

STATE OF WEST VIRGINIA
THIRTEENTH JUDICIAL CIRCUIT
OFFICE OF THE COURT MONITOR



REPORT
OF THE
SPECIAL ASSISTANT

E.H., et al., v. Khan Matin, et al.

January 10, 2011

REPORT OF THE SPECIAL ASSISTANT

The role of the Special Assistant to the Court Monitor is described in the Agreed Order (July 2, 2009) and the Court Monitor Order (July 3, 2009) issued by Judge Louis "Duke" Bloom for the Thirteenth Circuit Court in the matter of *E.H., et al., v. Khan Matin, et al.*

The Special Assistant is to be responsible for providing oversight for commitments in West Virginia, utilizing, in part, the tracking system created by DHHR in compliance with the Agreed Order. DHHR has created a tracking system which supplies the Office of the Court Monitor with daily reports regarding population levels in state and privately operated contractual psychiatric hospitals and weekly reports with individual demographics for each person committed to a diversion hospital, by location, and each person treated in a state facility. This data includes name, age, county of origin or residence, diagnostic group, length of stay and insurance status as available at the time of commitment. The Special Assistant conducts reviews of newly admitted patients through her access to the electronic records system of the state hospitals. Additionally she visits each diversion hospital regularly, reviewing records and interviewing patients when necessary.

Detailed in Appendix A is an analysis of two months' admissions (November and December, 2010) to the two state psychiatric hospitals as an example of the data that can be mined from medical records for the purposes of decision-making.

Additionally, Appendix B contains a brief analysis of the inpatient non-forensic population during the week of December 27, 2010 to January 3, 2011 (an arbitrarily chosen week).

The Special Assistant also meets regularly with the Department and working groups of representatives of the Comprehensive Behavioral Health Centers to review proposals submitted in compliance with the Court Orders and to discuss problems in the commitment or treatment system across the state.

As a result of data analysis, program reviews and meetings, the Special Assistant has arrived at the following conclusions:

- Most individuals who receive treatment through the commitment system legitimately require inpatient psychiatric intervention. Not all need to receive that treatment involuntarily, but almost all need to receive the treatment in a supervised, protected environment, at least initially. Contrary to some reports, there is very little manipulation of the system occurring by private diversion hospitals or physicians seeking guaranteed payment.

- A large proportion of committed patients cannot be appropriately treated in Crisis Stabilization Units (CSU) due to a history of or present aggressive behavior, threat of elopement or departure Against Medical Advice (AMA), and/or medical complications. Many have been refused commitment or voluntary admission to a CSU because of these issues. For whatever reason, some individuals refuse admission to a CSU, stating that they prefer inpatient acute care in a hospital. Additionally, the Office of Health Facility Licensure and Certification (OHFLAC) has created barriers to providers' ability to lock these units, creating risk management concerns for Centers. CSUs are a convenient, useful addition to a community-based system of behavioral health care, but they will never replace inpatient acute psychiatric care.

- Forensic patients occupy over half of the available state-operated psychiatric beds at Sharpe (75) and over 25 of 110 beds available at Bateman. If the forensic patients were removed from state operated psychiatric beds at Sharpe and Bateman, the Department would be required to divert few if any patients to private hospitals.

- Having pointed out that diversion of civilly-committed patients would not be necessary if there were adequate free-standing forensic beds, this Office believes that there is no inherent flaw in admitting patients to local acute-care psychiatric facilities. Not only is care then more community-based and accessible to families, but also the care provided is competent and normally provided according to "best practice" standards. Length of stay is generally shorter in diversion facilities, possibly because patients admitted are less severely ill. Additionally, the BHHF pays the cost of treatment for only about 40% of diverted patients due to the ability of many of the diversion facilities to invoice

Medicare and Medicaid for a portion of the provided acute psychiatric care. While diversion to a private facility is not suitable for all patients, it may be the preferred option for many.

- According to Bureau data, at least one third of committed individuals have primary or secondary diagnoses of substance abuse or dependence. The Special Assistant's data indicates that a more accurate estimate would be half or more, according to her record reviews. Substance abuse is far and away the most common reason for commitment, often in combination with moderate to severe psychiatric illness. Substance abuse is unquestionably the most common reason for *readmission* within two years, followed by non-compliance with prescribed medications. Unfortunately, addiction is a recurring illness. Often multiple admissions are required before an individual is able to regain lasting sobriety, particularly in cases of prescription drug abuse. Sometimes patients are never able to gain lasting sobriety and admissions for psychiatric care are the only interventions that allow them to regain some health, even if only temporarily.

- Public inebriacy (PI) facilities are under-utilized in many areas, or non-existent. As a result, emergency rooms are left to deal with inebriated individuals left by the police to sober up in a protected environment. Police are occasionally unwilling to use PI shelters because they are unlocked and intoxicated individuals often leave before legal procedures can be completed to force them to remain. If followed to the letter, the process for legally placing an individual in a PI shelter is cumbersome and unworkable for over-burdened police personnel.

- Medical clearance for individuals pending commitment remains a challenging problem, as it proves to be in most states. If the certifier or crisis worker from the Comprehensive Center does not ensure that medical clearance occurs, admissions office staff at Bateman and Sharpe cannot arrange diversion and the individual is therefore committed to the state facility, frequently throwing the hospital over its licensed capacity.

- The proportion of committed individuals with severe medical complications (often related to years of addictions) is becoming epidemic. Many require immediate transfer to general medical beds at local hospitals upon admission. A few have passed away there. The state psychiatric system is ill-prepared to treat severe acute medical illness. Commitments of this sort often are refused by diversion hospitals. On some occasions medically compromised individuals have been committed to a state facility out of an emergency room that should have dealt with the medical issues first by admitting the patient to a medical care bed. On several occasions, patients with terminal illness have been committed to a state psychiatric facility.

- Two thirds or more of all patients admitted to the state psychiatric facilities have been committed before. Most of the individuals committed repeatedly are well known to the Comprehensives and a significant proportion is involved in intensive community based programs. These individuals are extremely difficult to keep out of the hospital system for idiosyncratic reasons, and a more realistic treatment goal may be to decrease the frequency and length of stay of hospitalizations rather than to expect elimination of hospitalization.

- Most patients admitted for acute psychiatric care are known from previous admissions, have been previously admitted to other hospitals (many quite recently prior to admission) and/or are active patients of their community mental health center. In spite of that, they are not able to sustain long-term stability. Family dynamics, non-compliance with medical recommendations, and substance abuse are certainly major triggers for re-admission.

- According to data supplied by the Pretera Center, about a fourth of their committed patients are discharged from the state facility to an alternative provider (other than Pretera) and an additional fourth do not keep their initial appointments in spite of dedicated effort on the part of the Center to provide reminders and offers of transportation. Many later appear for services in crisis or as walk-ins. Transportation to appointments is an issue even in areas where the Center is able to supply limited

transportation. It is assumed that this data can be extrapolated to the other Comprehensive Centers.

- Kanawha County and its environs constitute about one fourth of all commitments state-wide. Many are from emergency rooms (EDs). CAMC and Thomas Hospital in particular complain that behavioral health patients often accumulate in their emergency departments overnight due to the Kanawha County Mental Hygiene Commissioners' policy of pending probable cause hearings until the following day in the mid to late morning. If a patient comes into the Emergency Department after 8 PM, they are often required to sit in the ED until mid- to late-morning on the following day. These patients create management problems for ED staff. Many are intoxicated and/or disruptive. Some are in mechanical restraints throughout that time. Neither behavioral health patients nor other emergency department patients are well-served by this policy.

- Additionally, in the Northern Panhandle, patients are ordered into the acute care unit of Ohio Valley Medical Center (Hillcrest) over weekends without a formal commitment/probable cause hearing. This places physicians of the unit in a legally impossible risk management situation in that they may not be able to appropriately treat an individual who is nonetheless informally placed in their care by the mental hygiene process, nor is the patient able to obtain appropriate and timely treatment.

- A significant number of patients funded for care by the Bureau are from out of state, particularly Ohio, a state that for whatever reason, has scaled back available community-based services in the areas contiguous to Wood County, in particular.

- Comprehensives in rural settings find it challenging to provide a full array of services. Transportation to outpatient care is always difficult. Few structured or supervised placements are available. Professional staff is impossible to recruit and hire. Billing and utilization management structures make it difficult for services to be provided flexibly as befit the challenges of the rural environment. Assumption of the "gatekeeping" role by rural comprehensives is very difficult due to lack of twenty four hour availability of

professional staff. Most rural Comprehensives do not operate Crisis Stabilization Units. Deputy Sheriffs available to provide transport to alternative placement are limited.

- Elderly and disabled consumers needing supervised placement are often left languishing in psychiatric beds awaiting personal care or nursing home beds. Individuals with DHHR guardians or health care surrogates frequently receive little assistance from guardians. Hospital social work staff in both state-operated and diversion hospitals are expected to locate placements for protected individuals without much, if any, assistance from the DHHR guardian.
- Individuals with mild mental retardation and significant behavior problems, not eligible for the Title XIX Waiver program, occupy a significant number of state psychiatric beds for long periods of time. While their behaviors make community-based placement challenging, lack of structured behavioral interventions in the state facilities make placement even less likely to succeed. Because these individuals are placed on units with other higher functioning and disruptive patients, they are often harassed or exploited by others. Staff may not have expertise in implementing behavioral programs or protocols consistently.
- Assisted Living Facilities (ALF) (Personal Care Homes and Adult Family Care Homes) have become the default supervised placement for adults with persistent psychiatric illness. This has become a national trend not unique to West Virginia. ALF's are a mixed blessing – providing placement alternatives not otherwise available on the one hand, while posing some philosophical clinical problems on the other. Several of the ALFs are operated by very caring, flexible individuals with an innate talent for dealing with the population. Others are not, which results in over-medicating and avoidable placement failure. While the facilities are licensed, many are large, sometimes rather institutional, and usually ill-equipped to deal with the psychiatric and behavioral challenges the population poses. Most do not have structured appropriate day time activities. Many do not have qualified psychiatric consultation.

- Nursing homes have varying ability to cope with disabled or elderly residents with behavioral/psychiatric problems. Often individuals are committed to acute care psychiatric facilities for inappropriate or demented behavior within the nursing home. The nursing home then refuses to readmit the person once they are stabilized. State operated nursing homes are filled with the individuals that private or non-profit homes were unable to manage because of behavioral problems. These state-operated homes are usually full, leaving many elderly individuals for long periods of time in diversion hospitals or state psychiatric hospitals, occupying acute care psychiatric beds and unfortunately, exhausting their Medicare hospitalization benefits for no good reason other than an inability to find a placement.

- Almost one in ten commitments is of an individual under the age of 18. The primary reason for this high rate of juvenile commitment is a statutory requirement of Chapter 27 of the West Virginia Code which states that juveniles must voluntarily consent to admission to acute psychiatric care if between the ages of 12 and 18 unless committed. In other words, although such youth are considered to be minors, parents cannot sign them into treatment without their consent except through the commitment process. Each committed juvenile is registered in the National Instant Criminal Index as required by law and then loses all right to purchase a firearm or explosive for life. An additional reason for the frequent commitment of juveniles is the requirement that a juvenile be in the custody of the DHHR before he or she can be placed in the Emergency Shelter system.

- The Highland Assessment Unit is a successful program as far as it goes but to date, participation in the program has been voluntary. The program was initially designed to be a mandatory three day screening mechanism for prevention of inappropriate commitment to the state psychiatric system. Instead, many individuals have been allowed to choose to be committed in preference to being evaluated and treated at Highland. A substantial portion of those individuals are homeless, addicted and looking for stable shelter and meals. In need of addictions treatment, they often threaten suicide as a means of accessing medications and health care, food and shelter.

- As the BHHF has moved to implement the court ordered group homes and supported living programs mandated by the agreed orders, it appears that some of the rulings of the Office of Health Facility Licensure and Certification (OHFLAC) have become an unnecessary barrier to establishment of clinically appropriate programs. Regulations and code are applied erratically, inconsistently and sometimes inappropriately, creating impossible situations for providers who are attempting with the best of intentions to fulfill their agreed mission to create community-based programs.

RECOMMENDATIONS

1. The DHHR should develop a free-standing forensic residential program for individuals deemed non-restorable and/or Not Guilty By Reason of Mental Illness. DHHR projects that by 2015 it will need 260 to 270 inpatient beds for provision of care for the forensic population. Construction of a new free-standing facility and/or privatization of forensic management would allow Sharpe's acute care facility and staff to regain focus on providing short and long term care for the non-forensic population.
2. Local hospitals should continue to provide psychiatric care for the acutely ill population. The state facilities can then focus on managing longer term or more difficult patients. The Treatment Advocacy Center, a national body representing stakeholders for mental health care, recommends that each state have 50 publicly funded mental health acute care beds (non-forensic, for individuals between the ages of 18 and 64) per 100,000 population. Given the current population of West Virginia, therefore, the state should have approximately 543 beds. The Special Assistant completed a survey of current acute care providers and determined that the state is currently able to provide, including those beds available for non-forensic care in state facilities, approximately 550 staffed

acute psychiatric care beds. However, those beds include geriatric treatment and long term care capacity in many instances. The 550 beds also include capacity for private acute care funded by other third party payors. The argument that the state focuses excessively on inpatient care to the detriment of community based care is not meritorious according to this data. In addition, it is unclear whether the 50 beds per 100,000 population calculation is designed to address the addictions population, who represent an enormous drain on behavioral health resources. The addition of new beds to the system should be carefully evaluated, however it would appear that taken in total, the current inpatient capacity is not excessive.

3. One or both state facilities should create a distinct unit for the treatment of individuals with Intellectual Disabilities and behavioral problems. Staff should be specially trained in positive behavior supports and behavior management. Principles should be applied consistently. Likewise, specialty substance abuse short term treatment units should be developed in the facilities or under contractual arrangements with inpatient acute care providers.
4. The state behavioral health standards for Certificate of Need and the state Behavioral Health Rules should be revised to reflect modern treatment modalities and standards. Regulations must be applied reasonably, consistently and judiciously by OHFLAC. The Office of the Court Monitor has volunteered to perform the bulk of the coordination and composition of the revision of both CON standards and the behavioral health regulations however the Department has not moved to convene an initial meeting of stakeholders to begin the work.
5. The Office of the Court Monitor appreciates that the BHHF is in the midst of technical assistance with the federal Center for Substance Abuse Treatment (CSAT), however a state plan for management of the current addictions crisis of prescription drug abuse is essential. The plan needs to be developed at the earliest possible opportunity. Cooperative agreements with drug courts and mental health courts operated by local judicial entities should be mandatory for comprehensive centers.

6. State code needs to be modified within Chapter 27 to enable the Highland Assessment Unit (and similar units yet to be created) to operate efficiently and effectively (See WVC 27-5-11 (c) (1) et seq.) Additionally, age of involuntary juvenile commitment must be increased from 12 to at least 16, if not 18 (See WVC 27-4-1 (b)).

7. DHHR guardians for protected adults must accept responsibility for placement of individuals who are involuntarily hospitalized but ready for discharge. It is not acceptable for hospital social workers to be forced to assume responsibility for identifying and arranging placements for protected adults with guardians. The Bureau for Children and Families should create positions in local offices for individuals whose only responsibility is to serve as guardians and health care surrogates (HCS). Currently most DHHR guardians are also Adult Protective Service Workers who are responsible for performing abuse and neglect investigations in addition to serving as guardians/HCS. Often investigations take precedence over guardianship activities.

8. Mental hygiene hearings must be held as legally required, that is, forthwith. It is not acceptable for hospital emergency departments to attempt to manage and control actively psychotic or intoxicated patients pending a mental hygiene hearing scheduled for hours if not days later. Standardized mandatory medical clearance procedures should be in place, similar to those required in Maine. Again, this Office recommended previously a peer review process for mental hygiene commissioners to be coordinated by the Supreme Court's administrative staff. No progress has been made on this issue.

9. The role of community-based CSUs must be re-evaluated. Most CSUs do not appear to be accepting patients who are legitimately in a crisis that would otherwise require inpatient acute care. In their current incarnation CSUs are appropriate placements for individuals who recognize their need to "take a break" from stressful situations in order to regroup, and gain some perspective. Given the fact that OHFLAC correctly or incorrectly currently forbids that they be locked, placement of actively suicidal or psychotic patients in CSUs seems to present a risk management problem for the patient and for the Center. A comprehensive review of community-based crisis services by a

working task force, followed by some reasonable recommendations, would be helpful. The task force should consider need for addictions treatment (short term detoxification) and the special needs of rural centers.

- 10.** On the positive side, the current funding mechanism for treatment of uninsured individuals is clearly defined and financially responsible. On the negative side, it does not address the need for funding of services designed to maintain individuals in the community in a flexible, yet fiscally responsible manner. Most of the “charity care” funding is utilized to provide two services: crisis stabilization (in a CSU) and assessment by a non-professional. Centers use these two codes heavily as they are, to some degree, profitable, enabling the Center to move funds to less fiscally sustainable but nonetheless necessary services such as medication management. Again, a task force should examine exactly what services need to be flexibly provided in the community to allow Centers to support individuals who are uninsured.
- 11.** Transitional Crisis housing with support is essential to reduction of inpatient commitment. Each Center should have access to funds and a facility that will enable it to provide this service. This housing could be available to prevent admission prior to hospitalization as well as to provide short term housing after release from the hospital.
- 12.** Detoxification facilities convenient for patients and police personnel should be available in adequate numbers to address the overwhelming need exemplified by the analysis of commitment data.

APPENDIX A

ANALYSIS OF ADMISSIONS DATA STATE PSYCHIATRIC HOSPITALS NOVEMBER, 2010

Admissions analysis does not include court-ordered (forensic) admissions. Whenever identifiable, county of residence rather than county of commitment is utilized.

WILLIAM R. SHARPE HOSPITAL:

52 admissions in November, 2010,
(plus 6 Court Ordered admissions).

32 Male, **20** Female

31 admissions had primary or secondary addictions diagnoses (60%)

10 patients were receiving intensive community-based services prior to admission
Such as ACT, MR/DD Waiver, supported group home (19%)

7 Patients were age 18 through 21 (13%)

4 Patients were over age 64 (8%)

3 Patients had significant Developmental Disabilities (6%)

11 Patients were Homeless prior to admission (21%)
Several more would lose their placement subsequent to admission

35 Patients had one or in many cases multiple previous psychiatric admissions to Sharpe or to a
diversion facility (private psychiatric hospital) (67%)

At least **2** are registered Sex Offenders

County of Origin

▪ Wood	8
▪ Grant	1
▪ Raleigh	5
▪ Berkeley	4
▪ Greenbrier	2

▪ Barbour	2
▪ Marion	4
▪ Monongalia	2
▪ Harrison	13
▪ Monroe	1
▪ Pocahontas	1
▪ Jackson	1
▪ Jefferson	1
▪ Taylor	2
▪ Pendleton	2
▪ Tucker	1
▪ Out of State	2

MILDRED MITCHELL BATEMAN HOSPITAL:

32 admissions in November, 2010
(plus one individual who was admitted twice in same month)

27 Male, 5 Female

22 patients had primary or secondary addictions diagnoses (69%)

At least **8 patients** were receiving intensive community-based services prior to admission
Such as ACT, MR/DD Waiver, supported group home (25%)

2 Patients were transferred to Bateman from Lakin Long Term Care Facility

6 Patients were age 18 through 21 (19%)

1 Patient was over age 64 (3%)

3 Patients had significant Developmental Disabilities (9%)

7 were homeless at time of admission (22%)
Several more would lose their placement subsequent to admission

22 Patients had one or in many cases, multiple previous psychiatric admissions to Bateman or to a diversion facility (private psychiatric hospital) (69%)

3 Patients were transferred from regional jails for treatment (9%)

At least **1 patient** was a registered sex offender.

County of Origin

▪ Out of State	5
▪ Cabell	8
▪ Kanawha	7
▪ Boone	2
▪ Logan	3
▪ Lakin (Nursing Home)	2
▪ Wayne	1
▪ Mingo	2
▪ Harrison (from Mercer)	1
▪ Putnam	1

ANALYSIS OF ADMISSIONS DATA STATE PSYCHIATRIC HOSPITALS DECEMBER, 2010

Admissions analysis does not include court-ordered (forensic) admissions. Whenever identifiable, county of residence rather than county of commitment is utilized.

WILLIAM R. SHARPE HOSPITAL:

31 admissions in December, 2010,
(plus 12 Court Ordered admissions).

19 Male, **12** Female

17 admissions had primary or secondary addictions diagnoses (56%)

4 patients were receiving intensive community-based services prior to admission
Such as ACT, MR/DD Waiver, supported group home (13%)

1 Patient was age 18 through 22 (3%)

1 Patient was over age 64 (3%)

Average age is **38** years.

2 Patients had significant Developmental Disabilities (6%)

11 Patients were Homeless prior to admission (35%)
Several more would lose their placement subsequent to admission

22 Patients had one or in many cases multiple previous psychiatric admissions to Sharpe or to a
diversion facility (private psychiatric hospital) (71%)

County of Origin

▪ Wood	4
▪ Doddridge	1
▪ Harrison	5
▪ Berkeley	1
▪ Randolph	3
▪ Brooke	1
▪ Marion	1

▪ Monongalia	2
▪ Lewis	2
▪ Ritchie	2
▪ Pendleton	2
▪ Jackson	1
▪ Jefferson	1
▪ Nicholas	1
▪ Calhoun	2
▪ Wetzel	1
▪ Braxton	1

2 Patients were readmitted from the Eastridge stepdown unit.

MILDRED MITCHELL BATEMAN HOSPITAL:

34 admissions in December, 2010

24 Male, **10** Female

25 patients had primary or secondary addictions diagnoses (74%)

At least **5** patients were receiving intensive community-based services prior to admission
Such as ACT, MR/DD Waiver, supported group home (15%)

3 Patients were transferred to Bateman from a Regional Jail

8 Patients were age 18 through 22 (24%)

3 Patients were over age 64 (9%)

Average age was **38** years.

2 Patients had significant Developmental Disabilities (6%)

At least **8** were homeless at time of admission (24%)
Several more would lose their placement subsequent to admission

23 Patients (or more) had one or in many cases, multiple previous psychiatric admissions to Bateman or to a diversion facility (private psychiatric hospital) (68%)

County of Origin

▪ Out of State	4
▪ Cabell	9
▪ Kanawha	12
▪ Boone	2
▪ Logan	2
▪ Mingo	1
▪ Mercer	1
▪ Mason	2
▪ Lincoln	1

APPENDIX B

Reference week of December 27, 2010 to January 3, 2011

SHARPE HOSPITAL:

- 83 patients were admitted or were already occupying beds in the hospital during this time (it should be recalled that a substantial proportion of this facility is occupied by forensic patients, 73 during this week).
- 77% of the 83 patients had been in the hospital more than 20 days.
- Average length of stay for non-forensic patients in Sharpe, according to BHFF data, is 138.89 days.

BATEMAN HOSPITAL:

- 89 non-forensic patients were admitted or were already occupying beds in the hospital during this time (there were 25 forensic patients in Bateman during the week).
- 84% had been in the hospital for greater than 20 days;
- Average length of stay for non-forensic patients in Bateman, according to BHFF data, is 379 days.

DIVERSION FACILITIES:

- During the reference week, 104 civilly committed patients were admitted or were already occupying beds in private psychiatric facilities.
- Thirty five patients (34%) had been in the hospital for greater than 20 days.
- Of the 35 patients hospitalized for greater than 20 days, 20 were in Riverpark Hospital and five in St. Mary's Medical Center in Huntington. Most of those patients were pending placement arrangements (housing or supervised/sheltered placement). Many had DHHR guardians.



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