Navigating Care From Afar: Ethical Considerations for Police Welfare Checks

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The clinical practice of contacting law enforcement to perform safety welfare checks for persons who have missed psychiatry appointments is commonly regarded as benign. However, in nonemergency situations, these interventions may carry greater risk than is usually assumed, especially if the person whose welfare is being checked belongs to a racial-ethnic minority group, and there is little evidence on the safety and effectiveness of these interventions. This Open Forum presents a case analysis to examine the central ethical considerations for these situations. Using crisis intervention teams, making repeated phone calls, or using other methods of communication may be clinically and ethically preferable to contacting law enforcement.

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Mr. Jones is a 31-year-old African American man diagnosed as having bipolar disorder who was recently involuntarily hospitalized for mania. He has a strong therapeutic alliance with his outpatient provider. Mr. Jones's manic episodes are characterized by cannabis and alcohol abuse, homelessness, destitution, risky sexual practices, and noncompliance with treatment recommendations.

After achieving inpatient stabilization 3 months prior, Mr. Jones met with his provider twice but did not appear for the third visit. He did not contact the provider to explain his reasons for missing the appointment. The clinician, who has concerns about the onset of another manic episode, has been unable to contact Mr. Jones. The provider is considering whether to call law enforcement for a safety welfare check.

CLINICAL CONTEXT

Black's Law Dictionary (1) defines a welfare check as "when police stop by a person's home to make sure they are okay. Requests for welfare checks are made by friends, family, and neighbors" when an individual is unreachable. Furthermore, "no court order is required for the police to conduct a welfare check. Essentially, as long as they have reasonable grounds to believe that an inhabitant in a residence is endangered, they can legally enter the premises" (1). The legality of welfare checks was upheld in *Roberts v. Spielman* (2), in which the court ruled that government officials were entitled to qualified immunity when "performing discretionary functions" that do not "violate clearly established statutory or constitutional rights of which a reasonable person would have known."

There are no evidence-based best practices to guide physicians on the indications of contacting police for a welfare check. A group of researchers at the University of Colorado found a "lack of any real medical literature" on using safety welfare checks for suicide risk management after performing "a thorough search on PubMed" (3, 4). We broadened the literature review by searching PubMed, Google Scholar, UpToDate, and APA PsycInfo by using combinations of the search terms "police," "wellness check," "welfare check," "mental illness," "mental health," "psychiatric emergency," and "mental health crisis." We did not discover any studies on the clinical effectiveness of police welfare checks.

Although they are commonly regarded as a benign intervention, welfare checks may be more dangerous than assumed. In September 2019, a 57-year-old woman with bipolar disorder was fatally shot by police officers during a welfare check that involved forced entry into a locked bedroom (5). Although deaths are an extreme example of the negative consequences of unannounced police visits, other potential harmful outcomes include distress, fear, arrest, incarceration, government intrusion, feelings that one's protected rights have been violated, consumption of police resources, and detriment to the therapeutic alliance (3, 4). Clinical choices, including the decision of a treatment provider to initiate a welfare check, should be made after balancing the risks and benefits and considering the ethical principles involved.

ETHICAL CONSIDERATIONS

In this Open Forum, we consider four ethical principles that are widely used in health care (6). We apply them to a

scenario in which Mr. Jones's provider contacts law enforcement to perform a safety welfare check.

Beneficence and Nonmaleficence

Focusing on the outcomes of an intervention, the principles of beneficence and nonmaleficence are concerned with promoting the best interests of patients and minimizing harm to them. Does the intervention promote the patient's best interests and inflict minimal harm?

Despite Mr. Jones's debilitating manic episodes, he has had no history of violence. Does missing an appointment represent an elevated risk of harm? If not, how do welfare checks fit into this assessment? Presumably, a welfare check would serve only as a search for more information to adequately perform a safety assessment. In this case, examples of harm include substance use, financial debt, potential homelessness, and risk of sexually transmitted diseases. These negative outcomes may be severe for a patient with unmanaged mania, but the clinician may not know whether the patient is currently manic.

One potential risk factor for negative outcomes resulting from a safety welfare check is the patient's race or ethnicity. Media reports of deadly interactions with police and the political activism of Black Lives Matter have raised awareness of inequities in the criminal justice system and have contributed to a widespread consensus that minority groups, especially African Americans, are at a higher risk of harmful outcomes resulting from police interactions. These interactions may extend to police welfare checks. Thus, it seems probable that individuals from minority groups would have a negative reaction to unannounced law enforcement presence. In fact, a 2016 survey found that 81% of African Americans believe law enforcement officers racially profile potential suspects, and just 40% of African Americans have a positive view of police. African Americans' perception of police has shifted minimally in the past 50 years (7).

Justice

Justice pertains to what is owed to persons; the concepts of fairness, equality, and entitlement are commonly used to explain this principle. Much of the work in medical ethics has focused on the nature of "distributive justice" in the context of health care, referring to "fair, equitable and appropriate distribution of benefits and burdens determined by norms that structure the terms of social cooperation" (6). Do police welfare checks promote or undermine distributive justice?

On one hand, suppose that Mr. Jones's clinician is hesitant to contact law enforcement to perform a welfare safety check because Mr. Jones is African American. Many people would see this as a problematic form of racial inequity. It might be argued that it would be an unfair discriminatory practice if patients who are not African American are preferentially given the service of safety welfare checks. Prima facia, it is unjust to distribute services differently on the basis of race.

On the other hand, one could argue that perception of police presence as influenced by race is an important consideration in determining whether to conduct a welfare check. Previous work has raised concerns about the judicious use of forced outpatient psychiatric engagement and the potential racial disparities that may exist in outpatient commitment (8). When caring for individuals with mental illness, the environmental context should be considered, including the influence of race (9). Both sides of this argument raise key considerations for this particular inquiry into relevant racial inequities.

Additionally, the role of law enforcement in relation to welfare checks is not well understood. Interactions between police and psychiatric patients received increased attention after a fatal 1987 shooting in Memphis, prompting the creation of crisis intervention teams (CITs) (10, 11). Despite frequent police interactions with individuals with mental illness, few police departments have specialized units similar to CITs (12). Surveys reveal that police officers feel that training on mental illness is insufficient and that they are open to learning more about this topic (13, 14). For welfare checks as part of safety assessments to function properly, police would ideally be willing participants. However, their role and the requirements for safety assessment remain unclear. Must law enforcement officers actually see the individual in order to ensure safety, or is a verbal response through a locked door sufficient? Input from police officers and lessons from their experiences will be crucial to better understand this interaction. These considerations reveal that the issue of welfare checks, as they pertain to the allocation of psychiatric services, lies at the intersection of criminal justice and distributive justice.

Respect for Autonomy

The ethical principle of respecting autonomy, in this context, concerns the patient who may need the welfare check. The interpretation and implementation of this principle are recurring challenges in psychiatry, and medicine generally, but they remain central considerations.

One resource gaining continued attention is use of psychiatric advance directives (PADs), which have the potential to increase respect for patient autonomy. These tools empower patients to document preferences in advance of a crisis. The Substance Abuse and Mental Health Services Administration and the National Alliance on Mental Illness support the use of PADs and offer detailed information online (15, 16). PADs have been shown to positively affect treatment attitudes and patients' feelings of empowerment, whether they are facilitated by peer support specialists or mental health professionals (17). Expanding the use of PADs has received much support, and PADs may serve as a valuable instrument for promoting discussion with patients regarding welfare checks. Patients' wishes, plans, and needs extend to more than just which medications they prefer; many patients likely have preferences about whether and

how police are called to their home as a method of assessment. When creating a PAD, it may be useful to discuss patient's preferences regarding police welfare checks in the event a provider is exceedingly concerned for a patient's safety and is unable to contact him or her. Welfare checks would fit naturally into safety planning discussions during the creation of a PAD while also raising awareness about the potential utilization of police welfare checks if appointments are missed. As with other patient preferences that are incorporated in a PAD, providers may acknowledge the limitations of these preferences during emergencies.

The Patient-Provider Relationship

The researchers at the University of Colorado cited above outline the case of a high-risk patient who missed a scheduled appointment (3, 4). The authors highlight the unlikelihood that a "blind welfare check might present at just the right moment" to change outcomes. In this circumstance, a welfare check has a higher risk of inflicting harm while damaging the therapeutic alliance and undermining the ethical principles of patient autonomy and nonmaleficence. The authors also examine the potential liability of clinicians in circumstances in which a safety welfare check initiated by a provider results in harm. They note that clinicians have a treatment relationship and a fiduciary responsibility to patients. Additionally, providers can be found liable for malpractice if harm stems from deviation in standard of care (1). The decision to call for a welfare check, or not to, should be clearly documented with evidence of weighing risks, benefits, and ethical considerations (4). Greater transparency about the policy of using safety welfare checks may be a way of improving the therapeutic alliance, promoting patient safety, and giving due consideration to the relevant ethical principles.

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The authors have confirmed that details of the case have been disguised to protect the privacy of the patient described.

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