Consent rules for mental health treatment are generally the same as for physical health treatment:

- Consent must be “informed”
- Patient must have legal, physical and mental capacity
- Minors can consent to mental health care
  1. as adults if they are emancipated, or
  2. for “sensitive services” if they are 12 or older, and sufficiently mature -- outpatient counseling only (not inpatient and not including medications)

Mental Capacity – Who decides capacity for physical health care decisions?

- Primary physician should determine that patient has legal, physical and mental capacity to consent (Probate 4658)
- If patient has no designated physician with primary responsibility for his/her health care, then any physician may undertake that responsibility (Probate 4631)
- If provider believes patient lacks mental capacity e.g., because of dementia, drugs, or psychosis, then consent can be provided by a surrogate decision maker; the mental capacity question is seen as a “clinical decision” made by the doctor.
Mental Capacity – Who decides for mental health care decisions?

- Hint: Not the primary physician.

Myths Associated With Treating Patients With Behavioral Health Issues

Myth: Patients with serious mental illness, or on a 5150 hold, lack capacity and therefore cannot give informed consent, or “non-consent” to mental health care.

Reality: Mental capacity is presumed by the law.

W&I 5331 - No person may be presumed to be incompetent because he or she has been evaluated or treated for a mental disorder or chronic alcoholism, regardless of whether such evaluation or treatment was voluntarily or involuntarily received

Myths (cont.)

Myth: Patient who meets criteria for 5150 (danger to self, others, or gravely disabled due to mental health disorder) must be put on a 5150 “hold.”

Reality: LPS Act favors voluntary treatment; if patient is willing to accept care voluntarily, law requires that “least restrictive” means be used and care be provided on that basis (See W&I 5150, 5151)

- proposed legislation that is currently pending would bar putting patient on a 5150 hold based solely on staff/facility “preference” – see discussion of AB 2983 below
Myths that were Believed When LPS Act was Written

• Enough “psychiatric emergency clinics” for 72 hour involuntary evaluation and treatment would be built to meet the need (and would admit all age groups, all levels of behavior & any payer source)

• Emergency clinics would be distributed liberally everywhere throughout the state (thus, the time to get from 5150 to 5151 was not worth mentioning; getting from hold to designated-LPS facility would just take a few minutes at most)

• No one who is a “danger to self” would have acted yet, so no (physical) health needs would be present

Myths that were Believed When LPS Act was Written (cont.)

• Psychiatric patients are in relatively good general health
• Psychiatric patients do not use alcohol or drugs
• Psychiatric drugs would soon be available that cure mental illness, or at least quell its symptoms
• Patients, grateful to be cured (or free of symptoms) would be compliant with their medications (and can afford them)
• Patients wouldn’t have crises near state borders, so conflicts with other states’ laws would not be an issue

Myths that were Believed When LPS Act was Written (cont.)

• Physicians will agree and collaborate on the medications that are best used for any particular patient/diagnosis
• Jail psychiatrists and correctional care mental health professionals will be able to adequately treat those individuals who have committed serious or violent felonies
• Physicians, local mental health professionals, the Courts and local law enforcement will all recognize their roles and work together to do their part to help patients statewide
• Mental health professionals always have the patients’ best interests in mind, so patients, realizing this, will be grateful for the help and compliant with their tx plan
Myths that were Believed When LPS Act was Written (cont.)

- **Myth:** Insurance coverage will be adequate to pay for medications & treatment
  - **Reality:** NOT true … leading to more and more untreated patients, especially patients needing crisis care

- **Myth:** Inpatient bed reimbursement rates will be adequate to cover hospitals’ costs to run a psychiatric unit
  - **Reality:** NOT true … leading to wide-spread closure of inpatient psychiatric beds.

- **Myth:** There will always be adequate numbers of mental health professionals to meet the needs of seriously mentally ill clients
  - **Reality:** NOT true … LPS-designated facilities often have to close beds on their units because there isn’t adequate staff coverage

Myth: The Clock

**Myth:** Somewhere the law will tell me, once and for all: when does the 72 hour clock start?

**Reality:** There are two different start times – one in W&I Code 5150 (when person is taken into custody) and another at W&I Code 5151 (when person is admitted into designated facility); neither is right or wrong …

Myths (cont.)

**Myth:** The “hold” is void / the “hold” is paused / the “hold” is still in effect when a patient has to be admitted onto an acute care hospital unit for a superseding medical emergency.

**Reality:** The law is silent about this event.
Myths (cont.)

**Myth:** If a 5150 patient is pregnant, paraplegic, needs sleep apnea equipment, is incontinent, or is an insulin-dependent diabetic, he or she will not be denied a psychiatric bed in a designated facility.

**Reality:** That is a common reason that beds cannot be found.

The Medical Clearance “Myth”

**Myth:** “The law” requires a medical screening exam before admission.

**Reality:** There is no mention of it in the statutes.

Guidelines for Medical Screening Exams and Labs

Since there is no law, it is extremely helpful to have policies that address and clarify:

1. Consent process for diagnostic testing (patient can refuse or question)
2. List of diagnostic tests and standardized approach to medical clearance that is region-wide (standard of care)

For example: pregnancy test for females (age appropriate), urine toxicology screen and ETOH blood alcohol (or Breathalyzer);

Optional: CBC & chemistry panel including blood glucose and other appropriate testing based on medical history.
Medical Screening – Do Not Forget EMTALA Obligations!

- In addition to the diagnostic tests that the designated locked facility wants, also:
  - Send medical and mental health history
  - Send list of medications (current and past, allergies)
  - Provide necessary and appropriate stabilization of any physical health issues, etc.
- Always better if you have agreements in writing with your frequently used designated inpatient psychiatric facilities that specify the expectations of both parties so they don’t suddenly ask for a random, time-consuming, expensive, or unnecessary test
- Helpful that there is consensus in the region so a “standard of care” can be established that everyone is comfortable with

Making Things Better

- Identify problem areas and develop policy where law is silent
- Everyone at the table: Patients’ Rights Advocates, NAMI, law enforcement, County Mental Health, CBO’s, transport, hospitals, etc.
- Meet on a regular basis to iron out rough patches on a friendly basis

Making Things Better (cont.)

- Be nice to your patients – they’re scared, and upset, and are having a terrible day
- Do not let your staff add to stigma (for example, calling them “frequent flyers”)
- Do not insist on things that aren’t important (e.g., let them keep their shoes on if it’s important to them and doesn’t really matter to you)
- Remember the Golden Rule
• **Myth:** The “wet ink” original copy of the 5150 application must accompany the patient through the entire process: the hold, transport to the hospital, medical clearance, transfer to the designated LPS facility, and admission to the LPS facility – a copy is not sufficient to keep a person on the hold.

• **Reality:** NOTHING in the law says that. And in fact, this myth harms our patients, and wastes valuable time and money.

• **New Legislation: AB 2099** – a copy of the 5150 Application form would equal the original “wet ink” copy – a very simple change (one line added to W&I 5150 statute) that will save countless wasted hours trying to find, transport and deliver an original copy.

• **Myth:** It is “safer” to put someone “on a hold” (also, we cannot admit a patient to a locked facility unless they are “on a hold”)

• **Reality:** Nothing in the law says that. In fact both 5150 and 5151, as well as the preamble to the LPS Act emphasize using “least restrictive means,” and the preference to provide care on an outpatient or voluntary basis whenever possible. Furthermore, forcing the person onto hold “status” creates anxiety and fear, is stigmatizing, and can have short-term and life-long negative consequences.

• **New Legislation: AB 2983** – would prohibit forcing a voluntary patient onto involuntary status (5150) for transport purposes or admission into designated facility.

• **Myth:** The definition of “grave disability” is crystal clear, and everyone agrees on it.

• **Reality:** It’s actually not that clear, and the whole concept of “medical neglect” due to paranoia or delusional/psychotic belief is absent from the definition.

• **New Legislation: AB 1971** – would change the definition of grave disability to include refusal of necessary and appropriate medical care due to mental health disorder (“Grave disability…means an inability to provide for his or her…medical treatment, if the lack of, or failure to receive, that treatment may result in substantial physical harm or death…”)

• See AB 2156, SB 1045, and other bills with similar changes to the definition or treatment of grave disability, or services to patients with behavioral health issues.
Newton’s Cradle

Why Science Teachers Should Not Be Given Playground Duty…

Questions