

The TDO patient crisis in state hospitals: contributing factors, possible responses and continuing challenges

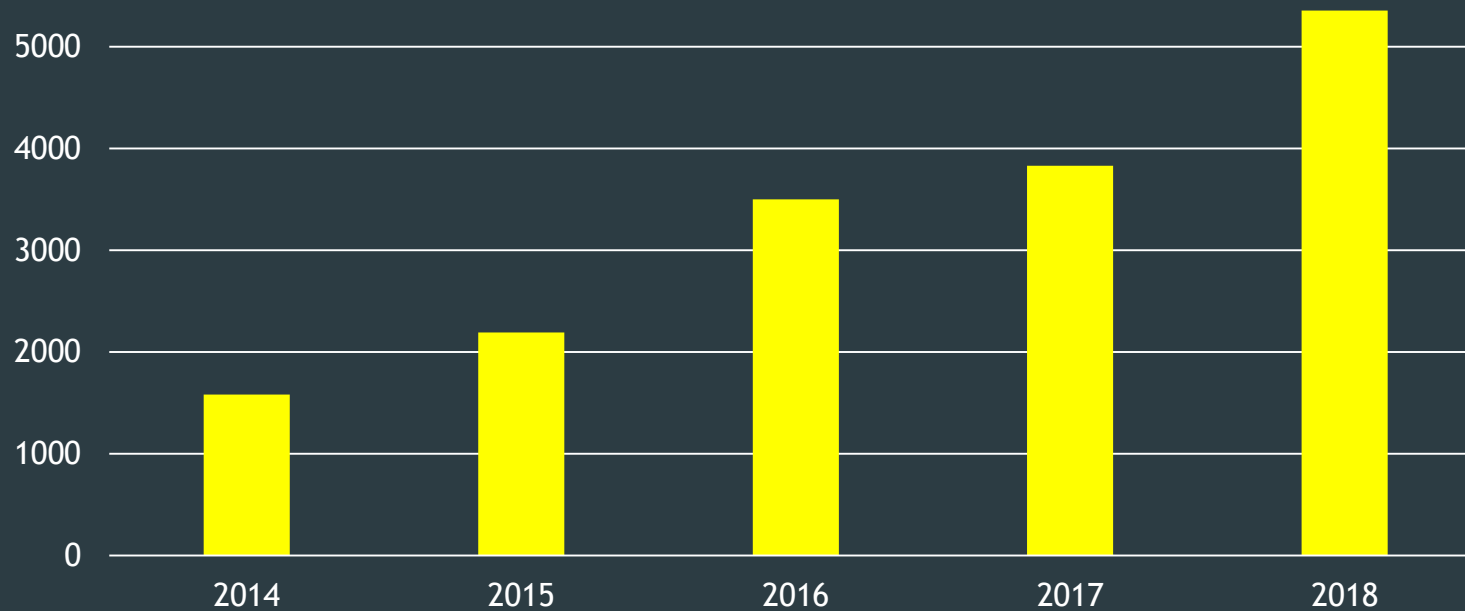
Institute of Law, Psychiatry and Public Policy

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Updated from 11/5/18

The crisis: TDO admissions to state facilities continue to rise dramatically

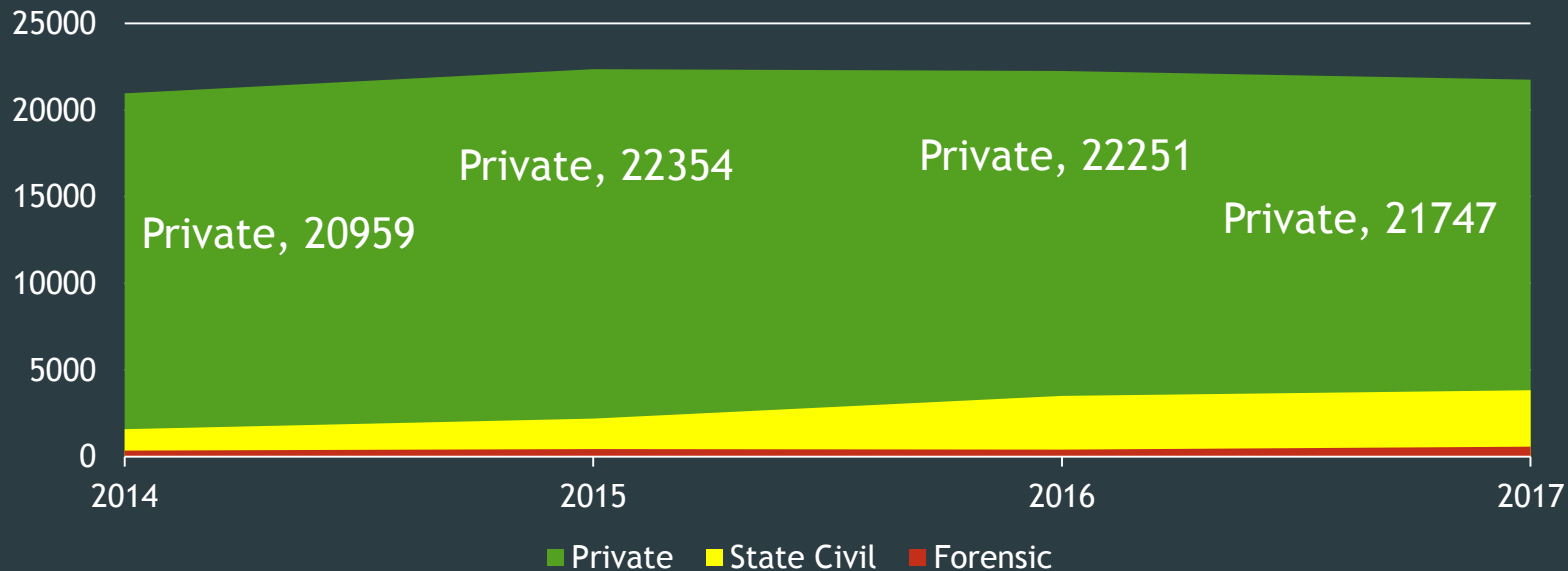
Civil TDOs to state hospitals by fiscal year



A key contributor: A decline in private hospital TDOs.

- ▶ Private hospitals continue to take the majority of TDOs, but there has been a decline in both the number and percentage of TDOs that they take.

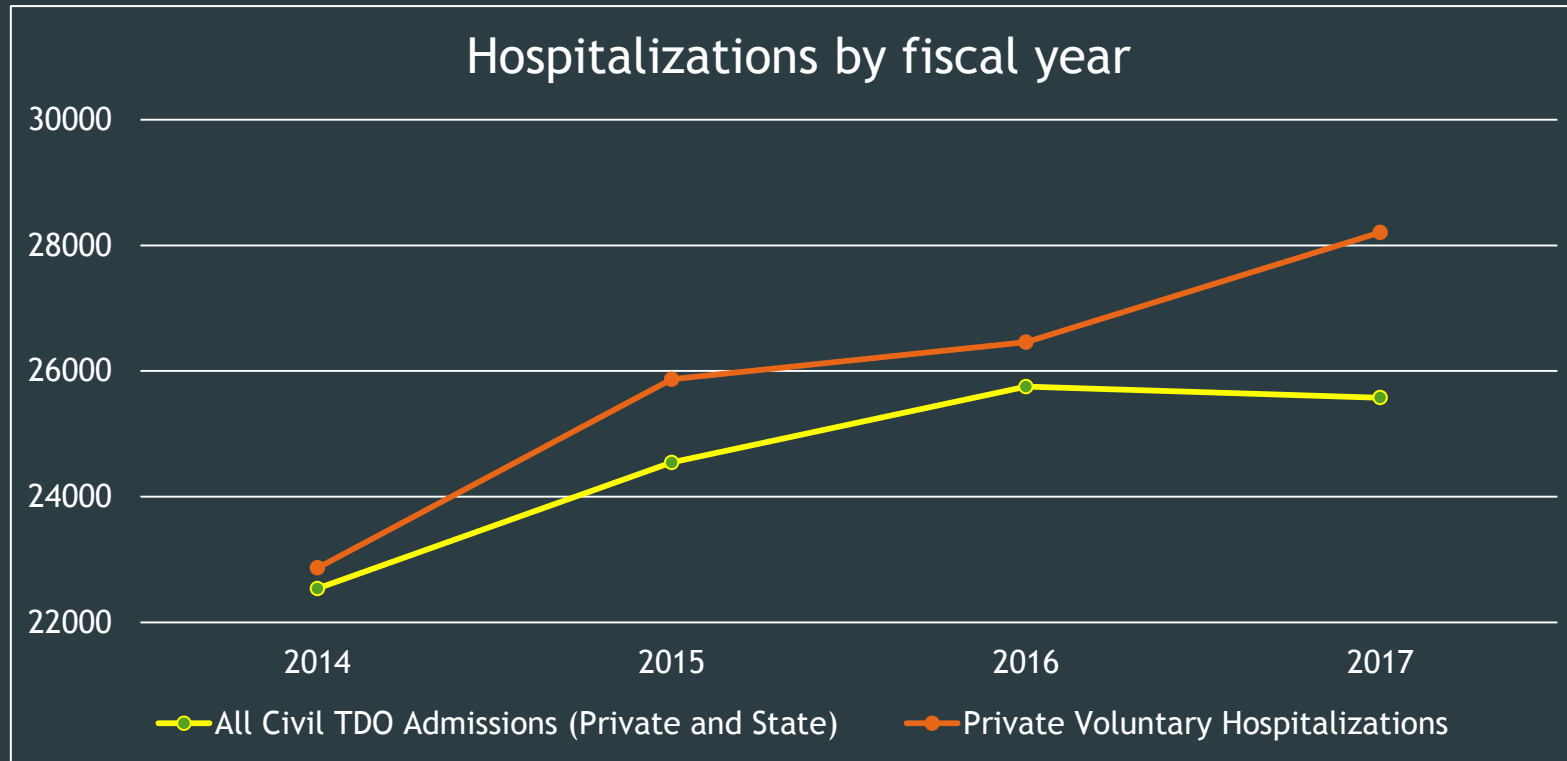
TDOs by Fiscal Year



TDOs	FY 2014	FY 2017
Forensic	344 (1.5%)	571 (2%)
State Civil	1580 (7%)	3828 (15%)
Private	20959 (91.5%)	21747 (83%)
Total	22883	26146

A key contributor: increasing voluntary admissions to private hospitals

- ▶ Since 2016, total TDOs statewide have stabilized, but voluntary admissions to private hospitals have increased, reducing the number of available beds.

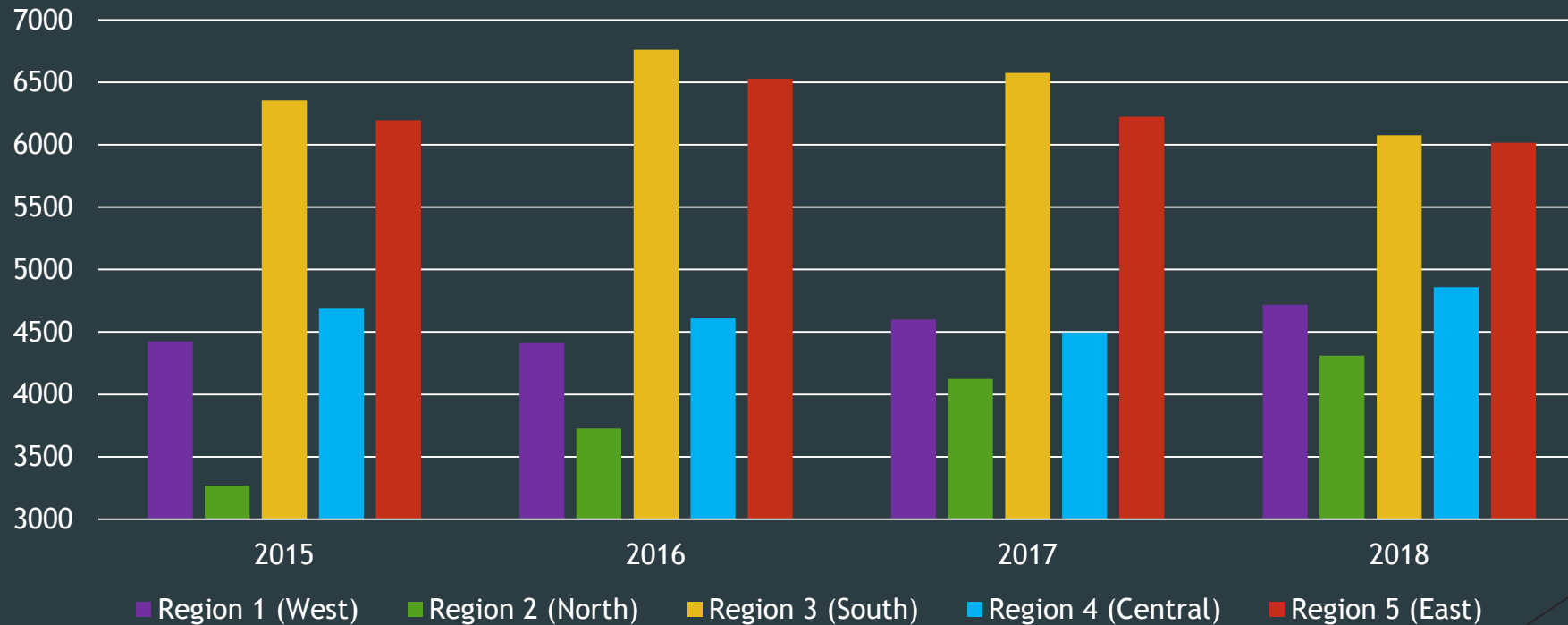


Loss of private beds due to other factors: “ligature” issues

- ▶ In FY 2018, admissions to private hospitals declined for the first time in years as the Joint Commission started taking beds offline due to ligature risk. This has led to permanent bed closures in rural hospitals like Augusta Health, and temporary closures in wealthier urban hospitals.

Regional Differences in Volume of TDOs over Time

All TDOs by Fiscal Year



Responses: reduce demand by preventing crises

- ▶ In Virginia, better access to outpatient mental health services is associated with fewer psychiatric crisis evaluations.*
- ▶ STEP-VA outlines some of the services needed to reverse the trends in crisis and hospitalization:
 - ▶ Outpatient mental health services
 - ▶ Same-day access
 - ▶ Targeted case management
 - ▶ Linkage to medical providers

*<https://uvamentalhealthpolicy.org/documents/2017/10/5/rise-in-temporary-detention-orders-in-virginia-2013-2017-possible-contributing-factors>

Responses: provide community based alternatives to the hospital

- ▶ During a survey in fall of 2016, 55% of psychiatric pre-admission screenings took place in emergency departments. The emergency department is not a therapeutic environment for patients with psychiatric disorders. Therapeutic approaches to psychiatric emergencies decrease the likelihood that a person in crisis will be hospitalized.*
- ▶ These approaches include:
 - ▶ Mobile Crisis Units
 - ▶ Peer Respite Centers
 - ▶ Psychiatric Emergency Centers

*Bouchery, Ellen E., et al. "The effectiveness of a peer-staffed crisis respite program as an alternative to hospitalization." *Psychiatric services* 69.10 (2018): 1069-1074.

Hugo, Malcolm, Matthew Smout, and John Bannister. "A comparison in hospitalization rates between a community-based mobile emergency service and a hospital-based emergency service." *Australian & New Zealand Journal of Psychiatry* 36.4 (2002): 504-508.

Gillig P, Hillard J, Bell J, et al. The psychiatric emergency service holding area: effect on utilization of inpatient resources. *Am J Psychiatry*. 1989;146(3):369.

Responses: give individuals under an ECO more time to recover in a supportive setting

- ▶ Psychiatric Emergency Centers (PEC) are most effective when staff have 24 hours to stabilize the client. If Virginia is to employ this approach, it is recommended that the laws surrounding emergency custody orders be amended so that there can be an extension to the ECO period specifically for people receiving treatment in a PEC.
- ▶ Observation units proposed by some private hospitals would provide an alternative setting to the hospital ED, and would also be based on providing more time to individuals for both assessment and recovery.

Responses: make it easier to transition patients from hospital ED to less restrictive care

- ▶ Some patients remain in the hospital ED longer than is necessary due to difficulties in finding a community placement. For these, step-down programs can ease the burden on the hospitals.
- ▶ These programs include:
 - ▶ Crisis Stabilization Units
 - ▶ Intensive Community Residential Treatment+
 - ▶ Assisted Living Facilities

Responses: develop community placements for hard-to-discharge patients

- ▶ General Assembly and DBHDS with on ongoing commitment to permanent supportive housing
- ▶ Region 2 study on the need of patients on Extraordinary Barriers List (EBL) for community placement with 24/7 supervision:
 - NVMHI: 24 of 34 individuals (71%)
 - Piedmont Geriatric Hospital: 15 of 15 (100%)

Region 2 survey of private psychiatric hospitals on TDO patients that they could not discharge: the need for 24/7 supervision in the community was the most common barrier to discharge

Growing challenges: Growing populations that may require different approaches to care

Some patients require specialized care, or may be completely inappropriate for state hospitals:

1. Complex medical conditions
2. ID/DD
3. High aggression/history of aggression
3. Dementia
4. “Frequent utilizers”

Patients with complex medical needs

- ▶ Patients with complex medical needs are particularly concerning, because the state hospitals do not have the medical capabilities to treat them safely. Because of the “last resort” legislation of 2014, state hospitals must accept them in spite of the risk to the patient.