STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

# Navigating the Legal and Clinical Complexities of Involuntary Treatment

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# Presenter Bio

- Clinical Director for the State of Iowa Department of Health and Human Services (HHS). Works closely with state-operated facilities, Behavioral Health and Disability Services, Medical Director's Office, and Family Planning and Well-being.
- Licensed psychologist in Iowa and Illinois, licensed attorney in California. Clinical and forensic psychology background.
- Adjunct Associate Professor at the Chicago School of Professional Psychology in Chicago – Forensic Psychology Department; Adjunct Assistant Professor at UIHC – Psychiatry; supervise APA-accredited doctoral practicum student.
- Illinois Clinical Psychologists Licensing and Disciplinary Board; American Psychological Association's (APA) Committee on Legal Issues (COLI); American Psychology-Law Society's (AP-LS) Teaching, Training, and Careers Committee; Co-chaired the 2017 American Psychology-Law Society conference in Seattle; HHS representative on Iowa's *Juvenile Justice Taskforce;* Planning committee for the *Iowa Court's Summit on Improving the Response to Individuals with Serious Mental Illness*.

# Disclosure & Disclaimer

- The presenter **does not** have a financial interest or arrangement related to the content of this presentation.
- The information and views expressed in this presentation are those of the speaker and **do not** necessarily represent the views, policies, or positions of the State of Iowa Department of Health and Human Services or related stakeholders.
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# Learning Objectives

DIFFERENTIATE TYPES OF INVOLUNTARY COMMITMENT THAT MAY IMPACT PERSONS IN LONG-TERM CARE SETTINGS

DISCUSS PSYCHIATRIC CONDITIONS COMMON TO INVOLUNTARY TREATMENT OF PERSONS IN LONG-TERM CARE SETTINGS

PROVIDE APPROPRIATE RESPONSES TO INVOLUNTARY TREATMENT SCENARIOS IN LONG-TERM CARE SETTINGS

IDENTIFY PROFESSIONAL RESOURCES FOR FURTHER GUIDANCE AND SUPPORT

# Legal Level Setting

- Criminal vs. Civil Systems
- State vs. Federal Courts
- Regulations (Executive) vs. Statutes (Legislature) vs. Case Law (Judiciary)
- Forensic vs. Justice Involved
- Capacity vs. Competence

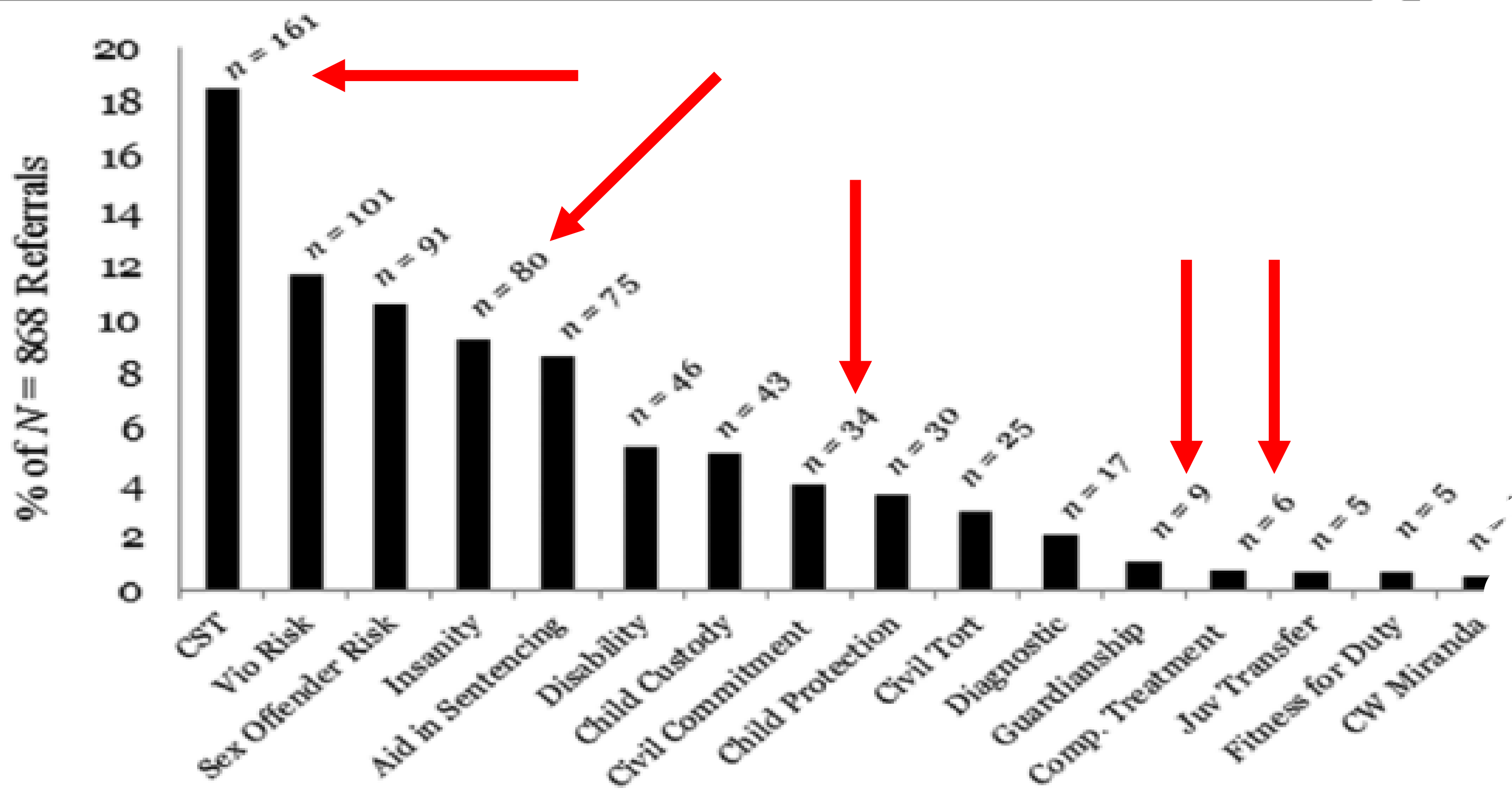


**Figure 1: Relative Percentages of Various Referrals**

*Note.* CST = Competence (Fitness) to Stand Trial; Vio Risk = Violence/Recidivism Risk; Insa
Responsibility/Mental State at Time of Offense; Child Protection (e.g., child abuse, termination of
Civil Torts (i.e., psychiatric, psychological, or emotional disability evaluations in civil suits); C
Competence to Consent to Treatment; Juv Transfer = Transfer (Waiver) of a Juvenile to/from
Miranda = Capacity to Waive Miranda Rights.

# Avenues to Involuntary Treatment

1. Competence to Make Treatment Decisions

2. Advance Directives:
   - Durable Power of Attorney (DPOA) for Healthcare Decisions
   - Living Will

3. Guardianship

# Informed Consent → Competence to Make Treatment Decisions

- Legal protection from unwanted or unnecessary interventions, except in emergency and court-ordered circumstances

- Informed consent:
  1. Patient **informed** of treatment-relevant information **disclosed** by providers;
  2. Patient makes choice **voluntarily**; and
  3. Patient is **competent** to decide (based on capacity assessment).



Grisso (2003)

# Functional Abilities of Capacity to Decide

| **Ability** | The person should be able to: |
|---|---|
| **Understanding** | Comprehend information about the disorder and treatment(s). |
| **Appreciation** | Determine the significance of the treatment and the option of no treatment, focusing on the nature of the diagnosis and the possibility that treatment would be beneficial or harmful. |
| **Reasoning or Formulating** | Compare treatment alternatives in light of consequences, drawing inferences about impact of alternatives on everyday functioning and quality of life. |
| **Communicating a Choice** | Communicate a decision, applying to those who are unable to express a reasonably consistent choice. |

Appelbaum & Grisso (1988)

Helpful questions to assess each of the four abilities required for medical consent may include:

| | |
|---|---|
| **Understanding** | Tell me in your own words what your understanding is of your condition. What are the risks and benefits of each treatment? How likely are the benefits and risks to occur? |
| **Appreciation** | What do you believe is wrong with your health? Do you believe that you need some kind of treatment? What is the treatment likely to do for you? What treatments does your provider recommend? What do you believe will happen if you are not treated? |
| **Reasoning or Formulating** | Tell me your thoughts about whether to accept or reject the treatment? Which factors were important to you in weighing different treatment options? Why did some alternatives seem better or worse than others? |
| **Communicating a Choice** | Have you decided whether to go along with your provider's recommendation? Can you tell me what your decision is? |



US Dept. of VA, Capacity to Consent to Medical Treatment, Educational Handout Series.

# Advance Directive – Living Will

- Planning tool for **end of life decisions** made while competent
- Revoked at any time with communication of intent to revoke
- May be combined with Medical Power of Attorney
- Providers must inquire about status and right to create upon admission to LTC placement

# Advance Directive – Durable Power of Attorney (DPOA)

- Planning tool to make **treatment decisions when person is incapacitated or dead**
- "Medical Power of Attorney" for a "principal" (person)
- Healthcare providers/associates are excluded as "agent" or "attorney in fact"
- Revoke at any time by communication of intent to revoke, regardless of condition
- Doesn't require court approval, overrides a Guardian
- Federal law requires healthcare providers to inquire and inform persons of this right upon admission



Iowa Code Chapter 144B; https://www.iowalegalaid.org/files/A3ED30CF-AFFE-7431-9310-0D521E4312AF/attachments/0665A8CB-E50A-FD8D-D399
19ADB9421AD1/241581Durable%20Power%20of%20Attorney%20for%20Health%20Care%20Decisions%20form.pdf

# Guardianship

- State court provides person/entity (the guardian) duty and power to make various personal decisions for another person
- To protect incapacitated adults and elders
- Option of “last resort”
- In full or limited to specific personal affairs decisions
- Personal or private individuals or entities



https://www.eldersandcourts.org/guardianship_conservatorship/general-information/basics

# Types of Involuntary Treatment

Civil Commitment – Inpatient and Outpatient

Competence to Stand Trial Evaluation and Restoration

Not Guilty by Reason of Insanity (NGRI)

# Civil Commitment in Iowa

- Legal mechanism to deprive persons of liberty for purposes of treatment for eligible conditions
  - Mental Illness (Iowa Code Chapter 229)
  - Substance-Related Disorders (Iowa Code Chapter 125)
  - Sexually Violent Persons (Iowa Code Chapter 229-A)
  - Exclusions: Intellectual Disability, IST, NGRI

# Involuntary Treatment Locations

- State-operated facilities (§229, §229-A)
- Substance abuse treatment centers (§125)
- Private hospitals and treatment programs (§229, §125)
- Community/Outpatient (§229, §125)

# Criteria for Involuntary Hospitalization (§229)

1. Respondent presents a danger to self or others; AND
2. Respondent lacks judgmental capacity due to either a serious mental impairment or substance-related disorder.
   - Impaired judgment &
   - Likely to harm a person

# Routes to Involuntary Hospitalization (§229)

1. Application for Involuntary Hospitalization
2. Immediate Custody
3. Emergency Hospitalization

# I. Application for Involuntary Hospitalization

1. Respondent's district court (residence or location) informs petitioner of preapplication screening assessment option
2. "Any interested party" may petition and become "applicant"
3. Application must explain, in writing, dangerousness and lack of judgmental capacity due to serious mental impairment or substance-related disorder
4. Statement of "licensed physician" or "mental health professional"
5. Court hearing after 48 hours of notice unless respondent waives notice requirement
6. Secure counsel for respondent, notify clerk, attorney(s), advocate
7. Respondents may appeal involuntary commitment within 10 days of court order
8. Chief medical officer provides psychiatric update within 15 days of placement opinion on needs – release, continued hospitalization, step-down to outpatient, or alternative placement

# 2. Immediate Custody

1. Sheriff may detain person until involuntary hospitalization hearing if judge finds probable cause, based on the application/statement(s), that commitment criteria met
2. Hearing must occur within 5 business days of court order for immediate custody
3. Least restrictive option to maintain safety considered – friend, family, hospital, community facility
4. May issue arrest warrant or notify of pending charges and require hospital or community placement to inform sheriff (jail) if person released before hearing

# 3. Emergency Hospitalization

1. Used only when a person appears to meet commitment criteria for "serious mental impairment" (no SUD), but application not yet filed, and person cannot be ordered into immediate custody or detained
2. Peace officer may take person, without warrant, to nearest available facility or hospital
3. Examining medical professionals may treat person, but only to save life or appropriately control behavior
4. Examining medical professional must contact nearest available magistrate if they believe commitment criteria is met
5. Magistrate provides court order for 48-hour hold that can be extended only if application for involuntary hospitalization filed within 48 hours and supports continued commitment
6. If arrest warrant or pending charges, sheriff can request same notice of discharge prior to release, and has 6 hours to retrieve person

# Due Process (Fairness) Considerations

- Evolving authority
- Procedural Due Process = notice, fair/impartial hearing, presence of respondent, and legal representation
- Respondent's welfare is #1, hearing is informal, all evidence admissible
- Applicant's burden to prove by "clear and convincing" evidence
- Licensed physician or mental health professional who examined the respondent must be present at the hearing, unless waived for good cause or attends virtually
- Medical provider's report – w/in 15 days of admission [§229.13(5)]

# Involuntary Placement Considerations

- Courts may order, but hospitals admit when bed/resources available
- Providers determine specific treatment intervention(s) service(s)
- Acute psychiatric hospitals may question ability to treat neuro-cognitive issues in older adults, especially with medical needs
- Medical provider recommends appropriate less-restrictive setting (e.g., RCF, CMHC)
- "Alternative Facility" vs. Outpatient Commitments

# Competency to Stand Trial (CST) vs. Not Guilty by Reason of Insanity (NGRI)

| | CST | NGRI |
|---|---|---|
| **Law** | Iowa Code Chapter 812 | Iowa Rule 2.22(8) Verdict; §701.4 Insanity |
| **Issue** | Threshold issue, adjudication paused until restored | Affirmative defense – *M'Naghten* (1843) standard |
| **Focus** | Present/current abilities | Time of alleged offense |
| **Change Potential** | Dynamic, may change over time | Static, will not change over time |
| **Roles** | Clinician evaluates and proposes, judge independently disposes | Clinician evaluates, jury disposes to determine guilt |
| **Frequency** | Most common forensic evaluation; approx. 50% found incompetent | Rare; < 1% felony pleas; 25% attempts succeed |
| **Opinions** | Ultimate issue opinions permitted albeit ethically questionable | Ultimate issue opinions prohibited (FRE 704b) |

Goldstein (2003)

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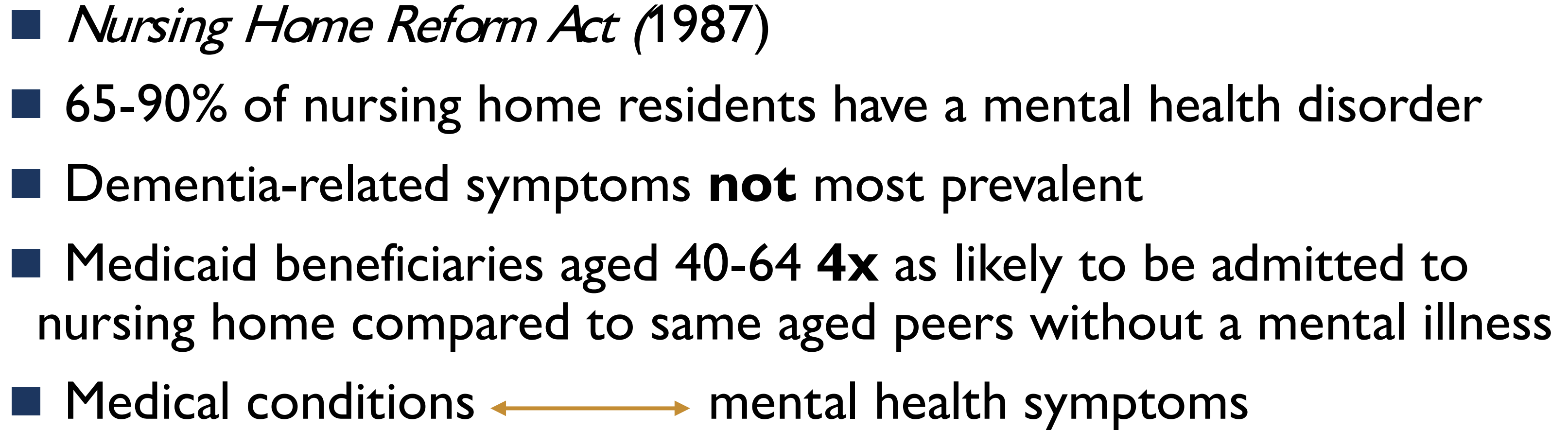
# Competency Restoration Treatment

- Broad "mental disorder" predicate in Iowa
- Focuses on symptom management, legal education, and skills training for restoration needs
- Setting options in Iowa (§812)
  1. Outpatient (BHDS Regions) – not pose danger to public peace and safety, qualified for pretrial release, cooperative
  2. Psychiatric Hospital (HHS, MHI) – not pose danger to public peace/safety, but held in custody or refuses to cooperate
  3. Dept. of Corrections (IMCC) – danger to public peace/safety, or not qualified for pretrial release, or refuses to cooperate
- Incompetent and unrestorable → dismiss charges, pursue civil commitment if still dangerous

# Relevant Mental Health Considerations

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Grabowski, Aschbrenner, Rome, & Bartels (2010); Fullerton, McGuire, Feng, Mor, & Grabowski (2009); Andrews, Bartels, Xie, & Peacock (2009); Blazer (2003); Jongenelis et al. (2003).

- Significant emotional, perceptual, and behavioral symptoms are important at determining safety to self or others
- Anxiety and depression are NOT normal aging changes
- Is "as needed," consultant-based psychiatric care enough?
- Could LTC settings benefit from increasing behavioral, therapeutic, and environmental expertise and interventions?

IOWA HHS

Grabowski, Aschbrenner, Rome, & Bartels (2010); Fullerton, McGuire, Feng, Mor, & Grabowski (2009); Andrews, Bartels, Xie, & Peacock (2009); Blazer (2003); Jongenelis et al. (2003).

# Scenario 1

# Scenario 2

# Additional Resources

- Iowa Legislature – www.legis.iowa.gov
- [State] Legal Aid Office – www.iowalegalaid.org
- [State] Disability Rights Office – www.disabilityrightsiowa.org
- Center for Elders and the Courts – www.eldersandcourts.org
- MacArthur Competence Assessment Tool for Treatment (MacCAT-T)
- National Resource Center for Psychiatric Advanced Directives – www.NRC-PAD.com
- UIHC – Advance Directives Templates – www.uihc.org/advance-directives
- National Association for State Mental Health Program Directors (NASMHPD) – www.nasmhpd.org
- Treatment Advocacy Center (TAC) – www.treatmentadvocacycenter.org
- The DICE Approach – www.diceapproach.com

# In Summary…

Expect persons in LTC settings to have a mental illness or significant symptoms beyond dementia

Involuntary treatment for mental illness often focuses largely on psychotropic medication, and options may be limited for persons in LTC settings

While psychotropics may be needed and useful for SMI, they're (at best) moderately effective at treating neurocognitive effects of dementia

These cases are often complex and may involve "avenues" and "types" of involuntary treatment, and require additional resources and consultation

Iowa Code Chapter 229 – Outpatient and Alternate Facility may be most direct routes for LTC settings

What can LTC settings do to meet this need without relying on involuntary treatment and psychotropic medication?

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*Relf vs. Weinberger (*1974)

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