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Hospital-Based Guardianship Courts: One Solution to Reducing Avoidable Inpatient Days for Behavioral Health Patients

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"Mental illness is not in the business of making sense of itself." - Roni Askey-Doran

"From the outside looking in, it's hard to understand. From the inside looking out, it's hard to explain." - Unknown

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INTRODUCTION

Patient J.S. is admitted to the inpatient psychiatric unit of a community hospital with a diagnosis of Acute Stress Disorder, Post-Traumatic Stress Disorder.[1] J.S. meets the admission criteria for active treatment per Center for Medicare and Medicaid Services (CMS).[2] The hospital anticipates a twelve day inpatient stay and receives certification from the physician. An individualized treatment plan proves to be effective and the patient no longer meets admission (payment) criteria by the tenth day *but* will require a lesser level of care/monitoring. Case Management identifies that the patient has no home address, no relatives or friends to assume care of the patient and therefore the hospital is unable to discharge. The hospital arranges for J.S. to appear in District Court for a Guardianship appointment on the first available date - *in three weeks*. The hospital has no option but to continue to board the patient without payment and, as a result, incurs potentially avoidable days.[3] In the meantime, as a direct consequence of J.S.'s situation, the hospital is unable to admit a patient that has been in the Emergency Department (ED) for five days awaiting an available inpatient psychiatric unit bed. When the day finally arrives for J.S. to appear in court, he is transported in wrist and ankle shackles as required by the Sheriff's Department policy to the Courthouse 20 minutes away where the patient awaits his appearance in a foreign, potentially hostile environment.

The secondary effects of an imperfect process can give rise to catastrophic results. This common scenario negatively impacts community hospitals and patients across the country. Statistics on both a national scale and specific to the rural state of New Mexico suggest that every state is struggling with the shortage of psychiatric hospital beds, and the availability of these beds continues to decline. Advocates suggest at least 40 to 60 beds for every 100,000 people. In 2016, the national average was 11.7[4] Notwithstanding a shortage of both inpatient psychiatric services and hospitals, patient care must be provided in an efficient manner and must include the ability of the patient to advance as quickly as possible to the next level of care. Rather than subject psychiatric inpatients to foreign courtroom environments, prolonged wait times and civil rights indignities, Gerald Champion Regional Medical Center (GCRMC) has implemented a hospital-based Guardianship Court, the details of which will be provided at the conclusion of this paper. By creating a court that exists at the hospital, GCRMC hopes to reduce the lengths of stay for inpatient psychiatric patients and to afford these patients a timely progression and quality of care.

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[1] DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, FIFTH EDITION, Section II: Diagnostic Criteria and Codes - Trauma and Stressor-Related Disorders, available at https://dsm.psychiatryonline.org/doi/book/10.1176/appi.books.9780890425596

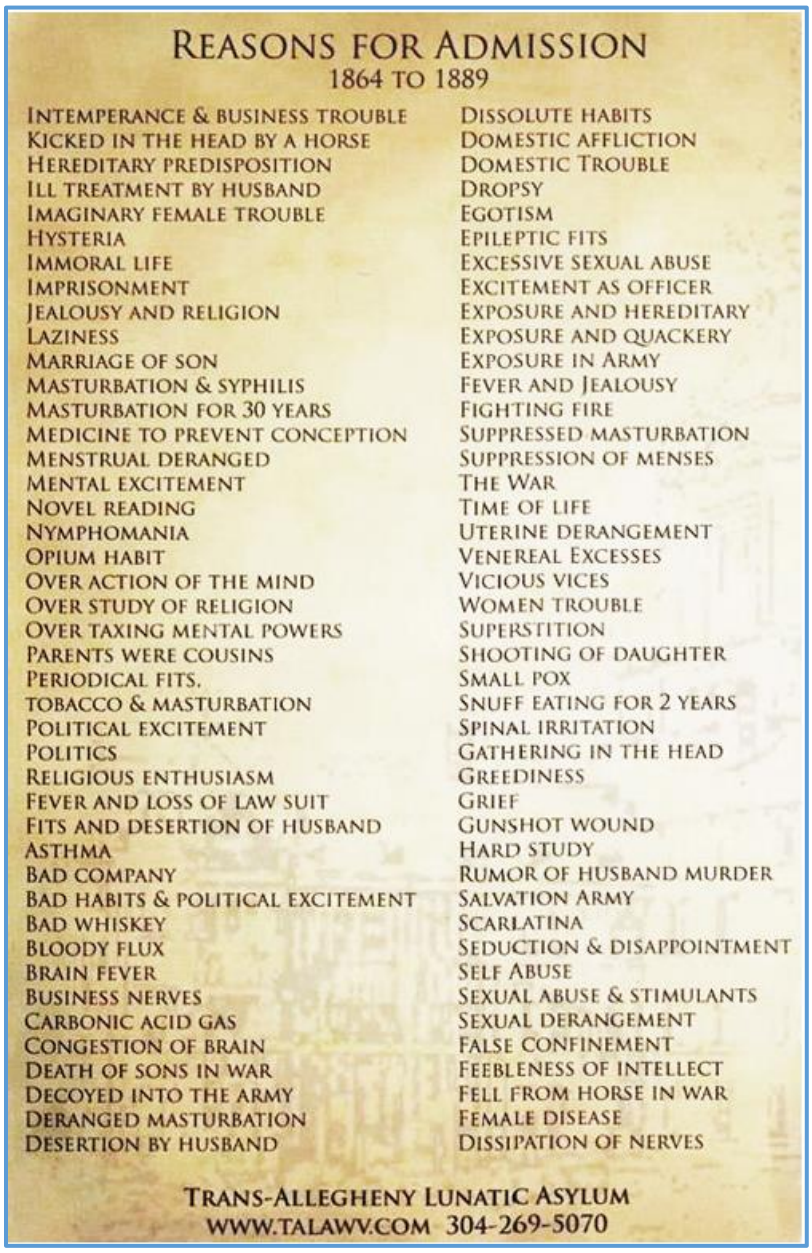
[2] Centers for Medicare & Medicaid Services, Publication 100-02, *Medicare Benefit Policy Manual - Chapter 2: Inpatient Psychiatric Hospital Services*, Rev.223, May 13, 2016, pg. 3, available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.html

[3] Kristin Dillon and Darcie Thomsen, Reasons for Delays in Hospital Discharges of Behavioral Health Patients - *Results from the Minnesota Hospital Association Mental and Behavioral Health Data Collection Pilot*, July 2016, page 1, available at https://www.mnhospitals.org/Portals/0/Documents/policy-advocacy/mental-health/MHA%20Mental%20Health%20Avoidable%20Days%20Study%20Report%20July%202016.pdf

[4] Michael Ollove, The Pew Charitable Trusts, *Amid Shortage of Psychiatric Beds, Mentally Ill Face Long Waits for Treatment*, August 2, 2016, available at http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/08/02/amid-shortage-of-psychiatric-beds-mentally-ill-face-long-waits-for-treatment

THE HISTORY OF MENTAL ILLNESS

"…were it not for the scant 120-odd years that have passed, pretty much every last one of us would have been a good candidate for the West Virginia Hospital for the Insane which operated from 1864 to 1869. Many are the reasons you could have found yourself on their not-at-all-exclusive guest list:"[5]



"Who qualifies as insane, what causes mental illness, and how such illness should be treated has varied wildly throughout recorded history, sometimes veering dangerously close to arbitrariness and often encompassing cures considerably worse than the illness itself."[6]

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[5] Huffington Post, *Literally All Of Us Would Have Been Sent To An Insane Asylum*, October 23, 2013 Updated December 6, 2017, available at https://www.huffingtonpost.com/2013/10/23/reasons-for-insane-asylum-admission_n_4151762.html

[6] ROY PORTER, MADNESS: A BRIEF HISTORY, Oxford University Press, (2002)

The early Greeks were the first to write about afflictions of the human condition in literature and mythology and for centuries directed the thinking of the medical community.[7] Now, fast forward to the 19th century where classification and separation is established for mental illness. Women were separated from men, dangerous patients from safe, and there was a shift in thinking that many of those suffering from 'insanity' and 'nervous diseases' were perhaps incurable.[8] The psychoanalytic approach became a focus in the U.S. by the 1950s, and the fact that regular people presented with mental disorders and neuroses was generally accepted by society.[9] The 1950s also introduced the use of anti-psychotic and anti-depressant drugs that allowed for the discharge of many patients from asylums and institutions. This action triggered the trend toward deinstitutionalization in the 1950s and 1960s[10] which would come to have a dramatic impact on bed availability and the shortages we experience today. The Joint Commission on Mental Health, created by Congress in 1961, fueled this movement which closed most asylums and institutions but failed to replace them with mental health systems at a community level as they had planned.[11] In 1956, Karl Menninger stated "Gone forever is the notion that the mentally ill person is an exception. It is now accepted that most people have some degree of mental illness at some time."[12]

Today, **nearly one in five U.S. adults lives with Any Mental Illness (AMI)** - an estimated 44.7 million adults aged 18 or older or 18.3% of all adults. The prevalence of AMI is higher among women (21.7%) than men (14.5%).[13] A 2013 Substance Abuse and Mental Health Services Administration (SAMHSA) study identifies rates of overall mental illness among adults by state (see below). New Jersey had the lowest national rates (14.7%), Utah the highest, at 22.3%. West Virginia had the most cases of Severe Mental Illness (SMI) among adults, at 5.5%. Many experts feel these statistics grossly understate the prevalence![14] What is perhaps more important to note, only 62.9% of those with SMI received mental health services in the year they reported the illness.[15]

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[7] Stacy Clark, *History of Mental Illness*, 2007, available at www.psy.vanderbilt.edu/courses/hon182/History_of_Mental_Illness_Fall_2007.ppt

[8] *Id*.

[9] *Id.*

[10] Samantha Raphelson, npr, *How The Loss Of U.S. Psychiatric Hospitals Led To A Mental Health Crisis*, November 30, 2017, available at https://www.npr.org/2017/11/30/567477160/how-the-loss-of-u-s-psychiatric-hospitals-led-to-a-mental-health-crisis

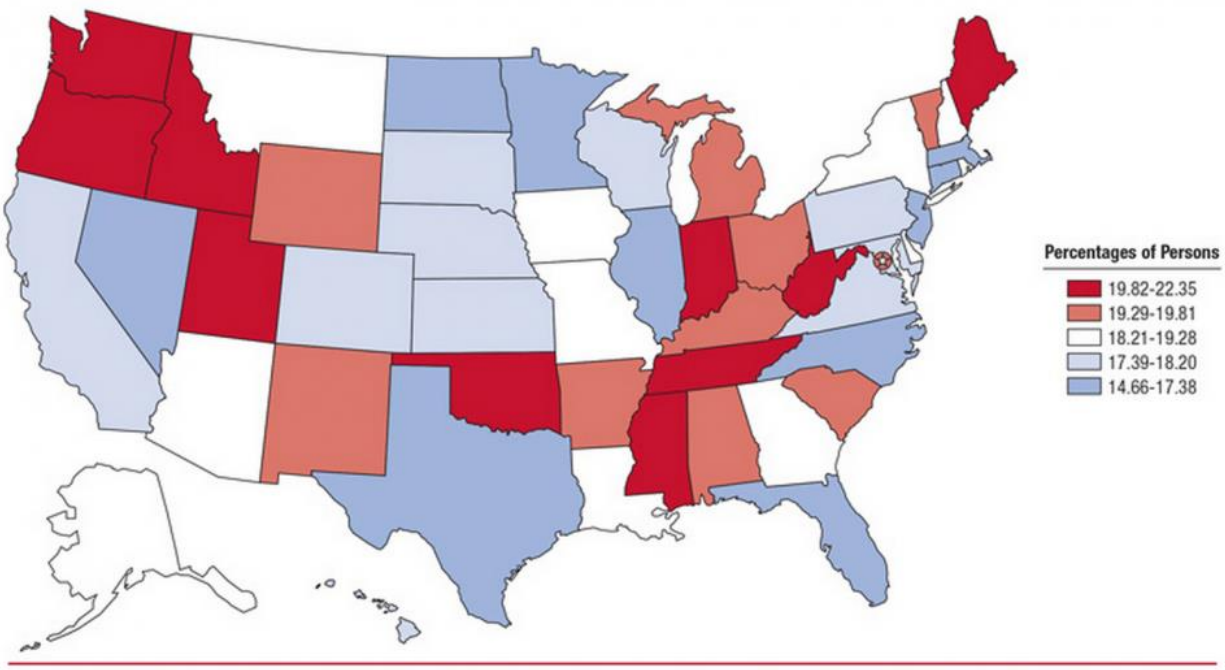
[11] David Chorney, *A Mental Health System in Crisis and Innovative Laws to Assuage the Problem*, 10 J. HEALTH & BIOMED. L. 215, 219

[12] Karl Menninger, *The Vital Balance: The Life Process in Mental Health and Illness*, New York (NY), Viking, pg. 33, 1963

[13] National Institute of Mental Health, Mental Illness Statistics 2016, available at https://www.nimh.nih.gov/health/statistics/mental-illness.shtml

[14] Victoria Bekiempis, Newsweek, *Nearly 1 in 5 Americans Suffers From Mental Illness Each Year*, February 28, 2014, available at http://www.newsweek.com/nearly-1-5-americans-suffer-mental-illness-each-year-230608

[15] *Id.*



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health (NSDUHs), 2011 (revised October 2013) and 2012.

LAWS & REGULATIONS IMPACTING MENTAL HEALTH

Laws and regulations that influence mental health services are presented herein and address, among other issues, the implementation of modern day protections for those with mental illness both at a State and a Federal level.

Groundbreaking legislative support for mental illness is no more evident than in the 1999 enactment of *Kendra's Law*. This Assisted Outpatient Treatment (AOT) law originated in New York following the tragic episode where Kendra Webdale was pushed into the oncoming path of a New York City subway car by a man with mental illness (schizophrenia) who was no longer taking his medication.[16] Many states, including New Mexico, have followed suit in providing legal protections to individuals with Serious Mental Illness (SMI). Kendra's Law allows courts to accept up to a year of outpatient treatment for certain patients as a condition for continuing to live in the community. According to a 2010 Columbia University study, individuals under an order for Kendra's Law, in spite of having a greater incidence of violence, "were four times less likely to engage in future violence than those in a control group".[17] New Mexico failed in previous attempts to pass its version of Kendra's Law but finally succeeded on March 9, 2016 with *SB 113 Assisted Outpatient Treatment (AOT) Act* by addressing civil liberty concerns that had been raised by its opponents.[18] One clarification made was that a failure on the part of the respondent to appear for treatment *does not* result in a contempt of court ruling nor justify the implementation of harsh measures such as involuntary commitment or forceful medication administration.[19]

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[16] Las Cruces Sun News, *Kendra's Law Will Protect Those with Mental Illness,* available at http://www.lcsun-news.com/story/opinion/2016/05/22/kendras-law-will-protect-mental-illness/84750666/

[17] Mental Illness Policy Org., *Kendra's Law: New York's Law for Assisted Outpatient Treatment (AOT)*: *A Brief Overview of the Law and the Results*, available at https://mentalillnesspolicy.org/kendras-law/kendras-law-overview.html

[18] Associated Press, *New Mexico Senate passes version of 'Kendra's law'. Law would require some residents with severe mental illness to get court-ordered treatment,* MODERN HEALTHCARE, February 6, 2016, available at http://www.modernhealthcare.com/article/20160206/NEWS/160209886

[19] SB 113 New Mexico Legislature, 2016 Regular Session, *Assisted Outpatient Treatment Act*, page 5, March 9, 2016, page 22,

Confidentiality rights, including those pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) are also granted to the respondent in this Act.[20]

Other notable laws with an impact on mental health/illness include the *Patient Protection and Affordable Care Act of 2010 (ACA)* which improved the ability of those with mental illness to obtain affordable healthcare coverage when they had previously encountered difficulties doing so with pre-existing mental health conditions.[21] The ACA enacted reforms that required qualified health plans to provide ten essential health benefits including "mental health and substance abuse disorder services/behavioral health treatment."[22] Additionally, with the decline of Medicaid funds in state budgets, the ACA is attempting to assist with a Medicaid matching provision, hopeful to halt the trend of the denial of access to mental health care services for Medicaid beneficiaries.[23] The *21st Century Cures Act - P.L. 114-255* was enacted with overwhelming bipartisan support in December 2016. This Act provides funding to a variety of governmental agencies so that they may offer grants/awards to states for research and projects related to the mental health crisis (among other important issues!).[24] This monumental reform bill included language from the *Helping Families in Mental Health Crisis Act of 2016,* which increased the number of psychiatric beds nationwide and promoted a focus on mental illness at the federal level by creating the position of assistant secretary for mental health and substance use disorders appointed by the President.[25]

The Americans with Disabilities Act (ADA), passed in 1990, speaks to discrimination prohibitions against the disabled (mentally ill).[26] The 1990 *Olmstead* decision further demonstrated intolerance for the unpardonable segregation of persons with disabilities. The Supreme Court determined that the ADA "applies to patients in state psychiatric hospitals and that states must undertake reasonable accommodations to support the community integration of individuals with mental illnesses."[27] In New Mexico, to accompany the 2016 *Assisted Outpatient Treatment Act*, the *Assisted Outpatient Treatment Funding Act - SB 4* was introduced in January 2018. Although postponed indefinitely, legislative efforts will continue in the hope of securing and distributing annually one million dollars ($1,000,000) to those New Mexico cities and states involved in the court assignment of AOT.[28]

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) offers protections to the mentally ill by "providing that large group health plans cannot impose annual or lifetime dollar limits on mental health benefits that are less favorable than any such limits imposed on medical/surgical benefits."[29] MHPAEA was by

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available at https://www.nmlegis.gov/Sessions/16%20Regular/final/SB0113.pdf

[20] *Id.* at 33

[21] H.R. 3590, Public Law 111-148, *Patient Protection and Affordable Care Act*, March 23, 2010, available at https://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf

[22] 42 U.S.C. § 18022(b)(1) (2010)

[23] David Chorney, *A Mental Health System in Crisis and Innovative Laws to Assuage the Problem*, 10 J. HEALTH & BIOMED. L. 215, 229

[24] H.R.34 - Public Law -114-255, *21st Century Cures Act*, Congress.Gov, December 13, 2017, available at: https://www.congress.gov/bill/114th-congress/house-bill/34/

[25] Treatment Advocacy Center, *21st Century Cures Act*, December 2016, available at http://www.treatmentadvocacycenter.org/fixing-the-system/21st-century-cures-act

[26] 42 U.S.C. Americans with Disabilities Act of 1990, § 12101, et seq.

[27] Olmstead v. L. C. by Zimring, 527 U.S. 581, 119 S. Ct. 2176 (1999)

[28] SB 4 New Mexico Legislature, 2018 Regular Session, *Assisted Outpatient Treatment Act Funding*, available at https://www.nmlegis.gov/Legislation/Legislation?chamber=S&legType=B&legNo=4&year=18&AspxAutoDetectCookieSupport=1

[29] CMS.gov, Center for Consumer Information & Insurance Oversight, *The Mental Health Parity and Addiction Equity Act (MHPAEA)*, available at *https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/mhpaea_factsheet.html*

amended by the ACA in 2010 to apply to individual health insurance coverage as well.[30] This statute, along with the ACA and The Emergency Medical Treatment and Active Labor Act (EMTALA) are good examples of laws which humanely deviate from the common law standard for access to mental health care services - "that a doctor has no duty to treat a potential patient".[31] Enacted in 1986, EMTALA "ensures public access to emergency services regardless of ability to pay and imposes specific obligations on Medicare-participating hospitals that offer emergency services".[32] In the case of a patient with an unstable psychiatric condition, EMTALA prohibits the ED from "holding" the patient for any length of time without providing appropriate psychiatric stabilization and treatment. A not-for-profit hospital system in South Carolina has agreed to pay nearly $1.3 million in the largest-ever EMTALA settlement in which psychiatric patients were detained in the ED for up as many as 38 days without being provided examination or treatment by a mental health provider.[33]

Hospitals nation-wide are battling this challenge which is often a consequence of the shortage of available inpatient psychiatric beds and a lack of qualified providers. This crisis will be addressed later in this paper.

The following New Mexico Statutes have promoted state mental illness advocacy efforts and supported innovative policy reform in the state. These statutes may be located in Chapter 24 - Health and Safety, Chapter 43 - Mental Health and Developmental Disabilities, and Chapter 45 - Uniform Probate Code:

1. §24-1-28 (2016) *Behavioral Health Planning Council Created; Powers and Duties; Membership*.
2. §24-7A-1 (2016) *New Mexico Uniform Health Care Decisions Act* has been embraced by only five other states since 1993 "to encourage the making and enforcement of advance health care directives and to provide a means for making health care decisions for those who have failed to plan."[34] New Mexico's law allows a person to make health care decisions for an incapacitated person based on a priority listing of those who may assume this authority.
3. §24-7B-1 (2017) *Mental Health Care Treatment Decisions Act* works to ensure that appropriate care and treatment is provided to persons with behavioral health needs in the community.[35] The New Mexico Advance Directive for Mental Health Treatment form may be accessed at https://hscethics.unm.edu/common/pdf/advance-directive-mh.pdf
4. §43-1-10 (2017) *Mental Health & Developmental Disabilities Code*. This section provides that a police officer has an option to shelter a person in need of emergency mental health evaluation and care *only temporarily* in a detention center- separate from prisoners and for no longer than 24 hours.[36]
5. §45-5-312 (2009) *General Powers and Duties of the Limited Guardian and Guardian*
6. §45-5-303 (2011) *Procedure for Court Appointment of a Guardian of an Incapacitated Person*

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[30] CMS.gov, Center for Consumer Information & Insurance Oversight, *The Mental Health Parity and Addiction Equity Act (MHPAEA)*, available at *https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/mhpaea_factsheet.html*

[31] David Chorney, *A Mental Health System in Crisis and Innovative Laws to Assuage the Problem*, 10 J. HEALTH & BIOMED. L. 215, 223

[32] CMS.gov, *Emergency Medical Treatment & Labor Act (EMTALA)*, available at https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/ date last modified March 26, 2012

[33] Harris Meyer, *S.C. hospital to pay $1.3 million for not properly treating emergency psych patients*, MODERN HEALTHCARE, July 5, 2017 available at http://www.modernhealthcare.com/article/20170705/NEWS/170709977

[34] NM Stat § 24-7A-1 et seq. (2016), available at https://law.justia.com/codes/new-mexico/2016/chapter-24/article-7a/

[35] NM Stat § 24-7B-1 et seq. (2017), available at https://law.justia.com/codes/new-mexico/2017/chapter-24/article-7b/

[36] NM Stat § 43-1-10 (2017), available at https://law.justia.com/codes/new-mexico/2017/chapter-43/article-1/section-43-1-10/

SHORTAGE OF INPATIENT PSYCHIATRIC BEDS AND PROVIDERS

"The lack of access to psychiatric services in health care has been a challenge for decades, resulting in significant delays to treatment with resulting consequences of reduced quality of care, low patient satisfaction, poor patient outcomes, reductions in the workforce and higher costs."[37] Nationally, there is approximately "one mental health provider for every 529 individuals".[38] In March 2017, the National Council of Behavioral Health (NCBH) reported "a national shortage of psychiatrists that is about to spiral out of control, with 77% of U.S. counties reporting a severe psychiatrist shortage".[39] "Through the shortage of mental health providers, hospitals lack the resources to provide mental health treatment in the ED and due to Medicaid cuts, the system lacks the incentive to find such resources."[40]

In a 2016 U.S. study of practicing psychiatrists, this population is noted to have dropped by ten percent between 2003 and 2013.[41] Working from a 2013 baseline for their projections, a report commissioned by the U.S. Department of Health and Human Services identified the following - "the current workforce of 45,580 psychiatrists would need to increase by 2,800 to meet current demand for mental health and substance use disorder conditions - in other words, there is currently a 6.4% shortage in the psychiatry workforce."[42] With estimations of psychiatrists retiring and with the introduction of new workforce members, it is projected that there will be a 12% workforce *deficit* in 2025.[43] Other mental health professionals will need to fill these gaps (which are projected to widen) and will need to continue to play a vital role in ensuring maintained access to timely mental health treatment for an expanding number of patients. Presently, there are 13,815 Psychiatric Mental Health Advanced Practice RNs, 1,033 Psychiatric Physician Assistants and 955 Board Certified Psychiatric Pharmacists practicing in the U.S.[44]

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[37] National Council for Behavioral Health, *Psychiatric Shortage - Causes and Solutions*, March 28, 2017, pg. 5, available at https://www.thenationalcouncil.org/wp-content/uploads/2017/03/Psychiatric-Shortage_National-Council-.pdf

[38] Mental Health America, *The State of Mental Health in America 2017*, pg. 33, available at http://www.mentalhealthamerica.net/sites/default/files/2017%20MH%20in%20America%20Full.pdf

[39] Merritt Hawkins, *The Silent Shortage: A White Paper Examining Supply, Demand and Recruitment Trends in Psychiatry 2018*, pg. 4, available at https://www.merritthawkins.com/uploadedFiles/MerrittHawkins/Content/News_and_Insights/Thought_Leadership/mhawhitepaperpsychiatry2018.pdf

[40] David Chorney, *A Mental Health System in Crisis and Innovative Laws to Assuage the Problem*, 10 J. HEALTH & BIOMED. L. 215, 222

[41] Tara Bishop, et al., *Population of US practicing psychiatrists declined 2003-13, which may help explain poor access to mental health care*, HEALTH AFFAIRS, 2016. 35(7): 1271-1277.

[42] National Council for Behavioral Health, *Psychiatric Shortage - Causes and Solutions*, March 28, 2017, page 15, available at https://www.thenationalcouncil.org/wp-content/uploads/2017/03/Psychiatric-Shortage_National-Council-.pdf

[43] *Id.*

[44] National Council for Behavioral Health, *Psychiatric Shortage - Causes and Solutions*, March 28, 2017, page 28, available at https://www.thenationalcouncil.org/wp-content/uploads/2017/03/Psychiatric-Shortage_National-Council-.pdf

The lack of psychiatric inpatient bed availability has also evolved into a nation-wide crisis with a decrease of over 500,000 beds reported by state psychiatric hospitals since the 1950's.[45] While statistics are available for state and county facilities, psychiatric inpatient services provided in other settings (general hospitals and residential treatment centers) are also experiencing a decline.[46] A 2015 query of state mental health agencies by the National Research Institute (NRI) of the National Association of State Mental Health Program Directors (NASMHPD) revealed that 35 of 46 states were experiencing inpatient psychiatric bed shortages.[47] As previously mentioned, Congress acknowledged these shortages of intensive psychiatric inpatient services in the passing of the *21st Century Cures Act*.[48] According to Dominic Sisti, director of the Scattergood Program for Applied Ethics of Behavioral Health Care at the University of Pennsylvania, "Many of the private mental hospitals still in operation do not accept insurance and can cost upward of $30,000 per month. For many low-income patients, Medicaid is the only path to mental health care, but a provision in the law prevents the federal government from paying for long-term care in an institution."[49] The lack of beds is an issue that will not soon be resolved, nor will it be an easy fix. According to a 2016 report from the Pew Charitable Trust, "the nation needs an additional 123,300 state psychiatric hospital beds."[50] Compounding the issue is the fact that nearly half of states don't have a means to track the number and location of psychiatric bed availability.[51] Several states including Georgia and Virginia have turned to technology to build online registries that can track and communicate the location of open psychiatric beds.[52] Additional proposed solutions to the bed and service shortage for those with a mental illness will be discussed in the next Chapter.

What does the future hold for the availability of educated mental health professionals? A workforce development initiative is under way by the Substance Abuse and Mental Health Services Administration (SAMHSA) that will work to increase the current supply of trained providers as well as improve the knowledge of those already working in healthcare who may wish to become "specialists" in behavioral health.[53] Thankfully, the behavioral health labor force is "one of the fastest growing workforces in the country".[54] As a result of the

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[45] Ted Lutterman, et al, National Association of State Mental Health Program Directors, *Trend In Psychiatric Inpatient Capacity, United States And Each State, 1970 To 2014*, pg. 4, August 2017, available at https://www.nri-inc.org/media/1319/tac-paper-10-psychiatric-inpatient-capacity-final-09-05-2017.pdf

[46] *Id.*

[47] *Id.* at 8

[48] H.R.34 - Public Law -114-255, *21st Century Cures Act*, Congress.Gov, December 13, 2017, available at: https://www.congress.gov/bill/114th-congress/house-bill/34/

[49] Samantha Raphelson, npr, *How The Loss Of U.S. Psychiatric Hospitals Led To A Mental Health Crisis*, November 30, 2017, available at https://www.npr.org/2017/11/30/567477160/how-the-loss-of-u-s-psychiatric-hospitals-led-to-a-mental-health-crisis

[50] Michael Ollove, The Pew Charitable Trusts, *Amid Shortage of Psychiatric Beds, Mentally Ill Face Long Waits for Treatment*, August 2, 2016, available at http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/08/02/amid-shortage-of-psychiatric-beds-mentally-ill-face-long-waits-for-treatment

[51] Treatment Advocacy Center, *Nearly Half of States Don't Track Psych Bed Availability*, February 25, 2014, available at http://www.treatmentadvocacycenter.org/fixing-the-system/features-and-news/2491-nearly-half-of-states-dont-track-psych-bed-availability

[52] *Id.*

[53] SAMHSA, *Strategic Initiatives*, last updated November 3, 2016, available at https://www.samhsa.gov/about-us/strategic-initiatives

[54] SAMHSA, *Workforce*, last updated September 15, 2017, available at https://www.samhsa.gov/workforce

passage of recent reform legislation, and due to the increasing numbers of military members receiving behavioral health services, it is projected that there will be a 36.3% increase in employment for mental health professionals by the year 2020.[55] In 1991, the University Of New Mexico (UNM) established a four year program with a mental health track dedicated to preparing psychiatry residents to practice in rural areas.[56] A 20-year follow-up survey reveals that 37% of the respondents continue to practice in rural New Mexico.[57]

INCREASED INPATIENT LENGTHS OF STAY/AVOIDABLE DAYS AND IMPACT

To add insult to access injury, there are often (lengthy) discharge delays in hospital inpatient psychiatric units. This far-reaching challenge impacts hospitals both domestically and abroad! A survey was distributed in the U.K. to mental health staff at the Bradgate and Brandon Mental Health Units of Leicestershire Partnership National Health Service (NHS) Trust in 2008 to identify reasons for extended stays (referred to as "prolonged admissions greater than 90 days").[58] Accommodation issues were noted as the "single largest factor in delaying discharge".[59]

In 2016, the Minnesota Hospital Association (MHA) conducted an initial study involving 20 hospitals in the state which identified the prevalence and causes of Potentially Avoidable Days (PADs).[60] Over the 45 day pilot period, 6,052 PADs were noted with the main contributing factors identified as wait list/no placement location (64%) and external agency delays such as social service, legal (civil appointments) and government involvement (30%).[61] I was unable to locate any additional studies of this type which could surely be instrumental in informing mental health policy and practice.

These discharge delays can result in a number of deleterious secondary effects for the patient, the hospital and the community. One such unanticipated outcome is prolonged boarding in the Emergency Department (ED) of psychiatric patients awaiting availability of an inpatient bed. "Prolonged boarding in the ED for psychiatric patients is associated with lower quality care for psychiatric patients and further contributes to overall ED crowding."[62] The loud, frenetic atmosphere in the ED is quite harmful for vulnerable psychiatric patients who may be in crisis - experiencing hallucinations or presenting with suicidal tendencies.[63] Extended stays *in the ED*

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[55] *Id.*

[56] Stacy Weiner, Association of American Medical Colleges, *Addressing the Escalating Psychiatrist Shortage*, February 2018, available at https://news.aamc.org/patient-care/article/addressing-escalating-psychiatrist-shortage/

[57] Bonham, Carolina, Melina Salvador, Deborah Altschul, Helene Silverblatt, *Training Psychiatrists for Rural Practice: A 20-Year Follow-up*, ACAD PSYCHIATRY (2014) 38: 623

[58] Susan Smith and Nandini Chakraborty, Progress in Neurology and Psychiatry September/October 2012, *Reasons for Prolonged Admissions on Acute Adult Psychiatry Wards*, pg. 28, available at https://onlinelibrary.wiley.com/doi/pdf/10.1002/pnp.251

[59] Susan Smith and Nandini Chakraborty, Progress in Neurology and Psychiatry September/October 2012, *Reasons for Prolonged Admissions on Acute Adult Psychiatry Wards*, pg. 29, available at https://onlinelibrary.wiley.com/doi/pdf/10.1002/pnp.251

[60] Kristin Dillon and Darcie Thomsen, *Reasons for Delays in Hospital Discharges of Behavioral Health Patients - Results from the Minnesota Hospital Association Mental and Behavioral Health Data Collection Pilot*, July 2016, page 1, available at, https://www.mnhospitals.org/Portals/0/Documents/policy-advocacy/mental-health/MHA%20Mental%20Health%20Avoidable%20Days%20Study%20Report%20July%202016.pdf

[61] *Id.*

[62] Zaynah, A., Meltzer, A, Lazar, D., & Pines, D., *Psychiatric Boarding in U.S. EDs: A Multifactorial Problem that Requires Multidisciplinary Solutions.* Center for Health Care Quality, Paper 1, June 2014, available at https://hsrc.himmelfarb.gwu.edu/sphhs_policy_chcq/1

[63] Beth Kutscher, *Bedding, not Boarding: Psychiatric Patients Boarded in Hospital EDs Create Crisis for Patient Care and Hospital Finances*, MODERN HEALTHCARE, November 16, 2013, available at:

create additional problems such as staff endangerment with an accompanying decrease in morale, added hospital financial burdens and the potential for "diverting resources from other patients' care".[64] In late May of 2017, "a patient in crisis caused several thousands of dollars' worth of damage to a New Hampshire hospital's emergency department while staff cowered nearby."[65] "Seventy percent of emergency department administrators report that they hold mentally ill patients for 24 hours or longer, with ten percent stating they had boarded some patients for a week or more."[66] Rhode Island's state mental health advocate H. Reed Cosper argues that "EDs fail to provide the basic rights guaranteed to psychiatric patients under state law, including the right to privacy and dignity, to wear one's own clothes and to be given reasonable access to telephones to make and receive confidential calls."[67]

Prolonged/unnecessary stays *in an inpatient psychiatric unit* may result in a compromise in the quality of care and patient safety and, as with the ED, may cause the distraction of staff from direct patient care.[68] As noted by the American Hospital Association, "patients with extended stays do not move efficiently through a continuum of care to receive the next level of care."[69] "For an individual, the extended stay [in an inpatient setting] denies them access to a more appropriate care setting and a more appropriate therapeutic environment."[70] It is the responsibility of the hospital to provide for a safe discharge plan, which often means maintaining a patient in a locked unit until the courts appoint a legal authority - a process that can take up to six weeks. Realizing the critical need to move a behavioral medicine patient through the continuum of care, GCRMC began the planning of its hospital-based court and also plans to implement a Behavioral Medicine Partial Hospitalization Program in January 2019.[71]

Financial effects: GCRMC has incurred 692 avoidable days from the opening of our Inpatient Behavioral Medicine Unit in January of 2015 through the end of July 2017.[72] Twenty patients contributed to this statistic with the avoidable days ranging from ten to 68 days. One patient was "ready to go" on day seven but remained in the unit for a total of 75 days. In an effort to quantify this issue for the New Mexico Hospital Association Behavioral Health Task Force, GCRMC examined the hospital stays for 12 behavioral medicine inpatients. These patient stays resulted in 493 avoidable days in the hospital. Daily costs to GCRMC per patient in the inpatient behavioral medicine unit were calculated at $2,866.50.[73] This $1.4 million total cost, in addition to legal fees and payments to temporary guardians and conservators is fully absorbed by this community hospital!

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http://www.modernhealthcare.com/article/20131116/MAGAZINE/311169992

[64] Nora Doyle-Burr, U.S. News and World Report Best States, *Mental Health Problems Put Stress on Emergency Rooms,* July 10, 2017, available at https://www.usnews.com/news/best-states/new-hampshire/articles/2017-07-10/mental-health-problems-put-stress-on-emergency-rooms

[65] *Id.*

[66] Jenny Gold, NPR, *Mentally Ill Languish in Hospital Emergency Rooms,* April 13, 2011, available at https://www.npr.org/2011/04/13/135351760/mentally-ill-languish-in-hospital-emergency-rooms

[67] *Id.*

[68] Susan Smith and Nandini Chakraborty, Progress in Neurology and Psychiatry September/October 2012, *Reasons for Prolonged Admissions on Acute Adult Psychiatry Wards,* pg. 28, available at https://onlinelibrary.wiley.com/doi/pdf/10.1002/pnp.251

[69] AMERICAN HOSPITAL ASSOCIATION - AHA HOSPITAL STATISTICS 2016 EDITION, PG 235

[70] Jeff Dye, President and CEO New Mexico Hospital Association, (July 12, 2017) *Recommendations for Improving Guardianship Capacity* [Memorandum]

[71] Gerald Champion Regional Medical Center Management Plan 2018 pg.30

[72] Gerald Champion Regional Medical Center, Inpatient Behavioral Medicine Unit Financial Data, July 2017

[73] Pam Kushmaul, Attorney-At-Law, John D. Wheeler & Associates, *Public Comments to NMHA*, July 2017

What is being done to manage the impact of these secondary effects on patients and providers? A California study proposes that a solution to ED boarding of psychiatric patients is to consider "alternative emergency care designs such as a Dedicated Psychiatric Emergency Services model" where all mental health patients in an identified region could be evaluated and treated, potentially reducing the need for many hospitalizations.[74] Psychiatric Crisis Stabilization Units have been established in Florida (and a handful of other states) which provide brief inpatient interventions. Following a stay of three to 14 days, patients often return to their own home, or are placed in a long-term mental health facility or other environment.[75] In addition to this model, many states are designing Behavioral Health Urgent Care Centers and Crisis Receiving Centers as alternatives to the ED but not intended as interim treatment sites. Telemedicine (face-to-face videoconferencing) used in the ED may be effective in treating mental health patients in areas where services are otherwise unavailable.[76] Telepsychiatry is working to ease the provider shortage and bring more timely care to psychiatric patients in the ED. Only 17% of ED physicians polled in 2016 "reported having a psychiatrist on call to respond to psychiatric emergencies."[77] The American Psychiatric Association's (APA) position on utilizing telemedicine for psychiatric services is one of support. "Telemedicine is a legitimate component of a mental health delivery system to the extent that its use is in the best interest of the patient and is in compliance with the APA policies on medical ethics and confidentiality".[78]

Additional policy reform and strategies to address access to mental health care services include supported housing guidelines championed in New York and Maine which have increased the quality of life for disabled individuals and have reduced their dependence on the ED.[79] The Massachusetts Behavioral Health Partnership provides an alternative to the ED and inpatient care through an inventive community-based mobile crisis intervention program called Emergency Services Program (ESP).[80] From a financial standpoint, New Mexico hospitals with inpatient behavioral medicine units are only now (at the recommendation of the New Mexico Hospital Association) beginning to negotiate with Managed Care Organizations (MCOs) for a "Days Awaiting Placement (DAP)" rate under NMAC 8.321.2.16.[81] One such example of MCO Level of Care Guidelines has been issued by Centennial Care.[82]

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[74] Scott Zeller, Nicole Calma, Ashley Stone, *Effects of a Dedicated Regional Psychiatric Emergency Service on Boarding of Psychiatric Patients in Area Emergency Departments*, June 11, 2013, available at https://www.calhospital.org/sites/main/files/file-attachments/effects_of_dedicated_regional_pes.pdf

[75] Agency for Health Care Administration, *Crisis Stabilization Units*, 2018, available at http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Hospital_Outpatient/crisis.shtml

[76] David Chorney, *A Mental Health System in Crisis and Innovative Laws to Assuage the Problem*, 10 J. HEALTH & BIOMED. L. 233 (2014)

[77] Jay H. Shore, Physician Reviewer, American Psychiatric Association, *What is Telepsychiatry?*, January 2017, available at https://www.psychiatry.org/patients-families/what-is-telepsychiatry

[78] *Id.*

[79] David Chorney, *A Mental Health System in Crisis and Innovative Laws to Assuage the Problem*, 10 J. HEALTH & BIOMED. L. 233, 234 (2014)

[80] *Id.* at 235-237

[81] New Mexico Administrative Code 8.321.2.16, *Inpatient Psychiatric Care in Freestanding Psychiatric Hospitals*, January 1, 2014, available at http://164.64.110.239/nmac/parts/title08/08.321.0002.htm

[82] *Behavior Health Level of Care Guidelines for Centennial Care MCOs*, pg. 8, May 2017, available at https://www.bcbsnm.com/pdf/forms/cc-bh-level-care-guidelines.pdf

CURRENT STATE OF COURT APPOINTMENTS AND GUARDIANSHIP

Although efforts to treat mental health cases justly and in a timely manner are ongoing, courts continue to be challenged to meet specific needs of a growing population.[83] As of 2016, over 400 communities across the country have implemented a Mental Health Court Model to manage those with mental illnesses who are involved in ***criminal*** proceedings.[84] "The percentage of inmates in U.S. state and federal prisons that have Serious Mental Illnesses (SMI) is three to four times higher than the rate of mental illness in the general population."[85] In New Mexico, as of 2017, the number of incarcerated adults with SMI was 3,066.[86]

For those hospital inpatients awaiting ***civil*** appointments, commitments or court-ordered outpatient treatments, crowded court dockets have resulted in increased wait times. Guided by the Mental Health Procedures Act (50 P.S. sec. 7102), the First Judicial District of Pennsylvania's Civil Mental Health Program is working to prevent "logjams" and provide an efficient due process with the implementation of court case management technology (e-filing) and court partnerships.[87] In New Mexico, there is no database in place to identify pending cases, which are estimated to be between 5,000 and 7,000 with some cases dating back decades.[88] One other hospital in New Mexico has implemented a successful hospital-based courtroom but extensive internet and other search types did not yield any information regarding any additional operations of this nature.

I had an opportunity to interview Angie K. Schneider, New Mexico District Judge, Division IV, Twelfth Judicial District who has been presiding over GCRMC's court proceedings. When asked how she felt about the newly implemented in-house process at GCRMC she responded with "I'm not speaking for the judiciary, but through *my* lens, I see this as the first step to impact the inhumanity of the current process. The hospital-based courtroom environment keeps an arguably fragile individual in a familiar milieu and provides them with the dignity and respect they deserve rather than treating them like a criminal. Individuals are transported to our courts in ankle and wrist shackles with no regard for their constitutional rights."[89]

If one is lucky enough to find a suitable guardian and secure a timely court slot for appointment, guardianship may be an option for the management of individuals with mental health issues and for reducing avoidable stay days, however, this process is beset with its own issues. Over the last several decades there have been many legal cases describing abusive guardianship scenarios including monetary withholdings and sub-par, unsafe assigned housing.[90] Aside from the issue of sheer volume, the current guardianship process nation-wide is plagued with issues related to civil/human rights. According to a 2016 General Accounting Office report, the

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[83] Thompson Reuters, *How Are Civil Courts Meeting The Challenge Of Mental Health?*, pg.1, available at http://legalexecutiveinstitute.com/wp-content/uploads/2016/08/How-are-Civil-Courts-Meeting-the-Challenge-of-Mental-Health.pdf

[84] *Id.*

[85] Steadman, Henry J., Fred C. Osher, Pamela Clark Robbins, Brian Case, and Steven Samuels, *Prevalence of Serious Mental Illness Among Jail Inmates*, 60: 6 PSYCHIATRIC SERVICES 761-5 (JUNE 2009).

[86] Treatment Advocacy Center, *New Mexico*, available at http://www.treatmentadvocacycenter.org/browse-by-state/new-mexico

[87] Thompson Reuters, *How Are Civil Courts Meeting The Challenge Of Mental Health?*, pg.2, available at http://legalexecutiveinstitute.com/wp-content/uploads/2016/08/How-are-Civil-Courts-Meeting-the-Challenge-of-Mental-Health.pdf

[88] Colleen Heild, Albuquerque Journal, *Guardianship Reform Bill Goes to Governor*, February 15, 2018, available at https://www.abqjournal.com/1134241/guardianship-reform-bill-goes-to-governor.html?utm_source=abqjournal.com&utm_medium=related+posts+-+politics&utm_campaign=related+posts

[89] Interview with District Judge Angie K. Schneider, June 22, 2018

[90] Emily Gurnon, Next Avenue, *Guardianship Laws: Improving But Problems Persist, Part 2,* May 24, 2016, available at https://www.forbes.com/sites/nextavenue/2016/05/24/guardianship-laws-improving-but-problems-persist/#482d1be47b40

guardianship process and the duty to protect those in the system from abuse, neglect, and exploitation falls not to the federal government but to the state and local courts.[91] In New Mexico, fees paid to guardians had not been addressed/regulated until the passage of New Mexico Senate Bill 19 (SB19). Pursuant to §45-5-107, separate accounts and records for the protected person shall be maintained by the guardian or conservator. The responsibility of the guardian may be expanded to include the making of health care decisions on behalf of the incapacitated person under the provisions of the Uniform Health-Care Decisions Act,[92] if no agent/entity is assigned the duty to consent/withhold consent for care or treatment.[93] Additionally, if no conservator is appointed, a guardian may be granted additional powers and duties such as the ability to make financial decisions for the protected/incapacitated person.[94]

On a positive note, New Mexico courts have been successful in their push for guardianship reform. NM SB19, which will help prevent abuse and exploitation of those under court-ordered conservatorship or guardianship, was signed by the Governor on February 28, 2018 and will take effect in July.[95] One of many provisions within SB19 contains language that allows court hearings for guardianship to be conducted "at a location of the alleged incapacitated person."[96] It is anticipated by GCRMC that this provision will help to eliminate unnecessary (avoidable) inpatient days and facilitate movement through the continuum of care for many behavioral health patients.

IMPLEMENTING HOSPITAL-BASED COURTS

The decision to implement a hospital-based courtroom at GCRMC began as a discussion with the hospital's legal counsel in 2015 and as a direct result of the need for improved care for those in the community suffering from mental illness. Implementation goals included:

- Decrease potentially avoidable days
- Increase ED throughput for patients with a primary psychiatric diagnosis
- Improve continuation of care
- Decrease payment issues
- Decrease trauma to patient
- Provide adequate security for patient and staff
- Increase community awareness/involvement
- Increase visibility of mental health issues

Sequestered hearings are conducted in GCRMC's courtroom once a week with the following actions and filings:

- Assisted Outpatient Treatment (AOT)

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[91] GAO-17-33, *Elder Abuse: The Extent of Abuse by Guardians Is Unknown, but Some Measures Exist to Help Protect Older Adults*, November 16, 2016, available at https://www.gao.gov/products/GAO-17-33

[92] NM Stat § 24-7A-1 to 24-7A-17 (1978), *Uniform Health-Care Decisions Act*

[93] NM Stat § 45-5-312 (1996 through 1st Sess 50th Legis) New Mexico Statutes Chapter 45: Uniform Probate Code, *General Powers and Duties of the Limited Guardian and Guardian*, available at https://law.justia.com/codes/new-mexico/2011/chapter45/article5/section45-5-312/

[94] *Id.*

[95] Dan McKay, Dan Boyd, Albuquerque Journal, *Governor Signs Guardianship Overhaul Law*, February 28, 2018, available at https://www.abqjournal.com/1139524/martinez-signs-legislation-for-military-families.html

[96] S.B.19, The Legislature of the State of New Mexico, 53rd Legislature, 2nd Session, 2018, *Guardianship Reform*, pg.10, available at http://www.sos.state.nm.us/uploads/files/CH10-SB19-2018.pdf

- Guardianship
- Treatment Guardianship
- Conservatorship
- Involuntary Commitments- Civil (Non-forensic) and Criminal (Forensic)
- Affidavits
- Filings
- Attorney Appointments

CONCLUSION

It may be too soon to determine if the implementation of GCRMC's hospital-based Guardianship Court has effectively reduced avoidable stay days for patients in the inpatient behavioral medicine unit however, it ***has*** met many essential goals related to human dignity and patient advocacy. GCRMC budget projections for Fiscal Year (FY) 2019, however, reflect that the average length of stay in the unit will decrease from 9.7 days in FY18 to 9.0 days in FY19, a variance of -7.2%.[97] We are proud to say that we have been successful in meeting many essential goals related to human dignity and patient advocacy.

[97] GCRMC Management Plan 2018, pg. 28

APPENDIX A – DEFINITIONS

*** Note**- The terms psychiatric disorders, mental health, mental illness and behavioral medicine and behavioral health may be used interchangeably throughout this paper.

- **Mental Health Treatment Facility - "**A mental health treatment facility is an inpatient facility that provides treatment for psychiatric disorders or habilitation for developmental disabilities."[98]
- **Guardian -** "A person appointed by the court to make healthcare and other mostly non-monetary decisions for someone who cannot make these types of decisions because of an injury, illness, or disability."[99]
- **Conservator -** "A person appointed by the court to take care of someone's finances when he or she cannot make these types of decisions because of an illness, injury, or disability."[100]
- **Incapacitated Person** - Following a legal finding by the courts, "an adult whose legal capacity is in question" [101] is referred to as an "Incapacitated or Protected Person".[102] Note: Ward is a term that has not been in use since 2009 (in New Mexico Statutes).
- **Limited Guardianship -** Appointed by a court if a person is determined to be able to "manage some but not all aspects of personal care. A person for whom a Limited Guardian has been appointed retains all legal and civil rights except those that have been granted to the Limited Guardian by the court."[103]
- **Full Guardianship -** An appointed individual granted all powers available to guardians under the law.[104]
- **Treatment Guardian -** "A person appointed pursuant to Section 43-1-15 NMSA 1978 to make mental health treatment decisions for a person who has been found by clear and convincing evidence to be incapable of making the person's own mental health treatment decisions."[105] A family member guardian is preferred but corporate guardians are often utilized. GCRMC pays the fees to the corporate guardian until an incapacitated person (patient) is assigned to them, then fees are paid from the incapacitated person's assets. This individual will sign in for the patient receiving treatment and will consent for medications as well as releases of information.
- **Corporate Guardian -** "A for-profit or not-for-profit entity that is paid to be the legal guardian either from the incapacitated person's assets, or by the state".[106]

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[98] Michie's Annotated Rules of New Mexico, Rules of Civil Procedure for the District Courts, Article 12. Domestic Relations Rules, 1-130 *Appointment of a Treatment Guardian*, 2018

[99] Kenneth Rosenau, Esq. and Evan Greenstein, Esq., LawHelp.org/DC, *Guardianship and Conservatorship: Frequently Asked Questions*, available at: https://www.lawhelp.org/dc/resource/guardianship-and-conservatorship-frequently-a

[100] *Id.*

[101] Patricia M. Galindo, Administrative Office of the Courts, *Adult Guardianship and Conservatorship - An Overview of New Mexico Law and Court Process, April* 28, 2017, pg. 11, available at https://cms.nmcourts.gov/uploads/files/NMAG%20Study%20Commission_28Apr17_disclaimer.pdf

[102] *Id.*

[103] S.B.19, The Legislature of the State of New Mexico, 53rd Legislature, 2nd Session, 2018, *Guardianship Reform*, pg. 14, available at http://www.sos.state.nm.us/uploads/files/CH10-SB19-2018.pdf

[104] USLegal.com, Limited Guardianship Law and Legal Definition, available at https://definitions.uslegal.com/l/limited-guardianship/

[105] SB 113 New Mexico Legislature, 2016 Regular Session, *Assisted Outpatient Treatment Act*, page 5, March 9, 2016, available at https://www.nmlegis.gov/Sessions/16%20Regular/final/SB0113.pdf

[106] Colleen Heild, Albuquerque Journal, *New Mexico Lags in Guardianship Reform*, March 18, 2017, available at

- **Health Care Power of Attorney -** "The designation of an agent to make health care decisions for the individual granting the power, made while the individual has capacity."[107]
- **Any Mental Illness (AMI) -** "A mental, behavioral, or emotional disorder. AMI can vary in impact, ranging from no impairment to mild, moderate, and even severe impairment."[108]
- **Serious Mental Illness (SMI)** - "A mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. The burden of mental illnesses is particularly concentrated among those who experience disability due to SMI."[109]
- **Involuntary Civil (Inpatient) Commitment -** "The admission of individuals against their will into a mental health unit. In the case of mental illness, dangerousness to self or others defines the typical commitment standard, with almost all states construing the inability to provide for one's basic needs as dangerousness to self."[110]
- **Outpatient Commitment AKA Assisted Outpatient Treatment (AOT**) - means "categories of outpatient services ordered by a district court, including case management services, care coordination or assertive community treatment team services, prescribed to treat a patient's mental disorder and to assist a patient in living and functioning in the community or to attempt to prevent a relapse or deterioration that may reasonably be predicted to result in harm to the patient or another or the need for hospitalization."[111]
- **Potentially Avoidable Days** are "reasons for days in inpatient behavioral health hospital care when a patient is stabilized and ready to be discharged, but is unable to be discharged. These patients still require some treatment, but no longer need hospital level care."[112]
- **Psychiatric Partial Hospitalization** is defined as "organized hospital services providing intensive day/evening outpatient services of three hours or more duration, distinguished from other outpatient visits of one hour."[113]

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https://www.abqjournal.com/972033/guardianship-system-in-nm-cloaked-in-secrecy.html?utm_source=abqjournal.com&utm_medium=related+posts+-+politics&utm_campaign=related+posts

[107] SB 113 New Mexico Legislature, 2016 Regular Session, *Assisted Outpatient Treatment Act*, page 4, March 9, 2016, available at https://www.nmlegis.gov/Sessions/16%20Regular/final/SB0113.pdf

[108] National Institute of Mental Health, *Mental Illness*, available at https://www.nimh.nih.gov/health/statistics/mental-illness.shtml, last updated November 2017

[109] *Id.*

[110] Cornell Law School, *Legal Information Institute: Involuntary Civil Commitment*, available at https://www.law.cornell.edu/wex/involuntary_civil_commitment

[111] N.M. Stat. § 43-1B-2 (2016)

[112] Kristin Dillon and Darcie Thomsen, *Reasons for Delays in Hospital Discharges of Behavioral Health Patients - Results from the Minnesota Hospital Association Mental and Behavioral Health Data Collection Pilot*, July 2016, page 1, available at https://www.mnhospitals.org/Portals/0/Documents/policy-advocacy/mental-health/MHA%20Mental%20Health%20Avoidable%20Days%20Study%20Report%20July%202016.pdf

[113] AMERICAN HOSPITAL ASSOCIATION - AHA HOSPITAL STATISTICS 2016 EDITION, PG 235

APPENDIX B - IMPLEMENTATION DETAILS
Courtroom Construction


Fig. 1


Fig. 2

An existing activity room at the end of the Behavioral Medicine Unit hallway has been converted into a Courtroom to be used to provide a forum for sequestered guardianship hearings and other legal determinations. This Courtroom conversion was a time and material project. Labor rates for this project were based on previous rates charged by the contractor on similar GCRMC projects and totaled approximately $25,000.

The Courtroom square footage measures 34 feet long by 12.8 feet wide. Both outward opening doorway entrances (to/from judge platform [Fig. 1] and to/from patient anteroom [back left in Fig. 2]) measures five feet wide per ADA clearance requirements.

Construction access and patient safety were of paramount consideration throughout the project. The Inpatient Behavioral Medicine Unit is a restricted, secured unit of the hospital. To protect patient safety, privacy and mitigate interference with ongoing daily activities within the unit, the contractor was required to:

- Provide supervised access to work crew and materials only through a secure, external door;
- Install a temporary construction wall just inside the external door. For patient safety and infection control purposes, this wall was constructed at the onset of each day and was removed at the end of each day. The wall was constructed in a manner in which it could be quickly removed in the event of an emergency requiring patient evacuation; and
- Utilize anti-ligature door handles and door hardware.

This conversion was completed in 25 days.

Additional design and building considerations within inpatient mental health units include providing an aesthetically-pleasing and non-threatening environment. That being said, all state and federal building codes must be complied with, even though they may convey an “institutional” look. Clean, well-lit spaces must include

safety features such as tamper-proof electrical and mechanical devices. A 20 watt public address system was installed in the Courtroom which included a microphone at the judge's bench and two ceiling-mounted speakers. Stretched canvas artwork is preferred over artwork with laminated glass to minimize any risk of self-harm. The Courtroom also contains a wooden 24 inch diameter Great Seal of the State of New Mexico which was carved by inmates of the New Mexico Department of Corrections at a cost of $400. Two flags (United States and State of New Mexico) with eight foot poles were purchased for $250 (See Fig.1).

The District Court Judge was given card key access as well as a parking space marked "*Reserved For District Judge*". The Judge and accompanying Sheriff's Office staff member enter the Behavioral Medicine unit through a secured exterior door. A changing room located near the Courtroom is provided for the Judge.

Forms

4-930. Petition for appointment of a treatment guardian for an adult. For use with Rule 1-130 NMRA:

http://www.nmcompcomm.us/nmrules/NMRules/4-930_11-1-2014.pdf

4-932. Order for appointment of a treatment guardian. For use with Rule 1-130 NMRA:

http://www.nmcompcomm.us/nmrules/NMRules/4-932_11-1-2014.pdf