insanity" (*Payne*, p 710 (citing *Barcroft*, p 1003)). The Indiana Supreme Court directly compared Mr. Payne's case with *Barcroft*, a similar case in which a guilty but mentally ill verdict was reached and later upheld despite unanimous expert testimony of the defendant's legal insanity. In *Barcroft*, the court found "flaws" and "inconsistencies" in the experts' opinions, including lack of agreement with respect to diagnosis and insufficient record review. Problems with the expert opinion in *Barcroft* helped support the court's finding that the factfinder was justified in rejecting the defendant's insanity defense and finding the defendant guilty but mentally ill, given the demeanor evidence in the case from which to infer the defendant's sanity. In *Payne*, the court asserted, there were no problems with expert opinion. Although one expert could not form a strong opinion regarding Mr. Payne's sanity at the time of the 2005 arson, the court did not construe this as a conflict between the experts.

Taken together, Mr. Payne's well-documented psychiatric history and the credible, unanimous expert opinions of insanity outweighed the probative value of demeanor evidence and led to the court's finding of not guilty by reason of insanity instead of guilty but mentally ill.

### Discussion

The insanity defense remains controversial, despite the fact that it has existed in some form or another for centuries. As the Indiana Supreme Court stated, mental health professionals play a key role in the factfinders' determination of insanity, but they often cannot opine regarding the ultimate legal question. As in *Barcroft*, the court in *Payne* evaluated the experts' opinions as a component of determining whether the lower court erred in its reliance on demeanor evidence in finding the defendant guilty but mentally ill. Ultimately, Mr. Payne's extensive, well-documented psychiatric history and expert consensus were sufficiently persuasive to the court, and both outweighed the probative value of the demeanor evidence in this case.

In addition to the defendant's extensive documented psychiatric history and consistency of expert opinions, the court also noted the thoroughness of the expert evaluations in this case as influential factors in its ruling. This contrasts with *Barcroft*, in which insufficient record review by the expert witnesses was cited as a determining factor in upholding the lower court's decision. These variable outcomes highlight for forensic psychiatrists that the process by which we reach our opinions is just as important to the court as our ultimate recommendations.

Notably, Mr. Payne spent 11 years undergoing competency restoration prior to standing trial. Significant variability exists regarding states' approach to competency restoration, including the maximum time allowed by statute for restoration or, after an initial finding of incompetence to stand trial, the maximum time a defendant can be hospitalized thereafter (Parker GF: The quandary of unrestorability. J Am Acad Psychiatry Law 40:170–6, 2012). Recent research, however, suggests that the majority of defendants are restored to competence within a year, and restoration becomes rare after three years (Morris DR, DeYoung NJ: Long-term competence restoration. J Am Acad Psychiatry Law 42:81–90, 2014).

## Length of Emergency Department Confinement for Psychiatric Patients

**Pratik Jain, MD**
***Fellow in Forensic Psychiatry***

**Hassan M. Minhas, MD**
***Assistant Clinical Professor of Psychiatry***

***Law and Psychiatry Division***
***Department of Psychiatry***
***Yale University School of Medicine***
***New Haven, Connecticut***

### Prolonged Involuntary Confinement of Psychiatric Patients in the Emergency Department Is Not a Constitutional Violation, Provided the Period of Confinement Is No Longer than Necessary

DOI:10.29158/JAAPL.210003L2-21

**Key words:** appeal; confinement; emergency department; EPIA; involuntary; detention period

In *Massachusetts General Hospital v. C.R.*, 142 N. E.3d 545 (Mass. 2020), the Massachusetts Supreme Judicial Court reversed the decision of the Appellate Division of the Boston Municipal Court. The appeal

pertained to two separate provisions under Mass. Gen. Law ch. 123 § 12 (2018). The first provision in the statute deals with the initial commitment to an emergency department (ED) for purposes of evaluation, stabilization, and disposition. The second provision deals with commitment for a more thorough evaluation of the patient after being admitted from the ED to an inpatient unit. Under the statute, the initial ED commitment does not have a defined time limit, whereas the initial commitment to an inpatient unit does (i.e., three days). The municipal court ruled that the clock on the three-day time period should start running when the patient is initially detained in the ED. The supreme judicial court disagreed and ruled that the three-day time period should begin only once the patient has been admitted to the inpatient facility, regardless of the length of time the patient may have been held in the ED.

### Facts of the Case

On August 10, 2018, C.R. was found to be exhibiting signs of mental illness at Logan Airport in Boston. Police were summoned, and they found C.R. in an agitated state, which led them to restrain and transport her to the Massachusetts General Hospital (MGH) ED. In the ED, C.R. was administered intramuscular antipsychotic medications and placed in seclusion in four-point restraints. On the basis of her mental state, physicians decided to seek a single-occupancy room for psychiatric admission. C.R. was held at the MGH ED until August 15, 2018, when an appropriate bed was located at a licensed inpatient unit at MGH (i.e., Blake 11). C.R. was transferred to Blake 11 for admission the same day. On August 16, MGH filed for a petition for commitment under Mass. Gen. Law ch. 123, § 12(b) (2018), which allows a three-day commitment for thorough psychiatric evaluation. MGH's reasoning for commitment stated that "because of her florid mania and delusional thinking, [C.R.] appears unable to take care of her basic needs in the community" (*MGH*, p 548).

C.R. filed a *pro se* petition on August 16 for an emergency hearing challenging her commitment, which was denied without a hearing. A second request for a hearing was filed by C.R.'s counsel the following day. At the hearing on August 20, the lower court denied her request for immediate release due to concerns of substantial risk of harm to others. On August 23, C.R. petitioned for dismissal of MGH's petition for lack of jurisdiction due to the petition having been filed outside of the three-day period. During the hearing, Dr. Stuart Beck from Blake 11 testified about the frequent question of ED boarding. He testified that patients are often kept for extended periods of time awaiting appropriate placement. Following the hearing, C.R.'s motion to dismiss MGH's petition was denied, and the judge granted an order for civil commitment for a period of up to two weeks. On August 29, C.R. appealed both the denial of motion to dismiss and the order of involuntary commitment. On September 5, 2019, the Appellate Division of the Boston Municipal Court reversed the lower court's denial to dismiss the petition for lack of jurisdiction. The Appellate Division also acknowledged the statute's lack of clarity about the start of the three-day detention period. The municipal court ruled that the three-day period "begins when a patient arrives at an emergency department or a psychiatric facility" (*MGH*, p 549) and that MGH had failed to file the petition in a timely manner because it was filed after the three-day period had elapsed. Following this verdict, MGH filed an appeal with the Massachusetts Supreme Judicial Court.

### Ruling and Reasoning

Mass. Gen. Laws ch. 123 § 12 (2018) governs the emergency restraint, evaluation, care, and potential hospitalization of persons posing risk of serious harm by reason of mental illness. This section has five further subsections, of which the two relevant to this case are § 12(a), which allows ED confinement of a patient deemed to present with imminent risk, and § 12(b), which allows inpatient confinement of a patient for a period of three days for purposes of thorough evaluation. The Massachusetts Supreme Judicial Court noted that, unlike § 12(b), § 12(a) does not have a defined time limit. The court stated that the time spent in the ED for evaluation under § 12(a) is crucial for accurate assessment and is required "to make a valid clinical determination of a patient's need for continued psychiatric hospitalization" (*MGH*, p 552). The court acknowledged that because the statute is silent on the maximum time period allowed to hold a patient in the ED, a patient may theoretically be indefinitely held should appropriate disposition not be available. The court discussed the current reality of lack of inpatient resources and weighed the downside of a lengthy ED stay with various alternatives (such as potentially

being taken into police custody to mitigate imminent risk). The court referred to *Pembroke Hosp. v. D.L.*, 122 N.E.3d 1058 (Mass. 2019) and *Matter of a Minor*, 148 N.E.3d 1182 (Mass. 2020), which both discuss the laws relating to conditions of prolonged confinements as requiring narrow tailoring to serve legitimate governmental interest and the least restrictive means to vindicate that interest.

In the ruling, the court held that the five days of confinement that C.R. experienced were justified, given that the period of confinement was no longer than necessary to find a clinically appropriate placement. The court refrained from defining a set time period for ED confinement and deferred the question of length of ED confinement to the state legislature.

### Discussion

Massachusetts, similar to other states, has a distinct set of laws governing involuntary mental health treatment. Mass. Gen. Laws ch. 123 § 12 (2018) allows for confinement for purposes of evaluation at a psychiatric facility for a three-day period. The statute, however, is silent on the length of time of confinement in the ED prior to placement at a psychiatric facility. It is possible that this is because, at the time the statute was written, the legislature did not anticipate patients being held for significant periods of time in the ED. Currently, however, it is not surprising for patients to be held in the ED for extended periods of time, due largely to a lack of available inpatient resources.

In stating that MGH was reasonable in holding the patient for as long as they did, the Massachusetts Supreme Judicial Court highlighted the theoretical possibility of a patient's being held indefinitely in the ED should appropriate inpatient placement not be available. This raises a practical concern that affects all psychiatric patients, especially those in the most vulnerable psychiatric patient populations, such as children and individuals with low baseline levels of functioning (e.g., those with autism spectrum disorder or intellectual disability). It is unfortunate that the populations of patients most negatively affected by being confined to an ED are the same ones who are most likely to be confined for a longer period of time.

As a second topic, this case highlighted that the right to appeal involuntary commitments under the Mass. Gen. Laws ch. 123 § 12 is applicable only from a psychiatric facility (i.e., a patient in the ED cannot petition the court). The court noted that EDs are not incentivized to prolong confinement of patients and that any delays in confinement would therefore be required for accurate assessment and stabilization. The court also cited the Expedited Psychiatric Inpatient Admission Protocol 2.0 (EPIA 2.0) of the Massachusetts Office of Health and Human Services, which has laid out clear steps for managing cases of individuals who are difficult to place. The court stated that the question of setting a time limit would be better addressed by the legislature, which was "diligently working" on situations of prolonged ED confinements. Enforcing a time limit on ED stays would also run the risk of premature discharges of patients with a level of psychiatric instability that would put them at risk for negative consequences to their mental health and safety or for endangering the public. This would disproportionally affect high-risk populations such as intellectually disabled or autistic children who already have limited options.

Balancing autonomy and civil liberty with paternalism (i.e., the need for mandated confinement or treatment for those severely ill) is not an uncommon challenge in psychiatric practice. Defining the time period that a patient may be held in the ED may be logical from a liberty perspective given the reality of limited resources, but such a time limitation is not practical. The utopian health system would have more beds than required, limited ED stays, and prompt treatment. In the absence of such a utopian system, both the legislature and the health care systems and providers need to continue to focus on addressing the challenges raised in this case, not by imposing time limits on ED confinement but rather by increasing available resources.

## A Reasonable-Time Standard for Identifying and Evaluating Students with Suspected Disability

**Cara Struble, MA**
***Predoctoral Fellow in Clinical Psychology***

**Alexander Westphal, MD, PhD**
***Associate Professor of Psychiatry***

***Law and Psychiatry Division***
***Department of Psychiatry***