AHLA

An Analysis of Legal Issues—Child and Adolescent Behavioral Health, Part III: Patient Safety—Identifying and Addressing Legal Issues Involved When Treating Pediatric Patients with Behavioral Health Needs

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What if the health care provider believes the patient poses a risk to self, to the treatment team, and/or to other persons?

The use of restraints and seclusion is among the most controversial practices in mental health care. This is due to the tension between a patient's right to freedom and a health care provider's duty to restrain unstable or dangerous patients, and to the medical risks posed specifically by restraints, but also by seclusion. For health care providers, guidelines for the use of restraints and seclusion often are obscured and made more complex by the individual facts. In addition to patient injury, health care providers face potential liability for improperly detaining patients, false imprisonment, and related claims. Alternatively, failure to restrain a patient may result in claims against the provider for harm to the patient or others.

Because resort to restraints and seclusion is highly controversial, it is heavily regulated at both federal and state levels. In general, the distinction between federal and state law in this area is that federal regulations provide a baseline standard of protection for individual safety, while state laws provide individuals with additional layers of protection reflecting the individual state orientation to the safety of behavioral health patients and protection of providers and the public. That said, federal and state law indicate a shared desire to provide minor patients—arguably the most vulnerable among the behavioral health patient population—with greater protections regarding the use, duration, and reporting requirements for restraints and seclusion.

Federal law

The primary federal law regarding the use of restraints and seclusion in hospitals is found in the Centers for Medicare & Medicaid Services (CMS) Conditions of Participation regulations regarding patient's rights.[1] Additional guidance is provided by the CMS Conditions of Participation regulations for psychiatric residential treatment

[1] These rules are provided in 42 C.F.R. § 482.13 and apply to hospitals providing psychiatric services.

facilities providing services to individuals under age 21.[2] The Children's Health Act of 2000 also provides guidance for non-medical community-based facilities for children and youth.[3] Health care providers must be aware of which federal regulations apply based on the type of facility serving the minor patient.

In every treatment setting, minor patients are owed broad protections regarding when restraints or seclusion may be used. CMS regulations provide that "All patients have the right to be free from restraint or seclusion of any form, imposed as a means of coercion, discipline, convenience or retaliation by staff."[4] Restraints and seclusion may only be used "to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time."[5] Moreover, "[t]he type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective" to protect the patient, staff, or others.[6]

With regard to simultaneous use of restraints and seclusion, federal regulations distinguish between treatment settings. Federal regulations in psychiatric residential treatment facilities prohibit simultaneous use of restraints and seclusion.[7] In contrast, restraints and seclusion may be used simultaneously in hospitals if the minor patient is continually monitored by trained staff.[8] Hospitals generally are advised to reduce such important guidelines to writing in the forms of policies and procedures and to provide periodic training to a mobile population of employees providing hospital services to pediatric and adolescent behavioral health patients.

In certain treatment settings, parental or legal guardian notification of the use of restraints or seclusion is required. For example, psychiatric residential treatment facilities must notify and supply a copy of its restraint and seclusion policy to the minor

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[2] These rules are provided in 42 C.F.R. Part 483, Subpart G. Psychiatric residential treatment facility is defined as "a facility other than a hospital, that provides psychiatric services" to individuals under age 21, in an inpatient setting. *Id.* at § 483.352.
[3] 42 U.S.C. § 290jj.
[4] 42 C.F.R. § 482.13(e).
[5] *Id.*
[6] *Id.* at § 482.13(e)(3).
[7] 42 C.F.R. § 483.356(a)(4).
[8] 42 C.F.R. § 482.13(e)(15)(i-ii).

patient's parent or legal guardian at admission.[9] The facility also must communicate its policy in an accessible format and obtain a written acknowledgment of the policy from the parent or legal guardian.[10] In addition, after a minor patient is restrained or secluded, the facility must notify the parent or legal guardian as soon as possible.[11] Medical record documentation must include the date, time, and name of the staff member who provided notification to the parent or guardian of the minor patient.[12]

In every treatment setting, minor patients are entitled to have trained staff implement restraints or seclusion.[13] Specific training requirements include a demonstrated competency in applying restraints; implementing seclusion; and monitoring, assessing, and providing care for a patient in restraint or seclusion.[14] Staff must be trained during orientation and on a periodic basis.[15] Personnel records must document that staff completed the training.[16] During the press of business these tasks are time-consuming but are integral parts of a facility's federally focused compliance program.

In addition, facilities must ensure that restraint or seclusion is ordered by a physician or licensed independent practitioner (LIP) responsible for the care of the minor patient.[17] Initial restraint or seclusion orders for managing violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient or others are limited to 24 hours by the federal regulations.[18] These orders must be renewed at two hours for children and adolescents ages nine–17 years old and at one hour for children eight years of age or younger.[19] If restraints or seclusion exceeds 24 hours, a physician or LIP must re-

[9] 42 C.F.R. § 483.356(c)(1), (4).
[10] *Id.* at § 483.356(c)(2-3).
[11] *Id.* at § 483.366(a).
[12] *Id.* at § 483.366(b).
[13] 42 C.F.R. § 482.13(f).
[14] *Id*. at § 482.13(f)(1).
[15] *Id*. at § 482.13(f)(1)(ii-iii).
[16] *Id*. at § 482.13(f)(4).
[17] *Id*. at § 482.13(e)(5).
[18] *Id*. at § 482.13(e)(8)(i).
[19] *Id*. at § 482.13(e)(8)(i)(B-C).

evaluate the patient.[20] The regulations do not specify how soon after 24 hours re-evaluation must occur, but require a physician or LIP to "see and assess the patient."[21]

Facilities also must ensure that minor patients placed in restraints or seclusion receive a face-to-face evaluation within one hour by a physician, LIP, or trained registered nurse or physician assistant.[22] The decision of whether to continue restraints or seclusion must be made at that time.[23] If a registered nurse or physician assistant conducts the evaluation, the attending physician or LIP must be consulted as soon as possible.[24]

Federal regulations require documentation of the following activities when restraints or seclusion are ordered for a minor patient. At a minimum, the patient's medical record must document: (1) the one-hour face-to-face evaluation; (2) the patient's behavior and intervention used; (3) alternatives or less restrictive interventions attempted; (4) the patient's condition or symptoms that warranted restraint or seclusion; and (5) the patient's response to the intervention and rationale for continued use.[25]

Lastly, when restraints or seclusion result in death, it must be reported to CMS.[26] The following deaths must be reported by the next business day: (1) deaths that occur in restraint or seclusion; (2) deaths that occur within 24 hours after a patient is removed from restraint or seclusion; and (3) deaths known to the institution that occur within one week after restraint or seclusion if reasonable to assume it contributed directly or indirectly to a patient's death.[27] Staff must document in the medical record the date and time the death was reported to CMS.[28]

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[20] *Id*. at § 482.13(e)(8)(ii).
[21] *Id.*
[22] *Id*. at § 482.13(e)(12)(i)(A-B).
[23] *Id*. at § 482.13(e)(12)(ii)(D).
[24] *Id*. at § 482.13(e)(14).
[25] *Id*. at § 482.13(e)(16)(i-v).
[26] *Id*. at § 482.13(g).
[27] *Id*. at § 482.13(g)(1)(i-iii).
[28] *Id*. at § 482.13(g)(3).

State law

States also heavily regulate the use of restraints and seclusion. In general, most states utilize the same federal legal framework to guide health care providers and offer more protections for minor patients. For example, most states, consistent with federal law, expressly prohibit the use of restraints or seclusion for coercion, discipline, punishment, or staff convenience.[29] Instead, restraints and seclusion must be used solely for providing effective treatment, eliminating dangerous or potentially harmful behavior, and protecting the patient and others.[30] In Washington, restraints or seclusion may only be used "when there is imminent danger to self or others and less restrictive measures have been determined to be ineffective to protect the consumer or others from harm."[31] Similarly, in Georgia, restraints or seclusion may only be used if "absolutely necessary . . . to prevent a patient from seriously injuring himself or herself or others and are required by the patient's medical needs."[32]

States also vary regarding the treatment settings in which restraints or seclusion may be used. Some states permit restraints and seclusion in a range of treatment settings, such as facilities for treatment of alcoholic and drug dependent individuals, developmentally disabled individuals, and individuals receiving psychiatric treatment.[33] Other states limit restraints and seclusion to residential treatment facilities and psychiatric treatment facilities.[34] With regard to how long a minor patient may be restrained or secluded, some states offer the same level of protection afforded by federal law.[35] Others are

[29] This includes, for example, Ohio, Oregon, Delaware, and New York. *See, e.g.*, OHIO ADMIN. CODE 5122-2-17 (D)(1)(d); OR. ADMIN. R. 309-022-0175(1)(c); 16 DEL. C. 5161(b)(6)(c); 18 NYCRR 441.17(b).
[30] *See, e.g.*, GA. REV. CODE § 37-3-165(a).
[31] WASH. ADMIN. CODE 388-865-0546 (involuntary treatment); *Id.* at 246-337-110(1) (residential treatment facilities).
[32] GA. REV. CODE. § 37-3-165(b).
[33] Georgia is one such state. GA. REV. STAT. § 37-7-165 (alcoholic and drug dependent individuals); *Id.* at § 37-4-124 (developmentally disabled individuals); *Id.* at § 37-3-165 (individuals receiving psychiatric treatment).
[34] This includes Washington and Ohio, for example. WASH. ADMIN. CODE 388-865-0546 (evaluation and treatment facilities); *Id.* at 246-337-110(1) (residential treatment facilities); OHIO ADMIN. CODE 5122-2-17 (regional psychiatric hospitals); *Id.* at 5122-30-17 (residential treatment facilities).
[35] This includes Washington and Arizona, for example. WASH. ADMIN. CODE 388-865-0546; ARIZ. REV. STAT. § 36-513.

more restrictive, limiting each initial order for restraint or seclusion to one hour, or up to two hours for a renewal of the order, regardless of the age of the minor patient.[36]

States differ according to which providers can order restraints or seclusion for a minor patient. In some states, such a decision requires a physician's order.[37] However, in other states the decision can be made by a variety of providers, including the attending physician, or a psychologist or clinical nurse specialist in psychiatry or mental health involved in the care and treatment of the patient.[38] When restraints or seclusion are used for longer periods of time (e.g., eight hours), some states require the decision to be made by the chief clinical officer.[39]

In emergency situations, most states allow attending staff or registered nurses to implement restraints or seclusion as needed.[40] However, attending staff or the registered nurse must immediately report to the physician, and sometimes to any psychologist involved in the care and treatment of the patient.[41] States vary regarding how soon notification must be provided in emergency situations, with some requiring notification within 30 minutes.[42] States also vary regarding how soon a physician must examine the patient, with some requiring examination within one hour.[43]

To conclude, this section provided an overview of the key requirements for using restraints and seclusion with minor patients. Although restraints or seclusion may be an appropriate response under certain circumstances, they must be carefully applied,

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[36] Ohio is an example of a state that provides more protection to minors regardless of their age. OHIO ADMIN. CODE 5122-2-17(F)(2)(b). New York also provides greater protection to minors: each written order for restraint or seclusion must be no more than one hour for children and adolescents ages nine–17, or 30 minutes for children under nine. 14 CRR-NY 526.4(c)(5)(ii).

[37] Ohio and Washington are two examples. OHIO ADMIN. CODE 5122-2-17(F)(2)(a); WASH. ADMIN. CODE 388-865-0546.

[38] *See, e.g.*, GA. CODE ANN. § 37-3-165(b).

[39] *See, e.g.*, OHIO ADMIN. CODE 5122-2-17(F)(2)(c).

[40] This includes states such as Illinois, Missouri, New York, Ohio, and Utah. 210 ILL. COMP. STAT. 85/6.20; MO. REV. STAT. § 630.175; 14 CRR-NY 526.4(c)(6)(i); OHIO ADMIN. CODE 5122-2-17(F)(2)(a); UTAH ADMIN. CODE 432-101-23(7)(e)(i).

[41] *See, e.g.*, 210 ILL. COMP. STAT. 85/6.20; OHIO ADMIN. CODE 5122-2-17(F)(2)(a); UTAH ADMIN. CODE 432-101-23(7)(e)(i-ii).

[42] Ohio is an example of a state that requires notification within 30 minutes. OHIO ADMIN. CODE 5122-2-17(F)(2)(e)(i).

[43] Ohio also requires a physician to personally examine the patient within one hour. OHIO ADMIN. CODE 5122-2-17(F)(2)(e)(iv).

closely monitored, and well documented. To ensure compliance, health care providers should have a working understanding of the federal and state laws surrounding this issue, as well as clear written policies based on those authorities and accepted standards of clinical practice.

What if the health care providers believe that the patient has been harmed by, or is at risk of being harmed by, a parent, guardian, or supervisor?

All states have some type of child abuse reporting law.[44] The laws vary but generally have these elements:

- Definition of "abuse" and "neglect";
- Definition of "mandatory reporters";
- Requirement for report to state agency or law enforcement when reporter has "reasonable cause" to believe or suspect abuse may have occurred;
- Immunity for report made in good faith;
- Penalties for failing to report suspected abuse; and
- Provisions for prompt investigation of reports.

Mandatory reporters include almost all health care providers, including mental health professionals. With few exceptions, child abuse reporting duties are an exception to patient confidentiality laws.

Arizona's law provides an example of a typical statutory scheme.[45] A person (including a wide array of health care providers) who "reasonably believes" that a child has been the victim of abuse or neglect must immediately report to a peace officer, the department of child services, or the appropriate tribal authority.[46] A limited exception

[44] National Council of State Legislatures, *Mandatory Reporters of Child Abuse and Neglect* (2013), *available at* www.childwelfare.gov/pubPDFs/manda.pdf (last visited Mar. 9, 2016).
[45] ARIZ. REV. STAT. § 13-3620.
[46] *Id.* at § 13-3620A.

exists for clergy members and for certain sex offender treatment situations outside the court system. The clergy member exception applies only to a confidential communication or confession and not to any personal observations.[47] For certain sex offender treatment situations, a physician, psychologist, or behavioral health professional may withhold reporting if they reasonably believe that non-disclosure is necessary to accomplish treatment.[48] A violation of the reporting law is a misdemeanor.[49]

Washington's law has an expansive definition of mandatory reporters, and includes persons in official supervisory capacities in for-profit and nonprofit organizations, department of corrections officials, and adults who have reasonable cause to believe that a child residing with them has suffered "severe abuse."[50]

The recurring challenge for all providers is determining what is "reasonable cause" in a situation where the occurrence of abuse is not necessarily clear. Health care providers understand the disruption and other consequences that can follow almost immediately from an abuse report. The range of consequences includes harm to the treatment relationship, loss of trust of patient and family, loss of a parent or guardian in the home, risk to livelihood of those who are the subject of the report, and reputational harm. The underlying policy of abuse and neglect laws, however, is to let the responsible government officials follow their training and judgment in analyzing these reports.[51]

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[47] *Id.*
[48] *Id.* at § 13-3620C.
[49] *Id.* at § 13-3620O.
[50] WASH. REV. STAT. § 26.44.030.
[51] *See generally* Starla J. Williams, *Reforming Mandated Reporting Laws After Sandusky*, 22 KAN. J.L. & PUB. POL'Y 236 (2013) (because of the gravity of failing to report suspected child abuse or neglect, "society prefers that professionals err on the side of caution"); Thomas L. Hafemeister, *Castles Made of Sand? Rediscovering Child Abuse and Society's Response*, 36 OHIO N.U. L. REV. 819, 829 (2010) (professionals encountering minor patients are "encouraged to err on the side of over-reporting to protect a child's safety" when they suspect abuse).

When do health care providers have the right to detain a minor patient and/or initiate involuntary commitment proceedings?

The decision to detain a minor patient or initiate involuntary commitment proceedings requires balancing the need to provide patients with appropriate mental health treatment while respecting the rights of those individuals to refuse treatment. A working knowledge of the statutes in the state in which the health care provider practices is essential.

This section explains state law practices regarding civil commitment for minor patients including both voluntary and involuntary treatment. It also examines the constitutional and state law protections afforded to civilly committed minor patients. Finally, it concludes by addressing a national crisis: psychiatric boarding.

The right to detain or initiate involuntary commitment proceedings

Understanding when a health care provider has the right to detain a minor patient or a duty to initiate involuntary commitment proceedings requires a working knowledge of both the voluntary and involuntary admission processes for minors.

Voluntary treatment

A health care provider may have the right to detain a minor patient for voluntary treatment based on a parent or guardian's consent. In general, minors are considered legally incompetent to consent to treatment, including the right to consent to psychiatric hospitalization.[52] However, most states also recognize that minors of a certain age, usually at least 14 years or older, have capacity to consent to treatment, including

[52] American Academy of Pediatrics, *Consent for Emergency Medical Services for Children and Adolescents,* PEDIATRICS, Aug. 2011, Vol. 128(2), at 429, *available at* http://pediatrics.aappublications.org/content/128/2/427 (last visited Mar. 9, 2016).

psychiatric treatment.[53] For minors 13 years old or younger, states have historically allowed parents or guardians to provide consent to psychiatric treatment on the minor's behalf.[54] Increasingly, however, states have provided minors of all ages with greater protections to safeguard their due process rights and ensure inpatient admission is appropriate.

States vary markedly regarding the specific admission procedures for voluntary treatment, but generally can be classified into one of three groups: (1) protective of parents' rights; (2) protective of minors' rights; and (3) intermediate approach.

States that follow the first category of being protective of parents' rights include Arizona, Maryland, Missouri, Minnesota, Ohio, Oklahoma, and Oregon.[55] These states take a traditionalist view, allowing a parent or guardian to approve admission to a psychiatric facility without the minor's consent.[56] These states do not require judicial review; however, some require a determination by an independent examiner, such as a medical director.[57]

States that follow the second category of being protective of minors' rights include Florida, Iowa, and New York.[58] Iowa requires a judicial hearing when a minor objects to treatment, while Florida requires a hearing regardless of whether a minor objects.[59] Generally, it must be shown that the minor will benefit from treatment and a less restrictive setting is not feasible.[60] Most of these states do not allow a holding period until the hearing.

A third group of states follow an intermediate approach to parental admission. These states include Colorado, Connecticut, Illinois, Kentucky, Michigan, North Carolina,

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[53] *Id.*
[54] *Id.*
[55] *See generally* ARIZ. STAT. § 36-518(C); MD. HEALTH-GENERAL CODE ANN. § 10-610; MO. REV. STAT. § 632.110; MINN. STAT. § 253B.04(1); OHIO REV. CODE ANN. § 5122.02(B); OK 43A-9-101(A)(3); and OR. REV. STAT. § 426.225.
[56] *Id.*
[57] *See, e.g.,* ARIZ. STAT. § 36-518(C)(1-5).
[58] *See generally* FLA. STAT. § 394.4625; IOWA CODE § 222.13A; N.Y. MENTAL HYG. § 9.13.
[59] *Compare* IOWA CODE § 222.13A(5) *with* FLA. STAT. § 394.4625(1)(a).
[60] *See, e.g.*, IOWA CODE § 222.13A(5)(a-b).

Virginia, Washington, and West Virginia.[61] Within this category, some states provide minors with the right to object to admission at a certain age. The age range is generally 12 to 15 years old.[62] A judicial hearing must be held when a minor objects to treatment.[63] These states allow a holding period until the hearing, but vary regarding the number of days a minor may be held. Once a holding period has concluded, some states require a court to determine whether the minor meets criteria for either voluntary or involuntary commitment.[64]

Involuntary treatment

In some circumstances voluntary admission is not feasible and a health care provider may initiate involuntary admission of the minor to a psychiatric treatment facility. Involuntary admission for minors may arise in the following scenarios: (1) the parent or guardian who originally applied for inpatient treatment of a minor revokes their consent; (2) a minor objects to inpatient treatment and the state does not allow for parental or guardian consent, or the parent or guardian objects; (3) a minor patient admitted voluntarily wishes to leave and the physician and treatment team determine the minor patient meets criteria for civil commitment; or (4) when a state has custody of a minor and seeks inpatient treatment. In each scenario, emergency detention may be initiated. If additional treatment is needed beyond the emergency detention period, involuntary commitment proceedings must be initiated.

The age requirement for initiating emergency detention or involuntary commitment varies widely from state to state. Many states have no age requirement, such as Arizona and Oregon.[65] Other states limit the age. In Washington, for example, children

[61] *See generally* COLO. REV. STAT. § 27-65-103; CONN. GEN. STAT. § 17a-498; 405 ILCS 5/3-503; KY. REV. STAT. ANN. § 645.030; MICH. COMP. LAWS § 258-1974-4; N.C. GEN. STAT. § 122C-221; VA. CODE. ANN. § 16.1-344(B); WASH. REV. STAT. § 71.34; W. VA. CODE ANN. § 27-4-1.
[62] State examples of when a minor may object to voluntary admission include Illinois (12 years or older) and Colorado (15 years or older). *See* 405 ILCS 5/3-505; COLO. REV. STAT. § 27-65-103.
[63] *See, e.g.*, COLO. REV. STAT. § 27-65-103.
[64] *See, e.g.*, CONN. GEN. STAT. § 17a-498(e).
[65] OR. REV. STAT. § 426.005(1)(e); ARIZ. REV. STAT. § 36-524-30.

13 years or older may be admitted for involuntary treatment.[66] However, children under the age of 13 may only be admitted to inpatient or outpatient treatment with parent or guardian consent.[67]

Civil commitment criteria for minors also vary from state to state, but generally are consistent with the criteria used for adults. Common criteria include the presence of a mental disorder, dangerous behavior to self or others or grave disability, likelihood of serious harm, and need for treatment. Some states require all of these criteria, while others require less than all. Some states also rely on less common criteria such as responsiveness to treatment, availability of appropriate treatment in the facility where the patient will be committed, refusal of voluntary admission, lack of capacity to consent to psychiatric treatment, and involuntary treatment, which is the least restrictive alternative.[68]

States vary regarding the maximum amount of time a minor patient may be held for emergency detention. Almost half the states allow patients to be held for up to 72 hours while waiting for an initial court hearing. In other states, the length of the emergency detention may be longer, ranging from seven days in Alabama;[69] to ten days in North Carolina, Rhode Island, and Utah;[70] and to 15 days in New York.[71]

States also vary regarding the amount of time a minor patient may be involuntarily committed. Some states commit minors for shorter time periods followed by substantially longer time periods, such as Washington, where minors are initially committed for 14 days followed by 180 days.[72] Other states initially commit minors for longer time periods, ranging from six months in states such as Georgia, to one year in

[66] WASH. REV. CODE § 71.34.700.
[67] WASH. REV. CODE § 71.34.500(1).
[68] *See, e.g.*, LA. REV. STAT. ANN. § 28:54 (refusal of voluntary admission); ARK. CODE ANN. § 20-47-207(c)(1)(C) (lacks capacity); IDAHO CODE § 66-329(3) (lacks capacity); DEL. CODE ANN. 16 § 5011(3) (refusal of voluntary admission and all less restrictive alternatives considered).
[69] ALA. CODE § 22-52-91(f).
[70] N.C. GEN. STAT. § 122C-268(a); R.I. GEN. LAWS § 40.1-5-7(g); UTAH CODE § 62A-15-631(8)(c).
[71] N.Y. MENTAL HYG. § 9.39(a).
[72] WASH REV. CODE § 71.34.740(13).

Idaho.[73] At least one state, Connecticut, does not specify the length of time for the initial commitment and instead allows petitions for release and annual reviews to determine if involuntary treatment is still necessary.[74] Finally, many states allow minors to be committed for extended treatment periods as needed.[75]

In summary, although the statutes governing civil commitment for minors vary markedly among states, there are certain things that providers can and should keep on their radar. With respect to voluntary treatment, providers should identify what category of admission procedures its state has adopted: is the state protective of parents' rights, minors' rights, or somewhere in the middle? As for involuntary treatment, providers should understand what scenarios warrant involuntary admission, age requirements, criteria for commitment, and the length of time a minor may be detained. Finally, because statutes governing civil commitment procedures are continually changing, it is essential for health care providers to remain informed regarding how the specific statutes operate in the state where the provider practices.

Constitutional and state law protections

Minor patients involuntarily committed are entitled to constitutional and state law protections. Recent case law supports these protections and makes it clear that there is no excuse for failing to provide patients with an appropriate placement in a timely manner.

Constitutional protections

Involuntary commitment is built on constitutional principles. All individuals have the constitutional right not to be deprived of liberty without due process of law.[76]

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[73] GA. CODE ANN. § 37-3-81.1(c); IDAHO CODE § 66-329(11)(b).
[74] CONN. GEN. STAT. § 17a-498.
[75] WASH REV. CODE § 71.34.750(8) (successive 180-day commitments are permissible).
[76] U.S. Const. amend. XIV.

Involuntarily detaining a person on grounds of mental illness is "a massive curtailment of liberty."[77]

Due process requires that every mentally ill individual detained receive treatment calculated to lead to the end of the involuntary detention.[78] To that end, states must provide all civilly committed persons with access to mental health treatment that gives them "a realistic opportunity to be cured or to improve [the] mental condition" for which they were confined.[79] "Adequate and effective treatment is constitutionally required because, absent treatment, [civilly committed persons] could be held indefinitely as a result of their mental illness."[80]

State law protections

State law embraces these same principles. For example, in Washington, minors have the right to receive adequate care and individualized treatment.[81] In addition, minors must be protected "against needless hospitalization and deprivations of liberty . . . to enable treatment decisions to be made in response to clinical needs in accordance with sound professional judgment."[82] Other states provide that a minor has the right to receive care and treatment suited to their needs.[83]

Psychiatric boarding

Psychiatric boarding of patients, or warehousing mentally ill patients in the emergency department, is a widely recognized epidemic across the United States. When

[77] *In re Labelle*, 107 Wash.2d 196, 201 (1986) (quoting *Humphrey v. Cady*, 405 U.S. 504, 509 (1972)); *Poletti v. Overlake Hosp. Med.Ctr.*, 175 Wash. App. 828, 836 (2013).
[78] *Or. Advocacy Ctr. v. Mink*, 322 F.3d 1101, 1121 (9th Cir. 2003); *Sharp*, 233 F.3d 1166, 1172 (9th Cir. 2000).
[79] *Ohlinger v. Watson*, 652 F.2d 775, 779 (9th Cir. 1980).
[80] *Id.* at 778.
[81] WASH. REV. CODE § 71.34.355(8); *In re Detention of Lane*, 182 Wash. App. 849 (2014).
[82] WASH. REV. CODE § 71.34.010.
[83] GA. CODE ANN. § 37-3-162(a).

psychiatric boarding occurs, patients are denied proper psychiatric care, other patients in the emergency department receive delayed treatment, and the system is forced to absorb exorbitant costs. Despite courts' clear messages, states have continued to rely on lack of funding, overcrowding, and good faith excuses for delays in placement.[84] As a result, psychiatric boarding remains a national public health crisis.[85]

The age group most severely impacted by the shortage of beds is consistently children and adolescents.[86] In one study, a pediatric hospital found that approximately one-third of the patients who required a psychiatric bed were instead admitted to a medical floor for a length of stay ranging from one to 51 days.[87] Another study found that when beds were filled, pediatric patients were sent to facilities in other regions of the state and sometimes across the country.[88]

Some states have begun to make pediatric beds and psychiatric services for children and adolescents a top priority. Arizona is creating new pediatric behavioral health facilities and investing in more pediatric beds and facilities.[89] Minnesota is adding 150 pediatric beds and has approved funding for a network of small treatment centers, as

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[84] *In re Det. of D.W.*, 181 Wash.2d 201 (2014) ("[p]atients may not be warehoused without treatment because of lack of funds."); *see also Or. Advocacy Ctr.*, 322 F.3d at 1121 (quoting *Ohlinger*, 652 F.2d at 779) ("Lack of funds, staff or facilities cannot justify the State's failure to provide [such persons] with [the] treatment necessary for rehabilitation.").

[85] The Joint Commission, *Alleviating ED boarding of psychiatric patients*, QUICK SAFETY, Issue 19, Dec. 2015, *available at* www.jointcommission.org/assets/1/23/Quick_Safety_Issue_19_Dec_20151.PDF (last visited Mar. 9, 2016); Zaynah Abid, et al, *Psychiatric Boarding in U.S. EDs: A Multifactorial Problem that Requires Multidisciplinary Solutions*, URGENT MATTERS, Vol. 1(2), June 2014, *available at* https://smhs.gwu.edu/urgentmatters/sites/urgentmatters/files/Psychiatric%20Boarding%20in%20U.S.%20EDs%20A%20Multifactorial%20Problem%20that%20Requires%20Multidisciplinary%20Solutions.pdf (last visited Mar. 9, 2016).

[86] California Institute of Mental Health, *Psychiatric Hospital Beds in California: Reduced Numbers Create System Slow-Down and Potential Crisis*, Aug. 30, 2001, at 6, *available at* www.cibhs.org/sites/main/files/file-attachments/acute_services_report_final_0.pdf (last visited Mar. 9, 2016).

[87] Jonathan Mansbach, et al, *Which Psychiatric Patients Board on the Medical Service?*, PEDIATRICS, June 2003, Vol. 111(6), at 696, *available at* http://pediatrics.aappublications.org/content/111/6/e693 (last visited Mar. 9, 2016).

[88] Arizona Hospital and Healthcare Association, *Waiting for Care: Causes, Impacts, and Solutions to Psychiatric Boarding in Arizona*, July 2015, at 13, *available at* www.azhha.org/wp-content/uploads/2015/07/Psychiatric-Boarding-Full-Report.pdf (last visited Mar. 9, 2016).

[89] *Id.* at 15, 19.

part of an expansion of services for children with mental illnesses.[90] Although these states have taken steps in the right direction, most have not. Psychiatric boarding can be expected to continue nationally unless efforts are made at the legislative level to address it as a policy issue.

When does the patient's behavior trigger a health care provider's duty to warn?

Confidentiality is essential to the provider-patient relationship. Patients must be assured that their communications with mental health professionals will be maintained in confidence to encourage them to seek necessary treatment and to avail themselves of the maximum benefit of the treatment. Various laws, regulations, and ethical standards protect communications made in the course of behavioral health treatment,[91] and duty to warn statutes and judicial precedent vary significantly by state.[92]

At the same time, exceptions exist for situations in which health care providers, including mental health professionals, learn about potential harm that their patients may cause to themselves or others. The types of dialogue and communication from the seriously mentally ill to their providers may make it difficult to assess actual risks associated with a patient-made threat. Where a serious and imminent risk exists, however, the provider has the ability, and sometimes the duty, to warn, with varying amounts of immunity in doing so.

There is considerable variation from state to state regarding civil protection in the disclosure of a risk of violence presented by a patient. Most states have statutes that were enacted following the landmark case of *Tarasoff v. Regents of University of*

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[90] Chris Serres, *Facing chronic shortages, Minnesota's mental health system gets a boost*, STAR TRIBUNE, May 29, 2015, 7:53 AM, *available at* www.startribune.com/facing-chronic-shortages-minnesota-s-mental-health-system-gets-a-boost/305409651/ (last visited Mar. 9, 2016).

[91] Child Welfare Information Gateway, *Mandatory Reporters of Child Abuse and Neglect*, 2014, *available at* www.childwelfare.gov/pubPDFs/manda.pdf.

[92] Approximately two-thirds of the states have enacted statutes to limit or clarify provider liability to third parties, and three states have rejected the doctrine in court decisions. *See* National Conference of State Legislatures, *Mental Health Professionals' Duty to Warn*, Sept. 28 2015, *available at* www.ncsl.org/research/health/mental-health-professionals-duty-to-warn.aspx.

California.[93] In some states there is a mandatory duty, while in others disclosure is permissive. Some state laws are specific about what must be done when a risk of violence is identified. Statutory immunity is available in some states, but not all, for warning of a patient's potential violent act. The appellate courts of some states have analyzed duties to warn based on state statutes and case law. Three states, Texas, Florida, and Virginia, have repudiated the rule in *Tarasoff.*[94] An excellent state-by-state resource has been provided by the National Council of State Legislatures.[95]

In the pediatric setting, the practitioner also must consider state laws relating to disclosure of information to parents, guardians, surrogates, and government officials. The Health Insurance Portability and Accountability Act Privacy Rule specifically authorizes disclosure when there is "a good faith belief that the disclosure . . . is necessary to prevent or lessen a serious and imminent threat to the health or safety of the patient or others."[96] The authorization is subject to "applicable law and standards of ethical conduct."[97] The Frequently Asked Question page of the U.S. Department of Health and Human Services uses the example of a teenage patient who has made a credible threat against a fellow student. In that case, federal law permits the mental health provider to "alert law enforcement, a parent or other family member, school administrators or campus police, or others the provider believes may be able to prevent or lessen the chance of harm."[98]

Ohio is an example of a state with a mandatory duty to warn law.[99] It provides that a mental health professional may be held liable for damages or subject to disciplinary action from a regulatory agency for failing to predict, warn, or take precautions to provide protection only if a patient or other knowledgeable person has communicated a

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[93] 17 Cal. 3d 425, (1976).
[94] *See also Boynton v. Burglass*, 590 So.2d 446 (Fla. Dist. Ct. App. 1991); *Thapar v. Xezulka*, 994 S.W.2d 635 (Tex. 1999); *Nasser v. Parker*, 249 Va. 172 (1995).
[95] *See supra* note 91.
[96] U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES, *520-Does HIPAA permit a provider to disclose PHI about a patient if the patient presents a serious danger to self or others?*, HHS.gov, *available at* www.hhs.gov/hipaa/for-professionals/faq/520/does-hipaa-permit-a-health-care-provider-to-disclose-information-if-the-patient-is-a-danger/.
[97] 45 C.F.R. § 164.512(j)(1).
[98] *See supra* note 96.
[99] OHIO REV. CODE § 2305.51.

specific threat to clearly identifiable potential victims and the provider has reason to believe that the patient has the intent and ability to carry out the threat.[100] The statute prescribes specific actions that the provider is required to take when those factors are present to benefit from statutory immunity.

Oregon is a permissive warning state.[101] ORS § 179.505(12) provides that "information obtained in the course of diagnosis, evaluation or treatment . . . that, in the professional judgment of the health services provider indicates a clear and immediate danger to others or society may be reported to the appropriate authority."[102] The statute also provides that a decision not to disclose does not subject the provider to liability.[103]

The ethical codes and guidelines of professional organizations also address the intersection of confidentiality and protection.[104] The subject of disclosing confidential patient communications to prevent or lessen the risk of the patient harming self or others has come under increased discussion following recent mass shootings and other events reported in the media. The inherent difficulty in predicting violent behavior, and in distinguishing between dangerous thoughts and the likelihood of acting on them, make this an issue of great concern to health care professionals.

What are health care providers' responsibilities regarding adolescent patient sexting?

Sexting, otherwise known as "the sending of sexually explicit messages or images by cell phone," has garnered significant attention as a major mental health problem among adolescents.[105] According to a 2015 survey, sexting is ranked as the sixth biggest

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[100] *Id.* at 2305.51 (B).
[101] *See* OR. REV. STAT. § 179.505(12).
[102] *Id.*
[103] *Id.*
[104] *See, e.g.*, Code of Ethics of the National Association of Social Workers, 1.07(c), *available at* www.socialworkers.org/pubs/code/code.asp; Ethical Principles of Psychologists and Code of Conduct, 4.05(a), *available at* http://www.apa.org/ethics/code/.
[105] Sexting, Merriam Webster, *available at* www.merriam-webster.com/dictionary/sexting (last visited Mar. 9, 2016).

health concern for children across the United States.[106] Other studies have shown that sexting may have potentially harmful consequences on this vulnerable population.[107]

Although sexting is frequently discussed in the media and academia, there is limited research, and therefore limited guidance available, regarding how health care providers should respond. In other words, what must a health care provider do if they learn that an adolescent patient has been involved in sexting?

Depending on the circumstances and contents of the communication, the health care provider may have a duty to report. Whether there is such a duty will vary based on the particular state's definitions of "abuse" and "neglect" and the mandatory reporting laws for child abuse and neglect.

Aside from reporting obligations, knowledge that an adolescent patient is involved in sexting may influence a health care provider's behavioral health diagnosis of the patient. Sexting may cause harmful psychological and physical consequences, including feelings of shame and guilt, substance abuse, depression, and suicide.[108] Sexting also may lead to digital abuse, online harassment, and cyberbullying. As a result, health care providers should consider how sexting may impact the patient's course of treatment and discharge planning.

Even when a health care provider has no knowledge that an adolescent patient is involved in sexting, they should consider screening for sexting behaviors. Providers also

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[106] C.S. Mott Children's Hospital, National Poll on Children's Health (2015), *available at* http://mottnpch.org/sites/default/files/documents/081015_top10.pdf (last visited Mar. 9, 2016).

[107] *See, e.g.,* Antoinette Davis, *Interpersonal and Physical Dating Violence among Teens*, NATIONAL COUNCIL ON CRIME AND DELINQUENCY, Sept. 2008, *available at* www.nccdglobal.org/sites/default/files/publication_pdf/focus-dating-violence.pdf (last visited Mar. 9, 2016); *see also* Elizabeth Miller and Robin Kirkpatrick, *Promoting Healthy Relationships (HEART) Primer and Training Project*, Presentation at the 2012 National Health Conference on Domestic Violence, Mar. 30, 2012, *available at* https://nchdv.confex.com/nchdv/2012/webprogram/Session2223.html (last visited Mar. 9, 2016).

[108] Sameer Hinduja & Justin Patchin, *Bullying, Cyberbullying, and Suicide*, ARCHIVES OF SUICIDE RESEARCH, 14(3), 206-221(2010), *available at* http://cyberbullying.org/cyberbullying_and_suicide_research_fact_sheet.pdf (last visited Mar. 9, 2016); Kim Zetter, *Parents of Dead Teen Sue School Over Sexting Images*, WIRED, Dec. 8, 2009, 8:00 AM, *available at* www.wired.com/2009/12/sexting-suit/ (last visited Mar. 9, 2016); Elizabeth J. Meyer, *'Sexting' and Suicide*, PSYCHOLOGY TODAY, Dec. 16, 2009, *available at* www.psychologytoday.com/blog/gender-and-schooling/200912/sexting-and-suicide (last visited Mar. 9, 2016).

should consider educating parents about sexting. This approach is supported by the American Academy of Pediatrics, which recommends providers counsel parents to talk with their children about the technologies they are using and develop a plan for online use.[109]

Sexting raises complex mental health issues. As a result, it is important for health care providers to stay informed about issues related to sexting. By staying informed, health care providers will know how to analyze the facts, recognize when a duty to report arises, and be able to inform patients and their families about the potential consequences and risks involved.

[109] American Academy of Pediatrics, *The Impact of Social Media on Children, Adolescents, and Families,* PEDIATRICS, Apr. 2011, *available at* http://pediatrics.aappublications.org/content/127/4/800.long (last visited Mar. 9, 2016).