Washington State
Institute for
Public Policy

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INPATIENT PSYCHIATRIC CAPACITY IN WASHINGTON STATE: ASSESSING FUTURE NEEDS AND IMPACTS (PART TWO)

In Washington State, individuals may be involuntarily detained by a court order to a psychiatric facility or hospital for 72 hours or longer to undergo evaluation and treatment. The state's Involuntary Treatment Act (ITA) outlines the criteria and guidelines for involuntary psychiatric treatment.[1] In general, these commitments occur in cases where persons with a mental disorder are either gravely disabled or pose a danger to themselves or others, and refuse or are unable to enter treatment on their own. Specially qualified investigators, called Designated Mental Health Professionals (DMHPs) make the decision if an individual meets the criteria for an initial (72 hour) commitment. Subsequent court hearings determine if the commitment should extend for additional periods of 14, 90, and 180 days, or if less restrictive alternatives are more appropriate.[2]

In 2010, the Washington State Legislature changed the ITA statute by allowing a DMHP to more fully consider witness accounts, historical factors, and patterns of behavior during the course of an ITA investigation.[3] These statutory changes take effect by January 2012. Prior to this time, the Legislature directed the Washington State Institute for Public Policy (Institute) to assess the extent to which involuntary commitments may increase as a result of these new criteria. The Legislature also directed the Institute to determine if current inpatient psychiatric capacity is sufficient to meet this potential increased demand.

Summary

In 2012, recent amendments to Washington State's Involuntary Treatment Act (ITA) will take effect. New legal guidelines will allow a designated investigator to more fully consider information from both credible witnesses and historical records when making commitment decisions. The 2010 Legislature directed the Washington State Institute for Public Policy (Institute) to estimate the number of additional psychiatric admissions that may occur as a result of this law and examine how many inpatient psychiatric beds may be necessary to accommodate this increase. These estimates were presented in a companion to this report (completed in July 2011).

This report outlines various approaches for addressing the projected increase in psychiatric admissions. First, we discuss options for developing additional capacity within the state's inpatient psychiatric system. Next, we highlight both programmatic and statutory alternatives that may help prevent (or divert) future psychiatric admissions. This section also summarizes laws from four different states that provide for alternatives to involuntary inpatient admissions. Finally, this report examines the relationship between ITA-related psychiatric admissions and utilization of both county jails and hospital emergency departments.

Suggested citation: M. Burley. (2011). *Inpatient Psychiatric Capacity in Washington State: Assessing Future Needs and Impacts* (Document No. 11-10-3401). Olympia: Washington State Institute for Public Policy.

[1] RCW 71.05
[2] See RCW 71.05.240 and RCW 71.05.290
[3] See RCW 71.05.212 and RCW 71.05.245

The legislative direction specifically asked the Institute to analyze the following:

- The extent to which the number of persons involuntarily committed for 72 hours, 14 days, and 90 days is likely to increase as a result of the revised statutory guidelines.
- The availability of community treatment capacity to accommodate that increase.
- Strategies for cost-effectively leveraging state, local, and private resources to increase community involuntary treatment capacity.
- The extent to which increases in involuntary commitments are likely to be offset by reduced utilization of correctional facilities, publicly funded medical care, and state psychiatric hospitalizations.[4]

A companion to this report (released in July 2011) addresses the first two tasks set forth in this legislative assignment.[5] Based on a survey of DMHPs from across the state, this first report includes estimates that the rate of initial commitments could increase from 40 percent (current) to 55 percent of all ITA investigations. A commitment rate of 55 percent translates into an *additional* 2,716 inpatient psychiatric admissions per year,[6] requiring 168 more psychiatric beds throughout the state.

This report discusses the remaining tasks assigned by the Legislature: outlining approaches to improving involuntary treatment capacity, and addressing potential impacts of increased commitments on other public resources. The following sections in this report will present background and options:

I. Capacity Needs and Background.
This section reviews trends in inpatient psychiatric capacity over time and discusses how Washington compares to other states. We also discuss administrative, statutory, and payment guidelines that may influence utilization trends.

II. Developing Additional Capacity.
Next we look at options for increasing the supply of available ITA beds both statewide and in regions with the fewest available beds.

III. Prevention Options and Alternatives to Detention.
A reduction in ITA inpatient admissions could also help ease the shortage in psychiatric bed space. This section examines crisis interventions, potential changes in the ITA statute, and additional interventions that may influence utilization levels.

IV. External Impacts.
Finally, we analyze the connection between involuntary commitment investigations and jail admissions, emergency department utilization, and subsequent commitments to state psychiatric hospitals.

[4] Laws of 2010, ch. 37 § 204 (3) (e), ESSB 6444
[5] M. Burley. (2011). *How will 2010 changes to Washington's involuntary treatment act impact inpatient treatment capacity?* (Document No. 11-07-3401). Olympia: Washington State Institute for Public Policy.
[6] In 2009, there were 7,530 ITA-related inpatient psychiatric admissions.

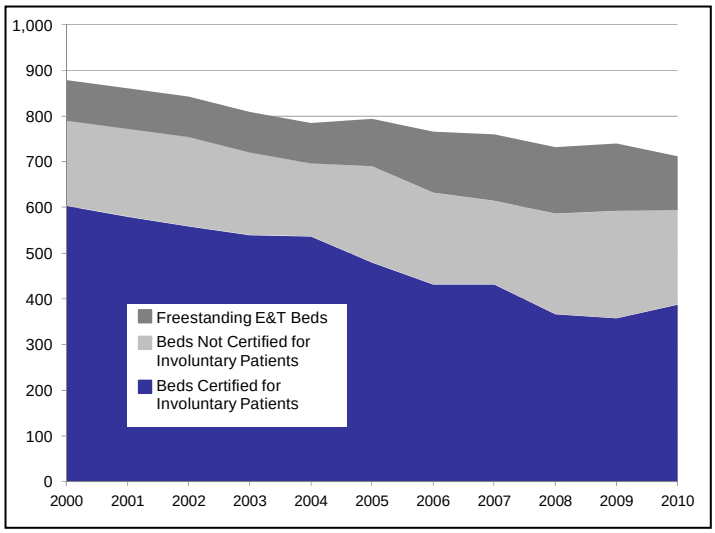
I. Inpatient Psychiatric Capacity Needs and Background

Persons who meet the legal criteria for involuntary treatment may be admitted to one of the following types of facilities:

- **Inpatient Psychiatric Beds in Community Hospitals:** Units within a community hospital that specialize in serving psychiatric patients. Not all of these hospitals, however, are certified to accept patients on an involuntary basis.
- **Evaluation and Treatment (E&T) Facilities:** 16-bed residential facilities that provide mental health services to help stabilize and return individuals to the community.
- **Single-Bed Certification:** When certified ITA beds are not available at licensed psychiatric facilities, a DMHP may ask a hospital to request a *single-bed certification* to hold involuntary treatment clients in an emergency department or other community hospital. These temporary placements are sometimes referred to as "psychiatric boarding." The issue of psychiatric boarding is discussed in further detail later in this report.

In 2000, there were 790 psychiatric beds (in both hospitals and E&T facilities), with 604 certified to accept involuntary patients. As Exhibit 1 shows, during the ten-year period between 2000 and 2010, ITA-certified beds decreased by 36 percent. By 2010, there were 593 psychiatric beds in the state, including 388 community hospital beds certified to accept ITA patients.

Exhibit 1
Inpatient Psychiatric Bed Capacity
2000–2010



WSIPP, 2011
Source: WSIPP analysis of Washington State Hospital Association (WSHA) publications

In terms of involuntary admissions, a range of factors must be considered when determining the most appropriate facility to treat the patient. Over the last ten years, an increasing number of 16-bed "freestanding" evaluation and treatment (E&T) centers have been built in Washington State. In 2000, there were four E&T facilities, with a total of 89 beds available to serve public mental health consumers. By 2010, there were 149 beds available in eight centers to serve this population.[7]

[7] Twenty-six of these beds (and one center) were designated for youth.

While the number of freestanding E&T beds grew slightly during this period, it is important to note several limitations with respect to these non-hospital facilities:

- To qualify for federal Medicaid reimbursement (for patients aged 21 to 64), these facilities cannot include more than 16 beds.[8] This payment exclusion was implemented in 1988 and was intended to promote smaller group living arrangements over larger institutions.
- Freestanding E&Ts are licensed by the Washington State Department of Health (DOH) to provide evaluation, treatment and stabilization services for individuals experiencing a mental health crisis. The facilities are staffed by licensed psychiatrists, nurses, and other mental health professionals. Routine medical care can be provided at these facilities, but E&Ts are not licensed or equipped to provide medical care for individuals with medical complications.[9] Individuals requiring an elevated level of medical care must be sent to a community hospital.
- Freestanding E&Ts are licensed (by DOH) as residential facilities, not hospitals. As such, Medicare or private insurances will not provide reimbursement for an E&T stay. While hospitals can bill Medicaid directly (through the ProviderOne system), E&T facilities contract directly with the Regional Support Networks (RSNs) for services.
- Individuals with pending felony charges or who pose a safety or security concern are detained to another appropriate facility.

[8] 42 U.S.C. §1396d(i)
[9] 246-337 WAC

Access to Care (Capacity Constraints)

As a whole, Washington State has a relatively low rate of *total* inpatient hospital beds per capita. While there are a fewer number of total hospital beds, Washington State also has lower rates of admission and shorter lengths of stay in comparison to other states.[10] Consequently, *overall* bed capacity for the general population of patients appears to be adequate. A 2011 report by the Navigant Consulting Group concluded:

> "While Washington's hospitals have, on average, higher occupancy rates than those in other western states, Washington's occupancy rates of 70 percent for acute service beds and 59 percent for rehabilitation service beds in 2009 indicate overall capacity in the system. It should be noted that, for psychiatric service beds in the State, the 2009 occupancy rate is at 93 percent, which indicates little excess capacity."[11]

A recent report by the American College of Emergency Physicians found that, based on a 2006 American Hospital Association (AHA) survey, Washington State "ranks 51st for rates of staffed...psychiatric care beds (…8.2 per 100,000 people)."[12] This ranking, however, did not account for beds in non-medical psychiatric hospitals. Updated information from the 2009 AHA survey (with all psychiatric hospitals included) showed that Washington State ranked 47th among all states with 10.52 psychiatric beds per 100,000 persons.[13] Complete rankings are presented in Appendix 1.

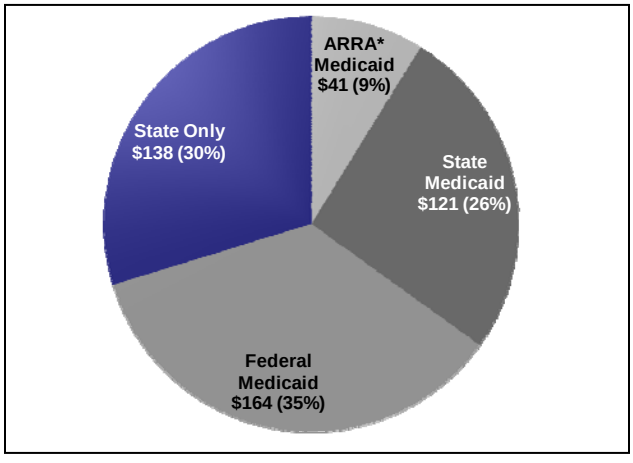
[10] See http://www.wsha.org/files/127/AHA2009stats.v1.ppt
[11] Navigant Consulting, Inc. (2011). *Analysis of the Washington inpatient and outpatient hospital Medicaid payment methodology.* Navigant Consulting, Inc., p. 15.
[12] Epstein, S. K., Burstein, J. L., Case, R. B., Gardner, A. F., Herman, S. H., Hirshon, J. M., Jermyn, J. W., ... Schwalberg, R. H. (2009, January 1). The national report card on the state of emergency medicine: Evaluating the emergency care environment state by state, 2009 edition. *Annals of Emergency Medicine*, p. 111.
[13] *AHA annual survey database for fiscal year 2009*

ITA Background: Regional Responsibility

Since 1989, mental health services in Washington State have been managed through Regional Support Networks (RSNs). There are currently 13 RSNs that contract with the state using a "capitated" financing system that allocates Medicaid funds based on a fixed amount per month for the care of each eligible person. Medicaid expenditures require a state match in order to receive federal funds. Medicaid dollars do not cover ITA investigations, basic residential care and supervision, and inpatient/outpatient care for persons who are not Medicaid eligible. Payments for these services are made through state-only funds which are allocated to RSNs based on population in each region.

Exhibit 2 displays the Fiscal Year 2010 RSN expenditures for mental health services by funding category.[14]

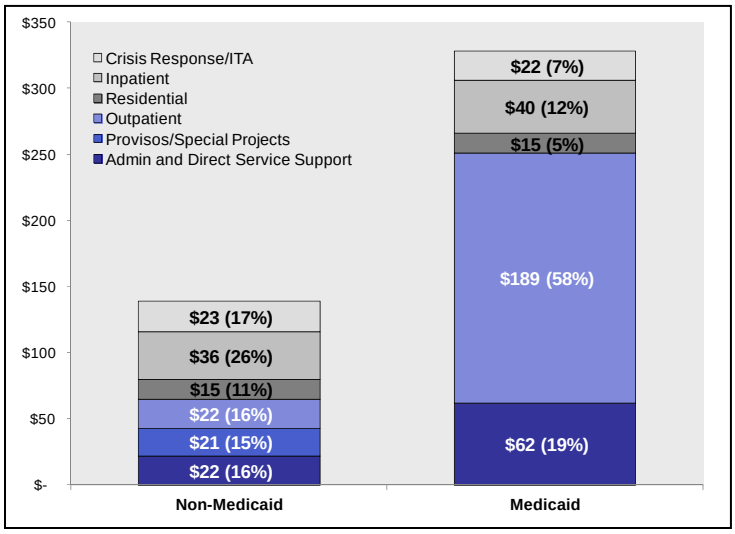
Exhibit 2
RSN Mental Health Fund Sources by Category
FY 2010 (millions)



*American Recovery and Reinvestment Act
WSIPP, 2011

As Exhibit 2 indicates, 70 percent of mental health services provided through the RSNs are paid with Medicaid dollars; the remainder are paid using state-only funds. In terms of services funded, approximately half of all expenditures for Medicaid clients receiving mental health services go to outpatient treatment, while 12 percent of Medicaid funds pay for inpatient treatment. Outpatient treatment services make up 16 percent of state-only mental health expenditures, while inpatient treatment represents 26 percent of total state-only costs (Exhibit 3).

Exhibit 3
RSN Mental Health Expenditures by Service Category
FY 2010 (millions)



WSIPP, 2011

[14] Expenditures for state psychiatric hospitals are not included in these figures since RSNs are not directly responsible for these costs.

The RSN assumes the financial risk if service costs exceed the amounts provided under the annual State Mental Health Contract (SMHC). These contracts (between the state and each RSN) also specify the following:

- The RSN must maintain agreements with sufficient numbers of certified involuntary evaluation and treatment facilities to ensure consumers eligible for regional support services have access to involuntary inpatient care;[15] and
- The RSN must authorize admissions, transfers, and discharges into and out of inpatient evaluation and treatment services for eligible consumers, including community hospitals.[16]

Every six years, each RSN submits an operating and capital plan that outlines how it will carry out the responsibilities defined in statute. These responsibilities include providing for residential services, community (crisis) support, and the investigation, transportation, and court-related services necessary under the Involuntary Treatment Act.[17]

ITA Background: Payment System

If a patient is admitted to the hospital under an involuntary commitment order, the hospital bills the state (DSHS) directly. DSHS then invoices the RSN for repayment from State Mental Health Contract funds. While existing administrative rules allow an RSN to contract directly with a hospital for the cost of inpatient care,[18] no RSN currently exercises this option. A direct contract would require the RSN to develop its own billing and payment system, which would require substantial costs for development and certification. Instead, inpatient hospital stays are billed through the state's ProviderOne claims system.[19] The reimbursements paid to hospitals are based on both state and federal program eligibility rules for each patient. Payers include:

- **Medicaid**: for patients who meet income guidelines and categorical eligibility rules.
- **Medicare**: for patients who meet age (typically 65) or disability guidelines. Federal funds cover the costs of hospital stays for Medicare patients.
- **Psychiatric Indigent Inpatient Program (PIIP)**: a state-funded program for indigent patients who do not qualify for Medicaid. PIIP funds can only be used for voluntary psychiatric inpatient stays and are subject to other limitations[20] .
- **State-only funds**: the state-administered program per diem rate is used to pay the costs of an ITA admission for non-Medicaid patients. This rate is based on the Medicaid per diem rate minus a discount (ratable factor) set by the legislature.[21]

In 2005, the Legislature directed DSHS to hire an independent contractor to submit budget-neutral recommendations for improving the inpatient hospital reimbursement system. Following publication of the contractor's report in 2006,[22] a new reimbursement structure was set for all inpatient hospital stays where costs were reimbursed by the state. Since 2007, psychiatric inpatient stays at community hospitals have been paid on a daily per diem basis. Hospitals receive different reimbursement rates that have been determined according to the characteristics of the hospital and population served.

[15] WAC 388-865-0229 (2)(a)
[16] WAC 388-865-0229 (3)(b)
[17] RCW 71.24.300 and 71.24.045
[18] WAC 182-550-2800
[19] http://hrsa.dshs.wa.gov/providerone/
[20] WAC 388-865-0217
[21] WAC 182-550-4800
[22] DSHS Health and Recovery Services Administration, Division of Finance and Rates Development (2006, November). *Hospital reimbursement study*, Olympia: Author. Retrieved from http://www.dshs.wa.gov/pdf/main/legrep/Leg0207/HospitalReimbNavStudy.pdf

Exhibit 4 (next page) shows the Medicaid psychiatric per diem rates for hospitals in Washington State between 2007 and 2011. Between 2007 and 2010, these rates remained flat. Rates increased following this period as a result of the Hospital Safety Net Assessment, enacted by the Legislature in 2010.[23] This act increased Medicaid hospital payment rates through the utilization of funds made available through the American Recovery and Reinvestment Act (ARRA).

It should also be noted that the inpatient rates outlined in Exhibit 4 only apply to psychiatric admissions within a community hospital. Commitments made to a freestanding evaluation and treatment center are reimbursed in a different manner. Medicaid dollars can be used to pay for treatment services that occur in an E&T facility. The room and board portion of these commitments, however, is paid with state-only dollars.

Most community hospitals received an increase of 13 percent in the per diem psychiatric reimbursement rate as a result of the safety net assessment.[24] To receive these enhanced matching funds, however, a tax was placed on hospitals based on the number of non-Medicare patient days in each facility. Monies from both the tax and federal match were placed within a special fund in the state treasury. These increased rates will stay in place until July 2013.

Prior to this time, DSHS is required to complete a study that will "recommend the amount of assessment needed to support future hospital payments and the departmental administrative expenses."[25]

As mentioned previously, the state administered program per diem psychiatric rate is used to reimburse claims for non-Medicaid ITA patients. Between 2007 and 2010, the per diem rate for these patients was set 18 percent lower than the Medicaid rates shown in Exhibit 4. While the Medicaid psychiatric per diem rates increased in 2011, the state-only per diem rates stayed the same. As a result, by 2011, reimbursements for non-Medicaid ITA admissions were 33 percent lower than corresponding Medicaid rates.

[23] Laws of 2010, ch. 30, E2SHB 2956

[24] Harborview and the University of Washington Medical Center received 3 percent increases in per diem psychiatric reimbursement rates since no assessment tax was levied on these public hospitals.

[25] RCW 74.60.090 (3)

Exhibit 4

Medicaid Inpatient Psychiatric Per Diem Reimbursement Rates

2007–2011

Name	2007	2008	2009	2010	2011
Hospitals Currently Certified to Accept Involuntary Patients					
BHC Fairfax Hospital – Kirkland	$811	$809	$809	$809	$914
Harborview Medical Center - Seattle	$1,169	$1,166	$1,166	$1,166	$1,201
Lourdes Counseling Center - Richland	$759	$758	$758	$758	$857
Navos (Psychiatric Hospital) - West Seattle	$811	$809	$809	$809	$914
Northwest Hospital - Seattle	$1,125	$1,123	$1,123	$1,123	$1,269
Providence Sacred Heart Medical Center - Spokane	$830	$828	$828	$828	$936
Skagit Valley Hospital - Mt. Vernon	$816	$814	$814	$814	$814
St. John Medical Center - Longview	$808	$807	$807	$807	$912
St. Joseph Hospital - Bellingham	$1,062	$1,060	$1,060	$1,060	$1,198
United Hospital - Sedro Woolley	$1,180	$1,178	*	*	*
Valley General Hospital - Monroe	$1,087	$1,085	$1,085	$1,085	*
Yakima Valley Memorial Hospital - Yakima	$866	$864	$864	$864	$976
Hospitals With Psychiatric Units But Not Currently Certified to Accept Involuntary Patients					
Auburn Regional Med Center - Auburn	$923	$921	$921	$921	$1,041
Harrison Memorial Hospital - Bremerton	$1,201	$1,198	$1,198	*	*
Highline Community Hospital - Burien	$811	$809	$809	$809	$914
Overlake Hospital Medical Center - Bellevue	$812	$810	$810	$810	$915
PeaceHealth Southwest Medical Center - Vancouver	$942	$940	$940	$940	$1,062
Providence St. Peter Hospital - Olympia	$1,493	$1,490	$1,490	$1,490	$1,684
Seattle Children's Hospital and Medical Center - Seattle	$1,561	$1,558	$1,558	$1,558	$1,761
St. Francis Hospital - Federal Way	$1,176	$1,173	$1,173	$1,173	$1,325
St. Joseph Medical Center - Tacoma	$1,101	$1,099	$1,099	$1,099	$1,242
Swedish Medical Center - Cherry Hill Campus - Seattle	$1,285	$1,282	$1,282	$1,282	$1,449
University of Washington Medical Center - Seattle	$1,169	$1,166	$1,166	$1,166	$1,201

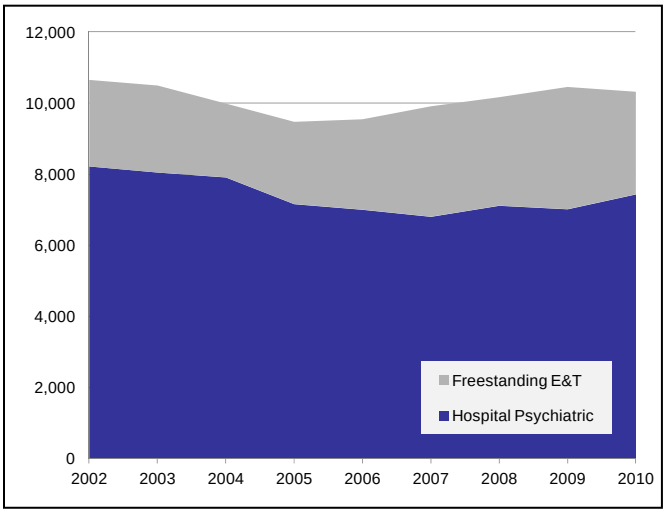
Source: http://hrsa.dshs.wa.gov/HospitalPymt/Inpatient/PPSHospital.htm

* Indicates closure of a psychiatric unit or hospital

ITA Background: Utilization Statistics

This section looks at how inpatient psychiatric facilities are utilized within Washington State. Trends in the number of admissions, characteristics, and circumstances of persons hospitalized, mix of payers for services, and length of stay are all important indicators of utilization. Overall, the number of psychiatric admissions that are reimbursed by public payers (federal or state) stayed relatively constant between 2002 and 2010. As Exhibit 5 shows, these admissions went from 10,663 in 2002 to 10,326 in 2010.

Exhibit 5
Number of Public-Pay Psychiatric Admissions in Washington State: 2002–2010



Source: DBHR (does not include Pierce County), MMIS
WSIPP, 2011

For freestanding E&Ts, admissions increased by 18 percent during this period (from 2,448 in 2002 to 2,897 in 2010). Publicly paid inpatient psychiatric admissions to community hospitals, on the other hand, decreased from 8,215 in 2002 to 7,429 in 2010.

In 2010, about 72 percent of admissions to freestanding E&T centers were made on an involuntary basis, while 36 percent of publicly paid psychiatric admissions to community hospitals were involuntary. Although freestanding E&T centers must accept ITA admissions, community hospitals can make the decision whether to seek and maintain a license to admit ITA patients.

Providing these types of services depends in part on whether expected revenue will cover costs of care. As noted previously, both the Medicaid and state-only per diem rates have stayed relatively constant over the last five years. In addition, hospital patients in psychiatric treatment are more likely to have public-pay insurance (such as Medicare or Medicaid) compared with other patients in acute care settings.

As Exhibit 6 shows, 30 percent of patients in a psychiatric unit within a community hospital were insured by Medicaid in 2009. In contrast, Medicaid was the primary insurer for 20 percent of all other patients in acute care settings.

Exhibit 6
Inpatient Hospital Discharges by Payer and Setting – Washington State, 2009

Primary Payer	Acute Care	Psychiatric Care
Public - Medicaid	127,591 (20%)	4,966 (30%)
Public - Medicare	195,336 (31%)	4,768 (28%)
Public - Other	11,078 (2%)	528 (3%)
Private	270,156 (43%)	5,924 (35%)
Other*	27,813 (4%)	632 (4%)
Total Discharges	**631,974**	**16,818**

Source: Comprehensive Hospital Abstract Reporting System
*Includes Charity Care, Self-Pay, Workers Compensation

While specific costs for psychiatric care were not available, across all care types, Medicaid reimbursements paid for 77 percent of the cost of providing care for patients admitted in 2009.[26] This reimbursement percentage is down from approximately 90 percent in 2004.

In addition to reimbursements for the cost of care, hospitals must take other factors into account when determining whether to accept involuntary admissions. First, many ITA patients pose a significant risk to themselves or others while hospitalized. Consequently, these admissions require additional staffing from nurses, social workers, security, and other staff. Second, hospitals that are ITA-certified must meet additional safety and security guidelines to admit these patients. Finally, involuntary patients may remain hospitalized for an extended period of time while awaiting court hearings or an available long-term bed. As shown in Exhibit 4, per-diem Medicaid rates are the same whether patients are admitted voluntarily or involuntarily.

Exhibit 7 displays the average length of stay (in days) for psychiatric admissions to community hospitals. Patients with an involuntary admission had significantly longer stays compared with those admitted voluntarily. Involuntary Medicaid patients, for example, were admitted for nearly 15 days on average, while voluntary Medicaid patients stayed for an average of nine days. State-funded (non-Medicaid) patients had a similar disparity, with 11-day admissions for involuntary patients and 8-day admissions for voluntary patients.

Exhibit 7
Inpatient Hospital Psychiatric Length of Stay by Legal Status and Public Payer, 2010

Days	Medicaid	State-Funded
Involuntary Admission	14.8	11.4
Voluntary Admission	9.0	8.2

Source: MMIS DBHR

At any given time, the number of psychiatric treatment beds available in the state depends on three factors: overall capacity, rate of admissions/entries, and average length of stay. While capacity within community hospitals has been declining, the rate of admissions and lengths of stay have remained steady. Consequently, there has been a persistent shortage of available beds within the system.

As mentioned previously, changes to the state's ITA law (taking effect in 2012) could result in up to 2,716 new inpatient psychiatric admissions each year. The remaining sections of this report outline options for addressing this potential influx of new ITA admissions. The sections discuss possible approaches, as directed in the legislative assignment, that involve: (1) increasing the available supply of beds, or (2) developing alternatives to divert or prevent future involuntary admissions. The final section discusses how an increase in ITA admissions may impact other public systems (jails, emergency departments, state hospitals).

[26] See www.wsha.org/files/127/FY2009FinalYE_Mar2011.ppt

II. Develop Additional Psychiatric Bed Capacity

Several strategies could be considered that may provide direct incentives or opportunities for the creation of additional psychiatric beds for involuntary treatment admissions. The responsibility for maintaining sufficient local access to inpatient psychiatric beds rests with the RSNs. Consequently, the state would not build or purchase inpatient beds directly. Rather, state policy makers could consider one or more of the following steps that may lead to regional increases in the number of beds:

- Utilize state resources to assist with the establishment of additional freestanding evaluation and treatment centers.
- Pursue new opportunities for expansion of Medicaid coverage for psychiatric treatment in existing facilities.
- Develop coordinated and targeted strategies for psychiatric emergency services.
- Test new reimbursement options for inpatient psychiatric admissions.

Option 1: Utilize state resources to assist with the establishment of additional freestanding evaluation and treatment centers

Existing law concerning the provision of inpatient services notes that "a regional support network may request that any state-owned land, building, facility, or other capital asset which was ever purchased, deeded, given, or placed in trust for the care of the persons with mental illness and which is within the boundaries of a regional support network be made available to support the operations of the regional support network. State agencies managing such capital assets shall give first priority to requests for their use."[27]

The state could publish a regular inventory of the capital assets that qualify under this statute. Such a list could be made available to each RSN as well as contractors who own and operate evaluation and treatment centers throughout the state. A preferred lease arrangement for an existing facility may aid in the establishment of additional freestanding E&Ts throughout the state.[28]

In 2004, a study of inpatient capacity and demand recommended the addition of 88 new beds at freestanding evaluation and treatment centers (55 in western Washington and 33 in eastern Washington). At the time, there were 89 beds available in these facilities (located in western Washington).[29] By 2009, 148 freestanding E&T beds were operating within Washington State.

Previous studies, however, have not examined the characteristics of patients who were involuntarily committed relative to capacity needs. Data on the medical acuity, severity of psychiatric symptoms, and functional capacity of involuntary patients have not been routinely collected across the RSNs operating within the state. Section III discusses assessments and utilization tools that could assist with capacity planning for patients admitted to both community hospitals and freestanding E&T centers.

Option 2: Pursue new opportunities for expansion of Medicaid coverage for psychiatric treatment in existing facilities

One of the clearest indicators of a shortage in psychiatric inpatient beds comes from the number of patients boarded and awaiting hospital admission. Psychiatric boarding in emergency

[27] RCW 71.24.300 (7)

[28] Facilities such as the Frances Haddon Morgan Center (Bremerton, WA), which will close at the end of 2011, could be utilized for such a purpose.

[29] Public Consulting Group. (2004). *Capacity and demand study for inpatient psychiatric hospital and community residential beds, adults and children: Final report*. Boston, MA: Author, p. 27. Prepared for the Washington State Department of Social and Health Services, Health and Rehabilitation Services Administration, Mental Health Division.

departments has been recognized as a problem in both Washington State and across the country.[30] A 2011 review of ITA investigations found that in 20 percent of cases, patients were "boarded" or sent to a temporary location while awaiting an inpatient psychiatric bed.[31] In some counties, boarding rates were even higher. According to statistics from King County, 25 percent of patients hospitalized in 2010 were boarded (n=695).

New facilities to alleviate boarding must take into account existing federal guidelines. As mentioned previously, under current federal guidelines, Medicaid payments cannot be made for adults treated in psychiatric facilities if the institution has more than 16 beds. This payment rule is known as the Medicaid institutions for mental diseases (IMD) exclusion. In Washington State, there are three psychiatric hospitals that are considered IMD facilities: Fairfax Hospital (Kirkland), Navos/West Seattle Psychiatric (Seattle), and Lourdes Counseling Center (Richard). Together, these facilities have 151 beds available for psychiatric treatment and care.[32] Without the ability to receive reimbursement under Medicaid for the cost of care, however, these facilities can only treat a limited patient population.

The 2010 Patient Protection and Affordable Care Act (ACA) established a three-year grant called the Medicaid Emergency Psychiatric Demonstration. This demonstration project will take place in up to eight states, starting in 2012. Participating states will be able to provide payments to psychiatric hospitals and institutions for inpatient emergency psychiatric care and treatment. The intent of this federal pilot project is to "improve access to appropriate psychiatric care, improve quality of care for Medicaid patients, and encourage greater availability of inpatient beds, thereby reducing the necessity of psychiatric boarding."[33]

The Medicaid Emergency Psychiatric Demonstration project is intended to help fill the gap for emergency and specialized psychiatric care that exists in Washington and other states. Given the documented shortage of inpatient psychiatric beds, Washington would seem well-suited to participate in this new demonstration project. Whether or not Washington is selected for this grant, additional steps should be taken to determine the extent of, and solutions to, psychiatric boarding in the state.

Option 3: Develop coordinated and targeted strategies for psychiatric emergency services

Determining the most effective use of inpatient resources depends on a more thorough understanding of how patients with behavioral health crises are admitted to hospitals. For some patients, high quality and timely care at the time of the crisis may reduce the need for an inpatient admission.[34] To develop effective strategies, however, additional steps may be needed:

- **Define and measure the overall and regional extent of boarding in the emergency department.**
  At present, there are no statewide data reported on emergency department visits within Washington State. As such, we cannot develop statewide estimates of the number of psychiatric patients who entered an emergency department and how long these patients awaited an available bed once admitted.

[30] Bender, D., Pande, N., & Ludwig, M. (2009, October). *A literature review: Psychiatric boarding*. Falls Church, VA: Lewin Group. Retrieved from http://aspe.hhs.gov/daltcp/reports/2008/PsyBdLR.pdf

[31] Burley, 2011.

[32] IMD Hospitals cannot provide medical/surgical care for patients with complicating medical factors.

[33] Retrieved from https://www.cms.gov/DemonstrProjectsEvalRepts/downloads/MEPD_Solicitation.pdf

[34] Stefan, S. (2006, August 1), *Emergency department assessment of psychiatric patients: Reducing inappropriate inpatient admissions.* Medscape Education [serial on the Internet; login required]. Retrieved from http://www.medscape.org/viewarticle/541478

During 2009 and 2010, the Washington State Department of Health (DOH) tested the feasibility of a statewide ED data collection system, by working with seven community hospitals that voluntarily agreed to a *one-time* submittal of data to DOH. The final report for this project noted many interesting facts about ED usage, including that 25 percent of all visits to the emergency department involved patients with a mental health or substance abuse (MHSA) diagnosis. For Medicaid patients, 37 percent had a main or contributing MHSA diagnosis.[35]

State policy makers could consider a requirement that emergency departments throughout the state report data to DOH. Implementing a uniform statewide data system could help state policy makers monitor efforts to better provide access to appropriate psychiatric and medical care.

- **Determine the relative effectiveness of developing specialized emergency department beds versus inpatient capacity.**
  If additional beds are added to the inpatient psychiatric system, it should be determined whether additional hospital beds or specialized emergency beds are more likely to meet the needs of ITA patients. Several states and localities have developed psychiatric emergency services (PES) that are often located within or nearby an existing emergency department. A PES center is staffed by both medical and mental health personnel and provides a separate location for psychiatric patients in crisis.[36] This type of specialized emergency center may be appropriate for hospitals with a high frequency of psychiatric visits to the emergency department.[37]

  To determine whether enhanced emergency department services are effective and economical, a pilot program could be established in a high demand area. The goal of such a pilot would be to determine if a psychiatric crisis and diversion center within the emergency department helps reduce inpatient admissions, lengths of stay, and recidivism relative to a standard emergency department.[38] To the extent such an approach demonstrates reduced costs to jails and emergency departments, additional funding partners could be identified.

Option 4: Test new reimbursement options for inpatient psychiatric admissions.

Budgetary considerations and legal requirements determine the level of reimbursement that states provide to hospitals for inpatient care. New Medicaid payment guidelines, established through the ACA, are scheduled to take effect in 2014. To the extent new regulations or funding sources permit changes to hospital reimbursements, the following options could be considered:

[35] Washington State Department of Health. (2011). Workgroup recommendations for implementation of a statewide emergency department data collection system in Washington: The coded emergency department data system (CEDDS) project. Olympia: Author. Retrieved from http://www.doh.wa.gov/ehsphl/chs/chs-data/public/CEDDS-2011.pdf

[36] See, for example: Carlson, G., & Allen, D. (2008). Psychiatric emergency services clinic (PES): A better way to treat psychiatric patients in crisis. *UAB Psychiatry, 2*, 4. http://www.psychiatry.uab.edu/wp-content/uploads/2010/01/Winter-20081.pdf

[37] Brown, J. (2005). Emergency department psychiatric consultation arrangements. *Health Care Management Review, 30*(3), 251.

[38] Bender et al, 2009, p. 18

- **Provide an enhanced reimbursement rate for patients admitted involuntarily.** As indicated previously, hospitals receive the same per diem reimbursement rate for psychiatric patients whether they are admitted on a voluntary or involuntary basis (see Exhibit 4). The liability risk, required infrastructure, and medical needs of involuntary patients, however, likely exceed per-patient costs for voluntary patients. In addition, discharge planning for involuntary patients is complicated, since they must await court hearings for discharge. State policy makers could consider an enhanced reimbursement rate for involuntary patients in recognition of these additional factors.

- **Enable an RSN to recapture costs of serving consumers outside their home boundaries.**
  One of the duties of an RSN, as defined in statute, is to "provide within the boundaries of each regional support network evaluation and treatment services for at least ninety percent of persons detained or committed for periods up to seventeen days according to chapter 71.05 RCW."[39] The closure of inpatient psychiatric units over the last decade means that very few RSNs are able to provide directly for these inpatient services within their boundaries.

  As Exhibit 8 indicates, only King and Spokane RSNs had 96 percent or more authorized admissions that occurred within their RSN in 2010. In many rural RSNs, a hospital psychiatric unit does not exist within the RSN borders. In other larger RSNs, however, only about half of hospital admissions occur in local hospitals.

Exhibit 8
Inpatient Hospital Psychiatric Admissions Within RSN Where Patient Lived, 2010

RSN (patient)	Hospitalization Within Same RSN	Total
Chelan-Douglas	5 (11%)	47
Clark County	248 (84%)	294
Grays Harbor	1 (2%)	60
Greater Columbia	537 (82%)	653
King County	2,552 (97%)	2,643
North Central	0 (0%)	197
North Sound	686 (53%)	1,287
Peninsula	19 (13%)	142
Southwest	50 (66%)	76
Spokane County	901 (96%)	940
Thurston-Mason	165 (56%)	296
Timberland	1 (1%)	84

Note: Data from Pierce County were unavailable

The consolidation of psychiatric hospital beds within the state's largest population centers creates additional challenges for serving patients. The current statute intends for patients to be served on a regional basis, rather than transported over extended distances. To encourage the use and development of local beds within an RSN, the state could permit a "host" RSN to charge a fee to outside RSNs that use inpatient beds within their service area. In addition to providing incentives and enacting policies to increase bed space, alternative approaches may include options that reduce or prevent the number of psychiatric admissions. This topic is discussed in the next section.

[39] RCW 71.24.300 (6) (c)

III. Prevention Options and Alternatives to Hospitalization

The decline in inpatient psychiatric bed capacity over the last ten years has been recognized by both professionals and policy makers. While utilization and occupancy levels are well-established, less is known about how various alternatives to detention may influence the demand for inpatient psychiatric services. This section discusses some of the programmatic, planning, and statutory alternatives that may provide a means to decrease hospitalizations. These prevention/diversion options include:

- Examining the effectiveness of crisis interventions
- Implementing a standard utilization management tool
- Requiring PACT (intensive outpatient) for patients with multiple commitments
- Implementing statutory changes with Assisted Outpatient Treatment (AOT)

Option 1: Examine effectiveness of crisis interventions

To effectively prevent or divert future psychiatric commitments, it would be helpful to intervene with these individuals before a hospitalization becomes necessary. To determine the service history in these cases, we looked at all persons with an ITA investigation that occurred between 2004 and 2010. Then, we examined both crisis services received in the two years prior to the ITA investigation. As Exhibit 9 shows, 39 percent of those persons with an ITA investigation had also received crisis services provided by the RSN in the previous two years. Fourteen percent of this total had received services on four or more separate occasions

Exhibit 9
Number of Persons Who Received RSN Crisis Services in Two Years Prior to ITA Investigation (2004–2010 Investigations)

Number of Crisis Service Contacts	Persons	Percentage
None	46,603	61%
One to Three	19,192	25%
Four or More	10,268	14%
Total	**76,063**	**100%**

Across the 13 Regional Support Networks providing mental health services in the state, a range of crisis response alternatives are available. Each RSN operates a 24-hour crisis hotline where trained professionals can assist individuals experiencing a mental health crisis.[40] Different types of crisis facilities are also operated by RSNs throughout the state. *Crisis triage facilities* are staffed by mental health professionals and designed to provide behavioral health assessments, medication monitoring, and stabilization in a residential environment. Persons served in these facilities cannot remain for more than 24 hours.

In 2007, the Legislature created a similar designation for crisis facilities, called *crisis stabilization units (CSU)*. CSUs provide services similar to crisis triage centers, but individuals may remain in a CSU voluntarily for several days to regain stability. A CSU may also hold individuals involuntarily for up to 12 hours, provided they are evaluated by a mental health professional within three hours of entry to determine if they meet detention criteria.[41] Currently, there is one licensed Crisis Stabilization Unit in the state (operating in Pierce County).

In 2011, the Legislature amended the emergent detention statute to allow persons to be delivered to a triage facility that has elected to operate as an involuntary facility. The person may be held by the facility for up to 12 hours (in addition to the

[40] http://www.dshs.wa.gov/dbhr/mhcrisis.shtml
[41] RCW 71.05.153

time spent in CSUs, E&Ts, and emergency departments).[42] This 2011 legislation also directed the Department of Health (DOH) and DSHS to work with the Washington Association of Counties and the Washington Association of Sheriffs and Police Chiefs to create rules that establish standards for certification of triage facilities. Triage facilities may be structured to serve either voluntary or involuntary clients.

Allowing triage facilities to accept short-term involuntary detentions should help expand the number of beds available to persons who initially refuse treatment. Short-term detentions at crisis centers are meant to facilitate voluntary admissions and provide extended interventions until individuals are connected with necessary resources. No structured evaluation of these interventions has been conducted to determine if the benefits of crisis detention exceed the costs.

Between 2006 and 2009, the legislature established the Integrated Crisis Response (ICR) pilot program in Pierce and North Sound RSNs. The ICR program created secure detoxification centers and allowed Designated Crisis Responders to detain individuals who were gravely disabled or presenting a likelihood of serious harm due to mental illness, substance abuse, or both.[43] An evaluation of this program, conducted by the Institute, found that the pilot ICR program achieved cost savings resulting primarily from fewer admissions to state and community psychiatric hospitals.[44] A similar study of crisis stabilization units and crisis triage facilities that accept involuntary detentions could help determine the effectiveness of this approach. Cost effectiveness research in this area may help generate additional investment in crisis response by RSNs or other local governments.

One of the difficulties in assessing the effectiveness of crisis response, however, stems from the lack of comprehensive information about the acuity of committed persons. Individuals with medical needs, for example, would still need to be detained in a hospital setting. The next section discusses the benefits of implementing a standardized tool for capacity planning and care decisions.

Option 2: Implement a standard utilization management tool

Many healthcare delivery systems routinely employ utilization management (also called utilization review) procedures to contain costs and manage resource allocation. The Utilization Review Accreditation Commission (URAC) defines utilization management as the "evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits plan."[45]

Utilization management techniques are not intended to replace clinical or medical judgment. Rather, the use of these tools can provide a more predictable and standardized means to analyze how symptoms, behaviors, and characteristics of the patient relate to the need for services. Opportunities for efficiencies can be better investigated if uniform and consistent data collection practices are in place.

A number of hospitals and Regional Support Networks rely on utilization management tools to help monitor treatment resources. A 2007 study in Washington State identified four utilization management instruments used in different areas.[46] One of the more common instruments is the Level of Care Utilization System (LOCUS) for

[42] Laws of 2011, ch. 148, SHB1170
[43] RCW 71.05 and 70.96B
[44] Mayfield, J. (2011). *Integrated crisis response pilots: Long-term outcomes of clients admitted to secure detox* (Document No. 11-05-3902). Olympia: Washington State Institute for Public Policy.

[45] https://www.urac.org/resources/careManagement.aspx
[46] Folz, B., Watson, J, Jaffe, D., Krupski, A., & Roy-Byrne, P. (2007). *Washington Inpatient Utilization Management Project*. Prepared for the Washington State Division of Mental Health Systems Transformation Initiative. Seattle, WA: Harborview Medical Center., p. 6.

Psychiatric and Addiction Services. The LOCUS is a publicly available instrument distributed by the American Association of Community Psychiatrists.

According to the manual, the LOCUS instrument has three purposes:

- Assess immediate service needs (e.g. for clients in crisis).
- Plan resource needs over time, as in assessing service requirements for defined populations.
- Monitor changes in status or placement at different points in time.[47]

The LOCUS tracks six different domains: risk of harm, functional status, co-morbidities, recovery environment, treatment/recovery history, and engagement. Scores on these domains are used in conjunction with other clinical information to help determine levels of care and service requirements. In Washington State, the Clark County RSN has started a three-year pilot project to test the feasibility of using the LOCUS instrument.

For involuntary admissions, of course, decisions about the treatment course and duration are guided by the legal process and courts. Even in these circumstances, however, a standard utilization management tool could be beneficial. This type of uniform assessment could be reviewed by judges and legal teams to make decisions about the appropriateness of Least Restrictive Alternatives (LRA) versus continued commitment. In addition, if this type of data were collected consistently over time, the effectiveness of various policy changes and program interventions among different populations could be more easily evaluated.

[47] http://www.communitypsychiatry.org/publications/clinical_and_administrative_tools_guidelines/LOCUS2010.pdf

In Washington's public mental health system, each RSN has the responsibility to authorize inpatient psychiatric admissions. State and federal monies are allocated to each RSN to manage inpatient admissions. Consequently, each RSN and hospital may elect to employ different utilization management practices. For the purposes of policy decision making, it may be worthwhile to consider the adoption of a statewide utilization management tool. Given the constraints in capacity, it is important to plan for the effective use of current resources and develop alternatives accordingly. Consistent, validated, and reliable information for mental health consumers across the state can help guide these decisions.

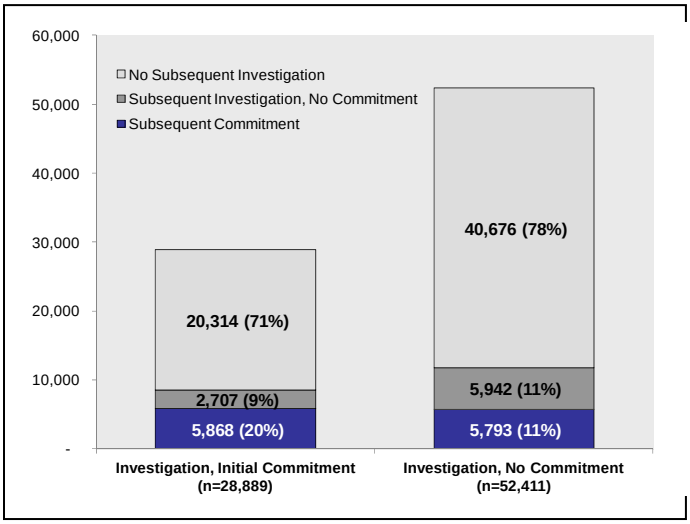
Option 3: Require evidence-based interventions for patients with multiple commitments

About one in five (20 percent) individuals with a hospital admission resulting from an ITA investigation will have another ITA-related hospital admission within two years. Among those individuals who are investigated, but not committed, about 11 percent will have a subsequent investigation and commitment within the next two years (see Exhibit 10, next page).

As mentioned previously, legislative changes that will take effect in 2012 may result in an additional 2,700 initial commitments per year (above current levels). These new commitments will result from new statutory language which permits a DMHP to more fully consider previous hospitalizations and patterns of historical behavior that may lead to deterioration.[48] For all ITA investigations examined between 2002 and 2008, between 10 and 20 percent had a subsequent investigation that resulted in a commitment within two years. For this population, alternative interventions that help reduce repeat hospital stays may be necessary. This section discusses such evidence-based practices for mental health that have demonstrated effectiveness.

[48] RCW 71.05.212 and RCW 71.05.245

Exhibit 10
Percentage With an ITA Investigation (2002–2008) Who Had Another Investigation Within 24 Months



WSIPP, 2011

Evidence-based practices (EBPs) are programs or interventions that have been demonstrated, through rigorous research, to be effective in helping consumers of mental health services reach desired outcomes. To achieve consistent results, an EBP must be delivered with adherence, or *fidelity*, to the program model. The federal Substance Abuse and Mental Health Services Administration (SAMHSA) has developed a number of implementation "toolkits" for evidence-based practices in mental health treatment, including:[49]

- Family Psychoeducation
- Illness Management and Recovery
- Integrated Treatment for Co-Occurring Disorders
- MedTEAM (Medication Treatment, Evaluation, and Management)
- Assertive Community Treatment (ACT)
- Supported Employment and Housing

According to a recent survey of state officials, the implementation of EBP substance abuse and mental health service delivery is becoming more widespread.[50] In 2003, Oregon was the first state to pass legislation requiring that an increased percentage of state funding for mental health and substance abuse treatment be directed toward the implementation of EBPs. By the 2009–11 biennia, 75 percent of all state treatment dollars were to be spent on evidence-based programs.[51]

In 2007, the Washington Institute for Mental Health Research and Training (WIMHRT) conducted a survey to identify EBP practices and implementation in Washington's mental health service system. Less than 40 percent of the mental health agencies surveyed (N=96, 62 percent) reported using any of the EBPs identified by SAMHSA.[52] A great majority of these mental health agencies (84 percent), however, indicated they wanted to implement EBPs in the future.

One EBP that may be appropriate for individuals with multiple inpatient psychiatric hospitalizations is the Program for Assertive Community Treatment, or PACT. PACT is an individualized approach to community mental health care that relies on a team of professionals (psychiatrist, nurse, social worker, etc.) who work together and provide necessary treatment and support for the consumer. The PACT approach also emphasizes services in a community setting, low client-staff ratios, and access to providers (24/7) in emergency situations. PACT is considered a framework for treatment, rather than a direct

[49] See http://store.samhsa.gov/facet/Professional-Research-Topics/term/Evidence-Based-Practices?filterToAdd=Kit

[50] Rieckmann, T. R., Kovas, A. E., Fussell, H. E., & Stettler, N. M. (2009). Implementation of evidence-based practices for treatment of alcohol and drug disorders: The role of the state authority. *Journal of Behavioral Health Services & Research, 36*(4), 407.

[51] The Oregon Department of Human Services, Addictions and Mental Health Division (AMH) reports that between 2003 and 2007, persons hospitalized for psychiatric reasons decreased by 5 percent and involuntary commitments declined by 18 percent. See: http://www.swofire.oregon.gov/OHA/mentalhealth/ebp/reports/joint-interim-judiciary08 report.pdf\

[52] http://www.mhtransformation.wa.gov/pdf/mhtg/EBPs_in_WA_with_Appendices.pdf

service. As such, a PACT team can incorporate other EBPs in a treatment plan for the consumer. In a review of 25 randomized controlled trials of PACT, Bond et al. (2001) found that this approach "substantially reduces psychiatric hospital use, increases housing stability and moderately improves symptoms and subjective quality of life."[53]

The implementation of PACT teams within Washington State has already occurred on a limited basis. In 2007, ten PACT teams (seven in Western Washington and three in Eastern Washington) began working with high-need consumers throughout Washington State. By early 2010, there were about 450 PACT participants statewide. An initial evaluation of PACT implementation in the state found that state hospital days for PACT participants in Western Washington decreased relative to a similar comparison group, resulting in a savings of $1.40 for every dollar spent on PACT.[54], [55]

This initial report on outcomes associated with PACT noted that a longer follow-up period and additional subgroup analyses would be necessary to gauge the full impact of the program. Consumers with repeat ITA admissions may be one group that would be suitable for PACT participation. In several states, programs with intensive outpatient treatment (such as PACT) have been used as a mandated commitment alternative or as a condition of discharge. The next section discusses the variety of state approaches in greater detail.

[53] Bond, G. R., Drake, R. E., Mueser, K. T., & Latimer, E. (2001). Assertive community treatment for people with severe mental illness: Critical ingredients and impact on patients. *Disease Management & Health Outcomes, 9*(3), 149.
[54] Morrissey, J. (2011, June 30). *Evaluation of Washington State's PACT Program: Final report.* Chapel Hill, NC: Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.
[55] The evaluation did not find a reduction in local hospital or emergency room use. This may be because the analyses focused only on PACT consumers who had prior state hospital admissions.

Option 4: Statutory changes with Assisted Outpatient Treatment (AOT)

In 2011, 44 states had laws that authorized the use of court-ordered outpatient treatment for mental health commitments.[56] This mandated treatment alternative, commonly referred to as "assisted outpatient treatment" (AOT) usually serves as (1) an alternative to hospitalization for patients who meet inpatient commitment criteria, (2) an alternative to hospitalization for patients who meet an *outpatient* commitment, or (3) a type of conditional release for patients who are discharged from an involuntary inpatient commitment.

In Washington State, AOT has employed a "less restrictive alternative" (LRA) to commitment. After an initial commitment for an emergency detention, the court may order "an appropriate less restrictive course of treatment for not to exceed ninety days."[57] This option provides an alternative to a subsequent 14-day inpatient commitment; however, in a recent analysis of commitment decisions in Washington, we found that LRAs are only ordered in 11 percent of commitment hearings.[58]

A less restrictive treatment alternative may be used less frequently in Washington State for several reasons:

- The criteria for an LRA (assisted outpatient treatment) are the same as the criteria for an inpatient commitment.
- Most ITA investigations in Washington result in the individual being taken into *emergency custody* (hospitalized) because of the imminent likelihood of danger.

A non-emergent petition for treatment requires an individual be examined by a DMHP within 48 hours (of notice being served) and for the court to

[56] http://www.treatmentadvocacycenter.org/storage/documents/State_Standards_-_The_Chart-_June_28_2011.pdf
[57] RCW 71.05.240 (3)
[58] Burley, 2011, p. 14.

rule on appropriate treatment options within one day after the examination.[59] In practice, however, non-emergent detentions are rarely initiated in Washington State, outside King County. County DMHPs and judicial officers report that legal costs and time considerations often preclude the use of these non-emergent petitions.

Other states, however, have established various legal requirements that expand available alternatives to inpatient hospital commitments. A brief summary of outpatient treatment commitment statutes in selected states is presented here.

Michigan

In Michigan, before a hearing for initial commitment takes place, the court orders "a report assessing the current availability and appropriateness for the individual of alternatives to hospitalization, including alternatives available following an initial period of court-ordered hospitalization."[60] At the hearing, the court has the option to dismiss the petition or order up to 90 days of treatment. The order may include alternative (outpatient) treatment (up to 90 days), or a combination of hospitalization (up to 60 days) and alternative outpatient treatment.[61]

In 2005, Michigan expanded outpatient civil commitment criteria to consider an individual's need for treatment, in addition to the likelihood of being dangerous to self or others. In particular, a petition can be filed when treatment for an individual "has been determined to be necessary to prevent a relapse or harmful deterioration of his or her condition and whose noncompliance with treatment has been a factor in the individual's placement in a psychiatric hospital, prison, or jail at least 2 times within the last 48 months or whose noncompliance with treatment has been a factor in the individual's committing 1 or more acts, attempts, or threats of serious violent behavior within the last 48 months."[62]

Any adult can file an AOT petition with the court alleging that the individual requires treatment and meets the above criteria. At an AOT petition hearing, the court may verify the individual meets the legal criteria and can order participation in outpatient treatment and testing, as available.[63] The Michigan statute allows the court to set the duration of the AOT order.

North Carolina

North Carolina also has a separate outpatient commitment statute. A person may receive outpatient commitment if the following conditions are met:

- The person has a mental illness,
- The person is capable of surviving safely in the community with available supervision,
- Treatment is necessary to prevent further deterioration that might result in dangerousness, and
- The person is unable to make an informed decision to voluntarily seek or comply with treatment.[64]

An individual may be held for up to 24 hours in order to be examined by a physician or eligible psychologist to determine if commitment criteria have been met. Persons who are mentally ill and deemed to be a danger to self or others can be detained in a 24-hour facility prior to the inpatient commitment hearing. If a person is not dangerous, and meets the outpatient commitment criteria (above) a court hearing is held within ten days of the initial examination.[65]

[59] RCW 71.05.235
[60] MCL 330.1453(a)
[61] MCL 330.1472a
[62] MCL 330.1401(d)
[63] MCL 330.1469a
[64] G.S. 122C-263(c)
[65] G.S. 122C-267

North Carolina also permits a "split" inpatient and outpatient commitment decision at the initial hearing. An initial outpatient commitment can be ordered for a maximum of 90 days (with 180 days possible after another hearing). Outpatient commitment hearings can be held within an outpatient treatment facility or judge's chambers. A respondent is not automatically assigned a defense counsel for these hearings unless requested or directed by the court. A physician or representative from the providing treatment agency may also be present at the hearing. An outpatient commitment order can be terminated at any point (by the court) if the treatment center or physician finds the individual no longer meets commitment criteria.

Oregon

A commitment hearing may be initiated in Oregon for a person who, as a result of a mental disorder, is dangerous to self or others, unable to provide for basic personal needs, or meets the following criteria:

- Is chronically mentally ill;
- Within the previous three years, has two or more placements (by the mental health division) in a hospital or inpatient facility;
- Exhibits symptoms or behavior similar to those that preceded one of the identified hospitalizations; and
- Will continue to physically or mentally deteriorate unless treated.[66]

Following the initial commitment investigation, the community mental health program director (or designee) can recommend one of the following options:

- No commitment hearing will take place.
- A 14-day period of intensive treatment (diversion) will take place. Intensive treatment can include both inpatient and outpatient treatment.
- A commitment hearing will take place (within five days).[67]

A commitment hearing "may be held in a hospital, the person's home or in some other place convenient to the court and the allegedly mentally ill person."[68] Oregon is unique in that the Mental Health Division director (with court approval) may authorize involuntary admissions or set the conditions for an outpatient commitment.[69] An outpatient commitment can be modified or revoked by the director at any time when a modification is in the person's best interest.[70]

Wisconsin

Similar to the diversion arrangement in Oregon, the Wisconsin statute permits the use of a "settlement agreement." This agreement postpones the commitment hearing for up to 90 days while the person engages in outpatient treatment.[71] A settlement agreement can be entered into at any time, and either party may request that the agreement be modified during the course of treatment.

Wisconsin law specifies that an individual cannot be evaluated or examined under the civil commitment law until the state determines whether the individual is enrolled in a health plan.

[66] ORS 426.005

[67] ORS 426.237
[68] ORS 426.095
[69] ORS 426.233
[70] ORS 426.127
[71] §51.20(8)(bg) Wis Stats

If the individual is enrolled, the insurer must first be notified that treatment is required.[72] For persons detained for a potential commitment, a probable cause hearing must take place within 72 hours of the detention. The probable cause hearing determines whether an individual meets the commitment criteria and what alternatives are necessary.

After the probable cause hearing, the judge may dismiss the petition, order continued detention (for up to 14 days), or allow the individual to remain in the community for up to 30 days pending the final hearing. Prior to the final hearing, the county mental health department provides the court with a written treatment plan. The treatment plan specifies the need for both inpatient and outpatient care, the availability of services, and expected providers.[73]

Effectiveness of Assisted Outpatient Treatment

There is not widespread research on the effectiveness of assisted outpatient treatment or outcomes following outpatient commitment orders. Several problems face evaluation efforts of these alternatives, including: (1) a lack of comparable committed and non-committed groups, (2) differences in commitment procedures between states or jurisdictions, and (3) selection effects stemming from courts choosing persons who are likely to succeed after receiving commitment orders.[74]

A 2005 Cochrane review of available literature on involuntary outpatient treatment found two high quality randomized control trials that evaluated outcomes for compulsory treatment. These two studies (from New York and North Carolina) did not find evidence of improvement in treatment compliance, re-hospitalization rates, arrest rates, or violent acts committed during the study observation period.[75]

An examination of these studies by Rand (2001), however, noted that the North Carolina study, "suggests that a sustained outpatient commitment order (180+ days), when *combined with intensive mental health services*, may increase treatment adherence and reduce the risk of negative outcomes such as relapse, violent behavior, victimization and arrest."[76]

[72] §51.20(7)(am) Wis Stats
[73] §51.20(10)(cm) Wis Stats
[74] Swartz, M. S., & Swanson, J. W. (2008). Outpatient commitment: When it improves patient outcomes. *Current Psychiatry, 7(*4), 25-35.

[75] Kisely, S., Campbell, L.., & Preston, N. (2005). Compulsory community and involuntary outpatient treatment for people with severe mental disorders. *The Cochrane Database of Systematic Reviews*, Issue 3. Art. No.: CD004408.pub2. DOI:10.1002/14651858.CD004408.pub2.
[76] Ridgely, M. S., Borum, J., & Petrila, J. (2001). *The Effectiveness of Involuntary Outpatient Treatment* Santa Monica, CA: Rand Corporation, p. 98. Retrieved from http://www.rand.org/pubs/monograph_reports/2007/MR1340.pdf

IV. External Impacts on Public Systems

As mentioned previously, upcoming changes to the Washington State's ITA statute may result in between 853 and 2,716 *additional* psychiatric admissions per year. The expected increase in ITA-related commitments may have impacts that reach beyond hospitals as well. The legislative direction for this study calls for an examination of "the extent to which increases in involuntary commitments are likely to be offset by reduced utilization of correctional facilities, publicly funded medical care and state psychiatric hospitalizations."[77]

This section of the analysis focuses on the number of jail bookings, emergency department visits, and long-term psychiatric hospitalizations following an ITA investigation. Two types of utilization impacts were examined:

- **Short-term:** If a person in need of psychiatric treatment is hospitalized, the patient would be diverted from potentially entering a jail or emergency department during this period of hospitalization.
- **Long-term:** If hospitalization results in needed treatment, the patient may be less likely to enter a jail or the emergency department following treatment.

For both types of impacts, we examined the outcomes of persons with an ITA investigation, but no commitment. This population will have an increased likelihood of being hospitalized when changes to the ITA statute take effect in 2012.

The average length of an ITA-related hospital stay was about *12 days*. This section looks at the 12-day period following an ITA investigation to estimate the number of persons who were diverted from jail or emergency departments. Then, we compared jail and emergency department utilization after this 12-day period for those with and without an ITA-related commitment.

Jail Outcomes

In 2010, there were 59 county or local jails operating in Washington State.[78] For this analysis, we matched all ITA investigation records for 2011 to statewide jail information. The following outcomes were observed:

Short Term. Among persons with an ITA investigation, but no commitment, we found only *1.8 percent* were booked into jail during the 12 days following the investigation. Given this figure, it is unlikely that increasing involuntary commitments would noticeably reduce jail bookings in the short-term.

Long Term. Given the timeframe for which data were available, we could only examine jail bookings that occurred in the three months following an ITA investigation. Exhibit 11 (next page) shows that 6 percent of those with an ITA-related hospitalization had a jail booking in the three months following an ITA investigation. Of those with an ITA investigation and no commitment, 7 percent were booked into a jail during the same period. The difference in jail utilization between these two groups was not statistically significant. A longer follow-up period or more detailed research design may be necessary to confirm these findings. These initial results, however, indicate that increasing psychiatric hospitalizations will not significantly change the rate of jail admissions among this population.

[77] Laws of 2010, ch. 37 § 204 (3) (e), ESSB 6444

[78] In recent years, jails in Washington State have provided regular data updates to the new statewide Jail Booking Reporting System (JBRS). By 2011, booking data was available for all jails in Washington State for research purposes.

Exhibit 11
Jail Bookings in the Three Months Following an ITA Investigation (2011)

Commitment Type	Jail Booking (Percentage)	Total Investigated
Involuntary Commitment	91 (6%)	1,561
Investigation, No Commitment	137 (7%)	1,907

p=0.11

Exhibit 12
Emergency Department Visits in the 12 Months Following an ITA Investigation (2008)

Commitment Type	Emergency Department Visit (Percentage)	Total Investigated
Involuntary Commitment	971 (31%)	3,103
Investigation, No Commitment	1,154 (29%)	3,916

p=0.10

Emergency Department Outcomes

Starting in 2010, payments for publicly funded medical care were handled by a new system called ProviderOne.[79] As a result of the migration to this new payment system, medical claims data were only available through 2009 for this analysis. Given this restriction, we looked at 12-month emergency department utilization for all persons with an ITA investigation in 2008. The utilization patterns showed the following:

Short Term. For persons who had an ITA investigation but were not committed, *7.6 percent* visited an emergency department in the (12-day) period after the investigation. Approximately 65 to 206 persons could be diverted from hospital emergency departments given the estimated number of additional ITA hospitalizations (between 853 and 2,716) that may occur after 2012. Since many of these psychiatric admissions may still take place through the emergency department, however, the reduction in emergency department visits may be even less.

Long Term. In the 12 months following an ITA investigation, there were no (statistically) significant differences in the emergency department utilization rate between those with a commitment and those without (see Exhibit 12).

For those with an involuntary commitment, 31 percent had a visit to the emergency department in the 12 months following their commitment. The emergency department utilization rate was nearly the same (29 percent) among those with an ITA investigation, but no commitment. At first glance, therefore, it appears that an increase in the commitment rate among this population would not significantly change the subsequent use of emergency departments.

State Psychiatric Hospital Outcomes

If, after a 14-day commitment, an individual remains gravely disabled or a danger to self or others, a judge may order the person be committed for a period of up to 90 days in one of the state's psychiatric hospitals.[80] If initial (14-day) commitments increase as a result of changes to the ITA statute, it is likely that the number of long-term (90-day) commitments to state psychiatric hospitals will increase as well. Previous estimates, completed for the first phase of this study, found that projected increases in involuntary commitments may result in an additional 122 to 388 long-term (90-day) admission to the state psychiatric hospital.[81]

[79] For more information, see http://hrsa.dshs.wa.gov/providerone/.

[80] Additional hospitalizations of 180 days are possible if it is found in subsequent hearings that the individual continues to meet the commitment criteria.

[81] Burley, 2011, p 28.

Conclusion

Beginning in 2012, the involuntary commitment statute in Washington will permit an investigator to give greater weight to witness accounts, historical factors, and patterns of behavior when making a commitment decision. Based on a survey of investigators and analysis of investigation records, we estimate that between 853 and 2,716 *additional* psychiatric admissions may occur each year as a result of these changes.

This report focused on strategies to increase inpatient psychiatric capacity and alternatives to reduce hospital admissions. In addition, we examined how jail and emergency department utilization vary based on the outcome of an ITA investigation (committed/non-committed). After an initial look at these outcomes, it appears that jail and emergency department usage will not be impacted significantly if psychiatric hospitalizations increase.

Given the decline in inpatient psychiatric bed capacity and expected increases in involuntary treatment admissions, careful consideration must be paid to which approaches and alternatives are most effective. This report suggests a number of strategies, but the corresponding costs and benefits from each of these options have not been quantified. One alternative not yet presented may be to delay implementation of the statutory changes while other diversion or prevention alternatives are studied. Given that inpatient psychiatric admissions are administered by 13 regional networks throughout the state, testing different approaches in various RSNs may be feasible, as well.

The Involuntary Treatment Act is intended to "encourage appropriate interventions at a point when there is the best opportunity to restore the person to or maintain satisfactory functioning."[82] A more complete understanding of which interventions are appropriate and effective will be necessary to develop alternatives and address the growing shortage of inpatient psychiatric resources.

[82] RCW 71.05.012

Appendix 1: Psychiatric Beds per 100,000 Population – by State (2009)

Rank	State	Psychiatric Beds	Psychiatric Hospitals	Total Population	Beds per 100,000 population
1	District of Columbia	284	8	599,657	47.36
2	Massachusetts	2,323	44	6,593,587	35.23
3	Wyoming	185	6	544,270	33.99
4	West Virginia	596	15	1,819,777	32.75
5	Arkansas	945	32	2,889,450	32.71
6	Louisiana	1,362	50	4,492,076	30.32
7	Pennsylvania	3,741	90	12,604,767	29.68
8	Missouri	1,771	48	5,987,580	29.58
9	Oklahoma	1,079	28	3,687,050	29.26
10	North Dakota	188	7	646,844	29.06
11	Kentucky	1,245	27	4,314,113	28.86
12	Mississippi	831	17	2,951,996	28.15
13	Alabama	1,252	37	4,708,708	26.59
14	New York	5,128	87	19,541,453	26.24
15	Vermont	157	5	621,760	25.25
16	Maryland	1,429	34	5,699,478	25.07
17	Tennessee	1,531	34	6,296,254	24.32
18	New Jersey	2,098	38	8,707,739	24.09
19	Maine	317	9	1,318,301	24.05
20	Idaho	352	7	1,545,801	22.77
21	Connecticut	792	22	3,518,288	22.51
22	Michigan	2,196	61	9,969,727	22.03
23	Illinois	2,833	63	12,910,409	21.94
24	Iowa	624	29	3,007,856	20.75
25	Wisconsin	1,139	40	5,654,774	20.14
26	South Dakota	160	5	812,383	19.70
27	Indiana	1,249	42	6,423,113	19.45
28	Delaware	170	3	885,122	19.21
29	North Carolina	1,769	45	9,380,884	18.86
30	Virginia	1,459	33	7,882,590	18.51
31	New Mexico	353	12	2,009,671	17.57
32	New Hampshire	229	10	1,324,575	17.29
33	Nebraska	296	8	1,796,619	16.48
34	Ohio	1,879	61	11,542,645	16.28
35	Kansas	450	21	2,818,747	15.96
36	Minnesota	824	24	5,266,214	15.65
37	Texas	3,851	80	24,782,302	15.54
38	Rhode Island	160	4	1,053,209	15.19
39	Hawaii	195	4	1,295,178	15.06
40	Florida	2,703	48	18,537,969	14.58
41	South Carolina	665	18	4,561,242	14.58
42	Georgia	1,306	29	9,829,211	13.29
43	Nevada	347	8	2,643,085	13.13
44	California	4,528	83	36,961,664	12.25
45	Montana	114	6	974,989	11.69
46	Colorado	567	15	5,024,748	11.28
47	**Washington**	**701**	**22**	**6,664,195**	**10.52**
48	Arizona	681	14	6,595,778	10.32
49	Oregon	353	14	3,825,657	9.23
50	Utah	252	10	2,784,572	9.05
51	Alaska	61	4	698,473	8.73

Source: *AHA annual survey database for fiscal year 2009*. Copyright: Health Forum, LLC, an affiliate of the American Hospital Association, 2010. Annual population estimates from US Census (www.census.gov/popest/states/NST-ann-est.html)

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