Summary of Submitted Remarks

Virginia College of Emergency Physicians

National Alliance on Mental Illness – NAMI/Virginia

Virginia Association of Community Services Boards, Inc.

Comments from Several Community Services Boards

Virginia Office for Protection and Advocacy

Excerpts of all Remarks

Virginia College of Emergency Physicians

To: Members of the Joint Commission on Health Care- Behavioral Health Subcommittee

From: Virginia College of Emergency Physicians

Date: June 25, 2012

RE: Mental Health Issues in the Emergency Department

The Virginia College of Emergency Physicians is deeply concerned about psychiatric patients who are forced to wait excessively to access the appropriate level of mental health services or worse, when emergency departments can no longer hold the patient after the ECO has run out and a TDO cannot be issued despite them still being deemed a danger to themselves or others.

We understand that Virginia shifted their policy in the last decade to move to providing mental health services in the least restrictive setting, with a laser like focus on community services, often as a cost saving proposition. However, such services are still not readily available, nor is there a reasonable expectation they will be in the near future. In addition, Virginia began cutting its psychiatric beds long before the community services had ramped up. This was reiterated in the VA Inspector General's Report, issued in February 2012 detailing the failings of our emergency mental health system: "The decrease in public and private psychiatric beds during the last decade, while the state's population has increased by over 10%, has not been accompanied by a commensurate expansion of community based programs and resources."[1] It is also significant that currently forensic patients occupy 36% of the public psychiatric beds, which severely limits access to non-forensic, acute patients.[2]

When emergency physicians cannot access the appropriate level of care for their psychiatric patients, the effect is not only felt on that patient and his/her family, but it also has a negative impact on access to emergency medical care for *all* patients – causing extended wait times, increasing frustration and diminishing the operational capacity of hospital staff to care for other patients.

VACEP has identified the following two issues outlined in the report as the most critical to the care of psychiatric patients in the emergency department:

1. Inappropriate medical clearance requested by receiving facilities, often resulting in unnecessary testing, expiring ECO's and a lack of bed space;
2. Lack of inpatient bed availability, resulting in TDO denial because there is no receiving facility to name on the order, which results in emergency physicians being required to release patients who have been deemed a danger to themselves or others.

Frustration with the mental health system is not unique to Virginia; a study by the Schumacher Group, a Louisiana firm that manages emergency departments across the county found that seventy percent of emergency department administrators report that they hold mentally ill patients for 24 hours or longer. Ten percent said they had boarded some patients for a week or more. Long wait times and even denial of appropriate care (often inpatient services) would not be tolerated for any other type of illness.

VACEP appreciates the Joint Commission taking a deeper look at the OIG reports and looks forward to helping in any way we can to identify ways to ensure proper care for our most vulnerable citizens in a psychiatric crisis.

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[1] *OIG Review of Emergency Services: Individuals meeting statutory criteria for temporary detention not admitted to a psychiatric facility for further evaluation and treatment*, OIG Report No. 206-11, G. Douglas Bevelacqua, February 28, 2012, page 2.

[2] *Ibid, page 9.*

PO Box 8260, Richmond, Virginia 23226 · (804) 285-8264 · www.namivirginia.org

Joint Commission on Health Care
P.O. Box 1322
Richmond, Virginia 23218

June 19, 2012

Re: Comments on the Inspector General's Reports: *Review of the Barriers to Discharge in the State-Operated Adult Behavioral Health Facilities; A 2011 Study Examining Unexecuted Temporary Detention Orders (TDOs) in the Commonwealth; and OIG Review of Behavioral Health Forensic Services.*

Dear Members of the Joint Commission on Health Care,

On behalf of the National Alliance on Mental Illness of Virginia, I am writing to provide comments on the Inspector General's recent reports: *Review of the Barriers to Discharge in the State-Operated Adult Behavioral Health Facilities; A 2011 Study Examining Unexecuted Temporary Detention Orders (TDOs) in the Commonwealth; and OIG Review of Behavioral Health Forensic Services.* Together, these reports call attention to numerous long-standing challenges that have plagued the mental health system, families, individuals, and communities for years. We commend you for further examining these issues, and thank you for giving us the opportunity to provide you with our input and perspective as families and people with personal mental illness experience, and first-hand knowledge of the challenges in Virginia's mental health system. Established in 1985, NAMI Virginia is the state office of the National Alliance on Mental Illness. Our 26 community-based affiliates provide support, education, and information to people in Virginia affected by mental illness.

The problems and the multiple and long-term effects articulated in the three reports cannot go unnoticed any longer. We strongly support the recommendations put forth by the Inspector General's office and believe wholeheartedly that, if enacted, they will truly make a difference. We would like to highlight what we see as the major issues from the Inspector General's reports:

1. **Diminished ability to provide safety net services for people in psychiatric crises.**

Approximately 12-14% of the total population in the state psychiatric hospitals are unable to be discharged into the community, despite being clinically-ready to do so, due to what are known as barriers to discharge. The IG's report found that, while approximately 27% of this population can be categorized as "forensic" patients facing difficult barriers regarding various forensic processes, the majority (53% according to the report) of the discharge-ready population can be classified as adult civil patients.

Failing to discharge people who are ready to transition back to their home not only diminishes their ability to engage in everyday life activities including family and social relationships, work options, educational opportunities, and general community engagement, it diminishes the state's

capacity to provide safety net services to others in need. The Inspector General's February 2011 report, *A 2011 Study Examining Unexecuted Temporary Detention Orders (TDOs) in the Commonwealth*, highlights the issue of "unexecuted TDOs". In the 90-day report period, 72 individuals who were found by specially-trained mental health professionals to meet the criteria for temporary detention in Virginia received less intensive treatment than was clinically indicated because no state-operated behavioral health hospital or private psychiatric facility would admit them, in part due to a lack of inpatient capacity at state psychiatric hospitals.

Part of the problem is that there has been a gradual reduction of licensed bed capacity in both private and public hospitals for more than decade. The number of state-operated inpatient hospital beds has declined while the population has grown by 13 percent in the last decade. Another issue is the lack of "willing providers"; private hospitals are not required to admit persons they don't wish to, and there are no incentives that would make admitting a person with challenging psychiatric issues more appealing or more possible. Perhaps the most significant problem is the longstanding shortage of community services that are needed in each community to provide proactive, intervening, and supportive services. The bottom line, however, is that if the public psychiatric hospitals — funded in part by state dollars — are allowed to deny even the most vulnerable and sickest of people needing care, then they are not serving as the health care safety net and, arguably, are not being good stewards of public funds.

2. Pressing need for community-based supportive housing.

The Review of the Barriers to Discharge in the State-Operated Adult Behavioral Health Facilities found that "the primary barrier throughout the Commonwealth to the timely discharge of clinically ready individuals is the lack of permanent supported housing". We concur wholeheartedly. Specialized and supportive housing is the cornerstone to stability and long-term recovery from serious mental illness. Lack of appropriate housing compromises a person's ability to live a stable and healthy life in the community and close to family and supportive networks, and *it renders treatment dollars ineffective*. Further, complexities, such as legal problems or complex medical needs compromise or negate the ability of some to use housing programs (such as Section 8) that may be available to others. Supportive housing is designed and funded for exactly this population: those individuals with mental illness whose care is considered the most serious and complex. Yet investments made for supportive housing and associated services are minimal.

3. Inefficient use of scarce, precious resources.

Maintaining a discharge ready list has a fiscal impact on Virginia. *The Review of the Barriers to Discharge in the State-Operated Adult Behavioral Health Facilities* states that the average annual cost of serving an individual in a state-operated facility is $214,000 while a conservative estimate for serving the people on the discharge ready list in the community is approximately $44,000 per year. It is estimated that Virginia could annually save approximately $170,000 (per person) if it served this cohort in the community rather than continuing to serve them in state facilities. The report goes on to state that there are at least 70 individuals who could reside in the community with appropriate community housing and this alone would save almost $12,000,000 annually in exchange for an estimated upfront expense of just over $3,000,000.

4. **Need for permanent funding.**

Without adequate and permanent funding, supportive housing and intensive services will not be available. Again, *The Review of the Barriers to Discharge in the State-Operated Adult Behavioral Health Facilities* states that the average annual cost of serving an individual in a state-operated facility is $214,000. A person who is ready to be discharged could be served in the community, in an appropriate setting, if permanent funding is available. It is prudent and sound public policy, as well as cost effective, to fund services that are supportive and proactive in nature and are proven to prevent mental health crises and lessen the need for unnecessary hospital admissions. These services include crisis stabilization, mobile crisis teams, supportive housing, and outpatient services such as counseling, psychiatry, support groups, and medication management.

5. **Challenges with Virginia's forensic process.**

Virginia's complex and often inefficient processes can create extreme barriers for many individuals in the various forensic categories (i.e. Not Guilty By Reason of Insanity; those in jails with mental illness; those awaiting competency restoration, etc). Procedural and resource barriers range from deficiencies in the competency evaluation process, to jail-based/mental health population challenges, to problems with restoration of competency "continuum", to complex processes for NGRI patients, including many other areas affecting the forensic population. These challenges must be identified and made part of the public policy discourse and decision-making process.

Recommendations

In general, we support the Inspector General's recommendations from all three reports particularly the following:

1. Expand funding for Discharge Assistance Projects that help individuals transition to the community, facilitating access to entitled federal benefits that can support community-based services.

2. Make funds available from the $7,000,000 housing trust fund recently appropriated by the General Assembly and use these funds to serve people in state-operated facilities with unmet community housing needs and homeless individuals at risk of institutionalization.

3. DBHDS should work with CSBs to assure that housing needs are considered a priority in the use of unexpended state balances by CSBs---especially in regions with large numbers of individuals on the Extraordinary Barriers List (EBL).

4. DBHDS should identify "unexecuted TDO" as a Quality Indicator of access to clinically appropriate services and develop a mechanism that allows for consistent tracking of such incidents at the Board and regional level.

5. DBHDS should identify "TDO executed beyond 6 hours" as a Quality Indicator for the timely execution of TDOs, and develop a mechanism that allows for consistent tracking of such incidents at the Board and regional level.

In addition to actions recommended by the IG, there are other actions which the Commonwealth should undertake to address the problems identified by the IG. These actions include:

1. Make an additional 20% of the funds available from the Housing Trust Fund recently appropriated by the General Assembly for permanent supportive housing – rental assistance and supportive service funds specifically – to serve people in state-operated facilities with unmet community housing needs and homeless individuals at risk of institutionalization. The current language indicates use of up to 20% of funds aimed at grants for rental assistance and supportive services – key components of permanent supportive housing.

2. Develop recommendations for addressing service gaps and service needs to facilitate the transition of individuals on the Extraordinary Barriers List (EBL) from state hospitals and other mental health facilities to community settings

3. Determine the cost of addressing service gaps and service needs and the potential savings to the Commonwealth resulting from the transition of individuals Extraordinary Barriers List (EBL) from state hospitals to community-based services.

4. Examine the current practices, best practices, and impediments to practices (i.e. resource needs, policy changes, etc.) related to the forensic population to develop recommendations that could have a positive impact on discharge barriers to this population, while maintaining family and community safety.

5. Ensure that DBHDS assumes responsibility for state psychiatric hospitals as the ultimate "safety net" provider for persons under a Temporary Detention Order.

6. Explore opportunities for developing a tiered TDO-rate system to create capacity in the private sector for persons under a TDO.

Again, thank you very much for the opportunity to comment. As families and people who have personal experience with mental illness and first-hand knowledge of the mental health system, we stand ready to assist you in whatever way may be helpful.

Sincerely,

Mira Signer
Executive Director

Virginia Association Of Community Services Boards, Inc.

Making a Difference Together

Comments of the Virginia Association of Community Services Boards (VACSB) to the Joint Commission on Health Care (JCHC) Regarding Office of the Inspector General (OIG) Reports:

- Unexecuted TDOs,
- DBHDS Forensic Services,
- Extraordinary Barriers to Discharge in state psychiatric facilities.

The VACSB produced a discrete response to the OIG report on extraordinary barriers to discharge (EBL), which is included in these comments. It is safe to say that these three reports, while separate and distinct reports on critical issues, all build upon the glaring need for a more adequate and thoughtful continuum of care for individuals who experience psychiatric crises as well as those who have long term treatment needs that, unattended, contribute to additional psychiatric crises in their communities.

Unexecuted TDOs

The VACSB appreciates the work of the Office of the Inspector General in investigating unexecuted TDOs and the issues encountered in this process. As well, the VACSB appreciates the recognition of the OIG that, as first responders, CSB/BHA Emergency Services clinicians are highly dedicated to serving consumers needing assistance.

For a number of years, the VACSB has published Public Policy Priorities that include recognition of continuum of care issues as well as, more specifically, the need to develop, in willing private facilities in each region of the Commonwealth, psychiatric beds that are able to accept individuals in crisis whose acuity and complexity preclude their admission to most private facilities.

At this time, a "willing facility" that accepts a TDO bills DMAS, the agency that currently administers the Supreme Court fund for temporary detention placements. The per diem rate may be adequate for many individuals in need of the TDO stabilization, evaluation, and treatment mandated by the Code of Virginia. However, when more acute and complex factors present with a person in crisis, addressing the needs of such individuals are beyond what most private facilities can accept.

One of the solutions proposed for years by the VACSB is to develop a mechanism for **tiered rates** that will provide private facilities who wish to increase staffing capability and treatment capability with the means to do so and, thus, be able to accept those individuals whose needs exceed the capabilities of most private facilities.

In the big picture, the numbers of individuals with unexecuted TDOs is small but the time and resources spent in attempting to find a needed bed are significant. Even with time and resources expended, a bed is often not available, as reflected in the OIG Report. For this reason, the VACSB believes that CSB Regional Projects should be directed to explore such a

mechanism with a few select facilities in their areas-not every private facility in the Commonwealth. **What this solution needs is additional funding and careful planning to empower selected private facilities to assist in addressing the acute and complex needs of individuals in crisis,** as designated by CSB Emergency Services clinicians.

Once the tiered rate is developed and private facilities have contracted with the CSB Regional Projects, **additional funding for Local Inpatient Purchase of Services (LIPOS) must be made available**.

Another funding solution that holds great potential is to increase the funding for existing Crisis Stabilization Units to be able to:

- Develop services that can address the acute/complex needs of such individuals so that they can accept such TDOs
- Develop medical detoxification for those who are under the influence of substances who also need TDOs.

In summary, **strategies that will provide for a more adequate crisis response and continuum of care in the community** to address this specific issue are:

- Tiered rates paid to selected private facilities willing to increase staffing and expertise in order to address high levels of acuity and complexity within psychiatric crises;
- Additional LIPOS funds for each Regional Projects/CSBs to be able to purchase those specialized beds;
- Additional funding for existing or new Crisis Stabilization Units so that they can accept TDOs and provide for Medical Detox.

DBHDS Forensic Services

The issues presented in this report and the strategies recommended will assist in both delivering more recovery-focused services within DBHDS facilities to those individuals who have been adjudicated NGRI and using outpatient competency restoration to increase the rapidity of an individual's time in jail. Unfortunately, not every strategy can be controlled or facilitated by DBHDS.

Strategies that DBHDS and CSBs can use consist of:

- Delivering person-centered, recovery-focused services for individuals considered NGRI, which can be inferred does take place now since 27% of those on the Extraordinary Barriers to Discharge list are in the NGRI process, meaning that they have a clinical readiness for discharge if the forensic process allows and if the services in the community are able to be developed,
- Provide training and information for attorneys who represent individuals who experience mental illness so that they are able to advise their clients of the likely results of an NGRI plea with regards to treatment and time spent in a facility.

However, the NGRI process itself is controlled through forensic review and, for the most part, decisions are removed from DBHDS and CSBs regarding risk assessment and release.

The VACSB May 2012 response to the OIG report on Extraordinary Barriers to Discharge, which follows, provides some direction that the Joint Commission may wish to explore, particularly with regards to streamlining the NGRI process and assuring more adequate crisis response and continuity of care.

Extraordinary Barriers to Discharge from State Psychiatric Facilities (written in May, 2012)

As the most recent Report of the BHDS Office of the Inspector General is issued, the VACSB and our member CSBs and BHA want to express our appreciation for the work that Office has done. Mr. Bevelacqua has produced reports that help to identify persistent problems for

individuals with mental illness, substance use disorders, and developmental disabilities regardless of the venue in which they may present for services.

For this most recent Report, the Inspector General has collected data from state hospitals and from CSB/BHA regional partnerships that demonstrates significant problems with regards to the status of individuals with serious mental illness (SMI) and other complex conditions who reside in state psychiatric facilities because of extraordinary barriers to their living in the community. This information, collected and analyzed, cries out for sustainable solutions—solutions that are contained within the wealth of data collected in the report.

Three specific factors emerge clearly:

- Approximately 27% of the individuals on the Extraordinary Barriers List (EBL) are in a legal process over seen by the courts. They have been judged "Not Guilty by Reason of Insanity" (NGRI). Once in that legal process, which has the further effect of fostering a conservative clinical approach, the timing for conditional release to the community is governed by statute, review and court processes. Given the need to provide continual assurance regarding community safety, the NGRI Forensic Review process can add considerable delay to the discharge of an individual to the community, even when clinically appropriate and a treatment plan is approved and ready. It is our hope that the OIG, in conjunction with DBHDS and other agencies/entities, will examine that process and develop legislative and administrative recommendations that could de-emphasize the lengthy court and review process and add flexibility to the process when it is clinically appropriate to do so.
- Specialized and supportive housing is the most critical barrier to discharge to the community for the majority of the individuals on the EBL list. The medical, behavioral, and legal issues that many individuals have in their backgrounds negate their ability to utilize the housing programs that may be available for other individuals with intensive needs. Specialized and highly supportive housing arrangements need to be designed and funded for those individuals and these housing arrangements must be combined with intensive, recovery-focused community supports.
- The third major factor deduced from the data in this report is the funding issue. Without adequate and permanent funding, specialized housing arrangements and intensive service will not be available initially or on a consistent basis. It is important to remember that, according to the OIG report, state hospital annual cost averages approximately $200,000 per year per bed. Most individuals on the EBL can be served for less than this cost per year in an appropriate community setting, if permanent funds are made available. These funds, which are known as Discharge Assistance Plan (DAP) funds, have been appropriated to CSBs in the past to assist in both downsizing facilities and assisting with discharges to the community of individuals with complex needs.

To place the numbers in this Report in context, it is worthy of note that CSBs support over 42,000 individuals with Serious Mental Illness (SMI) and other complex conditions in the community each year. What works in supporting these individuals is a combination of medical and behavioral services, housing, and intensive community supports; however, there are approximately 11,000 individuals in the community now who need more stable housing arrangements. In addition to those on the EBL already in facilities, supportive housing is very much needed for those individuals who may be at high risk of state facility hospitalization or incarceration.

The Office of the Inspector General has identified an average of 165 individuals on the EBL who need even more specialized support to be discharged to communities. Between these

individuals and the numbers of individuals in the community now who need more adequate housing and intensive services, the need for additional funding for such purposes is startlingly clear. The VACSB and our partner advocates have consistently informed elected and appointed leaders of the existing community need. Now the Inspector General has highlighted the need for the specialized housing and services in the community to implement adequate transfers from facilities.

In summary, solutions for the EBL involve:

- A **comprehensive examination of the NGRI/forensic process** and an assessment of how it can be streamlined followed by policy and administrative action to streamline;
- **Specialized and intensive housing arrangements** that serve individuals with extraordinary needs; and
- Adequate **permanent** funding to design and implement the housing arrangements in combination with intensive community services and supports. This is most often referred to as DAP funding.

The Inspector General has provided the alert needed for Virginia's elected and appointed leaders to respond. The VACSB/CSBs applaud that alert and stand ready to assist with the identified solutions to this problem that cuts across major systems in Virginia. But, in addition, our leaders should heed the data available in communities now which demonstrate existing community need that, if unaddressed, will increase the pressure on state or private psychiatric facilities for the most expensive service alternative and/or on jails for the least desirable service alternative.

Each report of the Office of the Inspector General sheds new light on the myriad needs of individuals with severe and persistent disabilities, needs that will be addressed either through efficient and effective person-centered community services or expensive alternatives that do not have the impact of fostering recovery and self-management. Regardless from which budget line the funding comes, the dollars will be spent. **Why not deliver services and expend resources in the most effective way?**

Strategy Summary:

- Tiered rates for select private facilities to develop enhanced capability to stabilize, evaluate and treat individuals in crisis with highly acute and complex needs;
- Additional LIPOS funding for Regional Projects to divert individuals to private facilities for TDO and other short term psychiatric hospital care;
- Additional funding for Crisis Stabilization Units (CSUs) to accept TDOs and deliver Medical Detox;
- Review the current NGRI and forensic review process and streamline wherever possible;
- Provide DAP funding for permanent, supportive housing for individuals on the ELB but funding also for those individuals in the community most at risk of hospitalization for lack of an adequate continuum of care in their communities.

Thank you for the opportunity to comment.

For additional information, please contact:
Mary Ann Bergeron, mabergeron@vacsb.org
VACSB-www.vacsb.org
804.330.3141

Comments from Community Services Boards

Rita M. Romano
Emergency Services Division Manager
Prince William County Community Services

I am the ES Division Manager for Prince William County. I understand that we are to send to you updates in procedural changes that we have implemented since the OIGs study of TDOs. One change that has been helpful is that our Chief Magistrate has been willing to have the magistrates in our area issue a TDO pending medical clearance. This has given law enforcement the legal authority to continue to hold an individual beyond the 6 hours allowed with an ECO. We ask for a TDO pending medical clearance when we think that it is likely that a person would medically clear or be found medically appropriate for the facility identified. If it turns out that the person is not found medically appropriate for the facility identified the magistrate is willing to change the facility identified. This has resulted in fewer people being released because law enforcement cannot hold them beyond the 6 hours allowed for an ECO. However, it does tie up law enforcement for longer periods of time.

Donna K. Mauck, LCSW, CSAC
Emergency Services Manager
Rockbridge Area Community Services

The challenge for our rural catchment area is that four hours plus the two hour extension is not adequate in most cases for securing a hospital psychiatric admission. The private sector hospitals, including the state psychiatric hospitals all require a full medical clearance from the local Emergency Room prior to someone being presented to them for admission. If staff are lucky enough to find a facility that will take the information, then it becomes a waiting game for the information to be faxed to them and a doctor paged that will review for admission. This process is slowed depending on acuity at each hospital and the time of day or night that they are contacted. Sometimes we wait upwards of three hours just for a call back regarding admission. This is further complicated when we finally get the call back and they state they have to have more testing done before they can accept a person for admission. The four to six hours are really eaten away by the time it takes to find a willing facility for acceptance. The state sets the time frames we have to abide by but the state cannot mandate whether or not a private facility will accept our clients for admission. Emergency Services personnel are often at the hospital ER's all night trying to find bed placements. It is not until after calling at least fourteen hospitals and getting turn downs that we can call our state hospital for admission (our mutual HPR I efforts to maintain appropriate referrals to WSH). The four to six hours is a barrier to TDO admissions. Also our CSB does not have a psychiatric hospital nor a crisis stabilization program in our catchment area which is also a barrier for psychiatric treatment. All admissions must go out of the local area for treatment.

Region V CSB Emergency Services Managers Comments

Primary Barriers to obtaining TDO beds:

*medical instability or a disagreement between the referring/accepting physicians regarding medical stability
*a dual diagnosis of mental health and intellectual / developmental disability
* no accepting facility or no beds AND no available safety net bed at ESH.

Primary barriers to discharge

*****adequate, supervised housing
*lack of community based resources

One case example of difficulty obtaining the "safety net bed" in HPRV:

Consumer #1005010

This consumer has been open to the HNNCSB since 1993 with a diagnosis of Bipolar Disorder. He has had significant episodes of instability and multiple hospitalizations, most of which resulted from threats of assault/physical aggression and/or actual assault/physical aggression.

This consumer did well for approximately 7 years, between 2005 and early 2012, and did not require a higher level of care than the outpatient treatment he was receiving. In the fall of 2011, he stopped taking his medication, became quite psychotic and required hospitalization on a temporary detention order (TDO) on 1/20/12.

The following is a chronological description of events that followed:

1/23/12: consumer was dismissed from his hearing Riverside Behavioral Health Center
1/25/12: consumer was re-detained to Riverside Behavioral Health Center
1/27/12: consumer was involuntarily committed Riverside Behavioral Health Center
2/13/12: request from RBHC to present to Facilities Management Committee for a transfer to ESH on 2/15/12, however, the request was not made by the due date of 2/10/12 so declined
2/17/12: consumer was discharged from RBHC
2/19/12: consumer taken to local ER on an emergency custody order (ECO) after assaulting his mother

* found to meet TDO criteria but unable to locate a TDO bed... "no bed" or consumer "not appropriate"…"too acute"

* RBHC found consumer to be "too acute"

* With 2 hours left on the ECO (extended) the safety net bed was sought and approved via project director. However, there was a disagreement regarding the consumer's medical stability. The consumer's blood pressure was 184/102. The ER physician believed the consumer stable for transfer but ESH MD requesting the consumer's blood pressure "be addressed". The ECO time expired and the consumer left the ER. ESH MD accepted the consumer after his departure from the ER. The consumer was taken into custody a short time later in the community and transported to ESH.

2/21/12: commitment hearing at ESH resulted in an involuntary commitment to Maryview Behavioral
2/29/12: approved for a transfer to ESH by Facilities Management Committee
3/19/12: discharged from ESH

*The last time HNNCSB requested the safety net bed prior to this was in August 2009.

The Emergency Services departments in the region exhaust all feasible, legal treatment options, safety plans, and community based resources before pursuing the safety net bed.

COMMONWEALTH of VIRGINIA

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June 25, 2012

Kim Snead, Executive Director
Joint Commission on Health Care
P.O. Box 1322
Richmond, VA 23218

Re: Remarks to the Behavioral Health Subcommittee of the Joint Commission on Health Care on topics addressed in reports of the Inspector General

Dear Ms. Snead:

Thank you for the opportunity to provide comments on issues raised by recent reports of the Inspector General on several important elements of the mental health services system.

The Virginia Office for Protection and Advocacy (VOPA) is the federally designated protection and advocacy entity for the Commonwealth of Virginia. VOPA's legally based advocacy includes work under the Protection and Advocacy for Individuals with Mental Illness Act (42 U.S.C. § 10801, et seq.) on behalf of individuals receiving mental health services at state-operated facilities.

The Inspector General's reports address several issues that have been of concern to VOPA and our constituents for many years. VOPA agrees that Virginia's mental health facilities detain individuals long after any legal justification to do so. These delays in discharge violate individual civil rights. Virginia's reliance on institutional care and failure to develop community mental health services results in unnecessary institutionalization, as the Inspector General notes.

VOPA has long-standing concerns about the failure of the DBHDS to develop and implement appropriate discharge plans and about the failure to discharge individuals from the state hospitals in a timely manner, as well. We initiated an investigation of the discharge planning process beginning in 2003. What we found and reported in 2004 remains true today. In short, discharge planning is grossly inadequate in Virginia. It frequently does not begin in earnest until an individual is determined to be

ready for discharge rather than upon admission, as required. As a consequence, individuals remain in the custody of the state when they no longer meet commitment criteria, in violation of their Constitutionally protected rights.

Likewise, the discharge system places too great a reliance on assisted living facilities, rather than offering smaller, individualized housing options. The current auxiliary grant program forces individuals into a level of care and restrictive institutional setting that they do not need and which is not conducive to recovery. Virginia's reliance on this system may also violate the Americans with Disabilities Act.

VOPA agrees that Virginia has continued to focus on institutional mental health care while failing to develop community services. Virginia has, for example, invested huge sums of money in rebuilding Eastern State Hospital and Western State Hospital. Meanwhile, there has been no serious increase in investment in community services. Often, individuals in need of acute psychiatric services are driven around the state in handcuffs by law enforcement officers because services are not available in their communities.

VOPA also agrees that the DBHDS operated forensic system is not sufficiently recovery oriented and person centered. Consequently, NGRI acquittees remain institutionalized when they are no longer mentally ill and dangerous, in violation of their Constitutionally protected rights.

However, VOPA is concerned that the Inspector General's reports on barriers to discharge and on temporary detentions make no reference to having interviewed individuals who experienced the discharge process or who were the subjects of temporary detention orders. Individuals with mental illness, patients, former patients, and peer advocates should be involved in the process of review and forming recommendations for improvement of the mental health system. Every workgroup, oversight committee, or other body that considers issues relating to the provision of care for individuals with mental illness must include individuals who have experienced Virginia's mental health system.

Thank you again for the opportunity to provide comment on these important issues.

Sincerely,

V. Colleen Miller
Executive Director

Excerpts from Submitted Remarks

Virginia College of Emergency Physicians
National Alliance on Mental Illness – NAMI/Virginia
Virginia Association of Community Services Boards, Inc.
Comments from Several Community Services Boards
Virginia Office for Protection and Advocacy

Virginia College of Emergency Physicians (VACEP)

"The Virginia College of Emergency Physicians is deeply concerned about psychiatric patients who are forced to wait excessively to access the appropriate level of mental health services or worse, when emergency departments can no longer hold the patient after the ECO has run out and a TDO cannot be issued despite them still being deemed a danger to themselves or others."

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"VACEP appreciates the Joint Commission taking a deeper look at the OIG reports and looks forward to helping in any way we can to identify ways to ensure proper care for our most vulnerable citizens in a psychiatric crisis."

NAMI/Virginia

"Together, these reports call attention to numerous long-standing challenges that have plagued the mental health system, families, individuals, and communities for years…. The problems and the multiple and long-term effects articulated in the three reports cannot go unnoticed any longer. We strongly support the recommendations put forth by the Inspector General's office and believe wholeheartedly that, if enacted, they will truly make a difference."

"In addition to the recommendations in the OIG reports, NAMI/Virginia supports the following additional actions:

1. Make an additional 20% of the funds available from the Housing Trust Fund recently appropriated by the General Assembly for permanent supportive housing – rental assistance and supportive service funds specifically – to serve people in state-operated facilities with unmet community housing needs and homeless individuals at risk of institutionalization. The current language indicates use of up to 20% of funds aimed at grants for rental assistance and supportive services – key components of permanent supportive housing.
2. Develop recommendations for addressing service gaps and service needs to facilitate the transition of individuals on the Extraordinary Barriers List (EBL) from state hospitals and other mental health facilities to community settings

3. Determine the cost of addressing service gaps and service needs and the potential savings to the Commonwealth resulting from the transition of individuals Extraordinary Barriers List (EBL) from state hospitals to community-based services.
4. Examine the current practices, best practices, and impediments to practices (i.e. resource needs, policy changes, etc.) related to the forensic population to develop recommendations that could have a positive impact on discharge barriers to this population, while maintaining family and community safety.
5. Ensure that DBHDS assumes responsibility for state psychiatric hospitals as the ultimate "safety net" provider for persons under a Temporary Detention Order.
6. Explore opportunities for developing a tiered TDO-rate system to create capacity in the private sector for persons under a TDO."

Virginia Association of Community Services Boards (VACSB)

"It is safe to say that these three reports, while separate and distinct reports on critical issues, all build upon the glaring need for a more adequate and thoughtful continuum of care for individuals who experience psychiatric crises as well as those who have long term treatment needs that, unattended, contribute to additional psychiatric crises in their communities. "

Unexecuted TDOs

"For a number of years, the VACSB has published Public Policy Priorities that include recognition of continuum of care issues as well as, more specifically, the need to develop, in willing private facilities in each region of the Commonwealth, psychiatric beds that are able to accept individuals in crisis whose acuity and complexity preclude their admission to most private facilities."

"In summary, **strategies that will provide for a more adequate crisis response and continuum of care in the community** to address this specific issue are:

- Tiered rates paid to selected private facilities willing to increase staffing and expertise in order to address high levels of acuity and complexity within psychiatric crises;
- Additional LIPOS [local inpatient purchase of services] funds for each Regional Projects/CSBs to be able to purchase those specialized beds;
- Additional funding for existing or new Crisis Stabilization Units so that they can accept TDOs and provide for Medical Detox."

DBHDS Forensic Services

"Strategies that DBHDS and CSBs can use consist of:

- Delivering person-centered, recovery-focused services for individuals considered NGRI [not guilty by reason of insanity], which can be inferred does take place now since 27% of those on the Extraordinary Barriers to Discharge list are in the NGRI process, meaning that they have a clinical readiness for discharge if the forensic process allows and if the services in the community are able to be developed,

- Provide training and information for attorneys who represent individuals who experience mental illness so that they are able to advise their clients of the likely results of an NGRI plea with regards to treatment and time spent in a facility.

However, the NGRI process itself is controlled through forensic review and, for the most part, decisions are removed from DBHDS and CSBs regarding risk assessment and release."

Extraordinary Barriers to Discharge from State Psychiatric Facilities (written in May 2012)

"To place the numbers in this [OIG] Report in context, it is worthy of note that CSBs support over 42,000 individuals with Serious Mental Illness (SMI) and other complex conditions in the community each year….The Office of the Inspector General has identified an average of 165 individuals on the EBL [extraordinary barriers list] who need even more specialized support to be discharged to communities.... In summary, solutions for the EBL involve:

- A **comprehensive examination of the NGRI/forensic process** and an assessment of how it can be streamlined followed by policy and administrative action to streamline;
- **Specialized and intensive housing arrangements** that serve individuals with extraordinary needs; and
- Adequate **permanent** funding to design and implement the housing arrangements in combination with intensive community services and supports. This is most often referred to as DAP funding.

The Inspector General has provided the alert needed for Virginia's elected and appointed leaders to respond. The VACSB/CSBs applaud that alert and stand ready to assist with the identified solutions to this problem that cuts across major systems in Virginia. But, in addition, our leaders should heed the data available in communities now which demonstrate existing community need that, if unaddressed, will increase the pressure on state or private psychiatric facilities for the most expensive service alternative and/or on jails for the least desirable service alternative."

Comments from Three Community Services Boards

Rita M. Romano, Emergency Services Division Manager
Prince William County Community Services

"One change that has been helpful is that our Chief Magistrate has been willing to have the magistrates in our area issue a TDO pending medical clearance. This has given law enforcement the legal authority to continue to hold an individual beyond the 6 hours allowed with an ECO. We ask for a TDO pending medical clearance when we think that it is likely that a person would medically clear or be found medically appropriate for the facility identified. If it turns out that the person is not found medically appropriate for the facility identified the magistrate is willing to change the facility identified. This has resulted in fewer people being released because law enforcement cannot hold them beyond the 6 hours allowed for an ECO. However, it does tie up law enforcement for longer periods of time."

Donna K. Mauck, LCSW, CSAC, Emergency Services Manager
Rockbridge Area Community Services

"The challenge for our rural catchment area is that four hours plus the two hour extension is not adequate in most cases for securing a hospital psychiatric admission. The private sector hospitals, including the state psychiatric hospitals all require a full medical clearance from the local Emergency Room prior to someone being presented to them for admission. If staff are

lucky enough to find a facility that will take the information, then it becomes a waiting game for the information to be faxed to them and a doctor paged that will review for admission. This process is slowed depending on acuity at each hospital and the time of day or night that they are contacted. Sometimes we wait upwards of three hours just for a call back regarding admission. This is further complicated when we finally get the call back and they state they have to have more testing done before they can accept a person for admission. The four to six hours are really eaten away by the time it takes to find a willing facility for acceptance. The state sets the time frames we have to abide by but the state cannot mandate whether or not a private facility will accept our clients for admission. Emergency Services personnel are often at the hospital ER's all night trying to find bed placements. It is not until after calling at least fourteen hospitals and getting turn downs that we can call our state hospital for admission (our mutual HPR I efforts to maintain appropriate referrals to WSH). The four to six hours is a barrier to TDO admissions. Also our CSB does not have a psychiatric hospital nor a crisis stabilization program in our catchment area which is also a barrier for psychiatric treatment. All admissions must go out of the local area for treatment."

Region V CSB Emergency Services Managers Comments

"Primary Barriers to obtaining TDO beds:

*medical instability or a disagreement between the referring/accepting physicians regarding medical stability

*a dual diagnosis of mental health and intellectual / developmental disability

* no accepting facility or no beds AND no available safety net bed at ESH.

Primary barriers to discharge

*****adequate, supervised housing

*lack of community based resources

The Emergency Services departments in the region exhaust all feasible, legal treatment options, safety plans, and community based resources before pursuing the safety net bed."

Virginia Office for Protection and Advocacy (VOPA)

"The Inspector General's reports address several issues that have been of concern of VOPA and our constituents for many years. VOPA agrees that Virginia's mental health facilities detain individuals long after any legal justification to do so. These delays in discharge violate civil rights. Virginia's reliance on institutional care and failure to develop community mental health services results in unnecessary institutionalization, as the Inspector General notes.

VOPA has long-standing concerns about the failure of the DBHDS to develop and implement appropriate discharge plans and about the failure to discharge individuals from the state hospitals in a timely manner, as well….[T]he discharge planning process…frequently does not begin in earnest until an individual is determined to be ready for discharge rather than upon admission, as

required. As a consequence, individuals remain in the custody of the state when they no longer meet commitment criteria, in violation of their Constitutionally protected rights.

Likewise, the discharge system places too great a reliance on assisted living facilities, rather than offering smaller, individualized housing options….

VOPA agrees that Virginia has continued to focus on institutional mental health care while failing to develop community services. Virginia has, for example, invested huge sums of money in rebuilding Eastern State Hospital and Western State Hospital. Meanwhile, there has been no serious increase in investment in community services....Often, individuals in need of acute psychiatric services are driven around the state in handcuffs by law enforcement officers because services are not available in their communities.

VOPA also agrees that the DBHDS operated forensic system is not sufficiently recovery oriented and person oriented. Consequently, NGRI acquittees remain institutionalized when they are no longer mentally ill and dangerous, in violation of their Constitutionally protected rights.

However, VOPA is concerned that the Inspector General's reports on barriers to discharge and on temporary detentions make no reference to having interviewed individuals who experienced the discharge process or who were the subjects of temporary detention orders….Every workgroup, oversight committee, or other body that considers issues related to the provision of care for individuals with mental illness must include individuals who have experienced Virginia's mental health system."