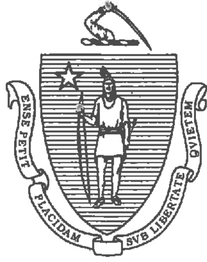

MENTAL HEALTH LEGAL ADVISORS COMMITTEE

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October 2, 2014

Kevin Beagan, Deputy Commissioner
Health Care Access Bureau
Division of Insurance
1000 Washington Street
Boston, MA 02118

RE: Standardization of Carrier and Provider Utilization Review Records

Dear Mr. Beagan:

Mental Health Legal Advisers Committee (MHLAC) commends you on your initiative to determine the factors that cause persons with psychiatric challenges to be "stuck" in emergency departments for extended periods of time. Frequently, clients use emergency rooms because their mental health needs, like speaking with their therapist or a medication refill, arise after traditional business hours. Since many clients complain about their emergency room experience, we've had occasion to consider changes in practice that might help to address this issue, and thus make the following recommendations:

***Emergency departments should properly apply the legal criteria for involuntary commitment before transferring patients to a mental hospital and do so no more than two hours prior to the transfer; re-visiting a prior determination if necessary to comply with this requirement.**

Persons with psychiatric challenges become stuck in emergency rooms when there are not enough beds in psychiatric facilities to accommodate them. To ensure that beds are not unnecessarily occupied by persons for whom a less intensive level of behavioral health care is appropriate, we recommend that the utilization review

records include verification that the person meets the standard for being held in a psychiatric facility, including a specific description of the factual basis for that determination, no more than two hours prior to transfer.

Under the prevailing legal standard, a person may only be confined in a hospital against their will when necessary to avoid "a likelihood of serious harm by reason of mental illness." "Likelihood of serious harm" means one of three things:

> •The person poses a substantial risk of physical harm to him/herself as manifested by evidence, threats of, or attempts at suicide or serious bodily injury; or
>
> •The person poses a substantial risk of physical harm to others as evidenced by homicidal or violent behavior or evidence that others are in reasonable fear of violent behavior and serious physical harm from that person; or
>
> •The person's judgment is so affected that there is a very substantial risk that the person cannot protect himself or herself from physical impairment or injury, and no reasonable provision to protect against this risk is available in the community. [1]

We are moved to articulate this standard because, over the years, many hospital records we've reviewed, including those generated by emergency service teams, are bereft of any legitimate explanation of the necessity for confinement, suggesting that at least some of these people are referred inappropriately. When psychiatric beds are filled with persons who should not be involuntarily confined, they become unavailable to persons that may genuinely need an intensive level of care but are "stuck" in emergency departments.

It is important that the evaluation or re-evaluation leading to the determination that a person needs hospital confinement be made close to the time of actual transfer. Symptoms of distress may subside during the 10, 24, or 36 hours individuals spend waiting for transfer, perhaps because of the provision of medication and/or talk therapy. A decision to involuntarily commit made in the first hour, therefore, may no longer correct later in the person's emergency room stay. Timely re-evaluation under the applicable standard shortly before transfer would therefore preserve beds for genuinely needy persons. Drawing the line at two hours seems to us reasonable.

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[1] Mass. Gen. L. ch. 123, § 1.

***Utilization review forms should indicate the person's presenting complaint and the steps taken, if any, to address that complaint.**

A common complaint of our clients is that emergency room staff aware of their psychiatric histories will tend to attribute physical complaints to psychiatric causes.[2] Not only can this tendency interfere with appropriate diagnosis and treatment, it understandably causes agitation and an emotional response that may be interpreted as evidence of a need for involuntary hospitalization. If persons are more appropriately treated for their physical complaints, psychiatric "crises" resulting in unnecessary psychiatric hospitalizations may be avoided.

***Utilization review forms should indicate that the emergency room has taken reasonable steps to rule out physical causes for psychiatric symptoms.**

Massachusetts law requires that any involuntary psychiatric hospitalization be based not solely on the "likelihood of serious harm" but also that the dangerous potential arises "by reason of mental illness." Research, however, shows that symptoms deemed to justify psychiatric admissions actually can be traced to physical causes in more than 10% of these cases.[3] For example, infection, vascular disease, exposure to toxins, hormonal irregularities, and medication reactions may cause symptoms consistent with mental illness. To avoid such confusion and the resulting undue use of psychiatric beds, emergency departments should be required to verify in utilization review records that they have taken reasonable steps to rule out physical causes for psychological symptoms.

Thank you for this opportunity to contribute to your deliberations on how standardized hospital utilization review records might enlighten the causes of and diminish the "stuck" patient syndrome.

Sincerely,

Susan Fendell
Senior Attorney

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[2] Inadequate physical health care due to the stigma associated with mental illness has been documented in numerous studies. See S. Fendell, *The Unintended Results of Payment Reform and Electronic Health Records*, 20 J. Health & Biomedical Law 173, 189-196 (2014). See also, A. van Nieuwenhuizen, et al., *Emergency department staff views and experiences on diagnostic overshadowing related to people with mental illness*, 22 Epidemiology and Psychiatric Sci. 255-262 (2013)(misattribution of physical symptoms to mental illness, among emergency medicine professionals, is a significant issue).

[3] See generally, Ed. R. Hall, Psychiatric Presentations of Medical Illness (Springer Netherlands 1980, rev. 2002)(citing Hall, *American J. of Psychiatry* (1980) and Koranyi, *Archives of General Psychiatry* (1979).