Should Danger to Self Statutes be repealed and replaced by Decisional Capacity evaluations?

A DISCUSSION WITH A PSYCHIATRIST AND A PERSON WITH LIVED EXPERIENCE

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Introductions

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Disclosures

Experience vs. Expertise

Personal vs. Institutional
Notes on Language and Scope

- Involuntary evaluation or admission, Confinement, Commitment for Danger to Self only
- Person, Patient
Our Observations:

• People’s aching desire to speak of, so to understand, their inner experiences.

• People’s hesitancy to answer protocol-guided questions about suicidal thoughts. “I don’t know if you’ll hospitalize me.”

• Trauma from involuntary hospitalization experiences, strong aversion to rehospitalization.

• Stunned surviving families unaware of the depth of despair, unable to say goodbye.
Our Observations:

• Healthcare providers with “Can’t take the risk” / “At least we can know we did everything we could” mindsets.

• Economic costs to people involuntarily admitted – hospital bills, loss of income, loss of home.

• People saying that involuntary admission was essential for recovery.

• By speaking candidly about their symptoms, people with every other ailment or medical issue having a liberty that people who have thoughts of suicide are, by law, not afforded.
PART 1

Speaking of Danger to Self
Rational Suicide, Irrational Laws

Examining Current Approaches to Suicide in Policy and Law

Susan Stefan

E. Fuller Torrey’s comments:

“When asked about the involuntary treatment of people who are suicidal but not psychotic, Dr. Torrey stated that he had no expertise with this patient population. “Suicide can be, and often is, a fully rational decision,” he said. “I won’t say I would never involuntarily hospitalize such a person, but it would take a very unusual set of circumstances.””

To reduce the suicide rate in the United States, we need to begin with five presumptions:

1. People living in the community are legally responsible for their actions, including their suicide attempts.

2. Not all people who attempt suicide have a psychiatric disability or could benefit from mental health treatment (as opposed to help or treatment focused specifically on being suicidal and the life problems underlying it).

3. For most people who are suicidal, whether or not they have psychiatric disabilities, outpatient rather than inpatient help and treatment is the standard of care....

“...To reduce the suicide rate in the United States, we need to begin with five presumptions:

...4. To save the most lives, risks must be taken such that despite the very best care and treatment, some people will commit suicide. Even if those risks are not taken, and people are institutionalized, some people will commit suicide (likely more people).

5. Perhaps most importantly, we must presume—and embody this presumption in both policy and law—that a mental health professional whose outpatient commits suicide has not failed unless he or she has acted intentionally or recklessly to cause the suicide. This is not a radical idea: indeed, it is settled law in many states.”

Stefan recommends:

1. Amended definition of “Danger to Self”.
2. Professionals’ immunity from liability for suicide of outpatient treated in the community.
3. Increased access to community and in-home assistance.
Stefan’s proposed statutes:

“Danger to self” is established by demonstrating that the person has recently inflicted serious bodily injury on himself or herself or has attempted suicide or serious self-injury and there is a reasonable probability that the conduct will be repeated if admission is not ordered.¹

...Any individual who seeks help for suicidal ideation, thoughts about suicide, and urges to commit suicide is not “dangerous to self” under this subsection, provided that nothing in this provision shall limit voluntary hospitalization for suicidality.

¹ This language is based on Ark. Code § 20-47-207 (c)(1)(A)"
Silenced by Statues

FIRST AMENDMENT OF THE US CONSTITUTION

“Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the Government for a redress of grievances.”
Silenced by Statues

CONNECTICUT CONSTITUTION

“SEC. 4. Every citizen may freely speak, write and publish his sentiments on all subjects, being responsible for the abuse of that liberty.”

“SEC. 5. No law shall ever be passed to curtail or restrain the liberty of speech or of the press.”
## Emphasis on Speech about Suicide

<table>
<thead>
<tr>
<th></th>
<th>Speech</th>
<th>Action</th>
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<tbody>
<tr>
<td>Danger to self</td>
<td>Discussing thoughts</td>
<td>Suicide attempt</td>
</tr>
<tr>
<td>Danger to others</td>
<td>Discussing thoughts vs Making a Threat</td>
<td>Violence towards others</td>
</tr>
<tr>
<td>Grave disability</td>
<td>n/a?</td>
<td>Demonstrated</td>
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</table>
Patient Care Assistance (PCA) Waivers

- Pay for in-home care by an aide for medical or mental health needs
- “...we could probably, in fact, have kept her alive with intensive peer support, “wraparound services,” a personal care assistant (PCA), or all three. In very different ways, she and [person with TBI] need the same thing—people paying intense attention to them in their homes.
  (emphasis added)
- The federal government doesn’t prohibit states from using the PCA benefit for people with psychiatric disabilities. It’s just that most states don’t do it.”

We’ve Observed
(not specific to danger-to-self concerns)

- Lengthy waitlists for PCA waivers (2+ years) in Connecticut
- Very attentive PCA’s
- Frequent turnover of PCA’s
- Confusion about the role of PCA’s – rehabilitative vs assistive
- Restrictions about ACT + waiver programs – “double dipping”
- Potential for In-home respite, folding in with Recovery Support Specialists
Care in the Community

Outpatient Professional Care

- Therapist
- Psychiatric Provider
- Patient Care Assistant

- Intentional Peer Support
- Peer Respites

- Actual Community

- Friends
- Neighbors
- Family
- People with shared interests
“If you could tell suicide prevention policymakers and mental health professionals three things, what would they be?”

“Listen to we who have traveled that path and lived to talk about what helped.”

“DON’T put someone in a ward full of other people in emotional distress, treat them as if they are annoying and difficult, and pump them full of drugs. LISTEN for God’s sake.”

“Don’t come from a place of preventing—come from a place of connecting ... Most importantly be present and LISTEN.”

“Listen, listen, listen. Listen with your whole being.”

“Be kind. Be understanding. Listen with your heart.”

Current Statutes about suicide are Incongruous with:

- Harm Reduction stance we take for substance use disorders
- Innocence until proven Guilty
- Human psychology/attachment
- UN Guidance
“Although challenging, it is important for countries to set goals and propose steps to eliminate practices that restrict the right to legal capacity, such as involuntary admission and treatment, and to replace these with practices that align with people’s will and preferences, ensuring that their informed consent to mental health care is always sought and that the right to refuse admission and treatment is also respected.” (p. 6)
Questions for Discussion:

1. If you are so willing, please expand upon or correct what I have presented to broaden knowledge for myself and the audience.

2. Thoughts on Susan Stefan’s proposals? Ideas for Action?

3. Thoughts on the Danger to Self statutes conflicting with Freedom of Speech? Ideas for Action?

4. Thoughts on Patient Care Waivers? Ideas for Action?
Decisional Capacity and Informed Consent
“Although challenging, it is important for countries to set goals and propose steps to eliminate practices that restrict the right to legal capacity, such as involuntary admission and treatment, and to replace these with practices that align with people’s will and preferences, ensuring that their informed consent to mental health care is always sought and that the right to refuse admission and treatment is also respected.” (p. 6)
Pathways to Inpatient Psychiatry

Community → Transportation to Emergency/Crisis → Medical ED

Medical ED → Medical Hospital

Medical Hospital → Psychiatric Hospital

Psychiatric ED → Psychiatric Hospital
Pathways to Inpatient Psychiatry

Community Transportation to Emergency/Crisis Medical ED Hospital Medicine or Surgery with Consultation Liaison Psychiatry

Emergency Medicine

Medical ED Medical Hospital

Psychiatric ED

Psychiatric Hospital Inpatient Psychiatry

Community Psychiatry Medical Hospital

Emergency Psychiatry
Pathways to Inpatient Psychiatry

Community Transportation to Emergency/Crisis

Emergency Medicine

Hospital Medicine or Surgery with Consultation Liaison Psychiatry

Medical ED

Medical Hospital

Psychiatric ED

Psychiatric Hospital

Inpatient Psychiatry

Community Psychiatry

Transportation to Emergency/Crisis
Pathways to Inpatient Psychiatry

- Suicidal thoughts
- Suicide attempts
- Decisional Capacity Evaluations
- And lots more

Community Psychiatry
Community Psychiatry

Emergency Medicine
Hospital Medicine or Surgery with Consultation Liaison Psychiatry

Emergency Psychiatry
Psychiatric ED

Transportation to Emergency/Crisis

Psychiatric Hospital
Inpatient Psychiatry
“Capacity for What?”

DECISIONAL CAPACITY IS:

- Ability to make a decision about a specific medical treatment
- In other words, ability to participate in the informed consent process about accepting or declining a specific medical recommendation.

WHAT IT IS NOT:

- Competency - “Competency is the legal analogue of capacity and is presumed for all adults. Hence, clinicians make judgments of capacity and incapacity, and judges make determinations of competency and incompetency.”
- Competency to stand trial
- Parental fitness evaluations
Capacity Assessment

1. Preference
   ◦ Person’s ability to communicate a consistent preference about a healthcare decision over time

2. Factual understanding—Healthcare Provider’s current understanding
   ◦ Inquiry about the nature of the patient’s illness or condition, the treatment options, the recommended treatment, the prognosis with and without treatment, and the risks and benefits of treatment

Capacity Assessment, Cont’d

3. Appreciation Application of the facts information presented
   ◦ Understanding of how information relates to oneself and one’s specific situation
   ◦ Consequences both of accepting and of refusing the proposed intervention
   ◦ Consequences of one decision or another for the individual’s future

4. Rational manipulation of information
   ◦ Demonstrate that their decision-making process is a rational one

Capacity Assessment, Cont’d

“The focus of inquiry and assessment is not on the final decision the patient makes, but rather on the process that the individual uses to arrive at that decision, taking into account the individual’s past preferences, values, and decisions.”
Informed Consent

“The process by which a patient agrees to permit a physician or other treater to do something to or for him or her is informed consent.”

Two parts of Informed Consent:

1. The person must have decisional capacity.
   ◦ Including being properly informed

2. Consent must be given voluntarily – freely and without coercion.

Exceptions to Informed Consent

1. Emergency situations (beneficence)
   - Informed consent must be obtained when stabilized
   - Except when a person is known to have declined the treatment had they been able to participate in the informed consent process.

2. “…the legal processes and criteria for temporary psychiatric detention and civil commitment do not as closely follow a decisional capacity–based approach”

Informed Consent

“Informed consent is required before any medical intervention because, in civil law, any unauthorized touching, including medical intervention, is considered a battery. In the treatment context, a patient must therefore give informed consent before any intervention can begin, and informed refusal if a treatment intervention is not authorized.”

Informed Consent

“A patient who is unable to make consistent and/or meaningful decisions cannot authorize, or for that matter refuse, proposed medical interventions.”

“In ethical terms, patients’ autonomy is diminished when they lack capacity. Informed consent is an extension of broad principles of individual autonomy and has been a solid cornerstone of medical treatment since the late 1960s (Dalla-Vorgia et al. 2001; Mohr 2000).”

If not the patient, then who consents to admission?

MEDICAL:
◦ Substituted or Surrogate Decision Maker
  ◦ Medical Power of Attorney
  ◦ Next-of-Kin
  ◦ Guardian
◦ Advance Directives guide the Surrogate Decision Maker

PSYCHIATRIC:
◦ Social worker initiating emergency confinement/transport?
◦ Physician initiating admission?
◦ Judge?
Decisional Capacity Evaluation is the most robust clinical process we have to understand the reasoning of another person.

They are conversations meant to evaluate understanding. And for the evaluator to understand what the person understands, the evaluator must understand what is being discussed.

Everyone must understand the situation.

Understanding a problem, and each other, is the beginning of any solution.
## Connecticut Physician’s Emergency Certificate

**State of Connecticut**

**Department of Mental Health and Addiction Services**

410 Capitol Avenue, Hartford, CT 06134

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**Instructions**

1. This certificate must be signed by the physician not more than three days prior to its delivery to the Superintendent of the admitting hospital.
2. Date of examination must be within three days of the date of the physician's signature.
3. Prepare in duplicate – Original to admitting hospital – Duplicate to the examining physician.
4. Use MHCC-15 (Transportation Authorization) to indicate transportation requirements.

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<table>
<thead>
<tr>
<th>TO: Superintendent</th>
<th>Hospital</th>
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<tbody>
<tr>
<td><strong>EXAMINING PHYSICIAN</strong> (name)</td>
<td><strong>PLACE OF EXAMINATION</strong></td>
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<tr>
<td><strong>PERSON EXAMINED</strong> (name)</td>
<td></td>
</tr>
<tr>
<td><strong>SEX</strong></td>
<td><strong>BIRTHDATE</strong></td>
</tr>
<tr>
<td><strong>MARITAL STATUS</strong> (s, m, w, d, sep)</td>
<td><strong>VETERAN</strong> (yes, no)</td>
</tr>
<tr>
<td><strong>NEAREST RELATIVE, FRIEND OR GUARDIAN</strong> (name)</td>
<td><strong>RELATIONSHIP</strong></td>
</tr>
<tr>
<td><strong>ADDRESS OF RELATIVE, FRIEND, OR GUARDIAN</strong> (no., street, town, state, zip)</td>
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**HISTORY OF PRESENT CONDITION** (including type and amount of present medication, if any)

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**OTHER PERTINENT HISTORY** (previous hospitalizations, treatment, suicide attempts, medication)
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FINDINGS AS TO PHYSICAL CONDITION

FINDINGS AS TO MENTAL CONDITION (include reasons for opinions stated)

I am of the opinion that the person examined has psychiatric disabilities and is in need of immediate care and treatment in a hospital for psychiatric disabilities, and (check as appropriate)

☐ The person examined is gravely disabled.

☐ The person examined is dangerous to himself or herself or others.

<table>
<thead>
<tr>
<th>CONN. MED. LIC. NUMBER</th>
<th>DATE OF SIGNATURE</th>
<th>SIGNED (examining physician)</th>
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<tr>
<th>For Hosp. Use</th>
<th>CASE NO.</th>
<th>ADMISSION DATE</th>
<th>ADMISSION TIME</th>
<th>ACCOMPANIED BY (name)</th>
<th>ADMITTED BY (name)</th>
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M.D.
**EMERGENCY MENTAL ILLNESS REPORT AND APPLICATION (M-1)**

<table>
<thead>
<tr>
<th>Name:</th>
<th>hereafter referred to as RESPONDENT</th>
</tr>
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<tbody>
<tr>
<td>Address Street</td>
<td>City</td>
</tr>
<tr>
<td>Place of contact</td>
<td>, Colorado</td>
</tr>
<tr>
<td>Previous Psychiatric Care: Where</td>
<td>When</td>
</tr>
<tr>
<td>Who Brought the Respondent’s Condition to the Attention of the Undersigned?</td>
<td></td>
</tr>
<tr>
<td>Nearest Relative: Name</td>
<td>Relationship</td>
</tr>
<tr>
<td>Address Street</td>
<td>City</td>
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</tbody>
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**APPEARANCE AND GENERAL BEHAVIOR (Circle Items That Apply)**

- Dress: Neat
- Un tidy
- Dirty
- Eccentric
- Posture: Erect
- Tense
- Relaxed
- Lying down
- Facial Expression: Fixed
- Changing
- Angry
- Perplexed
- Sad
- Happy
- Suspicious
- Physical Activity: Normal
- Under-active
- Over-active

**EMOTIONAL REACTION (Circle Items That Apply)**

- Attitude: Com posed
- Polite
- Cooperative
- Reserved
- Indifferent
- Silent
- Scared
- Sad
- Scared
- Happy
- Sarcastic
- Antagonistic
- Suspicious
- Insulting
- Profane
- Combative
- Sleepy
- Talk: Logical
- Conversational
- Illogical
- Rambling
- Nonsensical
- Rate: Normal
- Over-talkative
- Under-talkative
- Quality: Controlled
- Humorous
- Dramatic
- Forceful
- Shouting
- Screaming
- Mumbling
- Expressions: Ideas of Being Persecuted
- Feels People Are Watching Him, Talking About Him
- Ideas of Grandeur
- Strange or Bizarre Physical Complaints
- Very Self-Critical
- Hearing Voices
- Seeing Things
- Homicidal Thoughts
- Suicidal Thoughts
- Unusual Sexual Ideas
- Does Patient Know Who He is? (Yes No)
- Where He is? (Yes No)
- How he Feels? (Yes No)
- Counting from 20 to 1 Backward: Result: Good
- Fair
- Poor
- General Knowledge: President? (Yes No)
- Governor? (Yes No)
- Mayor? (Yes No)

Pursuant to the provisions of SECTION 27-65-105, C.R.S., as amended, the respondent was taken into custody by the undersigned and detained for seventy-two hour treatment and evaluation at
Pursuant to the provisions of SECTION 27-65-105, C.R.S., as amended, the respondent was taken into custody by the undersigned and detained for seventy-two hour treatment and evaluation at

(Designated or approved facility)

The respondent appears to be mentally ill and, as a result of such mental illness, appears to be an imminent danger [ ] to others [ ] or to himself/herself [ ] or gravely disabled. The circumstances, behaviors and presentations under which the undersigned believes there is probable cause leading to the above action are as follows:

(COMPLETE IF APPLICABLE) During the period of the seventy-two hour hold the respondent was transferred to

(Designated or approved facility) for evaluation and treatment.

LIST ANY PROPERTY OWNED BY SUBJECT WHICH MAY BE JEOPARDIZED BY HIS/HER DETENTION.
If you want to change healthcare providers’ behaviors:

1. Change the workflows:
   - Change the Laws
   - Change the Regulations
   - Change the Forms

2. Establish precedents of healthcare provider’s protection from liability
Questions for Discussion:

1. Why are “medical” laws different than “mental health” laws? What might it mean to a human being that the laws are different? What might it mean to the public? What might it mean to healthcare providers?

2. Thoughts on Informed Consent and Decisional Capacity in involuntary admission? Ideas for Action?

3. Thoughts on Substituted Decision Makers? How might family relationships impact a person’s desired outcome when a family is involved in substituted decision making?
References


Resources

Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice: https://www.samhsa.gov/sites/default/files/civil-commitment-continuum-of-care.pdf 2019

Contact Information

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The End