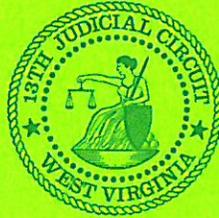


STATE OF WEST VIRGINIA
THIRTEENTH JUDICIAL CIRCUIT
OFFICE OF THE COURT MONITOR



An Analysis of the
Commitment Process in West Virginia

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

March 1, 2010

REPORT OF THE SPECIAL ASSISTANT TO THE COURT MONITOR

Provided to the Parties in E.H., et al., v. Khan Matin, et al.

AN ANALYSIS OF THE COMMITMENT PROCESS IN WEST VIRGINIA

March 1, 2010

■ INTRODUCTION ■

As required by the Agreed Order signed by Judge Louis “Duke” Bloom on July 2, 2009, the Office of the Court Monitor is to provide oversight of commitments to public and private psychiatric hospitals and as part of that activity, assess the impact of the commitment process on the overbedding crisis in Mildred Mitchell Bateman and William R. Sharpe psychiatric hospitals. Therefore, on December 10th, 2009, the Special Assistant to the Court Monitor convened a meeting of Certifiers for mental hygiene commitment representing Comprehensive Behavioral Health Centers (CBHC’s) from across the State.

Certifiers were asked to assist in the development of a list of problems in the commitment process that were helping to create and maintain the overbedding of Bateman and Sharpe psychiatric hospitals. Participants then turned their attention to recommendations for correction of some of the problems identified in the morning session.

The list was collated and circulated to the participants for comment and/or correction. A draft of this document was also circulated to Linda Richmond Artimez of the Supreme Court of Appeals and to the Bureau for Behavioral Health for comment. As of this date, no comment had been received from either.

It should be noted that the list is fairly exhaustive and does not necessarily represent problems that are universal in all areas of the state. Some, if not most, are unique to local governments or situations. There is no one problem in the commitment process which, if corrected, would result in improved functioning for all systems.

The Office of the Court Monitor feels that it is imperative to state that generally speaking, a universal complaint by all certifiers was that it was unfortunate that many consumers had to access voluntary treatment through an involuntary commitment process. That thought underlies all the work of the ad hoc committee.

■ *REPORTED ISSUES* ■

Mental Hygiene Commissioners

- In many counties, Community Mental Health Centers (CMHCs) are not involved early enough in the process. If involved at the point at which petitioners appear in the circuit clerk's office, the CMHC may be able to identify alternatives to commitment and thereby avoid it.
- At times, the commitment has already been initiated and all the parties necessary for the hearing are organized/scheduled before the certification has been performed. This creates expectations on the part of patients and family members that may not be appropriate and on some occasions, families or other individuals who provided transportation leave, believing that their relative will be cared for. At that point the patient has no way back home if released from the hearing.
- The time to have a guardian appointed takes 30 to 60 days in some areas of the state, which causes people to be committed for their own safety.
- Some MHCs are accepting poorly written petitions that do not sufficiently justify commitment or are accepting inappropriate petitions from particularly insistent petitioners even if they do not meet the standard.

- On occasion, after a certification is denied, petitions are refiled by the same or different petitioners until the petitioner or an alternative representative of the petitioner is successful in having their petition accepted and their significant other committed.
- MHCs are sometimes unavailable, particularly late at night. CMHCs often don't have staff available after closing hours to do on-site crisis intervention. Patients end up spending long hours in hospital emergency rooms, where they are disruptive and occupy needed medical beds.
- MHC's occasionally allow what appear to be frivolous petitions. There is sometimes no consistency in the quality of petitions accepted from one commissioner to another, even in the same county.
- MHCs do not always sufficiently explore testimony of petitioners under oath, allowing apparent inconsistencies and distortion or hearsay to pass as testimony.
- Several MHCs "waive" hearings illegally, committing people (particularly adolescents) who could be treated voluntarily.
- Some MHCs allow "hearsay" testimony from petitioners rather than requiring direct observation of a supposedly dangerous behavior.
- Domestic violence situations inappropriately appear in the mental hygiene process and inconsistent testimony is not explored. This is particularly true in issues of addiction/substance abuse. This allows the perpetrator to use the mental health system to evade accountability for criminal behavior occurring during periods of intoxication, and can be dangerous to victims once the individual is released.

- The Mental Hygiene process is on occasion used so that family members or significant others can “raid” the patient’s belongings or finances.
- The process is occasionally too informal and there is no recording/transcripts of most hearings. Paperwork is sometimes not completed totally or accurately (by MHCs and by certifiers) which creates a problem once the patient reaches the hospital.
- There are some areas where the CMHC’s “gatekeeping” responsibilities are not honored or utilized by the MHC/Circuit Clerk.
- Magistrates covering for MHCs after hours are often not adequately trained on the job (they receive didactic training from the Supreme Court staff but often are not supervised by the appointing authority thereafter).
- MHCs have no functional supervisors as they are appointed by Circuit Judges who frequently do not have the time to review or provide feedback. Many Judges are unaware of deficient performance on the part of an MHC.

■ Petitioners/Patients ■

- Many patients are addicted or abusing Xanax, narcotics, and other addictive medications prescribed by practitioners who do not recognize or deal with the consequences of addiction, abuse, and withdrawal. The patients appear in Emergency Departments (EDs) demanding medications and eventually threaten to kill themselves if their medications are not supplied. At that point, they often either receive more medication or they are committed. Individuals with Xanax dependency cannot be detoxified in less than 28 days and therefore they are released from diversion hospitals

either still prescribed Xanax or after extended stays, and are then re-prescribed the medication that got them into trouble, creating a cycle of readmissions.

- Individuals are committed for being a “passive danger”, e.g., drinking and driving, pregnant substance abusers, smoking in bed while intoxicated (most of these are substance abuse issues). This is a somewhat questionable use of the commitment process although no one can argue that the individual needs assistance.
- Geriatric persons and individuals with Traumatic Brain Injury (TBI) are being inappropriately “dumped” from nursing homes into the psychiatric system when their behavior becomes unmanageable, without sufficient evaluation by a qualified medical professional for possible reasons for unexpected inappropriate behavior such as side effects of multiple medications, illness, pain, etc.
- Physicians do not properly use Medical Surrogacy for elderly/demented patients or those with Developmental Disabilities (DD), instead having them committed.
- ED doctors often file as petitioner and the information they have is hearsay, based on statements from family members who are long gone from the ED. Also this creates an unviable political situation for CMHCs who staff crisis programs with less medically qualified individuals. Although they have options to offer, or may believe the person should not be certified, they are not given the credibility given to an ED physician.

- There is no data about who are petitioners, where do they come from? The Supreme Court of Appeals (SCA) is creating a data base for patients who are committed but there is no organized data available regarding petitioners and people who are not committed and are released by the MHC.

- Occasionally people are being certified by ED doctors or private physicians without the knowledge of the CMHC. This is particularly true when patients cross county lines and are committed from a different county. Some patients and families have learned to leave their county of origin and go to an adjacent county where there is more likelihood of the individual being committed from an ED. Some of these people could have been offered CRU or outpatient services in their county of origin.

■ Diversion Hospitals ■

- Some inpatient psychiatric units commit people once their insurance benefit is exhausted in order to retain payment for continued treatment which the patient may have been willing to accept voluntarily.

- Some inpatient psychiatric units are filing for commitment of voluntary patients who leave Against Medical Advice (AMA) as a risk management technique so that the hospital cannot be held liable if an adverse event occurs.

- CMHCs and the commitment process are used by EDs as methods of processing behavioral health patients rapidly while continuing to provide the hospitals with risk management. Most EDs have insufficient space to hold behavioral health patients as long as may be required to find them safe places to go or to calm them sufficiently to send them home.

Conversely, EDs have also become a “dumping ground” for behavioral health patients who are not processed “forthwith” by the Mental Hygiene system. Patients are sometimes left for hours overnight, waiting for a hearing and occupying an ED bed.

- JCAHO requires that EDs process people within a reasonable amount of time. When behavioral health patients require extended time in an ED in order to find a placement, the ED may be subject to criticism by JCAHO.

- Petitioners and families are misinformed with regard to the fact that the hospitalization will be very expensive and that they WILL get a bill which cannot be put on sliding scale if it is paid by the DHHR. The DHHR is required by state law to turn the invoice over to a collection agency. Often hospitals and doctors tell patients not to be concerned and that “the state will pay for it”. While the state does pay for it, the patient and his/her family are then invoiced, often adding immeasurably to financial stressors at home. The SCA has attempted to correct this by specifying on petitioner forms that the individual will receive a bill, but this warning is frequently ignored.

- Polypharmacy (complicated, expensive medication prescriptions) is wreaking havoc after discharge. This can be a problem presented by both state psychiatric and diversion hospitals. Most centers have no ability to supply expensive psychiatric medications for uninsured individuals post-discharge.

- Many diversion hospitals are not supplying medications at discharge, and some are not providing prescriptions, even if the patient can afford to obtain the medications.

- Many diversion hospitals are not coordinating care with CMHCs. Discharges occur abruptly and without warning or referral to the CMHC. Some CMHCs do not provide adequate contact with patients while they are in the diversion hospital. Doctors do not talk to each other between hospital and community to coordinate care.

- Evaluation of substance abuse issues varies widely from area to area. Drug screens need to be done on every admission (before admission if practical, after if not).

- Diversion hospitals do not always perform adequate discharge planning. Some diversion hospitals are not accessible for staff from CMHCs for discharge planning purposes.

- Often patients are held in psychiatric beds until they have a “place to go”, thereby lengthening stay. Doctors will sometimes wait for an empty residential substance abuse bed which may take an extended period of time. While the DHHR does require the diversion hospitals to report a need for extended stay, there is currently no functional prior authorization procedure for continued stay that is based on objectively assessed clinical need.

- Diversion hospitals often won’t accept anyone “homeless” and many missions/shelters will not accept discharges from hospitals. Some patients cannot be released to homeless shelters even if the shelter is willing to take them because the Homeland Security process requires that they have picture identification to enter a shelter. It’s unclear whether this is a requirement of all shelters or only some in the Northern Panhandle.

- Many psychiatric hospitals will no longer accept “voluntary” patients unless they are insured. This policy results in many people being committed who would otherwise be willing to accept treatment voluntarily.

State psychiatric hospitals/BHHF and other department policies

- The United Government Services (UGS) audit process of charity care funding for Crisis Stabilization Units (CSUs) does not allow centers to keep people temporarily if they cannot verify income and identification. Centers feel that they are at risk of denial/reversal of payment if they keep people who cannot immediately provide picture identification and verification of income. Many people in crisis do not have identification or proof of income at the time of presentation.
- Centers are concerned there is no written appeal process on UGS audits.
- CMHCs are unwilling to “spend” their charity care dollars to take care of a patient who is not from their region (e.g., in a CSU). The BHHF has been working to correct this problem.
- People are being kept in Sharpe because they need to complete their group therapy instruction in anger management, for example. This extends their stay.
- State hospital doctors sometimes hold patients pending the availability of a residential substance abuse treatment bed, which often takes months to surface.

- The Bureau for Medical Services moratorium on Intensive Outpatient Programs (IOPs) is preventing implementation of a full continuum of care in many areas. The Department is working on a process for approval of new IOPs.

- Medical clearance for individuals in the commitment process delays and complicates the entire commitment/diversion process. This is a problem created by both state hospitals and diversion hospitals. Clearance is often required of obviously healthy adults. Even statements by CMHC medical staff are not accepted by some physicians/hospitals.

- Med Express types of facilities cannot be used for medical clearance because of payment issues, so people and police end up sitting in EDs for hours, unnecessarily.

- If a patient is insured, he cannot be admitted to a CSU as a charity care patient even though his insurance will typically refuse to pay.

- Centers cannot be paid in CSUs for out of state patients, and those people who come across the border, often to EDs, therefore end up committed.

- Payment for use of CSUs as stepdown is inadequate.

■ Behavioral Health Centers ■

- There is limited availability of community psychiatrists, often leading to delays in first appointments. This causes people to run out of their medications and end up back in the commitment system at times.
- Few CSUs are actually capable of security. Staffing and physical plant will need to be “beefed up” for security risks. Licensing and the Fire Marshal make locked units very challenging under current policy interpretations. The Bureau is working to pilot CSUs with delay doors that can be used for commitments.
- CMHCs estimate that 50% of patients who are committed could be handled in CSUs, in part because so many of them could actually be treated voluntarily. Another cause of commitment in preference to CSU placement is payment limitations. Those limitations are in the process of being addressed by the Bureau and providers. Many are described above.

■ Systems issues ■

- Geriatric and TBI patients are being committed inappropriately, partially because there is no treatment or monitoring system which can be accessed as quickly as the commitment system, partly due to the instruction that some Adult Protective Services staff has received that they are to file for commitment in order to protect the individual in the short term.
- By statutory requirement, teenagers over age 12 must sign themselves into treatment voluntarily. Most adolescent psychiatric treatment units are

requiring that adolescents be committed in order to avoid their signing themselves back out of treatment as soon as their parents or the DHHR worker leaves (and for reasons of payment for those youth who are uninsured). Unfortunately once a teen is committed, most insurers including PEIA will not pay for the committed individual's inpatient treatment, holding that the person is in the hospital because of an action of the court. This results in the Bureau paying the cost of the child to be in treatment and the invoice therefore devolving to the parents for repayment.

- Children's Protective Services will place a child in inpatient psychiatric care utilizing the commitment process when emergency placements of youths in shelters or foster care is not possible or is unusually difficult.
- Additionally there are now very few beds for psychiatric treatment of children under age 12. This is occasionally a major problem.
- Estimates are that as many as 50% of individuals referred for commitment have never been seen by the CMHC before. This makes evaluation of the patient more difficult for the certifier as no history is available of past behavior to use for prediction of likelihood of danger to self/others.
- There are insufficient voluntary options for care, particularly detoxification of substance abusers.
- There is not an available continuum of care in most geographic regions which would allow increased outpatient support on a temporary basis. This creates problems in attempting to implement a Voluntary Treatment Agreement (VTA).

- The process for accessing VTAs is cumbersome and needs to be streamlined.
- Individuals with DD end up in hospitals because of lack of appropriately supervised and supported placements, then are extremely difficult to get out of the hospital for the same reason.
- The lack of availability of sheltered, partially or fully supervised placements is a huge problem in rural areas, in particular.
- CMHCs are unwilling to “spend” their limited charity care dollars to take care of a patient who is not from their region (e.g., in a CSU). Many urban areas end up assessing and coping with numerous patients from out of their region due to the fact that there are EDs in their area that are destinations for ambulances and/or families with members in a psychiatric or addictions crisis.
- There are few placement alternatives for children/youth that are not in custody of the Department. Often this results in a child in a familial crisis being admitted for inpatient treatment, perhaps inappropriately. MHCs wrestle on a regular basis with lack of placement alternatives for children/youth in crisis.
- The addictions population tends to be frequently readmitted. Each region needs a short term option to commitment for this population and stronger community based detoxification and treatment options.
- Transportation to CSUs is a huge problem in some areas because sheriffs are not required to transport once the hearing is dismissed. Few Centers are able to offer transportation, particularly at night and/or for a long distance.

■ COMMENTS ■

The Office of the Court Monitor is well aware that this list of problems is presented from only one perspective, that of the Centers; although it can be argued that certifiers tend to be more clinically focused than Center administrators and perhaps therefore a bit less biased. Nonetheless the experience of the Special Assistant is that all of the items on this list are true somewhere, but perhaps not everywhere, in the state. Some problems are insoluble due to their complexity and the nature of the target population. Other problems are already being addressed by the new administration of BHHF in collaboration with the SCA and providers. There is no single or simple solution that will address and correct all of these issues. Nonetheless, a few strategies are submitted for the consideration of the parties.

■ STRATEGIES TO CONSIDER ■

1. The SCA needs to have an organized data system to examine petitioner variables: who is filing, why, how often, etc.; and patient variables, including those who are released from certification and in particular, the reason for the filing and the disposition on discharge.
2. The Office of the Court Monitor strongly suggests that the SCA consider creating a peer review/quality assurance process for MHCs. This mechanism might include an anonymous complaint procedure so that Centers or petitioners can express concerns regarding the performance of MHCs. The complaint procedure should be described on documents provided to the petitioner and CMHC.
3. All CMHCs need to adopt the Pretera monitoring system for tracking commitments/certifications/follow-ups. CMHCs should be tracking commitments

by certifier as well, in order to identify individuals who “over certify” and in order to facilitate supervision.

4. CMHCs must be considered gatekeepers to the system. In order to do so, they should be consulted immediately that a petition is filed (and preferably, before the filing is accepted by the circuit clerk if possible). In turn, CMHCs must take accountability for “outside” “approved” certifiers. There should be Memoranda Of Understanding between the CMHC and the outside certifier identifying the respective responsibilities of each. Additionally, if the CMHC is to be the gatekeeper, it must have staff available after hours for crisis coverage of EDs and/or at the request of the Circuit Clerk, Magistrate or MHC. CMHCs unable to perform their gatekeeping functions are not comprehensive and crisis services should then be contracted to a party willing and able to perform the function.
5. Data regarding commitments needs to reflect not only county of commitment, but also county of origin. Many urban CMHCs have a very high commitment rate that consists in part of patients from more rural and/or distant areas (or from out of state for border counties). It is impossible to build an adequate community-based system if the appropriate community is not identified.
6. CMHCs should be able to provide 48 hours of crisis care outside the UGS audit requirements for identification, proof of income, and lack of insurance. A crisis is a crisis and will result in a commitment if community-based intervention cannot be provided because of payment rules.
7. Treatment needs to be coordinated between hospital and community so that patients who are sufficiently stable can access the remainder of their counseling/education processes at the local CMHC and can therefore be discharged.

8. The continuum of care in each area needs to include transitional supported housing with adjunct treatment. This is in development at the BHHF, with the collaboration of the providers and Office of the Court Monitor.
9. Diversion and state hospitals need to coordinate pharmacological management with formularies available in the community. Too often prescribed medications are not obtainable through reduced rate programs, and prescriptions must be changed, jeopardizing stability. Diversion hospitals must be required to provide adequate discharge medications to allow the individual to obtain refills in the community. The Department needs to study ways of providing essential basic medications for uninsured individuals until they can establish some type of access to medications. This recommendation should not be taken to mean that the Department should be paying for medications that are not a necessity to psychiatric stability nor should the Department be required to pay for medications for an unspecified length of time. It is the responsibility of care coordinators of the CMHC to facilitate insurance or reduced cost medications for patients within a reasonable time from discharge. This policy and procedure is in development at BHHF.
10. BHHF must issue an explicit policy affecting state and diversion hospitals regarding medical clearance prior to commitment (North Carolina and Maine could be used as examples). The BHHF must find a way to fund medical clearance in the most efficient manner possible (urgent care centers?). BHHF and the diversion facilities should accept the medical clearance of CMHC medical personnel unless that personnel proves themselves unreliable. The Bureau should require that diversion hospitals do so as a contractual element.
11. Drug screens should be performed on all admissions to both state and diversion facilities. Co-diagnoses of SA should be identified on all paperwork if illicit substance use is identified. This will help in the development of appropriate community-based services.

12. Short term detoxification beds should be made available in every geographic region.
13. The Mental Hygiene process should not be used for domestic violence situations. Persons with addictions who become abusive should be jailed, not committed.
14. The BHHF needs to coordinate an annual meeting of all certifiers and provide continuing education hours for participants. The program should be approved by various licensing boards to enable the participant to declare certification within their scope of practice.
15. Nursing homes should not be permitted to place individuals in the mental hygiene process abruptly and should provide adequate and appropriate psychiatric treatment on location, as required by participation standards from the Centers for Medicaid and Medicare Services (CMS). While this may not happen often, the state hospitals are not equipped to deal with elderly and medically fragile individuals who are tremendously difficult to get out of the psychiatric facility once they enter it.
16. The Bureau should tighten contract requirements for diversion facilities to include some of the strategies described above and to prevent some of the problematic issues that are delineated above. In the coming few years many more psychiatric beds are going to be made available to the system in the private market. If the Bureau continues to be reliant upon diversion facilities for psychiatric treatment beds, it should be able to select among the providers to obtain the terms that are most likely to address the needs of the Bureau and the community as the situation moves away from a “sellers” market toward a “buyers” market.

■ *IN CONCLUSION* ■

The Office of the Court Monitor has submitted an analysis of some problems described by providers in the community with regard to the commitment system. No one agency or entity is at fault for the problems identified, nor can one agency or entity correct them all. The Office believes that many of the problems can be addressed through a joint effort among the parties involved, including many of the individuals to whom this report is addressed. Some of the strategies suggested are already in process through activities of BHHF. Others may require new individuals to come to the table (representatives of provider agencies and hospitals and mental hygiene commissioners, for example). The Office is willing to take any role that will facilitate movement toward implementation of some of the strategies and looks forward to working with the parties in the next few months. We suggest that strategies for a coordinated approach be discussed at the next meeting of the parties, after review of this report by the membership.



David G. Sudbeck
Court Monitor



Sheila Kelly
Special Assistant
To The Court Monitor



Dan Connery
Administrative Assistant
To The Court Monitor