may be beneficial for medical doctors to consult the psychiatric service at their facility when a person is deemed medically stable.

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Patient populations often considered for holds

Evaluations for detainment are on a case by case basis. The following patient groups may have higher likelihood of involuntarily hospitalized:

- **Schizophrenia**: The level of violence is increased during the first psychotic break. It's to be noted, however, that somebody with schizophrenia is more likely to be a victim than a perpetrator of violence.
- **Bipolar Disorder**: prior to the advent of Lithium and other treatments, 20% of patients with bipolar disorder committed suicide. Psychiatric hospitalization are lifesaving, especially patients in manic episodes who are often times unaware of their own lack of capacity.
- **Suicidality:** Intent, plans, means, psychological motivation, and lack of support increases risk of life threatening events. In fact, 10-15% of patients hospitalized for depression will attempt suicide.
- **Anxiety**: Especially those with suicidal ideations can increase risk of life threatening events.
- **Substance abuse:** Disturbance of frontal lobe function can increase impulsivity and risk to self and others.

Informed Consent vs Capacity

Informed consent is based on the principles of autonomy and privacy. There are seven criteria that define informed consent:

1. Competence to understand and to decide.
2. Voluntary decision making.
3. Disclosure of material information.
4. Recommendation of a plan.
5. Comprehension of terms (3) and (4).
6. Decision in favor of a plan.
7. Authorization of the plan.

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Implied consent is defined as the signs, actions, facts, or inaction that raises the presumption of voluntary agreement—as in a person sticking out their arm in front of a health provider holding a needle implies consent for a blood draw.

Against Medical Advice (AMA) describes a person making a decision to leave a health care facility against the advice of their medical providers. Even in this case, the patient must demonstrate the capacity to make that decision.

Capacity can be determined by any medical provider, not only a psychiatrist. There are five criteria that define capacity:

1. Expressing a decision. Even a patient who is delirious that decides he would like to leave the hospital against medical advice would meet this criterion. Often the first thing we need to do is clarify what the patient wants.
2. Understand relevant medical facts—at least at a layperson's level be able to comprehend their condition and treatment recommendations.
3. Appreciate risk benefits and alternatives at a level appropriate to the choice being made.
4. Assessment of their ability to reason and rationalize through the first three criteria.
5. Is the decision consistent with the patient's values? Inconsistency and rash decision making usually indicates limited ability in criteria two and three

Other considerations when evaluating capacity:

- The world view of a patient may be more in line with alternative treatments. Balance should be sought to allow patients to make alternative decisions versus helping them reach their predefined goals.
- There may be a need to de-escalate situations and empathize with patients that are making irrational decisions based on an especially bad day. This is when psychiatry consults may be especially beneficial.
- Depression changes the way a patient may evaluate the world, making accurate assessments about their current situation and the future difficult.

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Addressing Incapacity

When patients cannot demonstrate capacity, we are often faced with three unappealing options:

1. Allow the patient to be discharged Against Medical Advice. This in inappropriate, as an AMA assumes they have the capacity to make that decision. Just because a patient signs an AMA form, does not mean the hospital or staff are protected from a claim of negligence.
2. Request that a psychiatrist place an involuntary psychiatric hold. This also may be an inappropriate request, as primary teams are often asking the psychiatrist to inappropriately detain a patient trying to leave or refusing treatment, without a mental health disorder causing the incapacity. Psychiatric detainment is only meant to keep patients in psychiatric hospitals. Involuntary treatment requires a separate judicial process.
3. Detain the patient out of an obligation to provide care while avoiding harm. There are no clear legal statutes on this topic, but significant case law showing that physicians and hospitals who justify their interventions are not held liable for harm.
    1. **Dr. Erik Cheung, a psychiatrist at UCLA, recently published a paper discussing a policy at UCLA that allows patients on the medical floors to be detained against their will if they are determined to lack decision making capacity.** There is no formal law that addresses such situations outside of individual facilities.

In every instance, whether the patient has capacity or not, document your decision thoroughly. Note any and all information about your encounter and assessment, including emergencies if they existed, a patient's ability to consent, and the benefits of treatment.

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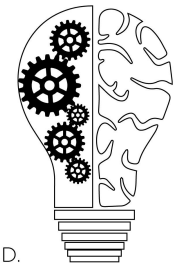

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Who Decides?

Give it time: Determine the emergent status of a capacity decision. Do you need to make a decision right now, or can this patient be observed with as needed medications until they demonstrate capacity?

Durable Power of Attorney or Advance Directive: Patients may name decision makers and lay out ground rules for providers to follow should they become incapacitated.

Substituted judgement: When an identified decision maker attempts to make the choice the patient would make. Different states have different rules about the order to seek substituted judgment. In California, we turn to next of kin—spouses, adult children, parents, other family members, and friends. At times it may be necessary to get your facility's ethics committee on board.

Best interest decision: Consult with colleagues and make a best interest decision on the patient's behalf. Document your decision thoroughly and with 2 signatures.

Legality of Treating Incapacitated Patients

To patients, involuntary holds may be construed as assault, battery, and false imprisonment. Courts have historically supported physician's actions, without consent, when the lack of demonstrable capacity has been shown and documented. Courts assume that a reasonable, competent adult would desire to be healthy.

Some notable case laws include:

- ***Miller v. Rhode Island Hosp***: A patient in a motor vehicle accident was forced to have a peritoneal lavage. Surgeons were sued by patient for assault, battery, and false imprisonment. Court ruled in favor of physicians because they acted in the patient's best interest.
- ***Youngberg v. Romeo***: A mother institutionalized her disabled adult son and later sued the hospital for using bodily restraints. Court established The Model Penal

> Code which allows “an exception from the assault statute for physicians…who act in good faith in accordance with the accepted medical therapy.” Court found there is a necessity to utilize physical detainment if you’re trying to do the right thing.

Utilize holds by acting in the patient’s best interest and document thoroughly. Do what you, as a provider, think is best even in very difficult situations. Empathize with those who are deemed incapacitated, and talk about goals that are beyond just going home; empathize and educate.

Final Thoughts:

We hope these often confusing topics are somewhat clarified in this article and podcast episode. First and foremost, building a strong therapeutic alliance (strong bond, common goals, mutual trust) allows for us to not need to use holds as frequently as we otherwise would need to. Sometimes, however, to keep a patient or community safe, we have to imagine what we would want for ourself or our children in a similar situation, if we were manic, psychotic or about to kill ourselves, what would we want done for us? In this case the most empathic thing to do, is to protect the patient from allowing an acute and treatable disease that would end their life. Care and kindness must be present in the midst of those safe measures, or the hold itself can become another trauma.

“The moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; those who are in the shadows of life, the sick, the needy and the handicapped.” -Hubert Humphrey