MHTF Residential and Inpatient Findings

Adults

1. The federal Department of Health and Human Services has determined that the percentage of the population with a serious mental illness is a constant (about 5%). As Washington's population continues to grow, the number of persons needing mental health services for a serious mental illness will also continue to grow as a function of population growth.

2. Washington has a documented shortage of residential capacity for adults.

    - The Public Consulting Group (PCG) discussed this shortage in the 2002 study prepared for DSHS. The 2004 PCG update to that study shows a continuing lack of residential capacity, and documented the following findings:

        - 93% of the intensive residential beds in the state are located in 5 of the Regional Support Networks (RSNs); King, Spokane, Pierce, Greater Columbia, and North Sound.
        - 9 RSNs; Chelan, Greater Columbia, King, North Sound, NEWRSN, Peninsula, Pierce, Southwest, and Spokane, are over 90% occupancy, including 5; Chelan, North Sound, NEWRSN, Southwest, and Spokane at 100% occupancy.
        - 5 RSNs: Chelan, Douglas, NEWRSN, Grays Harbor, Southwest, and Timberlands, comprising 11 counties, have no intensive long-term residential beds.

3. The Public Consulting Group (PCG) has documented a shortage of community inpatient capacity for adults. Community hospital bed capacity has been reduced by 95 beds since 2000.

    - This shortage was documented by PCG in 2002 and the ongoing loss of beds was documented by the Washington State Hospital Association and by the PCG update. Hospitals testified before the Task Force that the loss of beds is due to inadequate vendor rates for public clients.
    - In 2003, approximately 75% of the inpatient beds were located at Western and Eastern State Hospitals.
    - There are 78 E&T beds in Western Washington. There are currently no E&T beds in Eastern Washington.
    - 25 of the 39 counties have no community inpatient or E&T beds, impacting their ability to civilly commit persons needing involuntary treatment.
    - The Task Force received testimony that additional beds or facilities may be closed due to loss of funding if they are found to be IMDs. In other states, this has primarily affected skilled nursing facilities and psychiatric hospitals.

4. The PCG study found that a lack of community inpatient and residential services puts additional pressure on the state hospitals.

    - The 2002 PCG study showed 22% of persons discharged from the state hospitals had delayed discharges because of a lack of appropriate community services.

- The 2002 PCG study also showed that 25% of persons admitted to the state hospitals could have been avoided if there had been appropriate community services.
- The Center for Medicaid and Medicare Services (CMS) will only certify the state hospitals for acute inpatient care. Persons at the state hospitals whose medical needs do not require acute inpatient care must be placed in other settings to continue to be eligible for federal benefits. Testimony received by the Task Force stated that, in many communities, these settings do not currently exist.

5. DSHS has reduced the number of state hospital beds by 178 in recent years, including 147 in the past two years. These beds have been replaced with Expanded Community Services (ECS) beds and beds in skilled nursing facilities licensed by the Aging and Disability Services Administration.

    - The closed beds were in Program for Adaptive Living Skills (PALS), APU, and GPU beds.
    - $20.3 Million went to community treatment of these individuals through funding of either ECS or skilled nursing beds.
    - There was a one-to-one replacement ratio for the state hospital beds that were closed and DSHS did not reserve any hospital capacity for periodic needs of those persons moved to the community under this initiative.
    - Almost all of the persons transferred to the community under these reductions succeeded in community settings.

6. State hospital beds are allocated to the RSNs by a formula that is currently being phased in over a 6-year period ending in FY07. When the total hospital census exceeds the allocation, those RSNs that are over their allocated beds pay the state liquidated damages proportionate to their excess use.

    - In FY04, RSNs paid $1.7Million in liquidated damages. Collectively, King, Pierce, and Spokane RSNs paid 85% of the liquidated damages. Spokane alone paid 64% of the total.

7. The Task Force received testimony that the documented lack of community residential and inpatient beds creates a situation where some patients must stay in hospital emergency rooms, while the CDMHP attempts to find any available bed in the state.

8. Western State hospital is frequently over census and has issued letters to the RSNs instructing them to find other beds for their involuntary treatment clients. The Task Force received testimony that in some cases this situation may continue for months.

    - Lack of available residential and intensive supported housing services creates medically unnecessary delays in hospital discharge at the state and community hospitals. This creates discharge delays at E&T facilities.
    - Discharge delays mean that inpatient beds are not available to patients in crisis who need acute inpatient care.
    - The state hospitals are no longer a “no refusal” option for medically necessary acute inpatient treatment.

9. PACT and ACT programs provide intensive services to persons who have failed in residential treatment and have often lived at the hospital for many years. PACT differs from residential care in that the person is in a semi-independent setting such as a group home and the supports he or she needs to succeed in that setting are brought to him or her.

- PACT/ACT programs have very high success rates at a more independent level of living than residential or inpatient treatment.
- PACT/ACT programs, while expensive, cost less than intensive residential or inpatient programs.
- PACT/ACT do not present IMD issues because the services are provided by outside providers, not employees of the person's residential setting.

10. Some persons who meet medical necessity standards for inpatient or residential treatment are, nevertheless, ineligible for services in most community settings.

    - Licensing criteria prohibit skilled nursing facilities from treating persons with assaultive, combative or threatening behaviors. In many cases, these behaviors are linked to the person's mental disorder.
    - Persons with past histories (however old) of assault or arson or with criminal histories that include assault, drug use, arson, or sexual offenses are not eligible for most residential settings. In some cases federal law prohibits the person due to past criminal history, but in most cases the access barrier is either licensing restrictions or the provider's liability concerns.

11. Some persons who meet commitment criteria do not meet federal medical necessity standards for inpatient treatment because their needs are chronic rather than acute. If these persons present a likelihood of serious harm to others, they may be ineligible for residential treatment in existing facilities, despite their commitment.

12. Persons 65 years of age or older do not lose federal benefits if they are residents of an IMD.

Children

1. Children's mental health services are provided across many systems, including the RSNs, the Children's Long-Term Inpatient Placement Administration (CLIP), the Children's Administration, the Division of Alcohol and Substance Abuse, the Division of Developmental Disabilities, the Medical Assistance Administration, and the Juvenile Rehabilitation Administration.

    - According to the 2002 JLARC report, in FY00, the RSNs and CLIP provided services to about half the children receiving publicly funded mental health services.
    - Reporting and eligibility standards differ across systems so it is hard to know precisely what services are being provided and whether children have access to the needed levels and types of mental health services.

2. There is no statutory requirement for the RSNs to provide residential mental health services to children. Those RSNs that do provide some residential services do so jointly with the Children's Administration.

    - Children's Administration funds services for children in out-of-home placements through the Behavioral Rehabilitative Services (BRS) program and the Children's Hospital Alternative Program (CHAP).
    - In September 2003, approximately 75 children were served by the CHAP program and approximately 875 children were served in the BRS program. 80% of these children in the BRS program also had RSN contact in 2003.
    - Children in out-of-home placement, including residential mental health services, must have permanency planning under state and federal law.

3. There are three types of children's inpatient services: Community hospital inpatient beds, CLIP beds, and E&T beds. Community hospital and CLIP beds are statewide resources but E&T beds are local resources for the RSN in which they are located.

    - There are 93 inpatient beds designated for children and teens, located in King (59), Franklin (10), and Spokane (24) counties. On some occasions, single bed certifications have been granted for children in other inpatient settings.
    - There are 91 CLIP beds statewide, located in King (19), Pierce (59), and Spokane (13) counties.
    - There are 2 E&T facilities for children in Washington. Peninsula RSN has a 10 bed E&T for the children in its RSN and King County has a 2-bed E&T for its children.
    - 12 RSNs have no access to E&T beds for children.

4. Funding issues have resulted in the closure or threatened closure of both CLIP and inpatient beds.

    - Martin Center, a 12-bed CLIP facility in Whatcom County closed in June, 2004. 7 of the 12 lost beds have been contracted at other existing facilities, for a net loss of 5 beds.
    - Fairfax Hospital, which represents 44 of the 93 inpatient beds statewide, was instructed by its board to stop taking publicly funded children if no adjustment to its rates could be negotiated.

5. CLIP beds must meet stringent Medicaid regulations and, under federal law, children must be determined to be eligible not only by their RSN but also by the independent CLIP administration.

- Children’s length of stay in CLIP facilities averages nearly one year.

6. Children and Children’s facilities are not subject to the IMD exclusion.

Forensic & Correctional Mental Health

1. The Task Force also looked at the interaction of forensic and correctional mental health with the non-Medicaid and the residential and inpatient issues.

    - As used at the Task Force, "forensic mental health" referred to competency evaluations and restorations, diminished capacity evaluations, criminal insanity evaluations, and commitment to the state hospital as not guilty by reason of insanity.
    - As used at the Task Force, "correctional mental health" referred to mental health services provided by jails or prisons.

2. Forensic mental health services are currently provided by the state hospitals.

    - 80% of competency evaluations in Western Washington are done on an outpatient basis by state hospital staff. Eastern Washington courts are now permitting outpatient evaluations and the staff is doing an increasing number of these evaluations. Approximately half of those evaluated are not competent to stand trial and subject to competency restoration.
    - Competency restoration treatment is done at the state hospitals. The *Sell* case limited who could be restored to competency using involuntary medication. This has reduced the number of misdemeanant restorations at WSH but has not reduced the waiting list because the maximum legal period for restoration is 180 days for a felony, while it is only 29 days for a misdemeanor. Consequently, fewer persons can use the beds.
    - If a person is incompetent to stand trial and is unable to be restored to competency, he or she is referred for civil commitment and if he or she meets the commitment criteria, is committed for 90 days, which may be renewed. These "forensic conversions" count toward the RSN's bed allocation but are not within RSN control.

3. The forensic programs at ESH and WSH are at 100% capacity with waiting lists. There are significant delays in any inpatient services. Delays in competency evaluation and restoration are impacting the jails and the court.

    - Jails report waits of 3-12 weeks for inpatient services. WSH reports an average of _____ days wait in 2004.
    - WSH has been threatened with contempt and show cause orders for the delays.
    - Under the *Mink* case, long delays in evaluation and restoration must result in a dismissal of the case under the speedy trial provisions of the US Constitution. Washington cases are subject to the *Mink* limits and many cases are threatened with dismissal.

4. Washington jails and prisons reflect the national pattern in percentage of inmates with serious mental illnesses.

    - Nationally 16-23% of inmates are seriously mentally ill.
    - DOC reports that 12-15% of offenders in its system are seriously mentally ill.
    - In a survey completed by 22 counties and 8 cities, the largest group of jails reported10-20% of inmates with serious mental illnesses. 4 jails reported 20-30%.

5. The survey conducted for the Task Force showed that there is little consistent mental health information kept across jails, but some information was consistent.

- The most frequently diagnosed mental illnesses are schizophrenia, bipolar disorder, and major depression (including suicidal inmates). This is consistent with the illnesses of persons in the public mental health system.
- 70-80% of mentally ill inmates are charged with felonies.

6. Persons in jail are not eligible for Medicaid or SSI while in jail and, in this state their eligibility for these services is terminated after a maximum of 30 days in jail. In some regions eligibility is terminated almost immediately because the office controlling this checks jail census rolls. These persons are non-Medicaid clients on release and reestablishing Medicaid eligibility can take a substantial period of time.

    - CMS has recommended that states suspend, rather than terminate eligibility while incarcerated.
    - Following the CMS recommendation would require computer programming changes at DSHS and would require a change in procedure to presume that persons who entered jail eligible for Medicaid would be eligibile on release pending a status review instead of presuming them to be ineligible pending a status review.
    - A number of jails have appropriate medical staff to make a disability determination for jail inmates if the state Medicaid program would accept this determination. Such a system could shorten disability determination time for persons who are new to the public health system.
    - The King County CSO is working with the jail to restore eligibility for individuals who are eligible for SSI. These inmates are able to leave jail with their enrollment in place.

7. Mentally ill inmates spend three times as long in jail as non-mentally ill inmates. This is due, in part, to the competency restoration difficulties. In some counties, it may also reflect an unwillingness to release mentally ill defendants prior to trial either because they are seen as a flight risk or because they are ineligible for some pretrial release programs.

8. Jails pay all prescription drug costs. Those jails that estimated the cost of psychotropic medications estimated them at 50%-70% of total prescription drug costs.

    - Prescription drug costs varied. Of the 20 jails that could report prescription costs, 15 had average daily populations over 30 inmates. Of these, 6 jails spent between $20,000 and $50,000, 4 spent between $50,000 and $100,000 and 4 spent over $100,000 including two that spent approximately $1Million per year on prescriptions.
    - Pierce County was able to provide more specific data. This jail spent $707,000 of a $1,061,000 on psychotropic medications.