CHAPTER 7

Legal Issues in Inpatient Psychiatry

GABOR VARI, MACE BECKSON, AND ROBERT WEINSTOCK

The legal aspects of inpatient care often are not fully understood by or seem daunting to psychiatrists. The goal of this chapter is to provide an overview of legal issues involved in inpatient psychiatric care. Topics include hospital admission, informed consent, confidentiality, subpoenas, special considerations with suicidal and homicidal patients, legal issues involving involuntary administration of medication, and seclusion and restraint. Some of the details in this chapter are specific to the law in the state of California. The principles discussed, however, apply across states; most states have laws that address these issues. Practitioners should be aware of local laws because many of the legal principles discussed in this chapter vary state by state.

Admission

In the past, mentally ill patients had few rights. Patients were committed to mental hospitals by psychiatrists on the advice of families. Even when legal rights were recognized in theory, the problems patients had in legal representation in the absence of public defenders to handle such cases often made the theories hollow. Psychiatrists generally are most concerned with patient welfare or doing what is in the best interests of the patient. However, in recent decades the law has been less concerned with patient welfare and more concerned with balancing the patient's autonomy (civil liberties) with public safety. To the dismay of psychiatrists and families, patient welfare receded into the background in terms of justifying involuntary hospitalization.[1]

Two current theoretic concepts provide the state with justification for involuntary admission: police power and *parens patriae*. The principle of police power dictates that an individual's freedom may be restricted when he is deemed to be an acute danger to himself or others. *Parens patriae* (doing what is best for a patient much like a parent might do) is in conflict with the patient's right to autonomy. *Parens patriae* comes into play though only when the patient lacks competence to make his or her own decisions. In the past when psychiatrists had more authority to do whatever they thought best, they often ignored patients' autonomy and ordinary right to make their own decisions even if not the best ones. Concern for public safety and reluctance to take risks led psychiatrists to hospitalize patients for lengthy periods. Because of this, courts and legislation have had to balance these conflicting considerations. Many psychiatrists believe that the pendulum has swung too far in the direction of patients' rights as opposed to patient welfare. In many circumstances, a cumbersome legal bureaucracy more often interferes with treatment than provides meaningful patient protection. It can be unnecessarily wasteful of psychiatric and judicial time.[1] Often there are lengthy legal proceedings over a few extra days' hospitalization.

Case Vignette

Mr. A was a 45-year-old homeless man with a history of schizophrenia. He was brought to the emergency room by local police after they responded to a disturbance call. When the police encountered Mr. A, he was found walking in a residential area, breaking car windshields with a baseball bat and yelling "Jesus is Lord, savor his sword." A citizen attempted to intervene, and Mr. A postured aggressively threatening to kill him if he did not back away. When police arrived Mr. A did not respond to verbal redirection and swung his bat at officers. In the emergency room, psychiatric evaluation revealed a markedly tangential thought process and psychomotor agitation. The patient was clearly responding to internal stimuli. He had a record of multiple previous similar presentations to mental health facilities. He refused voluntary admission, and was, therefore, admitted to the inpatient unit as a danger to others.

In this case, Mr. A's involuntary admission was based on the psychiatrist's diagnosis of an active mental illness (in this case, a psychotic disorder) as well as danger to others. The patient's threatening behavior in the field was used as evidence. By using "danger to others" to justify Mr. A's admission and subsequent hold and evaluation period, the psychiatrist invoked the principle of police power. In this case police were actually involved, but the principle of police power may be invoked in the absence of involvement of law enforcement. Mental health professionals who are certified by the state to hospitalize patients involuntarily have the explicit legal power to deem a patient a danger to self or others and therefore place the patient on an involuntary hold using the concept of police power in some jurisdictions. In others after a short period of detainment the psychiatrist must apply to the court for civil commitment.

Case Vignette

Mr. B was a 47-year-old man with a history of bipolar disorder brought into the emergency room by his brother for recent worsening of manic symptoms. His brother stated that he found the patient wandering on the streets after days of looking for him; he had been missing for more than a week. The patient had stopped taking his lithium 2 weeks earlier. The patient appeared disheveled and was malodorous. On examination, Mr. B demonstrated pressured speech, grandiosity, and flight of ideas. He was able to attend, was alert and oriented four times, and clearly denied suicidal and homicidal ideation. When asked about plans to provide for his own food, clothing, and shelter, the patient replied, "A man, a plan, a canal, panama, palindromes, palindromes, motherfucker, what!" After repeated questioning the patient was still unable to provide a logical plan should he leave the emergency room. His brother said that he was unable to care for the patient in his current condition. The patient refused to consent to admission and was therefore admitted to the inpatient unit on the grounds of inability to care for himself. In states such as California such inability to provide for basic needs is called *grave disability*.

In this case, Mr. B was clearly not deemed to be a threat to himself or others and therefore police power could not be used to justify involuntary admission. The legal principle behind this admission

is *parens patriae*. The principle of *parens patriae* (literally "father of the country"), like that of police power can outweigh a patient's right to freedom. In contrast to police power, this principle emphasizes the paternalistic duty of the state; that is, the state at times can deem that a patient is not able to provide for his or her own basic needs due to a mental illness and, by means of detention, can provide for the individual. In this situation, the patient is deemed to be negligent toward himself or herself rather than an active threat.

When a patient is deemed to be a danger to himself or herself, a danger to others, or unable to provide for himself or herself because of a mental illness, then the patient meets criteria for involuntary admission to a psychiatric unit. Because the US Supreme Court determined that "clear and convincing" is the minimum standard for civil commitment the burden of proof in some jurisdictions can be as high as "beyond a reasonable doubt,"[2] but it must now be at least "clear and convincing."[3,4] The patient ordinarily should first be offered a voluntary hospitalization. In some states such as California there is a system other than civil commitment in which the patient is not held as a result of a judicial order. Instead the patient is hospitalized by means of a hold instituted by a mental health professional, and the patient files a writ of *habeas corpus* to the court to be released. It is unclear what standard of proof applies under this framework, but it often is treated as if the standard is one of a preponderance of the evidence. It therefore is very important to know the specific jurisdiction and its laws.

In some states such as California, courts do not care whether a patient has the capacity to consent to even psychotropic medication so long as the patient consents. Expediency trumps common sense here because incompetent consents in reality are meaningless. However, there is legal precedent for finding against the hospital. In Florida, a patient was voluntarily admitted after consenting to hospitalization while actively psychotic, thinking he was signing into heaven, and lacking the decision-making capacity to agree to this hospitalization.[5] This Florida case decided by the US Supreme Court was based on a Florida statute requiring that a patient being voluntarily admitted be competent to consent to hospitalization and treatment. The Court found that the hospital had deprived the patient of the due process that an involuntary hospitalization legal proceeding would provide. In most states a judge would be petitioned early in the process to continue to hold, evaluate, and treat the patient. If the judge gives such an order for continuing assessment and treatment, then the process is known as *civil commitment*. In other states like California, physicians place the patient on a continuing hold after the initial assessment and treatment, and the patient has a right to go to court for a writ of *habeas corpus* to be released. In some states a guardian *ad litem* is appointed to make decisions on the patient's behalf.

On inpatient medical and surgical wards, a patient may be deemed to lack decision-making capacity with regard to consenting to medical treatment. Procedures are more informal in some states, such as California, with courts encouraging doctors and family to work out what is best. Courts may need to be involved only in cases of conflict. A surrogate decision maker should be identified. Ordinarily, this is the closest relative or the person who is designated previously by the patient in an advance directive. Ideally, the surrogate decision maker should be familiar with the patient's general wishes and be able to exercise substituted judgment on the patient's behalf (what the patient would have decided if competent). If that is not known, then doing what is thought to be in the patient's best interest is the next best standard. If no such surrogate can be found then physicians may petition the court to act as the patient's temporary surrogate or, in circumstances when this is not immediately practical, may form a consensus amongst a team of physicians to act temporarily on behalf of the patient until a surrogate decision maker can be assigned. In an emergency, it generally is advisable if at all possible to have two physicians agree with the planned emergency medical treatment.

If a patient is admitted voluntarily to a psychiatric ward for treatment, this technically means that the patient may leave the psychiatric ward at any time unless the patient meets the criteria for involuntary hospitalization and can be detained. Should the patient request immediate discharge while admitted on a voluntary basis, a psychiatrist should evaluate the patient within a reasonable amount of time. That time is defined in some jurisdictions by statute. If the evaluation reveals that the patient meets criteria for involuntary hospitalization, then the patient may be placed on a hold at this time or a petition filed for civil commitment. However, if the patient no longer meets

criteria for hospitalization, then the patient cannot be kept against his or her will on the psychiatric unit. Some jurisdictions think such "involuntary" voluntary hospitalizations deprive patients of their rights to a judicial review and prefer patients who would not be allowed to leave be hospitalized involuntarily even if they are willing to be hospitalized. Because jurisdictions differ in the details about these procedures, the clinician must be familiar with the details of the local laws. Some policies may even differ between counties in the same state about procedures not specifically addressed in state law.

Treatment against the Patient's Will

In some states, including California, Massachusetts, Illinois, and New York, detaining a patient involuntarily for assessment and treatment does not automatically authorize involuntary treatment with psychotropic medication. This can often cause a dilemma for psychiatrists, nurses, and the ward milieu because many patients are hospitalized precisely because their behavior is felt to be grossly dangerous or out of control. Therefore, in these jurisdictions, a patient hospitalized because the need for treatment of mental illness was felt to trump the right to freedom under current civil law nonetheless cannot receive involuntary psychotropic medication absent an emergency.[6] In such states, in cases of medication refusal, a separate legal proceeding determines whether the patient lacks the capacity to refuse psychotropic medication.

In states with this requirement, involuntary treatment is allowed temporarily when there is clear evidence that a patient poses imminent danger to himself or herself or to others and there is an acute emergency. Frequent examples include agitated psychotic or manic patients and self-harm behaviors or suicide attempts in patients hospitalized for depression, mania, psychosis, or personality disorders. Involuntary psychotropic medication can be administered in the absence of an acute danger after the required legal proceeding. In many other states involuntary hospitalization automatically authorizes all psychiatric treatment against the patient's wishes, even psychotropic medication. Some states, though, have separate procedures for electroconvulsive therapy (ECT).

Often, problems with patient refusal of medication can be avoided by strictly following the principle of informed consent. This topic will be discussed in more detail later; briefly, informed consent for medication refers to full disclosure of a medication's risks, benefits, side effects, and alternatives. The informed consent process is a dialogue in which the psychiatrist discusses medication choice with the patient. Especially when patients are held in the hospital against their will, it is important to convey an air of cooperation. If the psychiatrist focuses on strengthening the therapeutic alliance and engages the patient fully in the informed consent process, the likelihood of medication adherence is higher. If the patient experiences side effects or otherwise does not tolerate or wish to continue with the medication, the patient is more likely to try other medications or engage in dialogue if there is a strong therapeutic alliance. Voluntary acceptance of medication usually is best regardless of the legal ability to administer it involuntarily. It also obviates the need for additional legal proceedings, which may be necessary when patients refuse. It also is more likely to result in patient compliance after discharge.

When a patient refuses treatment it is important to understand why the patient is refusing. Often, a severely ill patient refuses medication for a legitimate reason, such as a bothersome side effect. Assuming that patients are refusing medication because of psychosis or lack of insight is a common error in inpatient practice. It is important to attempt a dialogue with the patient so as to understand the reasons for refusal. The patient may have legitimate concerns about side effects of a specific medicine, such as weight gain. Often the concern can be accommodated by using a medicine low in the specific side effect that bothers the patient.

If the patient is unable or unwilling to participate in the initial informed consent process or later in the treatment course decides to stop complying, the psychiatrist must carefully evaluate the clinical picture in order to decide how to proceed. In such circumstances, informed consent must be obtained at a later time if the patient regains the capacity to give informed consent. Psychiatrists may forget to do this.

Case Vignette

Ms. C was a 42-year-old woman with borderline personality disorder and multiple somatoform disorders who had been admitted 3 days earlier on a hold for danger to self after she had attempted suicide by cutting superficially on her wrists and taking 10 pills of sertraline 100 mg. She was monitored briefly in the emergency room and had no significant medical sequelae of her overdose. Her wrists were treated with Neosporin and gauze bandages. Ms. C was well known to the hospital and the treating psychiatrist; this was her fourth hospitalization in the last 6 weeks. She had many episodes of low-risk self-injurious behavior. She reported having tried to hurt herself because her therapist recently left on vacation. She had failed multiple selective serotonin reuptake inhibitor (SSRI) trials and after detailed discussion about possible medication trials she was agreeable to starting a low-dose antipsychotic. After 2 days on this medicine, the patient refused to continue taking it. She complained of headache, stomach upset, and worsening of irritable bowel syndrome symptoms. Recommendations to wait through the side effects or try a new medicine were refused. She was able to explain the risks of refusing psychotropic treatment including decompensation and death. She denied current suicidal ideation, had been calm and cooperative on the ward, and demanded discharge. Her hold for involuntary hospitalization was to expire later in the day. She no longer met the legal criteria for involuntary hospitalization and appeared to have the capacity to consent to or refuse psychotropic medication.

Case Vignette

Mr. B, the manic patient described earlier, had been admitted to the ward on a hold for grave disability. His lithium was restarted in combination with an atypical antipsychotic. After 3 days he was sleeping more and was less hyperactive, but he remained manic and psychotic. He had also been placed on an additional 14-day hold as he remained gravely disabled and was unwilling to stay in the hospital. On hospital day 4 he refused lithium and the antipsychotic. Asked why he was refusing the medication, the patient began hopping on one foot and recited, "Able was I, ere I saw Elba" in falsetto. He was considered at high risk for elopement.

The above-discussed vignettes present some common therapeutic dilemmas faced by inpatient psychiatrists. In both vignettes, the patients are refusing medication and wish to leave the hospital. For Ms. C, discharge and more comprehensive outpatient treatment planning may best suit the patient's interests. It is unlikely that a petition to the court for involuntary medication will be successful as the patient demonstrated decision-making capacity. Additionally, even if the court did grant the petition, the patient would be unlikely to remain compliant once an outpatient. Moreover, the patient appears no longer to meet the criteria for involuntary hospitalization.

With Mr. B, the psychiatrists are confronted with a patient who is manic and psychotic and is now refusing medication. He does not demonstrate decision-making capacity and continues to remain gravely disabled. The patient should continue to be offered routine medication. If he continues to

refuse treatment, this should be documented along with his concomitant mental status. In this scenario, the treating psychiatrist in states that require this would likely petition the court in order to treat the patient with psychotropic medication against his will. If the court grants the petition then the patient may receive intramuscular injections against his will if he first refuses the offering of oral medication. Frequently, patients will take oral medicines they have previously refused once the court has found that they may be given injections against their will.

Guardianship or Conservatorship

A common clinical experience in inpatient psychiatry is the phenomenon of repeated admissions for a chronically seriously mentally ill patient, a phenomenon discussed in detail in Chapter 13. These admissions are frequently in the setting of severely limited psychosocial supports (e.g., homelessness and few friends or family) and poor medication compliance. This experience is frequently a frustrating one for health care providers. It is also typically financially burdensome for hospitals and, if many of these types of patients live in a given catchment area, can significantly tax mental health resources which are already stretched very thin in some areas.

Mr. D, a 38-year-old homeless man with schizophrenia, was hospitalized on a hold for grave disability after he was brought by police who had found him wandering through a busy intersection. He was grossly disheveled, emaciated, malodorous, and sunburned. On contact with police, he spoke illogically about Neptune, Poseidon, and the Toronto Maple Leafs. He was well known to the hospital and staff and had been hospitalized eight times over the last 12 months in this hospital alone, and a review of mental health records demonstrated multiple stays at other hospitals. During his recent hospitalizations his psychotic symptoms resolved with routine antipsychotic administration. Each time he was discharged with apparently intact reality-testing yet inevitably failed to follow up with outpatient psychiatric follow-up, stopped taking his medicines, became psychotic, and was brought in by police shortly thereafter.

In order to deal with chronically relapsing seriously mentally ill patients, states either have long-term civil commitments or have implemented systems such as a limited guardianship, guardian *ad litem*, a committee, or a mental health conservatorship. A guardian or conservator has fiduciary responsibility for the patient to make decisions regarding the patient's placement, finances, and, if approved by the court, medical decisions and psychiatric treatment decisions including psychiatric hospitalization. The patient need not consent to treatment; frequently conservatorship terms require that the conservator consent to the specific treatment on behalf of the patient. The spirit of conservatorship is to place the patient in "the least restrictive environment." Typically, however, individuals who have such a clearly demonstrable level of persistent grave disability require fairly restrictive living and treatment accommodations. Although in the past, mentally ill patients were considered incompetent for all purposes the presumption generally now is that they are competent for most civil purposes unless specifically adjudicated to be incompetent for a specific purpose.

Court hearings can be part of the process for conservatorships, writs of *habeas corpus*, guardianships, and conservatorships. Hearings in the psychiatric ward as well as hearings in a courthouse proper can seriously disturb the doctor–patient relationship. Inpatient psychiatrists and inpatient staff should be familiar with not only the logistics of conservatorship procedures but also the collateral psychological toll it can take on patients and, secondarily, the ward milieu.

Dementing illnesses in the elderly are not considered serious mental illnesses in some jurisdictions in the same vein as schizophrenia and bipolar disorder. For individuals who are gravely disabled or unable to care for themselves by virtue of a dementia, inpatient psychiatrists in some states must pursue probate conservatorship of the person and/or estate. In some states, including California, this form of conservatorship helps with discharge planning as severely demented patients can be placed in more appropriate locked units and can also provide the patient's family (if applicable) with the ability to manage the patient's estate. This is especially relevant if psychiatric treatment is not in question because in California probate conservators cannot place the patient in a mental hospital, but they can place patients in other facilities including locked ones. Some states use terms such as *limited guardianships* or *committees*.

Suicide Risk Management

Suicide is the number one cause of malpractice lawsuits against psychiatrists. Of the approximately 30,000 suicides annually in the United States, some 5% to 6% occur in the hospital.[7] There are examples of hospitals being found liable when patients complete suicide on psychiatric wards,[8] patients suffer harm after eloping from the ward,[9] and patients commit suicide after alleged negligent release.[10] Inpatient suicides usually occur within the first week of admission.[11] In addition, suicide is more common during shift changes and in the days and weeks following discharge.[12] Liability is based on the suicide being foreseeable. When a suicidal patient has been hospitalized, whether on a voluntary or involuntary basis, the hospital and staff have been put on notice and have a duty, greater than with outpatients, to take reasonable steps to protect such an inpatient from self-harm. The performance of the attending clinician, inpatient staff, and hospital may be at issue; most common are the failure to assess risk properly or, having assessed the risk, failure to take proper protective action, such as failure to implement the appropriate level of supervision and monitoring based on the risk assessment.[13] In addition, liability may be incurred through failure to plan and implement appropriate treatment interventions, premature discharge, and failure to arrange for appropriate outpatient treatment, including level of care (e.g., partial hospitalization, intensive outpatient treatment, or traditional outpatient treatment).

Increased risk for inpatient suicide has been associated with a history of suicide attempt[14] as well as mood disorders, family history of psychiatric illness, and documentation of suicide risk in the medical record.[15] Simon and Gutheil,[16] in a review of 100 cases of suicide in litigation, identified a recurrent pattern of characteristics of suicide victims: hard-working, middle-management, family men between the ages of 30 and 50; in their first psychiatric hospitalization; suffering from a major depressive episode, single, severe, with melancholic features and psychotic features; with prominent anxiety or agitation; hopeless; withdrawn and detached from relationships; with no therapeutic alliance; denying psychiatric illness; denying current suicidal ideation, intent, plan, or attempt; poor adherence to treatment; avoidance of activities; pressing for discharge; unable to work or perceived threat to job; ready access to guns; and with financial constraints to treatment. (See also, chapter 2.)

Each state has laws regarding the involuntary hospitalization and treatment of suicidal patients. When a suicidal patient is unwilling to remain in the hospital on a voluntary basis, the available legal interventions should be utilized as appropriate. In situations of uncertainty, erring on the side of safety as part of a good-faith effort to protect the patient is advisable. The trier of fact, such as a judge, will make the ultimate determination of whether there are adequate grounds to maintain involuntary hospitalization. Furthermore, the trier of fact has immunity from lawsuits, while the clinician may not. In many states there can be immunity for the discharge itself and for the acts of the patient after discharge if the patient is released by a psychiatrist from involuntary hospitalization. These laws were adopted to encourage release from involuntary hospitalization, but there may be exceptions to this immunity or other theories of liability. Also, such immunity does not extend to acts such as suicide committed while in the hospital, to voluntary patients, or in many states to patients released by clinicians other than a psychiatrist.

Since 1995, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has compiled statistics on "sentinel" (i.e., serious adverse) events, including inpatient suicides.[17] As of September 30, 2007, JCAHO had reviewed 4,693 sentinel events reported by its accredited organizations; inpatient suicide was the second most common type of sentinel event, comprising 12.2% of

the total. Root cause analysis of the inpatient suicides most commonly identified problems with "assessment," followed by "environmental safety/security." Environmental safety and security are almost automatically implicated in the event of a successful suicide: for example, if a patient has committed suicide by hanging, the most common means of inpatient suicide, then the utilized feature of the environment (e.g., bathroom grab bar, door knob, etc.) becomes a root cause. In recent years, there has been an increasing focus on implementing safety features in inpatient units, such as utilizing breakaway shower rods, recessed shower heads, concealed pipes, small mesh-covered ventilation, piano-type door hinges, unbreakable mirrors and glass, and windows that cannot be opened. However, no hospital can be made suicide-proof and relying entirely on the environment to prevent suicide is folly.[12] Although a hospital is expected to make the environment reasonably safe, determined patients can be inventive and a completed suicide often reveals a new environmental hazard, resulting in additional modification of the environment. Nevertheless, such modifications do make the means of suicide less readily available. Similarly, it is generally prudent to remove belts, bras, shoelaces, and sharps and to maintain a strict contraband policy; control and count utensils and razors; detect "cheeking" and hoarding of pills; and keep cleaning solutions locked away from suicidal patients. A guiding principle should be the balancing of suicide risk and related precautions with patient dignity and autonomy.[18]

Of greater importance in the prevention of suicide are the appropriate assessment of suicide risk and the determination and implementation of an appropriate treatment plan, all of which must be documented in the medical record. The clinical risk assessment is based on the history; a timely and complete psychiatric examination; observations; and collateral information obtained from family and friends; as well as available previous records, such as faxed discharge summaries. Treatment team meetings on a regular and as-needed basis provide an opportunity to bring together data from multiple vantage points, thereby assisting in the accurate assessment of risk. As noted by Simon,[12] suicide risk assessment is an ongoing process, not an event, and should be done on admission, at discharge, and at significant clinical junctures, such as changes in levels of suicide precautions. As patients generally improve gradually, sudden improvement may be feigned in order to obtain discharge or may reflect a decision to commit suicide.[12] Risk factors for suicide, as well as protective factors against suicide, are identified and an assessment of risk is made.[19] On the basis of this assessment, a treatment plan is devised with the goal of reducing dynamic risk factors and mobilizing protective factors, thereby reducing the overall immediate risk of suicide. A suicide prevention contract should not be relied upon as a means to reduce risk. Treatment interventions, along with appropriate level of supervision, are the mainstay of reducing suicide risk.[12] The inpatient hospital provides an intensive evaluation and therapeutic milieu with around-the-clock management that can quickly implement treatment.[20] An important function of the inpatient hospitalization of the suicidal patient is stabilization and return to the independent functioning required for outpatient treatment. Important goals are improved autonomy, efficacy, and self-control.[20]

Appropriate supervision and monitoring is based on the suicide risk assessment and may include, in increasing intensity, nursing checks every 15 minutes, continuous line-of-sight observation, 1:1 observation at arm's length, and four-point hard leather restraints. As with environmental safety, monitoring alone cannot be relied upon to prevent inpatient suicide, and determined patients have successfully committed suicide on 1:1 observation. In a study of 76 inpatient suicides, 9% were on 1:1 observation or with a staff member at the time. In addition, 1:1 observation causes loss of privacy, and may result in embarrassment, humiliation, increased hopelessness, and elevated suicide risk.[12] Furthermore, maintaining patient control by overutilizing suicide precautions, such as placing a patient on long-term 1:1 observation or keeping a patient in continuous physical restraints, would be countertherapeutic, promoting regression, dependence, and lack of self-control. Therefore, treatment of short-term risk factors and the underlying psychiatric disorder are crucial in reducing suicide risk and preventing suicide. In addition to treating the underlying mood or psychotic disorder, aggressive targeted treatment of anxiety, panic, agitation, and insomnia is very important. Detoxification from alcohol and drugs of dependence is similarly very important. A period of observation off individual safety precautions before discharge is prudent. When a voluntary patient requests a discharge against medical advice (AMA), a risk assessment should be performed, with involuntary hospitalization considered as appropriate. AMA discharges should be accompanied by documentation of discussion with the patient of the risks of discharge and the benefits of hospitalization and an assessment of the patient's capacity and understanding.[21] Before the discharge of a suicidal patient, verified removal of firearms by family members is important.[18]

In the present managed care environment, it is common for inpatient psychiatrists to feel pressured to discharge suicidal patients at the behest of insurance companies. Insurers will often initiate physician to physician review of the medical necessithy of the current hospitalization. At times they will deny payment of further hospitalization because MDs employed by insurance companies will declare that patients no longer meet criteria for inpatient hospitalization. This trend has resulted in much shorter inpatient stays than it was 20 or even 10 years ago. It is important for clinicians to trust their own judgment and to make appropriate treatment decisions even when these decisions run contrary to the insurance companies' requests or threats of nonpayment. In the management of the suicidal patient, if the inpatient physician believes that a patient remains suicidal and a significant threat to himself or herself, then the physician should allow his or her own medical and ethical judgment to trump the financially motivated judgment of the insurer. This may result in the provision of services that the insurer does not cover. However, it would be the best patient-care choice, and a money-saver in the event of a suicide and subsequent law suit.

Violence Risk Management

Violence or the potential for violence due to a mental disorder may be the basis for an inpatient hospitalization. As with suicidal patients, a clinical risk assessment for violence must be made based on all sources of information that are reasonably obtainable. Treatment interventions geared toward reducing risk of violence should be implemented including an appropriate level of supervision and monitoring. While maintaining immediate safety, an appropriate diagnostic assessment must be made such that treatment of the underlying disorder may be accomplished, thereby reducing violence risk. Several instruments have been developed that may aid in inpatient violence risk assessment.[22,23] Many risk factors for inpatient violence have been postulated including anger regulation problems, interpersonal style, disturbed mental state,[24] and earlier onset of illness.[25] Additionally, long-term hospitalizations, diagnoses of borderline personality disorder or antisocial personality disorder, frequent medication changes, use of multiple sedating medications, and a past history of violence all seem to correlate positively with risk of violence on the inpatient unit.[26]

The initial interview is an important time to gather information about risk factors for violence. In addition to standard static and dynamic risk factors, interviewers should pay attention to the quality of the therapeutic alliance in the interview. A poor therapeutic alliance during the initial interview is a predictor of violence during that stay.[27] Another group found that hostility during the initial assessment is a predictor of verbal aggression but not necessarily physical violence.[28]

While waiting for treatment to reduce the severity of the psychiatric disorder, use of sedative medication, seclusion, or restraint may be effective interventions to reduce the potential for violence and injury to the patient and staff. The environment must be reasonably safe and free of obvious potential weapons; contraband must be identified and removed. (See also, chapter 12.)

Hospitalization of the potentially violent patient serves to protect intended victims, although notification of intended victims may be advisable legally or clinically, or in rare instances required by the jurisdiction. Involuntary hospitalization may be required; the laws vary by jurisdiction and should be known to the inpatient psychiatrist. Probable cause is a common legal standard. In situations of uncertainty, erring on the side of safety to prevent harm is preferable, and the trier of fact will determine whether the patient may be held against his will. Failure to assess the risk of violence appropriately or failure to intervene when there is high risk may result in liability for the hospital and staff. Premature discharge or failure to make appropriate postdischarge plans may be additional sources of liability.[29,30] However, practitioners should note that a history of inpatient psychiatric hospitalization does not raise an individual's risk for violent behavior above that of the general public.[31] Violent patients may have criminal records, be on parole or probation, or even have a warrant for their arrest. Patient confidentiality precludes contacting law enforcement unless the jurisdiction has a Tarasoff-type requirement that is best satisfied in a particular case by contacting law enforcement.[32–34] This requirement is in reference to the landmark *Tarasoff* case, which ultimately established a duty for psychotherapists to take reasonable steps to protect third parties in cases in which the therapist deems the patient an immediate and realistic threat to that person.

"Duty to protect" has been interpreted differently in different jurisdictions, although practitioners frequently erroneously refer to the *Tarasoff* decisions as creating a "duty to warn." Most states including

California allow for alternative protective options to a "Tarasoff warning." Not all jurisdictions have Tarasoff-type obligations. The inpatient psychiatrist has no duty to report violent crimes previously committed by a patient; indeed, to do so would be a violation of confidentiality. Reporting a past crime is not a legal requirement. There is no ethical or legal rationale to report such a patient solely for punishment and not to prevent future violence. Although controversial and generally involving situations of double agentry in which the patient's and the hospital's interests conflict, many practitioners believe law enforcement may be contacted to report an act of intentional violence on the inpatient unit. These usually involve situations that result in patient or staff injury and which is not the result of paranoia or delusion caused by a mental disorder; typically, such acts are done by patients with antisocial traits.

Mr. E was a 24-year-old man with a history of opiate dependence who was admitted to the inpatient psychiatric ward voluntarily for opiate detoxification. Given his history of multiple failed detoxifications, drug use in prison, and having a friend bring him contraband heroin while detoxing in the past, he was thoroughly searched. A male staff member examined the patient while he was disrobed and went through his belongings to ensure that there was no contraband. He had intermittent symptoms of withdrawal in the first few days of admission and at times appeared lethargic with pinpoint pupils and absent withdrawal symptoms. On hospital day 7, he was found in the bathroom shooting up heroin. On detailed questioning, the patient revealed that he had smuggled a minute amount of heroin in with him by taping a small plastic bag to his scrotum which went undetected during the search.

In addition to preventing violence and suicide, inpatient wards are also charged with protecting patients from their own and other patients' impulsive behavior. For instance, manic patients are frequently sexually preoccupied and may seek sexual activity with patient peers, staff, or physicians. Ward staff and clinicians should monitor this type of behavior and make reasonable attempts to preclude this activity. Frequent verbal redirection may be necessary at times. Ideally, coed wards are structured such that men and women are housed in mutually inaccessible hallways, meeting only in common areas, but psychiatric units are often not so designed. Ward staff should be generally vigilant and should specifically closely monitor any patient who may pose a risk of sexual assault or other sexual misbehavior. Ward staff should also not overlook the possibility of impulsive same-sex sexual activity. Hospitals may be liable if they are found negligent in cases of transmission of sexually transmitted diseases or unintended pregnancy that result from such behavior.

Clinicians who are ultimately found liable are liable not for making the "wrong" decision but rather for failing to demonstrate and document a careful consideration and evaluation of clinical data justifying their decision within the standard of care, that is, negligence. Documentation of an adequate risk assessment is generally sufficient to demonstrate that this evaluation has taken place. In especially high-risk cases, clinicians are encouraged to obtain consultation from a colleague, preferably one with significant experience and expertise with the disorders at hand. Thorough documentation and consultation are the most important steps that clinicians can take in limiting their own liability in high-risk inpatient psychiatric cases.

Informed Consent

In the past, the patient–doctor relationship was seen primarily as paternalistic, with physicians prescribing or performing procedures as they saw fit for the patient. It actually was not until the end of the 19th century that consent was required. After the severe abuses of medicine by the Nazis and the Nuremberg trials, the doctrine of informed consent developed. At first, the standard was the

malpractice standard: what other physicians were doing. In the 1970s this changed to a "reasonable man" standard. In *Cobbs v. Grant*[35] and *Canterbury v. Spence*,[36] courts decided physicians needed to provide the information that a reasonable patient would want to know to make an informed decision. The current standard is referred to as a *reasonable patient* standard. Ideally the information a specific patient would want to know should be provided, but because of the difficulty in determining this, the minimum standard is to provide the information a reasonable patient would consider material.

The conceptualization of the patient–doctor relationship has evolved into a more collaborative one, with patients having more input into their treatment based on personal preferences. Emphasis on informed consent has been key to the evolution of the patient–doctor relationship.

The burden is on the physician to ensure that informed consent is obtained before initiating a treatment course for a medical disorder. This should be documented in the chart. Many inpatient facilities have a patient sign a sheet that details the risks, benefits, and potential side effects of and alternatives to individual treatment modalities. However, because most patients do not read a consent form carefully or retain much of what is in it, a meaningful discussion of the risks and benefits is the crucial element in informed consent. Written informed consent forms are helpful but do not themselves demonstrate true informed consent.

Informed consent is made up of three elements: information, voluntariness, and competency. First, the patient must be clearly informed of risks, benefits, and potential side effects of and alternatives to a particular treatment recommended by the physician. Patients need not be informed of every possible adverse outcome or every possible treatment alternative, but they should be made privy to potential side effects and alternatives that a "reasonable patient" would want to know. Frequency of occurrence and seriousness are important considerations in determining what should be discussed.

Some physicians are concerned that detailed discussion of potential adverse outcomes of a recommended treatment may discourage patients from accepting it. However, patients who feel that they are fully informed develop more trust in their physicians and are more willing to accept treatment recommendations even with full explication of potential side effects or complications. Many malpractice cases rest on the plaintiffs' arguing that they suffered a significant injury that they did not foresee because the physician did not explain the potential for this adverse outcome. This is to say that a procedure or medication was administered without fully informed consent.

A second component of informed consent is voluntariness. In order for a patient to provide informed consent, he or she must be willing to undergo the recommended treatment course free of coercion. Voluntary psychiatric patients should give informed consent to treatment including medication. However, in some states, including California, there generally is no concern that consent to psychiatric treatment be competent. The only concern is that the relevant information be provided and that the patient consent whether or not it is a competent consent. Some counties in California do prefer that the consent to hospitalization be competent and the patient otherwise be held involuntarily such that their legal rights are protected. Other California counties want patients who are incompetent to consent to treatment to be nonetheless allowed to sign in voluntarily just so long as they consent. Some states, including Florida, require that the consent to both hospitalization and treatment be competent. It is essential to know the law and interpretation of the law not only in your state but sometimes in your specific county.

The third component of informed consent is competency. Competency is a legal term, so commonly in psychiatric practice the concept of decision-making capacity is used instead. However, so long as it is clarified that a psychiatrist's opinion about a patient's competence or lack of it does not make the patient legally competent or incompetent, it is possible to refer to the psychiatrist's opinion about a patient's competence to make treatment decisions. Psychiatrists should evaluate individual patients for decision-making capacity by assessing the patient's capacity to weigh the risks and benefits of a specific procedure. This means that the psychiatrist decides whether the patient has an ability to understand his or her diagnosis, why the treatment is being recommended, and the potential risks, benefits, and side effects of and alternatives to the treatment. The patient should also have an appropriate understanding of the potential consequences of declining the treatment.

In addition to understanding, the term *appreciate* is generally used in assessing decision-making capacity. Appreciate includes a broader affective understanding than pure cognitive understanding. Although the term *appreciate* may ultimately need to be assessed in cognitive terms, it still is a useful

term to clarify that more than a simplistic cognitive understanding may be necessary for decision-making capacity in some contexts. The ability to reason is also necessary in reaching a competent decision in some contexts. Decision-making capacity is evaluated during a specific time for a specific treatment. For example, if a patient is deemed not to possess the capacity to make a decision about complex surgery, this does not mean that he or she lacks decision-making capacity to accept or decline a less complex medical treatment or psychotropic medication. In other words, the determination of decision-making capacity must be performed individually for different components of the patient's treatment. In some jurisdictions such as California, Massachusetts, and New York, in order to treat patients with psychotropic medicines against their will, as discussed earlier, the patient must be found to lack competence to give informed consent in some type of legal procedure.

Exceptions to informed consent also exist. There are times in treatment when the need for immediate treatment trumps the individual's right to autonomy and the patient need not be fully informed. In the concept of therapeutic privilege, the potential side effects of a medicine may not be volunteered to a patient who is too agitated and psychotic to understand and weigh the risks and benefits of a medicine or procedure. This privilege for the physician must be used cautiously. Patients even if mentally ill are presumed to have a right to give or withhold informed consent to treatment. Material information for a decision cannot be withheld just because a patient might refuse. Additionally, there is an obligation to discuss this with a patient as soon as the patient regains capacity to weigh the risks and benefits. Often physicians fail to do this, or doctors may change. Psychiatrists risk liability in such circumstances for failure to obtain informed consent when the patient becomes competent to give informed consent.

On the inpatient ward, agitated patients who are at immediate risk for harm to themselves or others should be treated in an emergency with psychotropic medication for their agitation regardless of consent. Sometimes, though, involuntary treatment can be avoided by redirection to a quiet area for decreased stimulation. Sometimes in emergencies, there can be a takedown with seclusion and restraints often thought by the law to be less intrusive than psychotropic medication because it is not mind altering, although most clinicians see things differently. In these emergency situations, consent need not be obtained, although there are frequently guidelines and regulations pertaining to more restrictive measures such as seclusion and restraint.

Seclusion and Restraints

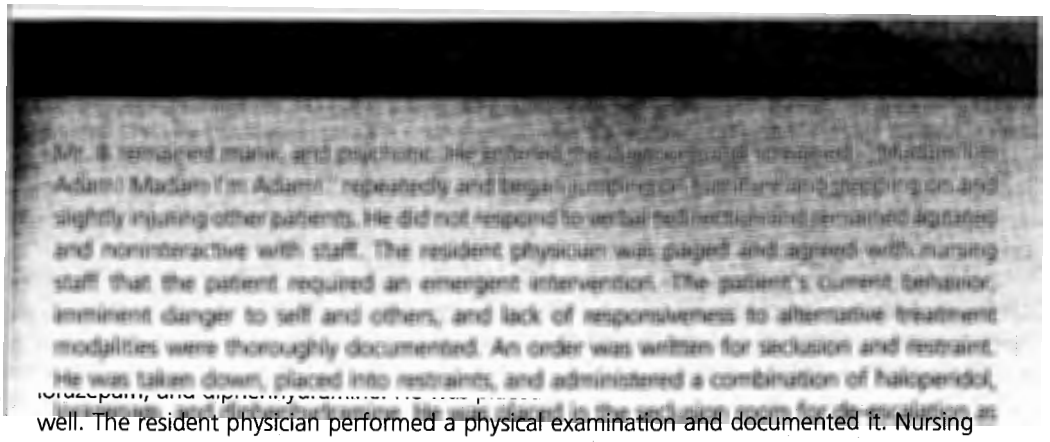
When a patient is agitated and not redirectable and there is imminent risk of harm to the patient, other patients, or staff, seclusion and restraint are sometimes employed. Consistent with contemporary focus on patient's rights, patients should be treated and their agitation best addressed with the least restrictive alternative. Seclusion and restraint should typically be used only in emergency circumstances and only when less restrictive alternatives, such as verbal redirection or sending patients to their rooms, have already been exhausted. Restraint and seclusion should never be used for punitive purposes. In prisons there often are pressures for a psychiatrist to condone seclusion, restraint, and psychotropic medication used as a punishment. Psychiatrists must resist such pressures in prisons and certainly in hospitals. These interventions play an important role in the management of the agitated patient as well as in decreasing stimulation in the ward milieu.

State and local statutes vary in regard to definitions of seclusion and restraints, documentation and monitoring requirements, and indications and contraindications. Practitioners are advised to be familiar with the requirements of their local jurisdiction regarding administration of seclusion and restraints.

The Joint Commission mandates that institutions have their own policies in place governing patient assessment and monitoring, type of restraints used, length and frequency of restraint or seclusion use, and physician orders and nursing documentation. Staff and physicians should copiously document the clinical justification for using seclusion or restraints, including the failure of less restrictive alternatives. Patients should regularly be monitored by physicians and nursing staff to ensure that they remain medically stable; morbidities associated with restraints include circulatory obstruction if restraints are administered too tightly, aspiration if the patient is kept horizontal, and respiratory suppression depending on which medicines were administered. Frequent monitoring assists in providing good patient care and also limits institutional liability exposure in this area.

Physicians are required to write an order for restraint or seclusion before the patient being secluded or restrained or immediately thereafter in emergencies. Additionally, the physician must evaluate the patient within a reasonable amount of time of entering seclusion or restraint to ensure patient safety. States may specify these time limitations. If patients are going to be placed in restraint, they should typically be medicated first. The medicine should be administered by mouth if the patient is willing or intramuscularly while the patient is restrained if the patient is uncooperative. Medicines are administered primarily to decrease agitation. Additionally, sedating medicines may be helpful in preventing the patient from fighting against restraints and thereby reduce risk of harm to self or others.

Keep in mind that there are exceptions to this general rule. For example, if neuroleptic malignant syndrome (NMS) is suspected to play a role in the agitation of a delirious patient then neuroleptics should not be administered in the course of placing the patient in seclusion or restraints. If the patient has an elevated creatine kinase (CK) in the setting of possible NMS, restraint may be relatively contraindicated as it could result in further CK elevations if the patient struggles. Additionally if delirium of unclear etiology is suspected to play a role in the agitation then benzodiazepines should be withheld as they have a propensity to exacerbate delirium.



well. The resident physician performed a physical examination and documented it. Nursing staff frequently monitored the patient to ensure his safety. After a few hours, he was allowed out of restraint and seclusion and interacted appropriately with staff and other patients.

Confidentiality

Patients admitted to a psychiatric ward have a right to confidentiality. On admission, patients should sign a release of health information form listing all parties to whom they permit the release of information regarding their health and admission. Absent such a release, under typical circumstances, staff and physicians should refrain from divulging any health information to any inquiring third party without the patient's permission. Indeed, employees should be trained to neither confirm nor deny even the presence of specific patients on the ward at any given time. In some jurisdictions, patient permission is needed even to contact family members and friends to get information necessary for the assessment. In most jurisdictions, involuntary hospitalization for assessment and treatment alone authorizes contacting third parties to collect necessary information.

Steps should also be taken to ensure patients' anonymity from one another. In some jurisdictions, charts may not have patients' full names visible from the outside. Identifiers such as social security numbers or medical record numbers should also not be plainly visible to patients or visitors. Many psychiatric wards have bulletin boards listing patients' names with their corresponding physician, therapist, social worker, and other support staff. Names on this list should be first name only and when patients of the same name are on the ward then the minimal additional distinguishing information should be provided.

There are exceptions to this rule of confidentiality. Some states permit breaking confidentiality to notify family of the inpatient hospitalization of their relative or to obtain information about an involuntarily hospitalized patient. Other jurisdictions, including California, require patient permission before doing this. When there is sufficient evidence that an inpatient is planning to harm another specific person, then clinicians in many jurisdictions may elect to execute their *Tarasoff* duty by informing the police or the intended victim, or both, of the specific threat including the patient's identity. In some jurisdictions, such confidentiality violations are not permitted. Confidentiality requirements also do not pertain to civil commitment proceedings, writs of *habeas corpus* from a mental hospital, or civil commitment procedures. In other words the patient need not consent to allow the physician to divulge specific clinical information at a civil commitment hearing or a hearing for a writ of *habeas corpus* for release from the hospital.

It is important to understand the difference between confidentiality and privilege. Confidentiality is an ethical requirement of the physician often reinforced by statute. Privilege is the patient's right to keep information out of a court or legal proceeding. Only a patient intentionally or by his actions can give up this privilege. The doctor cannot violate this privilege without patient permission or unless specifically ordered by a judge to do so.

It is important not to hand over records automatically in response to a subpoena. If the records are privileged, as treatment records are, the person requesting them may have no right to them without the patient's permission. It is important to check with an attorney or malpractice carrier. A subpoena means only that the person requesting the information has told a judge the information was relevant. It does not mean that the judge has considered competing privilege considerations or that the requesting person has a legal right to the information or records. Also, even in the absence of privilege, lack of relevance is a reason to keep sensitive or embarrassing information out of the courtroom. Often a treating psychiatrist may wish to enlist the help of the patient's attorney or the psychiatrist's or hospital's attorney to keep privileged or irrelevant information out of court.

A subpoena must be responded to but not necessarily by doing what is asked. There could even be liability for handing over information in response to a subpoena in violation of the patient's privilege. Psychiatrists sometimes fail to consider that the privilege is the patient's and not the doctor's. Unless specifically ordered to hand over the records by a judge after considering privilege issues, there can be liability for violating the patient's privilege. There are even greater protections for drug treatment records or reproductive counseling or reproductive health care. Care must always be taken before handing over any records without the patient's permission.

Conclusion

This chapter has aimed to cover basic legal issues that face the inpatient psychiatric clinician. Topics covered have included legalities of hospital admission, informed consent, confidentiality, subpoenas, special considerations with suicidal and homicidal patients, involuntary administration of medication, and seclusion and restraints. This chapter is not intended to be a comprehensive and exhaustive reference on each of these issues but rather a primer with basic principles of these topics. Clinicians are strongly encouraged to be cognizant of these various legal concepts as they pertain to inpatient psychiatric practice; a fundamental understanding of these concepts should aid in reduction of liability as well as more thorough and comprehensive delivery of patient care. Clinicians are also encouraged to familiarize themselves with their local and state statutes pertaining to individual aspects of inpatient psychiatry as these may significantly vary from one jurisdiction to another. Consultation with experienced practitioners, forensic psychiatrists, attorneys, and risk-management experts is often important.

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Editors

Fred Ovsiew, MD

Professor of Clinical Psychiatry and Behavioral Sciences
Feinberg School of Medicine
Northwestern University
Fellow and President
American Neuropsychiatric Association
Chicago, Illinois

Richard L. Munich, MD

Clinical Professor of Psychiatry
Weill-Cornell Medical College
Training and Supervising Analyst
Center for Psychoanalytic Training & Research
Columbia University College of Physicians & Surgeons
New York, New York


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