Behavioral Health Care Subcommittee

Joint Commission on Health Care

Discussion of Mental Health Recommendations Related to the Virginia Tech Tragedy

Kim Snead and Jaime Hoyle
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Background

- In the wake of the tragedy at Virginia Tech (VT) on April 16, 2007, two workgroups were convened to review the events, understand what went wrong, and make recommendations for improvement and prevention:
  - Virginia Tech Review Panel
  - Virginia Tech Internal Review
- The Supreme Court's Commission on Mental Health Law Reform, convened prior to the tragedy, will issue a preliminary report on civil commitment this winter.
- In addition the House Health, Welfare and Institutions Committee and the House Courts of Justice Committee met to hear presentations and study findings.

Information Sharing Between and Within Educational Entities

Information that Could Have Served as Warning Signs Was Not Shared

- Information was not sent by the school division to Virginia Tech; contributing factors include privacy issues and long-standing protocol.
  - Students entering colleges/universities are required to present immunization records but records related to mental health issues are not required.
- Within VT officials did not communicate effectively with each other or with Cho's family in part due to fear of violating privacy laws.

Related Findings & Recommendations of VT Internal Review

- The Interface Group review (an internal review undertaken as requested by the President of Virginia Tech) examined how to identify and support at-risk students. Recommendations included:
  - Refining and Expanding the CARE Team, a key SA group that responds to at-risk students, by including the Virginia Tech Police Department;
  - Creating a Threat Assessment Team to examine the most distressed students that would be empowered to act quickly;
  - Expanding Case Management Capacity to improve follow-up with students and to improve information flow about students at-risk; and
  - Improving communication between campus agencies, with particular focus on privacy law education.

POTENTIAL ACTIONS

- Examine Virginia's health privacy laws related to mental health records to determine if changes are warranted:
  - What sharing of mental health information between secondary schools and institutions of higher education is allowed?
  - What sharing of mental health information within an educational institution is allowed?

Intervention Opportunities and Community Resources

Access to Mental Health Care Is Limited

- Numerous studies and reports have indicated that Virginia's mental health system lacks needed community-based services.
  - The Access Task Force Report of the Commission on Mental Health Law Reform (subsequently referred to as the MHLR Commission) listed 13 major study initiatives completed between 1949 and 2000 which found significant deficiencies in available community resources.

Access to Mental Health Care Is Limited

- *Grading the States: A Report on America's Health Care System for Serious Mental Illness*, completed in 2006 by the National Alliance on Mental Illness (NAMI) gave Virginia an overall grade of D (and D+ for services and recovery supports)
  - NAMI report indicated that the proposed increase in funding and the adoption of more recovery-based policies were positive steps.
  - However, the report also noted:

"Beneath the excitement and hope…lies the reality that Virginia's public system has suffered from years of deep cuts that fell disproportionately on the community system."

Access to Mental Health Care Is Limited

- The Inspector General in examining emergency services provided by community services boards (CSBs) last year reported:

"The majority of Virginia's CSBs do not provide a comprehensive range of crisis intervention services for those with mental illness and substance abuse disorders. Almost all CSBs offer the least restrictive Crisis Response, Resolution, and Referral Services and most restrictive Inpatient Hospital Services, but very few offer the critical mid-range Community Crisis Stabilization Programs that effectively stabilize difficult crisis situations in the community….Non-Emergency Support and Clinical Services provided in the community (PACT, residential, medication, etc.) do not have adequate capacity. As a result, ESPs [emergency services programs] deal with crisis situations that could have been prevented if the consumer had received more intensive or a different array of services."

Access to Mental Health Care Is Limited

- The 2006 review of MH Case Management by the Inspector General found for CSBs:
  - "Average caseload in VA was 39 compared to nationally recommended caseload of 25.
  - Caseloads ranged from 20 to 71.5
  - 92.5% of CSBs had average caseloads that exceeded 25
  - CSBs estimate that approximately 230 additional case managers are needed"

Access to Mental Health Care Is Limited

- Workforce issues impact the availability of mental health services.
- The JLARC study *Availability and Cost of Licensed Psychiatric Services in Virginia* reported:
  - 47 VA localities have no psychiatrists practicing
  - 87 VA localities have no child psychiatrists practicing
  - "Medicaid rates for professional psychiatric services have generally been flat for over last 6 years…[and] may contribute to shortage of psychiatrists"
    - Higher rates are "paid by Medicare and other insurers"

New Initiatives to Address MH Workforce Needs Funded and Proposed

- Funding of $493,000 for 8 fellowship/internship positions in child psychology or psychiatry was included in FY 2008 budget:
  - VCU's VA Treatment Center for Children has agreed to train 2 child psychiatry fellows and 2 child psychology interns
  - Eastern VA Medical School has agreed to train 1 child psychologist intern.

Access to Mental Health Care Is Limited

- JLARC *Psychiatric Services* study reported that 2,467 psychiatric beds have closed since 1991
  - According to the JLARC study, licensed hospitals reported (for calendar year 2005) "under-reimbursement from commercial insurance" of:
    - $7 million for inpatient care
    - $16 million for emergency department care
- The Medicaid rate for psychiatric services was cited by hospitals as a source of concern in the JLARC *Psychiatric Services* study also:
  - "Unlike almost all medical services, per diem rate is used for psychiatric services [;] Licensed hospitals are paid for less than cost
    - Operating 84% of average daily cost
    - Capital 80% of cost"

POTENTIAL ACTIONS

- With regard to Medicaid reimbursement, JLARC recommended:
  - "The General Assembly may wish to direct DMAS to study the use of weighted per diem rates and outlier payments for inpatient acute care psychiatric services"
- Upon request, DMAS has undertaken a rate study related to Medicaid rates for mental health services; the study which will include observations not recommendations has not been finalized
  - Study participant reported findings that ½ of rates have not changed since 1990 and that rates would have doubled if they had been adjusted for inflation over that time period.
  - Any relevant observations that lead to legislative options could be included in the Decision Matrix (if released in time)
- Review any health-related workforce initiatives that are funded to ensure that mental health professionals are included where appropriate:
  - In any budget amendments – add or designate funding or add language to allow initiatives to address the need for mental health professionals too.

Involuntary Commitment Process

Involuntary Commitment Process:
Emergency Custody Orders (*Code of VA* § 37.2-808)

- **ECOs are issued by magistrate who has probable cause to believe that the person:**
  - Has mental illness; and
  - Is in need of hospitalization or treatment; and
  - Is unwilling to volunteer or incapable of volunteering for hospitalization or treatment; and
  - Presents an imminent danger to himself or others as a result of mental illness or is so seriously mentally ill as to be substantially unable to care for himself. volunteering or unwilling to volunteer for treatment.
- Requires primary law enforcement agency from jurisdiction served by the evaluating CSB/BHA to execute the order, take person into custody and provide transportation to a convenient location for an evaluation.
  - Does not preclude law enforcement from obtaining emergency medical treatment or further medical evaluation at any time for person in his custody.
  - CSB/BHA is responsible for conducting or arranging for ECO evaluation
  - Person subject to ECO is held until a TDO is issued or until released, but period of custody cannot exceed 4 hours.

Involuntary Commitment Process:
Temporary Detention Orders (*Code of VA* § 37.2-809)

- TDO may be issued without a prior ECO upon the sworn petition of a responsible person or by a magistrate
- Once the TDO has been approved, *Code of VA* § 37.2-809.G requires a hearing to be held within 48 hours unless the expiration occurs on a weekend or legal holiday. (The hearing would then be held the next day that was not a weekend or legal holiday.)
  - This timeframe has been criticized as being too short to allow for a thorough assessment of the individual; the MHLR Commission is specifically examining the timeframe.
    - Any increase in the timeframe would have a fiscal impact as State funding for the hospital services is provided for individuals who do not have health insurance.

Involuntary Commitment Process

- VT Review Panel found that there was little interaction or sharing of information by the hospital staff with the independent evaluator. The Panel recommended to:
  - Clarify the role and responsibilities of the independent evaluator in the commitment process
  - Clarify the steps required to assure that the necessary reports and collateral information are assembled before the independent evaluator conducts the evaluation
  - Include the following documents so they can be presented at the commitment hearing:
    - The complete evaluation of the treating physician, including collateral information; reports of any lab and toxicology tests; reports of prior psychiatric history; and all admission forms and nurse's notes.

Disclosure of Mental Health Records

- In addition, the VT Review Panel recommended amending the Virginia Health Records Privacy Act to:
  - Provide a safe harbor provision which would protect health entities and providers from liability or loss of funding when they disclose information in connection with evaluations and commitment hearings.
  - Ensure all entities involved with treatment have full authority to share records with each other and all persons involved in the involuntary commitment process, while providing the legal safeguards needed to prevent unwarranted breaches of confidentiality.
  - Expressly authorize treatment providers to report non-compliance with involuntary outpatient orders.
- The Commission on Mental Health Reform is reviewing the question of whether the involuntary commitment process is a health-related or judicial proceeding which would affect privacy questions.

Involuntary Commitment Process

- Virginia's involuntary commitment standard is one of the most restrictive in the nation; *Code of VA* § 37.2-817.B requires the judge or special justice to find:

  "by clear and convincing evidence that **(i) the person presents an imminent danger to himself or others as a result of mental illness or has been proven to be so seriously mentally ill as to be substantially unable to care for himself and (ii) alternatives to involuntary inpatient treatment have been investigated and deemed unsuitable** and there is no less restrictive alternative to involuntary inpatient treatment, the judge or special justice shall by written order and specific findings so certify and order that the person be admitted involuntarily to a facility for a period of treatment not to exceed 180 days from the date of the court order."

Involuntary Commitment Process

- The VT Review Panel recommended modifying the criteria for involuntary commitment to promote more consistent application of the standard and to allow involuntary treatment in a broader range of cases involving severe mental illness.
- The Task Force on Commitment (of MHLR Commission) is examining Virginia's involuntary commitment standard to offer options for the Reform Commission's consideration.

Involuntary Commitment Process

- Four preliminary proposals were developed and presented in August as no consensus had been reached by the Commitment Task Force members at that time.
  - Proposal 1 would not change commitment criteria.
  - Proposal 2 would only change the criteria slightly by specifying factors that the Court would be required to consider in reaching its judgment.
  - Proposal 3 would substantially change the criteria to make them less vague by including such wording as "substantial likelihood that in the near future" that physical harm would occur to self or others due to the individual's mental illness "as evidenced by recent behavior" or that harm will be suffered due to substantial deterioration or an inability to protect or provide for him/herself.
  - Proposal 4 would substantially change the criteria by adding a third criterion for commitment that addresses containing deterioration in the individual's "previous ability to function in the community."

Involuntary Commitment Process

- CSB staff are not required in statute to attend involuntary commitment hearings
  - The Inspector General found that there is no expectation that CSB staff attend
    - "CSB attendance at commitment hearing is inconsistent across the state."
    - CSBs reported barriers to meeting attendance
      - 48% cited staffing limitations
      - 25% hearings held outside of service area
      - 20% distance to hearings within service area
    - No requirement for CSBs to be notified of hearings.
- CSB staff did not attend the commitment hearing for Cho and the failure to certify a copy of the outpatient commitment order to the CSB resulted in an absence of oversight for Cho's outpatient treatment.

Virginia Tech Review Panel Recommendations

- The VT Review Panel recommended amending the *Code of Virginia* to:
  - Extend the time periods for temporary detention to allow for more thorough mental health evaluations;
  - Authorize magistrates to issue temporary detention orders based on evaluations conducted by emergency physicians trained to perform emergency psychiatric evaluations;
  - Require the presence of the pre-screener, or other CSB representative, at all commitment hearings, and to provide adequate resources to facilitate CSB compliance.
    - The independent evaluator, if not present in person, and the treating physician should be available where possible if needed for questioning during hearing.

POTENTIAL ACTIONS

- Fund additional crisis stabilization units (estimated annual cost of $1 million per unit)
  - Statewide coverage may require as many as 24 units, but it has been suggested we may want to begin by funding 4 or 5.
- Increasing the time frame for TDO hospitalization from 48 hours has been recommended and is being considered by MHLR Commission
  - Would raise issue of length of detention without judicial review
  - Would have a fiscal impact.
- Consider amending *Code of VA* to require CSB staff participation (perhaps via video or conference call) in all involuntary commitment hearings.
  - Recommendation of a number of groups.

Treatment Following Commitment

Treatment Following Commitment

- As noted in the Inspector General's investigatory report, CSBs are required to develop discharge plans as part of the involuntary commitment process; however:
  - There is no requirement to provide CSBs with assessments completed by the independent evaluator or the attending physician
  - Meaning of "course of treatment" is unclear
  - CSBs/BHAs or designated provider required in *Code of VA* § 37.2-817.C to monitor "compliance with the treatment ordered by the court"
    - No statutory provisions regarding actions to be taken if individual does not comply with treatment plan; including no guidance for holding a subsequent commitment hearing unless "there is clear evidence that new behaviors…meet TDO or commitment criteria…."

Involuntary Outpatient Treatment

- Additional issues related to involuntary outpatient treatment orders as noted by the Inspector General's report:
  - Limited access to involuntary outpatient treatment
    - Average wait times for CSB outpatient treatment services were:
      - Clinician 30.22 days for adults (13.54 days post emergency)
      - Clinician 37.42 days for children (16.5 days post emergency)
      - Psychiatrist 28.16 days for adults (13.54 days post emergency)
      - Psychiatrist 30.36 days for children (15.46 days post emergency)

Involuntary Outpatient Treatment

- The limitations in outpatient treatment capacity (as noted by the Inspector General's report):
  - "Often not possible to prevent crises
  - Individuals seeking service lose interest and fail to follow through
  - Staff have limited time to follow up on those who drop out
  - Not possible to meet the needs of the court for outpatient commitment
  - Court ordered treatment will cause delays for those who seek treatment voluntarily"

Involuntary Outpatient Treatment

- VT Review Panel recommended clarifying with regard to involuntary outpatient orders:
  - Need for specificity in involuntary outpatient orders.
  - Appropriate recipients of certified copies of orders.
  - Party responsible for certifying copies of orders.
  - Party responsible for reporting non-compliance with outpatient orders and to whom noncompliance is reported.
  - Mechanism for returning the noncompliant person to court.
  - Sanctions to be imposed on the noncompliant person who does not pose an imminent danger to himself or others.
  - Respective responsibilities of the detaining facility, the CSB and the outpatient treatment provider in assuring effective implementation of involuntary outpatient treatment orders.
- The MHLR Commission is examining issues related to involuntary outpatient orders.

POTENTIAL ACTIONS

- Increase State funding for CSBs to:
  - Allow for increased work if changes such as a lower standard for involuntary commitment are enacted
  - Provide for needed community-based services (including those involved in involuntary outpatient treatment orders).

Internet Address

Joint Commission on Health Care website
http://jchc.state.va.us

Contact Information
ksnead@leg.state.va.us
900 East Main Street, 1st Floor West
P O Box 1322
Richmond, VA 23218
804-786-5445 Fax 804-786-5538