

# **Statewide TDO Task Force: Second Interim Report December 4, 2018 Meeting of the SJ 47 Joint Subcommittee**

## **I. Introduction**

Since the submission of its first interim report to the SJ 47 Joint Subcommittee for the Subcommittee's November 5, 2018 meeting, the Task Force has reviewed proposed changes in the Virginia Code aimed at facilitating care and services for individuals in crisis, and has looked at proposals for crisis programs and services that emerged from the regional meetings held throughout the state over the course of 2018. Those changes and proposals, which were prepared by ILPPP staff for review, were reviewed and discussed at the Task Force's meeting on November 27, 2018. The proposals that were reviewed are attached. Specific recommendations for action are at the end of this report. In addition, slides have been added to the Power Point presentation made to the SJ 47 Joint Subcommittee on November 5, to better illustrate the evolving demands on the private and state psychiatric hospital systems that are summarized in the report below.

## **II. A Review of the Task Force's Findings**

The findings of the Task Force remain essentially the same as those presented at the November 5 meeting. They include:

***1. While the number of persons admitted to state hospitals under a TDO continues to increase, the number of private hospital beds available for TDO patients continues to decline, with no end to these trends in sight.***

The total number of TDOs statewide rose substantially from 2014 to 2016, but since their peak in 2016 those numbers have stabilized and even *declined in some regions*. Despite this decline, the number of TDOs going to state hospitals nonetheless has increased dramatically – from 1580 in fiscal year 2014 to 3498 in 2016 to 5356 in 2018. It is important to note that the private hospitals absorbed a substantial percentage of the statewide TDO increase from 2014 to 2016. However, the proportion of TDOs admitted by state hospitals has dramatically *increased* since the beginning of fiscal year 2016 (from approximately 10% of all civil TDOs to 20%), leading to the current crisis in state hospital overcrowding. A key question: why has the number of private hospital TDOs decreased?

***a. The greatest single contributor to the decline in TDO admissions to private hospitals appears to be a significant rise in the number of voluntary inpatient admissions to private psychiatric hospitals.***

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. Working together to obtain and analyze these data on an ongoing basis is

essential if we are to make informed projections on the availability of private hospital beds for TDO placements.

*b. 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.

***2. As the number of TDO admissions to state hospitals has increased, it appears that the number individuals presenting significant medical and behavioral challenges has also increased, further stretching hospital resources.***

Those individuals include:

*a. Individuals with complex medical conditions.*

It appears that an increasing number of individuals admitted to state hospitals have complex medical conditions requiring a high level of medical care that is not available in state psychiatric hospitals. The *Criteria for Medical Assessment Prior to Admission to a Psychiatric Hospital or Crisis Stabilization Unit*, developed through a consensus process by Virginia public and private hospitals to establish standards for medically screening and accepting psychiatric patients and implemented on November 5, includes a listing of criteria that *exclude* a person’s admission to a state psychiatric hospital (e.g., severe burns requiring acute care, unstable seizures, acute respiratory distress, intravenous fluids or IV antibiotics). However, 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, including those who have medical conditions that should exclude them from the state hospitals. Because there is no available data on the numbers of these patients in either private or state hospitals, the dimensions and trajectory of this problem is currently unknown,

*b. Individuals with ID/DD.*

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, with that result that they typically require a disproportionate percentage of hospital staff resources for behavioral management. It appears that the number of adults with ID/DD admitted to state hospitals has increased in recent years, from 293 in fiscal year 2014 to almost 700 in 2018.

Individuals with ID/DD now represent 9% of adult admissions to state hospitals, and 27% of admissions to the Commonwealth Center for Children and Adolescents.

*c. Important Note on Patients Difficult to Discharge Safely.*

This report focuses on admissions. However, one of the reasons for bed shortages is an increase in the number of individuals with serious, chronic illness that present obstacles to discharge. These include patients on the state hospitals' "Extraordinary Barriers List." In addition, private hospitals are also reporting increasing numbers of involuntary patients who spend weeks or months in what are supposed to be acute care units because a community placement for them cannot be found. Increasingly, this is due not only to the behavioral history and difficulty of these individuals, but also to dementia and/or extensive medical treatment needs.

**3. *The long-term strategy for reducing psychiatric hospital admissions is strengthening the community-based system of mental health care to reduce the number of persons experiencing mental health crises.***

*a. Full funding for STEP-VA.*

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). Expedient implementation of outpatient psychiatric services is a key step.

*b. Sufficient Medicaid funding to support community-based services.*

There is concern 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). The statewide operation of 6 Managed Care Organizations has been administratively burdensome and costly for CSBs, and has not supported innovation.

**4. *Crisis system solutions: make less restrictive crisis services more widely available***

*a. Provide alternatives to the hospital ED for the individual experiencing crisis*

The hospital emergency department (ED) is a 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 are destabilizing to a person in crisis, and make that crisis worse. Alternatives to the ED are needed. A full continuum of intensive crisis services includes:

(i) Mobile crisis teams 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.

(ii) Peer support recovery centers 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).

(iii) Psychiatric Emergency Centers (PECs) have a comprehensive model of welcoming "walk-ins", as well as referrals from police, hospital EDs and mental health providers. PECs utilize peer specialists as key partners in care and provide professional medical and mental health services. They 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.

(iv) Hospital observation units are located within the hospital complex but separate from the hospital ED, so that individuals who arrive at the ED in mental health crisis would have a quieter setting, staffed with professionals trained in mental health care (with medical care staff readily available) who can better assess and address these crises.

(v) Crisis Stabilization Units (CSUs) can be sufficiently staffed and funded to enable them to function more effectively as both an alternative to the hospital ED and psychiatric hospital and as a "step-down" from hospital facilities. Some Task Force members noted that differing standards, procedures and staffing capacities among CSUs made it more difficult to utilize some CSUs in a timely and effective way.

*b. Prevent unnecessary hospitalization by providing the option for some individuals in custody to have the time needed to recover from crisis in a clinical setting before issuing a TDO*

Under current Virginia law, whenever an emergency custody order is entered by a magistrate for a law enforcement officer to take a person into custody due to a mental health crisis, and whenever an officer based on his or her own observations takes such a person into custody, that person can be held for a maximum of 8 hours. Within that time, a CSB evaluator must examine the person and, if finding that the person meets the criteria for a temporary detention order (TDO), must also find a willing hospital for placement.

That 8-hour window may not be long enough to get an accurate picture of some individuals' condition, especially for those individuals whose crisis is fueled by alcohol or drug use, and whose clinical picture could be dramatically different once the alcohol or drugs are out of the person's body. The PECs and hospital observation units that operate in other states are longer term facilities in part for that reason. However, there are no facilities in Virginia that function like PECs or observation units. (Crisis Stabilization

Units have evolved into multi-day residential facilities that are used as either an alternative to a psychiatric hospital or as a “step-down” from the hospital.)

Currently, most people held under an ECO are evaluated in a hospital ED or in a Crisis Intervention Team Assessment Center (CITAC), where, by statutory requirement, they are under the supervision of a law enforcement officer. Neither of those facilities, nor the supervising officers, would welcome an extension of the ECO time period because their time and resources are already stretched thin. On the other hand, the 8-hour ECO window can result in premature decisions about the need for hospitalization in a significant proportion of cases.

While many individuals who are held under an ECO would benefit from a longer period of time in a supportive setting to recover and stabilize before a final decision is made about hospitalization, this approach would only be appropriate if the right facilities were developed to provide such a setting for recovery (coupled with on-site security that would allow law enforcement officers to return to duty instead of directly supervising the individuals they have taken into custody). If this approach were adopted, the ECO period would be extended only for individuals who are in a PEC or similar facility.

***5. Improve the linkages between the private and public mental health crisis response system so that individuals can transition more smoothly between placements and services***

Hospital EDs in particular report challenges in trying to make timely transfers of patients from the ED to community facilities and programs, particularly Crisis Stabilization Units (CSUs). There is a need for more uniform standards and protocols for such transfers, and for more robust staffing of the CSUs to enable transfers to be carried out more quickly.

***6. Make mental health workforce development and retention a major priority.***

The workforce crisis exists at all levels of the public and private mental health system, but it is becoming more acute, with the most acute consequences in the state psychiatric hospitals, where the rate of turnover is increasing along with the number of vacant skilled positions. A statewide commitment to workforce development and retention is needed.

**III. Task Force consideration of specific regional project proposals**

***Specific project proposals from the regional meetings:*** ILPPP staff highlighted to the Task Force two sets of proposed pilot projects that emerged out of the regional meetings: (1) PEC-like facilities based on the Living Room model (from Region 4, Region 3b and New River Valley Community Services (NRVCS), with the NRVCS and Region 3b programs including proposed budgets; (2) a mobile crisis program that would include services and consultation from a psychiatrist to enable more in-depth assessment and medication prescription as part of the mobile team services.

The response of most Task Force members was that, while the proposed services were consistent with the Task Force’s findings regarding the need for alternative services for individuals experiencing mental health crisis, it would not be appropriate to make recommendations for specific projects. Among the reasons: (1) the state is in the critically important process of fully implementing STEP-VA (which does include crisis services as a key component part, though the specifics of those crisis services are still in development), and focus needs to be concentrated on that process; (2) recommending specific projects to the committee would not be consistent with the historical practice of the General Assembly, which has been to provide funding for identified services, with the specific programs to provide those services being selected later through grant or RFP processes. *By convening regional meetings and inviting preparation of project proposals for consideration by the statewide Task Force, our goal has been to stimulate multi-stakeholder collaboration to develop creative service innovations at the local or regional level to expand the continuum of intensive crisis services as alternatives to hospitalization. The Task Force regards development and implementation of innovative service models as a key element of the Commonwealth’s mental health transformation strategy.* It is our understanding that DBHDS is in the process of facilitating similar regional conversations and collaborations. The future role of the Task Force in this effort, if any, remains to be seen.

#### **IV. Task Force consideration of statutory amendments to facilitate an effective and less restrictive crisis response process**

During the course of its deliberations, the Task Force was informed about several Code provisions that require minor tweaking to facilitate the emergency evaluation process. In addition, the Task Force reviewed proposals aiming to facilitate information sharing between public and private providers in connection with the hospital discharge process (see Finding 5 above). Finally, the Task Force has had extensive deliberations about the need to lengthen the ECO period in several specific clinical contexts. (See generally Finding 4b above.)

At its meeting on November 27, the Task Force considered the following three Code Amendments pending formal review by the stakeholder organizations. Although official Task Force recommendations would therefore be premature at this time, they are being included for Joint Subcommittee consideration pending receipt of further comments and suggestions from the Task Force members.

##### ***1. Amend VA Code Section 37.2-808(K) to ensure that custody of a person held under an ECO is maintained until the TDO that has been issued in a timely manner is actually served.***

Section 37.2-808(K) states that when a person is held in custody under an ECO, the person “shall remain in custody” until a temporary detention order is “issued”. Because there is often a period of time between the magistrate issuing the TDO and an officer actually serving it on the person, officers have raised concern as to what authority they

have to *keep* a person in custody *between the time the TDO is issued and the time it is served*, especially when the 8-hour ECO time period expires before the TDO is served. To address this, the proposed amendment to 37.2-808(K) states that the person in custody under an ECO will remain in custody until the TDO is issued *and served*, and that if the ECO's 8-hour limit is reached after the TDO is entered but before it is served, the person still remains in custody until service of the TDO, unless the TDO for any reason is rendered void. This amendment would provide needed assurance to officers regarding their custodial authority during the transition from an ECO to a TDO.

***2. Amend VA Code Section 37.2-1104 to authorize Magistrates to hear requests for Medical TDOs without requiring that the Court must first be found to be “unavailable”***

Section 37.2-1104 enables physicians to seek an order authorizing the temporary detention (up to 24 hours) of a patient incapable of giving or communicating informed consent to treatment when the “medical standard of care” calls for testing, observing or treating the patient within the next 24 hours “to prevent death or disability, or to treat an emergency medical condition that requires immediate action to avoid harm, injury or death”.

Most requests for these “medical TDOs” come from hospital ED physicians who are trying to treat patients in situations that require immediate action by the hospital ED staff. Section 37.2-1104 requires the physicians to first seek the TDO from “the court”. Only if the court is “unavailable” can a medical TDO be sought from a magistrate. This can often take many hours, and can discourage physicians from seeking medical TDOs.

The proposed amendment would improve the timeliness and the quality of care provided to patients in emergencies by allowing doctors to seek medical TDOs from the magistrate, without going to the court first.

***3. Amend VA Code Sections 37.2-813, 37.2-838 and 37.2-839 to ensure CSB access to patients and patient information for psychiatric hospital discharge planning***

Sections 37.2-837 and 37.2-839 already require discharge planning for individuals who are involuntarily committed to state hospitals, and authorize exchange of information between state hospitals and local CSBs to develop those discharge plans, thereby ensuring that supportive services are available for that person immediately upon discharge from the hospital.

There are no similar Virginia Code provisions governing communication between private hospitals and CSBs for discharge planning for patients TDO'd or involuntarily committed to private hospitals. This may be due in part to the fact that there is no specific funding to cover the CSBs' costs if they provide such planning. However, some CSBs are starting to offer planning services to some of these individuals (prioritizing those who were not in treatment at the time of their involuntary hospitalization) because such services may help people transition from the hospital to community-based services and support, and thereby stop “cycling” through the hospital system.

Because Title 37.2 does not address communications between the CSBs and private hospitals in regard to these patients, hospitals and CSBs may be uncertain about what information they are permitted to share under the federal HIPAA Privacy Rule and under state privacy laws in order to carry out effective planning for community-based services. The proposed amendments to Virginia Code Sections 37.2-813, 37.2-838 and 37.2-839, would provide that, where a local CSB offers to provide planning for community based services to individuals who have been TDO'd or involuntarily committed to a private hospital, the hospital *shall* provide reasonable and timely access by CSB employees, agents or contractors, and upon request shall provide client information to these individuals, so that this planning can be offered and carried out. The word “shall” is used for technical reasons rather than coercive ones. By requiring that this access and this information be provided, the amendments remove any legal ambiguities regarding whether hospitals are permitted to provide such access or information under state or federal law. By making the disclosure mandatory upon request, the Code removes any possible HIPAA impediment to disclosure. [Although the proposal is not in the packet of attachments, it will be necessary to add a reference to Code Sections 37.2-813 and, 37.2-838 to Section 32.1-127.1:03(D)(6) of the Virginia Health Records Privacy Act. Section 37.2-839 is already mentioned.]

Removing this impediment to cooperation between the private hospitals and CSBs will enhance the ability of the CSBs to provide timely and appropriate service planning services for individuals in the hospital to facilitate their successful discharge and their transition back to life in the community. The ability of CSBs to offer these important services will remain contingent upon CSBs obtaining the funding and staffing needed to do this work.

*We reemphasize that this proposal has not yet been vetted by the two key stakeholder organizations affected by it (VACSB and VHHA). It is being included in this report among the list of possible legislative actions on the assumption that any eventual proposal will reflect the views of those organizations.*

## **V. Task Force consideration of the serious problems posed in cases involving individuals in mental health crisis who have a complex medical condition**

As noted earlier in this report, the recently implemented *Criteria for Medical Assessment Prior to Admission to a Psychiatric Hospital or Crisis Stabilization Unit* includes a listing of criteria that *exclude* a person's admission to a state psychiatric hospital (e.g., severe burns requiring acute care, unstable seizures, acute respiratory distress, intravenous fluids or IV antibiotics). However, 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, including those who have these “complex medical conditions” that should exclude them from the state hospitals. Because the state psychiatric hospitals are not equipped or staffed to treat these conditions, individuals who are TDO'd there are at



elevated risk of harm, and the state hospitals must devote disproportionate staff time and hospital resources to caring for them (including transporting them to medical facilities, often miles away, for their medical treatment), thereby degrading the state hospitals' ability to care for other patients.

ILPPP staff, after discussions with some state hospital representatives about the impact of these patients, drafted possible changes to Virginia Code Sections 37.2-809 and 37.2-809.2, including a provision that would allow state psychiatric hospitals to decline a patient with complex medical needs if the hospital was not staffed or equipped to safely treat the patient. That provision would also extend the ECO period to provide additional time to find a hospital bed.

After extensive deliberation, the Task Force agreed that these patients pose major treatment challenges in any setting. The hospital ED representative noted that, from his experience, extending the ECO period was unlikely to increase the chances of finding an available private hospital bed, and in the meantime such patients likely would experience further psychiatric deterioration while waiting in the ED for a bed. The Task force members also agreed that the burden now carried by the state psychiatric hospitals, and the resulting risks to these patients, are inappropriate and that placing these patients in the state hospitals as the "default" placement is not acceptable and should be changed. The Task Force members also agreed that the most sensible policy solution to this dilemma is to develop and support clinically appropriate "med-psych" units -- or other clinically equivalent arrangements between medical and psychiatric facilities -- that are capable of caring for these patients.

Members noted that no data are readily available on how many individuals with complex medical conditions are ECO'd and then TDO'd to either private or state hospitals, and that a first step in finding solutions would be to determine the size of the problem. (An ILPPP researcher has noted that this will require a level of data collection that neither the state nor private hospitals currently practice.) It was noted that the process set up under the Medical Assessment Guidelines for resolving clinical disagreements might provide a useful source of data regarding the clinical characteristics and eventual placements of a subset of these cases.

The Task Force reached the following consensus recommendation:

***1. The Task Force recommends that a suitable body of experts be appointed to study and make recommendations to the General Assembly by the fall of 2019 on how best to address the treatment needs of individuals in mental health crisis who have complex medical conditions and prevent their admission to state psychiatric hospitals that are not equipped to care for them. The specific goals of the study would be to (i) review all relevant data from the CSBs and state and private hospitals to ascertain the clinical characteristics of these patients and the dimensions and scale of this problem and (ii) develop specific proposals regarding the type(s) and sizes of the facilities that are needed to serve them in crisis situations.***

The Task Force did not have the time to formulate a specific proposal to implement this recommendation. The Joint Subcommittee may want to consider requesting or directing DBHDS or the Secretary of HHR, or some other suitable body, to assemble the members of the Expert Work Group. It is also possible to direct the existing Task Force, in collaboration with DBHDS and VHHA, to assemble a work group with the necessary expertise. Necessary funding would also have to be arranged.

***2. The Task Force considered but was unable to reach agreement on what should be done while this study is being conducted.***

The key question is whether an exception to the “last resort” provision should be carved out for these cases, thereby putting the medical directors of the state hospitals on the same footing as the medical directors of private hospitals in assessing the medical and ethical suitability of admitting any particular patient with a complex medical condition specified in the “Medical Assessment Criteria.”

The following proposal was discussed at length:

*Amend VA Code Section 37.2-809 and add Section 37.2-809.2 to allow state psychiatric hospitals to decline the admission under a TDO of individuals in mental health crisis who have a complex medical condition and whose 8-hour ECO period has expired.*

ILPPP staff developed two alternative versions of this proposed amendment, which (i) would enable state psychiatric hospital medical directors to decline to accept patients with complex medical conditions they cannot safely treat and (ii) would extend the ECO period for these individuals when no hospital bed, public or private, can be found during the original ECO period. The main concern, as indicated above, was that enactment of the proposed amendment likely would serve primarily to shift the inappropriate burden to the hospital ED and change the risk to the patient from one of medical harm to one of psychiatric harm. ***In light of strong opposition to these proposals by key stakeholders, the details of the two versions were not discussed. Accordingly, the Task Force is passing on these two proposals to the Joint Subcommittee for information only..***