



**National Association of State Mental Health Program Directors**  
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## **Assessment #5**

# **Legal Issues in Crisis Services**

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# LEGAL ISSUES IN CRISIS SERVICES

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## LEGAL ISSUES IN CRISIS SERVICES

### Executive Summary Key Points

- Providers of crisis services offer necessary and critical aid to individuals and the community in times of behavioral health emergencies.
- For mental health providers of such services, it is important to understand the legal and regulatory issues pertinent to practicing in these settings.
- Issues discussed in this paper include civil commitment treatment orders, the role of guardians, restraint and seclusion, confidentiality, the criminal justice system, EMTALA, red flag laws, risk management, and how these important topics relate specifically to crisis services. This paper will also discuss the COVID-19 pandemic and its potential implications for legal issues related to crisis services.
- Understanding such key topics will aid the mental health provider in navigating the ever evolving and complex landscape of crisis services.

### INTRODUCTION

National efforts from the Substance Abuse and Mental Health Services Administration (SAMHSA)<sup>1</sup> and the National Association of State Mental Health Directors (NASMHPD) are inspiring systems to examine and develop the availability of robust crisis services.

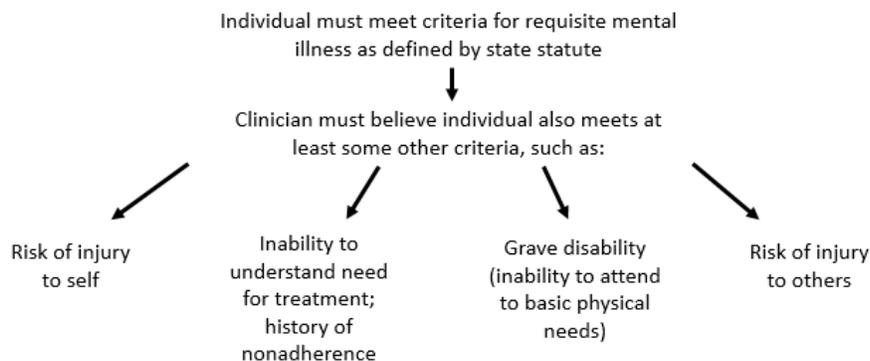
It is becoming increasingly clear that expanded crisis services are a critical part of the psychiatric care continuum for individuals and communities. Although they are important at any time, in the wake of recent events, such as various mass shootings, political unrest, and the COVID-19 pandemic, the need for these mental health crisis services is even more apparent. While the types of crisis services available in a community can vary,<sup>2</sup> the advantages to a robust crisis response system are numerous. Such a system can provide time-sensitive and efficient care for an individual in crisis and be an integral part of preventing harm that an individual may intend to themselves or others. Crisis services can be successful in diverting individuals from emergency departments when not needed and from entering a higher level of care, such as an inpatient setting, or from entering the criminal justice system. Effective crisis systems can also link individuals to community providers, connecting them to necessary resources that can help them stabilize with long-term supports. Navigating complex legal and regulatory issues, however, is an important element in crisis service delivery. In this paper, the authors describe key legal issues relevant to providers working in crisis settings as well as discuss implications for systems considering policies and practices related to crisis services. Although crisis services can start with a call or a text, this paper will describe legal and regulatory issues focused on crisis contacts that involve clinical assessments of individuals in crisis.

## EMERGENCY INVOLUNTARY HOLDS, CIVIL COMMITMENT AND ASSISTED OUTPATIENT TREATMENT ORDERS AND CRISIS SERVICES

Providers of crisis services may encounter patients with a clear need for psychiatric treatment for mental illness. However, providing such treatment is not always simple. At times, individuals may be unwilling to engage in recommended care, and this may result in risks to themselves or others. It may also be that the individual is not unwilling but unable to engage in treatment, due to economic barriers, lack of transportation to appointments, or cognitive limitations. Whatever the reason, individuals with mental illness with continued treatment non-adherence can be caught in a problematic pattern. Such individuals may present to crisis centers or emergency rooms with acute symptoms. They may experience improvement in their crisis symptoms and be stabilized with treatment in an acute setting such as an inpatient hospital. However, such individuals may then relapse after discharge due to withdrawal or non-adherence to treatment, prompting their symptoms to return, the cycle to restart, and mental health providers to see them in a crisis setting once again.<sup>3</sup>

While the majority of mental health services should be and are provided on a voluntary basis, civil commitment laws, including inpatient hospitalization and mandated outpatient treatment (also frequently referred to as Outpatient Commitment or Assisted Outpatient Treatment [AOT]), provide legal authorization for involuntary psychiatric treatment for individuals with mental illness who also meet certain other criteria.<sup>4</sup> These criteria vary from state to state, though every state in the United States utilizes some form of involuntary treatment authorized by civil commitment statutes.<sup>5</sup> Although some states have separate civil commitment laws for substance use, many are not used and they raise other complicated issues beyond the scope of this paper.<sup>6,7</sup> As such, civil commitment in this paper will therefore refer to those laws related to mental illness. A broad outline of common civil commitment criteria for mental illness can be seen in Figure 1.

**Figure 1: Examples of Mental Illness Civil Commitment Criteria**



Civil commitment laws typically take hold across three broad points in a time continuum.<sup>8</sup> A behavioral health crisis may trigger the need for an emergency “hold” or hospitalization for evaluation, typically for a short period of time (e.g., 72 hours, though the duration varies across jurisdictions). These clinical, involuntary holds for evaluation differ from “police holds”, in which law enforcement officers can place an individual who appears to be publicly incapacitated into protective custody for the

purpose of taking them to an emergency room or appropriate facility.<sup>9</sup> A second time point of reference can be inpatient civil commitment, where a judge orders involuntary hospitalization for an individual who meets the state's civil commitment criteria. The court-ordered inpatient commitment will be permissible for the period of time available by statute, and subject to renewals for individuals who continue to meet those criteria. A third time point or form can be outpatient civil commitment, or AOT, which is a method of providing involuntary, court-ordered mental health treatment in the community. Despite utilizing civil commitment statutes, national surveys shows that clinicians involved with civil commitments may lack knowledge about statutory criteria.<sup>10</sup> This may be especially problematic and relevant for providers of crisis services, where, due to the emergent nature of crises, involuntary detention or treatment may be considered necessary to mitigate risk.

Some crisis settings allow for involuntary detention under these types of laws, while others do not. If they do not, and if the individual appears to require a higher level of care but does not choose to accept it on a voluntary basis, the crisis provider may need to initiate a civil commitment process. The individual in crisis then might need to be transported to an emergency department on a petition (also called an application for hospitalization), which is a document that can be completed by any involved person detailing the basis for bringing an individual in for evaluation. Here again states vary, but in general there is broad authority to petition for evaluation, followed by process either through the courts or, if petitioned by allowable parties with special relationships to the individual (e.g., clinicians, law enforcement), to have the individual directly transported to the evaluation site. Often this is an emergency room or a designated crisis evaluation site. As crisis services evolve, part of that evolution will include whether crisis hub sites are able and appropriately staffed to manage involuntary patients. Regardless, once at the evaluation site, a clinical review would certify that the person still meets involuntary commitment criteria. Civil commitment laws require periodic reviews, and at any time the individual may consent to services voluntarily, negating the need for civil commitment. Individuals undergoing court-ordered inpatient commitment are also usually entitled certain due process protections under state and federal law, including the right to an attorney and the right to challenge their commitment before a judge or judicial authority.<sup>11</sup>

Regarding outpatient civil commitment, in general, AOT orders could be appropriate for individuals described above, particularly those with mental illness who have a history of persistent non-adherence to treatment and who therefore continue to pose some risk of harm. AOT programs, authorized by law in 47 states and the District of Columbia, were designed to motivate an individual, via the courts' authority, to participate in treatment.<sup>12</sup> Research has noted that AOT programs may be able to break the problematic pattern of treatment nonadherence for certain individuals. AOT programs, when continued for at least six months, appear to increase treatment engagement while significantly reducing hospitalization rates as well as re-arrest for select participants when compared with similar community services provided without court oversight.<sup>13 14</sup> Much of AOT's effectiveness is thought to be secondary to the presence of a court order and the intensive community supervision.<sup>15</sup> The American Psychiatric Association's position statement on AOT notes that not all individuals are appropriate for AOT, but that involuntary outpatient treatment programs have demonstrated their effectiveness when "systematically implemented, linked to intensive outpatient services, and prescribed or extended periods of time" for persons clinically evaluated and identified as appropriate for this type of court-ordered treatment.<sup>16</sup>

Crisis services provide an integral role for the individual on an AOT. An individual on an AOT who is in crisis may encounter a variety of crisis service providers. For example, law enforcement officers often act as first responders and extensions of the court when the provisions of an AOT order have been violated. They can be responsible for executing “pick up” orders on an individual who has been court-ordered to receive community-based services. These orders from the court can authorize an individual’s transport and even temporary hold in a crisis center or psychiatric facility for evaluation. Individuals on an AOT may also encounter providers in a crisis center or psychiatric emergency room after a symptom relapse. Ensuring robust collaboration between law enforcement, providers of crisis services, and an individual’s community-based AOT providers is essential, and may help in averting repeat hospitalizations, criminalization, and even in improving treatment engagement. Importantly, providers of crisis services considering involuntary outpatient treatment for their patient should also be cognizant of potential racial and ethnic disparities in practices. One study explored racial disparities in outpatient civil commitments, noting that African Americans are more likely than whites to be involuntarily committed for outpatient care in New York.<sup>17</sup> The authors note that depending on perspective, some providers could see this overrepresentation as positive, given it provides a potentially underserved population more access to treatment, while others could perceive this as negative, given the aspect of coercion and loss of an individual’s autonomy. Other issues regarding disparities in the public mental health system as a whole, and access to voluntary services in particular, are also relevant to interpreting this study’s findings. Providers of crisis services considering involuntary commitment should therefore be vigilant in their awareness of potential racial disparities and bias, as well as other pre-existing social determinants such as poverty and how public mental health care is structured and financed. Furthermore, with all this in mind, clinicians should work to provide culturally sensitive practices during patient interactions with a goal of maximizing engagement voluntarily before involuntary treatment is recommended. Voluntary engagement should always be the first priority.

Of note, providers of crisis services should also be mindful that Psychiatric Advance Directives (PADs) for an individual may be present. These directives, laid out by individuals with mental illness during a time of stability, outline their preferences for treatment and may help preserve an individual’s autonomy in a time of crisis.<sup>18</sup> Such advance instructions may be a method of communication of choice when an individual is deemed to lack decision-making capacity and may include the identification of a proxy decision-maker. Although they are still relatively new, PADs may allow other opportunities for accessing treatment without court involvement.

## **THE ROLE OF GUARDIANS IN CRISIS SERVICES**

Mental health providers working in crisis services may come across individuals who cannot legally make their own treatment decisions, such as individuals with designated court-appointed guardians who are authorized to make such decisions on their behalf. These “incapacitated persons” require careful consideration when it comes to all manner of mental health services that require informed voluntary consent, which usually would require the person to have capacity to provide it. Providers should therefore be mindful of several considerations when an individual under guardianship presents in crisis. For example, asking an individual to sign a release of information in order to obtain collateral information is common practice in psychiatric settings. A mental health provider must be

cognizant of the individual's guardianship status when asking for record releases, however, as the guardian's consent may be required.

As noted, guardians also have potential roles to play when inpatient psychiatric hospitalization is recommended for an individual in crisis. Generally, for people not under guardianship, the individual would be evaluated and, if inpatient psychiatric hospitalization was recommended, an assessment of the individual's competency to voluntarily consent to hospitalization would be conducted. Following such an assessment, the individual, if deemed to have decision-making capacity, would be offered a voluntary admission with informed consent. However, the process can be more complicated with someone who is not authorized to make their own treatment decisions. The ability of a guardian to provide the necessary consent to psychiatric hospitalization or treatment varies from state to state.<sup>19</sup> If a state's statute does not permit the guardian to consent to voluntary hospitalization on behalf of the incapacitated person and involuntary commitment is pursued, it may make it difficult to locate an inpatient setting for an individual who would benefit from treatment, but does not meet involuntary state commitment criteria.

In contrast to the states that do not allow a guardian to authorize an individual's psychiatric admission, other states allow the guardian to consent for the individual's psychiatric admission (or restrictions on consenting to psychiatric facilities are not specifically addressed in statute).<sup>20</sup> Still other states allow the guardian to consent as long as the individual under guardianship also assents to hospitalization.<sup>21</sup> Variations continue, with some states allowing a guardian to consent to an incapacitated person's hospitalization but only after obtaining a specific court authorization.<sup>22</sup> With all this taken into account, a mental health provider recommending voluntary hospitalization for an individual under guardianship should be familiar with the relevant state statute in which they practice.

## **RESTRAINT/SECLUSION IN CRISIS SERVICES**

Providers in crisis services can be faced with the scenario of caring for an individual in crisis who is acting in an imminently dangerous or agitated manner. Jurisdictional practices differ with regard to whether seclusion or restraint is legally authorized in particular crisis settings. In cases of acute agitation where there is concern that an individual could imminently harm themselves or others, where permitted, restraint or seclusion might be considered, though use of restraint and seclusion is controversial and must only be utilized as a last resort when less restrictive interventions fail. Numerous studies have pointed to the dangers of seclusion and restraint, including serious injury or death, loss of dignity, and psychological trauma to patients, as well as psychological and physical injuries to staff.<sup>23</sup> As a result, non-coercive de-escalation strategies should be first line and could begin upstream even with improving the therapeutic milieu to decrease potential precipitants to agitation.<sup>24</sup> Studies are beginning to identify specific strategies that may be key to reducing or eliminating seclusion or restraint, including strong leadership, procedural changes, staff training on specific issues, consumer debriefing, regular progress feedback using data to inform policy, and changes to organizational culture.<sup>25</sup> It is also critically important that crisis services be designed to be trauma-informed with staff training on seclusion/restraint prevention.

Making every effort to prevent seclusion and restraint and manage agitation with less restrictive strategies should be a core feature of a successful crisis service. If those interventions fail, there are

many considerations regarding seclusion and restraint that a crisis setting must first deliberate. First, whether a crisis setting is authorized to utilize restraint or seclusion varies. State licensure and laws will generally dictate whether a crisis site is eligible or ineligible for any hands-on holds of patients or any other type of restraint or seclusion. Hospitals and emergency rooms, in contrast, will be authorized to utilize these interventions and this may be one of the factors that is assessed when determining the level of care needed for the safest management of an individual's symptoms. That said, as previously noted, de-escalation and seclusion/restraint prevention can significantly reduce the use of these coercive and traumatizing strategies across the crisis continuum.

Where seclusion or restraint is allowable, regulatory structures must be followed. Restraint and seclusion in inpatient psychiatric treatment settings are among the most highly regulated practices in mental health, as the risks to patients can be severe with use, though failure to use restraint or seclusion in emergency situations can also result in adverse outcomes.<sup>26</sup> Providers should be mindful that seclusion or restraint is not a treatment per se, and as such, there should be every effort to minimize time in seclusion or restraint. Providers should also be mindful that certain racial or ethnic groups may be viewed as more violent, and that such misconceptions about racial groups could have serious repercussions related to the use of seclusion or restraint in particular populations.<sup>27</sup> Once a patient has gained control, implementing multiple strategies can be helpful at improving outcomes in managing future aggressive behavior. These strategies could include, but are not limited to, patient and staff debriefings and review processes aimed at examining the behavior leading to seclusion or restraint, as well as quality improvement initiatives examining overall seclusion and restraint utilization patterns.<sup>28</sup> A detailed exploration of possible preconceived notions in providers and education about cultural awareness and sensitivity could also be performed in order to help identify and eliminate racial or ethnic bias in the use of seclusion or restraint.

## **CONFIDENTIALITY AND DUTY TO PROTECT OTHERS IN CRISIS SERVICES**

Confidentiality in patient encounters can be a complex issue for mental health providers. Mental health providers are usually aware of major regulations governing confidentiality and privacy which stem from codes of professional practice, state statutes, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).<sup>29</sup> HIPAA is a federal law passed with the intent to protect individual health information. It requires a patient to authorize release of medical information prior to any distribution and necessitates that patients be informed how their medical information will be utilized. If an individual is in a crisis service for substance use needs, then the federal law, 42 C.F.R. Part 2 is the prevailing federal statute that requires strict maintenance of confidentiality. It is considered more restrictive than HIPAA for many reasons, including that it has criminal sanctions attached.<sup>30</sup> Despite these laws and regulations surrounding privacy and confidentiality, however, providers of crisis services may find themselves in acute situations where these tenets conflict with a patient's safety or the safety of others. For example, an individual may be brought to a crisis center by law enforcement after making homicidal or suicidal statements but refuse to answer provider questions or authorize a release for collateral information. The provider is then left without an adequate understanding of the circumstances and may be unable to make an informed risk assessment or provide appropriate treatment recommendations. In such situations, a mental health provider must weigh the patient and public's safety with the consequences of violating that person's privacy.

Providers of crisis services should be aware of potentially mandatory disclosures for threats of serious and imminent harm made by the patient. There is state to state variation on whether such “duty to warn” disclosures are required or simply allowed.<sup>31</sup> The reference to the “duty to warn” statutes arose from the 1974 landmark case *Tarasoff v. Regents of the University of California*, in which the California Supreme Court determined that a provider may have the duty to break confidentiality and warn a potential third party under certain circumstances, such as when the patient reveals ideas about harming the third party.<sup>32</sup> The Court revisited this ruling two years later in 1976. At that time, they noted that mental health professionals had a “duty to protect” an identifiable victim, and that warning the intended victim might be only one way to fulfill the duty to protect.<sup>33</sup> While the *Tarasoff* cases and subsequent California legislation only applies to practitioners in California, states have adopted variations on these themes. Crisis service providers should be aware of their state statute and provisions when an individual enters their care. If threats are identified, the crisis provider may need to take steps that can reasonably lead to protection of a third party or the public at large, which can include warning the identified third party, voluntarily or involuntarily hospitalizing the individual if clinically indicated, or notifying law enforcement of the threat under appropriate circumstances. Crisis service providers would do well to have policies and procedures for handling these types of situations and may need to seek legal counsel or clinical consultation on a case by case basis.

Crisis service providers should also be aware of other exceptions to confidentiality. For example, notable exceptions exist for disclosures required by law, such as mandated reporting of child abuse<sup>34 35</sup>, disabled persons abuse or elder abuse.<sup>36</sup> Mandated reporters are spelled out in state statutes, but typically include professionals working in crisis services, including social workers, physicians, nurses, therapists, law enforcement officers, and other health-care workers.<sup>37</sup>

## **ROLE OF CRISIS SERVICE PROVIDERS IN STATES WITH RED FLAG OR EXTREME RISK PROTECTION ORDERS**

A mental health provider working in crisis services may come across individuals who are thought to present a risk of harm to themselves or others. Access to a firearm for such individuals may increase their risk. What, then, should crisis services providers do when confronted with such an individual who owns guns? Although the answer requires a case by case multifactorial analysis and would likely involve a careful firearms-related risk assessment, obtaining collateral information, or a potential inpatient hospitalization to allow such risk assessment to be done in a higher level of care, several states have also recently passed laws allowing the permissible, temporary removal of firearms from an individual during a crisis. These laws, variably called gun violence restraining orders (GVROs), dangerous persons firearms seizure, risk-based gun removal, extreme risk protection orders, or “red flag” laws, allow for the temporary confiscation of firearms from an individual when there is a “red flag” raised by others.<sup>38 39 40</sup> These “red flags”, or concerns, center around the belief that the individual in question presents a risk of harm to themselves or others and that having access to a firearm could result in elevating that risk. “Red flag” laws are currently implemented in some form in seventeen states and the District of Columbia,<sup>41</sup> and have the benefit of addressing risk while ensuring that those with mental illness are not unfairly stigmatized, as these laws are not directly connected to mental illness or a previous civil commitment. In other words, anyone who presents the requisite “red flag” of risk could be subject to firearm removal provisions in those states where such laws exist.

Providers practicing in crisis settings should be familiar with their state procedures, allowances, and prohibitions regarding high risk individuals who have access to firearms. Depending on the state in which they practice, crisis providers should know whether it is permissible to report their concerns to police to initiate the firearm removal process or whether they can encourage family members or others to do so (including the patient themselves). According to Connecticut and Indiana data regarding their risk-based gun removal laws, the most frequent circumstance that led to firearm removal involved self-harm, with less frequent circumstances involving concerns about harm to others or a combination of the two.<sup>42 43</sup> Data indicates that in both the aforementioned states, the most common action taken by police at the time of firearm removal was transport to the hospital for psychiatric evaluation.<sup>44 45</sup> Thus, these situations were not likely initiated by crisis services, but resulted in crisis assessments. While the goal of these laws is to decrease the risk of violence toward self or others by removing the tools by which the individual might harm themselves or others—a so called “means reduction”—often they provide an opportunity for the individual to connect with treatment services as well. A review of the clinician’s role in this topic is summarized by Kapoor et al.<sup>46</sup>

## **THE ROLE OF LAW ENFORCEMENT, LEGAL REGULATION OF CRISIS SERVICES, AND THE CRIMINAL JUSTICE SYSTEM**

Providers of crisis services may see all manner of individuals in a behavioral health crisis, including those who are currently involved with the correctional or criminal justice system. Studies indicate that such individuals are high utilizers of crisis settings due to mental health and substance use concerns.<sup>47</sup> It may be likely that clinicians working in crisis settings could see such individuals at a time of transition, called “reentry,” when a person is leaving jail or prison. This transition period is high-risk, with studies indicating a death rate, including death from suicide, that is much higher than the general population.<sup>48 49</sup> States are also expanding access to community-based services for pre-trial defendants, such as those in outpatient competence to stand trial restoration programs, and these individuals may at times need crisis services.<sup>50</sup> Crisis providers should be aware of an individual’s legal situation and attempt to facilitate communication with appropriate resources for mental and physical health follow-up to prevent the individual’s return to the correctional system. Collaboration with community mental health providers who are knowledgeable about both the psychiatric and legal crises an individual is experiencing may help divert an individual away from the criminal justice system and into treatment in the mental health system. Crisis providers should also be aware of possible racial or ethnic disparities related to patients that could be involved in the criminal justice system. For example, some research indicates that individuals with mental illness who are from an ethnic minority group may be more likely to be referred to the criminal justice system rather than the mental health system.<sup>51</sup> Clinicians should work to increase their awareness and cultural competence regarding this population they may be serving.

In many cases, individuals with current involvement with the criminal justice system may come in contact first with law enforcement officers during a behavioral health crisis. There is increasing discussion about shifting police response in nonviolent circumstances to a behavioral health responder. In the meantime, one model for enhancing police responses involves the use of Crisis Intervention Team (CIT) trained officers as they are trained in de-escalation and understanding issues pertaining to individuals with mental illness.<sup>52</sup> The CIT program was originally developed to improve police response

and improve safety in interactions with individuals experiencing mental health crises, with the additional goal of providing improved access to mental health services or diverting individuals with serious mental illness away from the criminal justice system when appropriate.<sup>53 54</sup> Studies show that CIT-trained officers had an increased knowledge about mental illness and treatments, less stigma, better de-escalation techniques, and better referral decisions compared with non-CIT officers.<sup>55 56</sup> In some communities, law enforcement officers have made efforts to partner with mental health staff for calls, which can also be helpful at reducing negative outcomes.

## **CRISIS CENTERS AND EMTALA**

The Emergency Medical Treatment and Active Labor Act (EMTALA) was passed by the United States Congress in 1986.<sup>57</sup> The intent of EMTALA was to guarantee nondiscriminatory public access to emergency medical care regardless of an individual's ability to pay. This in turn was to prevent the practice of patient "dumping", defined as the "denial of or limitation in the provision of medical services to a patient for economic reasons and the referral of that patient elsewhere."<sup>58</sup> In short, EMTALA aimed to prevent hospitals from transferring patients who could not pay without consideration of their medical stability.<sup>59</sup> EMTALA requires all hospitals receiving Medicare funds to screen, examine, and stabilize a patient prior to a transfer taking place. In addition, EMTALA notes the receiving hospital must agree to the transfer and have facilities to provide the necessary treatment.

There are three criteria that must be met before a facility could be held liable for an EMTALA violation.<sup>60</sup> First, the facility must be licensed as a hospital under state law. Second, it must participate in Medicare. Finally, it must operate a dedicated emergency department (DED). Although it is usually readily apparent if a facility is licensed as a hospital and if it participates in the Medicare program, the third criteria could be less clear. The Centers for Medicare and Medicaid Services (CMS) define a DED as a department that is licensed as an emergency department, a department that presents itself to the public as a provider of emergency services, or a department that sees at least one-third of its visits for the treatment of emergency medical conditions on an urgent basis without a previously scheduled appointment.<sup>61</sup> This includes ambulatory outpatients who may present on an unscheduled basis to psychiatric intake centers. Thus, while Medicare-participating hospitals are required to comply with EMTALA requirements, a freestanding, walk-in Crisis Center or Crisis Stabilization Unit (CSU) could also potentially qualify.

Mental health providers working in psychiatric crisis services, including at freestanding Crisis Centers or CSUs, should be aware of EMTALA mandates and how they related to state licensing authorities. Although many walk-in crisis services focus on resolving a crisis in a less intensive setting on an urgent basis, at times, hospitalization may be recommended as necessary given the severity of the patient's crisis. If so, providers should be mindful of issues related to patient stability and transfer. Carefully considering the transport of the patient in crisis is also important, and assuring the safest method available (i.e., ambulance vs. patient car) should be the goal.

## **COVID-19 RELATED LEGAL ISSUES RELEVANT TO CRISIS SERVICES**

COVID-19 has presented numerous challenges to health care systems around the world. While the medical complications related to COVID-19 are often prominently discussed, the mental health impact of COVID-19 also has critical bearing on individuals and communities. More than one-third of Americans noted that the COVID-19 pandemic was having a “serious impact” on their mental health, according to a survey by the American Psychiatric Association released March 25, 2020.<sup>62</sup> Given ongoing implications related to the global pandemic, providers of behavioral health services, particularly crisis services, should be cognizant of COVID-19 related mental health issues that they may be encountering in individuals presenting in a behavioral health crisis. Such issues include social isolation resulting from quarantines, economic and financial concerns secondary to lockdowns, and stress related to job-loss or food insecurity.

Behavioral health providers should also be aware of COVID-19 specific implications for policies and practices related to crisis services. The full impact of COVID-19 on legal issues related to crisis services is not yet known, though there are many potential repercussions. For example, individuals presenting to a walk-in crisis center or psychiatric emergency room may require hospitalization or a transfer to a higher level of care given the severity of their crisis. However, arranging a safe and expedient transfer to a psychiatric bed may not be simple when factoring in COVID-19. It is possible that crisis providers may be asked to test individuals and consequently wait for COVID-19 test results prior to transferring patients to another facility in order to prevent possible transmission of the virus. This could result in longer emergency room boarding times in an era when some states are already being sued over bed waits.<sup>63</sup>

Crisis providers may also, as previously noted, be evaluating and treating individuals who are still actively involved in the criminal justice system. Jail and prison populations may be particularly vulnerable during this pandemic, given close living quarters, the potential for overcrowding, the difficulties with social distancing, and this population’s increased rate of chronic medical comorbidities compared to the general population.<sup>64</sup> It is not yet clear at the time of this writing whether persons with severe mental illness in a behavioral health crisis, who are also positive for COVID-19, will be more likely to be retained in jails instead of eligible for diversion into the community. Providers of crisis services should continue to communicate regularly with liaisons in the community who are aware of a patient’s physical and mental health as well as legal status.

In addition, although many crisis services moved to video, it remains important that in-person services be available, and that proper PPE and infectious disease protections and protocols be implemented. This is critical as crisis services must ensure proper staffing and evaluation capabilities to mitigate the risk of liability in those assessments. Another potential example of COVID-19 impacting legal issues related to crisis services arises when considering the management of an acutely agitated patient in a crisis setting. While some crisis facilities may be allowed to utilize restraints as noted above, attempting to restrain an agitated and likely un-masked patient—especially one with an unknown COVID-19 test status—could put both the patient and the crisis staff at significant risk. It is also important to note that public health codes, such as those outlined by the Centers for Disease Control and Prevention, define isolation and quarantine differently than restraint and seclusion.<sup>65</sup> Restraint and seclusion are regulated by Centers for Medicare & Medicaid Services and require least restrictive alternatives to be addressed, as opposed to isolation and quarantine, where infection control is the key

concern. Overall, in the COVID-19 context, crisis providers should work not only toward the first-line de-escalation strategies discussed above in this paper but should also be diligent in practices such as mask-wearing for all involved.

## **RISK MANAGEMENT AND LIABILITY WITH CRISIS CENTERS**

Working with individuals in crisis can be a positive and rewarding clinical experience in that crises can typically resolve with thoughtful communication and timely intervention. However, issues of liability can be an area of ongoing concern for providers who work in crisis settings. Issues of liability are particularly relevant when deciding to discharge a patient from a crisis setting. The decision to discharge should only occur after a determination of the appropriate level of care the individual needs, decided after a careful risk assessment based on the available information. Carefully and thoroughly documenting the decision, the considerations that went into the decision, and the recommendations made is of utmost importance and can help protect the mental health provider against liability should there be an unfortunate event after discharge, such as a patient suicide.<sup>66</sup>

In general, several elements must be present for the plaintiff in a case to prove medical malpractice. These elements are commonly referred to as the “four Ds”. They include duty, dereliction, damages, and direct causation.<sup>67</sup> Duty is established from the doctor-patient relationship, and dereliction, often cited as negligence or deviation from the standard of care, must directly lead to the damages.<sup>68</sup> In addition, for the plaintiff’s case to prevail, there is also the condition that the suicide should have been foreseeable.<sup>69</sup> Thus, the issue of liability will often hinge on whether the mental health provider appropriately assessed the risk that a suicide would occur, emphasizing again the importance of thorough clinical documentation.<sup>70</sup>

A clinician should therefore weigh the available information and use their professional judgment combined with clinical practice guidelines, while clearly documenting their reasoning and considerations in order to best protect themselves from liability.

## **CONCLUSION**

Providers in crisis settings offer necessary and critical services to individuals and the community. While working in such high-stakes settings can be emotionally taxing, it can also be rewarding. Crisis services provide opportunities for early intervention and treatment during a behavioral health crisis prior to more severe consequences occurring. Providers should be aware of key legal issues relevant to crisis service evaluations, with focus specifically on statute in the state in which they practice. These legal issues are also ever evolving, as highlighted with recent events related to COVID-19 and a renewed attention to racial and ethnic disparities. Although the work is complex, being mindful of the current legal landscape can help a crisis service provider protect themselves from liability while working to achieve the best outcome for the individual in crisis.

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