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Ethical and Legal Dilemmas in Risk Assessment and Confidentiality: Cannabis Use, Psychosis, and Recidivism in Young Adults

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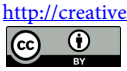

Abstract

This paper explores ethical and legal complexities related to confidentiality and risk assessment in young adults with cannabis use disorder and schizophrenia. Drawing from case law, professional ethical codes, and contemporary research, the article evaluates the justification for breaching confidentiality when the individual displays signs of verbal aggression and possible psychotic relapse. It also discusses the limits of foreseeability in predicting harm and outlines standards such as the Appelbaum test for assessing decision-making capacity. The analysis integrates statutory mandates, including HIPAA, FERPA, and New York State's Mental Hygiene Law, and addresses the central ethical dilemma of autonomy versus safety in clinical decisions.

Keywords

Confidentiality, Risk Assessment, Cannabis Use Disorder, Schizophrenia, Clinical Ethics

1. Introduction

Mental health and substance use disorders (SUDs) are among the most complex challenges in modern psychiatry, particularly when ethical and legal dilemmas intersect in clinical practice. Among young adults, comorbid conditions such as schizophrenia and cannabis use disorder raise significant concerns related to autonomy, confidentiality, and risk of harm. Clinicians, particularly in educational and institutional settings, must often navigate conflicting obligations, honoring client confidentiality and self-determination while also acting to prevent foreseeable harm to the client or others. These challenges are exacerbated by evolving social

attitudes toward cannabis, increasing awareness of neurodevelopmental vulnerabilities in young adults, and varying legal standards for involuntary intervention and disclosure.

Cannabis use among adolescents and emerging adults has increased in frequency and social acceptability, especially in regions where recreational use has been decriminalized or legalized. However, neurobiological evidence continues to link early cannabis use to alterations in dopaminergic function, potentially exacerbating psychotic disorders such as schizophrenia [1] [2]. These interactions are hazardous in individuals with an established history of psychosis, where cannabis can serve as both a precipitant and aggravator of symptom recurrence. At the same time, such individuals may legally be considered competent to make their own medical decisions, including refusing treatment, unless a formal legal and clinical evaluation finds otherwise.

A particularly contentious issue arises when young adults with known psychiatric histories engage in behaviors that suggest increased risk of violence or self-harm but refuse to disclose medical information or seek care. For instance, an undergraduate with a history of schizophrenia who exhibits aggression and cannabis use may not meet the statutory criteria for involuntary hospitalization, yet may pose a legitimate concern to counselors or university officials. Balancing the ethical obligation to respect confidentiality with the moral imperative to protect the client and the public requires clinicians to interpret ethical codes, institutional policies, and mental health law in tandem.

The American Counseling Association (ACA) Code of Ethics underscores respect for privacy and informed consent while outlining narrow conditions under which confidentiality may be breached, primarily when there is an imminent threat to self or others [3]. Legal doctrines such as *Tarasoff v. Regents of the University of California* (1976) have contributed to the codification of a therapist's "duty to warn" identifiable third parties of such threats, but ambiguity remains when the potential victim is unspecified, or when aggression is verbal rather than physical.

Furthermore, the assessment of decision-making capacity has become central to this discourse. Tools such as the Appelbaum and Grisso four-criterion model, understanding, appreciation, reasoning, and choice, have provided clinicians with a framework for determining capacity [4]. Yet, the application of such tools in young adults experiencing psychosis remains controversial, as the line between impaired cognition and temporary emotional distress is often difficult to define.

This paper explores these intersecting dilemmas through the lens of current research on recidivism and violence risk among individuals with comorbid substance use and psychotic disorders. Using a fictional case scenario grounded in real-world clinical and legal principles, the paper evaluates the limits of confidentiality, the ethical justification for breaching it, and the legal thresholds for involuntary intervention. Emphasis is placed on the practical implications of working within educational settings where FERPA (not HIPAA) governs the use of student

records and where age-related laws complicate parental notification.

By analyzing U.S. constitutional provisions, clinical ethics, statutory mandates (such as MHL §§ 9.37, 9.41, 9.45), and empirical evidence, the paper provides a framework for clinicians to navigate these ethically fraught situations. More specifically, the paper will use New York as the specific legal model for the analysis, relying to New York Mental Hygiene Law (MHL) and statutes. Therefore, the conclusions drawn from the analysis will primarily apply to New York. The overarching aim is to reconcile competing ethical values, autonomy, beneficence, and non-maleficence, while ensuring that clients receive the protection and care they need, even when such care may conflict with their stated wishes.

2. Recidivism and Risk Research

Understanding recidivism among individuals with mental illness, especially those with comorbid substance use disorders, has been a focus of forensic psychology and psychiatric research for decades. Although mental illness alone is not a strong predictor of violent crime or repeat offending, a growing body of literature indicates that when mental illness is coupled with substance abuse, particularly drug dependence, the risk of recidivism increases significantly [5]. This distinction is critical for clinicians, correctional professionals, and policymakers who must balance therapeutic support with public safety.

Zgoba *et al.* (2020) conducted a landmark study on inmates with co-occurring mental health and substance use disorders or just substance use alone, finding that while general recidivism rates were comparable across groups with and without mental illness, individuals with both mental illness and drug addiction were more likely to reoffend, and more quickly [5].

In the UK, parallel research has also revealed that individuals with untreated schizophrenia are disproportionately represented in repeat offender populations [6]. The same study emphasized that the cessation of antipsychotic medication plays a pivotal role in recidivism, a conclusion echoed in the U.S.-based CATIE trial. The CATIE (Clinical Antipsychotic Trials of Intervention Effectiveness) study revealed that discontinuation of medication among individuals with schizophrenia significantly increased the likelihood of arrest and violent behavior [7]. These results emphasize the critical role of sticking to treatment in minimizing danger, though substance use frequently interferes with proper medication compliance.

An emerging body of research suggests that cannabis use, particularly among individuals with schizophrenia, may contribute to elevated risks of aggression and impulsivity. A 2020 systematic review by Dellazizzo *et al.* found that cannabis use was associated with a higher incidence of violent behavior in patients with schizophrenia-spectrum disorders, potentially due to impaired impulse regulation. Although the causal pathways remain complex, THC appears to modulate dopaminergic activity, which may exacerbate psychotic symptoms and diminish behavioral inhibition, especially when high-potency cannabis strains are used [8].

Still, mental health providers must avoid overgeneralizing from group statistics to any one patient's situation. Pope *et al.* (2021) caution against applying this kind of logic to individual cases since it often relies on the incorrect logic of naturalistic and composition/division fallacies. These types of faulty reasoning place both ethics and confidentiality at risk [9].

Still, existing risk assessment tools are far from being accurate in predicting future violence. Methods such as the HCR-20 and VRAG provide predictive risk assessment scales, although their accuracy varies depending on the circumstances and the population [10]. These instruments should be viewed as additions to, rather than substitutes for, professional judgment during procedures addressing freedom.

3. Risk Assessment of Young Adults with Cannabis Use Disorder and Schizophrenia

Assessing dangerousness in young adults with cannabis use disorder and a history of psychosis poses a complex ethical and clinical challenge. Unlike older populations where patterns of behavior are more entrenched, adolescents and emerging adults are in a developmental phase characterized by volatility, impulsivity, and evolving identity. When cannabis use and schizophrenia co-occur, the task of predicting dangerousness becomes even more difficult due to overlapping symptoms, impaired insight, and limited treatment engagement [11].

The first complication in this demographic is the high prevalence of transient psychotic symptoms in the general youth population. Research indicates that up to 17% of adolescents report psychotic-like experiences, yet most do not go on to develop a chronic psychotic disorder [12]. When these experiences are coupled with cannabis use, particularly high-THC strains, there is evidence of increased risk for transition to schizophrenia or schizoaffective disorder [13].

Yet the mere presence of psychotic symptoms does not equate to danger. Clinical guidelines and legal statutes require more than diagnostic labels, they demand clear, observable behavior that suggests a risk of harm to self or others. In the absence of a stated threat or weaponization of symptoms, clinicians often struggle with the threshold for breaching confidentiality or initiating emergency evaluations. This gray area is especially problematic when aggression is verbal rather than physical, and when no identifiable target is named.

Tools like the Appelbaum & Grisso test help clarify decision-making capacity but do not directly assess danger [4]. Dangerousness assessments often rely on clinician judgment informed by behavioral observation, collateral information, and structured instruments like the START (Short-Term Assessment of Risk and Treatability). However, these tools offer probabilistic rather than definitive answers, raising ethical concerns about acting on partial or ambiguous data.

Assessing potential danger depends on considering a variety of interrelated factors. A combination of current health symptoms, the way substances have been used in the past, any prominent life challenges, and the influences of personal and academic environments. Additionally, they should consider their personal per-

ceptions, workplace guidelines, and the prevailing laws.

Fictional Case Scenario

Throughout this paper, a recurring fictional case scenario serves as the practical lens through which the ethical, legal, and clinical principles discussed are examined. The case involves a 20-year-old undergraduate student enrolled at a university in New York State with a documented history of schizophrenia who is currently engaged in cannabis use. The student has become increasingly verbally aggressive in interactions with counseling staff and peers, and shows signs of clinical deterioration, including diminished insight and possible psychotic relapse. Despite these observable changes, the student refuses to disclose their psychiatric history to university officials or parents, declines further mental health treatment, and does not meet the explicit statutory criteria for involuntary hospitalization, as no specific target of harm has been identified and no weapon or concrete plan has been articulated. The student is a legal adult whose educational records fall under FERPA rather than HIPAA, and whose right to refuse parental involvement complicates the institution's ability to intervene. It is this constellation of factors—comorbid schizophrenia and cannabis use disorder, verbal but not physical aggression, legal adulthood, refusal of care, and the absence of an identifiable and imminent threat—that renders the case particularly instructive for examining the limits of confidentiality, the thresholds for breaching it, and the ethical tension between autonomy and safety that underlies the legal and clinical analysis presented in the sections that follow.

4. Ethical and Legal Foundations of Privacy and Confidentiality

Privacy and confidentiality form the bedrock of the therapeutic relationship, particularly within mental health counseling. These ethics are defined in professional codes and laws to uphold the client's sense of self-worth and promote the best possible therapy. Clients feel more at ease with the knowledge that only those necessary for their care may access their personal information. The responsibility to preserve confidentiality is, nevertheless, limited by any serious threats to the client or others.

As the American Counseling Association [3] Code of Ethics, counselors are required to uphold a client's privacy (B.1.b) and safeguard confidential information (B.1.c). ACA indicates that counselors can disclose confidential information when the client or someone else is at serious and immediate risk. These provisions show that ethical confidentiality can be broken if the consequences of doing so outweigh the need to protect the information.

The U.S. Constitution does not include the right to privacy, but this principle is upheld in both ethics and constitutional law. It has been understood with references to the Fourth (protection from unlawful searches and seizures), Fifth (rights granted to protect individuals who testify in court), and Fourteenth (due process)

amendments.

Legal scholars such as Koocher and Keith-Spiegel (2016) interpret these provisions as supporting autonomy over one's medical and personal information. Accordingly, any breach of privacy must meet high ethical and legal thresholds [14].

This interplay becomes more complicated when patients refuse care or the release of medical information. For example, consider a 20-year-old university student with a history of schizophrenia and current cannabis use who refuses to share their psychiatric history or medical information with university staff or their parents. The counselor must determine whether honoring this autonomy would be ethically and legally responsible, particularly if there are signs of deteriorating mental status or verbal aggression. The ACA provides guidance under Section A.2.a, noting that informed consent is an ongoing process that must adapt to evolving clinical circumstances.

Ethical dilemmas also arise around the notion of "privileged communication." In legal contexts, privilege refers to the right of clients to prevent their therapists from disclosing information in court. Yet this protection, too, has limitations. Most jurisdictions allow clinicians to break privilege under specific circumstances, such as when a client poses a serious threat in the future, but not if the threat is in the past. For example, in the Tarasoff doctrine, the therapists must break confidentiality to protect individuals who are in imminent danger, as ruled by the *Supreme Court in Tarasoff v. Regents of the University of California* [15].

What if there is a likelihood of harm, although it may not be obvious? Examples like this test counselors' professional and moral values. A clinician may consider a patient's situation foreseeable for danger if that person displays increasing psychosis, shows signs of disinhibition, and fails to follow prescribed treatment. A therapist should record their rationale and weigh the issues governing ethics and law before choosing to disclose information against professional standards of confidentiality.

Overall, the principles of privacy and confidentiality are sacred, but not absolute. Professionals in mental health should weigh their obligations to safeguard confidentiality according to changes in risk, applicable exceptions, and the moral mandate to avoid causing harm. If a client loses the ability or refuses to make decisions that protect themselves, and there are reasonable fears of harm, then counselors may have to intervene, even by breaking confidentiality.

5. HIPAA, FERPA, and Confidentiality in Educational Settings

Navigating confidentiality in educational settings involves understanding two key federal statutes: the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA) [16]. While both laws aim to protect personal information, they apply differently depending on context, leading to substantial confusion among practitioners, students, and administrators.

HIPAA (1996) governs the privacy of health information in medical and men-

tal health settings. It mandates that protected health information (PHI) cannot be disclosed without patient consent, with limited exceptions [17]. However, HIPAA generally does not apply in educational institutions that receive federal funding and maintain student records, including health records, under FERPA [18]. According to federal regulations, student health records maintained by a university's counseling or health center fall under FERPA's jurisdiction (20 U.S.C. § 1232g).

FERPA provides students with rights over their educational records, including the right to control access. Once a student turns 18 or attends a postsecondary institution, these rights transfer from the parent to the student. However, FERPA contains a notable exception: under 34 CFR § 99.31(a) [10] and § 99.36(a), institutions may disclose information without consent if there is a "significant threat to the health or safety of a student or others."

This exception has profound implications for mental health professionals working with students who exhibit risk-related behaviors. For instance, a counselor who learns that a 20-year-old student with schizophrenia and cannabis use disorder has become verbally aggressive or is deteriorating clinically may be justified in notifying parents or university officials if they believe the student poses a significant risk to themselves or others. In such cases, FERPA permits, but does not require disclosure, placing the ethical burden on the clinician's judgment.

Another FERPA exception applies specifically to drug and alcohol violations. If the student is under the age of 21, FERPA allows institutions to notify parents of violations involving the use or possession of controlled substances (34 CFR § 99.31(a)(15)). This is particularly relevant in states like New York, where the Marijuana Regulation and Taxation Act prohibits cannabis use for individuals under 21. If a student under 21 discloses cannabis use during therapy, FERPA does not necessarily protect that information, especially if institutional policy prohibits such use.

However, the discretionary nature of these exceptions introduces ethical dilemmas. While legal permission to disclose exists, it may conflict with ethical standards emphasizing minimal disclosure and the need to protect client autonomy. According to the ACA's Code of Ethics (2014, Section B.2.e), when disclosure is necessary, counselors should reveal only the minimum information required to achieve the intended purpose.

The tension between these frameworks is particularly acute when a student resists parental involvement. Counselors must weigh the clinical risk, the legal permissibility of disclosure, and the ethical commitment to autonomy. Using structured tools like the Appelbaum test to assess decision-making capacity can aid in determining whether the student can reasonably refuse care or disclosure [4].

Ultimately, clinicians in educational settings must become adept at navigating the nuanced interplay between HIPAA and FERPA. They must be aware that while HIPAA offers robust privacy protections in medical settings, FERPA introduces conditional allowances for breaches in schools and universities. Knowing

when these exceptions apply and using them judiciously is a hallmark of ethical and legally informed practice.

6. Exceptions to Confidentiality: Duty to Warn and Foreseeable Harm

A major ethical and legal dilemma in mental health work surrounds when and how a therapist should disclose information about risk or danger to others. Lawyers based this requirement on the Tarasoff case, and it is the law in several states. Still, there is no universal and fragmented procedure for meeting this duty, and each situation is evaluated based on the likelihood of someone being harmed.

In *Tarasoff v. Regents of the University of California* (1976), the court decided that a psychologist was obligated to alert Tatiana Tarasoff after learning that his patient intended to harm her. After the patient killed Tarasoff, the court determined that the therapist was obligated to share the information with her to prevent the danger (15). Afterwards, the "duty to warn" developed into a more encompassing "duty to protect", which may necessitate informing the targeted person, reporting to police, or imposing compulsory detention.

Yet, not all threats are explicit or directed. In cases where clients exhibit escalating verbal aggression, substance use, or psychotic behavior—but do not name a specific target—clinicians must assess whether harm is reasonably foreseeable. Legal interpretations of foreseeability, such as those in Boynton v. Burglass (1991) and McIntosh v. Milano (1979), emphasize that while psychiatry is not an exact science, clinicians must act when a reasonable person would conclude that harm is likely [19] [20].

The ACA Code of Ethics (2014, Section B.2.a) supports breaching confidentiality to prevent serious and foreseeable harm. However, determining what is "foreseeable" requires careful assessment. According to Treasury guidance on foreseeability in tort law, foreseeable harm occurs when the clinician has sufficient information to conclude that a particular event will occur, not merely be possible [21]. This is critical when evaluating clients who are evasive, ambiguous, or delusional.

Complicating matters are logical fallacies that may bias risk assessments. The naturalistic fallacy, for instance, assumes that because a client belongs to a high-risk group (e.g., individuals with schizophrenia and cannabis use disorder), they must be dangerous. This flawed reasoning is ethically indefensible, as it disregards individual variability [9].

Clinical discernment between historical risk factors and present signs of being at imminent risk is imperative. A history of psychosis or past violence is not enough on its own to warrant duty-to-warn interventions, factors that may weigh in favor of hospitalization. If, on the other hand, the identifiable person is expressly specified, with a plan to buy a gun to carry out their violent behavior, and there's a weapon involved, it is necessary to give a warning; the police must be notified of the threat.

Suppose a client presents with signs of disinhibition and has a documented history of involuntary psychiatric hospitalization, placing them under the federal firearm prohibition outlined in 18 U.S.C. § 922(g) [4]. If that client also discloses current possession of a firearm, clinicians in New York may have a legal obligation to report the concern under Mental Hygiene Law § 9.46 if, in their reasonable professional judgment, the client is likely to engage in conduct that would result in serious harm to self or others. Under this statute, certain licensed mental health professionals must report such concerns to the local Director of Community Services (or designee), who may then transmit limited identifying information to the Division of Criminal Justice Services (DCJS), which can in turn affect firearm eligibility and NICS records. Such reporting is distinct from the clinician's limited "duty to warn or protect," which generally arises when a client makes a credible and imminent threat against an identifiable individual. While clinicians are not generally required to warn third parties in the absence of a specific threat, they may still be required to submit a report under MHL § 9.46 if the client's presentation indicates a substantial risk of serious harm.

In conclusion, while the duty to warn is a powerful legal and ethical exception to confidentiality, it must be invoked judiciously. Foreseeability, identifiable targets, and risk severity must all be considered in a structured and documented manner. Failure to breach confidentiality when required may expose clinicians to liability, while unjustified breaches may erode trust and violate clients' rights. Therefore, clear policy guidelines, legal consultation, and continuous training are essential for clinicians tasked with navigating this high-stakes ethical terrain.

7. Informed Consent and Decision-Making Capacity

Informed consent is foundational to ethical mental health practice. It embodies the principles of autonomy, transparency, and respect for persons, requiring that clients understand and voluntarily agree to the nature, purpose, and potential risks of treatment. However, when clients experience psychiatric symptoms such as psychosis, especially in the context of substance use, determining their capacity to provide informed consent becomes a complex clinical and legal undertaking.

The ACA Code of Ethics (2014, Section A.2.a) defines informed consent not as a one-time event, but as a continuous dialogue that evolves as treatment progresses [3]. Clinicians are responsible for ensuring that the client is fully aware of their rights and responsibilities and that any changes in clinical status, such as psychotic decompensation, are addressed in the consent process. Such difficulties in making sound decisions arise when clients start displaying signs of diminished insight, unclear thoughts, or delusions.

When these types of concerns arise, the capacity of the client to make decisions must be evaluated. Appelbaum and Grisso's (1988) four-criterion model is still the standard for evaluating a patient's capacity to make decisions. The four-criterion model assesses whether patients are capable of understanding their medical situation and treatments, applying this knowledge to their situation, weighing the

risks and benefits of various choices, and expressing what they want to do. Meeting grave difficulties within one of these criteria could result in the conclusion that the patient lacks necessary autonomy and lead to the need for a surrogate decision-maker to be involved [22].

The client's symptoms of psychosis can, at various times, affect their ability to understand, appreciate, reason, or communicate choices. A decision by the client to refuse treatment may still require evaluation for its basis in awareness of their situation or whether it stems from an inability to grasp relevant information. Psychosis itself does not always result in a total loss of mental capacity; in fact, most people with schizophrenia or related disorders can make their own choices despite going through a relapse or mental health crisis. Calcedo-Barba *et al.* (2020) underscore that psychosis does not automatically negate capacity, and that many individuals retain decision competency even amid active psychosis, while others are profoundly impaired because the symptom burden is so great [23]. Although psychosis is a cardinal characteristic of schizophrenia, it is a feature of other disorders as well (e.g., bipolar disorder, major depression). Crucially, schizophrenia is characterized by more widespread cognitive and functional deficits than psychosis alone, and capacity must be determined on a case-by-case basis.

Although professionals licensed in psychiatry and other mental health disciplines are authorized to interpret test results and use them in diagnostic and treatment decisions, determining whether a client is legally incompetent to make medical decisions typically requires formal capacity assessment and, in many cases, third-party confirmation—such as from a forensic evaluator, physician, or court—especially when the consequences involve overriding autonomy.

Importantly, incapacity is a clinical concept distinct from legal incompetence. As Palmer and Harmell (2016) argue, even individuals without full decisional capacity retain certain legal rights, and mental health professionals must avoid conflating psychiatric symptoms with blanket incapacity [4]. Therefore, documentation of capacity assessments is critical, particularly when the clinician's actions may override the client's stated preferences.

The ethical balance between respecting autonomy and protecting clients from harm becomes especially strained in educational settings. Here, clients are often legal adults who reject parental involvement. However, as discussed in earlier sections, FERPA and state law allow limited breaches of confidentiality when clients are under 21 and engaging in illegal substance use or pose a health risk.

Informed consent is ethically powerful but practically limited when psychiatric conditions impair cognition. It is the responsibility of the clinician to evaluate, document, and revisit consent in dynamic therapeutic contexts as it changes. Doing so ensures that treatment decisions respect client autonomy without compromising safety and care standards.

8. Legal Precedents and Involuntary Hospitalization

Involuntary hospitalization occupies a contentious space between individual lib-

erty and both public and individual safety. The state's power to detain individuals with mental illness against their will derives from parens patriae (the duty to protect individuals who are unable to care for themselves) and police power (the duty to protect society from harm), and is circumscribed by statutory and constitutional safeguards. In New York State, these powers are codified under Mental Hygiene Law (MHL) §9.37, § 9.41, and § 9.45, which outline procedures for emergency evaluation and involuntary commitment.

- **Section 9.41** authorizes peace officers or police officers to take into custody and transport to a hospital any person who appears to have a mental illness and poses a substantial risk of serious harm to themselves or others.
- **Section 9.37** allows for involuntary admission to a general hospital based on a physician's certification, provided that a staff psychiatrist confirms that the person has a mental illness requiring immediate inpatient care and treatment.
- **Section 9.45** empowers the Director of Community Services (DCS) or their designee to direct the removal of a person for psychiatric evaluation when there is credible information indicating the person is mentally ill and likely to cause serious harm if not hospitalized.

Unlike the "duty to warn" standard, civil commitment laws generally do not require the identification of a specific victim. Courts have recognized that generalized dangerousness—such as severe psychotic deterioration that results in the inability to meet basic needs—can justify emergency psychiatric detention under the parens patriae doctrine [24]. While definitions vary by state, some jurisdictions accept grave disability as a legal basis for involuntary commitment.

These principles are supported by the U.S. Supreme Court's decision in *Addington v. Texas* (1979), which established that clear and convincing evidence is the appropriate standard of proof for civil commitment. Although this threshold is lower than beyond a reasonable doubt, it requires substantial evidence and procedural safeguards, including careful clinical evaluation and due process protections. While the *Addington* decision does not specify clinical documentation or risk assessment, it emphasizes that due process protections must be observed and that the commitment decision must not rest on mere speculation or stereotypical assumptions.

In the context of a 20-year-old with schizophrenia and cannabis use who is refusing care that is essential to prevent serious health deterioration, this legal precedent may provide legal pathways for temporary detention. However, the clinician must still demonstrate that the individual meets statutory criteria for dangerousness, not merely that they are noncompliant or experiencing symptoms. Dangerousness must be operationalized as a substantial risk of serious harm to self or others, where self-harm may include the refusal of necessary medical care only when the consequences of that refusal pose an imminent and serious threat to the individual's life or physical safety.

Swanson *et al.* (2008) note that coercive treatment should be a last resort, employed only when therapeutic rapport, voluntary engagement, and support sys-

tems fail to ensure [7]. Moreover, clinicians must distinguish between emergency evaluation (typically limited to 72 hours) and full civil commitment, which requires judicial review and often includes testimony from two physicians.

Involuntary hospitalization has ethical implications as well. It risks violating autonomy and may lead to trauma, mistrust, and disengagement from services. Nonetheless, in cases of imminent risk, courts and clinicians prioritize safety. When appropriately implemented, temporary hospitalization can stabilize clients and facilitate longer-term care planning.

Ultimately, the clinician's role in initiating involuntary hospitalization is both medical and legal. It involves not only recognizing clinical risk but also adhering to statutory protocols that protect both the individual and the broader community.

9. Informed Consent Standards: Bolam vs. Reasonable Patient

Informed consent is shaped not only by ethical principles but also by legal standards that define what constitutes adequate disclosure. Two dominant models have emerged from case law: the Bolam test, which reflects a physician-centered perspective, and the reasonable patient standard, which prioritizes the patient's informational needs [25].

The Bolam test was established in Bolam v. Friern Hospital Management Committee [1957], a UK case, which held that a physician is not negligent if their actions conform to a practice accepted by a responsible body of medical professionals. This standard gives significant authority to the physician and focuses on customary medical practice, sometimes at the expense of patient autonomy.

In contrast, the reasonable patient standard was articulated in the U.S. case Canterbury v. Spence (1972), in which the D.C. Circuit held that physicians must disclose material risks that a reasonable patient would consider significant in deciding whether to undergo a proposed treatment. This model shifts the focus from physician judgment to patient autonomy, emphasizing the patient's right to make informed decisions.

Similarly, Wilkinson v. Vesey (1972) underscored that informed consent cannot rest on traditional medical paternalism alone; patients must be given sufficient information to make meaningful decisions [25].

Legal standards for informed consent vary by jurisdiction. For instance, New York's Public Health Law § 2805-d adopts a professional standard, requiring disclosure of reasonably foreseeable risks as judged by a reasonable practitioner under similar circumstances. While legally compliant, this approach may fall short of ethical best practices in psychiatric care, where patient autonomy and decisional capacity are more fluid and require a patient centered approach.

In cases involving psychosis, clinicians must assess the patient's capacity to understand and weigh treatment options. Tools like the Appelbaum and Grisso model help determine whether the patient can give informed consent. Failing to

assess capacity—or to obtain surrogate consent when needed—could lead to negligence.

Ethically, it is prudent for clinicians to integrate both standards: informing patients as a reasonable physician would, while ensuring that disclosures meet the informational needs of a reasonable patient. This dual approach fosters trust, strengthens clinical relationships, and minimizes legal risk.

Ultimately, informed consent is a dynamic process grounded in evolving legal precedent and ethical duty. While the Bolam test remains a foundational standard in some regions, the reasonable patient model aligns more closely with modern principles of autonomy and shared decision-making.

10. Ethical Dilemma: Autonomy vs. Public Safety

There is great difficulty in mental health between ensuring a client is treated respectfully and making sure they do not harm themselves or others. Mental health experts are sometimes challenged when a client exercises their freedom to make risky decisions, and they may find they should do something to prevent harm.

According to the ACA Code of Ethics (2014, Section A.1.a), clients ought to control what happens in their lives and healthcare. This is crucial in psychiatric care because clients have faced pressure, committal to asylums, and social ridicule. Showing respect for someone's autonomy helps them feel worthy and gives them a reason to join in their treatment.

Autonomy is, however, restricted when a client does not fully understand what is happening or could be a danger to themselves or others. Because of the non-maleficence or "do no harm" principle, clinicians at times need to put their values before the wishes of the client to protect them. Such actions can be found in duty-to-warn laws, civil commitment statutes, and rules for quick intervention.

When a 20-year-old has both schizophrenia and a cannabis use disorder, deciding between autonomy and keeping them safe is challenging. If a person refuses to cooperate, attacks clinicians verbally, and does not see the problem in their mental state, clinicians may think it is ethically necessary to act despite the person's wishes.

Even more confusion is added because the legal rules on this topic are not always clear. As Pope and Vasquez (2016) point out, clinicians need to avoid thinking that every person with mental illness is a danger to others [9]. The level of risk should be determined for each patient using reliable tools and the doctor's experience.

Also, FERPA and HIPAA put further blocks in the way of people or organizations from getting access to personal information. If there are genuine safety concerns, clinicians should be sure that their disclosures are kept as limited as possible (ACA Code, Section B.2.e). Losing trust due to major breaches of confidentiality could result in legal charges.

Clinicians can use the four principles from Beauchamp and Childress—autonomy, beneficence, non-maleficence, and justice—to guide them in difficult deci-

sions. Yet, there are no easy solutions offered by any framework. Cases need to be analyzed considering the situation, culture, and, if needed, together with security personnel and lawyers.

This ethical dilemma is not solved by picking one principle, but rather by finding a middle ground between them. Medical professionals should try the least limiting options, ensure they discuss and get consent before acting, and decide quickly if the situation demands it.

11. Conclusions

This work explores the intricate issues of confidentiality, risk assessment, and informed consent within the context of care for young adults with these two co-occurring conditions. An analysis of ethical codes, statutory mandates, and relevant cases makes it clear that privacy and autonomy guiding principles are progressively influenceable.

Studies of relapse and risk demonstrate how patients with co-occurring cannabis use and schizophrenia are at increased risk for repeating harmful behaviors, yet they are not necessarily dangerously unsafe. The Appelbaum test and other risk assessment techniques allow professionals to make informed and respectful judgments about a client's capacity to make decisions.

Giving informed consent involves ongoing consideration of clients' best interests as well as legal standards (e.g., Bolam and reasonable patient tests) and the dynamic nature of their clinical needs. Addressing the tension between a patient's autonomy and community safety involves procedural care.

Therapists must critically assess the foreseeability of harm, legal standards, and institutional policies while prioritizing the least intrusive interventions and the rights of their clients. Utilizing tools like the Applebaum test, applying FERPA and HIPAA appropriately, and understanding involuntary commitment laws are essential in navigating such challenging clinical and ethical dilemmas.

Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

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