NRS 433A.010 - NRS 433A.197

Nevada’s Emergency Psychiatric Hold and “L2K” Process
A Step by Step Review of the Law

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Agenda

- History
- The law
- Myths vs. reality
- EMTALA
- Making things better
First, a little History...

- 1800’s – Instead of “lunatic asylums” in dungeons, the Quakers in 1817 founded the first of many “retreats” which were park like settings, run by religious orders for those suffering from mental illness; many got better and returned to their lives – “those with mental disorders were perceived as suffering from great distress, yet still fully human.” (See Chapter 2, The Healing Hand of Kindness, in Robert Whitaker’s book Mad in America)

- Post Civil War – physicians reclaimed care for the mentally ill – no more spiritual care, no more dignity and respect…. Now it was “science”- mental illness caused by “irritated or worn out nerves” – many theories on how to attack this physical problem

- Late 1800’s - new belief that mental illness caused by a defective “germ plasm” leading to eventual acceptance of eugenics theories of “defective people” who needed to be isolated, sterilized, and destroyed once and for all
1900 - 1950 - “The Darkest Era”- horror stories as state hospitals flourished - lobotomies, hysterectomies, ECT, criminal victimization, isolation chambers, extreme hot or cold, starvation, noise, etc. (return to Bedlam)

Patients had no “rights” or representation, indefinite holds, often for lifetimes without any actual mental health diagnosis)
1960’s - new approach - “community-based care” - many state hospitals closed nationwide after horror stories were publicized (win-win solution - save money, kinder care)

- Ken Kesey’s One Flew Over the Cuckoo’s Nest
- Civil Rights Movement - focus on individual rights
- LSD - opening the mysteries of the mind
- Hair (“Age of Aquarius”) - anything is possible
- Drug company lies - we’ll be able to treat the symptoms, and cure the disease
The law:
Types of Admission to mental health facilities in Nevada - NRS433A.120

1. Voluntary admission - NRS 433A.140
2. Emergency admission - NRS 433A.145
3. Involuntary court-ordered admission - NRS 433A.200
Voluntary Admission

- **NRS 433A.140**
  - Person (or in the case of minors under age 18, the spouse, parent or legal guardian) may apply voluntarily to public or private facility for admission
  - If person applies to a division facility, he or she must be admitted or provided services if the person needs, and may benefit from services offered by the mental health facility
  - Person must be released immediately within the working day upon written request to responsible physician or designee, unless provider or designee w/in 24 hours or the request changes the status to an emergency admission

- **NRS 433A.145**
  - If physician desires to change the person’s status from voluntary to involuntary an L2K form must be completed pursuant to NRS 433A.160, together with certification pursuant to NRS 433A.170
  - A person whose status has been changed cannot be held longer than 48 hours after the change in status is made, unless a written petition for Court-ordered treatment is filed with the clerk of the district court per NRS 433A.200.
Emergency Admission (involuntary)

- **NRS 433A.150 – NRS 433A.160**
  - **Who** can initiate a “custodial hold?” (NRS 433A.160(1))
    - Accredited Agent of the Department
    - Law Enforcement Officer.
    - Physician
    - Physician Assistant (PA)
    - Psychologist
    - Marriage and Family Therapist (MFT)
    - Clinical Professional Counselor (CPC)
    - Social Worker
    - Registered Nurse
Emergency Admission - continued

- **When** can a “custodial hold” be initiated?
  - **NRS 433A.150** - when a person is alleged to be a person with mental illness per **NRS 433A.115** that person can be detained under emergency admission provisions
Emergency Admission - continued

- **Who** is a person with mental illness? (defined in NRS 433A.115)

- a person who has diminished capacity to exercise self-control, judgement and discretion in the conduct of his or her affairs and social relations, or the ability to care for his or her personal needs is diminished such that he or she presents a clear and present danger of harm to himself or others because:
Emergency Admission - Who? - continued

- Danger to Self (DTS)
  - within the prior 30 days has as a result of a mental illness acted in a manner in which it may be reasonably inferred that the person will be unable to satisfy his or her need for food, personal or medical care, shelter, self-protection or safety and a reasonable probability of death or serious harm within the next 30 days unless admitted to a mental health facility or
  - attempted or threatened to commit suicide or acts in furtherance of a threat to commit suicide and there is a reasonable probability that the person will commit suicide unless admitted to a mental health facility or
  - mutilated himself or herself

- Danger to Others (DTO)
  - within the immediately preceding 30 days has inflicted or attempted to inflict serious bodily harm on any other person, or made threats and committed acts in furtherance of those threats and there exists a reasonable probability that he or she will do so again unless admitted to a mental health facility
Emergency Admission - Steps

- **NRS 433A.150** – steps that must be taken for Emergency Admission:
  - **Step 1** – Probable cause to believe that individual is a person with mental illness *(fill out Page 1 of L2K form)*
  - **Step 2** – Get medical clearance (NRS 433A.165) by physician or PA or NP at a location where professional is authorized to conduct such an exam *(fill out top of Page 2 of L2K form)*
  - **Step 3** – Certify that patient is mentally ill and DTS or DTO *(fill out bottom of Page 2 of L2K form)*
  - **Step 4** – Admit to locked facility for up to 72 hours (including weekends and holidays) – **CLOCK STARTS HERE!!!**
Step 5 - Emergency Admission
Ends after 72 hours

- **NRS 433A.195** - Person must be released within 72 hours of admission to locked facility
  - Psychiatrist, Psychologist or Physician Assistant (include name of Supervising Psychiatrist on the form) must sign the “Certificate of Release” within 72 hours (complete page 3 of the L2K form)

- **UNLESS**, a petition is filed with the court pursuant to NRS 433A.200 and NRS 433A.210 for a court-ordered admission!
Court-ordered Admission - NRS 433A.200
Court-ordered Admission - NRS 433A.200

- Alternative to Emergency Admission when petition is filed directly by family members (spouse, parent, adult children, legal guardian) or by any physician, PA, psychologist, social worker, RN, Accredited Agent of the Department, or law enforcement officer
  - Petition must be accompanied by a certificate signed by a physician, licensed psychologist, PA under supervision of a psychiatrist, clinical social worker with psychiatric training, APRN with psychiatric training, or Accredited Agent of the Department stating that he or she has examined the person and believes they are a person with mental illness and DTS or DTO

- OR, Court-ordered Admission can follow an Emergency Admission
  - Petition for involuntary Court-ordered admission pursuant to NRS 433A.200 and NRS 433A.210 must be filed BEFORE the 72-hour Emergency Admission window of time elapses
Impliedly after receiving the petition, a hearing must be set by the clerk of the Court within 5 judicial days after the date on which the petition is received.

- This can “extend the time” up to an additional 5 judicial days.
- For example, if the petition is received on the third day of the 72 hour emergency admission, the person may be denied his or her liberty for up to 8 days; if it is received on the first day of the “hold” the total time could be up to 6 days.
- After the initial Emergency Admission, “due process” rights require the right to a hearing and representation.
Court-ordered Admission - continued

**NRS 433A.240** - After the petition is filed, the Court shall promptly cause two or more physicians or licensed psychologists, one of whom must always be a physician, to examine the person alleged to be a person with mental illness, or request an evaluation by an evaluation team from the Division of the person alleged to be a person with mental illness.

The two professionals who examine the person must submit a written summary of their findings and evaluation not later than 24 hours before the hearing date.
Court-ordered Admission -continued

- **NRS 433A.260** - In counties where the examining personnel required pursuant to NRS 433A.240 are not available, proceedings for involuntary court-ordered admission shall be conducted in the nearest county having such examining personnel available in order that there be minimum delay (in reality this will be the county where the inpatient facility is located)

- The entire expense of proceedings for involuntary court-ordered admission shall be paid by the county in which the application is filed, except that where the person to be admitted last resided in another county of the state the expense shall be charged to and payable by such county of residence. (!!)
Court-ordered Admission -continued

- **NRS 433A.310** - The order of the court is interlocutory (provisional) and does not become final if, within 30 days after the involuntary admission, the person is unconditionally released.

- The court-ordered hospitalization automatically expires at the end of 6 months if not terminated previously by the medical director of the public or private mental health facility.

- Facility of Division may petition to renew the involuntary admission of the person for additional periods not to exceed 6 months each.
A few important remaining issues: Medical clearance - if not medically clear at Step 2 ...

- **NRS 433A.165** – If, during the medical clearance step, the person is found to have an “intervening superseding medical emergency” and must be admitted to the hospital for medical care that will take more than 72 hours to resolve, the person who examined the patient must then petition the court on the first business day after making that determination, for permission to admit the patient to an involuntary psychiatric facility for an “emergency admission” once the medical problem is resolved.

- Seven days after filing such a petition, and every seven days thereafter, the physician must file and update, with the clerk of the court, a report on the medical condition and treatment of the patient.

- Note: “Certification” would not be appropriate until the medical issue is resolved, so often the ultimate disposition might be discharge from the hospital with no forced inpatient psychiatric care – do NOT complete bottom of page 2 (or page 3 of the form)
Certification - if person receives crisis intervention and is stabilized by Step 3 ...

- The L2K hold ends.
- Fill out bottom half of page 2.
- Do not fill out page 3 at all.
Myths vs. reality

- Law was apparently written with the following scheme in mind: Medical clearance and certification will take place at the door of the locked facility (thus, no need to address the period of time between initiation of the hold and arrival at the door of the locked facility)

- The issue of transport and boarding will be non-existent because there will be locked facilities in every community (obviously...or why write the L2K law as they did?)
  - Reality – in rural Nevada, it is likely going to take place hundreds of miles from a locked facility; transportation that is “appropriate” will be difficult to arrange in many cases, and the travel itself will take many hours
Myth vs. reality

- There will be ample inpatient beds, available 24/7, for all age groups, and for all levels of behavior

  - Reality – if you are very young, very old, very aggressive, have diabetes, are pregnant, use a sleep apnea machine, or are on medications, finding an inpatient psych bed will be difficult if not impossible
Myth vs. reality
Maybe it’s not so bad....?

- Experts estimate a need for a minimum of one psychiatric bed for every 2000 people (for patients with serious psychiatric disorders)

  - Nationwide average: 1 bed/4758
  - California: 1 bed/5975
  - Nevada: 1 public bed/15,030
Reality Check NV:

- Only 2 counties/16 (Washoe and Clark) have inpatient involuntary psych beds for non-insured or Medicaid “fee for service” patients; getting transport from Ely to Reno (320 miles), or from Battle Mountain to Las Vegas (416 miles), is hard especially in winter
  - NNAMHS - Reno
  - SNAMHS - Las Vegas
Myth vs. reality

- Parents, spouses and others close to the patient will always agree with the doctor, even when their loved one is going to be transferred to a facility that is hundreds of miles away.

- Insurance will pay for the time spent in the local hospital waiting for transport, and will pay for hospitalization in the nearest available locked psychiatric facility.
Myth vs. reality

• Law enforcement will support and help local hospitals dealing with a patient experiencing a psychiatric emergency by performing wellness checks, writing holds, providing security in the ED, and transporting patients....

• People on a hold will agree to diagnostic testing, and wait patiently and quietly when a bed cannot be quickly found

• People on a hold will never attempt to leave or threaten to leave, but if they do, hospital EDs have lots of legal options available to stop them
**Myth vs. reality**

- The NV legislature understands the problems of providing adequate services to rural Nevadans with mental illness and has good data on which to base its funding decisions.

- The legislature knows that their mentally ill constituents are a powerful voting block and is therefore generous in its efforts to assure and bolster local resources.

- Insurance companies, understanding the wisdom of early intervention, will be generous with mental health wellness dollars, and aftercare when patient is discharged.

- Co-occurring conditions (substance use disorder) are rare.

- Substance use disorder is easily treated even when a patient eschews care.
One more thing ... EMTALA*

- **Emergency Medical Treatment and Active Labor Act** (also known as the “anti-patient dumping act”)


*the reason L2K’s officially became the ED’s problem*
EMTALA - continued.

- Ensures access to emergency care regardless of ability to pay
- Strict rules that apply to hospitals with EDs:
  1. when a person comes to a hospital ...
  2. that person must be offered a medical screening exam ...
  3. to determine if they have an emergency medical condition, and if they do...
  4. they must be offered stabilizing treatment regardless of ability to pay or status as an "involuntary" psych patient ...
  5. if hospital cannot stabilize the EMC, they must offer to transfer the unstable patient to a facility that can (that facility must take patient if they have capacity and capability)
Definition of “unstable” includes:

- 1994: CMS (HCFA then): “emergency medical condition” includes psychiatric emergencies (42 CFR 489.24(b))

- Interpretive Guidelines (Tag A-2407/C-2407): “an individual expressing suicidal or homicidal thoughts or gestures, if determined dangerous to self or others, would be considered to have an EMC”
EMTALA “rule” - transfer of unstable patient with EMC

- If the patient cannot be stabilized at the first facility or requests a transfer,

- they may be transferred in an “unstable” condition to a *facility that CAN stabilize (doesn't say “hospital”)

- but only if certain things are done to make sure the transfer is as safe as possible.
Receiving hospital duties

- A Medicare-participating facility that is “covered” by EMTALA may not refuse to accept an appropriate transfer of an unstabilized patient if it has the **capacity** and **capability** to treat the individual.

- Most inpatient psych hospitals do not have EMTALA obligations because they do not have emergency departments – all patients are admitted with “appointments”

- Those that do have EMTALA obligations can refuse the transfer based on:
  
  - “Capacity” – the ability to accommodate the patient, including availability of staff, beds and equipment, and past practices of accommodating additional patients in excess of its occupancy limits
  
  - “Capability” – if unit already has several very aggressive patients, facility may say it lacks capability to take the individual
Receiving hospital duties - continued

- Capacity includes whatever a hospital customarily does to accommodate patients beyond occupancy limits.

- “Capability” includes coverage available through on-call list.

- CMS Representative told a hospital Behavioral Health Symposium in 2011 that refusal to accept psychiatric transfers was one of the most common reasons for EMTALA citations that year in the western region ("reverse dump").
EMTALA: Why Do Hospitals Worry?

- Violations may result in:
  - Patient harm
  - Medicare termination by the Centers for Medicare & Medicaid Services (CMS)
  - Fines by the Office of Inspector General (OIG)—up to $52,414 per violation for hospitals with fewer than 100 beds, $104,826 for larger hospitals (South Carolina hospital, AnMed Health paid $1.3M June 2017 after finding that 36 patients were not provided appropriate psychiatric treatment; recent Baltimore, MD case involving patient dumped to bus stop on cold night)
  - Physician exclusion from Medicare/Medicaid for gross/repeated violations
  - Physician fines—up to $104,826 per violation
  - Malpractice suits against hospitals and providers
Making things better...

- Identify problem areas and develop policy where law is silent – everyone at the table! (Patients’ Rights, NAMI, law enforcement, mental health, CBO’s, transport, hospitals)
Reducing Risk

- Educate your ED staff on Nevada law and EMTALA – often!
- Make a list of every possible inpatient bed, phone numbers, fax numbers, supervisors, trouble-shooters
- When things are calm, work out policies and protocols – who does what?
  - Who sits with the patient?
  - Who transports the patient?
  - Who assesses and reassesses the patient, and how often?
- Meet quarterly with all of the “players” to work on the “rough edges” and make policies better
Reducing risk -continued

- Get agreement on “medical clearance”
- Get clarity and agree on how confidentiality issues will be resolved, and who will share what with whom – train staff!
- Work together for more effective discharge planning
- Work together to increase resources in your community
- Reduce your personal risk: document, document, document!
Making things better ...

Be nice to your patients – they’re scared, and upset, and having a terrible day

- Don’t let your staff add to stigma (for example, calling them “crazy” or “frequent flyers”)
- Don’t insist on things that aren’t important (e.g., removing shoes, or all jewelry into a zip-lock bag) – you aren’t booking them into jail!
- Remember the Golden Rule
Questions