I. INTRODUCTION

Each year, millions of emergency department patient visits in the United States involve psychiatric issues. A 2010 study by the federal Agency for Healthcare Research and Quality found that more than 7.6 million adult emergency department visits involved mental health conditions. The number of mental health related emergency department encounters comprises an ever-increasing share of all visits.

There are multiple reasons for this situation. The lack of inpatient beds and community resources are often cited as primary factors. In 1970, there were over 500,000 inpatient treatment beds nationally. By 2010, there were less than 50,000, more than 90% fewer. During that time period, the U.S. population grew by over 100 million people. Deinstitutionalization had closed state hospitals, with the goal of having individuals with mental health needs receive care and support in their communities. But community mental health programs were never adequately funded, resulting in lack of access to primary mental health care and inadequate non-hospital crisis resources. More individuals ended up in need of acute care, often with the hospital emergency department as the only place to seek it.

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Other factors driving patients in psychiatric crisis to emergency departments include lack of continuity of care, insufficient numbers of behavioral health providers, lack of insurance coverage for treatment of mental disorders, decisions by hospitals not to provide psychiatric services, homelessness, and lack of alternative strategies for patients in crisis.

The Great Recession resulted in increased need for mental health services but dramatically shrinking resources. A March 2012 Congressional briefing by the National Association of Mental Health Program Directors reported that the economic downturn had resulted in $4.35 billion in public mental health spending cuts from 2009 to 2012.3

The increased presence of psychiatric patients in emergency departments has been the recent subject of media coverage, professional literature, discussion at conferences and by policymakers, legislation and, most recently, litigation.

The challenges associated with psychiatric patients are well known to the emergency department providers who care for them. A 2014 poll by the American College of Emergency Physicians asked about psychiatric boarding (when psychiatric patients are held in emergency departments because of the lack of inpatient treatment beds, sometimes for days or even weeks). 84 percent of responding hospitals reported that psychiatric patients boarded in their emergency departments. 91 percent reported that boarding had resulted in harm to other patients or staff.4

Treatment of psychiatric patients in the emergency and acute care settings involves a unique set of laws, requirements, and issues. Many patients access the mental health system through emergency departments, but this is often not an ideal or efficient access

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point. The federal Emergency Medical Treatment and Active Labor Act (EMTALA), is a significant consideration. Accrediting organizations have expectations for care of this population of patients, as do state and federal regulators. Often, civil commitment laws come into play, bringing a statutory and civil rights overlay to the patient encounter. Decisional capacity must be considered as emergency treatment and discharge options are assessed. And there are various liability issues of concern to hospitals and their providers.

Legal counsel often will be called on to assist hospital and provider clients with urgent and dynamic issues. Questions may range from decisions about release, placement or detention of an individual patient, to appropriate policies for compliance with laws and regulations. Sometimes these decisions must be made in a short window of time.

II. EMTALA

A. Basic EMTALA Requirements for Patients with Emergency Psychiatric Conditions

Hospitals that participate in Medicare are subject to EMTALA, commonly known as the “anti-dumping” law. Under EMTALA, any patient who presents to an emergency department must: (1) receive an appropriate medical screening examination (“including ancillary services routinely available to the emergency department”) to determine whether an emergency medical condition exists, and (2) if an emergency medical condition is diagnosed, be provided treatment to stabilize the condition or arrange for an appropriate transfer. A psychiatric emergency can trigger a hospital’s EMTALA obligations. Psychiatric emergencies for purposes of EMTALA can include situations in which an individual expresses suicidal or homicidal acts or thoughts, or is unable to take care of basic needs.

5 42 CFR 489.24(a)(1) and 42 CFR 489.24(d)(1).
If a hospital in good faith admits the patient for inpatient treatment to stabilize him or her, the EMTALA obligations end. However, there must be the intent to treat to stabilize the patient on admission. If treatment to stabilize the psychiatric condition can be completed in the emergency department or the patient is appropriately transferred, the EMTALA obligations are met, and inpatient admission is not required.

Not all facilities have the resources and capabilities to provide the services needed. Hospitals without psychiatric units or behavioral health professionals may have a difficult time providing the services needed to stabilize a patient with a psychiatric emergency. However, the EMTALA obligations exist, regardless. When needed, a hospital may arrange for an outside provider to screen a patient for a psychiatric emergency.

B. Impact of EMTALA in the Emergency Department

The Congressional Research Service recently issued a report on hospital-based emergency departments that included a section devoted to behavioral health care. The report states that a growing number of patients presenting to emergency departments for medical needs also have behavioral health needs (often due to lack of community behavioral health resources). This trend is further straining the financial and personnel resources of emergency departments that are often already overcrowded. However, while the emergency room is not the appropriate place to provide non-emergency care, the emergency room may be the appropriate place to respond to an acute psychiatric emergency.

Emergency departments are frequently the first place a patient may be taken when experiencing a psychiatric emergency. Emergency departments are open around the

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7 42 CFR 489.24(d)(2).
8 *Bryan v. Adventist Health System/West*, 289 F.3d. 1162 (9th Cir. 2002).
9 *Baker v. Adventist Health Inc.*, 260 F.3d 987 (9th Cir. 2001).
clock, and it may not always be clear whether patients are having only a psychiatric emergency or also a medical emergency, so both medical and psychiatric issues may need to be addressed. For the psychiatric emergency, there must be available staff to interview the patient, monitor them, attempt de-escalation if needed, and provide rooms and/or sits for the patient if needed. This is needed both for the patient experiencing an acute psychiatric emergency and for the safety of staff and other patients.

There will be times when patients experiencing a psychiatric emergency in an emergency department may need to be transferred. There are specific requirements under EMTALA that must be met before transfer can occur. First, the transferring hospital must provide the medical treatment that it can provide within its capabilities and that minimizes the risk to the patient. Second, the receiving facility must have the space and qualified personnel to provide appropriate treatment, and has agreed to accept the patient. Third, the transferring facility must provide all the available medical records regarding the emergency condition. Fourth, the transfer must occur with qualified personnel and transportation equipment.\(^{11}\)

When a patient experiencing a psychiatric emergency is believed to be gravely disabled or a danger to self or others, under state law, involuntary detention may be initiated (although this does not mean the patient will immediately leave the emergency department, as addressed further below in the psychiatric boarding discussion, Section V). There will also be times when the behavioral health professional charged with making involuntary detention decisions believes detention is not appropriate, but the emergency department providers disagree.

Under these circumstances, and especially for patients with questionable decisional capacity, EMTALA may provide a basis to keep the patient in the emergency department to avoid danger to the patient or others.\(^{12}\) There may be times when emergency

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\(^{11}\) 42 U.S.C.§1395dd(c)(2).

\(^{12}\) Under the EMTALA Interpretive Guidelines, § 489.24(d)(1)(i), a psychiatric patient is considered stabilized “when they are protected and prevented from injuring or harming him/herself or others.”
department providers find themselves in the middle of conflicts between involuntary treatment laws and EMTALA (including possible legal challenges by the patient’s representatives and even courts). Emergency department providers (in consultation with legal counsel as needed) need to keep in mind the safety of the patient and the community when assessing these potential conflicts and deciding whether EMTALA requires holding a patient in the emergency department. In many situations, there are no immediate options for transfer.

C. Enforcement

EMTALA enforcement actions begin with a complaint made against a hospital.\textsuperscript{13} If the investigation determines that a hospital “negligently violates” EMTALA, the hospital may be subject to financial penalties of a maximum of $50,000 (for a hospital with 100 or more beds; for hospitals fewer than 100 beds, the maximum is $25,000).\textsuperscript{14} Physicians may also be subject to up to a $50,000 penalty for negligently violating EMTALA.\textsuperscript{15} Enforcement actions typically begin with an Office of Inspector General (OIG) demand letter that sets forth the sanction the OIG is seeking. The OIG attempts to negotiate settlements, and is able to do so in most cases. Only if settlement cannot be reached will an administrative decision will be sought.\textsuperscript{16} Separate from these monetary penalties in OIG enforcement actions, hospitals can also be sued by injured parties in civil lawsuits for alleged EMTALA violations.\textsuperscript{17}

Recently, the OIG has stepped up its efforts to enforce EMTALA enforcement actions involving psychiatric care. In December 2013, Carolinas Medical Center in North Carolina paid $50,000 to resolve its liability for a civil monetary penalty. In June 2014,


\textsuperscript{14} 42 U.S.C. §1395dd(d)(1)(A).

\textsuperscript{15} 42 U.S.C. §1395dd(d)(1)(B).

\textsuperscript{16} https://oig.hhs.gov/fraud/enforcement/cmp/background.asp (online, 1/02/2015).

\textsuperscript{17} 42 U.S.C. §1395dd(d)(2).
OIG entered a settlement of $40,000 with Trinity Medical Center in Iowa for the hospital’s alleged failure to provide appropriate screening or stabilizing treatment to a patient who presented with an emergency psychiatric condition. In September 2014, Springfield Hospital in Vermont agreed to a $50,000 settlement with OIG to resolve allegations that the hospital violated EMTALA with respect to two patients in its emergency department with psychiatric needs. The OIG alleged that the hospital failed to provide treatment to stabilize the emergency psychiatric condition of one patient and failed to conduct an appropriate medical screening examination of the other, with both patients being criminally charged and transferred to jail.18

The OIG regulators have made it clear that hospitals with emergency departments must be prepared to manage any emergency that might come through their doors, including behavioral health emergencies. The fact that a hospital lacks a behavioral health unit is not a defense to an EMTALA violation involving a patient who is psychiatrically unstable. Given the current nationwide attention being paid to emergency psychiatric care, hospitals may be seeing more EMTALA enforcement actions involving behavioral health patients.

D. Civil Cases

The number of civil cases involving EMTALA violation claims over the last several years has been fairly small. However, it is anticipated that claims may increase. A recent report by the American College of Emergency Physicians (ACEP) found only 33 EMTALA violation lawsuits involving psychiatric patients, from the time of EMTALA’s enactment through 2012. Of these, about half were known to be defense verdicts. The cases typically involved patients who had an established psychiatric diagnosis and “were not evaluated by a psychiatrist and eventually committed or attempted suicide.” The ACEP report concluded that the most successful defense to EMTALA claims involving

18 http://oig.hhs.gov/fraud/enforcement/cmp/patient_dumping.asp (online, 1/02/2015).
psychiatric patients was to show that the patient had received a screening exam and did not find an emergency condition that required stabilization.\textsuperscript{19}

A recent highly publicized case involving allegations of EMTALA violations of psychiatric patients is \textit{Brown v. Southern Nevada Adult Mental Health Services}, 2014 WL 580780 (D. Nevada, February 13, 2014). \textit{Brown} involved allegations that psychiatric hospitals were involuntarily discharging patients and providing the patients with pre-paid tickets out of the area (including out of state). In that case, defendants moved to dismiss several claims by plaintiff Brown, including the EMTALA claims. The court granted the motion to dismiss Mr. Brown’s EMTALA claims, finding that that there was no EMTALA violation. The court reasoned that Mr. Brown had not experienced any harm, since the hospital had provided sufficient medication for his trip out of state, and upon arriving at his destination Mr. Brown received treatment at another facility.\textsuperscript{20} However, it is very possible that other courts faced with similar circumstances could find EMTALA violations.

In \textit{Baker v. Adventist Health Inc.}, 260 F.3d 987 (9th Cir. 2001), Mr. Baker committed suicide shortly after discharge from an emergency department. In that case, the issue was whether the hospital violated EMTALA by calling in a crisis worker from a community mental health department to screen the patient for a psychiatric emergency. The court confirmed that a hospital is only required to provide a screening that is within the hospital’s capabilities, and that calling in the crisis worker for the screening was not an EMTALA violation.

\textit{Moses v. Providence Hosp. & Med. Ctr. Inc.}, 561 F.3d 573 (6th Cir. 2009), represents a worst case scenario for an EMTALA violation. Mrs. Moses-Irons took her husband, Mr. Howard, to the emergency department with multiple medical and psychiatric complaints. Mrs. Moses-Irons told the emergency room providers that her husband was


demonstrating “threatening behavior” which made her afraid for her safety. Mr. Howard also told his wife that he “had bought caskets” and had recently attempted to board a plane with a hunting knife. While Mr. Howard was admitted for further treatment and assessment, he ultimately was discharged, even though he did not appear to be medically stable. Ten days after discharge, Mr. Howard killed his wife.\textsuperscript{21}

The case was initially dismissed at the trial court level, but the appellate court reversed the dismissal of the hospital and held that a third party (not just a patient) was entitled to bring suit against a hospital for an EMTALA violation if the injured party (here, Mrs. Moses-Irons) establishes that they were directly harmed by the hospital’s EMTALA violation. Further, just admitting a patient from the emergency department is not enough to meet EMTALA requirements. The hospital must also undertake to stabilize the patient’s emergency medical condition.\textsuperscript{22}

While most EMTALA cases involving behavioral health issues will not result in such a devastating outcome, the case does call attention to the need to be vigilant in screening and stabilizing patients who present to hospitals with psychiatric emergencies.

III. ACCREDITING ORGANIZATIONS

A. Joint Commission

The Joint Commission is an independent, non-profit organization that accredits and certifies more than 20,500 health care organizations and programs in the United States. Joint Commission accreditation is one way for hospitals to receive Medicaid and Medicare reimbursements.

The Joint Commission’s stated mission is “to continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations

\textsuperscript{21} Moses, 561 F.3d at 576-577. \\
\textsuperscript{22} Moses, 561 F.3d at 580-582.
and inspiring them to excel in providing safe and effective care of the highest quality and value.”

i. Treatment Standards

The Joint Commission has long had standards that touch on particular types of behavioral or mental health providers (for example, substance abuse treatment centers, inpatient and outpatient mental health centers) and particular behavioral health issues (for example, suicide in the emergency department (ED), restraints). It was not until the Joint Commission’s recent focus on ED overcrowding, hospital throughput, and overall patient flow that it identified a significant problem in the acute care setting: the boarding of psychiatric and behavioral health patients. The Joint Commission recognized that boarding of any type of patient created heightened risks for patients and inefficiencies for staff. With a closer look, however, the Joint Commission saw that psychiatric patients present different risks and challenges. Id.

ii. New Emergency Department Flow Requirements

In response to the “persistent evidence of ED overcrowding and [psychiatric] patient boarding,” in July 2012, the Joint Commission published a suite of revised standards and guidelines to address patient flow through the ED, with particular focus on behavioral health patients. Id. Most of the new psychiatric boarding standards and guidelines went into effect on January 1, 2013, with two of the more difficult behavioral health related guidelines going into effect in January 2014. The Joint Commission defined boarding

as “the practice of holding patients in the emergency department or another temporary location after the decision to admit or transfer has been made.”

The Joint Commission’s revised standards and guidelines include these requirements and guidelines:

- Hospitals must measure and set goals for mitigating and managing boarding of patients who come through the ED
- Psychiatric boarding times should not exceed 4 hours (recommended but not required)
- Hospital leaders must communicate with behavioral health care providers and/or authorities serving the community to foster coordination of care for behavioral/mental health patients
- Hospitals that do not provide psychiatric services must have a written plan for defining the care, treatment, and services or referral process for those patients
- With regard to boarded patients, hospitals must:
  - Provide safe, monitored location that is free of items patient could use to harm self or others
  - Provide orientation and training to any clinical and nonclinical staff caring for such patients in effective and safe care, treatment, and services (i.e. medication protocols, de-escalation techniques)
  - Conduct assessments and reassessments, and provide care consistent with patient’s identified needs

The Joint Commission further explained that hospitals “should set [their] goals with attention to patient acuity and best practice; it is recommended that boarding time frames not exceed 4 hours in the interest of patient safety and quality of care.” However, the Joint Commission emphasized that the 4-hour time frame was not a requirement for

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26 Id. at EP 6.
accreditation, and it acknowledged that meeting that time frame sometimes was not within the hospital’s control. Id.

iii. Survey Activity

Joint Commission surveyors visit accredited hospitals and health care organizations approximately every 18-36 months to conduct surveys. Most surveys are unannounced. During the surveys, surveyors select individual patients to follow through their hospital visit, using the medical records “as a roadmap to evaluate standards compliance.” After the survey, the Joint Commission may require the hospital to develop and submit a plan to address any identified issues. The Joint Commission can take a variety of actions including full accreditation, accreditation with follow-up survey, contingent accreditation, preliminary denial of accreditation, or denial of accreditation. A negative finding by the Joint Commission can have serious consequences for a hospital’s continued participation in federal programs.

In late 2013, Joint Commission surveyors conducted an unannounced visit to several hospitals in Washington State, focusing on psychiatric boarding. It found numerous deficiencies at one hospital in the greater Seattle area, which, like many hospitals around the country, lacked an inpatient psychiatric unit and provided medication but otherwise no psychiatric care to mental health patients boarded in its emergency rooms. The deficiencies included:

- Not training contract psychiatrists and ED staff in de-escalation of mentally ill patients
- Not training contract psychiatrists and ED staff in policies regarding restraint and seclusion

• Not providing mental health medication to patients awaiting evaluations for potential involuntary commitment
• Providing medication but not psychiatric counseling to committed patients boarded in the ED
• Not caring appropriately for patients awaiting transfer to other facilities

“Patient Flow” is one of the specific areas of survey focus that the Joint Commission has identified. Going forward, the Joint Commission may be looking closely at the psychiatric boarding policies and practices of hospitals, training and resources provided to staff and contractors, and the care provided to individual patients on psychiatric holds, as it conducts its surveys.

B. Other Accreditation Organizations

In addition to the Joint Commission, Centers for Medicare and Medicaid Services (CMS) has granted deeming authority to three other hospital accreditation organizations: Det Norske Veritas Healthcare, Inc. (DNV), Healthcare Facilities Accreditation Program (HFAP), and Center for Improvement in Healthcare Quality (CIHQ). While none of these other organizations have developed the kind of detailed standards addressing psychiatric boarding or psychiatric patients in the acute care setting that the Joint Commission has, they all have broad standards that would cover improper management of such patients, requiring accredited hospitals to meet the emergency needs of patients in accordance with acceptable standards of practice.

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C. Restraint and Seclusion

The use of restraints and seclusion is believed to have serious physical and psychological effects on behavioral health patients. However, there have been virtually no evidence-based studies on the effectiveness of restraints or seclusion on these patients. Id. Emphasis has been placed on de-escalation and other behavior modification methods, with restraint and seclusion being used only as a last resort. Many organizations recognize that minimizing the use of restraints in the emergency department setting is particularly challenging.

All four accrediting organizations have detailed standards governing the use of restraint and seclusion. These standards generally follow the CMS Conditions of Participation for Hospitals that cover restraints and seclusion. These standards include the following provisions:

- Restraint or seclusion may be used only when less restrictive interventions have been determined to be ineffective to protect the patient, staff, or others from harm.
- All patients have the right to be free from restraint or seclusion of any form imposed as a means of coercion, discipline, convenience, or retaliation.
- Restraint and seclusion may only be imposed to ensure the immediate physical safety of the patient, staff, or others.
- Restraint or seclusion must be imposed by trained staff only.
- Seclusion and restraint must be discontinued at the earliest possible time.

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Within one hour of the restraint or seclusion, the patient must be evaluated face-to-face by a physician or other licensed practitioner or by a RN or PA who has met specified training requirements.\textsuperscript{34}

IV. CIVIL COMMITMENT LAWS

A. Federal case law

The issues of mental illness and civil commitment have worked their way through the upper echelons of the judicial system on a number of occasions. In \textit{O'Connor v. Donaldson}, 422 U.S. 563 (1975), the Supreme Court unanimously determined that a state cannot constitutionally confine a non-dangerous person. This case marked a change in how society viewed how best to handle the care of those with mental illness; from institutionalizing those who need treatment to setting a standard for institutionalization based upon the danger those with a mental illness pose to themselves and others.

Before the \textit{O'Connor} decision, individuals who were suspected of having a mental illness, those with a diagnosis and individuals with other ailments who could not be cared for at home were institutionalized for treatment, despite the limited number of available treatments during that time period.\textsuperscript{35} The institutionalization of these individuals was justified by the state using the doctrine of \textit{parens patriae}. This doctrine enabled the state to act in the best interest of individuals who could not care for themselves, including using institutionalization to provide treatment for these individuals.\textsuperscript{36} Society viewed these individuals as people who lacked the capacity to make informed, rationale decisions about their care. This system did not provide confined individuals the opportunity to contest their captivity, have legal representation or to petition for their release.

committed individual’s inability to contest institutionalization continued to be an obstacle until the O’Connor decision changed the standard for commitment.

Mr. Kenneth Donaldson was a diagnosed paranoid schizophrenic and he was held in a Florida state hospital against will for 15 years. It was reported in the trial court that during his stay, Mr. Donaldson did not pose a danger to himself or others and that he was not receiving any form of special treatment that required hospitalization. After repeatedly petitioning for his release, his case was heard by the Supreme Court. The Court found that having a mental illness is not enough to justify holding an individual against their will, the individual must also pose a danger to themselves or others, is in need of psychiatric treatment, or the individual would be unable to avoid danger if they are free.37 After the Court’s finding, Mr. Donaldson was released.

This determination by the Supreme Court set procedural standards for civil commitment by which state courts determined how civil commitment proceedings are held. After the O’Connor decision, states set rules concerning how long individuals could be held, that they would have legal representation during commitment hearings, and the standard of proof needed to prove the dangerousness of the individual. The issue of the standard of proof needed for civil commitment was the matter in question in Addington v. Texas, 441 U.S. 418 (1979). In this case, the Supreme Court weighed an individual’s fourteenth amendment liberty interest against a state’s interest in caring for its citizens and protecting society from the dangerous impulses of some of the mentally ill. The Court determined that restricting an individual’s fourteenth amendment rights for an indefinite period of time was important enough to set the burden of proof for civil commitment to “clear and convincing” evidence. This is now the standard for a civil proceeding under state law to involuntarily commit an individual. This case also reinstated having a physician involved in making a determination about whether an individual needs to be civilly committed. Having a physician involved in determining medically necessary treatment and civil commitment for mental illness is now a component of some state statutes or case law on civil commitment.

Federal case law has influenced the creation of state statutes and case law on civil commitment. Presently, all fifty states and the District of Columbia allows for some form of involuntary inpatient commitment based upon mental illness and/or the dangerousness that the individual poses to themselves or others. Some states take other factors into consideration, such as drug or alcohol addiction or the likelihood of “severe emotional injury.” State statutes vary in their definition of mental illness, dangerousness, and grave disability. Many of these state courts take into consideration if the proposed treatment, including civil commitment, is the least restrictive means to care for the individual and whether the treatment is in the best interest of the individual. A number of state courts also consider the risks and benefits associated with the proposed treatment. While these state statutes now protect the constitutional rights of the civilly committed, a number of these statutes have gaps that propagate the potential for psychiatric boarding.

In the District of Columbia, Code §21-521 allows an individual to be kept for “observation and diagnosis.” Admitting a patient for observation and diagnosis at times keeps an individual restricted to the emergency department (ED) until medically necessary treatment is determined and the individual is assigned to a medical team that can manage treatment. At times individuals admitted under code §21-521 may not be provided psychiatric treatment until court proceedings take place. Due to the medical teams’ inability to provide treatment until court proceedings allow treatment, the individual is left in limbo before they can be assigned to a medical team that will manage the individual’s care. Some of these individuals may be released or assigned to a team for treatment after court proceedings, but if their diagnosis is primarily psychiatric and their treatment is best managed in a psychiatric unit, they may be boarded in the ED because

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39 District of Columbia Code §21-521. “Detention of persons believed to be mentally ill; transportation and application to hospital.”
of the danger the individual may pose to themselves or others until a psychiatric bed is available.

V. BOARDING

Psychiatric boarding occurs throughout the United States, and is widely recognized as a service delivery problem for the boarded patient, the hospital emergency departments that board them, other patients in the emergency department, visitors, and staff.

A. Psychiatric boarding defined

Psychiatric boarding has been defined in various ways. The American College of Emergency Physicians classifies psychiatric boarding as happening when “a patient remains in the ED for four or more additional hours” after a decision to admit to the hospital. This aligns with the Joint Commission recommended standard discussed above in Section III. A leading treatise uses a 24-hour threshold to define psychiatric boarding.

Other definitions are more qualitative. An often-cited 2008 paper written for the U.S. Department of Health and Human Services, defined psychiatric boarding as “the practice in which admitted patients are held in hallways or other emergency department (ED) areas until inpatient beds become available.”41 A more recent paper describes it as “the time spent waiting in a hospital emergency department…for an inpatient bed or transfer to another inpatient facility by patients with primary psychiatric conditions.”42 In the one reported appellate case dealing with the subject, the Washington Supreme Court described psychiatric boarding as “overcrowding-driven detentions.”43

Although different, these definitions contain common elements, namely that they involve (1) a patient with a psychiatric condition, (2) who presents to a hospital emergency

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department, (3) is in need of inpatient mental health services, and (4) remains in the ED for a prolonged period because there is no inpatient treatment bed available.

B. Reasons for psychiatric boarding

The primary reason for boarding psychiatric patients in hospital emergency departments is a lack of inpatient treatment beds, i.e., there is no appropriate admission or transfer option. The patients are held in the ED while staff members try to locate a bed, often competing with other hospitals attempting to do the same thing. The historical explanation for this lack of capacity is outside the scope of this paper, but generally has to do with national deinstitutionalization policies, increasing demand for services, legislative funding choices, lack of effective insurance coverage, and closure of hospital psychiatric units.

C. Consequences of psychiatric boarding

The impact of psychiatric boarding has been the subject of academic and professional studies and has received media attention.

Emergency departments are, by their nature, not an appropriate treatment environment (as opposed to assessment environment) for psychiatric emergencies. EDs deal with triage, diagnosis, and admission or discharge. Boarded patients, who have been assessed as needing inpatient treatment, generally do not get it in EDs.

Worse yet, emergency department boarding can actually exacerbate a patient’s psychiatric crisis. EDs can be loud, chaotic, fast moving, and confusing - the opposite of what a patient experiencing a mental health crisis needs. The situation is intensified when patients are boarded in hallways or locked rooms, in the presence of security personnel or other observers.
Quality of care is also a significant issue. In some emergency departments, psychiatric care simply is not available. In others, psychiatric services are severely limited. Very few emergency departments have the staff to provide comprehensive psychiatric care beyond medication, observation, and restraints. Unlike psychiatric professionals, ED providers generally are not trained in techniques such as risk identification, de-escalation, and therapies.

Boarding of psychiatric patients also impacts a hospital’s overall care environment, including the care provided to non-psychiatric patients. Boarded patients often are high acuity. A patient in an acute psychotic state can disrupt the care experience for other patients, their visitors, and staff. For example, studies have shown that boarding can create longer wait times and reduced quality of care for other emergency department patients, reduced staff availability, and increase patients’ and visitors’ overall frustration with their health care experience.

Other studies and interviews have shown that psychiatric boarding has a direct financial impact on the hospitals where it takes place, due to insurance and reimbursement issues. Hospitals often must incur the expense of hiring security or other personnel to monitor psychiatric patients, as attacks on staff members, sometimes resulting in serious injuries, are frequent.

It is important to note that the problem is not limited to adults. Minor patients with psychiatric needs also are boarded in emergency departments, sometimes for lengthy periods of time. The scarcity of inpatient treatment beds for children can be even more traumatic for the minor patients and daunting for ED providers.

**D. Psychiatric boarding and civil commitment laws**

In many cases, psychiatric patients who are boarding in an ED are not free to leave the hospital. After having been identified as dangerous to themself or others, or as gravely disabled, they have been detained pursuant to state civil commitment laws. While the
detention mechanism varies state to state, involuntary holds generally can be placed by law enforcement officials, physicians, and court investigators.

After the hold is placed, civil commitment laws provide for involuntary short term treatment, as well as access to courts for patients to challenge their commitment. A primary purpose of all civil commitment schemes is to provide prompt individualized treatment designed to stabilize the patient and allow a return to freedom. Civil commitment laws present massive civil liberties issues. The tradeoff for loss of freedom is treatment intended to restore it.

Psychiatric boarding fits uneasily into the civil commitment process. By definition, a boarded patient is waiting for needed treatment, not receiving it. A boarded patient on a psychiatric hold, generally, is being kept safe but is not receiving inpatient treatment that civil commitment laws and civil rights case law require.

This conundrum has been widely recognized but, until recently, was not the subject of litigation, perhaps because none of the stakeholders knew what the remedy might be. More bed capacity required more funds, which legislatures were not likely to provide. In fact, they were doing the opposite. A boarded patient could seek dismissal of a civil commitment case based on a lack of compliance with the civil commitment process or a civil rights violation, but that would result in a psychiatrically unstable patient being released, resulting in risk to self or others. The short timelines of the civil commitment process also created a barrier to court action. By the time a boarding situation could be presented to a court, the patient had moved on.

E. In the Matter of the Detention of DW

In August 2014, the Washington Supreme Court decided the case of In the Matter of the Detention of DW, 181 Wn.2d 201, 332 P.3d 423 (2014). In a unanimous decision issued six weeks after oral argument, the court ruled that psychiatric boarding as a remedy for
lack of state treatment bed capacity was illegal. This was the first appellate case in the country to address psychiatric boarding.

The case began in February 2013 when a group of individuals who had been civilly committed asked the trial court for a declaration that they were entitled to treatment in certified psychiatric facilities. The state of Washington and the county prosecutor argued that it was appropriate to hold the patients in hospital emergency departments at times when no psychiatric treatment beds were available. The trial judge ruled that the individuals were entitled to adequate psychiatric treatment as part of the civil commitment process. The Supreme Court agreed and affirmed, holding:

We affirm the trial judge’s ruling that the ITA [Involuntary Treatment Act] does not authorize psychiatric boarding as a method to avoid overcrowding certified evaluation and treatment facilities.

The civilly committed individuals were supported in the trial court and on appeal by two intervenor hospital systems, and on appeal by two groups of amici, including eight health care provider organizations and two civil rights groups.

After a four month stay of the effective date of the decision, In the Matter of the Detention of DW went into effect on December 26, 2014. The stay had been conditioned on the State of Washington’s commitment to fund and open additional treatment beds. As this paper goes to press, there has not been enough time to study the impact of the decision on psychiatric boarding in Washington state. Significantly, while the case declared psychiatric boarding of civil commitment patients to be illegal, it did not specify a remedy. Whether the Washington legislature will act in response to the decision is a critical question.
VI. IN VOLUNTARY TREATMENT AND RESTRAINTS

A. Autonomy & the Best Interest Standard

Physicians caring for those who are involuntarily committed are concerned with providing proper medical treatment and with respecting their patients as individuals. When considering civil commitment, medical providers need to balance the autonomous decisions of patients to make an informed refusal of treatment against the possibly beneficent act of providing care that the physician believes to be in the best interest of the patient. In Principles of Biomedical Ethics, Beauchamp and Childress delineated the path necessary to respect autonomy:

“To respect autonomous agents is to acknowledge their right to hold views, to make choices, and to take actions based on their values and beliefs. Such respect involves respectful action, not merely a respectful attitude.”

For physicians, respecting a patient’s autonomous decisions involves respecting and following through with autonomous treatment decisions the patient has made. In general, when providing care to a patient, physicians involve them in the decision making process and seek the informed consent of their patients. The process of gaining the informed consent of a patient involves discussing the medically appropriate treatments available, the risks and benefits of these treatments and having the patient determine which treatment option is compatible with their goals of treatment, values and beliefs.44

When treating psychiatrically ill patients, physicians may not have the ability to rely upon the patient making informed, autonomous treatment decisions. This patient population at

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times may lack the ability to make informed, rational treatment decisions that are in line with their treatment goals, personal values and beliefs. Physicians can deem these patients as lacking the decision making capacity to make an informed refusal or acceptance of treatment. When these patients lack the capacity to make medical decisions about their care, physicians are left in a conundrum to either treat these patients against their will with the goal of returning the patient to a capacitated state, petition the state to provide treatment, seek a surrogate decision maker to make medical decisions or release the patient. If a physician must seek consent from a surrogate decision maker, the surrogate or the state both are left to make decisions in line with the patient’s known wishes or that is in the patient’s best interest. In order to make treatment decisions that are in the best interest of the patient, the surrogate or state is performing a beneficent act that is of benefit to the patient. When petitioning the state for permission to treat a patient against their will, the state often takes into consideration whether the treatments available are in the patient’s best interest, which is accordance with the *parens patriae* doctrine of caring for citizens who cannot care for themselves.

**B. The Use of Restraints**

With the existence of civil commitment laws, physicians have the ability to treat mentally ill patients, either before, during or after legal proceedings take place, depending on the jurisdiction. Providing treatment to patients who are physically refusing or are not cooperating with the administration of treatment can add an additional layer of distress and difficulty when caring for these patients. In order to care for this population, the use of physical or chemical restraints is taken into consideration. Their use can especially be concerning for physicians because their use can be viewed as coercive, cause injury, be emotionally traumatizing and there is a potential that its use is abused and misused. Despite these concerns, the use of restraints continues in order to ensure the proper administration of treatment or to prevent a patient from harming themselves or others.

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Restraints are used in a variety of patient populations, from patients who are mentally altered to those who cause more harm to themselves by removing lines and tubes needed for treatment. Balancing the medical necessity to safely provide treatment against potentially causing emotional harm or injury can be a difficult situation for physicians to navigate. Their use is often justified by only using restraints as a last resort after other options to gain the patients cooperation have been exhausted as a last resort, only the least restrictive restraints are used to meet the treatment goals and their use is only employed to either keep the patient or others safe. Consent for their use should also be sought.

C. Professional and Ethical Standards of Care

The use of restraints has been found to be appropriate by several professional organizations including the American Medical Association and the American College of Emergency Physicians. Both organizations recognize an individual’s right to be free of bodily restraint and imprisonment. These organizations allow for the use of restraints and civil commitment in limited circumstances, including but not limited to under a court order, when the patient is a danger to themselves or others, or when other methods of de-escalation or treatment are not successful. Providing ethically appropriate, beneficent treatment without inflicting harm on the patient is the goal of care for these organizations and the medical providers who care for the patient populations who may need civil commitment and/or the use of restraints.

VII. LIABILITY ISSUES

A. Liability to Patients

Civil commitment and psychiatric boarding present massive civil liberties issues and thus can give rise to a claim for false imprisonment if the restraint is unlawful. An unlawful restraint occurs if a patient is held against his or her will and without valid procedural process (i.e. without properly following involuntary commitment laws or complying with a valid court order). A false imprisonment claim may be maintained even after only a brief restraint and even if there are no actual damages.\(^{50}\)

As the court acknowledged in *Arthur v. Lutheran General Hospital, Inc.*, 692 N.E. 2d 1238, 1243 (Ill. 1998), there is a “difficult and delicate balance between the need for quick involuntary commitment decisions and the rights of mentally ill patients… .” Because “involuntary commitment seriously invades a patient’s liberty interests,” courts often strictly construe state involuntary commitment laws in favor of the patient and against detention.\(^{51}\) However, when a mental health professional in good faith executes a procedurally valid involuntary detention, health care providers are often protected from false imprisonment claims because of state immunity laws.\(^{52}\)

Health care providers can also be liable to a patient, the patient’s family, or the public for the wrongful release of a patient. For example, providers are often sued for discharging a mental health patient who later commits suicide after his or her release. In *Estate of Lacko, ex rel. Griswatch v. Mercy Hosp., Cadillac*, 829 F. Supp. 2d 543 (E.D. Mich.


\(^{52}\) *See, e.g.*, *Williams v. Smith*, 179 Ga. App. 712, 716 (1986) (patient could not state a claim for false imprisonment where physician’s certificate complied with all procedural requirements for involuntary commitment).
2011), Shane Lacko was brought to defendant Mercy Hospital after threatening self-harm. Once he arrived at the hospital, he reported that he had purposefully overdosed an unknown amount of methadone and had a history of depression and bipolar disorder. Mr. Lacko was observed for a period of time, was determined not to be suicidal, and was discharged. He committed suicide two days later by taking an overdose of methadone. Plaintiff brought suit against Mercy alleging claims of malpractice and violation of EMTALA. The court granted the hospital’s motion to dismiss, dismissing plaintiff’s EMTALA claims for failure to state a claim and plaintiff’s medical malpractice claim for lack of subject matter jurisdiction.

In *Providence Health Ctr. v. Dowell*, 262 S.W.3d 324, 325 (Tex. 2008), the court reversed a jury’s verdict in favor of a patient’s parents who sued Providence Health Center for the suicide of their son. The court held that any causal connection between the son’s release and his suicide was too attenuated because he did not commit suicide until 33 hours after he was discharged from the hospital’s emergency room.

Finally, there is potential liability for the wrongful use of restraints and seclusion in the emergency department. In *Youngberg v. Romeo*, 457 U.S. 307, 316 (1982), the U.S. Supreme Court recognized that the deprivation of liberty interests posed by use of restraints, acknowledging that “liberty from bodily restraint always has been recognized as the core of the liberty protected by the Due Process Clause…,” an interest that “must also survive involuntary commitment.” The court held that restraint was necessary, however, to protect patients and others from violence. *Id.* at 319. In *Threlkeld v. White Castle*, 127 F. Supp. 2d 986 (D. No. Ill. 2001), a patient, who was deemed not to be a danger to herself or others, was ordered into restraints and medicated against her will by an emergency room physician. The court held that the patient had stated a claim for medical malpractice and battery when it denied the hospital defendant’s motion to dismiss. In *Scherer v. Waterbury*, No. CV 970137073, 2000 WL 254535 (Conn. Super. Ct. Feb. 22, 2000), the court held that a hospital policy that required all persons who enter the emergency department for psychiatric treatment to be placed into seclusion (and segregated from the rest of the emergency department) stated a claim of discrimination.
under the Americans with Disabilities Act. As emergency departments are increasingly
called upon to board mental health patients due to a lack of inpatient beds, their risk of
liability for using restraints and seclusion increases.

B. Liability to Staff

The increasing use of psychiatric boarding in hospital emergency departments also
increases the risk of liability to staff injured by psychiatric patients. Boarded patients are
often suicidal, homicidal, or in the middle of a psychotic episode and in need of
immediate psychiatric treatment. Boarding often requires these patients to be secured
to a gurney or confined to a room in a relatively chaotic emergency department without
comprehensive treatment, which only increases the patient’s agitation and potential for
aggression. Further, psychiatric patients typically have to wait approximately 42
percent longer in the emergency department than other emergency patients.

A 2011 study of violence in the emergency department found that over 48 percent of
nurses had been grabbed or pulled and 41 percent had been punched or slapped. Over
45 percent of the assaults were committed by psychiatric patients; the number one
reported factor that precipitated incidents of violence in the emergency department was
caring for psychiatric patients.

The Associated Press reported on an emergency room nurse who had been assaulted
twice in a year: bruises, scratches and a chipped tooth from a psychiatric patient one
month, and groping from an intoxicated patient in another. The article attributed the
increase in emergency room violence to a downturn in the economy, which led to closure

53 Hospital or jail? A broken system for mentally ill, Associate Press, October 25, 2014.
54 Psychiatric patients wait in ERs as inpatient beds are scaled back, The Washington Post, January 22,
2013.
55 Psych Patients Need Patience in the ER, Wait on Average 11 Hours, PR Newswire, available at
http://newsroom.acep.org/2012-05-02-Psych-Patients-Need-Patience-in-the-ER-Wait-on-Average-11-
Hours (May 2, 2012).
56 Emergency Department Violence Surveillance Study, Emergency Nurses Association, available at
57 Id.
58 Violent assaults on ER nurses rise as programs cut, Associated Press, August 10, 2010.
of state hospitals, cuts in mental health jobs, and elimination of outpatient and community programs.\textsuperscript{59}

Hospitals and health care workers have responded by hiring security personnel to monitor patients and protect staff in the emergency department. The American College of Emergency Physicians (ACEP) published the “Emergency Department Violence Fact Sheet,” in which it noted that the majority of assaults on health care workers are by patients or residents of a health care facility.\textsuperscript{60} In addition to trained security officers, ACEP proposes additional safety measures, including “panic buttons” for medical staff, coded badges for patients and visitors, bulletproof glass, and metal detectors.\textsuperscript{61} These measures may decrease the risk of violence to staff, but are not always sufficient and result in increased costs for health care systems. Hiring security personnel can also create a duty to protect patients from other patients or visitors.\textsuperscript{62}

Further compounding the problem, most people who work in emergency departments do not have the same training as those who regularly handle psychiatric patients, such that they are not trained to treat psychiatric patients while also keeping themselves safe.\textsuperscript{63}

\textbf{C. Liability to Public}

Generally there is no duty to protect third parties from potential harm unless a special relationship exists.\textsuperscript{64} Since \textit{Tarasoff v. Regents of Univ. of California}, 551 P.2d 334 (Cal. 1976), where the California Supreme Court imposed a duty to warn third parties of a patient’s threats of violence, some states have imposed liability on health care providers

\textsuperscript{59} Id.
\textsuperscript{61} Id.
\textsuperscript{62} See, e.g., \textit{Lane v. St. Joseph’s Regional Medical Center}, 817 N.E.2d 266 (Ind. 2004) (medical center had duty to implement and maintain reasonable measures to protect emergency room patient from harm where medical center had established duties for its security officers to patrol emergency room department, including monitor unruly or violent patients and restraining, if necessary).
\textsuperscript{64} Restatement (Second) of Torts § 315 (1965).
for injuries committed by a patient to non-patient third parties. In Tarasoff, the court held that, while there generally is no duty to warn a third party of eminent danger, “[w]hen a therapist determines…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.” Id. at 340.

In the 40 years since Tarasoff was decided, its principles have spread to other health care providers in different health care settings, including emergency departments. Schlegel v. New Milford Hosp., No. X02CV 960071253S, 2000 WL 670103 (Conn. Super. Ct. May 9, 2000), an unpublished case, involved Joseph Schlegel, a man with a history of mental problems who murdered his mother. Less than 24-hours before the murder, Joseph had been released to his mother’s care and custody by doctors in the defendant hospital’s emergency department, where he had been taken for treatment earlier that day for an acute psychotic episode. Plaintiff executors of the mother’s estate alleged that the hospital and physician defendants failed to control Mr. Schlegel by releasing him instead of admitting him and failed to warn the mother of her substantial risk of danger. Defendants moved for judgment as a matter of law because they owed no legal duty to the mother either to control Mr. Schlegel or to warn her upon his release. The court denied the defendants’ motions to dismiss, finding that it was “enough for a plaintiff to establish that his decedent was a member of a class of identifiable victims to whom the defendants’ patient was known or should have been known to pose a risk of harm.” As each state has its own privilege and immunity provisions, whether the same holding would be reached by other courts depends primarily on the immunity laws that govern the court.

D. Immunity

Almost every state has either a mandatory or permissive immunity law that protects mental health providers from liability for the violent acts of a patient in certain
circumstances. Typically, mental health professionals must keep confidential all information disclosed to them by a patient. However, after the California Supreme Court’s holding in *Tarasoff v. Regents of Univ. of California*, 551 P.2d 334 (Cal. 1976), most states passed “duty to warn” or “duty to protect” laws that require health care providers to disclose otherwise confidential information if a patient expresses an intent to harm others.

Each state’s immunity law is different and can create protections for mental health professionals specifically or health care providers generally. Idaho, for example, has a mandatory duty to warn law that creates immunity from civil and disciplinary liability for mental health professionals who do warn and those who do not warn. A mental health care professional who warns about a patient’s threats when there is a reasonable basis to do so has immunity; so does a mental health professional who fails to predict or take precautions to prevent a patient’s violent behavior when there is no specific threat. There can be liability for failure to warn, however, when “the mental health care professional failed to exercise that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of his professional specialty under similar circumstances.” New Jersey’s mandatory duty to warn law applies to physicians, nurses, and clinical social workers, in addition to psychologists and psychiatrists.66

Advocacy groups and courts continue to emphasize the difficulty for mental health professionals to predict future dangerousness and the potential negative effects on the physician-patient privilege. In *Hicks v. United States*, 511 F.2d 407, 417 (D.C. Cir. 1975), the court noted that the negligence standard “must take into consideration the uncertainty which accompanies psychiatric analysis…The concept of ‘due care’ in appraising psychiatric problems…must take account of the difficulty often inevitable in definitive diagnosis.” In *Soutear v. United States*, 646 F. Supp. 524, 536 (E.D. Mich. 1986), the court recognized that “[m]edical doctors cannot predict with perfect accuracy

whether or not an individual will do violence to himself or to someone else.”67 The American Psychological Association frequently weighs in on duty to warn cases, emphasizing that scientific evidence demonstrates the difficulty of predicting violent behavior and the potential damage of duty to warn laws to the physician-patient relationship.68

67 See also Higgins v. Salt Lake County, 855 P.2d 231, 235 (Utah 1993) (recognizing the “empirically demonstrated inability of trained healthcare professionals to reliably predict future dangerousness”).