Office of the Inspector General

Behavioral Health and Developmental Services

Presentation to the Joint Commission on Health Care
Behavioral Healthcare Subcommittee

June 28, 2012

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The Mission of the OIG

- The *Mission* of the OIG is to provide an independent system of accountability to the Governor, the Joint Commission on Health Care, and the citizens of the Commonwealth for the quality of services provided by the Department of Behavioral Health and Developmental Services (DBHDS) and other licensed providers of behavioral health and developmental services.
- This Mission is authorized by the *Code of Virginia* §§ 37.2-423, 37.2-424, & 37.2-425 that requires the Office to inspect, monitor, and review the quality of services in state facilities, and other licensed providers, and to make policy and operational recommendations in response to complaints of abuse, neglect or inadequate care.
- To support its *Mission*, the OIG periodically reports to the Governor, the General Assembly, and the Joint Commission on Health Care concerning significant problems, abuses, and deficiencies relating to the programs and services of state facilities and other licensed providers.

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Virginia's System of Behavioral Healthcare

- In FY 2011, through its 40 CSB/BHAs and 8 state-operated behavioral health facilities, the Commonwealth served citizens with behavioral health problems:
  - CSBs served 108,892 individuals.
  - State-operated facilities served 5,200 people.
  - As of December 31, 2011, there were 1,252 persons residing in the state-operated facilities.

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The Interdependence of the Community and Facility Systems

- There were 4,366 admissions (front door) & 4,421 separations (back door) from state facilities in FY2011. According to the VACSB, the state's CSB's support over 42,000 persons with serious mental illness (SMI).
- The constant movement of thousands of individuals from the community to the state facilities – and back to the community means that, if the community system, or the state facility system, exceeds its operating capacity, the entire system will be frozen or, at best, sluggish.
- This report found that the system's current bottleneck is an inadequate supply of DAP funding, along with insufficient community-based supported housing to receive people discharged from the state-operated facilities.

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The Recovery Model

- The recovery model of treatment affirms that people can recover from serious mental illness and it supports self-determination, empowerment, resilience, and the highest level of participation in all aspects of community life. [State Board Policy 1036]

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Recent OIG Reports

- *A review of Behavioral Health Forensic Services [Report No. 200-11]*
- *Review of Emergency Services: Individuals meeting statutory criteria for temporary detention not admitted to a psychiatric facility for further evaluation and treatment.* [Report No. 206-11]
- *Review of the Barriers to Discharge in State-Operated Adult Behavioral Health Facilities* [Report No. 207-12]

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Review of Forensic Services

- This focused review sought to answer the question, "Are forensic patients in state-operated facilities receiving services that reflect the DBHDS's commitment to the recovery model of treatment and to person-centeredness?"
- This review was deemed relevant because:
  - In FY 2010, 36% of the adult mental health utilization was attributed to individuals admitted under a forensic status;
  - The stigma sometimes attached to the forensic population;
  - NGRI residents are often in state facilities for five or six years, and there are significant challenges in providing recovery and person-centered services to these individuals.

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Forensic Code Provisions

- § 19.2-169.1 of the Code of Virginia authorizes the Department to conduct evaluations of the competency of defendants to stand trial on a criminal charge.
- § 19.2-169.2 of the Code of Virginia authorizes the Department to provide inpatient treatment of individuals found to be incompetent to stand trial who need restoration to competency.
- § 19.2-169.3 of the Code of Virginia authorizes the Department to provide treatment of individuals found to be unrestorably incompetent who have been involuntarily admitted pursuant §37.2-817.
- § 19.2-169.5 of the Code of Virginia authorizes the Department to conduct evaluation of a defendant's mental status at the time of the offense.
- § 19.2-169.6 of the Code of Virginia authorizes the Department to provide inpatient treatment for a criminal defendant transferred from a jail to a hospital if the defendant is found to be mentally ill and imminently dangerous to himself or others.

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Additional Forensic Code Provisions

- § 19.2-176 of the Code of Virginia authorizes the Department to evaluate and provide emergency treatment to a person who has been convicted or has pled guilty to a crime and is being held in jail to await sentencing.
- § 19.2-177.1 of the Code of Virginia authorizes the Department to provide inpatient treatment of a jail inmate who has been sentenced, is in a local or regional jail, and has been found to be mentally ill and imminently dangerous to themselves or others.
- § 19.2-182.2 of the Code of Virginia authorizes the Department to conduct evaluations of individuals found not guilty by reason of insanity to determine whether they should be kept in the hospital for further treatment, placed on conditional release in the community, or released to the community without conditions.
- § 19.2-182.3 of the Code of Virginia authorizes the Department to provide inpatient treatment to individuals found to be not guilty by reason of insanity and committed by the court.

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Forensic Review Findings

- Persons admitted to DBHDS facilities pursuant to the forensic statutes are receiving person-centered services driven by the facility and program leadership.
- However, services vary considerably and it was recommended that the DBHDS take a leadership role in standardizing the process of identifying emerging and best practices at its facilities.
- Some individuals admitted under NGRI statutes do not understand the extent and duration of an NGRI plea, while some patients may have received misinformation from their attorney.
- It was recommended that DBHDS work with CSB leadership to promote a better understanding of the conditional release process to individuals served and to their attorneys.

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The State Facilities' Front Door: Failed TDO Report

The criteria for a Temporary Detention Order (TDO) are spelled-out by § 37.2-809 *Code of Virginia* and include:

- "A substantial likelihood…in the near future" that a person is at risk for "serious harm to himself or others…lacks capacity to protect himself [and is] in need of hospitalization or treatment."

- This Report was issued in February, 2012 and summarized the results of a three-month study including:
  - 72 persons meeting criteria for temporary detention (TDO) were denied the level of care deemed clinically appropriate because no state facility, or private psychiatric facility, would admit these individuals. There were between 4,500 and 5,000 TDOs successfully executed during this three-month study;
  - The study also found that 273 persons received TDO's after the 6-hour Code imposed time limit for converting an ECO into a TDO;

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Additional Findings and Recommendations: Failed TDO Report

- Hampton Roads and Southwest Virginia accounted for 75% of the failed TDOs and the state behavioral health facilities in these two regions were routinely at capacity and unable to provide safety net psychiatric beds for individuals needing temporary detention and further evaluation;
- In southwest Virginia, 36% of SWVMHI long-term residents were originally Tennessee residents, and the facility's LOS has inexplicably increased from 40 to 57 days – effectively reducing the region's acute treatment capacity by over 40%;
- Hospital emergency department directors and CSB emergency services directors around the state agreed that the standards for medical screening and assessment need to be standardized and updated;
- The system sometimes discriminates against the people who are the most challenging to serve by limiting whom they will serve based on age, gender, psychiatric profile, history of assaultive behaviors, suicidal ideation, substance use, security concerns, medical complications, hours of operation, self-care ability, and psychiatric support staff availability;

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Failed TDO Report (Continued)

- Accountability for emergency services is fragmented and the OIG recommended that a senior level manager from each region, along with a senior staff member from the DBHDS, be designated and empowered to locate a private psychiatric hospital or state-operated facility to admit individuals meeting TDO criteria when prescreeners were unable to locate a "willing" facility with an "appropriate bed";
- OIG Recommended increasing regional accountability, standardizing medical screening and assessment guidelines, considering the creation of "intensive psychiatric beds" with private psychiatric hospitals, and further evaluation of the unique issues in Hampton Roads and Southwest Virginia.

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The State Facilities' Back Door: Extraordinary Barriers to Discharge Report

- This Report summarized the results of a six-month study and found:
  - That an average of 165 individuals, or 13% of the 2011 facility census, who were deemed clinically ready for discharge could not be discharged because of "extraordinary barriers to discharge;"
  - At the conclusion of this study, in December 2011, these 165 individuals had been on the discharge ready list for roughly eight months;
  - The most often cited barrier to discharge from state facilities was the lack of community-based supported housing.

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Housing: Not a new problem for Virginia's mentally ill

- …The shortage of affordable housing and accompanying support services causes people with serious mental illness to cycle among jails, institutions, shelters, and the streets; to remain unnecessarily in institutions; or to live in seriously substandard housing." (The Federal *New Freedom Commission Report*, 2003)
- "The evidence we have reviewed suggests that the primary barrier to discharge for persons with mental illness is the failure, by treatment teams, to identify appropriate community placements." (VOPA letter to Commission Reinhart containing Preliminary Findings of Discharge Planning Investigation, December 2004)
- "There are a significant number of individuals who are currently in state facilities who cannot be discharged due solely to a lack of community housing." (*Staff Report: Housing for the Mentally Ill*, JCHC, October 26, 2007)

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Recent Activities by the U. S. Department of Justice

- The review found that, based on DOJ's 2011 findings in the State of New Hampshire, Virginia is at risk for a similar finding of non-compliance with the relevant aspects of the *Americans with Disabilities Act* as interpreted by the *Olmstead* decision;
- The behavioral health systems in Virginia and New Hampshire are similar in the following important respects:
  - The lack of community based housing is a barrier to discharge from state-operated facilities;
  - The failure to develop sufficient community services is a barrier to discharge for individuals who could be served in a more integrated community setting;
  - The lack of community housing places disabled persons with mental illness at risk for unnecessary institutionalization;
  - Both New Hampshire and Virginia continue to fund more expensive institutional care when less expensive and therapeutically effective community-based care could be developed.

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Fiscal Impact:
The cost of community care vs. facility care

- The average annual cost of serving a person in a state operated facility is $214,000;
- The average annual cost of serving a person in the community is conservatively estimated at $44,000;
- The difference of $170,000/year for serving people in the community vs. the state facilities for 165 individuals exceeds $28 million per year.
- However, in order to realize these hypothetical savings, state-operated facilities would have to reduce their operating cost structure.

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Impact on Safety Net Admissions

- The Failed TDO study confirmed that 54 people were denied admission to state-operated facilities in Hampton Roads and Southwest Virginia during the same time that ESH and SWVMHI had 51 and 8 beds, respectively, occupied by individuals deemed discharge ready and waiting for a community placement.

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Safety Net Services

- It could be plausibly argued that, if community services – including supported housing – had been available in Hampton Roads and Southwest Virginia, ESH and SWVMHI could have admitted many of the 54 persons meeting TDO criteria who were denied admission and referred to less intensive services than had been determined to be clinically necessary.

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Additional Findings and Recommendations

- The Commonwealth does not offer community services and supports in sufficient quantities to serve all Virginians;
- An average of 165 adults remained institutionalized for roughly eight months during this study;
- It was recommended that DBHDS publish a quarterly summary of individuals on the EBL;
- That DBHDS identify the housing requirements of each region to curtail the extraordinary barriers list;
- That DBHDS evaluate best practices at all state hospitals and replicate the most effective that have produced measurably superior discharge outcomes;
- That DBHDS seek to expand funding for discharge assistance to help individuals transition back to the community.

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Barriers Report: Epilogue

- "Extraordinary Barriers" is a term coined to indicate that a person has been discharge-ready for thirty days.
  - The barrier identified in the OIG's study for the adult civil cohort (87/165 – 53%) was DAP funding – conspicuously lacking in "extraordinary" characteristics;
  - Future EBLs should clearly distinguish between individuals with complex legal and medical issues (like many in the geriatric and forensic cohorts) from persons whose only real barrier to discharge is the money to fund an ISP with an average cost between $25,000 to $40,000 per person/per year.
  - Future EBLs should also distinguish those persons who require services that do not currently exist in their catchment or those whose release poises a public safety hazard.

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DAP Funding: Next Steps

- FY 2012 DAP Funding:
  - Direct to CSBs 11,345,347
  - Regional Funding 7,586,582
- Almost $19 million in annual statewide DAP funding warrants further review to understand the formula for allocating local and regional funds and the effectiveness of the DAP funds provided to the individual CSBs and their regional access committees.

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Conclusion

- In 1976 Virginia mental health hospitals served 5,967 persons. If the level of acuity and chronicity remained constant, while the population increased by 37% in the last thirty-five years, the Commonwealth would need 8,175 beds to serve this cohort.
- At the end of 2011, the census in state facilities was 1,252.
- Statewide, there are about 7,000 persons living in our communities today who, for the purposes of this thought experiment, in 1976 would have been residents of state hospitals.
- How many community-based supported housing slots have been created since 1976 to serve the almost 7,000 individuals who would have resided in the state-operated facilities under the mental health treatment paradigm of an earlier day?

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Conclusion

- While Virginia has made historic progress towards creating a true community-based system of care, the project will remain incomplete until our focus and funding on the creation of community services truly matches our rhetoric.

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