

Statewide TDO Task Force: Interim Report for the November 5, 2018 Meeting of the SJ 47 Joint Subcommittee

Background

In January of 2018, the SJ 47 Joint Subcommittee directed the creation of a statewide task force to look at the causes of the dramatic rise in admissions to state psychiatric hospitals under temporary detention orders (TDOs) and the resulting patient census crisis in those hospitals, and to identify possible solutions. Following the model of the CSBs of Health Planning Region (HPR) 4, which in March of 2018 convened a regional “stakeholders” meeting on the TDO crisis that identified key concerns with the current mental health system and proposed several possible reform and service initiatives, staff of the ILPPP contacted the CSB leadership of each HPR and requested a stakeholders meeting to address the crisis. All agreed, and regional meetings (as well as follow-up group meetings in HPR 4) were held throughout the state from April through October (with Region 3 having a separate meeting for each of its 3 sub-regions.) The other regional meetings did not include the level of peer/advocacy organization involvement that characterized the Region 4 meeting. However, the identified concerns and proposed reform and service initiatives were remarkably consistent across the regions, with certain local inflections that reflect differences between the rural and urban/suburban areas of the state. The concerns identified and reform and service initiatives proposed as a result of those meetings are set out in the report submitted to the SJ 47 Joint Subcommittee in October, entitled “Mental Health Crisis Emergency Response: Improving Care for People in Crisis in Virginia” (referred to below as the “Crisis System Response report”).

The statewide Task Force, in addition to receiving and reviewing that report, along with research conducted by staff of the Institute of Law, Psychiatry and Public Policy (ILPPP), has met twice: on August 1 and on October 29. The information and findings below are outcomes from those meetings.

Findings and Key Areas of Concern

While the members of the Task Force, who reflect the wide array of stakeholders in the mental health services system, have not yet reached consensus for specific recommendations to the SJ 47 Joint Subcommittee, the Task Force’s meetings, coupled with related research from the ILPPP, have generated the following findings and areas of concern:

I. System Issues and Trends

A. The best long-term solution to psychiatric crises is strengthening the community-based system of mental health care:

The Task Force members all support the full funding of STEP-VA, which would establish a more uniform statewide system of public mental health care by expanding and funding the array of mandated services provided by all local community services boards (CSBs). It was noted that while the General Assembly has provided initial funding for “same day access” to care (the first of the new mandated services), such access is meaningless without the funding needed to build the other components of the STEP-VA system, which include (among other things) outpatient treatment, targeted case management, integration with primary health care, and peer and family support services, in addition to crisis services. The following concerns were expressed: that an incomplete roll-out of STEP-VA would further erode the existing community based system of care; that the current funding structure of Medicaid Managed Care fails to properly pay for services that help maintain the stability of persons with serious mental illness (thereby contributing to their instability and repeated hospitalizations), and fails to adequately pay for other key services (including psychiatry and peer support services), and the statewide operation of 6 Managed Care Organizations is administratively burdensome and costly.

B. The number of private hospital beds available for TDO patients continues to go down, with no end to this trend in sight.

The total number of TDOs statewide rose substantially from 2014 to 2016, but since their peak in 2016 those numbers have *declined*. Despite this, the number of TDOs to state hospitals has dramatically *increased* since 2016 (from less than 10% of all TDOs to more than 20%), leading to the current crisis in state hospital overcrowding. (In the central and eastern parts of Virginia, the total numbers of TDOs are at pre-2014 levels, but the numbers of TDOs going to state hospitals nonetheless has increased dramatically.)

1. The greatest single contributor to this phenomenon appears to be a significant rise in the number of voluntary inpatient admissions to private psychiatric hospitals.

Notably, the private hospitals absorbed a substantial percentage of the increased overall TDOs statewide from 2014 to 2016, but since then the absolute number of available private beds has continued to fall. The ILPPP is currently working with the VHHA to gain access to private hospital data that would help us understand the reasons for, and likely trajectory of, these voluntary admissions. This would facilitate informed projections on the availability of private hospital beds for TDO placements.

2. Other factors are also contributing to the decreasing number of available private beds.

They include: the closure of beds in some facilities because of their inability to meet new facility requirements from the Joint Commission on the Accreditation of Hospitals (JCOAH) to reduce “ligature” risks – that is, risks of suicidal patients hanging or strangling themselves; the temporary reduction in available beds due to the lack of sufficient numbers of psychiatrists or nurses to “cover” those beds; the months-long

occupancy of beds in private hospitals by patients for whom the hospitals are unable to find a community placement, due to the significant care needs and instability of these patients.

II. Possible Crisis Response System Reforms

A. *Resolution without hospitalization: making less restrictive crisis services available*

1. Beyond the hospital ED: more options for the individual experiencing crisis

There was consensus in the group that the hospital emergency department (ED) is often a very poor environment for a person experiencing mental health crisis. The ED is not set up or staffed to address mental health emergencies, and the constant movement and noise of many EDs can be very destabilizing to a person in crisis, and make that crisis worse. Alternatives to the ED are needed. They include:

- a. ***Mobile crisis teams*** that can come to the individual and provide assistance and support: Mobile crisis is specifically included as part of the array of services envisioned in a fully implemented STEP-VA. Blue Ridge Behavioral Health has submitted a detailed mobile crisis team proposal (included in the October 1, 2018 Crisis Services report to the Joint Commission) that includes the services of a psychiatrist who would be able to provide both treatment and prescriptions for needed medication. The lack of timely access to needed medication can be a critical element in the escalation of some mental health crises.
- b. ***Peer support recovery centers*** that are peer operated and offer a home-like environment for individuals to seek assistance and support when they sense that they are entering into crisis. Models for such centers exist in other states, and according to a 2014 SAMHSA report have demonstrated efficacy in helping to reduce individuals' use of the ED and inpatient care (with further and more rigorous research on outcomes being recommended in that report).
- c. ***Psychiatric Emergency Centers (PECs)*** that have a comprehensive model of welcoming "walk-ins", as well as referrals from police, hospital EDs and mental health providers. PECs, which utilize peer specialists as key partners in care but which also include medical and mental health services, operate as outpatient facilities, with the maximum stay for a person being just under 24 hours. During that time, with engagement from peer specialists and treatment staff, many individuals are able to work through the most intense moments of their crisis without hospitalization and return home with a treatment plan or transfer to a treatment setting (e.g., a detoxification unit, a Crisis Stabilization Unit, or peer support recovery center) other than a psychiatric hospital. PECs following this model have been working successfully for years in several states. The CSBs of Region 4 have proposed developing a PEC of this kind (included in the October 1 report to the SJ 47 Joint Subcommittee), and recently toured

such a facility, operated by RI International, in Newark, Delaware. Region 2 has expressed an interest in the same model.

Each of these services provides a means for addressing and resolving a person's mental health crisis early on in that crisis, and in a supportive setting specifically focused on mental health care and support.

2. Preventing unnecessary hospitalization: providing the option for some individuals in custody to have the time needed to recover from crisis

Even with services available to individuals early in their crisis, that crisis for many will still reach the stage where a law enforcement officer must take physical custody of the individual, either through an Emergency Custody Order (ECO) issued by a magistrate or through the officer's own determination that the safety of the individual (and/or others) requires that the individual be taken into custody. For many years, the hospital ED was the primary place to which officers brought these individuals for evaluation by a CSB evaluator to determine whether the individual met the criteria for involuntary psychiatric hospitalization under a TDO. In recent years, Crisis Intervention Team (CIT) Assessment Centers have been established in many Virginia jurisdictions to provide an alternative place for officers to bring some of these individuals for evaluation (often as an alternative to incarcerating them).

Under current Virginia law, whenever a person is taken into custody by a police officer in this way, the person can be held under the ECO for a maximum of 8 hours. During those 8 hours the CSB evaluator must evaluate the individual and, if finding that the person meets the criteria for a TDO, must then find a private hospital willing to accept the person under a TDO. If no placement can be found, then the person is placed in the custody of a state psychiatric hospital. The state hospitals have no discretion or authority to decline a person in these circumstances.

A number of these individuals recover more quickly from their crisis than others, and within 24-48 hours reach a point where they no longer meet the statutory criteria for involuntary hospitalization. (This does not mean that they don't need treatment, only that they no longer meet the criteria for involuntary hospitalization.) Their cases are dismissed at the 3-day involuntary commitment hearing. This occurs in both private and state hospitals. These individuals likely would be better served by less restrictive care than hospitalization, and the hospital beds they occupy could be used by those who really need inpatient care. However, current Virginia law does not allow the holding of such individuals beyond the 8-hour ECO period. If they meet the criteria for involuntary hospitalization, a TDO must be entered by the end of the 8 hours. Even if authority were granted by statute to hold such individuals for a longer period, the hospital ED – where most of these individuals will be – is, as noted, a poor place for holding a person for additional observation and possible treatment. (In addition, if such authority were granted, that grant would also need to allow the officer holding the individual to return to duty.)

Two possible alternatives to the hospital ED for extended observation and care of selected individuals who are under an ECO would be:

- a. ***Hospital observation units*** – Private hospitals, through the VHHA, are in discussions with staff of DBHDS about the creation of observation units that would be calming environments, separate from the hospital ED, in which individuals under an ECO could be held for additional time if it appeared that their crisis and treatment needs could be addressed without involuntary psychiatric hospitalization. The specifics of such a facility, and how the placement would be paid for, are reportedly still in discussion. This proposal is seen as a major step in improving and expanding the public-private system partnership in responding to individuals experiencing mental health crisis.
- b. ***Psychiatric Emergency Centers (PECs)*** – Both New River Valley Community Services (NRVCS) and Piedmont CSB (in partnership with two private health systems - Sovah and Frontier Health) have developed proposals for a PEC that would operate more narrowly than the PEC model proposed by Region 4 and Region 2. As set out in the proposals that are attached to the October 1 report to the SJ 47 Joint Subcommittee, individuals in crisis who are seen by CSB evaluators in the hospital ED or the CIT Assessment Center (both proposals plan to co-locate their CIT Assessment Center and the proposed PEC), and are found to be likely to benefit from services in the PEC would be referred to the PEC for further observation and engagement. It is anticipated that many of these individuals will not need involuntary hospitalization, but instead can be treated in less restrictive settings. The PEC model proposed by Region 4 and Region 2 would also serve individuals who are under an ECO. The key difference is that the Region 4 and 2 model is a “take all comers” model, while entry into the other PECs would occur only after an assessment by the CSB evaluator. The PEC concept is not currently included as a listed service in STEP-VA or in any current proposals from DBHDS. Task Force members expressed their concern about ensuring that the STEP-VA agenda, and the funding for that agenda, are honored first. State support for pilot PEC projects in partnership with private hospitals or health systems might alleviate these concerns.

B. Challenging conditions and their impact on the private and state psychiatric hospitals

1. Overview

The October 1 Crisis Response System report to the SJ 47 Joint Subcommittee identifies conditions that are posing a special and ongoing challenge to the mental health care system. They include: (i) individuals with ID/DD; (ii) individuals with complex medical conditions; (iii) individuals who are physically aggressive or threatening and/or have a history of aggression; (iv) those who are difficult to discharge because of the lack of

appropriate community placements (often due to the high level of care required or the individual's difficult behavioral history).

2. Individuals with ID/DD

Time constraints did not allow the Task Force to address any of these groups in depth at its meetings. It was noted that both private and public hospitals have enormous difficulty working with individuals with ID/DD because these individuals present unique behavioral challenges, respond differently than other mental health patients to external stimuli, and often do not respond to standard mental health treatments and protocols. While these individuals represent less than 10% of most state hospital populations, they require a disproportionate percentage of hospital staff resources for behavioral management. Most notably, individuals with ID/DD now constitute 29% percent of the admissions to the Commonwealth Center for Children and Adolescents. This is the potential future in the adult facilities, and it is a challenge that requires immediate attention.

3. Individuals who are difficult to discharge

It was noted that the overcrowding at the state hospitals was exacerbated by the fact that so many patients spend months in the hospitals because there are no community placements that will accept them. The General Assembly, through the efforts of the SJ 47 Joint Subcommittee, has made a major commitment to permanent supportive housing for individuals with mental illness. DBHDS staff have noted that the Department has made a major commitment to more integrated home-like community placements for individuals. At the same time, CSB staff from Region 2, based on direct inquiry to Western State Hospital and Piedmont Geriatric Hospital staff, have confirmed that the vast majority of the patients on their "Extraordinary Barriers" List (EBL) for community placement require 24/7 supervision. For that reason, Region 2 has proposed development of community based housing for these individuals that includes an Assisted Living Facility (ALF) and an Intensive Community Residential Treatment (ICRT) facility. The Region 2 proposal is included in the October 1 Crisis Services report to the SJ 47 Joint Subcommittee.

4. Patients with complex medical conditions

Under Virginia's "placement of last resort" requirement, state psychiatric hospitals must provide a bed for any person in mental health crisis whose 8-hour ECO period has run out and for whom a private bed has not been found. This includes individuals who have complex medical conditions that the state hospitals are not staffed or equipped to treat. These individuals are very difficult to treat, and a proposal included in the October 1 Crisis Response report to the SJ 47 Joint Subcommittee includes a proposed Virginia Code change that would enable state hospitals to decline the TDO placement of individuals with medical conditions that the state hospital medical directors determine their hospitals are not equipped or staffed to treat. In that report, and in the Task Force discussions, it was noted that the best placement for such individuals would be a general

hospital with a psychiatric unit, so that both psychiatric care and complex medical care would be available for the patient in the same building or complex. In state hospitals, these patients require disproportionate staff time and hospital resources because they have to be transported by staff to medical facilities miles away from the state hospital to receive their medical care. The deep concern of the hospital EDs is that if the placement-of-last-resort requirement were removed, these individuals would remain in the ED when both public and private facilities declined to take them, and that this would lead to the mental deterioration of these patients in the ED. There was agreement that these patients present major challenges in any setting, public or private. The concern of the state hospital representative is that, because the state hospitals are now required to assume the care of these patients whenever a private placement cannot be found within the 8 hour ECO period, there is no incentive for private hospitals to improve their capacity to meet these patients' needs and accept them under a TDO. Discussion on this issue is continuing.

C. Improving linkages between the private and public mental health crisis response system

While there was insufficient time to pursue this line of discussion, Task Force members did note the current challenges that exist in trying to transfer patients from one part of the response system to another, particularly when it is from a private treatment setting to a public one. A key frustration that was noted was in regard to trying to transfer individuals from a hospital ED to a Crisis Stabilization Unit. There was consensus on the need for more uniform standards and protocols for such transfers, and for more robust staffing to enable transfers to be carried out more quickly.

III. The Workforce Crisis

All Task Force members agree that both the public and private mental health service sectors are experiencing a workforce crisis. It is clear the overcrowded conditions in state hospitals are accelerating the loss of qualified treatment staff in those facilities.

Conclusions and next steps

While the Task Force has not reached consensus on the proposals generated by the regional meetings and set out in the October 1 Crisis Response report, there is general agreement around certain key principles, which will guide Task Force deliberations over the next few weeks:

1. More services must be available in the community to allow individuals experiencing crisis to seek and obtain help before their crisis escalates.
2. For those individuals who have reached the point in their crisis where they are taken into custody under an ECO, there are those who may make significant progress, and not require involuntary hospitalization, if given more time in a supportive environment than

the current 8-hour ECO period allows. A set of appropriate services, available outside the hospital ED setting, and an additional period of time (usually 24 hours) should be available for these individuals, so that they are not unnecessarily hospitalized. NOTE: The Task Force members agree that the individuals to whom an ECO expansion would apply should be clearly and narrowly described. They do *not* see a need to expand the ECO period more generally, and are concerned that a general expansion would dramatically disrupt and degrade the existing system.

3. In both public and private hospitals, more patients with serious and persistent mental illness are proving to be harder to return to the community, resulting in acute care beds being occupied for months by such patients as community placements are sought. Appropriate permanent supportive housing is needed for those individuals in order for them to be in the least restrictive appropriate placement and for more beds to be available in both state and private hospitals for acute care.

4. The needs of other individuals who present special challenges must be addressed effectively to prevent state hospitals from being overwhelmed, including those with ID/DD, those who are highly aggressive, and those with complex medical conditions. There is no agreement between the private and public hospitals regarding the appropriate placement of persons who have complex medical conditions, other than the agreement that they are very difficult cases. The care of this population in particular needs to be immediately addressed.

5. Improving linkages between the public and private mental health facility systems is necessary in order to facilitate movement of patients from private acute care and hospital ED settings to community based public facilities such as Crisis Stabilization Units and other residential programs.

6. Research is needed to better understand why there is a continuing increase in the number of voluntary admissions to private psychiatric hospitals, how that increase is impacting private hospitals' ability to provide TOO placements, and whether this phenomenon will continue into the future. The findings have major implications for planning on crisis care and hospitalization.

The Task Force plans to continue its work, with the goal of providing a set of recommendations by the end of November.