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Highlights From This Issue

Feature Article—We review the practical steps to initiating and supporting advance directive discussions and highlight the benefits of psychiatric advance directives for individuals with serious mental illness.

Feature Q&A—Drs. Zhong and Wasser challenge the reflexive use of psychiatric holds for grave disability, urging the field to recognize when hospitalization becomes futile and to invest in more humane, community-based alternatives.

Article on page 6—Moral injury in psychiatry arises when clinicians feel ethically compromised by systemic constraints. We review how to recognize and treat moral injury and how to distinguish it from burnout and PTSD.

Q&A on page 8—Dr. Minkoff explores the challenges of civil commitment for addiction, emphasizing that while well intentioned, these laws often fail due to inadequate treatment, lack of infrastructure, and the risk of misuse unless paired with compassionate, evidence-based care.

Advance Directives: Guiding Patients Toward Dignity and Autonomy

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Mr. Patel, a 67-year-old man with advanced heart failure, is admitted to the hospital after experiencing worsening shortness of breath. When his physician brings up advance directives (ADs), Mr. Patel shifts uncomfortably and says, "I don't want to talk about that—I'm not giving up. What I really need is to get my breathing under control." His care team notices a pattern: Whenever treatment decisions arise, he steers the conversation toward his medications or discharge plans, avoiding discussions about his preferences for future medical care.

ADs play an important role in patient care, but talking about them isn't always easy, as many individuals have fears and misconceptions about them that can make these conversations uncomfortable. While ADs are often associated with end-of-life planning, they also shape decisions long before the final stages of illness. Here we explore how ADs function, when psychiatry may be involved, and how to approach these discussions effectively.

What are ADs?

ADs are legal tools that empower patients to express their preferences for medical

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Rethinking Psychiatric Holds for Grave Disability

Q&A With the Expert

Rocksheng Zhong, MD, MHS

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Dr. Zhong owns stock in Mind Medicine, Inc. Relevant financial relationships listed for the author have been mitigated. Dr. Wasser has no financial relationships with companies related to this material.

CHPR: Many of us in inpatient psychiatry often feel helpless when we work with patients who cycle in and out of involuntary hospitalization often without real progress, so I'm glad you're writing about this issue (Zhong R and Wasser T, *Psychiatric Services* 2024;75:1279–1281). What drew you both to focus on it?


Rocksheng Zhong, MD, MHS


Tobias Wasser, MD

Dr. Zhong: As medical director at a community mental health agency, I saw many individuals with serious mental illnesses who were repeatedly hospitalized. They'd be discharged, only to return within days or weeks, often brought in by police after causing a public disturbance. It wasn't clear that hospitalization was helping them.

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care in situations where they cannot communicate. Although requirements for ADs vary by state, they generally include two components:

1. *Living will:* Outlines a patient's preferences for specific treatments, such as life-sustaining measures like CPR or artificial nutrition, and the level of comfort care or pain management the patient desires.
2. *Durable power of attorney for health care (health care proxy):* Designates someone to make medical decisions on behalf of the patient if they become incapacitated.

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Without an AD, patients' values and priorities may remain unclear, leaving loved ones and clinicians to make difficult decisions without guidance. By starting these conversations early and revisiting them regularly, you can help patients articulate their treatment preferences, reduce their uncertainty during crises, and reassure them that their care will reflect their values and wishes.

To address Mr. Patel's anxiety and encourage meaningful participation, his physician consults psychiatry for support in facilitating the conversation. The psychiatrist meets with Mr. Patel and helps him explore his fears about losing control over his care. "This isn't about giving up; it's about making sure your doctors know how to care for you in a way that aligns with your values," the psychiatrist explains. The psychiatrist provides reassurance while helping Mr. Patel identify and verbalize his treatment preferences. His physician then reviews the options with him, ensuring his wishes are clearly documented. A hospital social worker helps Mr. Patel complete an AD that outlines his wish to prioritize comfort care over aggressive interventions. Before discharge, the AD is uploaded to his electronic health record (EHR), and a copy is provided to him for safekeeping.

Psychiatrists' role in AD discussions

Mr. Patel's case highlights how emotional distress can be a barrier to advance care planning. Psychiatrists also get involved when patients have difficulty making informed decisions due to delirium or psychiatric illness. Consider the following scenarios:

- A patient with delirium refuses life-sustaining treatment. The medical team consults psychiatry to assess whether the patient currently has the capacity to make this decision and, if not, whether their AD provides guidance.
- A depressed patient with a terminal illness refuses a potentially beneficial intervention. Psychiatry is asked to determine whether the patient's decision is influenced by untreated depression and whether treatment might restore their ability to make informed choices.
- A psychotic patient with longstanding delusions about medical care has an AD refusing interventions that might be lifesaving. The psychiatrist must assess whether the AD was created during a lucid period and remains a valid expression of the patient's wishes.

If a patient lacks permanent decision-making capacity, their AD may inform care, but final decisions would fall to their legally designated health care proxy or, in some cases, a court-appointed conservator.

Related medical orders

While ADs provide a general outline of patients' preferences and goals, they can sometimes be vague, so they often need to be supplemented by actionable medical orders. Important examples include:

- *Do-not-resuscitate (DNR) and do-not-intubate (DNI) orders:* These physician-signed orders specify whether resuscitation or intubation should occur in emergencies.
- *Physician orders for life-sustaining treatment (POLST):* POLST forms go a step further by translating patients' treatment preferences into detailed, legally recognized orders, like for interventions such as CPR or feeding tubes. Research shows they are more effective than ADs alone in honoring patients' wishes (Hickman SE et al, *J Am Geriatr Soc* 2010;58(7):1241–1248).

Psychiatric advance directives (PADs)

PADs are a specialized type of AD designed for individuals with chronic mental illness. They allow patients to document their preferences for treatment during crises, including preferred medications, hospitals or facilities where they would feel most comfortable, and the use of therapies like ECT. PADs also allow patients to designate a trusted decision maker.

Ms. Lopez, a 34-year-old woman with schizophrenia, is admitted to the hospital during a severe psychotic episode. She is refusing all medications, requiring the care team to obtain a court order for involuntary treatment.

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Before initiating medications, the psychiatrist reviews Ms. Lopez's PAD, which was uploaded to her EHR during a prior hospitalization. The PAD specifies her preferences for medications, noting that she has responded well to olanzapine in the past and experienced severe side effects with haloperidol. It also highlights her preference for oral medications over injections when possible and suggests nonpharmacologic calming strategies, like providing a quiet room and limiting stimulation.

Why PADs matter

You've likely rarely, if ever, encountered PADs, as they are underutilized compared to other types of ADs. This may be because PADs typically address less critical decisions than traditional ADs.

Even so, PADs are worth considering because they help individuals with chronic mental illness maintain autonomy over their care and achieve better outcomes. Studies show that PADs reduce the need for coercive interventions (Swanson JW et al, *J Ment Health* 2008;17(3):255–267) and improve patient adherence and satisfaction. For example, one study found that individuals prescribed at least one medication listed in their PADs were almost 8 times more likely to adhere to their treatment regimens over 12 months (Wilder CM et al, *Psychiatr Serv* 2010;61(4):380–385).

Guided by the PAD, the team initiates treatment with olanzapine and implements Ms. Lopez's preferred calming strategies. Her agitation begins to decrease over the next 24 hours, and her condition improves without requiring medications that she has previously had difficulty tolerating. When she becomes more lucid, Ms. Lopez expresses relief that the team respected her preferences.

PADs may not always be followed in cases of involuntary treatment, such as when a patient meets criteria for danger to self, danger to others, or grave disability. For example, a patient who prefers oral medications might still be court-ordered to receive intramuscular treatment during an acute psychotic episode. Even then, PADs provide critical guidance to help align care as closely as possible with the patient's preferences.

Overcoming barriers to AD adoption

Despite the importance of ADs, fewer than one-third of adults in the US have completed one (Yadav KN et al, *Health Affairs* 2017;36(7):1244–1251). Some feel uncomfortable talking about future health scenarios, while others equate ADs with "giving up." Cultural or religious beliefs, limited health literacy, and lack of awareness also pose challenges. Systemic factors, such as time constraints during appointments and inconsistent EHR integration, further contribute to low completion rates.

Psychiatrists can play a key role in overcoming these barriers, particularly by reframing ADs as tools for maintaining autonomy rather than surrendering control.

Who helps provide education?

When patients express interest in learning about ADs or PADs, you can play a key role in starting the conversation and addressing their questions, whether you're a doctor, nurse, or other member of the care team. For more detailed guidance or assistance with completing forms, refer patients to colleagues who specialize in advance care planning, such as social workers, care coordinators, or patient advocates.

Ensuring accessibility in emergencies

Even the most thoughtfully crafted AD is useless if care providers can't consult it when needed. Help your patients make their documents readily accessible by encouraging these steps:

- Provide copies to family, health care proxies, and PCPs.
- Upload the directive into their medical record.
- Keep physical copies easily accessible (eg, in a wallet or refrigerator).
- Store the directive digitally using smartphone apps or cloud services.
- For patients with chronic or terminal conditions, medical alert jewelry indicating the presence of an AD can make a huge difference in emergency care.

When to revisit ADs

Remind patients that ADs aren't one-and-done documents. Encourage them to revisit their ADs regularly, especially after major life changes such as a new diagnosis, hospitalization, or even retirement.

CARLAT VERDICT ADs and PADs are powerful tools for preserving dignity and autonomy, yet they remain underutilized. Discussing and initiating ADs and PADs can be challenging, whether due to patient hesitation, capacity concerns, or systemic barriers. By making them a routine part of care, we can reduce uncertainty, improve decision making, and ensure patients receive treatment that aligns with their values.

Tips for Talking About Advance Directives	
Reframe the discussion	If a patient is hesitant, facilitate the conversation by focusing on how ADs (including PADs) reflect their personal values and priorities.
Normalize the conversation	Make these discussions a routine part of care, regardless of a patient's age or illness stage. Ask, "Have you thought about how you'd want your care handled if you couldn't speak for yourself?"
Provide education	Educate patients about the purpose and benefits of ADs and PADs by offering clear, accessible resources. The National Institute on Aging's Advance Care Planning: Advance Directives for Health Care page is a great page to start (www.tinyurl.com/424kpp2h).
Address cultural and language needs	Use resources like the MedlinePlus Advance Directives page for multilingual information (www.tinyurl.com/4x8pcmak). Hospitals may also have multilingual materials available through their patient education departments. If forms are unavailable in the patient's language, enlist professional interpreters to assist.
Simplify the process	Refer patients to reliable sources for obtaining state-specific forms, such as the AARP (www.tinyurl.com/ytc7t3f5) or the National Resource Center on Psychiatric Advance Directives (https://nrc-pad.org). Provide clear, step-by-step instructions.
Integrate into workflows	Work with your IT team to integrate AD and PAD prompts and templates into the EHR.

Expert Interview — Rethinking Psychiatric Holds for Grave Disability

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Dr. Wasser: I've seen the same pattern across emergency rooms (ERs) and inpatient units, both in the private sector and in state institutions. We use the tools available to us, but for some patients, those interventions simply don't work. Meanwhile, we deprive these patients of liberty and erode their trust in treatment. Dr. Zhong and I are both board-certified forensic psychiatrists, and our experiences have led us to wonder: How can we find the right balance between patients' rights, safety, and the legal and ethical responsibilities of care? And, given the resource-constrained world we live in, are we making the best use of our resources?

Dr. Zhong: Our inpatient and outpatient clinicians often felt compelled to admit these patients, even though they knew it wasn't really going to make a difference. So, we wanted to explore why.

CHPR: But what alternatives exist for individuals with chronic mental illnesses who might be found living on the streets in rags and malnourished?

Dr. Wasser: We're not arguing against civil commitment for grave disability. But we believe there's a subset of patients for whom inpatient care has proven futile. The issue isn't just ethical; it's also pragmatic. Psychiatric beds are a scarce resource, and their availability has declined dramatically over the past several decades. Since 1970, there's been a nearly 80% decline in inpatient and other residential treatment beds (www.tinyurl.com/2dujc3tn). One alternative would be a massive expansion of inpatient services. If beds were abundant, resource constraints wouldn't be a reason to rethink hospitalization. However, that still wouldn't make inpatient care any more effective or respectful of patient autonomy. Another option is significantly investing in involuntary outpatient commitment (IOC). While 46 states and Washington, DC, have IOC statutes, fewer than half have implemented them in ways that lead to meaningful improvements in outcomes, often due to limited funding, insufficient community-based infrastructure, and inconsistent enforcement mechanisms. (Meldrum ML et al, *Psychiatr Serv* 2016;67:630–635). And too often, funding for IOC comes at the expense of other mental health services—robbing Peter to pay Paul and leaving other vulnerable populations underserved.

> **"As physicians, our job is to recommend treatments that help. For a subset of patients, hospitalization no longer provides meaningful benefit. At some point, any clinician will recognize that repeated admissions aren't helping. Whether that's after 5, 30, or 100 stays, we must ask: If hospitalization isn't helping, why keep doing it?"**
>
> Rocksheng Zhong, MD, MHS

CHPR: Have any states implemented IOC more successfully despite those challenges?

Dr. Wasser: New York and North Carolina have shown the most success, largely because they've paired IOC with robust community services and made dedicated investments rather than reallocating funds from other programs (Phelan JC et al, *Psychiatr Serv* 2010;61(2):137–142).

CHPR: In addition to outpatient commitment, what about conservatorships?

Dr. Wasser: Conservatorships or guardianships are an option in many states for individuals who are chronically gravely disabled with repeated hospitalizations and a clear inability to manage their own health care decisions. In some states, conservatorship can sometimes lead to long-term hospital care. But in many other states, it doesn't actually affect whether someone can be hospitalized or how long they stay.

CHPR: One strategy that's often discussed to reduce repeated hospitalizations is expanding the use of long-acting injectables (LAIs)—possibly even on an involuntary outpatient basis. What are your thoughts on the feasibility and ethics of that approach?

Dr. Wasser: While many jurisdictions allow forced LAIs on an outpatient basis, implementing these laws is another matter. LAIs can reduce repeated hospitalizations, especially for individuals who disengage from care. At the same time, this approach raises serious questions about autonomy, consent, and coercion. While we recognize their potential benefits, especially in improving stability for some patients, compulsory use remains ethically fraught. And practically speaking, such mandates are unlikely to gain the political support or funding needed for broad implementation.

CHPR: Some patients don't show significant clinical improvement from inpatient care, yet benefit from, and seem to appreciate, basic necessities like warm meals, clean clothes, and a shower. But hospitalizing them for those services, if they're not also going to improve clinically, does seem excessive.

Dr. Zhong: That's at the heart of our argument. Our society places a high value on personal liberty, yet we detain people preemptively for not functioning well in the community. If hospitalization provides only temporary shelter and basic needs, with no lasting benefit, we must question its ethics and utility. Compelling someone into care for minimal gain imposes major costs on systems and autonomy. There are few other areas where we detain someone simply for living in a way we disapprove of.

CHPR: What feedback have you received for your arguments?

Dr. Zhong: Most of the feedback has fallen into two camps. One group, largely from the substance use recovery community, including individuals with lived experience of serious mental illness and those who provide direct services, has been generally supportive, appreciative, and eager to explore how we can further engage with these ideas.

CHPR: What concerns do psychiatrists raise about your approach?

Dr. Zhong: Many psychiatrists strongly disagree. Some reference the phrase "letting people die with their rights on," which emerged in the 1970s when mental health laws were reformed to require stricter legal standards, such as demonstrating dangerousness, before someone could be involuntarily hospitalized. The concern then, as now, is that these protections are well intentioned but may leave vulnerable individuals on the streets without adequate care or support. We understand that concern; no one wants to see people suffer due to a lack of care. But as physicians, our job is to recommend treatments that help. For a subset of

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> **“Terms like ‘palliative psychiatry’ and ‘futility’ make people uneasy, but these concepts already exist in medicine. In other fields, when treatments no longer help, we shift focus. We stop chemo for terminal cancer patients. Why don’t we think the same way in psychiatry?”**
>
> Tobias Wasser, MD

patients, hospitalization no longer provides meaningful benefit. At some point, any clinician will recognize that repeated admissions aren’t helping. Whether that’s after 5, 30, or 100 stays, we must ask: If hospitalization isn’t helping, why keep doing it?

CHPR: Might clinicians risk liability if they avoid hospitalization and a bad outcome occurs?

Dr. Zhong: We do live in a very litigious society, and there is always a risk of being sued for a bad outcome. In the long run, our goal is to start a conversation that shifts professional expectations so that clinicians will feel less obligated to admit patients who are unlikely to benefit from hospitalization even if they technically meet criteria for commitment. And if everyone is doing it—that is, not admitting people who won’t benefit from admission—then the standard of care changes and legal liability decreases. When a person dies of cancer, people usually don’t blame the oncologist for failing to administer every possible chemotherapy because there is no expectation that an oncologist should administer every possible chemotherapy.

CHPR: What practical steps can clinicians take to protect themselves legally when choosing not to hospitalize?

Dr. Zhong: In the short run, effective documentation of clinical reasoning is critical to protecting yourself legally. The clinician’s duty is to perform an adequate risk assessment and implement reasonable interventions, not to predict the future with perfect accuracy. So long as you do conduct that risk assessment and then make a reasonable judgment that hospitalization is not medically appropriate, while explaining all this in your documentation such that someone reading your note can understand your decision, you’ll be well prepared to defend yourself in a lawsuit.

CHPR: How do you handle family pushback when you recommend against admission?

Dr. Zhong: It can be challenging, but as with any other disagreement between clinicians, patients, and families, it’s important to communicate the decision and rationale behind it in a compassionate and caring way. Clinicians can emphasize that the outcome, while different from what the family had in mind, is nonetheless arrived at with the patient’s interests at heart—given that involuntary hospitalization is not likely to help and may actually harm the patient. Then they can offer outpatient resources.

Dr. Wasser: Some pushback stems from the language we’ve used. Terms like “palliative psychiatry” and “futility” make people uneasy, but these concepts already exist in medicine. In other fields, when treatments no longer help, we shift focus. We stop chemo for terminal cancer patients. Why don’t we think the same way in psychiatry? We’re not calling for the end of civil commitment, but we are asking the field to consider whether there’s a point where continued involuntary hospitalization causes more harm than good. If so, we need to explore alternative approaches that might actually help these patients.

CHPR: Right. Like with a terminal illness, at some point, continuing aggressive care can do more harm than good.

Dr. Zhong: Exactly. Instead of forcing people into ineffective hospital stays, let’s invest in community-based care, like assertive community treatment (ACT) teams, outreach programs, social services, housing, employment support, and education. These interventions are far more likely to provide meaningful, lasting benefits. But these interventions require voluntary participation, and many patients, especially those with co-occurring substance use disorders, are reluctant to engage.

Dr. Wasser: I won’t pretend there’s an easy solution. Substance use comorbidity complicates everything. It affects motivation, willingness, and sometimes even the ability to engage in care. One promising approach is greater investment in recovery-oriented services. We need to see these individuals as people with mental illness, not just “mentally ill people.” That means focusing on the same things that matter to all of us—safe housing, a sense of community, meaningful work, and educational opportunities.

CHPR: What specific strategies have shown promise in engaging these hard-to-reach patients?

Dr. Wasser: Peer support is huge. When you hire individuals with lived experience, there’s strong evidence showing that peer support specialists can engage patients in ways that clinicians often cannot (Lee SN and Yu HJ, *Healthcare (Basel)* 2024;12(12):1179). Think about it—seeing someone who has been through similar struggles and found stability can be deeply motivating. If we could fund and co-locate these services, providing mental health care alongside housing, employment, and social engagement opportunities, we’d have a much better chance of connecting with patients and improving outcomes.

CHPR: What can us frontline clinicians do when we feel hospitalization may be futile?

Dr. Zhong: Make sure to document your reasoning. A good resource is the blog post “How to Write a Suicide Note” (www.tinyurl.com/y7fvtu93). It’s framed around discharging a suicidal patient from the ER, but it applies just as well to other contexts and for people with treatment-resistant disease and grave disability for whom the clinician doesn’t believe hospitalization is helpful. The more clinicians choose not to hospitalize patients when they don’t think it’s appropriate and are able to explain why, the more we can shift expectations over time among care providers, patients, families, administrators, and litigators.

Dr. Wasser: Also, collaborate. Contact outpatient providers or community teams. They may be able to engage the patient more effectively, or at least help develop a community-based plan. And even if ACT or housing isn’t immediately available, advocating for those options in your notes and treatment team meetings helps build a case for systemwide changes. These steps might seem small, but they lay the groundwork for broader reform.

CHPR: Thank you for your time, Dr. Zhong and Dr. Wasser.

Moral Injury in Hospital Psychiatry: Recognizing and Addressing an Invisible Wound

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Dr. Burns has no financial relationships with companies related to this material.

As psychiatrists, we strive to do all we can for our patients, but what happens when circumstances force us to do less than our best?

Moral injury refers to the emotional toll of witnessing or participating in actions that violate our moral or ethical beliefs. It can arise when external constraints force us to compromise patient care, such as discharging someone too early because their insurance won't pay for more days.

What distinguishes moral injury from everyday ethical dilemmas is the depth and persistence of the psychological impact. It's not just feeling bad about a tough decision; it's that decision continuing to haunt us and changing how we see ourselves as healers. While we all face ethical challenges, moral injury occurs when these conflicts cause lasting emotional wounds—persistent guilt, shame, or a fundamental loss of trust in ourselves or our profession.

The term "moral injury" was originally used to describe Vietnam War veterans who showed symptoms similar to PTSD but didn't respond to traditional treatments (Dean W et al, *Fed Pract* 2019;36(9):400–402). It's now recognized in other professions too, including health care workers, police officers, and child protective service workers.

Clinical scenarios that can lead to moral injury

Most of us have had moments where we question whether we've done the right thing. Here are a few situations where moral injury can arise:

- Involuntary treatment: *A psychotic patient becomes aggressive and is physically and chemically restrained. Later, he tells you that being restrained and involuntarily medicated was the most traumatizing experience of his life.*
  In emergency department or inpatient settings, we often have to weigh patient autonomy against safety. When patients are restrained or medicated against their will, we may be left questioning whether we've done more harm than good.
- Confidentiality vs safety: *You report a patient's threat to harm someone, knowing that your action may shatter the patient's trust in you.*
  Sometimes we're legally required to break confidentiality to prevent harm, such as in Tarasoff-related cases. Even when it's necessary, it can feel like a betrayal and damage the therapeutic relationship.
- Systemic constraints: *A patient needs ECT for catatonic depression, but the insurance refuses to pay.*
  A lack of beds, staff, or insurance coverage can force premature discharges or prevent needed admissions. These decisions can leave us feeling helpless or complicit.
- Challenging clinical situations: *A psychiatrist treating a violent offender feels unsafe and frustrated. The patient is stuck in the system and not improving; staff are frequently injured while caring for them. The psychiatrist begins to question whether continuing treatment under these conditions is ethical or simply enabling further harm.*
  Working with patients who are severely ill, chronically violent, or unresponsive to treatment can evoke fear, frustration, and moral distress, especially when we're legally required to continue care despite believing the current approach may be ineffective or even retraumatizing.
- Financial pressures: *A psychiatric resident is told to prepare a discharge summary after learning that a patient's insurance has stopped covering the hospitalization, even though the patient remains suicidal and lacks a safe discharge plan.*
  We're sometimes asked to justify decisions based on cost rather than clinical judgment. These moments can chip away at our professional integrity.

Recognizing moral injury

Moral injury can leave us feeling emotionally numb, guilty, ashamed, or even angry at our institutions, ourselves, or our peers. We might avoid ethically complex cases or feel disconnected from work that we used to enjoy. It can also affect our lives outside of work. In one study, nearly a quarter of health care workers with moral injury reported moderate impairment in family, social, or occupational functioning. Younger clinicians, or those without a strong support system or spiritual framework, were especially vulnerable (Mantri S et al, *J Nerv Ment Dis* 2021;209:174–180).

How to identify moral injury

If you're concerned about your emotional well-being, consider whether you're carrying unresolved ethical dilemmas, persistent guilt, or spiritual distress. The Moral Injury Symptom Scale–Health Professionals (MISS-HP) is one tool that can help clarify whether moral injury may be affecting your functioning (Mantri S et al, *J Relig Health* 2020;59:2323–2340). It includes 10 questions covering themes like betrayal, shame, difficulty forgiving, and spiritual distress. A score above 36 suggests that moral injury is interfering with functioning. Supervisors and support teams may also find the scale useful during debriefings or wellness check-ins.

Approaches to healing

There's no quick fix for moral injury, but several therapeutic approaches can help:

- Cognitive processing therapy (CPT) helps reframe ethical conflicts and replace distorted beliefs with more compassionate, realistic ones.
- Acceptance and commitment therapy (ACT) promotes psychological flexibility and encourages "values-driven action": taking steps that align with one's core beliefs, even when it's difficult. A 2017 study on the feasibility and acceptability of ACT, delivered over six group sessions, showed promising results in the treatment of moral injury (Griffin BJ et al, *J Trauma Stress* 2019;32:350–362).

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- Peer support groups and narrative therapy (which uses storytelling to process experiences and find meaning) offer opportunities to share experiences, reduce isolation, and rebuild a sense of community and trust.
- Pastoral or chaplain support can be especially helpful for those struggling with spiritual distress.

Institutional and leadership responses

Because moral injury is often caused by systemic issues, addressing it depends on responsive and engaged leadership. When leaders openly talk about moral injury, share their own struggles, or create space for discussion (eg, through ethics rounds and support groups), it sends a powerful message: "You're not alone, and this work is hard for all of us."

Distinguishing moral injury from burnout or PTSD

Moral injury often gets confused with PTSD, but the two are not the same. PTSD involves threats to bodily integrity and includes symptoms like hypervigilance, flashbacks, and nightmares. Moral injury involves threats to moral integrity and centers on guilt, shame, and demoralization.

Moral injury also differs from burnout. Burnout is typically driven by excessive workload, systemic inefficiencies, and emotional exhaustion. While burnout may respond to rest or self-care, moral injury is rooted in ethical conflict, and addressing it requires a different approach.

In some cases, moral injury may overlap with depression or with compassion fatigue—a form of emotional depletion from prolonged exposure to others' suffering. But unlike those conditions, moral injury is specifically anchored in moral and ethical distress.

Prognosis and long-term considerations

If we don't recognize and address moral injury, it can take a toll on our mental health, our relationships, and even our desire to remain in the profession. Studies show that moral injury is a major predictor of clinicians expressing a desire to leave the practice of medicine altogether (Mantri et al, 2021).

But with the right support, we can recover from moral injury and reconnect with our work in a way that is more grounded and meaningful. Cultures that acknowledge ethical dilemmas and validate clinicians' emotional experiences help foster healing and long-term resilience.

A case of moral injury

Dr. C, an attending psychiatrist on an inpatient psychiatric unit, was treating Maria, a 28-year-old woman with bipolar disorder admitted during a severe manic episode. Maria was still significantly symptomatic, but her insurance had a strict 72-hour limit. Despite her clinical judgment that discharge was premature, Dr. C felt pressured by administration to discharge the patient.

Two days later, Maria was brought back to the emergency department after a car accident during another manic episode, this time with her young daughter in the car. "I couldn't sleep for weeks," Dr. C says. "I kept thinking about that little girl who could have been killed because I didn't fight harder against the discharge. I started questioning every decision and even considered leaving psychiatry altogether." Dr. C's healing began when she joined a peer support group and learned through CPT to separate her professional integrity from systemic failures beyond her control.

CARLAT VERDICT We are vulnerable to moral injury when we feel that our actions, or those of our colleagues, conflict with our core ethical beliefs. It can be painful, isolating, and disorienting—but it's also something we can recover from, especially when leaders and colleagues acknowledge the reality of these struggles and support honest, compassionate dialogue.

In Brief: Palliative Psychiatry

Palliative psychiatry is an emerging and thought-provoking approach that challenges us to rethink how we care for individuals with severe and persistent mental illness. Unlike standard psychiatric care, which aims for symptom remission and functional recovery, palliative psychiatry acknowledges that in some cases, the relentless pursuit of clinical improvement may do more harm than good (Westmair AL et al, *Aust N Z J Psychiatry* 2022;56(12):1535–1541).

We've all seen patients for whom the next medication trial, hospitalization, or forced intervention is unlikely to help and may, in fact, make things worse by eroding trust, causing side effects, or deepening hopelessness. Palliative psychiatry asks us to shift the focus from finding a cure at all costs to improving quality of life.

Drawing from palliative medicine, palliative psychiatry emphasizes relief of suffering, even when symptoms persist. It's not about giving up on care, but about redefining care when a cure is no longer a realistic goal. It prompts a different set of questions: What does this person still find meaningful? How can we reduce their distress and support their sense of dignity, autonomy, and connection, even if the illness remains? This approach is still evolving, and it raises important ethical and practical questions. For a subset of patients, though, it may offer a more realistic and compassionate path forward.

—*Victoria Hendrick, MD. Editor-in-Chief,* The Carlat Hospital Psychiatry Report.
Dr. Hendrick has no financial relationships with companies related to this material.

Q&A With the Expert

Civil Commitment for Substance Use Disorders

Kenneth Minkoff, MD

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Dr. Minkoff has no financial relationships with companies related to this material.

CHPR: To start us off, what originally led states to create civil commitment laws for substance use disorders (SUDs)?

Dr. Minkoff: These laws have been around for decades, and they usually come from a place of deep frustration. Family members, law enforcement, and others in the community encounter people with serious SUDs—people who are spiraling, refusing help, and putting themselves or others at risk. There's a sense of helplessness: "If we could just make them get treatment, we could save their lives." That impulse has driven a lot of legislation. But whether these laws are truly effective is another story. A recent survey showed that 37 states, plus the District of Columbia, have these laws *(Editor's note: See map on page 9)*, but most states rarely use them (www.tinyurl.com/4vxsznun). California became the most recent state to enact similar legislation, in October 2023. The only two states that have made regular use of these laws are Florida and Massachusetts.

CHPR: Why do you think these laws are so rarely used, despite being on the books in so many states?

Dr. Minkoff: In many places, there's just nowhere to send people, and there is no clear indication that civil commitment produces benefit for people with SUDs. Facilities may be full, under-resourced, or not equipped to accept involuntary patients. In Massachusetts, for example, the law doesn't permit people with SUDs to be committed to a mental health facility. They're typically sent to correctional or specialized addiction treatment settings. Men are often placed in treatment centers located on prison grounds—they're technically not incarcerated, but the setting feels like one. Until recently, women didn't even have access to a noncarceral option. In California, many mental health facilities aren't licensed to admit people solely for addiction, and there is no option for involuntary treatment in SUD settings. Locked facilities specifically for SUDs are largely unavailable, which limits the ability to implement civil commitment even when it is legally permitted. In Florida, civil commitment for SUD is permitted under the Marchman Act, but there are few, if any, published data on how the law is applied and on the outcomes for individuals who receive these interventions.

CHPR: Even when the laws are used, the care people receive often isn't very effective.

Dr. Minkoff: Right. Across the country, people who've experienced involuntary treatment often report substandard care—limited access to effective medications like buprenorphine or methadone, and very little follow-up support once they're discharged (Evans EA et al, *J Law Med Ethics* 2020;48(4):718–734). Even when facilities are available, if they aren't connected to a strong continuum of care, people just fall through the cracks. You can commit someone, but if they walk out the next day or never get meaningful help, what have you actually accomplished? Further, we know that the "brain disorder" of addiction does not go away simply because the person is confined for an extended period. Something different needs to occur AFTER the involuntary intervention in order to promote progress over time.

> **"When a law like this is passed, it can act like a big hammer, and suddenly, everyone looks like a nail. There's a real risk that systems will respond to public pressure by using involuntary treatment just to get people off the streets, rather than as a meaningful part of a care plan."**
>
> Kenneth Minkoff, MD

CHPR: It's interesting that, even though the evidence behind these laws is shaky, more states are still passing them, like California did two years ago.

Dr. Minkoff: The big driver in California was the crisis of visible homelessness related to substance use. Emergency medical services and law enforcement were watching people overdose and die, and the public wanted action. Combined with the worsening opioid epidemic, the urgency was hard to ignore.

CHPR: How does civil commitment differ from court-mandated treatment through the criminal justice system?

Dr. Minkoff: Both are involuntary, but the kind of coercion is different. In the criminal justice system, people might be offered treatment as an alternative to jail, but they still experience themselves as making a choice to accept that alternative. Civil commitment doesn't involve a crime, nor is a choice available—someone else decides you're at risk and forces you into treatment. That kind of power needs to be used very thoughtfully.

CHPR: How do you identify the right candidates for this kind of intervention?

Dr. Minkoff: In California, the focus is on people with very visible, untreated severe SUDs, who are often chronically homeless, with frequent emergency room visits, arrests, and severe medical needs. They're often stabilized in emergency medical or psychiatric settings and then released, only to repeat the cycle. Many also have co-occurring psychiatric conditions that are masked by their substance use. Or once the substance use improves, their psychiatric symptoms seem less severe and they fall off the radar. Either way, they fall through the cracks. The goal is to reverse that. Involuntary commitment isn't the goal; it's just a tool to get people into relationships and services that they'll stay connected to voluntarily.

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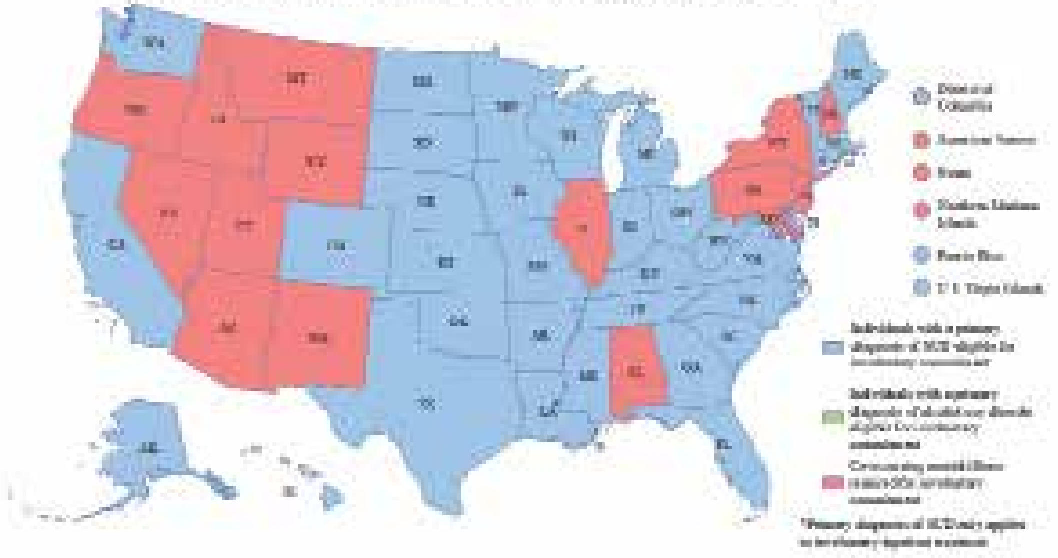
Involuntary Commitment Laws: Primary Diagnosis of SUD Eligible for Commitment



Source: Image reprinted with permission from Legislative Analysis and Public Policy Association. Involuntary Commitment of Those With Substance Use Disorders: Summary of State Laws; December 2024; www.tinyurl.com/yma83nx2

CHPR: **Part of the reason they fall through the cracks is stigma, right? These people are often viewed as less deserving of care.**

Dr. Minkoff: Yes, that's a huge reason. There's still this idea that addiction is a choice—not a disease—and that people who use heroin or meth brought it on themselves. Meanwhile, people with conditions like schizophrenia are often seen as more deserving of care. That attitude shows up in policy decisions, in treatment access, and in how individual clinicians interact with patients (Adams JM and Volkow ND, *AMA J Ethics* 2020;22(1):E702–E708). In focus groups, people with lived experience tell us it only takes one judgmental comment—"You've been here 40 times; why haven't you gotten sober?"—to shut them down. We emphasize relationships that are based in empathy, hope, and continuing support. If involuntary treatment is handled poorly, it just drives people away.

CHPR: **How do we draw the line between someone capable of refusing care and someone who truly meets criteria for involuntary intervention?**

Dr. Minkoff: That's one of the toughest decisions, especially with substance use. The key is to look at the person's ability to make decisions in the context of their illness. Are they refusing care because they understand the risks and have a coherent reason, or because their brain is hijacked by addiction, withdrawal, or co-occurring symptoms like psychosis or cognitive disorganization? Someone might say they don't want help, but if that refusal is coming from acute impairment—like they're actively psychotic, cycling through withdrawal, experiencing overwhelming cravings to use, or unable to meet their basic needs—then that's not informed refusal so much as a symptom of the underlying brain disease of addiction. You have to assess whether they can engage in a rational decision-making process about their own safety. Repeated overdoses, disorganized behavior, or total disengagement from reality are all red flags. And you have to look at patterns. One bad decision doesn't mean someone lacks capacity. But a consistent inability to recognize danger, despite serious harm, may indicate they truly need protection. That's when civil commitment becomes a consideration. It's important to know your state's standards and document how the person meets them *(Editor's note: For more state-by-state details, see: www.tinyurl.com/yma83nx2)*.

CHPR: **Does the SUD legislation allow the same types of involuntary commitment holds for addiction as it does for psychiatric diagnoses?**

Dr. Minkoff: Each state is different. It does in California, where the same legal mechanisms, like 72-hour holds, 14-day holds, and conservatorships, now apply to people with SUDs. That's a big shift. But what happens next, what services they get, and whether they're actually helpful hasn't really been figured out. So far, only a few counties—San Francisco and San Luis Obispo—have formally implemented the law. But all counties must have implementation in place by January 1, 2026. Therefore, most of the others have started implementation planning. And each one is essentially running its own natural experiment. Other states have different rules. In Massachusetts, for example, you can commit someone for up to 30 days under a separate civil substance use law. In Florida, it's also a separate law (Marchman Act) that results in typically shorter-term holds, just long enough for brief stabilization. But even when the law allows longer holds, that doesn't guarantee the person will actually receive meaningful care.

CHPR: **You're working with San Mateo County in Northern California. How are you approaching implementation there?**

Dr. Minkoff: Our goal isn't to lock people up and hope that fixes addiction. Addiction, like mental illness, is a chronic brain disease. It doesn't go away just because someone's confined. In fact, if someone is released after detox without real support, their reduced tolerance puts them at higher risk of overdose. We started by creating a steering committee, including law enforcement, people with lived experience, providers, and community leaders. One key takeaway was the need to engage people in a way that builds hope, trust, and a sense of possibility. Many of these individuals have experienced repeated failure and have come to believe that what's being asked of them is impossible. If we're going to take away someone's liberty, the result should be connection to relationships that are voluntary and inspiring. And while they're in that involuntary process, the care we offer has to be meaningful—not just a requirement to sit in groups or get sober, but access to real help.

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Research Update IN PSYCHIATRY

ANTIPSYCHOTICS

Tapering Antipsychotics in Patients With Schizophrenia or Recurrent Psychotic Disorders

Sébastien Hardy, MD. Dr. Hardy has no financial relationships with companies related to this material.

REVIEW OF: Moncrieff J et al, *Lancet Psychiatry* 2023;10(11):848–859; Liu CC et al, *Early Interv Psychiatry* 2022;16(2):178–185

STUDY TYPE: RCTs

Many patients with schizophrenia or recurrent psychotic disorders want to reduce or stop their antipsychotic drugs to minimize adverse effects like sedation, weight gain, and emotional blunting, all of which can impair social functioning. While abrupt medication discontinuation raises the risk of relapse, two recent RCTs—RADAR and GARMED—explored whether gradual antipsychotic dose reduction or discontinuation could enhance social functioning without increasing relapse risk.

The RADAR trial

Moncrieff et al investigated gradual dose reduction every two months, aiming for medication discontinuation where possible, compared to maintenance treatment. The study enrolled 253 participants, most of whom were middle-aged, male, unemployed, and diagnosed with schizophrenia. Follow-ups were conducted remotely due to COVID-19 restrictions. Participants in the reduction group followed a planned schedule aiming for discontinuation within 12–18 months, with larger dose cuts occurring earlier in the trial. However, high relapse rates later in the trial led to dose increases for some participants. As a result, the median dose reduction, which had peaked at 67%, dropped to 33% by the 24-month mark.

Results after 24 months favored the maintenance group. Relapse rates were higher in the dose reduction/discontinuation group (41% vs 22%; p=0.007), as were severe relapses (25% vs 13%; p=0.007). Regarding quality of life, there were no significant improvements in the reduction group based on either the Manchester Short Assessment of Quality of Life (MANSA) or the Objective Social Outcomes Index (SIX) (p=0.86 and 0.26, respectively).

The GARMED trial

Liu et al explored a slower, personalized approach to tapering among 97 patients who had been stable for six months. The guided dose reduction (GDR) group followed a hyperbolic dose reduction schedule, where reductions became smaller as doses decreased to minimize withdrawal symptoms and relapse. Reductions were capped at 25% of the previous dose every six months, with shared decision-making to empower patients to pause tapering if needed. Follow-up included in-person visits every month during tapering and every three months after stabilization.

Results after 24 months favored the GDR group. Relapse rates were lower (12% GDR vs 17% maintenance; p=0.66). Seventy-five percent of GDR participants remained in remission, reducing doses by 40%–80%. There was also significant quality of life improvement in the GDR group, measured by the EuroQoL-5D visual analog scale (p=0.0009).

Why the discrepancy in results?

The two studies differed in key ways. First, RADAR participants had worse baseline functioning, with 70% of participants unemployed as compared to 27% in the GARMED trial. Second, the RADAR trial aimed for complete discontinuation within 12–18 months, while GARMED focused on achieving the lowest effective dose, with no strict timeline and a gradual tapering strategy. Finally, RADAR was constrained by remote follow-ups during the pandemic, and patients were not allowed to pause tapering; in contrast, GARMED relied on frequent in-person visits and gave patients the flexibility to pause their taper.

CARLAT TAKE

Tapering antipsychotics in patients with schizophrenia or recurrent psychotic disorders isn't right for everyone. Weigh the risks of relapse carefully against the potential benefits and tailor your plan to each individual.

For those struggling with significant side effects, a taper may be worth considering—provided you do this cautiously and collaboratively. Ensure your patient has been stable for at least six months before starting. Taper gradually, and monitor symptoms closely. Pause the taper if your patient experiences discomfort or worsening symptoms, and return to the previous dose promptly if a relapse occurs.

Expert Interview – Civil Commitment for Substance Use Disorders

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CHPR: What does that kind of hopeful, voluntary engagement look like in practice?

Dr. Minkoff: Let's say someone is brought in under an involuntary hold, disoriented, using meth, and refusing care. Instead of just holding them for 72 hours and discharging them with a flyer, we create a connection with the person right away. That might mean a peer support worker—someone who's been through recovery—sitting with them and saying, "I've been where you are." Or a clinician offering medication to ease withdrawal or anxiety so that the person can stabilize enough to listen. Once they're engaged, we link them to a team that includes housing support, a therapist they trust, and ideally a prescriber who understands both addiction and mental health. The goal is to shift the experience from "I'm being forced to do this" to "These people actually care and might be able to help."

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CME Post-Test

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For those seeking ABPN Self-Assessment (MOC) credit, a pre- and post-test must be taken online at http://thecarlatcmeinstitute.com/self-assessment/

This page is intended as a study guide. Please complete the test online at www.TheCarlatReport.com.

1. What are the two main components generally included in advance directives?
    [ ] a. Health care proxy designation and insurance information
    [ ] b. Living will and durable power of attorney for health care
    [ ] c. Emergency contact list and medication preferences
    [ ] d. POLST forms and do-not-resuscitate orders

2. According to Dr. Zhong and Dr. Wasser, what is the primary goal when making decisions about hospitalization for patients who have been repeatedly admitted without meaningful benefit?
    [ ] a. To prioritize family wishes over patient autonomy
    [ ] b. To always follow legal criteria regardless of clinical judgment
    [ ] c. To conduct adequate risk assessment and implement reasonable interventions based on clinical reasoning
    [ ] d. To avoid liability by hospitalizing every patient who meets legal criteria

3. According to Dr. Minkoff, what represents a key component of the "full-service partnership" model in California?
    [ ] a. Mandatory 30-day residential treatment programs
    [ ] b. Court-supervised medication compliance monitoring
    [ ] c. A recovery-oriented team program model that follows people across settings
    [ ] d. Weekly drug testing with legal consequences for positive results

4. True or False: Younger clinicians and those without strong support systems or spiritual frameworks are especially vulnerable to moral injury.
    [ ] a. True
    [ ] b. False

5. In the GARMED trial, what was the maximum percentage dose reduction allowed every six months during the guided dose reduction protocol?
    [ ] a. 10%
    [ ] b. 20%
    [ ] c. 25%
    [ ] d. 33%

6. When might psychiatric advance directives not be followed in cases of involuntary treatment?
    [ ] a. When the patient's family disagrees with the directive
    [ ] b. When the hospital lacks the preferred medication
    [ ] c. When the patient meets criteria for danger to self, danger to others, or grave disability
    [ ] d. When the directive is more than one year old

7. Which states have shown the most success with implementation of involuntary outpatient commitment?
    [ ] a. California and Florida
    [ ] b. New York and North Carolina
    [ ] c. Massachusetts and Texas
    [ ] d. Virginia and Oregon

8. According to Dr. Minkoff, what does research show about the experience of people who have received involuntary treatment for substance use disorders?
    [ ] a. They report positive outcomes and improved treatment engagement
    [ ] b. They show satisfaction rates similar to voluntary treatment participants
    [ ] c. They often report substandard care with limited access to effective medications and minimal follow-up support
    [ ] d. They demonstrate higher rates of long-term recovery compared to voluntary treatment

Expert Interview — Civil Commitment for Substance Use Disorders

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CHPR: It's important to focus on the relational aspect of care, not just the clinical. What services are in that support system?

Dr. Minkoff: We're making sure people can access medication treatment, like buprenorphine or methadone, even long-acting forms if they're open to that. Naltrexone may be a valuable first step for those with alcohol use disorders, even those who may continue to use alcohol. Peer support is also critical. We're making sure there's continuity of care, whether the person is doing well or not. Everything is wrapped into a "full-service partnership"—that's California's term for a recovery-oriented team program model that follows people across settings. It's not typically used for people with addiction as their main diagnosis, but we think it could be.

CHPR: Are there any best practices on how long to hold someone in a substance use–related crisis, like overdose or withdrawal?

Dr. Minkoff: Honestly, we don't know yet. We just don't have good data. With opioids, someone might be revived with naloxone, and as soon as they're awake, they leave. That's not because they want to die; it's because their brain is screaming at them to get high again. So, how long do we need to hold someone before they're able to really hear us saying, "We can help you"? Seventy-two hours might be enough for some, but what really matters is what happens during that time. Are they in a supportive environment? Is withdrawal being managed? Is someone actively and compassionately engaging with them? Is buprenorphine immediately available? With methamphetamine withdrawal, it's even tougher. People may be paranoid, psychotic, or cognitively disorganized, and it can take 7–14 days before they're able to engage, due to the lingering effects of the drug or the severity of withdrawal symptoms.

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But we don't have much infrastructure to support that kind of sustained engagement, especially on an involuntary basis.

CHPR: How is the field of addiction treatment evolving to meet these challenges?

Dr. Minkoff: The 4th edition of the ASAM Criteria, released in late 2023, is a big step forward (Waller RC et al, eds. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, Volume 1: Adults*. 4th ed. Center City, MN: Hazelden Publishing; 2023). It outlines more realistic, individualized standards for what good addiction treatment should look like. Much of addiction treatment is still based on outdated models of "program completion" that assume once people get sober, they'll be fine. That approach does work for many, but the people we're seeing today are far more complex than they used to be.

CHPR: Do you have any concerns about how civil commitment laws might be misused?

Dr. Minkoff: Definitely. When a law like this is passed, it can act like a big hammer, and suddenly, everyone looks like a nail. There's a real risk that systems will respond to public pressure by using involuntary treatment just to get people off the streets, rather than as a meaningful part of a care plan. My hope is that California can become a model not just for what works, but also for what doesn't. But without thoughtful oversight, these laws can easily turn into blunt instruments used for punishment. That's what worries me most. The need is real and urgent, but how we respond to that need makes all the difference.

CHPR: Thank you for your time, Dr. Minkoff.