

Detention, Capacity, and Treatment in the Mentally Ill—Ethical and Legal Challenges

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For individuals whose mental illness impair their ability to accept appropriate care—the depressed, acutely suicidal mother, or the psychotic lawyer too paranoid to eat any food—statutes exist to permit involuntary hospitalization, a temporary override of paternalistic beneficence over personal autonomy. This exception to the primacy of personal autonomy at the core of bioethics has the aim of restoring the mental health of the temporarily incapacitated individual, and with it, their autonomy.

Regional distinctions may exist (between countries, or even jurisdictions within a country) regarding applicable mental health laws, or even bioethical ideals strived for (e.g., relatively stronger emphasis on personal autonomy in so-called Western countries), but the tension between autonomy versus paternalism is universal in acute care psychiatry.¹

Similar to other parts of the world, here in the United States, consent for treatment during psychiatric involuntary commitment was, at one point, presumed not to be the right of the detained—that is, under *parens patriae*, when long-term confinement in state hospitals was the norm, involuntary treatment was essentially synonymous with involuntary detention.² This rightfully changed under several rulings^{3,4} but notably in our state, in the California Supreme Court ruling *Riese v. St. Mary's*

Hospital (1987)^{5,6} which gave detained patients the right to demonstrate capacity to refuse treatment. However, psychiatric treatment remains inextricably linked to involuntary detention—a patient must first meet detention criteria before capacity determination regarding psychiatric treatment can be considered.

Criteria for each are, at this point, quite distinct legally—involuntary detention criteria may again vary by jurisdiction, but may be similar to local laws based on an individual being imminently dangerous, either via direct harm to self (e.g., suicide) or others (homicidal behavior), or due to self-neglect, e.g., inability to provide for basic needs of food, clothing, shelter (termed “gravely disabled”) due to a mental illness, and refusing voluntary hospitalization.^{7,8} In contrast, determination of capacity for treatment follows capacity declaration in other areas of medicine—that is, a patient’s awareness and understanding of their acute condition, the nature of the proposed treatments and alternatives, and potential risks of treatment and nontreatment. To our knowledge, no other area in medicine requires a different set of legal conditions be met before capacity can be determined. Two cases below illustrate clinical circumstances where this discrepancy may pose barriers to treatment.

Acknowledgement: This manuscript was produced with significant contribution from, and intellectual inspiration of, Guillermo Palchik, Ph.D., Clinical Neuroethicist, California Pacific Medical Center, San Francisco, CA.

Case 1: Ms. A, a 45-year-old investment banker with a history of bipolar disorder type I, seeks voluntary psychiatric hospitalization for treatment of an acute manic episode. After an intense business trip involving a change in time zones and degradation in normal sleep, she was noted to be distinctly and unusually euphoric, loquacious, hyperkinetic, grandiose, and disinhibited. Among other behaviors, Ms. A had been wandering the streets, offering her valuable stock options to strangers. In the initial phases of hospitalization, she resumed her usual regimen of mood stabilizer, lithium, which her outpatient psychiatrist suspected had been stopped shortly prior to manic decompensation. However, after a few doses, Ms. A abruptly stopped medication treatment, explaining, "I'm great, I'm cured, I'm a natural, I'm not bipolar, that's a bold-faced lie!" despite documented history to the contrary.

It was the opinion of both the treatment team and the outpatient psychiatrist that the patient currently lacked capacity regarding psychiatric treatment, and thus a petition under the Riese ruling was strongly considered. However, Ms. A remained quite agreeable to hospitalization; she called it "the best hospital in the world," and viewed the experience as an opportunity to "help the doctors and nurses," regarding it as her duty as "I own this hospital, I'm the CEO and president here." Her decision to stay despite refusing treatment was felt also to be swayed by a rapid affinity developed to a younger peer (the two were noted to be holding hands, and dancing together on the patio).

At one point previously, Ms. A had been suicidal during a depressed phase of her illness, but this was over a decade ago. She was not noted to have any history of violence or danger toward others, and was felt to possess resources

to care for her basic needs (owns her own home, high income with sizable assets) obviating consideration of grave disability. As such, Riese petition for involuntary psychotropic treatment could not be filed with the courts, and Ms. A eventually elected to leave the hospital against medical advice (AMA) when her young peer was also discharged.

Case 2: Mr. B, a 21-year-old college junior with no prior psychiatric history, was admitted after several months' onset of withdrawal, internal preoccupation, and bizarre statements, accompanied by diminishing food and fluid intake. These symptoms led his family to bring him to the emergency room, where he was found to be essentially mute. He was offered antipsychotic medication, and within a brief period of days, he was able to return to verbal communication.

Mr. B revealed to the treatment team that he had seen interlinks between his studies, the government, and the "secrets to the universe." He spent hours on the unit with eyes closed, attempting to extract information via "meditation," as well as auditory experiences he believes he is tracking from the government and other sources. He noted that he was very happy to be in the hospital, stating that he had learned much from interactions with his peers—he described his hospitalization as an "awakening," rather than treatment. Mr. B's intake of food improved, and, although his thought process is full of tangents, he was able to express a clear plan of self-care. He had not expressed, nor displayed, any dangerousness to himself or others.

Some days into his hospitalization, he began to refuse his scheduled antipsychotic medication, stating that it was interfering with his growth and inhibiting his eventual goal of unlocking the

secrets of the universe. Although he acknowledged a change in mental status, he did not believe he had a mental illness; he regarded his recent change as a “gift,” and felt it his responsibility to seek answers for himself and society. After a long conference with treatment team members and family, Mr. B agreed to restart medications, and he was able to continue his improvement.

Both cases put the treatment team at odds with existing law—involuntary detention is designed for those who require, but refuse, hospital care. For those patients who agree to hospital care, and/or do not meet detention criteria, but may nevertheless be incapacitated to refuse treatment during its course, there is a gap in legal measures permissible. In other words, for those whose illness is severe enough to render them incapacitated, and debilitated, but not imminently dangerous, legal means to facilitate treatment are missing. From our experience, most of our acutely ill patients who are incapacitated regarding treatment options also tend to meet detention criteria, and thus, cases similar to the above constitute a relatively rare, but significant portion of the patient population with which we work. Often represented are those with bipolar disorder type 1, where mania may render patients incapacitated, acutely debilitated, but not necessarily dangerous (as illustrated in case 1).

Both cases also illustrate the distinction between detention criteria based on dangerousness, which neither patient met, versus capacity to understand need for hospitalization, which both patients likely lacked. Although inability to comprehend need for hospitalization is an important consideration, it is not part of the key elements to meet detention criteria. It should also be pointed out that, at least under local interpretation of detention laws, indiscretions

that might accompany an acute manic phase, such as the giving away of possessions in case 1, would not necessarily be considered evidence of “grave disability,” hence precluding involuntary detention. This is consistent with the primacy of autonomy in bioethics, which allows for ill-advised decisions in those deemed capable of doing so.

Even for those legally detained against their will, the distinctly different criteria for detention versus capacity place a burden on the patient and the legal team designed to help patients. From our view, the mental health legal team in San Francisco tasked to aid patients—judges, public defenders and district attorneys—are all able to compassionately guide patients should they choose to contest either their involuntary hold, or the petition to administer medications against their will. Nevertheless, for our patients forcibly hospitalized, often in unfamiliar surroundings and not close to their best (neither physically or mentally), it may be difficult enough to address one set of legal criteria, not to mention two, which directly impact their personal liberty.

It should also be noted that involuntary detention is initially presumed via probable cause, whereas capacity determination requires a hearing. For example, a trained peace officer, or any county-designed individual (e.g., crisis intervention team, emergency room staff) may initiate involuntary detention based on available evidence—such as responding to an emergency call to find an unconscious patient with empty pill bottles and a suicide note—but only in a hearing can a Riese petition be approved. This presumably serves to protect both the patient’s safety (allowing for detention based on probable cause) and the patient’s autonomy over their body until legally determined otherwise; but practically, this may result in potential delays wherein an

involuntarily detained and incapacitated patient “lingers” untreated until court determination for treatment can occur.

Our patients and clinicians are relatively very fortunate here in San Francisco, where there is no longer than a few days’ delay for hearings (so-called “probable cause” hearings), which conveniently are conducted by a traveling legal team that visits the few remaining hospitals in our city with psychiatric beds. In addition, patients in our jurisdiction are also allowed to contest their hold in a formal court of law (so-called “Writ” hearings), should the probable cause hearing be ruled against them. Administration of the legal rights of patients differ widely from county to county, where longer delays to hearings, burden of travel to and from court, or the complete absence of appropriate acute psychiatric treatment facilities, is not uncommon.

It should be noted that the law allows for emergency treatment to prevent imminent bodily harm to either the patient or those around them, but scheduled, on-going treatment requires approval of Riese petition. Often, a few doses of medications administered in such emergencies may help patients recompensate sufficiently to contest successfully in hearings, but this may serve against the patient long term, as acute psychiatric conditions generally require ongoing treatment (usually at least weeks) for sustained remission to occur. Consider such an example below:

Case 3: Ms. C, a 36-year-old woman with known history of Schizophrenia, is transferred to the emergency room on involuntary hold (California Welfare Code 5150) placed by San Francisco police responding to a 911 call, wherein she was noted to be yelling and screaming incoherently in public, spitting and throwing objects at passers-by.

Ms. C also has a known history of extensive recreational substance use, notably stimulants (methamphetamines), thus complicating the instigating factors of the current presentation; however, prior periods of relatively lengthy sobriety were also associated with psychotic symptoms, notably hearing voices of angels and/or demons, religious preoccupations, and paranoia. She attempted to kick and spit at staff in the emergency room, and threw back medication and water offered; she was thus felt to require immediate medication treatment to prevent harm to herself or others, which was administered parenterally (intramuscular injection).

After a single dose, she is noted to have less agitation, and is deemed clinically stable for transfer to inpatient psychiatric facility. Antipsychotic medication, helpful in ameliorating Schizophrenia symptoms previously, are ordered in oral (pill) form, but Ms. C refused them. Her explanations as to why are difficult to understand, as she remains with disjointed, disorganized thought process consistent with prior decompensations of her illness. A Riese affidavit is filed to petition for involuntary antipsychotic medication treatment, but in accordance with existing law, the matter of the involuntary detention is heard first. Although her testimony remains somewhat jumbled, she very clearly denies any intent for dangerous behavior to others. This is supported by behavior toward staff and peers during her short hospital stay, which has been tense, but peaceful, with no signs of the dangerous behavior present during initial detention by police, or subsequent emergency room stint. She also describes a rudimentary plan for self-care, listing a number of shelters and free resources for the homeless, among which she is one. The court rules that, despite ongoing psychotic symptoms, she no longer

meets criteria for detention; she declines voluntary admission, and is thus discharged AMA before her Riese affidavit can be presented in court. Some 3 days later, she is brought in by police on involuntary hold under highly similar circumstances.

How did this potential gap in the legal system come to exist? The laws in California that govern psychiatric involuntary detention, the Lanterman-Petris-Short (LPS) Act, signed into law in 1967,^{7,8} was not designed to definitively set standards for treatment (necessitating the Riese ruling 20 years later), or comment on the capacity of the psychiatric patient in general. In essence, it served to end the mass, indefinite (typically long-term) institutionalization of psychiatric patients in state hospitals typical at the time by establishing time-limited criteria for civil detention. Such detention under LPS begins with a 72-hour involuntary hold (code 5150 as above), and treatment clinicians may petition for extensions, initially for 14 days (code 5250), if involuntary detention criteria continue to be met, and further treatment is felt to be medically necessary. Extensions beyond 5250 are governed by different codes of the law dependent on criteria being used—5260 (danger to self, 14 days), 5300 (danger to others, 180 days), 5270 (grave disability, 30 days), and, by our experience, carry with them a higher burden of proof in court to sustain detention. Criteria for detention established around the concept of “dangerousness”—either to others, or to self, via harm or neglect—were an attempt to address the ever-present balance between personal autonomy and beneficence, and, it may also be argued, to address the duty to protect the autonomy of others (e.g., safety of community).

At the time of its ratification, support for the LPS law was garnered

bilaterally, from liberal civil rights champions who fought to restore the legal rights of the psychiatrically ill, to the fiscally conscious conservatives, who sought to remove the state from the costly prospect of long-term, often lifetime care of the severely mentally ill. No doubt, it greatly improved the rights of those with mental illness, who were previously detained with minimal protection, oversight, or time limit, e.g., simply via the wishes of family and their agreement with hospital personnel.⁹ Nevertheless, from an ethical standpoint, LPS law continued to segregate psychiatric patients by establishing a set of detention criteria unique to mental illness, and which did not explicitly include informed consent determination consistent with other areas of biomedicine. Some of the original authors of the legislation have since expressed regret regarding the unintended consequences of “deinstitutionalization,”¹⁰ and reform of the 51 year-old laws have been proposed.¹¹ Interestingly, justification for reform has not been driven by bioethical marginalization of the mentally ill—rather, at least locally, it is the public burden of the homeless¹² or incarcerated,¹³ the heavy representation of the mentally ill in these populations, or the consequence of high-profile homicides involving the mentally ill.^{14,15}

Several aspects on the current state from our experience bear comment. Treatment considered under Riese ruling consists of medication, or pharmacologic, treatment, which is by no means the only intervention possible in the acute setting. Talk-based interventions, such as counseling, psychotherapy, occupational therapy, group therapy, are strongly encouraged, but cannot be forced; other biological interventions, namely electroconvulsive therapy (ECT) are considered separately via their own legal petition.¹⁶

Involuntary treatment outside of the hospital setting is possible in many jurisdictions via so-called court-ordered assisted outpatient treatment (AOT), alternatively termed simply outpatient commitment. Thus far, the evidence of efficacy of these interventions is not robust,¹⁷ and, like local mental health care in general, implementation is left up to local county jurisdiction, with a high degree of variability. Patients under these commitments have either met, or continue to meet LPS criteria for detention, as these legal mandates for treatment often accompany those under long-term civil commitment (LPS conservatorship). Hence, those who may never meet these criteria are often again ineligible for outpatient treatment in this manner.

Currently, long-term treatment under these statutes is, with a few exceptions, practically limited to depot antipsychotic medication, which in the maintenance phase of treatment may only require periodic administration (e.g., once every 30 days). Although this class of medication may be used effectively for a variety of conditions, notably long-term debilitating illnesses such as schizophrenia or schizoaffective disorder, they are not considered the pharmacologic treatments of choice for a number of other chronic conditions, such as bipolar disorder¹⁸ or major depression,¹⁹ whose mainstay of best evidence-based treatment pharmacologically relies on mood stabilizers or antidepressants, currently unavailable in depot formulation. Hence, the current state of both available pharmacotherapy and the law might combine to deny the best available treatment for those with particular mental health diagnoses.

The distinction of capacity determination in the mental health setting from the rest of medical treatment has previously been highlighted.²⁰ Although this

may continue to foster discrimination and negative stereotypes toward psychiatric patients, some differences may actually facilitate legally-supported treatment of the mentally ill. As has been pointed out recently, the management of the incapacitated patient in the nonpsychiatric, medical setting is by no means clearly defined, placing patients, families and clinicians in murky circumstances. Although the bioethics of capacity determination may be well defined,²¹ the laws supporting its implementation, at least locally here, are not.²² In contrast, particularly under *Reise*, a legal framework exists for the declaration of capacity in a court hearing. In our experience, in contrast to decision making in the medical setting, there is less emphasis on seeking the opinion of family or other potential surrogate decisionmakers. Although less ideal ethically, it allows for expeditious treatment of our patients who may be estranged from their kin, or otherwise socially isolated (exceptions are not uncommon however, and may greatly facilitate treatment, as suggested by case 2). By allowing for such treatment only in those involuntarily detained, it places additional legal safeguards on the use of psychiatric paternalism. This is likely consistent with current public sentiment, no doubt fostered by the past overreach of paternalism,²³ as well as ongoing misunderstanding and prejudice regarding mental illness, which, like the laws that govern its treatment, may vary by region, but seem to persist regardless of locale. Potential changes to legislation that goes against this grain may be bioethically more sound, less discriminatory, and allow for treatment in those currently not served, but may not yet be palatable to the general public, whose rights these laws are designed to protect. As our understanding of mental illness continues to grow, and the gap between insanity due to

psychiatric illness and debility from biological diseases of the brain narrows, it remains to be seen whether this discrepancy and distinction between the mentally and medically ill can remain, and the acutely psychiatrically ill continue to be considered under a distinct bioethical standard.

Notes

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