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Authors

Heldt, Jonathan P

Zito, Michael F

Seroussi, Ariel

et al.

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Original Research Report

A Medical Incapacity Hold Policy Reduces Inappropriate Use of Involuntary Psychiatric Holds While Protecting Patients From Harm



Jonathan P. Heldt, M.D., Michael F. Zito, M.D., Ariel Seroussi, M.D.,
Sharlena P. Wilson, M.D., Paul L. Schneider, M.D., Thomas B. Strouse, M.D.,
Erick H. Cheung, M.D.

Background: The use of involuntary psychiatric holds (IPH) to detain patients who lack the capacity to make health care decisions due to nonpsychiatric conditions is common. While this practice prevents patient harm, it also deprives civil liberties, risks liability for false imprisonment, and may hinder disposition. Medical incapacity hold (MIH) policies, which establish institutional criteria and processes for detaining patients who lack capacity but do not meet criteria for an IPH, provide a potential solution. **Methods:** A retrospective chart review was conducted on adult medical/surgical inpatients placed on an IPH or MIH over the 1-year periods before and after implementation of a MIH policy at an academic medical center. The primary outcome was frequency of IPH utilization in patients who did not qualify for an IPH as determined by 2 independent physician reviewers. A Cohen's kappa was calculated to determine inter-rater reliability. Differences in patient

demographics and outcomes were compared using a Student's t-test, Wilcoxon rank-sum test, and Pearson chi-square test ($\alpha = 0.05$). **Results:** The Cohen's kappa was 0.72 indicating substantial agreement. Seventy MIHs were placed after implementation (mean duration 4.3 days). Before MIH implementation, 17.6% of IPHs were placed on non-qualifying patients, which decreased to 3.9% following MIH implementation ($p < 0.01$). The average length of stay for patients on an IPH or MIH did not change following MIH implementation. No instances of patient elopement, grievances, or litigation were found. **Conclusion:** MIH policies benefit both patients lacking capacity and the health care systems seeking to protect them while avoiding inappropriate use of IPHs.

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Key words: medical incapacity hold, involuntary hospitalization, capacity, treatment refusal [MeSH], commitment of mentally ill [MeSH], mentally ill persons/legislation & jurisprudence [MeSH], public policy [MeSH].

INTRODUCTION

Altered mental status (AMS), also known as delirium when it occurs acutely, is frequently encountered in hospitals, with as many as half of all medical and surgical inpatients experiencing some form of confusional state during their stay.¹ Patients with AMS often lack the capacity to make informed health care decisions, which may include difficulty in clearly communicating choices, demonstrating an understanding of relevant

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Received March 2, 2018; revised May 30, 2018; accepted June 1, 2018. From the Jane and Terry Semel Institute for Neuroscience and Human Behavior (J.P.H., M.F.Z., A.S., S.P.W., E.H.C.), Psychiatry, Los Angeles, CA; VA Greater Los Angeles Healthcare System (P.L.S.), Psychiatry, Los Angeles, CA; University of California Los Angeles David Geffen School of Medicine (T.B.S.), Psychiatry, Los Angeles, CA. Send correspondence and reprint requests to Jonathan P. Heldt, M.D., Jane and Terry Semel Institute for Neuroscience and Human Behavior, 760 Westwood Plaza C8-193, Los Angeles, CA 90024; e-mail: jheldt@mednet.ucla.edu

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information, appreciating the gravity of their medical situation, and/or reasoning about treatment options.^{2,3} Patients who decline care and request to leave the hospital against medical advice (AMA) owing to a lack of understanding of their situation are at particular risk of harm, disability, or death.⁴ Psychiatric consultants are frequently asked to assess these cases, with approximately a quarter of capacity consults being related to requests to discharge AMA.^{5,6}

Given this risk, physicians and health care systems have a moral, ethical, and legal responsibility to protect patients without decisional capacity from discontinuing treatments that they would otherwise have accepted in a rational frame of mind. However, most states do not have laws addressing the detainment of patients who lack capacity. While involuntary commitment statutes vary across all 50 states and the District of Columbia, many states do not have provisions for detaining patients who lack capacity to make informed health care decisions. Instead, the only form of detainment permitted by law in many jurisdictions is an involuntary psychiatric hold (IPH), also known as civil commitment.⁷ IPHs have different names depending on the jurisdiction (e.g., “5150” in California, “pink slip” in Ohio, “pink paper” in Massachusetts, “Baker Act Form” in Florida) and differ in policy specifics, such as the length of time that detainment is permitted.^{8,9} However, these laws are consistent in that they apply only to patients with a statutorily-defined mental disorder who are a danger to self, a danger to others, and/or gravely disabled as a result of that disorder.⁷

Clinical situations frequently arise in which detainment is necessary in the absence of a mental disorder as defined by the legal system. This often leads to inappropriate utilization of IPHs for patients whose impaired decisional capacity stems from a medical, rather than psychiatric, etiology.¹⁰ While this phenomenon has been insufficiently documented, it is believed to be common across the United States.¹¹ Despite its frequency, use of IPH statutes for patients without a mental disorder is problematic for several reasons. First, the presence of a mental disorder does not imply lack of capacity, nor does a lack of capacity imply mental disorder.¹² Second, using IPHs for this purpose is arguably illegal, as it applies mental health law to patients without evidence of a mental disorder as defined by the legal system. Third, an IPH implies a need for psychiatric

hospitalization and treatment once medically stable, which may delay appropriate disposition (such as a transfer to a skilled nursing facility) or result in a transfer to an inpatient psychiatric hospital without clear indication. Due to shortages of inpatient psychiatric hospital beds across the United States, this can be a significant barrier to discharge and often leads to longer lengths of stay.¹³

Providers seeking to act in accordance with IPH law are left with 2 other options: discharging the patient AMA or detaining them involuntarily without recourse to a specific law or statute. Discharging the patient AMA can result in harm, disability, and/or death from untreated medical illness. Furthermore, it places the provider at risk of liability for negligence and wrongful death. In addition, patients who are discharged AMA are known to be at increased risk for frequent readmissions and high health care utilization, resulting in significant financial costs to institutions.¹⁴

This makes detaining the patient involuntarily without regard to legal statutes an attractive option, as it viewed as benevolent, mitigates medical risk, limits risk of liability for negligence, and preserves the intent of IPH statutes. However, despite being common practice in many hospitals, this practice is not without its problems. First, it exposes the individual provider to the risk of liability for false imprisonment. Second, the lack of an institutionally standardized process deprives patients of civil liberties without external accountability, due process, or clear procedural expectations for patients or staff. Finally, the practice may seem ambiguous to other physicians, nurses, and security staff, who may ask for an explicit hold order to be placed before they feel comfortable restraining or detaining a patient. Indeed, capacity evaluation requests are often associated with frustrating or complicated cases, for which the disambiguating effect of an IPH can provide temporary relief.^{15,16} This places pressure on psychiatric consultants to consider an IPH, especially in acute situations where a patient is actively attempting to leave.¹¹

Given that the first 3 options are associated with significant problems and risks to patients, providers, and the health care system, our hospital designed and implemented a new institutional policy known as a medical incapacity hold (MIH).¹⁷ A visual summary of the MIH policy is found in Figure 1. The MIH policy

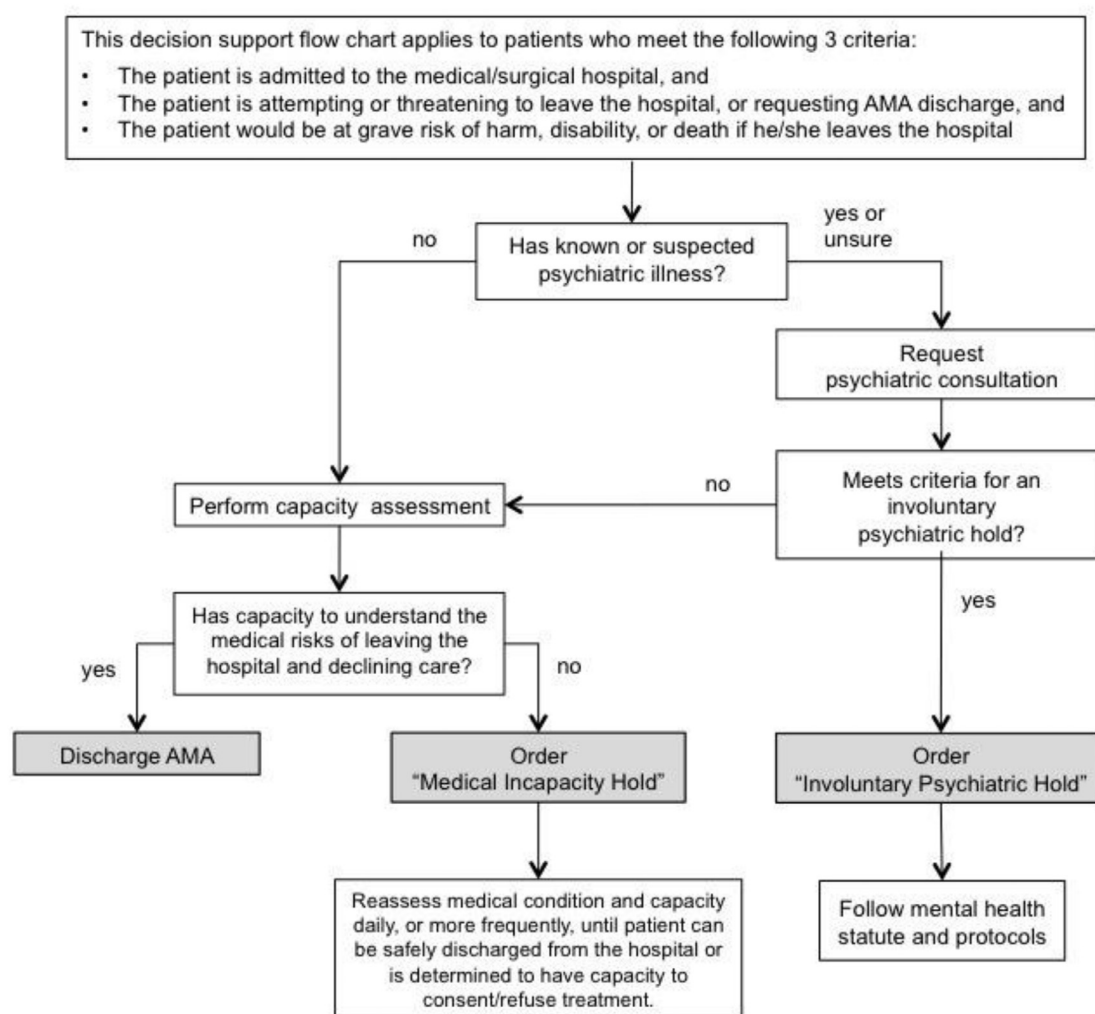
clearly articulates the parameters and criteria for use of an MIH in order to minimize medical risks to the patient, reduce inappropriate use of IPH statutes, distribute the risk of liability for false imprisonment across the health care institution rather than placing it solely on the provider, introduce an element of due process, and resolve the ambiguity associated with detainment without regard to legal statutes. The advantages and disadvantages of each approach to a patient who requests to leave the hospital but lacks capacity to make this decision are summarized in [Table 1](#). We have previously reported on the rationale

for and process of developing this policy.¹⁷ In the present study, we report on patient and institutional outcomes after its implementation.

METHODS

The MIH policy was implemented on August 15, 2016. To assess the effect of the MIH policy on patient and institutional outcomes, a retrospective chart review was conducted on all adult medical and surgical inpatients placed on either form of involuntary detainment (IPH or MIH) at a single medical center over the 1-year study

FIGURE 1. A Visual Summary of the Medical Incapacity Hold (MIH) Policy



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TABLE 1. Advantages and Disadvantages of 4 Approaches to a Patient Who Requests to Leave the Hospital yet Lacks the Capacity to Make this Decision

	Discharge AMA	Involuntary psychiatric hold	Involuntary detention without regard to statutes or policies	Medical incapacity hold
Medical risk to patient	Increased due to untreated medical illness	Mitigated, though there remains a risk of psychologic or physical harm from detainment and restraints, if used	Mitigated, though there remains a risk of psychologic or physical harm from detainment and restraints, if used	Mitigated, though there remains a risk of psychologic or physical harm from detainment and restraints, if used
Diagnostic implications	None	Inaccurately implies the presence of a mental disorder and need for psychiatric hospitalization	None	None
Civil liberty of patient	Preserved	Deprived in violation of civil commitment laws	Deprived without regard to statutes	Deprived without regard to statutes but in accordance with hospital policies
Risk of liability	Primarily on provider for negligence or wrongful death	Primarily on provider for false imprisonment and/or inappropriate use of civil commitment statutes	Primarily on provider for false imprisonment	Distribution of risk across institution for false imprisonment
Due process	n/a	Variable depending on statutes but present in many jurisdictions	None	Yes, explicitly established through hospital procedures and grievances
Effect on care team	Unambiguous, but demoralizing	Unambiguous to medical providers, but problematic for psychiatrists	Ambiguous, with pressure for clear solution	Unambiguous as procedures are institutionally defined
Disposition	Premature or inappropriate patient discharge	May delay placement to medical facilities through implication of need for psychiatric treatment	Likely unaffected	Likely unaffected
Estimated financial cost	Likely increased through incomplete treatment of acute medical condition and subsequent higher rate of health care utilization	Likely increased through delayed disposition and inappropriate use of psychiatric and legal resources	No effect	No effect
Assessment of clinical actions to address a patient who meets the following criteria: 1.) Demonstrates an intent or desire to discontinue treatment and leave the hospital 2.) Lacks decisional capacity as determined by a qualified provider 3.) Would be at grave risk of harm, disability, and/or death if permitted to leave 4.) Does not qualify for an involuntary psychiatric hold				

period directly before implementation of the MIH policy (8/15/15–8/14/16, hereafter referred to as the “pre-MIH” cohort). These cases were then compared with the 1-year study period immediately following MIH implementation (8/15/16–8/14/17, hereafter referred to as the “post-MIH” cohort). Cases were analyzed on a “per hold” basis, with each hold being treated as a discrete statistical entity, rather than on a “per patient” basis. This means that the total number of holds analyzed will exceed the number of individual

patients, as some patients were placed on multiple holds during the same visit.

The primary outcome was the frequency of IPH utilization in patients without chart evidence of a mental disorder that would meet statutory grounds for civil commitment (referred to as an “inappropriate IPH”) as determined by 2 independent physician reviewers. A Cohen's kappa score was calculated to analyze agreement between the 2 reviewers. Secondary outcome measures included patient length of stay (days), rate of

patient elopement, rate of grievances filed, and rate of litigation. Differences in patient demographics and outcomes were compared using a 2-tailed Student's *t*-test for parametric continuous variables, a Wilcoxon rank sum test for nonparametric continuous variables, and a Pearson chi-square test of independence for categorical variables. Statistical analysis was conducted using Microsoft Excel 2011 Version 14.5.0.

RESULTS

The Cohen's kappa score was 0.72 indicating substantial agreement between the 2 independent physician reviewers. The pre-MIH patient cohort did not differ significantly from the post-MIH cohort in terms of age (52.3 vs 49.1 years, $p = 0.15$) or gender (53.0% vs 54.8% male, $p = 0.93$).

A total of 182 holds were placed in the pre-MIH period, representing 129 unique patients. In the pre-MIH study period, 17.6% (32 of 182) of all IPHs were found to have been placed inappropriately on patients who lacked a clearly defined mental disorder as determined by the 2 reviewers. The most common primary diagnoses found in patients inappropriately placed on an IPH are found in Table 2.

A total of 212 holds were placed in the post-MIH period, representing 168 unique patients. In the post-MIH study period, the rate of inappropriate IPHs decreased from 17.6% to 3.9% of all IPHs ($p < 0.01$) (Figure 2).

A total of 70 MIH orders were placed in the post-MIH study period. Of these, 72.9% (51 of 70) were appropriately placed for patients without chart evidence of a mental disorder accounting for their lack of capacity (Figure 2). Only 2.9% (2 of 70) were incorrectly placed when an IPH would have been more appropriate. The reviewers disagreed on the remaining 21.4% (15 of 70), as seen in Figure 2. The mean MIH duration was 4.3 days (range 0.0–17.7 days). Of all MIH cases, 78.6% involved a psychiatric consultation, while 18.6% involved an ethics consultation. The most common diagnoses found in cases where an MIH order was placed were physical head trauma, metabolic disturbances, and infections (Table 3).

Average length of stay for all patients on any form of involuntary hold decreased from 11.0 days (st dev = 15.6 days) to 9.1 days (st dev = 8.5) following MIH policy implementation; however, this effect was

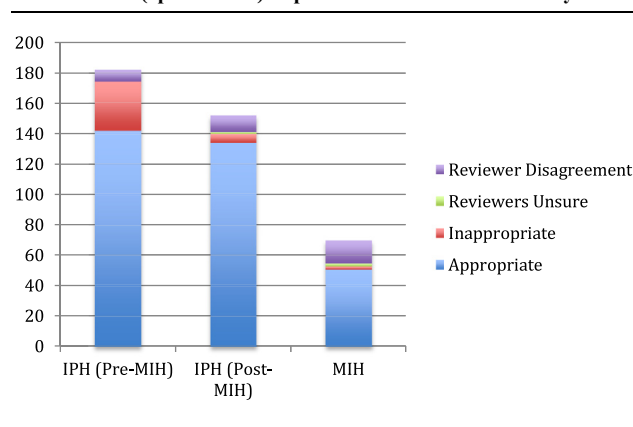
TABLE 2. Primary Diagnoses of Patients Placed on an Involuntary Psychiatric Hold (IPH) in the Absence of a Defined Mental Disorder in the Period Before Medical Incapacity Hold (MIH) Policy Implementation

Condition	Prevalence
Organic intracranial pathology	43.5% (10/23)
– Intracranial bleed (4)	
– Primary or metastatic tumor (3)	
– Infection (3)	
Major neurocognitive disorders	13.0% (3/23)
Substance-induced syndromes	13.0% (3/23)
– Alcohol withdrawal	
– Unintentional opioid overdose	
– Steroid-induced	
Post-operative	8.7% (2/23)
– Femoral endarterectomy	
– Orthotopic liver transplantation	
Epilepsy or other seizure disorders	8.7% (2/23)
Unknown etiology	8.7% (2/23)
Metabolic disturbance	4.3% (1/23)
– Liver failure and hepatic encephalopathy	

not statistically significant ($p = 0.70$). Even looking only at those patients for whom an MIH was determined to be the most appropriate form of detainment, there was no difference in length of stay following MIH policy implementation (10.1 before vs 7.9 days after, $p = 0.28$).

No instances of patient elopement, patient grievances, or litigation for either negligence or false imprisonment were found in either study period.

FIGURE 2. Appropriateness of Involuntary Psychiatric Hold (IPH) and Medical Incapacity Hold (MIH) Orders as Determined by 2 Independent Physician Reviewers in the 1-year Study Periods Before (“pre-MIH”) and After (“post-MIH”) Implementation of the MIH Policy



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TABLE 3. Primary Diagnoses of Patients Placed on a Medical Incapacity Hold (MIH) in the Period Following MIH Policy Implementation

Condition	Prevalence
Physical head trauma	17.6% (9/51)
Metabolic disturbance	15.7 (8/51)
– Renal failure (4)	
– Liver failure and hepatic encephalopathy (3)	
– Diabetic hyperglycemia	
Infectious	13.7% (7/51)
– Bacteremia and sepsis (4)	
– Cellulitis	
– Pneumonia	
– Urinary tract infection	
Organic intracranial pathology	9.8% (5/51)
– Intracranial bleed (2)	
– Cerebrovascular accident	
– Viral encephalitis	
– Neurosarcoidosis	
Substance-induced syndromes	9.8% (5/51)
– Alcohol withdrawal (4)	
– Unintentional opioid overdose	
Other	9.8% (5/51)
– Aortic dissection	
– Transplant rejection	
– Diverticulosis	
– Sjögren syndrome	
– Myocardial infarction	
Major neurocognitive disorders	9.8% (5/51)
Post-operative	7.8% (4/51)
– Coronary artery bypass surgery	
– Exploratory laparotomy	
– Lung transplant	
– Deep brain stimulator placement	
Developmental disability	5.9% (3/51)
– Wilson's disease	
– Chromosomal deletion syndrome	
– Idiopathic	
Epilepsy or other seizure disorders	2.0% (1/51)

A summary of patient demographics and outcomes in the pre-MIH and post-MIH study periods is found in [Table 4](#).

DISCUSSION

Psychiatric consultants are frequently asked to place an IPH for patients who lack decisional capacity to leave the hospital but do not have a mental disorder. In our study, 17.6% of all IPHs before implementation of the MIH policy were inappropriately placed on patients without evidence of having a mental disorder. While use of an IPH for this purpose provides an unambiguous resolution to an acute crisis, it also results in an

TABLE 4. Comparison of Patient Demographics, Patient Outcomes, and Utilization Frequency of Involuntary Psychiatric Hold (IPH) and Medical Incapacity Hold (MIH) Orders Between the 1-year Study Period Directly before Implementation of the MIH Policy (“pre-MIH”) and the 1-year Study Period Immediately Following MIH Implementation (“post-MIH”)

	Pre-MIH	Post-MIH	<i>p</i>
Age (years)	52.3	49.1	0.15*
Gender (male)	70 (53.0%)	92 (54.8%)	0.93†
Number of patients	129	168	n/a
Number of IPHs	182	152	n/a
Appropriate IPH	142 (78.0%)	134 (88.2%)	<0.01‡
Inappropriate IPH	32 (17.6%)	6 (3.9%)	<0.01‡
Reviewer disagreement on IPH	8 (4.4%)	11 (7.2%)	n/a
Reviewers Unsure on IPH	0 (0%)	1 (0.7%)	n/a
Number of MIHs	n/a	70	
Appropriate MIH	n/a	51 (72.9%)	n/a
Inappropriate MIH	n/a	2 (2.9%)	n/a
Reviewer disagreement	n/a	15 (21.4%)	n/a
Reviewers unsure	n/a	2 (2.9%)	n/a
Length of stay (days)	11.0	9.1	0.70‡

* Two-tailed Student's *t*-test.

† Pearson's chi-square.

‡ Wilcoxon rank sum test.

arguably unlawful deprivation of the patient's civil liberties under existing IPH statutes, the possibility of liability for false imprisonment for the provider, and a potential obstruction to appropriate disposition. Our data suggest that implementation of an MIH policy is effective at reducing inappropriate use of IPHs while also protecting patients from harm, providing an institutionally approved option to providers, alleviating concerns about liability, creating clear expectations of standards of care, and facilitating the appropriate medical treatment and disposition for the patient.

We further note that the implementation of an MIH policy can introduce an element of due process to situations in which a patient's rights might otherwise be violated without legal recourse. In speaking with providers in other health care systems, it is our experience that many hospitals that permit indefinite detainment of patients without regard to legal statutes do not include any element of due process, although formal data on this subject are lacking. Under our MIH policy, patients are reminded of their right to contact the hospital's Patient's Rights Office, the state's Department of Public Health, and/or the Joint Commission to object to the

hold and/or file a grievance.¹⁷ However, we note that we could not find any evidence of patients utilizing these avenues during the study period. The roles of psychiatry and other consultations are also explicitly articulated in the policy, and these services can provide distinct perspectives on complicated cases.¹⁸ In addition, MIH utilization patterns are monitored periodically by the institutional quality committee.

Implementation of an MIH policy is not without risks. We advocate for the use of this hold with significant caution, as the psychologic impact of involuntary detainment cannot be understated.¹⁹ Furthermore, there is the additional risk of physical harm if restraints or physical holds are required to enforce the policy.²⁰ It should be noted that both of these risks are also found with use of an IPH or other forms of detainment.

In addition, as with any policy-related initiatives, all providers must be fully educated on the changes and instructed on proper use. It was our experience that educating providers on the existence of the MIH order was immediate and effective, as the primary outcome (rate of inappropriate use of IPH orders) decreased from 17.6% to 4.3% even in the first 3 months following the change. The rapid adoption of the MIH order appears to confirm the perceived need for this change on the part of providers.

We believe our determinations of the presence of mental disorders to be valid, as the inter-rater reliability as measured by the Cohen's kappa score indicated substantial agreement overall. In addition, previous studies have found that different raters generally agree on the question of whether a patient qualifies for an IPH.²¹ Nevertheless, making a determination between a mental disorder and a physical illness as the etiology for behavioral symptoms is not always straightforward. Indeed, some have argued that the distinction between “physical” and “psychiatric” illness is outdated, stigmatizing, and lacking in scientific validity.^{22,23} One could further make the argument that AMS, by virtue of its inclusion in the Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition under the name delirium, qualifies as a psychiatric diagnosis.²⁴ While there is substantial merit to these views, from a legal perspective the distinction between “medical” and “psychiatric” illness is preserved in the language and intent of IPH statutes. Thus, such a distinction remains obligatory, even though it is not necessarily clinically valid or accurate.

The complex relationship between psychiatric and physical disorders is evident in the cases on which our reviewers disagreed. While reviewer disagreement was relatively rare for IPHs (representing 4.4% and 7.2% of IPHs in the pre-MIH and post-MIH periods, respectively), it occurred more commonly in evaluating MIH cases, with the 2 reviewers disagreeing in 21.4% (15 of 70) of all MIH orders. Closer analysis showed that 2 common factors in MIH cases involving reviewer disagreement were the presence of a known long-standing psychiatric condition (33.3%) and recent substance abuse (26.7%). In these cases, the extent to which a mental disorder contributed to the clinical presentation was often unclear. For example, a middle-aged male with a history of treated schizophrenia was brought into the hospital following a seizure. He requested to discharge AMA but was found to lack the capacity to do make an informed refusal of care. However, there was no evidence of acute psychotic symptoms, such as auditory hallucinations, thought disorganization, or delusions on examination, implying that he did not require further treatment for schizophrenia. In addition, patients with a seizure disorder are inherently at higher risk of altered mental status regardless of psychiatric comorbidity.²⁵ Nevertheless, it is possible that his lack of capacity was at least partly related to the chronic cognitive deficits found in patients with schizophrenia.²⁶ This case, and others like it, illustrates the ambiguity inherent to making a distinction between “medical” and “psychiatric” illness.

Another source of reviewer disagreement on MIH cases were major neurocognitive disorders, accounting for 13.3% of disagreements. While the Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition lists major neurocognitive disorders as psychiatric diagnoses, some have argued that these disorders are more appropriately classified as physical illnesses.²⁷ Legal statutes on major neurocognitive disorders vary depending on the state. Use of IPHs to detain patients with no mental disorder other than a major neurocognitive disorder is permissible in some states (e.g., Wisconsin), whereas other states (e.g., Delaware, Washington state) explicitly prohibit this. Further compounding the problem is that in many states, including California, the probate conservatorship process for a patient with a major neurocognitive disorder is separate and distinct from the conservatorship process for a patient with a mental disorder.^{28–33}

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Clinical experience tells us that patients with an acute behavioral disturbance related to a major neurocognitive disorder are frequently treated in both medical and psychiatric facilities.^{34,35} Given this ambiguity on both the legal and clinical level, it is perhaps no surprise that neurocognitive disorders represent an area of disagreement in our study. In the absence of more concrete guidelines, our current institutional practice is to pursue psychiatric hospitalization (with use of an IPH, if necessary) when there is an acute neuropsychiatric need such as behavioral dysregulation requiring the specialized skills of a geriatric psychiatrist. Patients without an acute psychiatric or behavioral concern are best served by admission to the medical ward and, if necessary, the use of a MIH to enable appropriate disposition (e.g., to a skilled nursing facility) and probate conservatorship measures as appropriate.

The legal implications of the medical incapacity hold policy require further study. We have made the case that use of IPHs for patients without evidence of a mental disorder as commonly recognized by the legal system is not only inappropriate but arguably illegal, as it represents a misuse of mental health statutes. However, cases of successful litigation for malpractice or false imprisonment resulting from use of IPHs in these circumstances are rare. This is likely due to several factors. First, providers and institutions are better positioned to defend against allegations of false imprisonment on the basis of benevolence, treatment, and safety than to defend against allegations of poor outcomes resulting from passive negligence.³⁶ In addition, the claimant must show that the provider acted in such a way as to illustrate ill intent towards the patient, as good faith on the part of the provider is presumed.³⁷ Nevertheless, cases of successful litigation for false imprisonment do exist (e.g., *Barker v. Netcare Corp* and *Heath v. Peachtree Parkwood Hospital, Inc.*). In these cases, even though the hospital staff acted in accordance with what they believed was best for the patient, proper protocols and policies were not followed. This illustrates the importance of having formalized policies for these situations.

While this study provides preliminary retrospective evidence supporting the efficacy of MIH policies in addressing the shortcomings of current statutes on involuntary detainment, it has several limitations. First, in this analysis determinations of the presence of a mental disorder were made by chart review rather than by in-person evaluations. It is well known that medical

documentation does not always accurately reflect the actual clinical scenario for a number of reasons, though this is improving in the age of electronic health records.^{38,39} Nevertheless, it is possible that our conclusions would have been different if in-person evaluations had been used instead. Second, this study was not a randomized controlled trial and instead represents a retrospective analysis of patient and institutional outcomes before and after implementation of the MIH policy. We note that the total number of holds increased after policy implementation. While we cannot offer a definitive explanation, we hypothesize that while there were many instances of inappropriate IPHs being placed in the pre-MIH period, there were also likely other instances where patients were detained without use of a formal order of any kind. After the MIH policy was introduced, it is likely that it was used in these cases which could account for the overall increase in number of holds. Third, our data on changes in length of stay are also subject to various confounding factors, as it cannot be assumed that implementation of the MIH policy was the only variable factor between the 2 study periods. Fourth, the policy was implemented in only a single medical center. This is beneficial in some regards, as it eliminates potentially confounding factors, such as geographic location, hospital culture, and patient population. However, it also limits the generalizability of our findings and underscores the need for this study to be replicated in other settings. Our study group was also limited to medical and surgical inpatients, which may further limit generalizability to acute settings such as the emergency department where these clinical scenarios also occur.⁴⁰ Finally, as mentioned in the “Methods” section, cases were analyzed on a “per hold” basis, with each hold being treated as an individual entity, rather than on a “per patient” basis. The decision to analyze on a “per hold” basis was made to address the concern that many patients were placed on multiple holds throughout their admission, with each subsequent hold reflecting the evolving circumstances of the patient's clinical situation. Therefore, there were several instances where the reviewers felt that the type of hold should change even for the same patient (e.g., a patient whose AMS persisted even after treatment of an underlying infection, raising suspicion for a primary psychiatric diagnosis rather than delirium). It is possible that the results of our analysis would have differed if we had analyzed the cases on a “per patient” basis.

Finally, as discussed previously, our study results have likely been impacted by the fact that the study period included the period immediately after the policy was implemented. It is possible that continued use of and familiarity with the MIH policy could produce different outcomes if this study was replicated in the future, even at the same institution.

CONCLUSIONS

We believe that our MIH policy has been effective at preventing inappropriate use of IPH statutes while protecting patients from harm. We recommend further study of similar policies in other health care systems to replicate these findings. We recognize that this study provides only preliminary evidence to support such a

policy and does not fundamentally change relevant statutes. However, we hope that it may present an opportunity to propose changes to relevant laws in the interest of offering formal statutory guidance to providers and health care systems attempting to act in the best interests of their patients.

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