

“Pink Slips” and “Pink Slip” Disorders

**Practical Approaches to Behavioral Health
Emergencies**

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Outline

- Introduction to “pink slip” basics
- Identifying behavioral health emergencies and “pink slip” situations
- Forensic background and ethical implications
- Case examples
- Summary

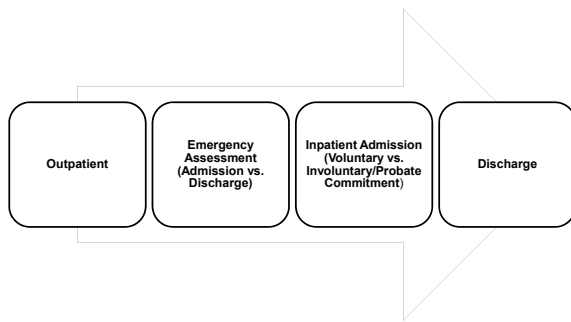
Introduction

- What are “pink slips?”
 - Nickname for Ohio’s Application for Emergency Admission form (DMHAS-0025)
 - Reflects a legal process used during a behavioral health emergency
 - Ohio Revised Code 5122
 - Facilitates conveying a patient in crisis to a hospital setting emergency examination/treatment
 - Necessary for involuntary transport or holding for examination when a patient is not consenting for treatment
 - Active during a period of emergency assessment
 - “72 hour hold”

<http://mha.ohio.gov>
Treatment → “Application for Emergency Admission”

The image shows two versions of the Ohio DMHAS-0025 Application for Emergency Admission form. The left version is a scanned document with text and checkboxes, and the right version is a blank form with a grid for notes.

Emergency Admission Process



Who can use Ohio's form?

- Psychiatrist
- Licensed Physician
 - Includes residents
- Licensed Clinical Psychologist
- CNS (psychiatry/mental health, ANCC certified)
- CNP (psychiatric mental health NP, ANCC certified)
- Health officer
- Parole officer
- Police officer
- Sheriff

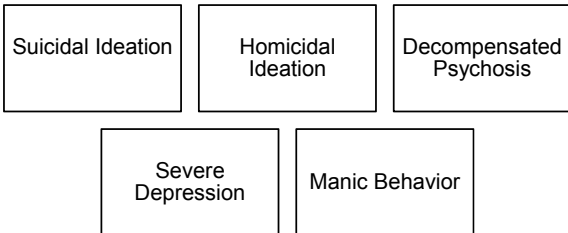
Facilitating Emergency Evaluation

- Outpatient
 - Home/Street → Emergency Room/Crisis Center
 - Clinic → Emergency Room/Crisis Center
 - Clinic → Direct Admission to Inpatient Psych Bed
- Emergency Room/Crisis Center
 - ED/Crisis Bed Hold → Inpatient Psychiatric Bed
- Inpatient
 - General Hospital Bed → Inpatient Psychiatric Bed

What am I stating?

- I believe this person has a mental illness
 - "...a substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life"
- I believe this person is in imminent danger
- I believe this person needs emergency behavioral health assessment and/or treatment
 - "Represents a substantial risk of physical harm to self or others if allowed to remain at liberty pending examination"
- Uncertain?
 - Psychiatric Consultation
 - Risk Manager

Emergent Symptoms Potentially Warranting Psychiatric Hospitalization



Diagnostic Differential of Emergent Psychiatric Syndromes

- **Mood Disorders**
 - Depression
 - Bipolar Disorder
- **Psychotic Disorders**
 - Schizophrenia
 - Delusional Disorder
- **Delirium or Dementia**
 - Medical issues with secondary behavior changes
 - Initially transported to emergency/general hospital settings

Diagnostic Differential of Emergent Psychiatric Syndromes

- **Personality Disorders**
 - Antisocial, Borderline, Narcissistic, Paranoid
- **Substance Withdrawal**
 - Alcohol, Barbiturates, Benzodiazepines
- **Substance Intoxication**
 - PCP, Bath Salts, many others
- **Impulse Control Disorders**
- **Many others...**

Emergency Criteria

1. “Represents a substantial risk of physical harm to self as manifested by evidence of threats of, or attempts at, suicide or serious self-inflicted bodily harm”
2. “Represents a substantial risk of physical harm to others as manifested by evidence of recent homicidal or other violent behavior, evidence of recent threats that place another in reasonable fear of violent behavior and serious physical harm, or other evidence of present dangerousness”

Emergency Criteria

3. "Represents a substantial and immediate risk of serious physical impairment or injury to self as manifested by evidence that the person is unable to provide for and is not providing for the person's basic physical needs because of the person's mental illness and that appropriate provision for those needs cannot be made immediately available in the community"
4. "Would benefit from treatment in a hospital for his mental illness and is in need of such treatment as manifested by evidence of behavior that creates a grave and imminent risk to substantial rights of others or himself"

Completed Form (Front) + (Top Half of Back)

Ohio Department of Mental Health and Addiction Services
 Application for Emergency Admission
 DMH-AS-0023 In Accordance with Sections 5122.01 and 5122.10 ORC

TO: The Chief Clinical Officer of: Twin Valley Behavioral Healthcare Hospital (Columbus, Ohio) 3/15/19
(Regional Psychiatric Hospital - RPH Facility Name) (Date/Time)

The undersigned has reason to believe that: John Doe
(Name of Person to be Admitted)

1. is a mentally ill person subject to hospitalization by court order under division B Section 5122.01 of the Revised Code, i.e., this person
 - (1) Represents a substantial risk of physical harm to self as manifested by evidence of threats of, or attempts at, suicide or serious self-inflicted bodily harm;
 - (2) Represents a substantial risk of physical harm to others as manifested by evidence of recent homicidal or other violent behavior, evidence of recent threats that place another in reasonable fear of violent behavior and serious physical harm, or other evidence of present dangerousness;
 - (3) Represents a substantial and immediate risk of serious physical impairment or injury to self as manifested by evidence that the person is unable to provide for and is not providing for the person's basic physical needs because of the person's mental illness and that appropriate provision for those needs cannot be made immediately available in the community; or
 - (4) Would benefit from treatment in a hospital for his mental illness and is in need of such treatment as manifested by evidence of behavior that creates a grave and imminent risk to substantial rights of others or himself.
2. Represents a substantial risk of physical harm to self or others if allowed to remain at liberty pending examination. Therefore, it is requested that said person be admitted to the above named facility.

STATEMENT OF BELIEF

Must be filled out by one of the following: a psychiatrist, licensed physician, licensed clinical psychologist, clinical nurse specialist who is

manifested by evidence of behavior that creates a grave and imminent risk to substantial rights of others or himself.

2. Represents a substantial risk of physical harm to self or others if allowed to remain at liberty pending examination. Therefore, it is requested that said person be admitted to the above named facility.

STATEMENT OF BELIEF

Must be filled out by one of the following: a psychiatrist, licensed physician, licensed clinical psychologist, clinical nurse specialist who is certified as a psychiatric mental health CNS by the American Nurses Credentialing Center, certified nurse practitioner who is certified as a psychiatric mental health NP by the American Nurses Credentialing Center, health officer, parole officer, police officer, or sheriff.

(Statement shall include the circumstances under which the individual was taken into custody and the reason for the person's belief that hospitalization is necessary. The statement shall also include a reference to efforts made to secure the individual's property at his residence if he was taken into custody there. Every reasonable and appropriate effort should be made to take this person into custody in the least conspicuous manner possible.)

Mr. Doe was brought to the OSUWMC Emergency Department by Columbus Fire Department medics after friends called dispatch and reported a suicide attempt via heroin overdose. Mr. Doe was unconscious upon arrival, was resuscitated in the ED, and is now medically stabilized. While in the ED, he continues to report that he has additional thoughts of wanting to harm himself, has access to a loaded firearm at his home, and does not feel that he would be able to keep himself safe. He also reports active symptoms of Major Depressive Disorder, has a history of prior suicide attempts, and has numerous risk factors for suicide. He is not currently participating in outpatient behavioral health treatment. He is also experiencing opioid withdrawal symptoms and is making threats to leave the hospital. Because of his overdose in an attempt to harm himself, continued suicidal thoughts, and need for additional stabilization, he would benefit from additional inpatient psychiatric care.

Original - Medical Record, Copy - Suspense File Page 1 of 2 APPLICATION FOR EMERGENCY ADMISSION DMH-AS-0023 (Rev. 10/18)

U.S. Supreme Court: 1975 - 1982

- Youngberg v. Romeo
 - US Supreme Court, 1982
 - Mr. Romeo was profoundly intellectually disabled
 - Injured on 63 occasions in a two year period at Pennhurst State School and Hospital in Pennsylvania
 - “Respondent has constitutionally protected liberty interests under the Due Process Clause of the Fourteenth Amendment to reasonably safe conditions of confinement, freedom from unreasonable bodily restraints, and such minimally adequate training as reasonably may be required by their interests.”

Youngberg v. Romeo

- Mr. Romeo did have a constitutionally protected due process right to:
 - Reasonably safe conditions of confinement
 - Freedom from unreasonable body restraints
 - Such minimally adequate training as reasonably may be required to accomplish the previous two.
- ...And in determining what is ‘reasonable’, courts must show deference to the judgment exercised by a qualified professional, whose decision is presumptively valid.”

Right to Refuse Treatment

- Shift from paternalistic to dangerousness-oriented criteria for admission
- “Parens patriae” – English common law, King as “general guardian of all infants, idiots, and lunatics”
- Shift away from global incompetence
- Concerns about quality of care/Mind control by Psychiatrists
- By-product of right to treatment suits

Right to Refuse Treatment

- Arguments for:
 - Religious beliefs
 - Competency/informed consent – right to control their body
 - Countering stigma/honoring right to refuse
- Arguments against:
 - Increased risk of harm to staff, other patients, disruptive
 - Prompt treatment prevents long stays
 - Prompt treatment decreases risk of chronic illness
 - Forced meds to restore competence (so not mind control)
- Justice Cardozo 1914:
 - “Every human being of adult years and sound mind has a right to determine what shall be done with his own body.”

Constitutional Base

- 1st Amendment – free speech
- 8th Amendment – prohibits cruel & unusual punishment
- 14th Amendment – provides for due process & equal protection
- Right to Privacy – penumbra of 1st, 4th, 5th, 9th.

Different Models of Right to Refuse

- Varies by state
- Based on case law and each state's statutes
- Hospital regulations
- Rights driven vs Treatment driven

Rights-driven model

- Primary concern is individual autonomy
- Protect patient's right to choose course of treatment
- Capacity to give informed consent
- Legal adjudication
- Decision making model – Best interest or substituted judgment

Rogers v Commissioner

Mass. Supreme Court, 1983

- Class action suit by 9 patients saying forced medication and seclusion violated their constitutional rights.
- Federal District Court:
 - Constitutional right to refuse treatment
 - Need for consent by a guardian
- Appealed, First Circuit Appellate Court
- Massachusetts Supreme Judicial Court

Mass. Supreme Judicial Court

- **A committed patient is competent until judicially found incompetent.**
- **If found incompetent, a judge uses a full adversarial hearing decides on course using a substituted judgment model based on what the incompetent patient would have wanted.**
- **Substituted judgement based on 6 factors:**

Substituted Judgment

- 1. patient's previously expressed preference
- 2. patient's religious convictions
- 3. impact on family from the patient's viewpoint
- 4. probable side effects
- 5. prognosis with treatment
- 6. prognosis without treatment

- Right to "manage his own person"
- State trend to counter SCOTUS deference to medical judgment?

Capacity to Give Informed Consent

- **Understand informed consent process**
- **Ability to understand information presented and express a choice**
- **Appreciation of nature of problem**
- **Rationally manipulate information**
- **Voluntary**

Informed Consent

- **Appreciate role of medication in treating an illness**
- **Type of medication and what it is for**
- **Potential benefits, risks, and alternative treatments (including their benefits and risks)**
- **Consequences of no treatment**
- **Exceptions?**

Exceptions to Informed Consent

- Emergency
- Therapeutic Waiver
- Incompetence

Treatment Driven

- In contrast to the *Rogers* right-driven approach, there is the treatment driven approach.
- Medical decision makers using internal reviews make decisions in the best interest of the patient.
- The *Rennie* case...

Rennie v Klein

US Court of Appeals, Third Circuit, 1983

- Rennie, “revolving door” patient at Ancora State Hospital in New Jersey, had 12 psychiatric hospitalizations.
- Rennie sued in federal district court to enjoin the hospital from administering psychotropic medications to him in the absence of an emergency. Cited 1st, 8th amendments.
- District Court: said he had right to refuse treatment, was entitled to due process (hearings for competency/dangerousness, LRE)
- 3rd Circuit Court – agreed, said use “least restrictive means” test
 - Meds could be forced in non-emergency in competent patient if treatment represented the least restrictive available.

Rennie v Klein

- Appealed to SCOTUS, which instructed circuit court to reconsider in light of the Youngberg v Romeo case.
- 3rd Circuit Court said: should apply “accepted professional judgment” to medication choice, administrative policy sufficient (professional medical review of treating psychiatrists decision), hearings not needed.



Washington v Harper US Supreme Court, 1990

- Right of a competent prisoner to refuse anti-psychotics.
- Administrative scheme to override treatment refusals without a judicial hearing was constitutionally adequate.
- *Rennie* model

Ohio

- Utilizes a hybrid of *Rennie*, *Rogers*, and *Washington* for medical decision-making in an emergency.
- *Rogers* model for non-emergencies
 - best interest judicial decision maker, not substituted judgment.

Forensic Processes

Emergency Admission (Clinician/Police)	Order of Detention (Prescreener/ Judge)	Hospitalization/ Commitment Order
Emergency Forced Medications	Court Ordered Treatment	Guardianship

Emergency admission

- There is a frequent need for immediate intervention to prevent harm to self or others, so most states have commitment schemes allowing emergency admission with a minimum of process.
- CALIFORNIA: Either a police officer or clinician may authorize emergency admission.
- NEW YORK: decision is made by a clinician at a facility or by the county director of mental health.
- VIRGINIA: A judge or magistrate makes the emergency detention decision.
 - Not necessary that judge/magistrate sees the respondent.

Emergency admission

- With the previously mentioned states, the respondent is not:
 - Afforded a hearing;
 - Granted a right to contest the action at a formal proceeding;
 - Or entitled to counsel prior to hospitalization.
- The petitioner does not have to meet a high level of proof in establishing committability.
- Virginia and New York do not have an established level of proof.
- California only requires "probable cause" (***) 51% to believe the person is mentally disordered and, as a result, gravely disabled or a danger to self/others.

Emergency admission

- Each state does require that the detained be given prompt notice of:
 - How long the confinement is likely to last;
 - When the right to counsel becomes available;
 - When the patient becomes entitled to a hearing.
 - In Virginia, the above is relayed via a judge at a "probable cause" hearing held within 48 hours of the detention.
- In New York and California, the detaining facility provides the necessary notice.
- Except for California, counsel is theoretically made available immediately after notice
 - In California, right becomes available only if individual held greater than 72 hours.
- In New York, pts automatically have the benefit of the Mental Hygiene Legal Service (advocacy organization located on facility grounds).

Emergency admission

- In most states, the period of emergency admission is sharply circumscribed.
 - For example, 48 hours in Virginia, 72 hours in California.
- In New York, patient maybe detained up to 15 days on an "emergency" basis if a second physician examining the pt within 48 hours of their admission finds them to be mentally ill and a danger to self/others.
 - Monitored by Mental Hygiene Legal Service;
 - Pt may request judicial hearing any time.

Pre-hearing screening

- Since the 1980s, some states have established by custom or statute "screening" organizations.
- At community level, these organizations refer people with mental illness to the most effective treatment program available.
- In these jurisdictions, most are not seeing the inside of a courthouse, as they are screened and diverted to more suitable alternatives.
- Many elect to enter treatment voluntarily.
- Some are discharged shortly after arrival.
- Most of these jurisdictions exempt "emergency" cases, but some of these cases still avoid the involuntary commitment process via these scheme.

Long-term detention

- Emergency admissions are designed to further state interest of confining acutely ill and dangerous individuals.
- In contrast, long-term detention requires a judicial approval of continued confinement in an adversarial process.
- The respondent is entitled to a number of rights before and during the hearing.

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Case Examples

Case #1: Law Enforcement

- A family member calls police dispatch and asks for a well-being check on their loved one, Tim. The caller indicates that Tim has not been acting like himself for several weeks and made a comment about “being ready to be done with it all” yesterday and has not answered his door since. The caller said that Tim goes through these episodes a couple of times a year but they seem to be getting worse.
- When officers arrive at the home, Tim is slow to answer the door. He appears to have not showered for several days and has dark circles under his eyes. He is slow to answer questions and is quiet in his speech. He makes little eye contact with the officers. When asked about the comment to his family member he says “they always make a big deal of nothing.”

Case #1: Law Enforcement

- From the doorway, officers observe numerous pill bottles, a half-empty bottle of vodka, and a suicide note on the kitchen table behind him. He said he missed an appointment with his therapist last week, and is having active suicidal thoughts today.
- Tim feels that seeking help is “pointless.”

Case #1 Emergency Criteria

1. “Represents a substantial risk of physical harm to self as manifested by evidence of threats of, or attempts at, suicide or serious self-inflicted bodily harm”
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Case #1 Emergency Criteria

4. “Would benefit from treatment in a hospital for his mental illness and is in need of such treatment as manifested by evidence of behavior that creates a grave and imminent risk to substantial rights of others or himself”

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Case #2: Emergency Department

- A McDonald's manager calls 911 to report a woman causing a disturbance in the parking lot. She was reportedly running back and forth between the cars in the drive through line, knocking on windows and proclaiming that she would buy lunch for everyone present, for the "glory of God!"
- Upon arrival, officers observe her loudly and rapidly blurting provocative comments into the drive through speaker while distractedly yelling at someone on her cell phone. She becomes very irritable as the officers approach, telling them that she owns all of the businesses on the street. She stares intensely at one of the officers and begins repeatedly shrieking "Customer appreciation!"

Case #2: Emergency Department

- Officers are later able to make contact with family members who report that she has a history of bipolar disorder, has not slept in several days after returning from an out-of-town business trip and "losing her meds."

Case #2 continued

- After initially agreeing to voluntary transport to the emergency department for further care, her blood pressure is found to be 185/110, her blood glucose is 360, and serum Cr is 1.5. UDS and BAL are negative.
- She becomes enraged with her nurse about wanting to leave, and begins sprinting around the unit.
- When she sees you approach to examine her, she runs towards you with outstretched arms and begins screaming "I'm dead! I'm dead!" and attempts to run out of the ED.

Case #2 Emergency Criteria

1. "Represents a substantial risk of physical harm to self as manifested by evidence of threats of, or attempts at, suicide or serious self-inflicted bodily harm"
2. "Represents a substantial risk of physical harm to others as manifested by evidence of recent homicidal or other violent behavior, evidence of recent threats that place another in reasonable fear of violent behavior and serious physical harm, or other evidence of present dangerousness"
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Case #2 Emergency Criteria

4. "Would benefit from treatment in a hospital for his mental illness and is in need of such treatment as manifested by evidence of behavior that creates a grave and imminent risk to substantial rights of others or himself"

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Case #3: Primary Care Clinic

- A man in his late twenties came to the family medicine clinic due to "difficulty breathing." He reports that his neighbor has a microwave device aimed at his bedroom which the neighbor is using to intentionally disrupt the man's ability to breathe. He tells you that he has the windows of his home covered with black paper and has moved his bed to the basement "to keep my neighbor from stealing my thoughts," as he is intent on "repopulating the world after the culling."
- The man says his neighbor is a part of a covert group that is trying to stop him in his efforts to save the world and he knows this because he intercepts their communications which say that he is a "pervert" and "a failure."

Case #3: Primary Care Clinic

- He tells you that he has been hearing voices which told him to "get rid of the neighbor's dog," which is part of the conspiracy, and has been leaving out antifreeze for the animal to drink. He asks for your help in dealing with his neighbor noting that he has "tried everything to handle this the right way," and now also has thoughts of harming the neighbor.

Case #3 Emergency Criteria

1. "Represents a substantial risk of physical harm to self as manifested by evidence of threats of, or attempts at, suicide or serious self-inflicted bodily harm"
2. "Represents a substantial risk of physical harm to others as manifested by evidence of recent homicidal or other violent behavior, evidence of recent threats that place another in reasonable fear of violent behavior and serious physical harm, or other evidence of present dangerousness"
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Case #3 Emergency Criteria

4. "Would benefit from treatment in a hospital for his mental illness and is in need of such treatment as manifested by evidence of behavior that creates a grave and imminent risk to substantial rights of others or himself"

Crisis Intervention Team (CIT) Officers

- Law enforcement officers frequently encounter individuals experiencing a mental health crisis
 - First opportunity for many acutely ill individuals have to receive help
- Crisis Intervention Team (CIT):
 - Front line patrol officers within a law enforcement agency who have received additional training:
 - Identification
 - Assessment
 - De-escalation
 - Resolution/disposition



Crisis Intervention Team (CIT) Officers

- Calls to police dispatchers thought to involve a person experiencing a mental health crisis
 - CIT officers are selected to respond
 - Improved crisis outcomes (safety, crisis resolution, disposition)
- Consider proactive contact with local law enforcement to discuss emergency transport situations



Ten domains of verbal de-escalation

1. Respect personal space
2. Do not be provocative
3. Establish verbal contact
4. Be concise
5. Identify wants and feelings
6. Listen closely to what the patient is saying
7. Agree or agree to disagree
8. Lay down the law and set clear limits
9. Offer choices and optimism
10. Debrief the patient and staff

Verbal De-escalation of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup, Western Journal of Emergency Medicine, 2012

Summary

- Consider if the situation represents a behavioral health emergency
 - Can exist across a variety of clinical conditions
- Assess risks/benefits of involuntary treatment
 - Consider least restrictive option
 - Maintain attention to safety of patient, provider
- Review emergency examination/admission process in your jurisdiction
 - Consult with psychiatric provider, risk manager, local law enforcement