

Crain's Detroit Business

Effort under way to update state's mental health code

Sunday, February 10, 2019

By Jay Greene

An effort is underway to update Michigan's 45-year-old mental health code to encourage the development of more psychiatric urgent care and crisis centers that would work more closely with hospitals, group homes and families to hold and treat people with behavioral health problems until inpatient hospital beds are available.

The state's mental health code, which was written in 1974 and had its last major update in 1996, prohibits crisis centers from holding patients against their will longer than 24 hours unless they receive treatment — even if there is a legitimate public health and safety reason.

State law also prohibits ambulances from transporting patients with psychiatric conditions to crisis centers with "pre-admission screening units," a change mental health providers would like to see made along with appropriate emergency services training.

Last fall, Partners in Crisis Services and the Michigan Association of Community Health Boards began working with health care attorney Greg Moore of Dickinson Wright PLLC in Troy to develop a white paper that they hope can help convince legislators and state officials to change state emergency medical statutes and what they believe is an antiquated mental health code.

Such changes, advocates believe, can ultimately spur development of more outpatient community mental health crisis centers across Michigan and reduce long waits in hospital emergency rooms, a problem known as "ER psychiatric boarding" that has huge and unnecessary human and financial costs.

"Michigan's mental health code has simply not kept pace with the clinical and social advancements in crisis services," Moore said. "Too many individuals in need of services end up in jails and hospital emergency rooms. We must pave the way for individuals in crisis to receive targeted, specialized services. The starting point is the removal of barriers in the code."

Bob Sheehan, CEO of the Community Mental Health Association of Michigan, said the association and mental health professionals are planning to lobby

legislators to update the mental health code. They also will be asking officials at the Michigan Department of Health and Human Services to remove some barriers under Medicaid regulations, including creating additional reimbursement codes for treatment at crisis centers.

"We first got involved because the law is not so clear on crisis centers" and the rules on restraining aggressive or abusive patients, Sheehan said. "When we started looking at the code we found there were a number of problems."

The first problem, Moore said, is that crisis centers' pre-admission screening units (PSUs) have only 24 hours allowed by the code to evaluate a patient when they come from a hospital after being medically certified. But the center must release that patient before 24 hours if no treatment is provided.

"The statute can be clarified to follow models in other states where upon examination, if a person is a danger to others, they can be held for a period up to 72 hours," Moore said. "The problem is people are being 'streeted' within 24 hours. There is just not enough time for an inpatient psychiatric bed to be located."

Moore said one of the problems is that crisis centers are not being paid for treatment, only for evaluation. "There is nothing in the code to say they must treat. It would (also) be nice if (Medicaid and private insurance) funding were available to PSUs to provide outpatient services while inpatient bed is located. (Right now) they are not getting paid for treatment."

Heather Rae, CEO of Common Ground, which operates a 24/7 crisis center in Pontiac, said many pre-admission screening units at crisis centers hold psychiatric patients longer than 24 hours, technically violating the state mental health code, mostly because an inpatient bed cannot be found.

"We have been operating outside of that on a regular basis and many others do, too," Rae said. "We may assess someone, but if no one takes them, we have the choice of keeping them or treating them and letting them go."

But what if a crisis center holds the patient longer than 24 hours without clear authorization by the code and state law?

"If we break the law, can we do it for the public good?" said Rae, who is a member of Partners in Crisis Services.

In the white paper report, Moore said the mental health code does not clearly address several critical areas, but he believes providers can hold patients

against their will for longer than 24 hours if they are a danger to themselves or others.

Moore said the code generally only requires the crisis center screening unit to conduct an assessment of the patient within two hours of arrival and then either authorize or deny authorization to hospitalize the patient.

One question arises if a bed isn't immediately available. Can the PSU hold the patient?

"Not forever," according to Moore's white paper. The "PSU may continue to detain an individual only for so long as the patient requires hospitalization. (The) PSU must treat them, but let them go at the time that the treatment brings the individual back to a level when hospitalization is no longer required."

Bob Nykamp, vice president and COO of Pine Rest Christian Mental Health Services in Grand Rapids, said the 24-hour hold limit for hospitals only "clogs the EDs, because it might take longer to find a bed. Most other states have taken care of this issue."

For example, Arizona, Indiana and California have much more relaxed standards for 24-hour stays at crisis centers with PSUs. They also have similar rules on restraints, but there is a general agreement with state licensing agencies that supports using restraints on aggressive patients.

Moore said Indiana allows for 72-hour holds for psychiatric patients at PSUs.

Another common example that needs clarification in the code is if police bring in an individual in protective custody and then leave. Many police officers don't have time to wait for evaluation and treatment even though the code requires the officer to "execute a petition for hospitalization of the individual."

But does the crisis center have authority to hold the individual? "Yes. The peace officer has made a discretionary determination that the individual is dangerous to himself or others," Moore wrote.

Sheehan said some crisis centers are concerned they must let patients go if the officer leaves. "They can't hold them against their will," he said.

Benefits to mental health code changes

"The (state mental health) code is a barrier to having more crisis centers. It is very outdated because it was written in the 1970s and assumed there were enough psychiatric beds in hospitals that would accept anyone," Rae said.

"There aren't enough beds for the people needing it the most."

Sheehan said there are three operating crisis centers in Michigan — Pontiac, Livonia and Lansing, and three more in development, in Grand Rapids, Ann Arbor and Detroit.

The Detroit Wayne Mental Health Authority has plans to open one in Wayne County near the Boston-Edison neighborhood off Woodward Avenue and could open two more in the coming years.

"Every urban area needs to have a center, so (at least) another five crisis centers. They don't work well in rural areas. It's better to go to the ER and have crisis workers go there," Sheehan said.

In April, Pine Rest plans to open a 3,000-square foot outpatient urgent care center in Grand Rapids for behavioral health patients.

Nykamp said updated and common-sense rules in Michigan could allow crisis centers to take patients with moderate psychiatric problems and avoid hospital ERs, where many wait hours or days for a psychiatric bed.

ERs are "the worst place for psychiatric patients to alleviate symptoms," Nykamp said.

One of the first changes recommended is to increase to three days how long a crisis center PSU can hold a psychiatric patient and allow treatment to be provided.

"The time limitation does make some sense," Sheehan said. "We don't want a lot of people being held against their will. It's a civil liberties issue if applied in the wrong direction. The 24-hour rule made sense when you could get a hospital bed in a couple hours. The world of easy access is over."

Second, crisis centers should be allowed to restrain people who are aggressive, a danger to themselves or require more time to settle down. The code is ambiguous about restraints, experts say.

Moore said the code requires each mental health "facility" to develop policies on use of restraints. It prohibits physical restraints except in limited circumstances on "residents," but it does not define who is a resident, only that it is an individual who receives services in a "residential facility."

As a result, some centers interpret to allow restraints under certain circumstances. Others view the language as a total prohibition. The Medicaid provider manual states that providers are prohibited from using methods of seclusion, restraint and other restrictive interventions.

"The use of restraint and seclusion in psychiatric treatment settings is one of the most controversial and highly regulated practices in mental health treatment," Moore said. "We owe it to ourselves to have an honest and thorough debate regarding the therapeutic and safety value. Right now there is just avoidance of the topic by the statutory ambiguity."

Rae and Sheehan, two longtime mental health professionals, have such a policy disagreement.

"You can't restrain in crisis centers, not for one minute," said Sheehan, who interprets the use of restraints very conservatively. "You can do it in a hospital setting (with medical certification). We think the rules should be the same for crisis centers and allow more time for evaluation" and to allow patients to settle down, receive treatment or for staff to find an inpatient bed.

On the other hand, Rae at Common Ground believes there are instances where restraints can be used on people having a mental health crisis under certain circumstances for the protection of the patient and staff.

Rae said the center uses restraints about twice a month, adding that crisis centers that interpret the rules as a straight prohibition on restraints can cause the centers to become highly selective in who they serve. "You serve only the easy people."

The confusion in the law has contributed to at least one crisis center closing.

Last fall, the Macomb County Mental Health Authority completed phasing out its two-year-old behavioral health urgent center because of funding losses related to the 24/7 staffing.

But there were also regulatory concerns related to 24-hour holds and the use of restraints, said three sources who asked for anonymity. Macomb now offers a crisis hotline and same-day 9-5 nonurgent-care services.

"Everyone in Macomb County must now go to a (hospital ER) for urgent and emergent mental health crises," said one knowledgeable source. "Changes in the mental health code could resolve this problem."

Debra Pinals, M.D., medical director of behavioral health and forensic programs with MDHHS' behavioral health and developmental disabilities administration, said several changes have been made in the mental health code in the past two years, though none that would affect crisis centers.

On the new proposals, "we need to see how the language is and the impact it has," Pinal said. "The goal is always to find different doors and avenues for good care."

Use of ambulances, service payments

Another positive change could be to allow ambulances to transport patients to crisis centers, experts said. The current code bars this.

However, emergency physicians are concerned patients could bypass ERs before they are medically cleared. But mental health experts believe paramedics can be trained to evaluate behavioral health problems.

"There are no provisions for ambulances," Rae said. "The police are clamoring for changes. ... Some crisis centers want to use ambulances, but can't do it."

Moore said the emergency medical services provisions of the public health code could be modified to allow ambulances and specially trained paramedics to transport patients with psychiatric conditions to crisis centers after they have been medically cleared.

Experts contend that if more people with behavioral problems who do not need medical treatment were transported by ambulances to crisis centers, such as states like Arizona and California allow, hospital ER boarding would be drastically reduced.

Another problem is that insurance limits payments to ambulances to transportation of patients to hospitals, Rae said. In addition, Medicaid should reimburse crisis centers for holding and treating patients, Sheehan said.

About 20 years ago, Medicaid paid for crisis observation treatment services at crisis centers and hospitals, the so-called 23-hour-hold payment, said Sheehan. But that fee-for-service payment was phased out.

Dom Pallone, executive director of the Michigan Association of Health Plans, said Medicaid HMOs would pay for costs beyond their current responsibility of medical screening, stabilization and mental health assessment at hospitals and crisis centers if Medicaid mandated it and carved it into payments.

Pallone said he supports expanding the number of crisis centers and allowing them to treat patients under state law. "That could help with the boarding problem," he said.

But Pallone also said allowing HMOs to manage both physical and behavioral health in the Medicaid system, which will be the subject of a pilot program later

this year, could coordinate care better and reduce the need for emergency visits to hospitals. He said savings on the medical side could be used to expand mental health services.

Jay Greene: (313) 446-0325 Twitter: @jaybgreene