Attachment I

LPS REFORM TASK FORCE II

The Case For Updating California's Mental Health Treatment Law

MARCH 2012

SEPARATE AND NOT EQUAL

THE CASE FOR UPDATING CALIFORNIA'S MENTAL HEALTH TREATMENT LAW

A Report of the LPS Reform Task Force II

Editors

Mark Gale

Randall Hagar

Carla Jacobs

Sheree Kruckenberg

Darby Patterson

Vincent Wales

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POB 17602 17th Street, #102

Tustin, CA 92780

714-771-2321

For more information, including state laws and regulations pertaining to the LPS Act, go to www.lpsreform.org.

We are grateful to the following people for their input and contributions to this report. Each brought a unique perspective and expertise to the process. Some were consulted others participated more actively in the work of committees. The Task Force operated by consensus, yet acknowledged differences in viewpoint among its members. Each member acted as an individual rather than a representative of the organization(s)/agency with which they are associated.

Gil Abdalian
William Arroyo, MD
Lauren Ball, LCSW
Ofc. Randy Beckx
Neisha Becton, Ph.D.
Theresa Berkin
Christina Bivona-Tellez BSN, MPH
Andrew Booty, MD
Stuart Buttlaire, Ph.D, MBA
Jason Bynum, MD
William Callahan MD
Gary Chang, JD
Elaine F. Crisostomo
Paul Cumming
Steve Cummings, MD
Jana Du Bois, JD, RN
Robert Ervais, JD
Ross Estrada
Ofc. Joel Fay, PsyD
Nancy Fernandez
Mark Gale
Elizabeth Galton, MD
Randall Hagar
Steve Hawkins
Karen Henry, JD
Robert Horst, MD
Carla Jacobs
Brenda Jensen, MD
Reza Karkia, DBA
Judge Suzanne Kingsbury
Sheree Kruckenberg, MPA
Kathleen Connolly Lacey, LCSW
Richard Lamb, MD
Paul Linde, MD
Judge Wendy Lindley
Steve Lipton, JD
Lucille Lyon
Frank Maas, RN, BSN, MBA
Judge Stephen Manley
Susan Masarweh, JD
Catherine Osborn O'Reilly, RN, MSN, BC
Sgt. Barry Perrou, Psy.D (LASD, Ret.)
Cam Quanbeck, MD
Paul Rains, RN, MSN
Jody Rawles, MD
Mary Read, MD
Stephen Read, MD
Joyce Riley
John Rouse, MD
Rod Shaner, MD
Donald Sharps, MD
Judge Maria E. Stratton
Cass Sylvia
Stewart Teal, MD
Cap Thomson, MD
Gary Tsai, MD
Vincent M. Wales
Robert Weinstock, MD
Nick & Amanda Wilcox
Glen L. Xiong, MD
Judith Yates, MPH, BSN
Melinda Young, MD
Denis Zilaff, JD

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The LPS Reform Task Force---Who are we and what did we do?

Introduction

This report, the result of 30 months of study, seeks to generate reform of our adult mental health system in fundamental ways that include scientific knowledge with a renewed commitment to the underlying principles of the Lanterman Petris Short Act. Referred to as LPS, the Act is that portion of the California Welfare & Institutions Code (WIC) that governs involuntary civil commitment to psychiatric hospitals in California.

The Task Force consisted of individuals and organizations with first-hand experience and understanding of the complexities of California's current mental health treatment laws. Our study included a review and assessment of changes to the state's mental health system since the LPS Reform Task Force I issued its seminal report, *A New Vision for Mental Health Treatment Laws* in 1999. [1]

Findings: Inpatient psychiatric beds have been substantially reduced[2] and emergency rooms are now at the forefront of battle[3, 4] in mental health treatment. Parole realignment assumes that many individuals with mental illness will be treated in the community rather than prison, but little consideration has been given of the failure of the mental health system to prevent their initial incarceration.[5, 6, 7] California's Assisted Outpatient Treatment statute, Laura's Law, was passed to reduce repeat hospitalization and jailing, but has only been implemented in two counties.[8] The public adult system of care system received great influxes of additional funding most notably through the passage of Proposition 63, the Mental Health Services Act of 2004, but little of it has been directed to individuals who may need it involuntarily in the community or in a hospital.[9, 10, 11] A person with severe mental illness is now four times more likely to be in jail than in a hospital beds.[12] The LPS Act is forty five years old and it has not changed in response to an evolving mental health delivery system. [13]

Questions:

What can be done legally and procedurally for people with mental illness who are:

a) badly in need of treatment; b) likely to suffer significant harm without treatment; and,

c) unlikely to accept and stay in treatment in the current system configuration?

Is the statutory involuntary treatment scheme being equally and consistently applied county-to-county and does it afford equal protection to the individuals who may be subject to it?

Introduction endnotes:

[1] http://www.treatmentadvocacycenter.org/storage/documents/report%20by%20the%20lps%20reform%20tast%20force%20%20rdc%20pdf.pdf
[2] http://www.calhospital.org/general-information/psychiatric-inpatient-bed-data
[3] http://www.hcup-us.ahrq.gov/reports/statbriefs/sb92.pdf
[4] http://articles.latimes.com/2011/jul/31/local/la-me-hospital-violence-20110731
[5] http://www.cdcr.ca.gov/Parole/parole-realignment.html
[6] Markowitz FE: Psychiatric hospital capacity, homelessness and crime and arrest rates. Criminology 44:45-72,2006
[7] Lam HR, WeinbergerLE, Marsh JS, et al, Treatment prospects for persons with severe mental illness in an urban county jail. Psychiatr Serv 58:782-6, 2007
[8] http://en.wikipedia.org/wiki/Laura's_Law
[9] http://www.ebudget.ca.gov/2004
[10] http://www.cccmha.org/announcements/govbudget
[11] http://www.dmh.ca.gov/Laws_and_Regulations/docs/REGSDec29final.pdf
[12] http://www.mentalhealthamerica.net/go/position-statements/52
[13] http://www.cdcr.ca.gov/comio/docs/MENTALLY_ILL_IN_JAILS_PAPER%20.pdf

Separate and Not Equal

How California's Mental Health System Discriminates Against People with the Most Severe Mental Illness

Executive Summary

Our state is at risk. Our once unchallenged preeminence in treatment and civil rights for individuals with mental illness has been tarnished as our treatment laws and mental health system have not kept pace with the complex needs of our most severely disabled individuals with mental illness.

Instead, certain names and events are etched into our collective memory: Aaron Bassler and the Fort Bragg killings; Kelly Thomas, beaten to death on Fullerton streets; and young Laura Wilcox murdered with two others at Nevada City's Behavioral Health Department.

Every tragedy seen in headlines is but a shadow of thousands more tragedies that go by quietly and unnoticed. Each is underscored by a common denominator: untreated severe mental illness.

Schizophrenia, clinical depression and bipolar disorder are brain disorders.* People with these severe mental illnesses come from all backgrounds and walks of life. Most recognize they have a mental illness and participate willingly in treatment. Many have a biologically determined inability to recognize, or consistently recognize, they are ill. Linked to frontal lobe dysfunction and brain abnormalities, they decline or fail to consistently engage in community mental health treatment. Instead, they revolve through short term hospitalizations, incarceration, homelessness, or—too frequently—tragic victimization, violence or death.

The LPS Act designed to govern involuntary civil commitment to psychiatric hospitals in California, reflects the then current political, legal and social ideas of the 1960s when it took effect in 1969.

Our society and its mental health treatment system seem to have lost sight of the basic purposes of the LPS Act and the high expectations and disciplined effort needed to attain them:

- To end inappropriate, indefinite, involuntary commitment
- To provide prompt evaluation and treatment

* For more information on brain disorders see Appendices starting on page 29, particularly the article by Cameron Quanbeck, MD.

- To safeguard individual rights
- To protect mentally ill individuals from criminal acts
- To guarantee and protect public interests

The LPS Act became the Magna Carta of civil rights for those individuals who are well enough to respond to treatment in a voluntary mental health treatment system. For others, the intervening 45 years since the passage of the LPS has represented increasing neglect and despair:

- Suicide: 15% of people with untreated or undertreated mental illness kill themselves.
- Homeless: 33% of homeless people have an untreated mental illness.
- Arrest: 20% of incarcerated inmates in both jails and prisons have a mental illness.
- Victimization: People with a mental illness are at least three times as likely to be assaulted or raped compared to the general population.
- Violence: 10% of all homicides are committed by individuals with a mental illness.
- Death: People with a mental illness die 25 years earlier than the general population.

Statistics show only the surface of the difficulties we face. Beneath lies a tension between hope, frustration and reality. But, the depth of reality is apparent.

√ Being in the community has not been a solution for all people with severe mental illnesses.

√ Involuntary treatment and coercion have increased through criminalization.

√ Piecemeal legislative revisions of due process within the LPS Act may have had an unintended consequence of preventing quick and effective access to treatment or release.

√ The incarceration of mentally ill individuals has risen dramatically since state hospitals starting releasing individuals to the community.

Prompt treatment and equal protection sometimes requires tough decisions. What is needed is reform that assures that the most severely disabled among us receive treatment in a system that recognizes the reality of mental illness and the scientific knowledge behind it.

Clearly, it's time. We can no longer tolerate neglect.

Summary of Recommendations

Following is a brief summary of recommendations contained in this report. Discussion is included in associated Problem Statements and Recommendations in the following sections of this report.

Recommendation #1: Define "Grave Disability" to address the individuals' capacity to make informed consent to treatment and assess their ability to care for their health and safety.

Recommendation #2: Adopt concurrent legal processes to determine probable cause for hospitalization and capacity to refuse medication in one hearing.

Recommendation #3: Conform initial acute care hospital certification periods to 28 days, renewable for 28 days. Consider less restrictive alternatives to hospitalization at each hearing or upon renewal of holds.

Recommendation #4: Establish criteria for an LPS conservatorship to be "grave disability" as defined under Recommendation # 1 of this report. Establish conservatorships by clear and convincing evidence. Revise procedures to allow for efficient application and due process for conservatorships applied for from community settings.

Recommendation #5: Authorize an additional 90 day certification to continue acute care hospitalization for individuals who meet the demonstrated dangerousness standard in WIC 5300, with a right of appeal. Provide notice of application for impending post certification commitment under WIC 5300 to County District Attorneys and Public Defenders 30 days before expiration of the 90 day certification. Commitment should be for one year, renewable, with the relevant historical course of the individual's illness considered during the trial, and demonstrated danger established by clear and convincing evidence.

Recommendation #6: Adopt a statewide standardized form to record the historical course of a person's illness.

Recommendation #7: Develop local systems of interagency coordination to ensure timely transportation and placement in facilities appropriate to the person's needed level of care.

Recommendation #8: Ensure Medi-Cal definitions for voluntary and involuntary hospitalization are consistently defined, monitored and applied. Appeals should conducted by a neutral third party.

Recommendation #9: Prioritize services to the most seriously disabled adults with a mental illness whether those services are needed on a voluntary or involuntary basis in the community or a hospital setting.

Recommendation #10: Implement Assisted Outpatient Treatment (Laura's Law) statewide.

Recommendation #11: Expand mental health courts in all jurisdictions and increase the capacity and utilization of current mental health calendars statewide.

Recommendation #12: Conform local emergency response capability in each county under a legislative framework that requires standardized training for all designated response entities.

Recommendation # 13: Set uniform state custodial standards for who can generate a 5150 hold and clarify who can enforce, release or continue that hold.

Recommendation # 14: Ensure statewide uniform application of the Lanterman Petris Short Act to achieve equity and equal protection for all consumers statewide.

LPS and Recovery

Since the passage of the Mental Health Services Act in 2004, California has sought to increase the services delivered by the voluntary community-based mental health system. It has been a positive development that helped many engage in treatment and provided a wide array of community supports necessary for full recovery and a return to a productive life. Yet tens of thousands of other individuals with serious mental illness are unable to engage in their mental health treatment within that structure. This document seeks to provide recommendations that will provide assistance to these individuals with serious mental illness who are coming to harm in our communities, are revolving through our criminal justice system, are homeless, receiving only short-term crisis care in emergency rooms or repeated hospitalizations in the few acute inpatient facilities that still remain.

The Task Force sought to develop recommendations that would balance the right to self-determination of one's treatment with the needs of those individuals who, without some level of intervention and/or substitute decision making, might never have the chance to become healthy and join others who have chosen to embrace their personal journey of recovery. The "politics of recovery" in California surrounding these two groups of mental health consumers (those who accept treatment voluntarily and those who do not) has become divisive instead of inclusive. Appropriate emergency, short and long-term care provided with all due process considerations that facilitates treatment rather than acts as a barrier to treatment will serve to increase the numbers of persons willing to engage our voluntary mental health system enabling both levels of care to experience greater successful outcomes. The goal is to increase recovery for all. This cannot be accomplished by ignoring the challenges of a population of people with serious mental illness who are currently being treated in the least appropriate, most expensive and most restrictive settings such as jails, prisons, community hospital emergency departments and our state hospitals.

Although the passage of the LPS Act brought many needed reforms, the current statutory and procedural structure has been given its opportunity to show proven results for *all* and it has failed. With the appropriate and necessary reforms recommended by this Task Force, California can begin to move forward in providing desperately needed treatment and services to *all* its citizens with serious mental illness.

Conclusion

The Lanterman Petris Short Act was intended to protect persons with serious mental illness from inappropriate and indefinite institutionalization. The statute was not intended to act as a barrier to treatment, but rather to rapidly facilitate due process and appropriate treatment. It has succeeded in allowing the majority of Californians with mental illness to achieve self-determined recovery in the community. For others, however, it has led to isolation, discrimination, criminal institutionalization, abuse and neglect, deterioration in health and mental health, and a violation of their civil rights.

"I wanted the LPS Act to help the mentally ill. I never meant for it to prevent those who need care from getting it. The law has to be changed."

Frank Lanterman

RECOMMENDATIONS

A Note on the Recommendations: The mission of the Task Force was to increase access to treatment and early intervention at appropriate levels of care for people with severe mental illness who require involuntary intervention. Such care should be delivered in a manner that decreases discrimination, criminalization and homelessness while improving due process and the efficiency and coordination of the legal and service delivery systems in a cost-effective manner. The final recommendations below reflect that mission. Also, throughout this white paper the term "psychiatric treatment" may include necessary medications as well as community services and supports with a recovery orientation.

1. Criteria for Inpatient Evaluation & Treatment Problem Statement

A person may be involuntarily treated only if that person meets statutorily defined criteria. Current California law emphasizes deinstitutionalization of people from long-term, state-run, psychiatric hospital facilities. Today, as the original LPS proponents intended, state institutions are nearly a thing of the past. No one advocates a return to unnecessary long-term placement; our dilemma is how to provide treatment to people who lack the capacity to make decisions about psychiatric treatment and to accept or access it themselves, and who live in a community environment.

To do this, the criteria in California's 45-year old LPS Act must be updated to incorporate current medical science regarding mental illness. It should correspond more closely with the Medi-Cal definition of 'medical necessity' and, most importantly, provide treatment before tragic social, criminal justice and/or medical consequences occur. Further, the laws must help de-stigmatize mental illness by recognizing that individuals with mental illness deserve parity in treatment as provided to individuals with other judgment-impairing medical conditions when symptoms of a mental illness render them unable to accept, obtain or utilize such treatment for themselves.

RECOMMENDATION #1:

The "gravely disabled" standard should be modified to consider whether an individual is incapable of satisfying his or her need for either nourishment, personal or medical care, shelter or self-protection.[1] This standard should also be redefined to incorporate an added element that addresses the capacity of the person to provide informed medical decisions. The gravely disabled standard should also be amended to incorporate specific criteria that includes more comprehensive details such as the probability the person would experience substantial bodily harm, serious illness, significant psychiatric deterioration or debilitation without adequate treatment.

Furthermore, a standard of "incapable of making an informed medical decision" would offer practical guidance to help assure uniform statewide application of the statute, and should be included in any amended statute. An individual's medical and psychiatric history should be considered when making a grave disability determination, as required by current law,[2] and a specific reference to that must be inserted in any new amendments to the grave disability statute.

2. Riese Hearing Problem Statement

California's law currently divides the legal processes of commitment from the clinical processes of treatment. Derived from a court case of the same name, a Riese hearing determines a person's capacity to give informed consent, in this case to accept or refuse psychotropic medication.[3]

Wide variation in procedure exists from county to county,[4] with some counties holding Riese hearings simultaneously (or back-to-back) with Welfare and Institutions Code Section 5250 certification hearings, while others hold them as distinct hearings separate in time and place. In some cases, the interval between an initial detention for evaluation and the determination of capacity to make an informed decision regarding psychotropic medication can take seven days and is regularly longer. Having an interval of this length produces an inherently cruel and costly circumstance forcing medical professionals to confine a psychotic, delusional, suicidal or dangerous patient to an inpatient unit without being able to provide necessary treatment, including needed medication.

[1] California Welfare and Institutions Code Section 5332 et.seq. (WIC §5332) / [2]WIC §5008.2 / [3]Riese v. St. Mary's Hospital & Medical Center, 209 Cal.App3d 1303 / [4]Survey, LPS Reform Task Force II of County Counsels

Additionally, the Riese hearing statute restricts consideration of capacity to make informed consent to a person who is actively refusing psychotropic medication, while there is no statutory requirement to examine the capacity of individuals who accept medication. Some individuals simply take medication because it is given to them. Individuals who accept medications, yet who lack capacity to make informed decisions regarding psychotropic medications, may therefore be denied the right and benefit of a substitute decision maker or decision-making process to protect them from potential abuse from inappropriately prescribed medication.

RECOMMENDATION #2:

Adopt concurrent legal processes to determine probable cause for hospitalization and capacity to refuse medication in one hearing. During the initial 72-hour period for evaluation and treatment, the treating physician should be required to evaluate whether or not the patient who is refusing clinically appropriate and medically indicated medication has the medical capacity to do so. If the patient has previously signed an Advance Directive assigning substitute decision-making for treatment to a professional or family member in the event that his or her judgment becomes impaired, and a copy of that Directive has been provided to the treatment facility, medication will be administered only under the terms of the Directive unless the person is imminently dangerous to self or others.

If the person has not assigned a substitute decision-maker and in the treating physician's opinion the patient does not have the capacity to make medication decisions, the patient would benefit from medication and would most likely deteriorate further without medication. A Riese hearing should be initiated so that medication may be administered even over objection. Before any administration of medication, the treating clinician must make reasonable attempts to obtain the patient's agreement. Treating staff should be sensitive to all input given by the patient or his/her family regarding complaints of side effects, previous medications used or problems with the prescribed medication.

3. Length of Certification Problem Statement

Holds for involuntary psychiatric treatment vary according to the statute cited. For example, a WIC §5150 hold is generally 72 hours and a WIC §5250 hold adds an additional 14 days. There are other circumstances in which a hold may be extended, such as a when a person is deemed "dangerous" to self or others. Counties in California use different approaches to determine which holds to place and therefore the length of time accumulative holds represent. Application deadlines imposed for the filing of temporary conservatorships also vary. Some counties use the 30-day LPS hold provision[5] while some do not. Thus, depending on geographical location and varied timelines, individuals throughout California are being given widely divergent access to due process procedures as well as treatment.

One of the underlying assumptions in the LPS statute is that patients determined incompetent to provide informed consent are presumed to have regained competency when their hold status expires or changes. This may not be the case and the assumption can negatively affect the success and continuity of a patient's treatment, sometimes delaying their recovery and release from an inpatient setting. These inconsistent practices also ignore the individual's right to rapid access to treatment.

The process that currently exists under the LPS Act is often unnecessarily lengthy, multi-layered, non-therapeutic, cumbersome and costly. The California model is frequently referred to as the most complicated and "Byzantine" in the nation.

RECOMMENDATION #3: After the 72-hour period, certification for treatment should be for 28 days, regardless of the criteria under which the patient was initially certified, and renewable for an additional 28-day period. At each certification or renewal, consideration of conservatorship, Assisted Outpatient Treatment[6] or extended order of medication in the community should be considered as less restrictive options.

[5] WIC §5270.10

[6] WIC §5345 et.seq.

4. Conservatorship Problem Statement

WIC §5350 of the LPS Act provides that a substitute decision maker with court granted powers may make treatment decisions for individuals who have been placed on a conservatorship due to grave disability, currently defined as the inability to effectively use food, shelter or clothing if provided to them. This conservatorship is not available to individuals who have been hospitalized under criteria of danger to self or others despite the fact that they may be in need of substitute decision making.

In an effort to remedy these inequalities, in some California counties, well-intended local clinicians and officials stretch the criteria for an LPS conservatorship from "dangerous to self or others" to a finding of "gravely disabled." A simpler and more rational response would be to provide the LPS conservatorship option to any person with a mental illness who lacks the capacity to provide informed medical decisions regarding their treatment needs. In making the consideration of whether the person fits the criteria for a conservatorship, the courts should also take into account the historical course of a mental illness in addition to the individual's presenting mental condition.

Moreover, while the LPS Act allows for application for a conservatorship from the community, the procedures to obtain one are so complex and convoluted that the legal provision is rarely, if ever, used. As a result, the vast majority of LPS conservatorships must be initiated from a hospital setting. Therefore, some individuals who lack capacity to make their own treatment decisions may be subjected to unnecessary inpatient hospitalization or receive no help at all.

California is one of the only states to require that a conservatorship can only be granted if determined under the "beyond a reasonable doubt" standard—a standard that is normally restricted to criminal cases. This requirement means that some people will be denied help because the bar was set—some would say arbitrarily—too high. A person who is incapacitated due to mental illness is not a criminal and should receive help and treatment without having to qualify under criminal standards.

RECOMMENDATION#4: LPS Conservatorships should be available for any person who lacks the capacity to make informed decisions regarding treatment and meets the standard of grave disability as proposed in Recommendation 1 of this report. Procedures within the LPS Act should also be revised to allow efficient application from a community setting to avoid unnecessary inpatient hospitalization when the community is the least restrictive environment appropriate for the person's needs. The standard for LPS Conservatorship should be clear and convincing evidence. A judicial order appointing a conservatorship should be recognized by officials in other California counties and apply throughout the state, rather than only in its county of origin.

5. Demonstrated Danger Problem Statement

The only true civil commitment in California occurs under WIC§5300, which allows a person who is a "demonstrated danger to others" to be placed on a 180-day commitment following an initial 14-day certification for involuntary treatment. This section of the LPS Act is rarely used. It stipulates that, prior to or during the initial hospitalization period, the person demonstrated a danger of inflicting substantial physical harm on others and that the demonstrated danger was based on "infliction, attempt or serious threat of harm."

Danger of this level rarely occurs in a supervised hospital environment. Individuals who have been hospitalized due to danger to others, but who have not reached this higher standard of demonstrated danger, are simply released after a completion of the 14-day certification under WIC §5250. However, even for those few patients who, because of symptoms of their illness, have demonstrated inpatient danger, the procedures involved in obtaining a 180-day commitment are so stringent that they are often a barrier to needed treatment and supervision.

The person detained under WIC §5300 must be brought to trial within 10 days unless his or her public defender applies for an extension, is granted a jury trial (if so desired) and is found to be a demonstrated danger beyond a reasonable doubt. During the 180 days, which is renewable, the person may be placed in a locked psychiatric facility or placed

on outpatient committal status. The outpatient committal may happen only if the professional in charge of the facility and the county mental health director advise the court that the person will no longer be dangerous, will benefit from outpatient status and will participate in an appropriate program of supervision and treatment.

The limit of commitment (180 days) may not allow sufficient time for in-hospital stabilization as well as successful reintegration to the community through supervised outpatient committal. It's often the case that more treatment time is needed to reach stabilization and remove the threat of danger.

Additionally, the law currently provides that "demonstrated danger" may be based on assessment of present mental condition, which is based upon a consideration of past behavior of the person within six years prior to the existing incident. The six-year time frame is an arbitrary period, which will not necessarily contain essential historical course of illness information regarding the person's mental illness.

RECOMMENDATION #5: If the person has proven to be a demonstrated danger to others during the initial WIC §5250 certification, an additional certification period for 90 days of acute care hospitalization should be allowed. The patient should have the right to appeal this additional certification through a writ to the Superior Court. If, at the end of 60 days of the additional 90-day certification period, the person is thought to be a continuing demonstrated danger to others, notification should be given to the County District Attorneys office and Public Defenders office of the impending commitment application in order to allow adequate time to prepare for trial to determine commitment.

The finding for a commitment of demonstrated danger should be based on clear and convincing evidence. The length of the commitment should be extended from 180 days to one year to conform to the term of conservatorship in order to provide the individual sufficient time to gain treatment stability and community reintegration. Commitment should be renewable annually.

WIC §5300.5(c) should also be modified so that 'demonstrated danger' is based on assessment of present mental condition, with no time limitation regarding consideration of the individual's past behavior. The historical course of the person's mental disorder shall be considered when it has a direct bearing on the determination of whether the person is a danger to others under this code section.

6. Historical Course of Illness Problem Statement

AB 1424 (Thomson, 2002), which is existing state law,[7] provides that the historical course of a person's mental illness shall be considered in all involuntary commitment proceedings, from detention and transport in the community through the long-term care provisions in conservatorships. Although AB 1424 became law in California on January 1, 2002, information concerning the historical course of a person's mental illness continues to be considered randomly both within and between California jurisdictions. There is little consistency in its application due to a lack of education regarding the requirements of the law and absence of a standardized and accepted process for implementation.

Recommendation #6: The historical course of an individual's illness shall be considered at each step of the involuntary process. A standardized AB 1424 form should be developed and approved by the appropriate state mental health agency and other necessary governmental agencies as needed and used in every county of California. This standardized form should be accepted and used by every police force, sheriff's department, psychiatric mobile response team, clinical/medical facility, superior court and hearing officer in California.

7. Non-designated Hospitals Discussion Problem Statement

Designated hospitals are facilities designated by a county and approved by the state for the evaluation and treatment of persons detained under the LPS Act.

Non-designated hospital emergency departments are not capable of offering the level of care and treatments required for most involuntarily detained mental health

[7] WIC §5008.2

patients or even those who are admitted voluntarily. Substantial numbers of those persons being involuntarily evaluated under LPS regulations first arrive at non-LPS designated emergency departments. Multiple federal, state and local regulations come into conflict with one another as non-LPS designated emergency departments attempt to properly care for and place mental health patients in appropriate psychiatric beds.

RECOMMENDATION #7: The State shall develop a system of interagency collaboration among mental health departments, law enforcement, designated and non-designated hospitals and transport entities. This should be done under a legislative framework that requires a specific administrative entity to be responsible for oversight, coordination, interagency payment and accountability. This framework would ensure rapid placement in and access to a facility appropriate to the person's needed level of care, as well as providing standardized training to all public and private entities designated to make such a placement. Compliance standards for both voluntary and involuntary hospitalization should be uniformly implemented and monitored statewide.

8. Medical Necessity Problem Statement

"Medical Necessity" definitions in Medi-Cal statutes and regulations for both voluntary and involuntary hospitalizations are not clinically appropriate for acute psychiatric episodes and are not being defined, monitored or applied consistently throughout the state. The appeals process for a denial of payment is heard by the same entity that "pays the bill"— the local mental health plan— and usually occurs retroactively after the patient's discharge. Thus, financial incentives exist for both mental health plans and providers to prematurely discharge psychiatric patients, which can increase the likelihood of negative outcomes.

RECOMMENDATION # 8: Adopt medical necessity definitions appropriate to acute psychiatric illness episodes and ensure that Medi-Cal definitions for both voluntary and involuntary hospitalization are consistently defined, monitored and applied with appeals to be conducted by a neutral third party.

9. Hospital Bed Reduction Problem Statement

Over the past two decades, the number of acute psychiatric inpatient beds has decreased 30% throughout California. Twenty-five of California's 58 counties have no adult inpatient psychiatric beds. Based on population, California has one psychiatric care bed for every 5651 residents; nationwide, the average number of acute care psychiatric beds is one for every 4887 people.[8] California's community mental health system has not been able to compensate for the loss of these beds. Many people with severe mental illnesses are just too ill to be treated in a voluntary community setting and the vast majority of community mental health services are not geared to those individuals' clinical needs. Also, treatment needs have become more complicated with an increased number of those with severe mental illnesses having co-occurring medical conditions such as addictions or chronic physical health conditions coupled with a mental illness.

RECOMMENDATION #9: The recognition that some people, due to the severity of their illnesses, will experience acute episodes that require inpatient treatment must be acknowledged and corresponding policy incorporated into all aspects of the adult mental health system of care. Crisis stabilization services should be available in every county and a full array of step-down levels of care should be available to increase opportunity for recovery. Priority should be given to the most seriously mentally disabled adults, whether services are needed by them on an involuntary or voluntary basis in the community or in a hospital setting.

10. Assisted Outpatient Treatment Problem Statement

Laura's Law is "on the books."[9] However, implementation in any particular county requires a public hearing process that is so complex and cumbersome that few county boards of supervisors are willing to take on the commitment. Along with the lengthy and contentious hearing process, County mental health directors must prove that implementation of the law will not reduce voluntary services and, further, county supervisors must pass a resolution verifying that there will be no reduction in voluntary

[8] http://www.calhospital.org/general-information/psychiatric-inpatient-bed-data

[9] WIC §5345 et.seq.

services. Because of these significant complexities, Laura's Law has been implemented in only two of the state's 58 counties.

Lack of implementation of Laura's Law deprives communities of an effective early intervention tool that can prevent costly, potentially dangerous deterioration when an individual is refusing treatment. This tool could be one of many that could help people with histories of repeat hospitalization or arrest due to threat of violence. Laura's Law targets a small but significant population that poses the greatest risk to public safety. Implementation would have clear benefit for courts, law enforcement and emergency responders, as well as hospital emergency departments. At the same time, individuals with a severe mental illness will receive needed treatment before a public tragedy occurred.

RECOMMENDATION #10: More fully implement Laura's Law statewide. Remove the requirement of a Board of Supervisors resolution in order to make Laura's Law more available statewide. Review and develop an expansion strategy based on the report to the Legislature required on July 31, 2011. Extend or remove the current sunset date of January 1, 2013.

11. Mental Health Courts Problem Statement

The California Department of Corrections and Rehabilitation (CDCR) reported that one in seven parolees were enrolled in mental health programs while incarcerated. Recidivism rates for these parolees were higher than for any other subset of parolees, with more than three out of four re-offending and being sent back to prison. Under California's 2011 Public Safety Realignment, new protocols have been established for Post Release Community Supervision (PRCS) for non-serious, non-violent, non-sexual offenders. These probationers will not be returned to prison for violations, but serve their sentences in the county jail and then remain in the community with the need for forensic specialized mental health services and supports.

Since the LPS Act was passed in 1967, two generations of people living with the symptoms of serious mental illness have been criminalized. In fact, the population of persons who fail to engage in the community mental health system has been trans-institutionalized from state hospitals and acute inpatient facilities to our jails and prisons. Although well-intentioned when developed, the reliance on the existing criteria as written in the Lanterman Petris Short Act has set a standard that left California with the unintended consequence of criminalizing many thousands of individuals over the last forty years. Yet, with balanced and substantive reforms, those requiring assistance might have the opportunity to get the treatment and support they need before they commit a criminal offense .

Finally, all California counties have dramatically reduced mental health programs over the last four years in response to the ongoing economic crisis. There is a growing body of evidence that shows significantly increased incidents of police interdiction of persons with serious mental illness in the community with the resulting increase in court appearances as programs are cut or consolidated.

RECOMMENDATION #11: Seek expansion of mental health courts and mental health calendars in all jurisdictions and increase the capacity and utilization of current mental health courts.

12. Emergency Response Problem Statement

Emergency response to mental health crisis varies throughout the state. Some counties have mobile psychiatric response teams; others may rely heavily on private versions of these teams, while most counties have none at all. In many cases, law enforcement, fire departments and emergency medical services (ambulances) are the only available response when individuals are in a psychiatric crisis due to mental illness. Yet, first responders may not be able to appropriately intervene if they are

not aware of community mental health resources or alternatives to hospitalization. First responders may not have the authority to detain individuals under the LPS Act, may not have information regarding which hospitals are LPS-designated and/or may lack sufficient training to determine what components of the emergency situation may be related to mental illness.

Several jurisdictions in California have developed successful law enforcement/mental health collaborations to ensure that an appropriate response occurs when people are in crisis because of a mental illness and require emergency services. The best practices of these collaborative working relationships must be replicated and expanded to fire departments, other law enforcement agencies and emergency medical services.

RECOMMENDATION #12: Each county shall develop a comprehensive and coordinated emergency response capability under a legislative framework that requires emergency responder and mental health interagency collaboration and standardized training for response teams.

13. Non-Designated Hospitals Problem Statement

There is considerable variation in opinion as to peace officer obligation to remain present and retain custody for the duration of an individual's stay at a non-designated facility while on a 5150 hold. Non-designated hospitals are often recipients because they are closer to the transporting authority or because there are acute physical health conditions which need immediate emergency attention. There are very few designated facilities when compared to non-designated facilities in California communities. In addition, there is some difference of opinion as to whether the 5150 hold remains in force and effect if a custodial officer is not present. There is also ambiguity as to whether or not the initiation of a 24-hour hold by an emergency department[10] dissolves the 5150 hold of the custodial officer.

[10] Health & Safety Code Section 1799.11 (H&SC §1799.11)

If the transporting officer departs, emergency departments of non-designated hospitals often place a 24-hour emergency room hold on the individual to resolve the uncertainty, even if a 5150 hold is preferred or more appropriate for its longer duration. For example, an emergency room physician may determine that an individual who may be experiencing an acute episode of mental illness also needs to detoxify from intoxicating substances or, if there is a physical injury or a medical condition, those issues must be stabilized and medically cleared before psychiatric treatment can be addressed.

These issues raise the question of the ability of an emergency physician in a non-designated facility to enforce the 5150 hold until the patient in his care can be transferred to a designated facility. In addition, physicians may face a liability risk by ordering an unauthorized detention.

Police officers may leave non-designated hospitals without turning over documentation indicating that they have detained and transported an individual under authority of a 5150. When police officers do provide documentation to the hospital, it is unclear as to whether or not it imposes a legal obligation on a non-designated hospital.

If an individual is medically cleared and the emergency department arranges transportation to a designated facility for a psychiatric assessment, ambulance companies designated for transport may not recognize a 5150 without any documentation or may reject the documentation as not legally binding and refuse to accept perceived liability in transporting the individual.

RECOMMENDATION # 13: There should be a uniform state standard of custodial requirements for personnel who generate a 5150 hold and greater specificity in the LPS Act regarding status of detention, who can continue a hold, who can enforce a hold and who can release a hold. A workgroup consisting of representatives of hospitals, county counsel, law enforcement and transportation entities should be established to produce a uniform standard that can be incorporated into statute.

14. Cross-Cutting Issues Problem Statement

California is not only a huge state but a diverse state with a number of large urban areas and many rural or small county areas. California's realigned mental health delivery system is also a decentralized system in which county mental health systems, and not the state, deliver the majority of mental health services in the local community and in which funding and administrative authority for mental health programs are vested in counties. This arrangement of minimized state involvement provides flexibility in California's many diverse regions to tailor programs to local needs. This in turn has also led to wide variability in ways of doing business from county to county, in the availability of particular mental health services, in local policies and priorities, as well as application of the laws governing community mental health services.

Uniform application of the Lanterman Petris Short Act is lacking on a county-to-county basis.[1] This poses a number of dilemmas and raises issues of equity and equal protection. For instance, a determination of a person as gravely disabled in one county does not necessarily mean that the same person in the same circumstances would be determined to be gravely disabled in another county. So, too, coordination across county lines over issues governed by the Lanterman Petris Short Act is difficult and in some cases impossible. For instance, the authority of the Public Guardian often ends at the county line so that other counties may not recognize or acknowledge the powers of conservatorship within their own jurisdiction.

State guidance and oversight over LPS issues is often lacking or non-existent. For instance, involuntary medication due process procedures (called Riese hearings) are conducted in a bewildering variety of ways in a variety of settings. No state guidance has been issued on this subject. In particular, no regulations exist that would help achieve uniform interpretation of the applicable statute. In response, the Superior Courts in four counties (Kern, Los Angeles, San Diego, Tulare) have produced local rules of court to govern intra-county consistency in the Riese hearing process while the remaining 54 have no such formal guidance.[12]

[11] Lanterman Petris Short Act (LPS) Dialogue Project summary report (Department of Mental Health, 2002) / [12] LPS Task Force Survey, 2009, accessing www.courtinfo.ca.gov/rules/localrules

Similar issues and concerns arise in transporting individuals:

- Between hospitals and across county lines
- Sharing psychiatric records concerning individuals between counties
- Records shared between state institutions and counties
- Between hospitals and county mental health authorities
- Between those authorities and hospitals or emergency rooms

RECOMMENDATION #14: Ensure statewide uniform application of the Lanterman Petris Short Act to achieve equity and equal protection for all consumers statewide.

SUMMARY & CONCLUSIONS

To better serve the course of justice, civil rights and the people of California, it is critical that the LPS Act be updated. Not only should it embrace new scientific findings about mental illnesses, it should better reflect the intentions of the 1967 legislation to create equity and parity for all the state's residents. As part of this mission, Laura's Law must be implemented in counties throughout the state. Applying only to a very small minority of people whose mental illness is so severe it poses a danger to the public and to themselves, Laura's Law will help to prevent public tragedies that lead to unnecessary violence and deaths.

The passage of time has revealed both strengths and weaknesses in the LPS Act. This set of carefully considered recommendations offers specific changes that will improve the delivery of justice and mental health treatment under the LPS Act. In addition, advances in medical science over the past four decades provide new understanding and options for the treatment of mental illness. Using these resources, the experience over time and advanced scientific knowledge, we have an opportunity to build a more just and equitable California for all our people.

"There is a sizable minority of persons with serious mental illness who do not believe that they are mentally ill and, as a result, are generally resistant to psychiatric treatment (including medications)."

Dick Lamb

"My sister did not meet the criteria for involuntary treatment even though she was living on the streets with her 10 year old son. She became a criminal and qualified for treatment simultaneously when she murdered our 78 year old mother. Waiting for danger is too late."

Brian Jacobs

". . . the Riese case cloaked anti-treatment ideology in the language of civil rights . . ."

Jonathan Stanley, JD

"The longer an incompetent patient may lawfully reject antipsychotic medication which, in the judgment of medical professionals, may offer therapeutic benefit, the more tenuous the possibility for effective crisis management."

Justice Benson,
Concurring in the opinion of Riese v St. Mary's (209 C.A.3d 1303)

APPENDICES

Acknowledgments: We want to gratefully acknowledge the contributions of many individuals in helping to collect the information contained in these appendices. Special thanks are owed to the Treatment Advocacy Center[13] for generously making available many of their excellent fact sheets, from which much of the following material is derived.

1. Overview of serious mental illness: Schizophrenia and bipolar disorder

Cameron Quanbeck, MD
Schizophrenia is a condition that first shows clear manifestations in males in adolescence and in females in early adulthood. Bipolar disorder typically develops in both genders in the early to mid 20s. Both disorders are biologically-based and have a strong genetic component, e.g. they are passed down in families.

Approximately 2% of the population, 1 in 50 persons, suffers from these serious mental illnesses. Both illnesses, if left untreated, exhibit a remitting-relapsing or fluctuating course. Adverse events (hospitalization, arrest, jailing, and violent behavior) are most likely to occur in the manic phase of bipolar disorder and during relapses into psychosis in schizophrenia.

In recent years, a large amount of research has clearly demonstrated that a significant percentage of patients (40-50%) with serious mental illnesses suffer from deficits in insight. Those with impairments in insight are unable to or have difficulty realizing: 1) they are suffering from a serious mental illness; 2) the symptoms they experience, e.g., delusions, hallucinations, mania are part of the mental illness; and, 3) that they would benefit from psychiatric treatment. (Cairns et al., 2005; Dell'Osso et al., 2002; Pini, Cassano, Dell'Osso, & Amador, 2001; Pini et al., 2003). This difficulty accepting one's mental illnesses is biologically-based; those with a serious mental illness who lack insight into their illness have abnormalities in the parietal and temporal lobes of the brain when compared to those who retain insight (Cooke et al., 2008).

[13] www.treatmentadvocacycenter.org

Persons with a serious mental illness who have impaired insight and ability to make treatment decisions are more likely:

- To receive involuntary rather than voluntary psychiatric treatment
- Fail to take their prescribed medication in the community and function poorly (Mohamed et al., 2009; Olfson, Marcus, Wilk, & West, 2006; Yen et al., 2005)
- To experience more hospitalizations, suicidal and violent behavior (Yen, Chen, Yen, & Ko, 2008)
- To be more socially dysfunctional (Lysaker, Bell, Bryson, & Kaplan, 1998)

Insight can improve with treatment. If patients with poor insight who initially resist taking medication are ordered to take medication, after a month of treatment, the vast majority of patients (83%) retrospectively agreed with the decision to order medication against their wishes, e.g. they regained insight into the benefits of treatment (Owen et al., 2009). Patients who have frequent mood episodes also lose insight (Yen, Chen, Ko, Yen, & Huang, 2007). From a population perspective, 1% of California's population has both a serious mental illness and also suffers significant impairments in insight, which is about 370,000 of its citizens.

2. Adverse consequences of untreated mental illness

Persons with a serious mental illness who do not engage in psychiatric treatment suffer a multitude of adverse consequences that make addressing this issue a high priority. Some of the devastating consequences for the patient themselves include:

Neurotoxicity:

Neuroimaging studies have demonstrated that episodes of psychosis in schizophrenia and mood episodes in bipolar disorder damage critical brain regions, including:

- The prefrontal cortex (McClure et al., 2006; Moore et al., 2009)
- The cingulate gyrus (Atmaca, Ozdemir et al., 2007; Sassi et al., 2004)
- Hippocampus (Atmaca, Yildirim, Ozdemir, Ogur, & Tezcan, 2007)

Conversely, studies have demonstrated that taking psychotropic medications protects the brain against this damage (Stip et al., 2009).

3. Consequences of delaying treatment in persons with schizophrenia

Compared with those individual who are treated at the onset of schizophrenia, those with schizophrenia with a significant duration between onset and treatment experience:

- A poorer response to treatment and more severe and persistent symptoms (Gunduz-Bruce et al., 2005; Haas, Garratt, & Sweeney, 1998)
- Deficits in attention and memory and a lower verbal IQ and verbal learning ability (Atmaca, Ozdemir et al., 2007; Lappin et al., 2007)
- A higher likelihood of being unemployed, on disability, and cost three times as much to treat compared to those who receive early treatment (Mihalopoulos, Harris, Henry, Harrigan, & McGorry, 2009; Sarotar, Pesek, Agius, Pregelj, & Kocmur, 2008)
- Less likelihood of recovery from their illness (Mihalopoulos et al., 2009)

4. The high costs of acute psychiatric care

The most expensive form of mental health treatment is acute care provided in emergency rooms and psychiatric inpatient units. Patients with serious mental illness who do not take their prescribed medication in the community are at high risk of relapse and acute psychiatric care. Patients who relapse and are hospitalized also incur increased costs in the two months after hospital release (Fitzgerald et al., 2009). Even small decreases in medication non-adherence can lead to large financial savings for a health care system (Damen, Thuresson, Heeg, & Lothgren, 2008; Gianfrancesco, Sajatovic, Rajagopalan, & Wang, 2008). Failing to continue taking medication after release from the hospital dramatically increases risk of re-hospitalization (Hassan & Lage, 2009); even missing one prescription refill dramatically increases the risk of a psychiatric hospitalization for persons with schizophrenia (Law, Soumerai, Ross-Degnan, & Adams, 2008).

A study of California Medi-Cal recipients with schizophrenia found that those who were non-adherent to prescribed medication were twice as likely to be hospitalized than those who were adherent (Gilmer et al., 2004). Similarly, Californians with bipolar disorder in managed care plans who do not adhere to medications are twice as likely to use emergency and inpatient services (Lew, Chang, Rajagopalan, & Knoth, 2006). Those with serious mental illness who do not adhere to medications cost a health system three times

as much annually than those who take medications regularly (Knapp, King, Pugner, & Lapuerta, 2004). Risk of hospitalization was significantly correlated with compliance. Lower compliance, however defined, was associated with a greater risk of hospitalization over and above any other risk factors for hospitalization. For example, the presence of any gap in medication adherence was associated with increased risk of hospitalization. A gap as small as one to ten days produced an odds ratio [OR] of 1.98, or nearly twice the likelihood for hospitalization when compared to no gaps in medication. A gap of 11 to 30 days was associated with an OR of 2.81, and a gap of more than 30 days was associated with an OR of 3.96 (Weiden, Kozma, Grogg, & Locklear, 2004).

A study of Wisconsin Medicaid participants with schizophrenia found that irregular medication users had significantly higher rates of hospitalization than regular users (42 percent versus 20 percent), more hospital days (16 days versus four days), and higher hospital costs ($3,992 versus $1,048). Irregular medication use was one of the strongest predictors of hospital use and costs even after the analyses controlled for diagnosis, demographic characteristics, baseline functioning, and previous hospitalizations (Svarstad, Shireman, & Sweeney, 2001).

In the United States, there are roughly 87,000 annual acute care inpatient admissions of Medicaid patients for the treatment of schizophrenia. These admissions include a total of approximately 930,000 hospital days at a total cost of $806 million. Improving adherence to eliminate gaps in antipsychotic medication treatment could lower the number of acute care admissions by approximately 12.3% and reduce the number of inpatient treatment days by approximately 13.1% resulting in a savings of approximately $106 million in inpatient care costs for the national Medicaid system.

In short, poor adherence to antipsychotic medications was consistently associated with higher risk of relapse and rehospitalization and higher hospitalization costs. To reduce the rate of hospitalization and the cost of hospitalizations among patients with schizophrenia, it seems clear that efforts to increase medication adherence should be undertaken (Sun, Liu, Christensen, & Fu, 2007).

5. The financial consequences of arrest and incarceration

In 2009, California's prison population numbered 174,000 inmates, while California's jail population averaged 75,339. Data from the State of California indicates that about 32,000 prisoners during this period had a severe mental illness, while almost 200,000 individuals received psychiatric outpatient services in jails settings, which amounts to about 17,000 jail inmates with a severe mental illness at any one time. Another 25,000 parolees had severe and persistent mental illness. Clearly the amount of individuals receiving care in the criminal justice system is a significant portion of the population that qualifies for treatment in California's public mental health system.

According the Jean Fraser, Chief of the San Mateo Public Health System, the annual costs of providing mental health care in various settings varies widely, the most expensive of which is within the criminal justice system (see table below). Providing mental health care in the criminal justice system places a heavy financial burden on county and state government. The costs of housing and treating a mentally ill inmate in a jail or prison falls entirely on local taxpayers; 100% of the funding for this expense comes out of county and state general funds, respectively. In contrast, the cost of providing community treatment is shared equally with the federal government because county funds are matched by dollars from the federal entitlement programs Medi-Cal and Medicare.

SETTING	COST (annualized)
Full Service Partnership (Proposition 63)	$24,000
Enhanced board and care	$26,000 - $153,000
Mental health rehabilitation center or Skilled nursing facility	$43,000 - $78,000
Forensic skilled nursing facilities	$150,000+
Napa State Hospital	$185,000
Psychiatric inpatient bed	$511,000
Jail housing	$36,500 + treatment + court and legal costs
Inpatient unit in a jail	$636,500 + court and legal costs
Prison housing	$46,000
Prison treatment costs	$2,000 - $185,000

Scientific evidence, financial analysis of costs of current modes of treatment, and lack of access to federal financial participation mechanisms for mental health care all suggest that changes in mental health public policy could benefit patients, providers, and taxpayers.

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Historical background and current state of mental Illness treatment and science

The following information was sourced from the work and research of the Treatment Advocacy Center .

1. What percentage of individuals with serious mental illnesses are receiving no treatment?

SUMMARY: For the past 20 years, studies have consistently estimated that almost half of all individuals with schizophrenia or bipolar disorder are receiving no treatment for their mental illness at any given time. According to recent estimates of National Institute of Mental Health (NIMH), this means that approximately 3.5 million such individuals are receiving no treatment.

45 percent receive no treatment

In 2010, NIMH estimated that 40 percent of adults with schizophrenia and 51 percent of individuals with severe bipolar disorder receive no treatment in a one-year period. NIMH also estimated that there are 2.6 million adults with schizophrenia (1.1% of the adult population) and 5.1 million adults with severe bipolar disorder (2.2% of adult population). That means that there are 3.5 million adults with schizophrenia or bipolar disorder not being treated in the US on any given day.[14]

41 percent untreated within 30 days of hospital discharge

Mark Olfson et al. at Columbia University reanalyzed 2003 national Medicaid claims for 49,239 individuals with schizophrenia who were hospitalized. They found that 41 percent of the patients received no psychiatric follow-up treatment in the month following their discharge from the hospital. The strongest predictors of which patients would not get follow-up treatment were substance abuse and a history of not having received treatment prior to their hospitalization.[15]

[14]NIMH website. Prevalence of serious mental illness among U.S. adults by age, sex, and race. http://www.nimh.nih.gov/statistics/SMI_AASR.shtml; http://www.nimh.nih.gov/statistics/1SCHIZ.shtml; http://www.nimh.nih.gov/statistics/1BIPOLAR_ADULT.shtml; http://www.nimh.nih.gov/statistics/1MDD_ADULT.shtml; all accessed March 22, 2011 / [15]Olfson M, Marcus SC, Doshi JA. Continuity of care after inpatient discharge of patients with schizophrenia in the Medicaid program: a retrospective longitudinal cohort analysis. *Journal of Clinical Psychiatry* 2010;71:831–838.

2. Why individuals with serious mental illnesses often do not take their medications

SUMMARY: The single most significant reason why individuals with schizophrenia and bipolar disorder fail to take their medication is because of their lack of awareness of their illness (anosognosia). Other important reasons are concurrent alcohol or drug abuse and a poor relationship between psychiatrist and patient. Medication side effects, widely assumed to be the most important reason for medication nonadherence, are, in fact, a less important reason compared to the other factors cited.

Background: The failure of individuals with schizophrenia and bipolar disorder to take prescribed medications (usually antipsychotics and/or mood stabilizers such as lithium) is one of the most serious problems in psychiatric care. It often leads to relapse of symptoms, rehospitalization, homelessness, incarceration in jail or prison, victimization or episodes of violence. The failure to take medication is referred to as noncompliance or *nonadherence*; the latter is a better term. Nonadherence is also a problem for other medical conditions for which medication must be taken for long periods, including hypertension, diabetes, epilepsy, asthma, and tuberculosis. Nonadherence may be total but is more often partial; it has been suggested that partial adherence be defined as a failure to take 30 percent or more of the prescribed medication during the past month.[16]

The single best study of why individuals with severe psychiatric disorders do not take medication was done by Kessler et al.[17] In interviews with those not taking medication, ***the single most common reason, cited by 55 percent of the individuals, was that they did not believe they were sick.*** They had anosognosia.

Other reasons for not taking medication were cited much less frequently:

- 7 percent "scared about hospitalization against own will"
- 6 percent "concerned about what others might think"
- 5 percent "not satisfied with available services"
- 1 percent "could not get an appointment"
- 0 percent "language problem"

[16] Scott J, Pope M. Nonadherence with mood stabilizers: prevalence and predictors. *Journal of Clinical Psychiatry* 2002; *63*:384–390 / [17] Kessler et al, The prevalence and correlates of untreated serious mental illness. *Health Services Research 2001;36:987-1007*

The Kessler et al. study thus contradicts claims that many individuals with serious mental illnesses do not seek treatment because of fears of involuntary hospitalization, stigma or dissatisfaction with available services. It is commonly claimed that "if you make the psychiatric services attractive enough and culturally relevant, then individuals with serious mental illnesses will utilize them." This appears to not be true. Very few individuals cited "not satisfied with available services," "could not get appointment," "language problem," etc., as a reason why they were not in treatment. ***The greatest reason for nontreatment by far was the person's lack of awareness of their illness***. Such individuals will not voluntarily utilize psychiatric services, no matter how attractive those services are, because they do not believe that they have an illness.

Lack of awareness of illness, also called anosognosia.
In a review, 10 of 14 studies that examined lack of awareness of illness and medication nonadherence in schizophrenia reported that the two are strongly associated.[18]

Other studies have also reported a strong association between lack of awareness and medication nonadherence. When impaired awareness of illness is compared with other reasons for medication nonadherence, it is invariably found to be the single most important reason. This is true for individuals with bipolar disorder as well as for those with schizophrenia.[19,20]

Concurrent alcohol or drug abuse
The second most important reason for medication nonadherence in individuals with severe psychiatric disorders is concurrent substance abuse. This association has been reported in at least 10 studies (Lacro et al., op cit.).[21]

Poor relationship between psychiatric staff and patients
Every study that has examined this has found a poor relationship between psychiatric staff and patients to be a factor in patients' nonadherence to medications (Lacro et al., op cit.). It is often referred to as a poor therapeutic alliance. Such relationships include psychiatrists, psychologists, nurses, social workers and psychiatric aides in both inpatient and outpatient units. It involves things such as taking the time to listen to patients, treating them with respect, explaining things to them and involving them in treatment decisions insofar as this is feasible.

[18] Lacro J, Dunn LB, Dolder CR et al. Prevalence of risk factors for medication nonadherence in patients with schizophrenia: a comprehensive review of recent literature. *Journal of Clinical Psychiatry* 2002; *63*: 892–-909 / [19] Faruqui RA, Andrews MD, Oyewole R et al. Clinical correlates of adherence to antipsychotic treatment in pre-discharge patients with schizophrenia [abstract]. *Schizophrenia Research* 2003; 60: 322 / [20] Greenhouse WJ, Björn M, Johnson SL. Coping and medication adherence in bipolar disorder. *Journal of Affective Disorders* 2000; *59*: 237/ [21] Hunt GE, Bergen J, Bashir M. Medication compliance and comorbid substance abuse in schizophrenia: impact on community survival 4 years after a relapse. *Schizophrenia Research* 2002; 54: 253–264

Medication side effects

This is often cited as the most important reason individuals with schizophrenia and bipolar disorder fail to take their medications. Studies, however, suggest that it is a much less important reason than the three reasons discussed above. In one review, only 1 out of 9 studies found a significant association between side effects and medication adherence in individuals with schizophrenia (Lacro et al., op cit.). "... Effects may have less influence on [medication] adherence than is currently presumed" (Day et al., op cit.)[22].

Other factors

Other factors known to contribute to medication nonadherence in individuals with schizophrenia and bipolar disorder include cost of medication, no improvement in symptoms, confusion, depression, lack of access to medication because of being homeless or in jail and (for individuals with bipolar disorder) purposeful stopping of medication because they enjoy being manic.

3. The effects of involuntary commitment and involuntary medication on individuals with serious mental illnesses

SUMMARY: Some people have claimed that involuntarily committing or medicating individuals with serious mental illnesses causes devastating and long-lasting effects on the person and leads to widespread lack of cooperation with future treatment. Follow-up studies of such individuals do not support this claim. In most such studies, the majority of patients subjected to involuntary commitment or involuntary medication retrospectively agreed with the treatment or were neutral about it.

In 2005, researchers conducted face-to-face interviews with 76 assisted outpatient treatment (AOT) recipients to assess their opinions about the program, perceptions of coercion or stigma associated with the court order and quality of life as a result of AOT. After they received

[22] Day JC, Bentall RP, Roberts C et al. Attitudes toward antipsychotic medication. *Archives of General Psychiatry* 2005;*62*:717–724, 2005.

treatment, interviewed recipients overwhelmingly endorsed the program.[23]

- 75 percent reported that AOT helped them gain control over their lives.
- 81 percent said that AOT helped them to get and stay well.
- 90 percent said AOT made them more likely to keep appointments and take medication.

In 2004, interviews were conducted with 104 individuals with schizophrenia and related disorders regarding their feelings about involuntary (assisted outpatient) treatment. Such mandated treatment was regarded as being effective by 62 percent and as being fair by 55 percent of these individuals. Those who had awareness of their own illness (insight) were much more likely to regard mandated treatment as fair.[24]

In 2003 in New York, 117 individuals with severe mental illness were followed up for 11 months after discharge from a psychiatric hospital. Those who perceived themselves as being forced to take medication ("high perceived coercion") were compared with those who did not perceive themselves as being forced to take medication. At the end of 11 months, there were no differences between the two groups in their adherence to medication.[25]

In 1996, 30 patients who had been forcibly medicated during their psychiatric hospitalization were interviewed by telephone one to two weeks later by individuals who had not been involved in their treatment. Eighty-seven percent of the patients had been diagnosed with schizophrenia or bipolar disorder. Among those who refused, 30 percent recalled having refused the medication because they had believed there was nothing wrong with them and 20 percent said they had refused because they had believed the medication was poison.

In 1995, 28 outpatients who had felt pressured or forced to take psychiatric medications within the preceding year were administered a questionnaire by their peers. They were part of a larger group of users of psychosocial rehabilitation centers. In reply to questions about how they felt about having been pressured to take medications, 9 (32 percent) were

[23] *Kendra's Law: Final Report on the Status of Assisted Outpatient Treatment* (New York: Office of Mental Health, March 2005) / [24] Swartz MS, Wagner HR, Swanson JW et al. Consumers' perceptions of the fairness and effectiveness of mandated community treatment and related pressures. *Psychiatric Services* 2004;55:780–785 / [25] Rain SD, Steadman HJ, Robbins PC. Perceived coercion and treatment adherence in an outpatient commitment program. *Psychiatric Services* 2003;54:399–401

positive, 9 (32 percent) expressed mixed views, 6 (21 percent) reported no effect and 3 (11 percent) reported a negative effect. In addition, 12 patients (43 percent) said that the experience gave them a sense that people were looking out for their best interest. The authors also noted that "only a few respondents said that past experiences of pressured or forced medication had had any effect on their subsequent willingness to take medication.[26]

5. Homelessness: One of the consequences of failing to treat individuals with serious mental illnesses

SUMMARY: People with untreated psychiatric illnesses constitute one-third, or approximately 250,000, of the estimated 744,000 homeless population in the United States. The quality of life for these individuals is abysmal. Many are victimized regularly. One study found that 28 percent of homeless people with previous psychiatric hospitalizations obtained some food from garbage cans and 8 percent used garbage cans as a primary food source.

In many cities, such as San Francisco, homeless people with severe mental illnesses are now an accepted part of the urban landscape and make up a significant percentage of the homeless who ride subways all night, sleep on sidewalks or hang out in the parks. These mentally ill individuals drift into the train and bus stations, and even the airports.

Many other homeless people hide from the eyes of most citizens. They shuffle quietly through the streets by day, talking to their voices only when they think nobody is looking, and they live in shelters or abandoned buildings at night. Some shelters become known as havens for these mentally ill wanderers and take on the appearance of a hospital psychiatric ward. Others who are psychiatrically ill live in the woods on the outskirts of cities, under bridges, and even in the tunnels that carry subway trains beneath cities.

A 2007 survey by the National Alliance to End Homelessness reported that there were approximately 744,000 homeless persons in the U.S. Numerous studies have reported that

[26] Lucksted A, Coursey RD. Consumer perceptions of pressure and force in psychiatric treatments. *Psychiatric Services* 1995;46:146–152.

approximately one-third of homeless persons have a serious mental illness, mostly schizophrenia or bipolar disorder. The percentage is higher among those who are chronically homeless and among homeless women and is lower among homeless families. If overall one-third of homeless persons are seriously mentally ill, that means that there are approximately 250,000 homeless persons with serious mental illnesses in the US.[27]

The homeless population, especially homeless persons with serious mental illness, has increased steadily since the 1970s. This is seen in all major cities but also in smaller cities and towns.[28,29] In 2006, Markowitz published data on 81 U.S cities, looking at correlations between the decreasing availability of psychiatric hospital beds and the increase in crime, arrest rates and homelessness. As expected, he found direct correlations.[30,31] This is consistent with past studies in Massachusetts and Ohio that reported that 27 and 36 percent of the discharges from state mental hospitals had become homeless within six months. It is also consistent with a study in New York that found that 38 percent of discharges from a state hospital had "no known address" six months later.[32]

Officials think they are saving money by dumping patients out of the mental hospitals and onto the streets and public shelters, but they are not. "In 2001, a University of Pennsylvania study that examined 5,000 homeless people with mental illnesses in New York City found they cost taxpayers an average of $40,500 a year for their use of emergency rooms, psychiatric hospitals, shelters, and prisons.[33]"

Mentally ill homeless people are victimized regularly. In New York, 949 homeless men were interviewed regarding having been assaulted or injured. Twelve percent of the men were psychotic, and this group was significantly more likely than the nonpsychotic men to have been robbed, beaten, threatened with a weapon or injured (concussion or limb fractures). A study of homeless women in Baltimore found that nearly one-third of the women had been raped.[34]

[27] Ohlemacher S. Study: 744,000 homeless in U.S. Associated Press archives, January 10, 2007, http://www.ap.org/, last accessed March 28, 2011 / [28]Hammack L, Adams M, Roanoke turns its focus on homeless. *Roanoke Times*, December 16, 2007 / [29] Gagnon D. Role of Maine shelters in flux. *Bangor Daily News*, December 11, 2007 / [30]Markowitz FE. Psychiatric hospital capacity, homelessness, and crime and arrest rates. *Criminology* 2006;44:45–72 / [31] Belcher JR. Rights versus needs of homeless mentally ill persons. *Social Work* 1988;33:398–402 / [32] Belcher JR. Defining the service needs of homeless mentally ill persons. *Hospital and Community Psychiatry* 1988;39:1203–1205, [32] Drake RE, Wallach MA, Hoffman JS. Housing instability and homelessness among aftercare patients of an urban state hospital. *Hospital and Community Psychiatry* 1989;40:46–51 / [33] Brinkman, P. Brown County Mental Health Center funding funnels into community placement; new trend impacts former, current institution residents. *Green Bay Press Gazette*, October 30, 2005, [33] Mangano PF, Blasi G. Stuck on skid row: L.A. should do what other cities already are: move the homeless into permanent housing, and stop just managing the problem. *Los Angeles Times*, October 29, 2007 / [34] Padgett DK, Struening EL. Victimization and traumatic injuries among the homeless: associations with alcohol, drug, and mental problems. *American Journal of Orthopsychiatry* 1992;62:525–534, [34] Breakey WR, Fischer PJ, Kramer M et al. Health and mental health problems of homeless men and women in Baltimore. *Journal of the American Medical Association* 1989;262:1352–1357

5. Victimization: One of the consequences of failing to treat individuals with serious mental illnesses.

SUMMARY: Multiple studies have shown that individuals with severe psychiatric disorders are especially vulnerable to being victimized. This frequently involves acts such as theft of clothing or money, but also includes assault, rape or being killed. Women who have a severe psychiatric disorder are especially vulnerable. Some of the studies suggest that individuals who are victimized are less likely to have been compliant with their medication. This association is strongly supported by the 2002 North Carolina study by Hiday et al. that showed that individuals with severe psychiatric disorders who were on outpatient commitment, and thus were taking their medication regularly, were *victimized only half as often* as those who were not on outpatient commitment.

A 2009 review of victimization studies reported: "Rates of victimization among severely mentally ill persons were 2.3–140.4 times higher than in the general population." Victimization occurred more frequently among individuals who were also abusing drugs and/or alcohol and among individuals who had the most severe symptoms.[35]

A National Crime Victimization Survey interviewed 936 patients with "chronic and severe mental illnesses." "More than one quarter . . . [of them] had been victims of a violent crime in the past year, a rate more than 11 times higher than the general population." The authors suggested that the study "may underestimate victimization.[36]"

In Los Angeles, 172 individuals with schizophrenia who were living in the community in stable housing were followed for three years. During that time, 34 percent of them were victimized by violent crimes (robbery, assault or rape). Individuals who were victimized were more likely to have had more severe symptoms, although medication compliance was not assessed in this study. The authors concluded: "This finding suggests that the most ill and vulnerable persons with schizophrenia are the most likely to be victimized.[37]"

In San Francisco, 103 individuals with schizophrenia spectrum disorders and 36 with bipolar disorder were asked whether they had been victimized (by robbery, rape, mugging

[35] Maniglio R. Severe mental illness and criminal victimization: a systematic review. *Acta Psychiatrica Scandinavica* 2009;119:180–191 / [36] Teplin LA, McClelland GM, Abram KM et al. Crime victimization in adults with severe mental illness. *Archives of General Psychiatry* 2005;62:911–921 / [37] Brekke JS, Prindle C, Bae SW et. al. Risks for individuals with schizophrenia who are living in the community. *Psychiatric Services* 2001;52:1358–1366

or assault) within the past six months. At the time of the interview, all were living in residential homes. One-third of those with bipolar disorder and one-fifth of those with schizophrenia spectrum disorders had been victimized. Females were almost twice as likely to have been victimized compared to males.[38]

In North Carolina, detailed information on victimization was obtained on 184 individuals with schizophrenia, schizoaffective disorder, and affective disorders, who were followed for one year. Eighty-five of the individuals were on outpatient commitment for part or all of the year and 99 were not. Victimization was classified as either a violent crime (e.g., assault, rape or mugging) or a nonviolent crime (e.g., burglary, theft of money or being cheated) against the psychiatrically ill person. Among the 85 individuals on outpatient commitment, 24 percent were victimized, while among the 99 not on outpatient commitment, 42 percent were victimized. The authors noted: "Furthermore, risk of victimization decreased with increased duration of outpatient commitment." Individuals in the outpatient-commitment group were victimized significantly less often despite the fact that individuals in both groups received standard outpatient care and case management services.[39]

The authors suggest that "outpatient commitment reduces criminal victimization through improving treatment adherence, decreasing substance abuse, and diminishing violent incidents" that may evoke retaliation.

6. Suicide: One of the consequences of failing to treat individuals with serious mental illnesses

SUMMARY: Suicide accounts for approximately 29,000 deaths each year in the United States. Studies suggest that at least 5,000 of the individuals who commit suicide have schizophrenia or bipolar disorder at the time of their suicides. Other studies indicate that most of these individuals were not receiving adequate psychiatric treatment at the time of their deaths. Adequate psychiatric treatment could save up to 5,000 lives per year.

Estimates of the completed suicide rate for individuals with schizophrenia range from **10 to 13 percent**, and for individuals with bipolar disorder the rate is about **15 percent**. This

[38] White MC, Chafetz L, Collins-Bride G et al. History of arrest, incarceration and victimization in community-based severely mentally ill. *Journal of Community Health* 2006;31:123–135 / [39] Hiday VA, Swartz MS, Swanson JW et al. Impact of outpatient commitment on victimization of people with severe mental illness. *American Journal of Psychiatry* 2002;159:1403–1411.

rate is at least four times higher than similar studies from the period from 1913 to 1940, suggesting that the suicide rate has risen markedly since deinstitutionalization began.[40]

One study examined the psychiatric histories in 134 individuals who committed suicide. It reported that 19 percent of these individuals had had symptoms of psychosis (e.g., delusions) in the month preceding their suicide. If this study is representative, then it means that almost one-fifth of all suicides are related to psychoses. Since there are about 29,000 suicides a year in the U.S., then at least 5,000 of them are psychosis-related[41].

Several studies have reported that suicide among individuals with serious mental illnesses occur most commonly in individuals who are not taking their medication. For example, a study in Kentucky found that only 2 of 28 individuals with schizophrenia who committed suicide had evidence in their blood of having taken antipsychotic medication. Thus, 93 percent of them were not being treated.[42]

7. How unawareness of illness (anosognosia) increases violent behavior in individuals with serious mental illnesses

SUMMARY: Unawareness of illness (anosognosia) is found in approximately half of all individuals with serious mental illnesses. It increases the likelihood that such individuals may become aggressive and violent. Unawareness of illness increases the chances that such individuals will not take medication, which therefore increases the person's symptoms and chances of becoming violent. The most important way to decrease violent behavior in individuals with serious mental illnesses is to make certain that they are being treated.

In the United States (five sites), 1,011 outpatients with severe psychiatric disorders were assessed for medication adherence and physically assaultive behavior over six months. Those who became physically assaultive were significantly more likely to have treatment nonadherence, to be sicker, to be a substance abuser, and to have a personality disorder.[43]

[40] Caldwell C, Gottesman I. Schizophrenics kill themselves too: a review of risk factors for suicide. *Schizophrenia Bulletin* 1990;16:571–-589, [40] Goodwin FK, Jamison KR. *Manic-Depressive Illness* (New York: Oxford University Press, 1990), p. 230 / [41] Stephens J, Richard P, McHugh PR. Suicide in patients hospitalized for schizophrenia: 1913-1940. *Journal of Nervous and Mental Disease* 1999;187:10–14 / [42] Robins E. Psychosis and suicide. *Biological Psychiatry* 1986;21:665–672; [43] Elbogen EB, Van Dorn RA, Swanson JW et al. Treatment engagement and violence risk in mental disorders. *British Journal of Psychiatry* 2006;189:354–360

In the United States (multi-site study), 1,906 individuals with schizophrenia and related disorders were prospectively followed and assessed for three years. Medication nonadherence was significantly associated with being violent, arrested and victimized.[44]

In Ohio, 115 individuals with schizophrenia who had committed violent acts for which legal charges were incurred were compared to 111 individuals with schizophrenia who had no history of violent acts. The violent individuals had marked deficits in insight and were much more symptomatic. Compared to the nonviolent individuals, those who had been violent scored significantly lower on awareness of mental disorder, awareness of achieved effect of medications and awareness of social consequences of mental disorders.[45]

In North Carolina, 331 severely mentally ill|| individuals who had been involuntarily admitted to a psychiatric disorder were assessed for their history of assaultive and violent behavior. The findings indicated that substance abuse problems, medication noncompliance, and low insight into illness operate together to increase violence risk.[46]

In Massachusetts, 133 outpatients with schizophrenia were assessed for violent behavior over six months. During that period, 13 percent of the study group were characteristically violent, and this was associated with medication nonadherence. Seventy-one percent of the violent patients had problems with medication compliance compared with only 17 percent of those without hostile behaviors.[47]

In New York, 60 male patients with psychosis who had been charged with a violent crime were assessed. Severity of community violence was strongly associated with poor insight, medication nonadherence and substance abuse.[48]

[44] Ascher-Svanum H, Faries DE, Zhu B et al. Medication adherence and long-term functional outcomes in the treatment of schizophrenia in usual care. *Journal of Clinical Psychiatry* 2006;67:453–460, [44] Grevatt M, Thomas-Peter B, Hughes G. Violence, mental disorder and risk assessment: can structured clinical assessments predict the short-term risk of inpatient violence? *Journal of Forensic Psychiatry and Psychology* 2004;15:278–292 / [45] Buckley PF, Hrouda DR, Friedman L, et al. Insight and its relationship to violent behavior in patients with schizophrenia. *American Journal of Psychiatry* 2004;161:1712–1714 / [46] Swartz MS, Swanson JW, Hiday VA et al. Violence and severe mental illness: the effects of substance abuse and nonadherence to medication. *American Journal of Psychiatry* 1998;155:226–231; [47] Bartels SJ, Drake RE, Wallach MA et al. Characteristic hostility in schizophrenic patients. *Schizophrenia Bulletin* 1991;17:163–171 / [48] Alia-Klein N, O'Rourke TM, Goldstein RZ et al. Insight into illness and adherence to psychotropic medications are separately associated with violence severity in a forensic sample. *Aggressive Behavior* 2007;33:86–96;

8. Violence Creates Stigma

SUMMARY: Stigma is one of the most important problems encountered by individuals with severe psychiatric disorders. It lowers self-esteem, contributes to disrupted family relationships and adversely affects the ability to socialize, obtain housing and become employed. In December 1999, the Surgeon General's Report on Mental Health called stigma "powerful and pervasive," and the Secretary of Health and Human Services added: Fear and stigma persist, resulting in lost opportunities for individuals to seek treatment and improve or recover.

Recent studies have demonstrated that stigma against people with mental illnesses has increased over the past half century and is still increasing. Multiple studies have also shown that the major cause of this stigma is the perception that some individuals with mental illnesses are dangerous. Given this fact, it seems self-evident that stigma will not be decreased until we decrease violent behavior committed by mentally ill persons, and this can only be done by ensuring that they receive treatment.[48]

A. Stigma against mentally ill persons is increasing

In 2010, Pescosolido et al. assessed stigma against mentally ill persons, comparing results in a 2006 survey with a similar survey conducted in 1996. They reported that stigma had increased during that 11-year period and that "significantly more respondents in the 2006 survey than the 1996 survey reported an unwillingness to have someone with schizophrenia as a neighbor. . . . Our most striking finding is that stigma among the American public appears to be surprisingly fixed, even in the face of anticipated advances in public knowledge.[49]"

B. Violence is the major cause of this stigma

In 2008, a Harris poll reported that a majority of the public believes that violent behavior is a symptom of schizophrenia, and "roughly one in four Americans say they would feel uncomfortable around adults who have been treated for schizophrenia.[50]"

[49] Pescosolido BA, Martin JK, Long JS, Medina TR, Phelan JC, Link BG. "A disease like any other"? A decade of change in public reactions to schizophrenia, depression, and alcohol dependence. *American Journal of Psychiatry* 2010;167:1321–1330. Treatment Advocacy Center (www.treatmentadvocacycenter.org)/ [50] Schizophrenics battle stigma, myths in addition to disease. *USA Today*, June 8, 2008 /

A 1994 survey of Utah residents reported that 38 percent agreed that "people with mental illness are more dangerous than the rest of society." In 1999, a man with schizophrenia killed two people in a library in Salt Lake City. According to a newspaper account, within hours Valley Mental Health began getting calls from frightened clients. "Clients were just sobbing," said Connie Hines, public relations director for Valley Mental Health. They were afraid, she said, that the public would want to retaliate against them and that whatever progress had been made in the de-stigmatization of mental health had been set back years by the shooting.[51]
.
In 1999, a study reported that 61 percent of adults believed that an individual with schizophrenia was "very likely" (13 percent) or "somewhat likely" (48 percent) to do "something violent to others.[52]"

In 1996, a study of American university students reported that reading a newspaper article reporting a violent crime committed by a mental patient led to increased "negative attitudes toward people with mental illness.[53]"

A 1993 survey reported that more than half of people agreed with the statement that "those with mental disorders are more likely to commit acts of violence.[54]"

9. Schizophrenia as a brain disease: Studies of individuals who have never been treated

There is a lot of misinformation regarding what is wrong with the brain in schizophrenia. Thomas Szasz, MD, once claimed that nothing is wrong and that schizophrenia is merely a myth. Peter Breggin, MD, has argued that people with schizophrenia bring the symptoms on themselves because of cowardice or failure of nerve. Daniel Fisher, MD said that schizophrenia is merely severe emotional distress and loss of social role brought on by trauma. Scientologists even claim that the symptoms of schizophrenia are caused by the drugs that are used to treat it.[55]

[51] Fraser ME. Educating the public about mental illness: what will it take to get the job done? *Innovations and Research* 1994;3:29–31; [51] Jarvik E. Mental health clients fear growing stigma. *The Deseret News [Salt Lake City, Utah]*, April 24, 1999/ [52] Pescosolido BA, Monahan J, Link BG et al. The public's view of the competence, dangerousness, and need for legal coercion of persons with mental health problems. *American Journal of Public Health* 1999;89:1339–1345/ [53]Thornton JA, Wahl OF. Impact of a newspaper article on attitudes toward mental illness. *Journal of Community Psychology* 1996;24:17–24; [54]Clements M. What we say about mental illness. *Parade Magazine*, October 31, 1993 / [55] Szasz TS. *Schizophrenia: The Sacred Symbol of Psychiatry* (Syracuse: Syracuse University Press, 1976). Breggin PR, *The Psychology of Freedom* (Buffalo: Prometheus Books, 1980); [55] Condon G, quoting Daniel Fisher on WTIC-TV, Hartford, Connecticut, April 6, 2005

Such statements indicate a profound ignorance about schizophrenia. Research has now clearly demonstrated that schizophrenia is caused by changes in the brain and that these can be measured by changes in both brain structure and brain function. More than 1,000 such research studies have been published. Schizophrenia is thus a disease of the brain in exactly the same sense that Parkinson's disease, multiple sclerosis, epilepsy and Alzheimer's disease are diseases of the brain.

The same thing can be said about some other severe psychiatric disorders, specifically bipolar disorder (manic-depressive illness), schizoaffective disorder, severe depression, autism and severe obsessive-compulsive disorder.

The following sections will briefly review the evidence representative of 120 studies indicating that schizophrenia is a brain disease.

A. Structural Abnormalities

The modern era in schizophrenia research can be dated to 1976, with the publication of the first research using the newly developed computerized axial tomography (CT) brain scans. Since then, at least 35 studies of brain structure have been done on individuals with schizophrenia who had never been medicated. All six studies that measured the size of the brain ventricles found them to be significantly enlarged. In addition to ventricular size, abnormalities in brain structure in never-treated individuals with schizophrenia have been reported for the frontal cortex, temporal cortex, hippocampus, amygdala, cingulate, thalamus, cerebellum, corpus callosum and septum pellucidum.[56]

B. Neurological Abnormalities

Since 1976, at least 33 studies have reported significantly more neurological abnormalities in individuals with schizophrenia who had never been treated with antipsychotic medications compared to unaffected controls. The neurological abnormalities include Dyskinesias, which are spontaneous movements, usually involving the tongue, facial muscles or arms. Eleven

[56] Johnstone EC, Crow TJ, Frith CD et al., Cerebral ventricular size and cognitive impairment in chronic schizophrenia, *Lancet* 1976;2:924; [56] Gur RE et al., Reduced gray matter volume in schizophrenia, *Arch Gen Psychiatry* 1999;56 905–911; [56] Cahn W et al., Brain volume changes in first-episode schizophrenia: a 1-Year follow-up study, *Arch Gen Psychiatry* 2002;59:1002–1010/

studies have demonstrated that such movements occur more often among never-treated individuals with schizophrenia than among unaffected controls. Eight recent studies have also reported that never-treated patients with schizophrenia have neurological abnormalities resembling those seen in Parkinson's disease, including rigidity, tremor and slowing of movements.[57]

C. Neuropsychological Abnormalities

For almost two centuries, it has been observed that individuals with schizophrenia have deficits in some neuropsychological functions, especially memory, attention and planning (also called executive function). Since 1994, ten studies have been carried out on patients who had never received antipsychotic medications, confirming these observations. Several research groups studied individuals with first-episode schizophrenia, some of whom had never been medicated and some of whom had been briefly medicated, and reported that the never-medicated patients had significant neuropsychological deficits.[58]

D. Neurophysiological Abnormalities

Electrical impulses are one method used to communicate between brain cells. Electroencephalograms (EEGs) have been used for many years to assess brain function in schizophrenia. Consistent with past studies, two recent studies used EEGs to examine sleep patterns in never-medicated individuals with schizophrenia, and both reported more abnormalities in the patients compared to the unaffected controls. Another technique commonly used in psychiatric research to measure neurophysiological function is a type of electrical impulse called an evoked potential. For example, a startle reflex, measured electrically, may be evoked by a loud sound. Three recent studies of evoked potentials have been carried out on never-medicated individuals with schizophrenia; all three showed significantly more abnormalities in the patients than in unaffected controls.

[57] Owens DGC, Spontaneous involuntary disorders of movement, *Arch Gen Psychiatry* 1982;39:452–461; [57] Rogers D, The motor disorders of severe psychiatric illness: a conflict of paradigms, *Br J Psychiatry* 1985;147:221–232; [57] Fenn DS et al., Movements in never-medicated schizophrenics: a preliminary study, *Psychopharmacology* 1996;123:206–210. [58] *See* Brickman AM et al., Neuropsychological functioning in first-break, never-medicated adolescents with psychosis, *J Nerv Ment* 2004;192:615–622; [58] Neuropsychological deficits in neuroleptic naïve patients with first-episode schizophrenia, *Arch Gen Psychiatry* 1994;51:124–131; [58] McCreadie RG et al., Poor memory, negative symptoms and abnormal movements in never-treated Indian patients with schizophrenia, *Br J Psychiatry* 1997;171:360–363

Another measure of neurophysiological brain function is the recently developed transcranial magnetic stimulation (TMS), in which the brain is stimulated using magnets. A study of 21 neuroleptic-naïve individuals with schizophrenia reported them to be significantly different from 21 unaffected controls on some TMS measures. These studies suggest abnormal electrical and magnetic circuits in the brains of individuals with schizophrenia, evidence of neurophysiological dysfunction.[59]

E. Cerebral Metabolic Abnormalities

The measurement of cerebral metabolic activity is comparatively new and technically complex. Three ways of doing this are by positron emission tomography (PET), single photon emission computed tomography (SPECT) and functional magnetic resonance imaging (fMRI). Since it is known that antipsychotic medications can affect these tests, it is important to use individuals who have not been treated whenever possible. Since 1991, 21 studies have examined cerebral metabolic abnormalities in individuals with schizophrenia never treated with antipsychotic medications. In comparison with control subjects, patients showed reduced activation in the right thalamus, the right prefrontal cortex and the parietal lobe . . . bilaterally. Of the 21 studies reported to date, all except one found more cerebral metabolic abnormalities in the individuals with schizophrenia compared to the controls.[60]

[59] A Weike AI et al., Effective neuroleptic medication removes prepulse inhibition deficits in schizophrenia patients, *Biol Psychiatry* 2000;47:61–70; [59] Valkonen-Korhonen M, Altered auditory processing in acutely psychotic never-medicated first-episode patients, *Brain Res Cogn Brain Res* 2003;17:747–758; [59] Eichhammer P et al., Cortical excitability in neuroleptic-naïve first-episode schizophrenic patients, *Schizophr Res* 2004;67:253–259 / [60] Braus DF et al., Sensory information processing in neuroleptic-naïve first-episode schizophrenic patients: a functional magnetic resonance imaging study, *Arch Gen Psychiatry* 2002;59:696–701/ [60] Buchsbaum MS et al., Frontostriatal disorder of cerebral metabolism in never-medicated schizophrenics, *Arch Gen Psychiatry* 1992;49:935–942; [60] Barch DM et al., Selective deficits in prefrontal cortex function in medication-naïve patients with schizophrenia, *Arch Gen Psychiatry* 2001;58:280–288.

Hillmont Psychiatric Center
A Brief History
Covering IPU, A&R, PES, OPOS, CSU issues

2004-05

The Hillmont Inpatient Unit (IPU) IPU operated with 60 beds
Team A, B, C, D – each with 15 beds, each with a separate treatment team (nurses, doctor, etc.)
The Assessment & Referral (A&R) unit accepted patients directly.
Medical clearance was done in A&R, on occasion, clients were walked over to VCMC for a chest X-ray if a TB clearance was needed.

Sometime later, one wing (unit) was closed down, continuing to operate with 45 beds.

Dec 18, 2008

NAMI made a request: *Recommended that HPC have a contract with Aurora Vista del Mar (VDM) to send clients when no beds are available at HPC. There is a contract for adolescents, but adults are sent out of county.*

IPU response: (Angela Timmons, Operations Manager): *VDM is contracted to provide service to our 12 year old to 18 year old minors needing acute psychiatric hospitalization. Contract for adult services is cost prohibitive as the facility is private and does not accept Medi-Cal. This however does not preclude ongoing efforts to negotiate a mutually acceptable daily rate.*

Jan 2, 2015

Psychiatric Emergency Service (PES) planned, first presentation made to NAMI and stakeholders, by:
Leticia Rodriguez, COO, VC Medical Center
Elaine Crandall, Director, VC Behavioral Health
Dr Joe Vlaskovits, Medical Director, Hillmont IPU
Dan Powell, Operations Manager, Hillmont IPU

As presented: the building will be re-configured, A&R will be converted to a PES.

Jul 23, 2015

In response to a query (PES vs CSU), Dan Powell responded:
"The plans we presented at the meeting with NAMI early this year have not changed significantly, except for the name of the service. There have been some minor changes to the physical layout we presented due to requirements imposed by the regulatory agencies. We were told by the local regulators that we were not permitted to have "two emergency services on the same campus" (their words). Further, unlike the document from the CHA, California law does not specifically define a PES. Indeed, all the PESs in California are licensed by the State to provide and bill for Crisis Stabilization Services. Due to the regulator's insistence, we had to change the name to a Crisis Stabilization Unit (CSU) in order to proceed with regulatory approval. Otherwise, the plans would have, in all likelihood, been rejected by the regulators. "

Jul 29, 2015

Email response to questions from NAMI, from Dan Powell, referencing Guy Qvistgaard, Chief Admin Officer at Alameda County's John George Psychiatric Hospital:

In the very early stages of planning and designed our service, we looked to an outside consultant, namely Guy Qvistgaard of Alameda Health Systems, whom I understand you know well. Guy, for those who do not know is the Vice President for Psychiatry. His experience encompasses over 30 years of psychiatric hospital administration and he has developed the psychiatry services at Alameda Health Systems into a model and those services are the basis for Ms. Kruckenberg's attached concept paper. We had many discussions with him and others about the scope of our services and how we could best deliver them.

With regard to your specific questions;

1. Will the new unit be "Open with physician available 24/7"?

As we discussed with NAMI at our meeting, we plan to have a physician present for two eight hour shifts with an overlap. For the remainder of 9 hours from very late in the evening until early in the morning, we plan to cover by telephone. We discussed this extensively with Guy and others. While we would ideally like to have 24 hour physician coverage present, our discussions generated that in the current marketplace for psychiatrists in Ventura, this would likely be cost prohibitive. We know this, because Guy shared his challenges in recruiting psychiatrists for the overnight shift in the PES in Alameda County, which due to its centralized location can immediately draw on the population of the Bay Area and a much larger pool of psychiatrists. We also know from speaking to our physicians that San Diego for instance has very similar challenges. Ventura, on the other hand, is removed enough from the Los Angeles area that makes such recruitment much more difficult. Further, the advantage from having an additional physician is somewhat mitigated by the fact that our current A&R staff is well versed in admitting and transferring patients after hours by telephone order.

2. Required to assess all who present?

"All" is a very broad word and not even the existing PESs assess "all who present." For instance, the Alameda County PES only sees adults. If minors or geriatric patients present, they are referred elsewhere. Further, if someone presents but needs medical clearance, they will be referred to the Emergency Department. This is common practice, everywhere, even in PESs.

3. Will 5150 law enforcement drop-offs be allowed, as in the PES model?

We plan to improve on our existing model. When designing the service, we took a look at the fact that nearly 50% of our patients come directly from law enforcement and based on discussions with law enforcement, we want to be able to support the needs of those brought in by officers. In our planning, we have designed 3 rooms dedicated to triage for those coming as an "emergency," vastly increasing our present capability. Further, we designed a staging area, if those three rooms were filled at one time. Further, we plan to triage as soon as the law enforcement officer brings the patient through the "emergency" entrance. This is exactly like Alameda. Just as in San Diego, for instance, when an MD is present, we will attempt to have them interview the patient along with the law enforcement officer to determine what the patient needs immediately. (Alameda and Contra Costa, whom we visited, have very few patients brought directly by law enforcement; their patients overwhelmingly present by ambulance. From that perspective, San Diego's situation is closer to ours than Alameda or Contra Costa.) If an MD is not present, we plan to have a dedicated triage RN.

I think that the word "drop-offs" is somewhat misleading, because we plan to engage with the patient and the law enforcement officer, just as we do now, but to a greater degree having more hours of an MD present to determine the need for services.

However, if the referral from the law enforcement officer is outside our scope, for instance, for urgent or emergent medical reasons, we will refer them to our emergency department immediately from triage. We also plan to work with our partners in law enforcement to educate them on our services.

It is important to note, as we discussed in detail at the NAMI meeting, that we have not planned to have the service be a "Psychiatric Urgent Care." This was due to extensive discussions between us and VCBH. VCBH has indicated to us that they plan to develop their clinics into having evening and urgent care capability. So, for instance, if someone solely presents wanting to be started on an antidepressant and does not present an imminent danger to themselves or others, we would refer them to VCBH. Further, there are some services that we will not offer, such as evaluations for disability, refills, "medical marijuana" etc...

March 3, 2016

Minutes of the BHAB Adults Committee:

1. Ms. Milstien made an overview on the changes and latest developments of the In-Patient Psychiatric Unit at Hillmont.
2. She mentioned that Jason Cooper is the new Medical Director and Jeff Hawkins is the Clinical Nurse Manager of IPU.
3. The construction of the Crisis Stabilization Unit (CSU) became a simple reorganization of the Assessment and Referral (A&R) space which utilized only $50,000. This was an effort to make client assessment and registration simple and quick. ***Medical screening for inpatient services is now conducted at the A&R rather than the E.R.*** *The updated and revised A&R is referred to as the Adult Crisis Stabilization Unit as of January 2016.* ***It has an assessment area with ten recliners,*** *a separate room for law enforcement referrals, and two rooms for clients requiring a higher level of intervention.*
4. The new process includes a warm handoff of clients to outpatient services, home or other placement or transitioning in coordination with VCBH Crisis and RISE Team.
5. Regular morning meetings headed by the Clinical Nurse Manager and Medical Director are conducted to increase communication.
6. Ms. Milstien mentioned that they are looking into increasing bed capacity.
7. Co-Chair Bates suggested offering recovery groups at In-Patient Unit (IPU).
8. The plans for welcoming lobby reception area designed to be family- friendly were not implemented.

2017-18

Delay in opening CSU was attributed to licensing issues with California Department of Public Health (CDPH).
One wing (15 beds) converted to Outpatient Psychiatric Observation Service (OPOS).
IPU now operating with 30 beds.

Now (2019)

CSU Scheduled to open in April 2019 with 4 recliners.
IPU continues to operate with 30 beds

Attachment III

LPS Reform Workgroup

Workload Data Elements
October 2019

The following are data elements that are required to monitor behavioral health outcomes in Ventura County. There should be one report for the Inpatient Unit (IPU), a separate report for the Crisis Stabilization Unit (CSU), and separate reports for community hospital emergency rooms (ERs). The emergency room data should also be compiled into a single report for all ERs in the county.

IPU

Data should be collected and displayed by age group (adult, transitional age youth, children and older adults) and cumulative for the IPU as a whole. The spread sheet should include prior month and year data for comparative purposes. Reports are to be submitted on a quarterly basis. Data elements should include:

- Number of admissions
- Number of discharges
- Average length of stay
- Average daily census
- Frequency of client/patient census for each day of the month
- Number of readmissions within 7, 30 and 60 and 90 days
- Number of clients admitted on a 72-hour hold
- Number of clients admitted voluntarily
- Number of clients whose 72-hour hold was converted into a voluntary admission
- Client discharge destination; home, board and care, etc.
- Client discharge referrals for aftercare by major agency; VCBH, Gold Coast Health Plan, etc.

CSU

- Number of admissions
- Number of discharges
- Number of clients admitted on a 72-hour hold
- Number of clients admitted voluntarily
- Client discharge destination; home, board and care, etc.
- Client discharge referrals for aftercare by major agency; VCBH, Gold Coast Health Plan, etc.
- Number of readmissions within 7, 30 and 60 and 90 days

Community Hospital ERs

- Number of admissions
- Number of discharges
- Average length of stay
- Client discharge destination; psychiatric inpatient hospital. home, board and care, etc. (destination city should also be specified)
- Referrals for aftercare by agency for clients transferred for inpatient hospitalization
- Number of readmissions within 7, 30 and 60 and 90 days

Community hospital reports should be by age group and include data for the prior month and year. These reports are to be submitted monthly.

Attachment IV

OFFICE OF RESEARCH & PUBLIC AFFAIRS

EVIDENCE BRIEF

NOVEMBER 2019

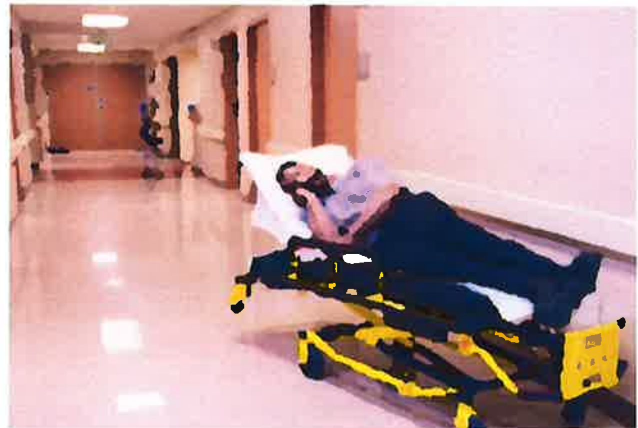
DELAYED AND DETERIORATING:

Serious Mental Illness and Psychiatric Boarding in Emergency Departments

INTRODUCTION

The number and proportion of mental health crisis emergency department visits have been steadily increasing in the United States in recent years. In 2014, there were more than 2.2 million emergency department visits by patients whose primary diagnosis was serious mental illness.[1] And as a result of a multitude of factors and failures in our mental health care system, instead of receiving timely and effective treatment, individuals are boarded in the emergency department, waiting for days or sometimes weeks, with nowhere to go and sometimes no treatment.

Psychiatric boarding occurs when individuals in need of psychiatric treatment present to emergency departments and are forced to wait for extended periods of time until meaningful care is received. The problem is widespread across the United States, with emergency departments commonly referred to as a "safety net"[2] or even a "dumping ground"[3] for people with mental illness seeking care. According to a 2016 survey by the American College of Emergency Physicians, over 90% of emergency physicians say psychiatric patients board in their emergency departments.[4] And more than 21% of these physicians reported waits of two to five days for an inpatient bed.[5]



Boarding in emergency departments is not unique to individuals with mental illness—anyone can face long wait times that have detrimental effects on the person's health. However, psychiatric patients are disproportionally affected by boarding.[6] Their waits are also longer, and the effects can be more serious. And for people with the most severe mental illnesses, delays in care simply because treatment is unavailable or inefficient may result in such deterioration in their condition that recovery is less achievable.

HIGHLIGHTS

- Emergency department visits for people in psychiatric crisis have been steadily increasing in the United States.
- Lack of affordable, comprehensive psychiatric treatment services is largely to blame for psychiatric boarding in emergency departments.
- Individuals with serious mental illness are disproportionately affected by psychiatric boarding.
- Boarding of patients with serious mental illness has significant negative impacts on long-term health outcomes.

EVIDENCE OF PSYCHIATRIC BOARDING

Although there are a number of external circumstances and patient characteristics that contribute to psychiatric boarding, research suggests that a lack of affordable, comprehensive psychiatric treatment services is largely to blame.[7] An unfulfilled transition from state psychiatric facilities and inpatient beds to community-based treatment beginning in the 1950s, combined with inadequate funding for mental health services generally,[8] has led to an influx of psychiatric patients seeking care in emergency departments.[9] Tellingly, the number of emergency department visits related to mental health or substance use has consistently grown over time, increasing by 41%—from 7.1 million to 10 million—in just six years between 2009 and 2015.[10] And with more and more individuals with mental illness searching for care in places unable to provide it, psychiatric boarding in emergency departments has become commonplace.

There is no agreed-upon definition of how long is "too long" for an emergency department wait or at what point boarding begins.[11] However, a number of studies illustrate the magnitude of the problem by comparing the wait times of psychiatric and nonpsychiatric patients in emergency departments across the country:

- A retrospective analysis of national emergency department data from 2001–2011, using the National Hospital Ambulatory Medical Care Survey (NHAMCS),[12] found that psychiatric patients were more than twice as likely to experience emergency department stays* longer than six, 12 or 24 hours, compared to patients without primary substance use disorders or mental health concerns.[13]

- Another analysis of NHAMCS data from 2002–2011 also suggests evidence of psychiatric boarding. Psychiatric patients experienced longer lengths of stay* compared to nonpsychiatric patients, regardless of whether they were admitted for observation, transferred to an inpatient facility or discharged.[14] Psychiatric patients admitted for observation had a median length of stay of 5.9 hours, while nonpsychiatric patients waited more than an hour less, at 4.7 hours. The difference was starker for patients requiring transfer, with psychiatric patients waiting 5.2 hours after the decision to transfer was made, compared to nonpsychiatric patients, who waited just 3.3 hours. Even when comparing patients who were discharged, people with mental illness faced wait times nearly an hour longer than those of nonpsychiatric patients.

- Earlier research analyzing NHAMCS survey data from 2002–2008[15] and 2001–2006[16] found that mental health-related emergency department visits resulted in an additional 1.20 and 1.25 hours per visit,† respectively, compared to non-mental health visits.

The definition of psychiatric boarding

In the most common definition of the term, psychiatric boarding can be characterized as the period of time a psychiatric patient waits in an emergency department following a disposition decision after evaluation by a clinician (i.e., admission, transfer or discharge). For these patients, clinicians have already determined the next steps in their care, but various barriers—including bed availability, insurance constraints or administrative hurdles—prevent immediate access to treatment or discharge.

Entire length of stay, which begins as soon as a patient walks through the door of an emergency department and ends when the patient leaves, may be used to measure psychiatric boarding if the time elapsed between a disposition decision and admission, transfer or discharge is not available.

Measurement may also involve selecting a threshold for what constitutes boarding, where portions of or entire lengths of stay are longer than two, four, six, eight, 12 or 24 hours.

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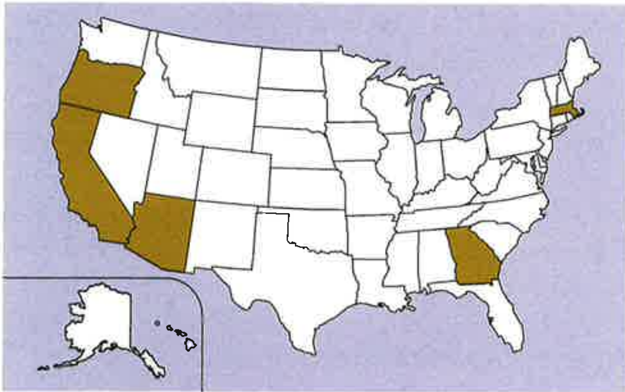
* Where length of stay is defined as the difference in time between triage and departure from the emergency department.

† Where length of stay is defined as the amount of time from emergency department admission to discharge.

State-specific data also highlight the problem:



- **ARIZONA**: More than 3,000 emergency department patients experienced psychiatric boarding, defined as stays longer than 24 hours following a disposition decision (i.e., admission, transfer or discharge), in 2013.[17]
- **CALIFORNIA:** Between 2007 and 2008, psychiatric patients of a Los Angeles emergency department who required hospitalization waited an average of 18.2 hours for an inpatient bed, compared to just 5.7 hours for nonpsychiatric patients requiring hospitalization.[18] And in a survey of California emergency department directors, respondents reported that in 2010 psychiatric patients waited an average of 10 hours between the decision to admit and placement or transfer to an inpatient bed, while nonpsychiatric patients had an average wait of 7 hours.[19]
- **GEORGIA:** The average emergency department wait for psychiatric patients requiring an inpatient bed exceeded all accepted definitions of boarding, at 34 hours, in 2008.[20]
- **MASSACHUSETTS**: Emergency department psychiatric patients who required admission or transfer saw mean total lengths of stay of 16.5 and 21.5 hours, respectively, compared to just 4.2 and 3.9 hours for medical or surgical patients over a two-week period in 2012.[21] An earlier study of more than 1,000 individuals presenting for emergency psychiatric evaluations at Massachusetts hospitals found that 8% spent more than 24 hours‡ in the emergency department, with a median stay of 31 hours between 2008 and 2009.[22]
- **OREGON:** More than 2% of all emergency department visits and nearly 15% of those that were psychiatric visits resulted in boarding, defined as stays longer than six hours, between 2014 and 2015. More than 3% of psychiatric visits resulted in stays longer than 24 hours.[23]

SERIOUS MENTAL ILLNESS IN PSYCHIATRIC BOARDING

Research suggests that the presence of serious mental illness, specifically, may increase the chances that an individual will board in the emergency department:

- Research using national data found that patients with severe psychiatric conditions were more likely to experience long emergency department waits. Patients with bipolar disorder or psychosis faced stays longer than 24 hours more often than patients with other psychiatric diagnoses, such as dual substance use psychiatric disorders or depression.[24] The study authors also note that most patients with a severe mental illness ultimately required admission or transfer to an inpatient facility.[25] The finding aligns with other research suggesting that the risk of psychiatric boarding increases when patients are transferred or admitted.[26] However, even when these patients were discharged, they were still more likely to spend more than 24 hours in the emergency department compared to patients without a severe mental illness.[27]
- According to a study of psychiatric patients in Oregon, which defined boarding as emergency department stays longer than six hours, visits by patients with severe psychiatric conditions were *twice as likely* to result in boarding compared to visits by those with 'non-severe' psychiatric conditions.[28] Nearly one-quarter (24%) of patients with severe psychiatric conditions boarded in the state's emergency departments between October 2014 and September 2015.[29] Of all patients who were boarded, those with severe psychiatric conditions experienced longer stays: 27 hours, compared to 15 hours for patients with

‡ Where length of stay is defined as the interval between presentation to triage and discharge.

'non-severe' psychiatric conditions.[30] Stakeholder interviews with Oregon officials suggested that schizophrenia and bipolar disorder among patients with "severe and persistent mental illness" were the top causes of boarding.[31]

- An analysis of Florida emergency department data from 2010–2013 also noted the role of severe mental illness in psychiatric boarding. Schizophrenia, along with self-harm and suicidality, was associated with longer stays compared to other psychiatric diagnoses.[32]

Serious Mental Illness and High Utilizers

Individuals with serious mental illness are also overrepresented in the population of patients considered "high utilizers" of health care resources.[33] High utilizers are individuals who use a disproportionate amount of health care services and visit emergency departments more often than the average patient,[34] leaving them with a potentially greater chance of experiencing boarding. In a study of San Diego emergency departments, frequent emergency department users accounted for just 9% of emergency department patients in the region but 37% of total emergency department visits. Of this group, over half (56%) were diagnosed with a psychotic disorder.[35] Among other studies of individuals with serious mental illness and high health care utilization, one group of researchers using predictive modeling techniques found a "consistent increase in the rate of [emergency department] visits as mental illness severity increased from mild to moderate to severe."[36]

Serious Mental Illness and Insurance

Another factor implicating serious mental illness in psychiatric emergency department boarding is insurance status. A number of studies have shown that psychiatric patients who are uninsured face longer emergency department stays or increased chances of boarding.[37] Conclusions about the effect of public insurance versus private insurance on psychiatric boarding are more mixed, but the data suggest that individuals covered by plans such as Medicare or Medicaid tend to experience longer waits and an increased likelihood of boarding.[38] Data collected by the Substance Abuse and Mental Health Services Administration suggest that individuals with serious mental illness are more likely to either be uninsured or covered by public insurance compared to the broader population of individuals with any mental illness. In 2018, 13% of individuals with serious mental illness were uninsured and 47% were covered by public insurance programs,[39] while uninsured and public insurance rates for individuals with any mental illness were 11% and 45%, respectively.[40]

SYSTEMIC FACTORS LEADING TO PSYCHIATRIC BOARDING

The mental health care system is complicated, overburdened and underfunded. Individuals with mental illness face both limited treatment options and structural barriers to receiving appropriate care if or when it is available. The result is a number of systemic factors that lead to psychiatric boarding in emergency departments.

Gaps and Inefficiencies in the Continuum of Care

The effect of inadequate resources on psychiatric boarding is twofold. By limiting access to vital treatment services, both inpatient and community-based, the health care system prevents individuals with mental illness from addressing and managing their symptoms in a timely manner, before reaching a crisis point. And when dedicated crisis services are also in short supply, individuals in the midst of a psychiatric crisis have nowhere to go but the nearest emergency department[41]

The limited availability of inpatient psychiatric beds also contributes to psychiatric boarding in emergency departments by creating a bottleneck. Patients presenting to the emergency department who require inpatient care may experience extensive waits to be admitted to the hospital or transferred to an appropriate external psychiatric treatment facility, within which there are very few available beds.[42]

The transfer process itself is also problematic, involving "several steps, including medical clearance, psychiatric screening and evaluation, insurance authorization ... and arranging for transportation"[43]—some of which are unique to psychiatric patients.[44] Waits for transfer are worsened by nonstandard admission requirements across inpatient facilities.

Facilities may have entirely different admission requirements based on factors such as preexisting patient conditions, administrative burdens and the results of laboratory testing.[45] One study notes a specific discrepancy between patient transfers to public versus private facilities, with public facilities associated with longer emergency department stays.[46] This results in a phenomenon known as "shotgun referrals," where an individual is referred by emergency department staff to multiple facilities all at the same time because of the long waits and selective admission practices of hospitals.[47]

In order to access an inpatient psychiatric bed in many parts of the country, an individual must first present to a local emergency department. According to a 2015 survey of state mental health departments, 29 of 46 responding states reported that individuals with mental illness remain in the emergency department while waiting for an appropriate placement.[48]

Given the difficulties associated with bed availability and the transfer processes, a patient's individual disposition decision can increase the likelihood and length of boarding time as well. Although evidence suggests that psychiatric patients often wait longer in emergency departments than nonpsychiatric patients regardless of disposition,[49] psychiatric patients who are admitted to the hospital for inpatient care or transferred to another inpatient facility are most likely to experience boarding and tend to wait the longest:[50]

- Transferred psychiatric patients boarded[§] for an average of 9.2 hours, compared to six hours for admitted patients and 1.3 hours for discharged patients, in a study of 10 Massachusetts emergency departments in 2012.[51]
- Transferred psychiatric patients had total average lengths of stay[¶] of more than 11.5 hours, compared to discharged patients, who experienced lengths of stay of seven hours, in Florida emergency departments between 2010 and 2013. Over 73% of transferred psychiatric patients were boarded, defined as a length of stay greater than six hours.[52]
- Psychiatric patients transferred to an external location saw an average total length of stay[**] of 15 hours, compared to 8.6 hours for discharged patients, in a study of five Boston-area emergency departments between 2008 and 2009.[53] The authors note that the time spent waiting between a disposition decision and admission or transfer was the primary cause of extended lengths of stay, with admitted and transferred patients waiting an additional 3.3 and 7.4 hours after a decision, respectively.[54]
- Nearly all (94%) psychiatric patients with lengths of stay[††] greater than 24 hours were individuals requiring admission or transfer, in a study of an urban academic emergency department from 2009 to 2010.[55]

Availability of Treatment Professionals

Complicating matters is the scarcity of psychiatric professionals on-staff in emergency departments. Emergency departments are not designed for care and management of chronic conditions such as mental illness.[56] As a result, many emergency departments do not have dedicated psychiatric services or psychiatrists available at all times,[57] and general emergency department clinicians are not necessarily trained in the provision of appropriate or long-term psychiatric care.[58] Rather, most mental health training for emergency clinicians and nurses focuses on initial diagnosis and emergency interventions such as sedation.[59] As a result, emergency physicians may, for example, "err on the side of caution" in favor of inpatient psychiatric treatment, potentially due to liability concerns if a patient is discharged and then experiences a subsequent crisis.[60] However, this type of decision making can lead to patients waiting hours or days for a psychiatric bed, only to find that inpatient treatment is not appropriate once they are evaluated by a mental health professional.[61]

§ Where boarding is defined as the time spent waiting between the disposition decision and discharge.

¶ Where length of stay is defined as the time from emergency department arrival to discharge.

** Where total length of stay is defined as the interval between triage time and discharge time.

†† Where length of stay is defined as total length of stay from registration to departure.

Legal Considerations

The Emergency Medical Treatment and Labor Act (EMTALA) is a federal law that requires stabilization and treatment of all people presenting to an emergency department, regardless of their insurance status or ability to pay. In addition, EMTALA requires transfer to an appropriate facility for stabilization if such services cannot be adequately provided in the current location. The receiving facility has a duty to accept the transferred patient if it has an on-call specialist and capacity to treat the individual.

Although the federal government has clarified EMTALA guidelines‡‡ for psychiatric emergencies, questions remain regarding the minimum clinical standards for stabilization and treatment of psychiatric patients.[63] The process of patient dumping, sometimes referred to as "streeting," or discharging psychiatric patients who have not yet received appropriate treatment, still occurs as a mechanism to prevent boarding of psychiatric patients who have no appropriate options for timely placement.[64] Conversely, hospitals also report boarding psychiatric patients in emergency departments instead of discharging when appropriate, due to fear of EMTALA violations.[65] In either case, the care of psychiatric patients in emergency departments may be determined more by complex legal structures than individual patient needs.

When psychiatric patients must be transferred for treatment, inpatient facilities can exacerbate barriers to adequate care. Inpatient psychiatric facilities may have a preference for accepting "lower acuity" patients, or those with less severe and more easily treatable conditions,[66] resulting in a practice known as cherry-picking.[67] The incentive to accept these lower-risk patients leaves emergency departments with the remaining high-acuity patients, who, intuitively, are actually the patients most in need of immediate inpatient care. Experts have recommended greater local, state and federal oversight of adherence to EMTALA to prevent such practices.[68]

Between 2002 and 2018, almost 20% of EMTALA violations resulting in civil monetary penalties were due to psychiatric emergencies, with psychiatric emergency violations requiring the largest monetary payouts.[69] More than two-thirds of those cases were due to the hospital failing to provide stabilizing treatment to psychiatric patients in the emergency

The Case of Rebecca

Viral video footage from a cold winter night in January 2018 reveals the reality of treatment in emergency departments for people with severe mental illness. The video shows a woman dressed only in a hospital gown despite the freezing temperatures, walking on the street outside University of Maryland Medical Center Midtown in Baltimore. Rebecca was removed by security after resisting discharge from the emergency department, where she had been treated for a head wound after a motorbike accident.

Rebecca suffered from severe mental illness and struggled with adhering to treatment, according to her family. She cycled between various homeless shelters throughout Maryland and had been hospitalized almost 10 times in recent years.

Federal regulators have reportedly charged the hospital with violating patient safety, including violating a patient's right to receive care in an emergency department in a safe setting. According to Rebecca's family, she is still being hospitalized due to her mental illness and suffers flashbacks from her experience in Baltimore.

‡‡ According to the Centers for Medicare and Medicaid Services' interpretive guidelines for EMTALA regulations, "Psychiatric patients are considered stable when they are protected and prevented from injuring or harming him/herself or others." [62]

department, resulting in situations such as psychiatric boarding or patient dumping. Almost half (44%) of EMTALA violations for psychiatric emergencies cited the hospital for either failing to transfer or failing to accept an appropriate transfer.

Financing and Payment

Insurance structures and reimbursement rates may affect psychiatric boarding as well. Historically, insurance payers have reimbursed physicians for admitted psychiatric patients at low rates,[70] disincentivizing timely treatment for these patients in emergency departments. One study of patients admitted to an academic medical center emergency department found that physician reimbursement rates were 40% lower for psychiatric patients compared to nonpsychiatric patients.[71] A report of the Arizona Hospital and Healthcare Association describes the contractual nature of the relationship between providers and payers, which can lead to some individuals being more readily accepted at inpatient facilities following an emergency department visit, simply because the facility is in their insurance plan's network.[72]

Federal public policy related to mental health care financing and payment also plays a role. For inpatient psychiatric facilities specifically, a federal policy known as the Institutions for Mental Disease (IMD) exclusion categorically prevents Medicaid reimbursement for the care of most individuals with mental illness in facilities with more than 16 total beds.[73] States are currently able to apply for waivers granting them an exception to the policy rule, but the IMD exclusion remains the governing law without proactive efforts on the part of each individual state. Not onl y does the IMD exclusion serve as an example of the lack of reimbursement parity between mental health and non–mental health services, but it also provides a disincentive for the building and maintenance of large inpatient psychiatric facilities that could provide care to more patients.

THE COSTS OF PSYCHIATRIC BOARDING

Psychiatric boarding has serious consequences for individuals with mental illness, other patients and the health care system overall. Psychiatric patients experience symptom exacerbation and general decompensation, while other patients see their own delays in treatment, physicians feel the stress of crowded conditions, and hospitals face the burdens of increased costs and ambulance diversions.

Symptom Exacerbation and Decompensation for Individuals With Mental Illness

Even when operating efficiently, emergency departments are not designed to provide long-term treatment or management of patients with chronic diseases, particularly mental illness.[74] In addition to lacking sufficient specialized resources, emergency departments are characteristically loud and hectic, creating an environment that is counterproductive for de-escalating psychiatric crises.[75] When psychiatric patients experience boarding, the situation becomes even worse. As they wait for treatment, boarded patients spend extended periods of time in this overstimulating environment, often with infrequent communication from staff and no understanding of the situation.[76] Shuffled wherever they can fit, "they lie on gurneys or sit in chairs ... often filling every available space, including the hallways."[77] Boarded psychiatric patients face constant concerns related to stress, general safety and timeliness of treatment and can see symptoms exacerbated simply due to their stay in the emergency department.[78]

According to a 2008 survey by the American College of Emergency Physicians, a majority (62%) of the nation's emergency department directors reported that "there are no psychiatric services involved with patient care" while boarding,[79] speaking to the potential for significant decompensation over an hours- or dayslong wait. Boarded patients may even require hospitalization purely *as a result of* symptoms that were left untreated or that worsened while boarding.[80] Additional emergency department practices, such as the use of "safe hold" rooms for boarded psychiatric patients, can further traumatize individuals with psychiatric conditions, comparable to the experience of solitary confinement in the criminal justice system.[81]

Treatment Delays for Other Patients

Boarding often leads to emergency department crowding, leaving less space and fewer resources for incoming patients who have their own urgent medical needs. These patients, too, may see delays in treatment[82] and have been shown to report dissatisfaction with their care when boarding is prevalent. Tending to boarded psychiatric patients in common areas such as hallways or waiting rooms also increases the chance that other patients will witness distressing or traumatizing medical events.[83]

Increased Stress for Emergency Clinicians

For emergency clinicians, crowded conditions and patients with untreated mental health needs increase pressure, distractions and stress, making already complex care provision more difficult. Staff may also feel inadequate, as they are unable to effectively treat individuals with serious mental illness due to lack of relevant training.[84] Boarding may also increase the risk to clinicians and staff of physical harm at the hands of aggressive patients whose conditions worsen over the course of extensive stays.[85]

Fiscal and Procedural Costs Incurred by the Health Care System

A psychiatric emergency department visit in which an individual is boarded can cost hundreds of dollars more than a visit that results in timely treatment.[86] Among Oregon emergency department visits covered by Medicaid between October 2014 and September 2015, boarded psychiatric visits cost an average of $695 per visit, while nonboarded psychiatric visits cost an average of $418 per visit—a difference of $277.[87] The unique costs associated with boarding, such as the time a patient spends waiting for transfer, may also not be accounted for in insurance reimbursement rates, leaving facilities operating at a loss when they provide care to boarded patients.[88]

Boarding also prevents emergency departments from admitting, and receiving reimbursement for, additional patients. According to one study of an academic medical center emergency department in Los Angeles, California, the decrease in bed turnover due to the presence of boarded psychiatric patients cost the facility $2,264 per patient.[89] Relatedly, if emergency departments have no available space for incoming patients, ambulances transporting these patients must be diverted to alternate hospitals.[90] Ambulance diversion burdens the overall system of emergency care by delaying treatment for patients and consuming greater amounts of paramedics' valuable time.

PSYCHIATRIC BOARDING AS A MEASURE OF BED NEED

While psychiatric boarding presents a number of deeply concerning problems, it may also help answer one of the most salient questions in American mental health care: how many psychiatric beds does a community need?

As localities have wrestled with the closing of psychiatric hospitals, an emphasis on community-based treatment and an overwhelming number of individuals with mental illness in need of care, experts have used a variety of strategies to determine the optimal number of inpatient psychiatric beds.[91] In a novel approach to the problem, psychiatric boarding can serve as a proxy measure to help researchers understand the needed capacity for psychiatric care within a given health care system, and what resources might lessen the burden.

Termed the observed-outcome approach, this new model proposes that levels of access to psychiatric beds can be connected to observable outcomes in systems and populations. By examining the relationship between bed numbers and indicators, researchers can calculate the minimum and optimum bed requirements for a particular area to avoid negative outcomes. Specifically, measures of the extent of psychiatric boarding of patients with severe mental illness in emergency departments can be used as an indicator of adequate inpatient treatment supply.

CONCLUSION AND RECOMMENDATIONS

A patient in the midst of a heart attack would not be left to languish because treatment is unavailable or inconvenient. The notion that such an individual could be set aside, and his or her condition allowed to deteriorate to the point that recovery is less attainable, would be unthinkable. However, for people with mental illness, society and systems have made the unthinkable a reality.

As a consequence of inadequate preventive treatment options in the community, diminishing supplies of higher levels of care and other factors, individuals in psychiatric crisis present to local emergency departments and wait for treatment. Emergency departments are thus flooded with individuals seeking help for conditions that could be better addressed elsewhere in a functioning system of care. The evidence presented shows that serious mental illness is a significant contributor to emergency department boarding, and any solutions to combat psychiatric boarding must address treatment gaps for individuals suffering from these conditions.

Gaps in treatment options differ from place to place, and all psychiatric beds are not created equal. State statutes, local policies, procedures and financing all dictate who can access what type of bed, when and for how long. Bed types include public psychiatric beds in state hospitals and psychiatric units in general hospitals, as well as acute care, subacute care, crisis and residential beds. Any community could have an adequate supply of one type but a shortage of another, limiting treatment access for people with severe mental illness who will need multiple forms of care at various stages of their illness.

Future work is needed to determine the extent of psychiatric boarding at the state and national level. Such efforts represent a unique opportunity to assist in the development of psychiatric bed targets and help communities better address the critical treatment needs of their populations.

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TREATMENT ADVOCACY CENTER

200 North Glebe Road, Suite 801
Arlington, Virginia 22203
Phone: (703)294-6001
Fax: (703)294-6010

info@treatmentadvocacycenter.org

Providing Leadership in Health Policy and Advocacy

April 2015

TO: Whom it May Concern

FROM: Sheree Kruckenberg, Vice President Behavioral Health

SUBJECT: Access to Timely Psychiatric Emergency Services

California, like the nation, is struggling to ensure individuals with a suspected/potential mental illness are able to receive a timely psychiatric evaluation and access to an appropriate level of treatment, if needed.

The California Hospital Association (CHA) represents over 400 hospitals. In 2011, these hospitals received over 1.1 million individuals in their emergency departments (EDs) in need of some level of behavioral health intervention. An analysis of emergency department utilization data between 2006 and 2011 verified that the overall use of EDs for behavioral health visits increased 47% during this 5-year time period and the trend data indicate this continues to increase each year.

The vast majority of individuals arriving at a community medical/surgical hospital ED with a behavioral health need do not have a physical health condition that requires an emergency level of care intervention. This holds true for psychiatric emergency medical conditions as well. Unfortunately, however, there are often no alternative behavioral treatment settings available on a 24/7 basis. This forces hospital emergency departments, including those without behavioral health clinicians, to become the only available resource in many communities.

The increasing dependence on medical/surgical hospital EDs to provide behavioral evaluation and treatment is not appropriate, not safe, and not an efficient use of dwindling community emergency resources. This includes not only hospitals, but emergency transportation providers and law enforcement. More importantly, it impacts the patient, the patient's family, other patients and their families, and of course the hospital staff.

In a few California counties, an innovative, effective, and efficient treatment model has evolved that provides dedicated emergency behavioral health evaluation and treatment service. The model, known as Psychiatric Emergency Services (PES), is explained in more detail in the attached document. A recent study of this model showed that a PES in a system decreased time in an emergency department by 80% and led to behavioral health stabilization and discharge without needing inpatient admission more than 75% of the time.

We believe this model or a hybrid of emergency psychiatric care, if replicated across the state, would immediately improve outcomes for patients, alleviate patient backlogs in emergency departments, free up ambulances and other emergency transportation providers, and reduce the time law enforcement personnel are spending in medical/surgical hospital emergency departments. The model could be regionalized by identifying a location to act as the primary "hub" to provide support into surrounding counties and act as a telemedicine "spoke" site (see attachment) linking the PES to hospital EDs and/or psychiatric specialists, where geographic barriers prohibit transportation between sites.

For additional information or to arrange a tour of a PES, please contact skruckenberg@calhospital.org or 916/552-7576.

1215 K Street, Suite 800, Sacramento, CA 95814 · *Telephone:* 916.443.7401 · *Facsimile:* 916.552.7596 · www.calhospital.org

Corporate Members: Hospital Council of Northern and Central California, Hospital Association of Southern California, and Hospital Association of San Diego and Imperial Counties

The PES – Crisis Stabilization and Evaluation for All
Regional Dedicated Psychiatric Emergency Services (PES)
Dedicated Psychiatric/Substance Use Disorder Emergency Department

Too often, individuals with urgent mental health needs have no alternative but to go to medical emergency rooms (ER) at hospitals, where there can be few staff trained in mental health, the environment is not conducive to healing, and there may be little alternatives for disposition but psychiatric hospitalization.

The vast majority of individuals in mental health crisis who arrive at a hospital emergency department are placed on an involuntary LPS 5150 police detainment order and brought to a hospital by law enforcement or emergency transportation vehicles. The method by which an individual is placed on an LPS 5150 detainment and subsequently transported varies by county. There is also wide variation on whether a law enforcement officer physically stays with the individual detained on an LPS 5150 once they arrive at a hospital emergency department.

Unfortunately, there are no local or statewide mechanisms to track the number of LPS 5150 detainment orders written, nor is there a way to determine how many of the LPS 5150s are evaluated under LPS 5151and upheld for detainment. This also holds true for determining the number of individuals who ultimately are involuntarily committed on an LPS 5152, 72-hour hold. It is estimated that a minimum of 300,000 individuals are on 5150 detainment in hospital emergency departments annually. It is also estimated that at least 210,000 (70%) of these 300,000 individuals did not meet the criteria for inpatient admission under the LPS 5152, 72-hour involuntary hold criteria.

A Psychiatric Emergency Services (PES) unit is a far better alternative for people in crisis. A PES can be located on a hospital campus or in the community, but even when on the hospital grounds, the PES interior is far more calming and welcoming than a medical ER. PES layouts typically have décor, lighting, sound/music, and open spaces designed with the goal of encouraging healing and recovery, which make them quite different from a hectic, antiseptic medical ER with its noisy machinery and frightening equipment.

PES programs are designed to provide accessible, professional, cost-effective services to individuals in psychiatric and/or substance abuse crisis, and strive to stabilize consumers on site and avoid psychiatric hospitalization whenever possible. A PES provides emergency/urgent walk-in and police-initiated evaluation and crisis phone service 24 hours a day, 7 days a week.

A PES provides complete evaluation and treatment for all who present, regardless of level of acuity or insurance status. PES programs do not have "exclusion" or "no-admit" lists which prevent certain patients from entering their facility. Rather, a PES will work with everyone in need, following "Zeller's Six Goals of Emergency Psychiatric Care":

- Exclude medical etiologies of symptoms
- Rapidly stabilize the acute crisis
- Avoid coercion

- Treat in the least restrictive setting
- Form a therapeutic alliance
- Formulate an appropriate disposition and aftercare plan

As studies have estimated as many as 20-30% of psychiatric emergencies may be due to, or are combined with, serious medical concerns, it is important that all crisis patients receive an appropriate medical screening. Next, all efforts are made to stabilize or reduce the symptoms that are causing a person distress – be they suicidal thoughts, auditory hallucinations, severe paranoia, mania, or other difficult conditions. Whenever possible, all evaluation and treatment is done free of coercion, with staff forming a therapeutic, collaborative partnership with each consumer. Treatment is done in the least restrictive setting, so restraints and/or seclusion are to be avoided, and consumers should be returned to their home or freedom in the community as soon as possible. All who leave the PES should have a solid aftercare plan including follow-up appointments, medication information, and strategies to help the person avoid crises in the future.

A typical dedicated PES department meets all these goals, and is staffed with psychiatric physicians and mental health professionals around the clock who can provide:

- Screening for all emergency medical conditions and provide basic primary medical care (e.g., oral alcohol withdrawal, asthma, diabetes management, pain, continuation of outpatient medications)
- medication management
- laboratory testing services
- psychiatric evaluation/assessment for voluntary and involuntary treatment
- treatment with observation and stabilization capability on site
- crisis intervention and crisis stabilization
- screening for inpatient psychiatric hospitalization
- linkage with resources and mental health and substance abuse treatment referral information

A PES can dramatically improve access to care and quality of care while decreasing costs to the health care delivery system. Today, in communities without a PES, patients are taken to traditional hospital emergency rooms and often languish with no psychiatric assistance or intervention for hours, sometimes days, awaiting the arrival of an individual trained to provide a psychiatric assessment or an available inpatient psychiatric bed. This, in and of itself, undermines the formation of a positive therapeutic alliance for the patient, delays treatment for the patient, ties up staff time and an ER bed in an already overburdened medical emergency department. Unfortunately, for safety reasons, too often patients are placed in restraints, with a sitter, or both, if considered a danger to themselves or others.

A 2009 survey of Medical Directors of medical emergency departments in hospitals across the U.S. called for Regional Dedicated Psychiatric Emergency Programs as a potential solution to the major national problems of psychiatric patients boarding for long hours in emergency departments. Indeed, a recent study showed that a PES in a system decreased boarding times

over 80% compared to overall California boarding times, and led to stabilization and discharge without needing inpatient admission over 75% of the time.

The ability of a PES to avoid hospitalization for the vast majority of patients is due to being able to treat patients for up to 23 hours and 59 minutes (thus sometimes referred to as "23-hour treatment facilities"). This permits time for treatment, observation and "healing time," which is often sufficient to stabilize patients' symptoms so they can return home or to another less-restrictive level of care. This follows a simple truth, that most patients in psychiatric crisis do not need hospitalization, though they do need urgent intervention and care.

The goals of healthcare reform include improved access to care, improved quality of care, improved timeliness of care, along with less hospital admissions and reduced costs. Adding a PES to appropriate systems helps to meet all these goals.

To standardize definitions, the key concept that differentiates a true PES from what are more often called crisis stabilization units, crisis clinics, etc., is that a true PES is a program separately housed from a medical hospital ED (i.e., not considered to be just a wing of a larger ED) that can take ambulance/police deliveries independently from the field. This makes it different from the typical Crisis Stabilization Unit, which usually evaluates and treats patients who have already been initially received and medically screened in a medical ED, then transfers over when considered medically stable. However, both programs do what is basically called "Crisis Stabilization," and there are so many variations in design that difference in these programs can be minimal.

The concept of a PES being a "dedicated emergency department" comes from EMTALA law:

> "A dedicated emergency department is defined as meeting one of the following criteria regardless of whether it is located on or off the main hospital campus: The entity: (1) is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; or (2) is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions (EMC) on an urgent basis without requiring a previously scheduled appointment; or (3) during the preceding calendar year, (i.e., the year immediately preceding the calendar year in which a determination under this section is being made), based on a representative sample of patient visits that occurred during the calendar year, it provides at least one-third of all of its visits for the treatment of EMCs on an urgent basis without requiring a previously scheduled appointment. This includes individuals who may present as unscheduled ambulatory patients to units (such as labor and delivery or psychiatric units of hospitals) where patients are routinely evaluated and treated for emergency medical conditions."

A PES is not a "medical emergency department," nor a "community clubhouse model," but a blend of both, which is community-based and uses the Recovery Model concept.

In California, there are at least 10 PES departments operating in seven counties. There may be other comparable facilities or programs as well. The current PES departments are:

1. Alameda Health System, Oakland
2. Contra Costa County Regional Medical Center
3. Los Angeles County (Harbor-UCLA Medical Center, LAC+USC Medical Center and Olive View Medical Center)
4. Marin County
5. San Francisco General Hospital
6. San Mateo County
7. Valley Hospital (Santa Clara County)
8. One under construction in Ventura County

There is a need for at least an additional ten PES units; see attached map.

Psychiatric Emergency Services (PES) vs. Crisis Stabilization Unit (CSU)

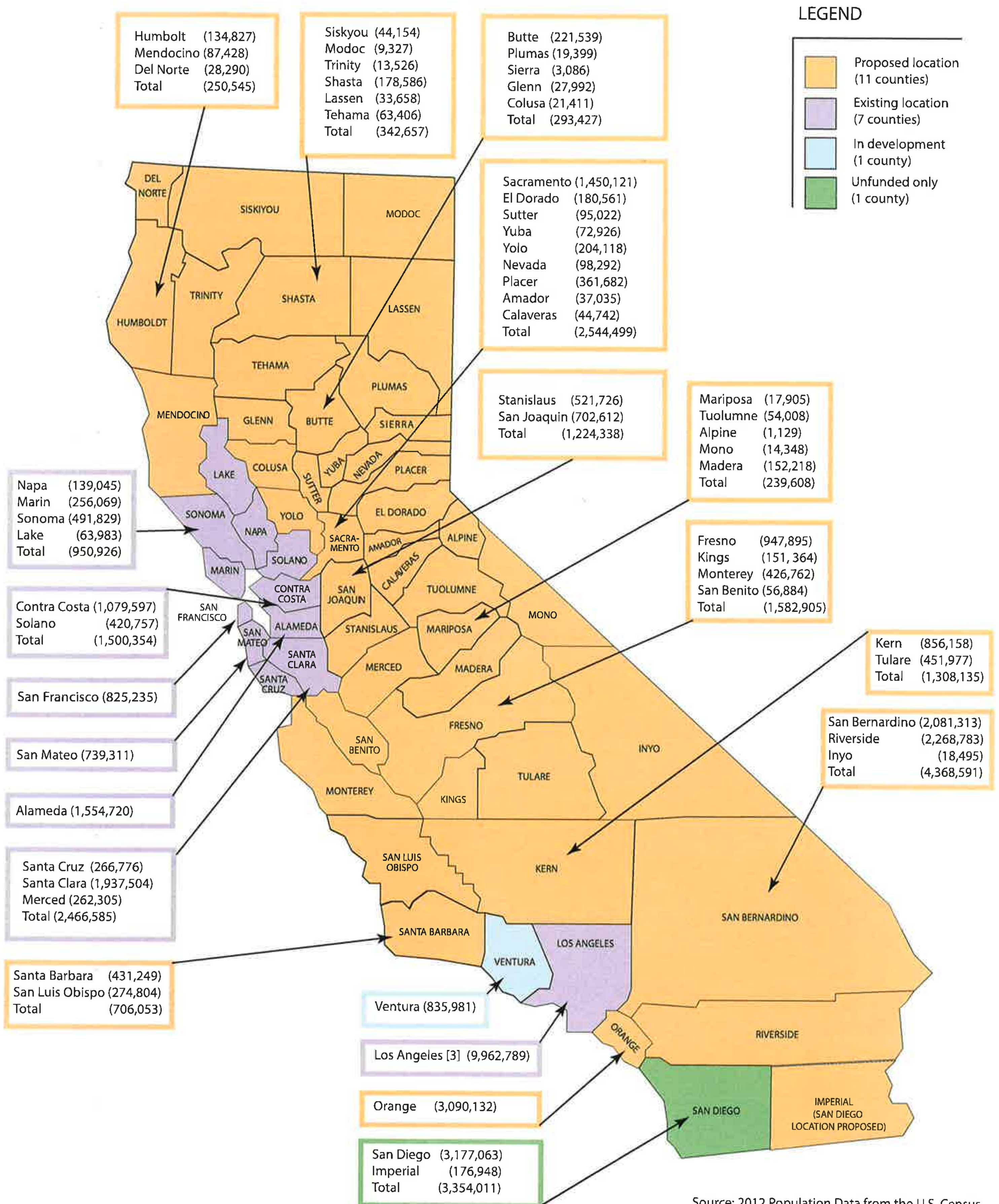
Psychiatric Emergency Department	Proposed Blended Model Emergency Treatment Services	Crisis Stabilization Unit
Operates as an active Treatment Model and services are available 24/7 and no one is restricted from using the service as it falls under EMTALA rules as patients are seen as having an "Emergency Medical Condition"	Open 24/7	Provides Triage and limited treatment, assessment for starting or discontinuing a hold and referral services. A psychiatrist is the lead clinician either in person or via telepsychiatry – may not be available 24/7
Open with physician available 24/7	Medical staff available 24/7 including telepsychiatry services	Not open 24/7 or have physician present
Capacity to screen for all "Emergency Medical Conditions"	Capacity to screen for all "Emergency Medical Conditions"	Does not have capacity to screen for all "Emergency Medical Conditions"
Has contracts for payment with plans	Contracts for payment with plans	Does not typically contract with plans
Qualifies under EMTALA	EMTALA qualification to be determined	Does not qualify as EMTALA provider
Required to assess all who present	Required to treat all individuals, regardless of payment or legal status (voluntary and involuntary)	Can be selective about patients served
Can bill Medicare		Cannot bill Medicare
Can bill under Medi-Cal Waiver		Can bill under Medi-Cal Waiver
Do not maintain "Do not admit lists"		May maintain a "Do not drop off list"
Law enforcement drop-offs allowed	Drop-off by EMS, law enforcement, family, friend, or self	No 5150 law enforcement drop offs
Typically located on hospital grounds	May be located on hospital grounds or in the community	May be located on hospital grounds or in the community

Regulations:

Residential Treatment: Welfare & Institutions Code §5671

Crisis Stabilization: Title 9, Division 1, Chapter 11, Subchapter 1, Article 2, §1810.210

Proposed and Existing Psychiatric Emergency Services (PES) and Service Areas in California (with population)



Source: 2012 Population Data from the U.S. Census
November 20, 2013

Ventura County
Behavioral Health Advisory Board

April 8, 2019

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Marlen Torres
Sheri Valley

Dr. Sevet Johnson, Director
Ventura County Behavioral Health

Ventura County Board of Supervisors
800 S. Victoria Avenue
Ventura, CA 93008

Dear Board of Supervisors:

At its regularly scheduled meeting on March 18, 2019, the Ventura County Behavioral Health Advisory Board (BHAB) passed a motion, by a unanimous vote, requesting that your Board prepare a letter to the State of California asking the State to apply for a waiver to the Institutions of Mental Disease (IMD) Exclusion that would allow Medicaid to pay for in-hospital beds at psychiatric hospitals and facilities.

Background

Currently, federal law does not allow Medicaid to pay for care in many psychiatric hospitals. Specifically, the law prohibits payment for adults between ages 21-64 in hospitals or treatment facilities that have more than 16 beds and that primarily provide mental health or substance use care. Updating the IMD exclusion will help those who suffer from serious and persistent mental illnesses receive improved access to the level of care which they so badly need and deserve. By doing so, this will help address the critical shortage of inpatient psychiatric hospital beds by increasing available beds and will also help to alleviate emergency room and jail overcrowding.

The Ventura County Behavioral Health Advisory Board urges the Ventura County Board of Supervisors to stand with NAMI Ventura County, NAMI Los Angeles County, the County Behavioral Health Directors Association, the California State Association of Counties, and numerous other California organizations in advocating for and urging that California submit an application for this IMD Exclusion Waiver as quickly as possible.

Recommendation

The Ventura County Behavioral Health Advisory Board (BHAB) respectfully requests that your Board prepare a letter to the California Department of Health Care Services requesting that the State of California apply for the IMD Exclusion Waiver to allow Medicaid to pay for in-hospital beds at psychiatric hospitals and facilities.

Thank you for your consideration. Should you have any questions or require additional information, please let me know.

Sincerely,

Jerry M. Harris, Chair
Ventura County Behavioral Health Advisory Board

Address:
1911 Williams Drive, Suite 200
Oxnard, CA 93036
Phone: 805-981-1115
Fax: 805-658-4512

BEFORE THE BOARD OF SUPERVISORS
COUNTY OF SANTA BARBARA, STATE OF CALIFORNIA

RESOLUTION NO. ___________

RESOLUTION
IN SUPPORT OF THE STATE'S
PARTICIPATION IN THE MEDICAID
IMD EXCLUSION WAIVER

WHEREAS, under the U.S. health care system, there have been significant gaps in health care coverage for the treatment of mental illnesses which disproportionally affect low income individuals in need of mental health treatment. Currently, federal Medicaid funding cannot be used for institutional services provided to adults between ages 21 to under age 65 with serious mental illness (SMI), known as the Institutions for Mental Disease (IMD) exclusion.

WHEREAS, the IMD exclusion prohibits states from receiving Medicaid payments for individuals in an IMD that are between the ages of 21-64 years. The law defines an IMD as a "hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services."

WHEREAS, in 1965, the Social Security Act was amended to establish the federal Medicaid and Medicare programs. The IMD exclusion was built into the foundation of the Medicaid program via these and subsequent amendments to the Social Security Act. The intent of the IMD exclusion was to prevent states from shifting the responsibility and costs of inpatient psychiatric care to the federal government via the Medicaid program.

WHEREAS, as outlined in Section 1115 of the Social Security Act, the U.S. Secretary of Health and Human Services may authorize a state to conduct experimental, pilot, or demonstration projects that, in the judgement of the Secretary, is likely to assist in promoting objectives of the Medicaid program.

WHEREAS, in November 2018, the Centers for Medicaid and Medicare Services (CMS) announced that the federal government would begin to consider state applications for a waiver of the IMD exclusion which would allow Medicaid coverage for IMD treatment to those who suffer from SMI.

WHEREAS, Medicaid is the largest payer of mental health services and expansion of this coverage would be critical to those who are in need. As a County, we must explore all funding options to support the goal of providing mental health treatment and services to County residents in need.

NOW, THEREFORE, BE IT RESOLVED, that the Board of Supervisors for the County of Santa Barbara does hereby determine that expansion of the Medicaid program for IMD treatment to those who suffer from a severe mental illness is critical to those in need, including but not limited to some of County's most vulnerable residents, and urges the State to apply for a waiver from the IMD Exclusion allowing for the expansion of Medicaid coverage to the excluded population in need of inpatient mental health treatment. The Board furthermore directs Dr. Alice Gleghorn, Director of Behavioral Wellness of the County of Santa Barbara, to send this approved Resolution to Governor Gavin Newsom and to the California Department of Health Care Services.

PASSED AND ADOPTED this 25TH day of February, 2020, by the following vote:

AYES: ________ NOES: ________ ABSTENTIONS:_________ ABSTENT: _________

____

GREGG HART, CHAIR
BOARD OF SUPERVISORS
COUNTY OF SANTA BARBARA

ATTESTS:
MONA MIYASATO, COUNTY EXECUTIVE OFFICER
CLERK OF THE BOARD

By: ____________________________ (SEAL)
Deputy Clerk