Update for the Joint Commission on Health Care
Biannual Report of the
Office of the Inspector General
Behavioral Health and Developmental Services

THE PRACTICE OF "STREETING"

"STREETING" BACKGROUND: While following-up this spring on the impact of last year's downsizing of Eastern State Hospital (ESH), OIG Report No. 197-10, the OIG learned that 25 individuals had been *streeted* in Hampton Roads during the first quarter of 2011.[1] The OIG was alarmed that a bed could not be located for these individuals, who had been determined to meet TDO criteria, so we conducted a brief survey of the Emergency Services Directors at all forty CSBs to determine if this problem was isolated to Hampton Roads, or if it existed elsewhere in the state.

The incidence of *streeting* is formally tracked weekly in HPR V by the Facility Management Committee (FMC) – the gatekeeper for admission to ESH, but in other parts of the state *streeting* is not used, so we defined the term as follows for all survey respondents:

- The person, who meets TDO criteria, is released from an ECO because a private acute care bed cannot be found prior to the expiration of the ECO, or
- The person, who meets TDO criteria, is released because a willing receiving facility is not located in the allotted time for executing the TDO.

The results of our survey are attached to this Memo and the summary reflects that about half of the state's CSBs report that people meeting TDO criteria were released because a willing receiving state facility, or private provider, could not be located. Inasmuch as many boards do not track the incidence of *streeting*, some of these numbers represent their best estimate of its frequency; however, while the precise number of individuals *streeted* in the Commonwealth last year may be a moving target, the raw numbers and the anecdotal reports accompanying many of the survey responses make it clear that streeting is a problem statewide.

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[1] As noted in the OIG's Semi-Annual Report, the instructions for completing the "HPR V Emergency Services Weekly TDO Report" contain the following operational definition of streeting: "**# Streeted**: The person was released. For example, a person who is brought in under ECO, who meets [TDO] criteria, but has to be released from custody at the expiration of the ECO as there is no bed available." [Bold in original] Of the approximately 200 people *streeted*, not all were detained pursuant to an ECO prior to evaluation for TDO.

It is important to note that *streeted* does not necessarily mean that people were literally put on the street. Although individual outcomes are difficult to track, the OIG is convinced that emergency service staffs are diligent and pursue a range of alternatives to keep these individuals as safe as possible. The outcome for a *streeted* person might include: seeking admission to a crisis stabilization program if they are capable of accepting a TDO; when available, developing a safety plan with family members, that includes strategies for the individual to be seen for intensive services through the CSB; or seeking an agreement for the individual to stay in the emergency room, if the crisis is after-hours, with intensive CSB supports to follow the next day. Also, crisis workers reported that charges might be filed, if warranted, so that a person could be retained in a safe setting rather than be *streeted*.

That said, it is essential to understand that a reported outcome that *appears* benign – or even positive may, in fact, be unacceptable as demonstrated by the *Virginian Pilot's* June 6th article profiling the account of a suicidal 17-year old girl who was *streeted* and returned home with her mother when emergency services workers could not find a psychiatric bed in Hampton Roads. The official record doubtless reflected that the girl was returned to her mother's care with a safety plan for the night and instructions to call in the morning.

But that official record would not reflect the mother's account of locking away the knives and medications, removing the doorknobs from the girl's bedroom and bathroom doors so she could check on her, the terror when her daughter's head slipped below the water in the tub, or the feeling of panic because she fell asleep during her all night vigil awaiting a psychiatric bed for her daughter.

UPDATE ON HAMPTON ROADS (HPR V): This week, the CSB Executive Directors in HPR V approved a new protocol to access recently created safety net beds at ESH. A copy of the "Safety Net Protocol, Quick Guide to Implementation and Use Effective June 15, 2011" is attached for information. Our analysis of HPR V's weekly TDO Reports for the first quarter of this year suggests that two or three safety net beds at ESH would have largely, if not completely, eliminated *streeting* in the region. The OIG is optimistic that the new leadership at ESH, in collaboration with the region's CSBs, appears to be on track to curtail *streeting* in Hampton Roads and we will monitor this issue going forward to verify the actual outcome in the region.

OIG ACTIONS SINCE THE REPORT WAS ISSUED: The OIG has requested that DBHDS's *State Hospital Effectiveness and Efficiency Workgroup*, an outgrowth of the Department's *Creating Opportunities Plan*, examine this issue and make recommendations to end the practice of *streeting* in the Commonwealth.

The OIG and the DBHDS are creating a new *TDO Outcome Report* that will be shortly forwarded to all CSB Emergency Services Divisions. The report will ask that emergency services staff contemporaneously report all instances where persons meeting TDO criteria are not accepted by a public or private psychiatric facility, or a suitable crisis stabilization program, and their actual disposition.

The OIG will forward a follow-up report to the Governor, the Joint Commission, and the General Assembly on this issue by the end of summer that will include the results of our on-going tracking, interviews with stakeholders, regional progress to eliminate *streeting*, and recommendations as appropriate.

THE USE OF RESTRAINT AND TREATMENT OVER OBJECTION

BACKGROUND: In May of 2011 the Office of the Inspector General requested clarification from the Centers for Medicare and Medicaid Services (CMS) on the intent of CFR 42, Part 482 *Medicare and Medicaid Programs; Hospital Conditions of Participation: Patients Rights* specific to the use of restraint to provide non-emergent involuntary medication to individuals in facilities operated by the Department of Behavioral Health and Developmental Services (DBHDS). This request was made because the DBHDS had received guidance from the Office of the Attorney General (OAG) that using restraint to medicate over a patient's objection was a violation of Federal regulations as articulated at 42 CFR § 482.13(e) *Standard: Restraint or Seclusion.*

The OIG is concerned that the OAG's prevailing interpretation of this Federal regulation rules out the use of a brief restraint to administer medically necessary treatment that could restore a delusional person to a baseline of competency, except to ensure "*the immediate physical safety of the patient, a staff member, or others.*" We believe this interpretation leads to a denial of medically necessary palliative treatment and may constitute abuse and neglect under § 37.2-100 *Code of Virginia*.

UPDATE ON RESTRAINT AND MEDICATION OVER PATIENT OBJECTION: As of June 11, 2011, CMS has not formally responded to the OIG's May petition. Since the OIG's request for clarification, our office has reviewed involuntary medication practices in other states, discussed the issue with national representatives of the National Alliance on Mental Illness (NAMI), reviewed pertinent sections of the Code of Virginia, and revisited the CMS Interpretive Guidelines for 42 CFR Part 482.

CONSULTATION WITH NATIONAL NAMI OFFICIALS: Appended hereto please find a letter from NAMI's National Director of Policy and Legal Affairs supporting the OIG's interpretation of 42 CFR Part 482. The letter is unequivocal that NAMI regards any form of physical restraint as the "least desirable option" that should only be used "as a last resort." The OIG completely agrees with NAMI's position on physical restraint.

Mr. Honberg observes that the OAG's well-intentioned, but narrow, reading of this regulation appears contrary to the regulation's intent, and could have the effect of preventing "needed treatment in certain cases involving individuals with the most severe psychiatric symptoms." Mr. Honberg's national perspective allows him to conclude that the OAG's interpretation of the regulations is "at odds with the remainder of the states and the District of Columbia." Most importantly, he observes that, should Virginia follow the path charted by the OAG's interpretation of 42 CFR Part 482, "it will have the effect of delaying or denying treatment for those most in need...."

STATE PRACTICES GOVERNING INVOLUNTARY MEDICATION: In October 2007, the Legal Division conference of the National Association of State Mental Health Directors (NASMHD) included a presentation on the *State Practice for Non-Emergent Involuntary Medication,* a copy of which is appended hereto for convenient reference. The presentation affirmed that each state had statutes or regulations permitting medication over objection. The various state statutes and regulations fit into five broad categories:

▪ Permit upon admission	9 States
▪ Allowed upon judicial commitment	13 States
▪ Separate judicial hearing required	21 States[2]
▪ Judicial hearing required to appoint guardian	2 States
▪ Administrative hearing required	5 States

REVIEW OF CMS INTERPRETIVE GUIDELINES: The OIG believes that the Interpretative Guidelines for 42 CFR Part 482: *Physical Holding for Forced Medications* demonstrate CMS's expectation that every effort be made to minimize the use of force to medicate over objection, but that these guidelines clearly anticipate that the

[2] According to this 2007 NASMHD summary, Virginia requires a separate judicial hearing for non-emergent medication over a patient's objection. This is consistent with then-Attorney General McDonnell's official advisory opinion stating that local courts could authorize a jail superintendent "to force an individual in his custody to take prescribed medication for treatment of mental illness to restore his competency to stand trial." (Attorney General's *Advisory Opinion* to Speaker Howell dated September 20, 2007)

need for some form of restraint may be required under certain emergency circumstances, or when a court order has been secured.

REVIEW *OF THE CODE OF VIRGINIA*: The OIG believes the *Code* recognizes that treatment of an individual over objection can be necessary and a commitment to assuring that such treatment only occurs when it meets medical and ethical standards. It is noted that §§ 37.2-1101 & 37.2-1108 *Judicial authorization of treatment* and *Effect of chapter on other laws* respectively would seem to allow a legally authorized representative to provide consent for treatment over objection where a person is unable to give informed consent as defined by § 37.2-1100 *Definitions*.

Please let us know if the Joint Commission has any questions or requires any additional information concerning the issues presented in the OIG's Semi-Annual Report or this update. Thank you for the opportunity to be of service to the JCHC and its important work on behalf of the Commonwealth's citizens. I remain

Sincerely,

G. Douglas Bevelacqua
Inspector General
Behavioral Health and Developmental Services

C: Martin Kent, Chief of Staff for Governor McDonnell
Jasen Eige, Senior Counselor to Governor McDonnell
Dr. William A. Hazel, Jr., M.D. Secretary of Health and Human Resources