State Hospital Effectiveness and Efficiency Implementation Team

Forensic Subcommittee Report

The forensic subcommittee met on four occasions between 10/22/10 and 2/4/10. For the last two meetings, the subcommittee met jointly with the Criminal Justice subcommittee of the Emergency Services Implementation Team.

Core Membership: Rebecca Stredny, Richard Wright, Kathleen Sadler, Michael Schaefer, Donna Moore, Lynda Hyatt, Katherine Poindexter, Daniel Murrie, Alfred Head, and Victoria Cochran. Consultation provided at the final two meetings from Cynthia McClaskey, Laura Totty, and Leslie Weisman.

The mission of this group was to examine the trends and issues associated with a growing forensic population, and recommend specific strategies that will reduce or divert admissions and increase safe conditional releases/community discharges.

This report will first describe the various categories into which forensic inpatient consumers fall, and the issues/challenges associated with each. This will be followed by a set of recommended strategies, many of which address the issues associated with more than one group of forensic consumers.

SECTION I: CATEGORIES OF FORENSIC CONSUMERS AND ASSOCIATED CHALLENGES

A. Persons Requiring Emergency Treatment Prior to or After Trial (§ 19.2-169.6)

A person with criminal charges, or who is awaiting sentencing or serving a sentence in a local correctional facility, may be admitted to an inpatient facility for emergency treatment upon a finding of probable cause that he/she has a mental illness, and that there exists a substantial likelihood that he/she will, in the near future, cause serious physical harm to self or others as a result of that mental illness (inability to care for self is not an available prong for commitment under this statute).

These are typically acute treatment cases with brief lengths of stay. It is not uncommon, however, for a person to be admitted under this status and for an order for forensic evaluation to then follow. The challenges associated with this population are:

- Lack of available bed space at ESH, where there is high demand (this is rarely an issue at other facilities).
- Lack of Departmental policy regarding which persons should be directed to the CSH maximum security unit versus admitted to a local facility.
- High-risk, extremely dangerous inmates sometimes use harm to self or others in a deliberate manner to facilitate admission to a mental health facility, typically as a function of personality disorder. These are low-frequency occurrences, but the potential for harm to vulnerable hospital patients is high and the risk can be very challenging to manage.

B. Evaluations of Competency to Stand Trial and Sanity at Time of Offense (§ 19.2-169.1 and 19.2-169.5)

These evaluations allow a maximum 30-day inpatient stay. For persons believed not to be competent, restoration treatment may be ordered. The challenges associated with this population are:

- Although the Code expresses a preference that these evaluations be conducted on an outpatient basis whenever possible, some regions of the state experience a shortage of qualified or willing evaluators. This is true in Southwest Virginia (low supply) and Northern Virginia (ample supply, but evaluators are unwilling to work for the standard state rate). Even in areas where there are available evaluators, Courts often refer for inpatient evaluation first. Anecdotally, this happens for one of several reasons: either the defense or prosecution insists on an inpatient evaluation; the Court is dissatisfied with the outpatient evaluators available; or simple tradition (a Court is most familiar with utilizing inpatient resources for this purpose). Most state facilities devote significant employee time to diverting these admissions by helping the Court locate a willing outpatient evaluator so that it can amend its order.
- There are many complaints regarding the uneven quality of outpatient evaluations (which are most often completed by persons in private practice who are not subject to any oversight or supervision). Complaints have been voiced by judges, prosecutors, defense attorneys, and mental health professionals. However, it is well-established in research that Courts give heavy weight to the opinion of a single forensic evaluator and often simply defer to it. The impact on state facilities of evaluations that do not meet professional practice standards is twofold: they can result in unnecessary admissions for restoration, and, even more challenging, they can result in NGRI findings in cases where legal criteria do not appear to have been met. The latter is a low-frequency event, but very costly for DBHDS. By conservative estimate, there were about 10 persons in the last 3 years found NGRI who did not appear to meet legal criteria. Based on per diem costs in the forensic unit and average per diem costs for civil hospitalization, multiplied by average length of stay, these 10 patients alone cost DBHDS $11,406,500.00. This estimate is very conservative, and most such acquittees tend to have longer (and more behaviorally complicated) lengths of stay. Therefore, it is likely that “inaccurate” NGRIs cost the Department more than even this estimate, and that preventing even relatively small numbers of such admissions would have a significant positive fiscal impact.

C. Restoration to Competence to Stand Trial (§ 19.2-169.2)

After undergoing an initial evaluation of competence to stand trial, some defendants are adjudicated incompetent and ordered to undergo treatment to restore competence. These renewable orders are for up to six months of treatment (except for a small handful of misdemeanor charges, which can limit restoration to 45 days). The challenges associated with this population are:

- Although the Code expresses a preference for outpatient competence restoration whenever possible, there is no reimbursement mechanism to CSBs for providing this service and thus the availability of this service is limited. As a consequence, many courts are accustomed to reflexively ordering inpatient restoration, even in cases where the defendant could be expected to respond positively to outpatient (often jail-based) services. It is not uncommon for state facilities to admit persons for restoration who are living in the community on bond and would otherwise be appropriate for outpatient services.

- Poorly reasoned (or overly expedient) evaluations conducted by outpatient evaluators can result in unnecessary restoration admissions of persons who are malingering or who already meet competency criteria (as referenced above).
- Once defendants are restored to competence they are typically returned to jail unless they meet emergency treatment criteria (which is rare). In some cases, there is then a lengthy wait for the competency hearing, the person begins refusing medication, and his or her psychiatric stability (and competency) erodes. This can result in a repeat admission to restore competence again. In an effort to forestall this cycle in the case of people known to refuse medication in the jail, some facilities attempt to keep the person hospitalized and try to get the court date expedited. However, keeping someone hospitalized until a competency hearing, and throughout the necessary subsequent proceedings, results in increased bed usage—which in turn can contribute to the accretion of waiting lists.

D. Mandatory Parolees (§37.2-814 et seq)

These individuals are admitted directly from the Department of Corrections as civilly committed persons upon the expiration of their sentences. The term "mandatory parolee" is an historical one now largely a misnomer due to the abolition of parole in Virginia. Instead, most of these individuals are subject to probation supervision rather than parole stipulations. The challenges associated with this population are:

- Via an MOU with the DOC, all individuals requiring civil commitment are admitted initially to the maximum security unit at Central State Hospital (CSH). They can then be transferred to civil units after an initial period of assessment. However, the large majority of these individuals do not appear to require maximum security and often they are former patients of state civil units that are very familiar with them.
- It appears that a large percentage of this population are psychiatrically stable and discharge-ready at the time of admission, but no placement was available. CSH admitting psychiatrists were asked to examine the list of persons admitted on this status over the last year, and estimated that approximately 50% met discharge criteria at time of admission. Similarly, one mandatory parolee with no mental illness recently appealed his civil commitment shortly after admission and was successful.

E. Not Guilty by Reason of Insanity Acquittees (§ 19.2-182.2 and 19.2-182.3)

These individuals are admitted first for an evaluation period of 45 days, after which about 20% are granted conditional release. Most are committed to the custody of the Commissioner, a renewable commitment that lasts for one year (misdemeanant acquittees are limited to one year of commitment as an NGRI acquittee, but can then be civilly committed if necessary). After commitment, NGRI acquittees can gradually obtain privileges that integrate increasing levels of community access, until they are considered appropriate for conditional release. Acquittees remain under the jurisdiction of the original trial court, which makes the decision regarding conditional release and supervises the acquittee while on release. Currently, the mean length of inpatient stay for NGRI acquittees is 6.3 years. The challenges associated with this population are:

- Departmental policy currently requires that all acquittees be admitted to the maximum security unit for temporary custody. While this does streamline some operations, this population tends to be psychiatrically stable and rarely in need of this level of security. In addition, for those

acquittees who are committed, they must then request civil transfer and await approval of their facility Internal Forensic Privileging Committee and the Forensic Review Panel. The treatment team packet-writing process and the committee review process, as a whole, can add up to two months to an acquittee's length of stay. For individuals placed directly into civil facilities for temporary custody, their overall length of stay might be decreased and, in some cases, we might avoid some of the iatrogenic issues caused when persons are placed in a high-security environment unnecessarily.

- The length of stay in general for NGRI acquittees is much longer than for most civil patients, many of whom have similar clinical and risk profiles.
- Misdemeanant NGRI consumers are a significant cost to the DBHDS, and many have minor charges (such as trespassing) that would result in little jail time. It appears that courts may sometimes use the NGRI process as a "back door" to get intensive treatment for chronically mentally ill persons who may be considered nuisances in the community. Once these individuals are admitted they cause significant systemic challenges (due to their limited commitment time). Often these individuals do not get the benefit of being conditionally released (which involves significant community oversight and support), and instead are discharged as purely civil patients because their NGRI commitment has expired.

SECTION II. RECOMMENDED ACTIONS

A. Implementation of Oversight on Outpatient Forensic Evaluation System

We recommend implementing a system of oversight on community forensic evaluators, who wield significant power over who gets admitted to state hospitals (by virtue of the courts' tendency to defer to their opinions). Such a system has the potential to reduce unnecessary admissions for pretrial evaluation, competency restoration, and NGRI acquittees. The group discussed many models employed by other states, which range from statutory requirements for CE units to full-fledged certification programs with ongoing peer review mechanisms. We believe that statutory changes will be needed to accomplish meaningful changes in this area. The group concluded that this is a complex issue on which recommendations should not be arrived at quickly, but one which should not be ignored due to the potential fiscal benefits. The group recommends that the Commissioner form a task force to examine this issue and create specific recommendations to make adjustments to Virginia's pretrial evaluation system.

B. Make Resources Available to Support Adult Outpatient Restoration

An organized, funded outpatient juvenile restoration system exists, but there is no funding available for outpatient adult restoration despite the fact that the need for adult restoration is far greater, and inpatient adult restoration is a very significant cost to DBHDS. Although the Code expresses a preference for outpatient restoration, this is not an attainable reality in most localities because it is an unfunded mandate. Even where outpatient restoration is being done, there is no funding available to accomplish

the outcome evaluations, and there is no incentive for CSBs to continue to provide this important but unreimbursed service. Diversion of inpatient admissions to outpatient services would obviate many forensic admissions and therefore be a significant source of cost savings. The group recommended that funding be identified for outpatient restoration and outcome evaluations. Implementation of such a program would require providing some training to CSBs; however, such training is already underway in HPR-5 and could be easily transported to other regions as needed.

In addition, we recommend that a structured restoration treatment protocol be outlined to serve as guidance for CSBs and/or for facilities. This should include specific recommendations for medications trials, in order to ensure defendants are receiving appropriate active treatment to restore competence.

C. Provide More Training on Forensic Issues to the Legal Community

Judges and attorneys encounter mental health issues in a relatively small proportion of the cases that come before them. Many are unaware of the procedural sequelae and systemic costs of an NGRI adjudication, for example, or the challenges associated with maintaining trial competence throughout an extended legal process. There is also limited awareness of how best to use outpatient resources for many forensic services before ordering inpatient services. The group recommends that DBHDS take the lead in identifying opportunities to provide training to legal personnel. Helping courts become better-informed consumers of forensic reports may also help shape higher-quality reports from community evaluators. One training of this type is already underway for attorneys and court personnel in HPR 5. CSB staff in Arlington are preparing to conduct a similar training in Northern Virginia and may be able to share the resources they developed with DBHDS in order to help facilitate other such training sessions.

We also recommend that an online informational resource should be created for courts and attorneys, and placed on the DBHDS website. This would include links to relevant model orders and case law, a summary of steps in the NGRI post-adjudication process, flow charts for various legal statuses, and links to relevant Departmental policy documents, such as the NGRI manual. With permission, forensic staff are prepared to act on this immediately.

Finally, we recommend that forensic issues be integrated into all Cross-Systems Mapping events going forward, and that a database of resources available at each CSB across the state be created. This would facilitate consultation with courts and attorneys, and facilitate the conditional release planning process for acquittees. This action would require no additional financial resources, as the available facilitators already have the necessary expertise, and the latitude to create this focus within the existing curriculum.

D. Implement Changes in Departmental Policy Regarding Management of NGRI Acquittees

We recommend that temporary custody of new insanity acquittees be implemented in state hospital civil beds instead of the maximum security unit whenever possible based on clinical/risk status. This proposal is also being put forth by the NGRI manual workgroup and will be recommended as part of that policy document as well. It may be necessary to divert some resources to civil hospitals to implement

this recommendation. In addition, human rights issues may arise if acquittees with low-risk profiles cannot be admitted to ESH due to bed space issues.

We also recommend that a formal consultation process be implemented for insanity acquittees with longer than average lengths of stay. In the past the focus of the Forensic Review Panel (FRP) when reviewing Annual Packets was to review the packet to insure that the acquittee was at an appropriate level of privilege. The FRP has begun expanding its review of Annual Packets to include consultative feedback to the Treatment Team, and requiring a response from the Team within the 3 week timeframe that is stipulated in policy. The FRP Chair and Central Office forensic staff are continuing to discuss ways to utilize the current 90 day reviews to target those acquittees who may need the FRP to review their privileges more frequently than annually, who would otherwise not come to the attention of the Panel until they have gone without privileges for a full year.

For many years, the FRP has operated under guidance from the Commissioner's office that only the barest minimum levels of risk were acceptable when considering requests for privilege increases and conditional release from insanity acquittees. The long-time cultural effects of a low-risk philosophy have likely permeated the rate at which treatment teams are willing to even submit requests. Even though the FRP currently approves the vast majority of requests submitted, it is a perennial misperception that the FRP has a low approval rate, and thus facilities may be reluctant to invest the time in preparing packets that they do not anticipate will be approved. In the interest of shifting to a more community-based level of care, we recommend expanding the array of historical behavior patterns that are eligible for consideration of requesting increases in privileges for insanity acquittees, including conditional release (always with consideration of the unique constellation of risk factors a given individual may possess). Traditionally, psychiatric stability, medication compliance, lack of behavior problems, and acquittee insight have all been expected in order to move through the privileging process (to varying degrees depending upon the privilege sought). This leads to a higher bar to discharge for insanity acquittees than is expected of civil patients, many of whom have very similar histories and risk profiles. Acquittees who have committed crimes such as murder may pose a higher level of risk than some civil patients based solely on history, but generally speaking acquittees are clinically a very similar group to civil patients (many of whom have serious legal histories but do not currently happen to be on a forensic status). We recommend the formation of a committee to formulate guidance to facilities and treatment teams on this issue.

Finally, we recommend that facilities be encouraged to explore options for the creation of units with that are more consumer-managed with reduced staff supervision for NGRI's deemed clinically stable, close to conditional release, and completing the final steps in the graduated release process (e.g., 8-hour or 48-hour community visits). It may be necessary for facilities to consider de-certifying some beds to accomplish this.

E. Evaluate the Size of the Maximum Security Unit at CSH

The maximum security unit at CSH is larger than some other states on a per capita basis, and is extremely expensive to operate. Some of the recommendations made earlier in this document (such as conducting temporary custody of new acquittees at civil units) would reduce the need for bed space in the maximum security unit, thus beginning to free up resources for more community-based options, such as outpatient restoration. Usage of the maximum security unit might also be decreased with the implementation of Departmental policy regarding when patients should be admitted to the unit for emergency treatment or competency restoration. Most individuals with misdemeanor charges, and some with felony charges, can be treated in a local facility without need for maximum security. Currently Southern Virginia Mental Health Institute is the only institution with a written policy in this regard. It is well-reasoned and might serve as a template for a Departmental policy.

Below is a table illustrating how Virginia's maximum security bed capacity compares with that of some other states (population data are from the 2010 census; bed data were obtained by polling the NASMHPD Forensic listserv). Virginia falls in the average range but, as the table demonstrates, a number of states have been successful in reducing their maximum security bed use significantly.

State	Population	# of Maximum Security Forensic Beds	Maximum Security Beds Per 100,000
Florida	18,801,310	1180	6.27
New York	19,378,102	715	3.68
Arkansas	2,915,918	94	3.22
Missouri	5,988,927	177	2.95
Rhode Island	1,052,567	28	2.66
Connecticut	3,574,097	91	2.54
New Jersey	8,791,894	200	2.27
Virginia	**8,001,024**	**177**	**2.21**
Indiana	6,483,802	84	1.29
Mississippi	2,967,297	35	1.17
Texas	25,145,561	265	1.05
Illinois	12,830,632	110	.85
New Hampshire	1,316,470	10	.75
Ohio	11,536,504	65	.56
Georgia	9,687,653	46	.47
Maine	1,318,301	6	.45
Tennessee	6,346,105	24	.37
North Carolina	9,535,483	32	.33
West Virginia	1,852,994	0	N/A
Massachusetts	6,547,629	0	N/A
Hawaii	1,360,301	0	N/A

Finally, usage of the forensic unit might be decreased by reassessing how mandatory parolee admissions are managed. Conferring with the DOC about how to avoid admissions of persons who are not acutely ill may be of assistance, as well as potentially altering the MOU with DOC to allow mandatory parolees to be admitted directly to civil facilities at the Commissioner's discretion. This has been tried in a few isolated cases with the permission of all parties, and has worked out well. As movement toward outpatient evaluation and restoration increases it is likely that demand for maximum security bed space will decrease in tandem.

In order to manage the forensic unit safely and securely, we also recommend requesting a human rights variance to permit prophylactic seclusion/restraint of patients deemed high risk.

F. Broad Review of Forensic Code Sections

We recommend that a task force undertake a broad review of forensic Code sections, and make suggestions for needed revisions. DBHDS staff has most of the necessary expertise to carry out such a review, with assistance from the Office of the Attorney General and perhaps from the Institute for Law, Psychiatry, and Public Policy. We strongly recommend that this task force be convened as quickly as possible, with the goal of putting forward at least some legislation with the 2012 General Assembly. Any work on implementing a forensic evaluation oversight system will likely require Code changes, and there has already been a preliminary look at some of the NGRI statutes (especially those pertaining to revocation of conditional release). In light of the committee's charge to look for specific strategies that would reduce forensic bed use, we recommend that the following revisions be considered (please note these are not necessarily endorsements, but ideas that have been successful in some states):

- Eliminating the misdemeanant provision for NGRI acquittees (which might serve as a deterrent to courts and attorneys using the defense for minor crimes), or consider allowing the insanity defense only for felony offenses.
- Requiring outpatient evaluations of competency and sanity, and allow inpatient evaluations if and only if an outpatient evaluator recommends it; likewise, require outpatient restoration whenever possible, and allow inpatient restoration only if an evaluator recommends it, or the person also meets emergency treatment criteria. These changes would significantly reduce forensic bed use, but they will only work if resources are devoted to support adult outpatient restoration and outcome evaluations.
- Requiring that defendants be placed on docket within 2 days (or some other brief period) of evaluation/restoration completion.
- Requiring a second opinion whenever an insanity defense is raised.
- Requiring relevant ongoing continuing education for forensic evaluators, and implement a program that allows some type of Departmental oversight on quality (as discussed earlier).

- Allowing the Commissioner the right to refuse an admission for emergency treatment, forensic evaluation, or competency restoration in high-risk cases, and instead devise an alternative plan for the services to be provided.

G. Improved Availability of Data

At this time, the data sources available to forensic staff are very limited and hamper useful policy analysis and recommendations. There is currently no reporting mechanism from CSBs to help us understand what forensic evaluation and treatment activities are already occurring in the community. The Forensic Information Management System (FIMS) collects a wealth of data but the software is very limited in what can be reported out. Forensic staff does not have access to AVATAR, and the staff who are available to pull reports from this system already have extraordinary time demands placed upon them. We strongly recommend an upgrade to FIMS that would improve the ease with which data can be pulled and readily analyzed. This would allow more informed estimates of potential costs and savings associated with policy changes, as well as assist with analysis of training and other needs in the system. We also recommend that as electronic health records come online, data fields be included to capture key forensic data going forward.