

Involuntary Evaluation Capacity and Medical Clearance

Capacity means you can understand the facts, see how they apply to you, reason through your options, and tell someone your choice.

THE STORY IN ONE SENTENCE

Capacity means you can understand the facts, see how they apply to you, reason through your options, and tell someone your choice.

“An involuntary hold needs danger plus mental illness plus unable to care for self plus no safer option. Capacity needs understanding plus appreciation plus reasoning plus communication. Medical clearance needs vital signs plus labs plus safety risk plus a physical exam. Every piece of capacity is tested for THIS decision right now—not forever, not for everything.”

Normal anatomy — the body's job

Your brain uses chemical messengers—dopamine (pushes action and reward), serotonin (smooths mood and sleep), norepinephrine (wakes you up and focuses you), GABA (the main brake that calms everything down), and glutamate (the main gas pedal that fires neurons)—to keep your thinking, feeling, and choosing in a safe, flexible range.

BODY'S JOB

The prefrontal cortex (the front strip of your brain, right behind your forehead) plans ahead, weighs options, and puts the brakes on big feelings or risky ideas. The limbic system (a loop of structures deep in the center, including the amygdala that flags danger and the hippocampus that files memories) decides what is safe or scary and tags every moment with an emotion. These two teams talk constantly—so you can feel fear when you see a threat but also think through whether the threat is real and choose a smart response instead of just running or freezing.

1. The amygdala (your alarm center) scans everything you see, hear, or remember and flags anything that might be dangerous.
2. It sends that alarm signal up to the prefrontal cortex (your planning and braking center) to double-check: Is this actually a threat right now, or just a memory or a misread?

3. If the prefrontal cortex agrees there is real danger, it helps you pick the safest action—run, freeze, call for help, or fight only if you must.
4. If the prefrontal cortex sees no real danger, it sends calming signals (using GABA) back down to quiet the amygdala so you can relax and move on.
5. Meanwhile, dopamine (reward messenger), serotonin (mood smoother), and norepinephrine (alertness messenger) adjust how motivated, steady, and focused you feel while you make the choice.
6. When all these messengers and brain regions stay balanced, you can understand new information, see how it applies to you, weigh your options, and clearly tell someone your decision.

What breaks

Chronic stress, trauma, severe mental illness (like schizophrenia or bipolar disorder), substance use, or a medical emergency (brain bleed, infection, dangerously low blood sugar, thyroid storm) can flood or starve the brain's chemical messengers and damage the prefrontal cortex (the part that plans and brakes) and the hippocampus (the part that files memories and context). When that happens, the amygdala (alarm center) stays on high alert with no one to calm it down, so every moment feels dangerous even when it is not, and the person cannot think through choices clearly or see how the facts apply to their own safety.

CLINICAL TERM

Dysregulation of dopamine, serotonin, norepinephrine, GABA, and glutamate signaling—combined with structural or functional impairment of the prefrontal cortex and limbic circuits (amygdala hyperactivity, hippocampal atrophy from chronic cortisol exposure)—produces the clinical picture: impaired insight (anosognosia), disorganized thought process, fixed false beliefs (delusions), perceptual disturbances (hallucinations), or severe mood dysregulation that together prevent the patient from meeting the four criteria for decisional capacity.

How the body compensates

The brain tries to defend itself by turning up the alarm system (more adrenaline and norepinephrine to stay alert) or by shutting down completely (flat affect, no motivation) to

conserve energy. Both strategies can hide how sick someone really is—until the system runs out of workarounds and the person suddenly cannot function at all.

1. {'step': "Early on, high adrenaline and norepinephrine (the body's fight-or-flight chemicals) keep the person moving, talking, and looking alert even though their reasoning and insight are already broken.", 'hidden_risk': "They may seem just 'difficult' or 'anxious,' so the team does not realize the person has lost the capacity to weigh risk and is about to leave against medical advice into a dangerous situation."}
2. {'step': 'Or the brain shuts down into flat affect, poverty of speech, and no motivation (negative symptoms, often from low dopamine or exhaustion of the prefrontal cortex) so the person looks calm and cooperative.', 'hidden_risk': 'The team assumes capacity is intact because the patient is quiet, but the person is not actually understanding or reasoning—they are just too depleted to argue or ask questions.'}
3. {'step': 'Meanwhile, social chaos (homelessness, active substance use, abusive relationships, untreated chronic pain) keeps pouring stress hormones (cortisol, adrenaline) into the system, so the brain never gets a chance to reset, and every compensation breaks down faster.', 'hidden_risk': 'If you only treat the biology (give antipsychotic or mood stabilizer) but send the patient back into the same chaos, the medications cannot work and the cycle repeats in days.'}
4. {'step': 'Biggest danger: a true medical emergency (brain bleed, low blood sugar (hypoglycemia), thyroid storm, serotonin syndrome, severe infection) that presents with confusion, agitation, or paranoia and gets mistaken for primary psychiatric illness.', 'hidden_risk': 'The patient is rushed to a psychiatric hold without a full physical exam and labs, and the bleeding or metabolic crisis is missed until they collapse. Always check vital signs (including temperature and oxygen), fingerstick glucose, and a focused neuro exam before assuming the problem is purely psychiatric.'}
5. {'step': "Patients of color, especially Black men, are statistically more likely to be placed on involuntary holds, physically restrained, and undertreated for pain or medical complaints because of implicit bias—so the same refusal or agitation is seen as 'dangerous behavior' instead of a symptom of fear, pain, or medical crisis.", 'hidden_risk': 'The system moves too fast to coercion and misses both the medical differential and the chance to build trust and restore capacity through calm explanation and shared decision-making.'}

Domino effect

1. Chronic stress, trauma, or untreated mental illness floods the brain with cortisol (the body's main stress hormone), which over time shrinks the hippocampus (your memory and context filer) and weakens the prefrontal cortex (your planner and brake). — With a smaller hippocampus, you cannot file new memories or pull up the right context to make sense of what is happening now—so the doctor's explanation does not stick, and you cannot connect the facts to your own safety. With a weaker prefrontal cortex, you cannot weigh options, see consequences ahead, or calm down the amygdala's alarm signals. This breaks two of the four pieces of capacity: understanding (you cannot hold the information) and appreciation (you cannot see how it applies to you).
2. The amygdala (your alarm center) loses its brake from the prefrontal cortex and stays on high alert, tagging safe people, safe places, and helpful medical care as threats. — You feel terror or rage even though the nurse is just trying to start an IV, so you refuse, pull away, or try to leave—because your brain is screaming danger. This looks like 'behavioral' refusal, but it is actually a broken threat-detection system, and it breaks the third piece of capacity: reasoning (you cannot weigh the real risks because everything feels like a threat).
3. In psychosis (schizophrenia, severe bipolar mania, or drug-induced), dopamine signaling in the mesolimbic pathway (deep reward and emotion circuit) runs too high, creating hallucinations (you hear voices that are not there) and delusions (you believe things that are not true and cannot be talked out of them). — The extra dopamine makes your brain assign meaning and importance to random noise—so you hear the voice of God or the CIA in the static, or you believe the medical team is poisoning you. This breaks appreciation and reasoning: you cannot see that the facts the doctor is telling you are real, because your brain is generating a louder, scarier alternative reality.
4. At the same time, low serotonin (common in depression and anxiety) removes the mood stabilizer, and low GABA (the brain's main calming signal) removes the brake on panic and agitation. — You swing between hopelessness so deep you cannot see any point in treatment (breaks communication of a choice—you just say 'I don't care' or go silent) and terror so intense you cannot sit still long enough to hear the explanation (breaks understanding—you cannot take in new information when your nervous system is in overdrive).
5. Social amplifiers—homelessness, active substance use, untreated chronic pain, abusive relationships, isolation—keep the stress-hormone tap wide open, so the brain never gets a break to repair the circuits. — Cortisol and adrenaline stay high, inflammation stays high, sleep stays broken, and nutrition stays poor—so even the right medication (antipsychotic, mood stabilizer, antidepressant) cannot work if the environment is still dangerous. Biology and social factors are not separate; they feed each other in a loop, and you must treat both at the same time or the person will cycle back into crisis within days of discharge.

6. A hidden medical emergency (hypoglycemia, intracranial bleeding (hemorrhage), thyroid storm, serotonin syndrome, severe infection, or acute liver failure) disrupts the brain's fuel, oxygen, or chemical balance and produces confusion, paranoia, aggression, or refusal that looks identical to primary psychiatric illness. — The person cannot answer simple orientation questions, their speech is garbled, they are combative or trying to leave, and the team assumes 'agitated psych patient'—but the real problem is the brain is starving for glucose, drowning in toxins, bleeding, or on fire with fever. If we skip the vital signs, fingerstick glucose, and basic labs, we miss the one thing that will kill them in the next hour, and we lose the chance to restore capacity by fixing the medical crisis first.
7. Once you stabilize the biology (safe blood sugar, controlled blood pressure, right psychiatric medication, treatment of infection, fluids, oxygen) AND reduce the social stressors (safe place to sleep, case management for housing or substance treatment, harm reduction, trauma-informed care, pain control) at the same time, the prefrontal cortex and hippocampus can start to recover, the amygdala can calm down, and the neurotransmitters can rebalance. — Capacity is not permanent—it can come back as the brain heals. As the person becomes less confused, less terrified, and more able to hold a conversation, they often regain the ability to understand the facts, see how the facts apply to them, reason through the options, and communicate a stable choice. The goal of the involuntary hold is always to restore capacity as quickly as possible so the person can make their own decisions again, not to keep them locked up. We are buying time for the brain and the social safety net to stabilize together.
8. Throughout this process, we must watch for implicit bias—especially the tendency to see refusal or fear in patients of color, particularly Black men, as 'dangerous' or 'non-compliant' rather than as a symptom of pain, medical crisis, or justified distrust of a system that has historically harmed them. — If we move too fast to restraints or involuntary holds without doing the full medical workup and without taking time to build trust and explain clearly, we worsen the trauma, break the therapeutic relationship, and miss the real diagnosis. Capacity assessment and medical clearance must be done with the same rigor and respect for every patient, regardless of race, and we must name and interrupt our own biases every single shift.

Symptoms · what the patient feels, and why

- Patient cannot explain what the proposed treatment is or what it would involve: The frontal lobe (the planning and understanding part of the brain) may be injured by illness, confusion, or altered mental state, so the person cannot hold or repeat back the basic facts being explained to them.
- Patient cannot say what might happen if they accept or refuse the treatment: Damage or disruption to the prefrontal cortex (the part of the brain that weighs choices and outcomes) keeps the person from connecting a choice to its likely result, even when told clearly.

- Patient cannot weigh the risks and benefits to make a choice: Executive function circuits (the brain's decision-making wiring) are offline due to psychosis, delirium, intoxication, or severe depression, so the person cannot compare options or settle on one.
- Patient's reasoning is driven entirely by a delusion or false belief: The dopamine pathways in the limbic system (deep emotion and reward circuits) are overactive or misfiring, locking the person into a fixed, false idea that blocks logical thought about the real situation.
- Patient cannot communicate a stable choice over time: Fluctuating consciousness (as in delirium) or severe thought disorganization (as in acute psychosis) means the person's answer changes minute to minute because attention and memory are unstable.
- Patient is cooperative but answers are vague, off-topic, or nonsensical: Wernicke's area or other language and reasoning centers in the left hemisphere are impaired by stroke, encephalopathy, or severe psychiatric illness, so words come out but do not form a logical thread.
- Patient seems alert but cannot hold new information for more than a few seconds: The hippocampus (the brain's memory-storage gatekeeper) is disrupted by low oxygen (hypoxia) (low oxygen), infection, or metabolic problems, so new facts slip away immediately and capacity cannot be tested.
- Patient refuses to engage in the capacity interview at all: Severe depression, paranoia, or catatonia shuts down motivation and communication; the refusal itself does not prove incapacity, but it prevents the four-part assessment from being completed.

Focused exam

- Patient refuses psychiatric evaluation or medical exam: Refusal itself is not proof they cannot decide. You must write down exactly WHAT they refuse and WHY they say they refuse it. This creates the record you need before you decide if they truly lack capacity for THIS choice.
- Does the patient understand the situation? (Ask: 'Doctors are worried about you. Can you tell me what is happening right now?'): Understanding is the first piece of capacity. They need to grasp the facts: where they are, what the worry is, what people are asking them to do. If they cannot repeat back the basics, that piece is broken. Capacity is decision-specific—they might understand other things perfectly.
- Does the patient believe the information applies to them? (Ask: 'Do you think you are in danger? Do you think this problem is real for you?'): Appreciation is the second piece. A person can repeat your words but not believe they are sick. This is called anosognosia (lack of insight into illness). If they cannot see that the danger or illness is real and happening to them right now, that piece is broken.

- Can the patient reason through the choice? (Ask: 'What might happen if you leave? What might happen if you stay?'): Reasoning is the third piece. They need to weigh what happens with each option—'If I stay, I get help. If I leave, I might get hurt.' If they accept or refuse care without any thought about consequences, that piece is broken.
- Does the patient state a clear choice? (Listen for: 'I want to leave' or 'I will stay,' even if the choice seems wrong): Expression is the fourth piece. You need to hear them say a choice out loud. Silence, mumbling, or jumbled words mean you cannot assess this piece, and without it you cannot say capacity exists.
- Vital signs (heart rate, blood pressure, temperature, oxygen, glucose), plus a quick neuro check (pupils, strength, speech): Thyroid storm, low blood sugar (hypoglycemia) (low blood sugar), brain bleed, serotonin syndrome, and severe infections can all LOOK like a mental health crisis but they kill if you miss them. Medical clearance happens first, before any psychiatric hold.

Diagnostics · every test answers a question

- Fingerstick glucose → Is the brain getting enough fuel right now?
- Complete blood count (CBC) → Is there infection or severe anemia hiding?
- Basic metabolic panel (BMP, also called Chem-7) → Are sodium, potassium, or kidney function out of balance?
- Thyroid-stimulating hormone (TSH) → Is the thyroid running too fast or too slow?
- Urine drug screen (UDS) → Is intoxication or withdrawal driving the behavior?
- Electrocardiogram (ECG) → Is the heart rhythm stable and safe for psychiatric medications?
- Urinalysis (UA) and urine culture if indicated → Is a urinary tract infection causing delirium?
- CT head (non-contrast) if new confusion, focal weakness, severe headache, or fall → Is there bleeding, stroke, or a mass in the brain?

Treatment logic

- Assess the four capacity components for THIS specific decision: understanding the situation, appreciating it applies to them, reasoning through choices, and stating a clear choice → Documents exactly which thinking steps are broken and whether the person can legally consent to or refuse care. This protects their autonomy when capacity is intact and justifies involuntary care when it is not.

- Medical clearance: rule out delirium, intoxication, low blood sugar (hypoglycemia), infection, stroke, thyroid storm, or medication side effects mimicking psychiatric crisis → Finds and fixes reversible medical causes that look like mental illness. Treating a UTI-driven delirium or giving glucose for low blood sugar (hypoglycemia) can restore capacity in minutes to hours without any psychiatric medication.
- Involuntary psychiatric hold (criteria: imminent danger to self, imminent danger to others, or grave disability preventing basic self-care) with interpreter services if needed—never use family as interpreter for safety or consent questions → Removes the person from immediate harm and creates a monitored space to stabilize the brain without the crisis stressor making things worse. Allows you to assess and treat safely.
- Medication targeting the specific brain circuit: antipsychotic (blocks dopamine) for psychosis, antidepressant (boosts serotonin) for severe depression, benzodiazepine (boosts GABA, the brain's calming signal) for acute agitation or panic → Rebalances the neurotransmitter the brain was using to cope with stress. Dopamine blockers quiet hallucinations and paranoia. Serotonin boosters lift mood and reduce suicidal thinking. GABA boosters stop the thought-spiral and physical panic.
- Before discharge: coordinate housing, substance-use treatment if needed (medication-assisted treatment for opioid or alcohol use disorder), outpatient psychiatry appointment within 7 days, and a written safety plan with crisis phone numbers → Removes the chaos and isolation that broke capacity in the first place. Stable housing, addiction treatment, and a follow-up plan lower the chance the person lands back in crisis.
- Reassess capacity after 24 to 72 hours of treatment, safety, and sleep. Capacity is task-specific and can return even if the underlying illness remains → Proves whether the person can now participate in their own care or whether involuntary treatment is still needed. Restoring capacity means restoring autonomy as soon as it is safe to do so.

Medications

Haloperidol (Haldol) · First-generation (typical) antipsychotic

Haloperidol blocks dopamine receptors (the brain's signaling spots for dopamine, a chemical messenger that controls movement and thinking). By blocking these receptors in certain brain areas, it turns down psychotic symptoms like hallucinations and dangerous agitation.

1. Dopamine tries to land on its receptors (D2 receptors) in the brain's emotion and thinking circuits.
2. Haloperidol sits on those receptors and blocks dopamine from binding.
3. With less dopamine signaling in the mesolimbic pathway, the brain's false alarms (hallucinations, delusions, severe agitation) quiet down.

4. The drug also blocks dopamine in the movement circuit, which is why it can cause stiffness, tremor, or restlessness (extrapyramidal symptoms).

SAFETY WATCH

Extrapyramidal symptoms (stiffness, tremor, restlessness, or slow shuffling walk) are common; diphenhydramine or benztropine can help. · QT prolongation: Haloperidol can stretch the heart's electrical recovery time (QT interval), which rarely can trigger a dangerous rhythm (torsades de pointes). Get an ECG before giving it if the patient has heart disease, low potassium, or low magnesium, or is on other QT-prolonging drugs. · Neuroleptic malignant syndrome (very rare but life-threatening): high fever, severe muscle stiffness, confusion, and fast heart rate. Stop the drug immediately and get intensive care. · Acute dystonia (sudden muscle spasm, especially of the neck, jaw, or eyes) can happen within hours; treat with diphenhydramine or benztropine IV. · Sedation and low blood pressure, especially in older adults or with IV dosing. · Does NOT treat alcohol or benzodiazepine withdrawal seizures; use benzodiazepines for those.

Lorazepam (Ativan) · Benzodiazepine

Lorazepam boosts the action of GABA (gamma-aminobutyric acid, the brain's main calming signal). When GABA binds to its receptors, it opens tiny gates that let chloride ions flow into nerve cells, making those cells less likely to fire. Lorazepam makes GABA work stronger, so the whole brain quiets down—calming severe anxiety, agitation, seizures, and alcohol withdrawal symptoms.

1. GABA (the brain's natural brake chemical) lands on GABA-A receptors on nerve cells.
2. When GABA binds, the receptor opens a channel that lets chloride ions flow into the cell.
3. Lorazepam latches onto a special spot on the same receptor and makes the channel open more often and stay open longer.
4. More chloride flowing in makes the nerve cell much harder to activate, so the brain's activity slows down—reducing agitation, panic, and seizure risk.

SAFETY WATCH

Respiratory depression (slowed or shallow breathing), especially when combined with opioids, alcohol, or other sedatives. Monitor breathing closely; have naloxone and flumazenil available if needed. · Over-sedation and risk of falls, especially in older adults. · Paradoxical agitation (rare): some people, especially older adults or those with dementia, become more agitated instead of calmer. · Dependence and withdrawal: even a few days of regular use can cause rebound anxiety, tremor, or seizures if stopped suddenly. Taper when stopping. · Low blood pressure (Hypotension) (low blood pressure) when given IV, especially if the patient is dehydrated or has heart problems. · Does NOT treat delirium tremens or withdrawal seizures alone—combine with thiamine, IV fluids, electrolyte replacement, and monitor closely in a supervised setting.

Olanzapine (Zyprexa) · Second-generation (atypical) antipsychotic

Olanzapine blocks dopamine receptors (especially D2) and serotonin receptors (especially 5-HT2A) in the brain. By blocking dopamine in the emotion circuit, it quiets hallucinations, delusions, and severe agitation. By also blocking serotonin, it causes fewer movement side effects than older antipsychotics and can help stabilize mood in bipolar disorder.

1. Dopamine and serotonin try to bind to their receptors in emotion, thinking, and movement circuits.
2. Olanzapine sits on D2 and 5-HT2A receptors and blocks both chemicals from binding.
3. Blocking dopamine in the mesolimbic pathway turns down hallucinations, delusions, and dangerous agitation.
4. Blocking serotonin (5-HT2A) in the nigrostriatal pathway lowers the risk of stiffness and tremor compared to first-generation antipsychotics.
5. Blocking histamine and other receptors in the hypothalamus increases appetite and can lead to weight gain and metabolic changes.

SAFETY WATCH

Metabolic syndrome: Olanzapine commonly causes weight gain, high blood sugar (hyperglycemia, which can unmask or worsen diabetes), high cholesterol, and high triglycerides. Monitor weight, fasting glucose, and lipids regularly. · Sedation, especially at higher doses or when starting. · Orthostatic low blood pressure (hypotension) (dizziness or fainting when standing up quickly), especially in older adults. · Extrapyramidal symptoms (stiffness, tremor) are less common than with haloperidol but can still happen, especially at high doses. · Prolonged QT interval (rare): can increase risk of dangerous heart rhythm. Get an ECG if the patient has heart disease or is on other QT-prolonging drugs. · Neuroleptic malignant syndrome (very rare): high fever, severe muscle stiffness, confusion. Stop the drug and seek emergency care. · Avoid in acute alcohol or benzodiazepine withdrawal seizures—use benzodiazepines for those.

Ziprasidone (Geodon) · Second-generation (atypical) antipsychotic

Ziprasidone blocks dopamine receptors (D2) and serotonin receptors (5-HT_{2A}) in the brain. Blocking dopamine in the emotion circuit reduces hallucinations, delusions, and severe agitation. Blocking serotonin lowers the risk of movement side effects. Ziprasidone is often chosen when weight gain and metabolic side effects are a concern, though it carries a higher risk of QT prolongation than some other atypicals.

1. Dopamine and serotonin try to bind to their receptors in the brain's emotion, thinking, and movement circuits.
2. Ziprasidone blocks D2 and 5-HT_{2A} receptors, preventing those chemicals from landing.
3. Blocking dopamine in the mesolimbic pathway turns down hallucinations, delusions, and dangerous agitation.
4. Blocking serotonin in the nigrostriatal pathway reduces the risk of stiffness and tremor.
5. The drug also affects potassium channels in the heart, which can prolong the QT interval (the heart's electrical recovery time).

SAFETY WATCH

QT prolongation: Ziprasidone stretches the heart's electrical recovery time more than most other atypical antipsychotics. Get a baseline ECG and avoid in patients with known long QT, recent heart attack, uncontrolled heart failure, or those taking other QT-prolonging drugs. Check potassium and magnesium levels and correct if low. · Extrapyramidal symptoms (stiffness, tremor, restlessness) can occur but are less common than with first-generation antipsychotics. · Orthostatic low blood pressure (hypotension) (dizziness or fainting when standing), especially when starting or increasing dose. · Sedation, though usually milder than with olanzapine or quetiapine. · Lower risk of weight gain and metabolic problems (diabetes, high cholesterol) compared to olanzapine or quetiapine, but still monitor weight, glucose, and lipids. · Neuroleptic malignant syndrome (very rare): high fever, severe muscle rigidity, confusion. Stop the drug immediately. · Must be taken with food (at least 500 calories) to be absorbed properly; not ideal for acutely agitated patients who refuse to eat.

Red flags

- Active hallucinations or delusions that control the patient's reasoning about treatment
- Fluctuating level of consciousness or attention span under two minutes
- Recent head injury, stroke, overdose, or metabolic crisis (hypoglycemia, severe sepsis, liver failure) that was not medically cleared
- Patient is a danger to self or others and emergency psychiatric hold is indicated under state involuntary-commitment law

Nursing priorities

1. Place patient on continuous observation with a sitter or in a room visible from the nursing station if danger to self or others is suspected — Patients with suicidal ideation, homicidal ideation (thoughts of hurting others), or severe agitation can act impulsively; direct observation prevents self-harm, elopement (leaving against medical advice), or violence in the seconds it takes to intervene
2. Obtain bedside fingerstick glucose immediately and repeat if below 70 mg/dL or above 250 mg/dL — Low blood sugar (Hypoglycemia) under 55 mg/dL causes confusion, aggression, and altered mental status that reverses in minutes with glucose; high blood sugar (hyperglycemia) above 250 can cause delirium; both mimic psychiatric emergency but need opposite treatments

3. Check vital signs including oxygen saturation, and perform a brief neurologic check: pupils equal and reactive, speech clear, face symmetric, grip strength equal — Fever suggests infection like urinary tract infection or pneumonia causing delirium; low oxygen causes agitation; unequal pupils or weak grip signals stroke; abnormal vitals require medical workup before psychiatric diagnosis
4. Remove any objects from the room that could be used for self-harm: belts, shoelaces, cords, sharp items, glass, and heavy objects — Patients in crisis have impaired impulse control (ability to stop an action before doing it); environmental safety reduces access to lethal means and buys time for de-escalation and psychiatric intervention
5. Speak in short, calm sentences; offer choices when safe; avoid arguing about delusions or asking why the patient feels a certain way — A confused or psychotic brain cannot process complex language or abstract questions; simple communication lowers the patient's stress response (fight-or-flight activation) and reduces agitation that can escalate to violence or medical decompensation
6. Document the four capacity components in the chart: does the patient understand the facts, appreciate they apply to them, reason through options, and communicate a stable choice — Legal and medical decisions hinge on structured capacity assessment; vague documentation like confused or uncooperative does not meet the standard for involuntary treatment or discharge planning and exposes the team to liability
7. Notify the physician immediately if the patient has fluctuating consciousness, cannot stay awake, or attention span is under two minutes — Waxing and waning alertness is the hallmark of delirium, a medical emergency with 25 percent mortality if the cause like sepsis, stroke, or medication toxicity is not found and treated within hours
8. Coordinate with social work and psychiatric services early to determine whether involuntary hold criteria are met under state law and to arrange safe disposition — Involuntary commitment requires specific legal criteria (imminent danger, grave disability) that vary by state; early involvement ensures the patient gets the right level of care—medical floor, psychiatric unit, or outpatient—and prevents unsafe discharge

Sources

- Appelbaum PS. Assessment of Patients' Competence to Consent to Treatment. NEJM 2007
- EMTALA and the Patient Anti-Dumping Law (CMS guidance on psychiatric screening and stabilization)
- APA Practice Guideline for the Psychiatric Evaluation of Adults, 3rd ed. 2016
- Grisso T, Appelbaum PS. Assessing Competence to Consent to Treatment: A Guide for Physicians and Other Health Professionals. Oxford 1998

Last reviewed: 2026-07-07