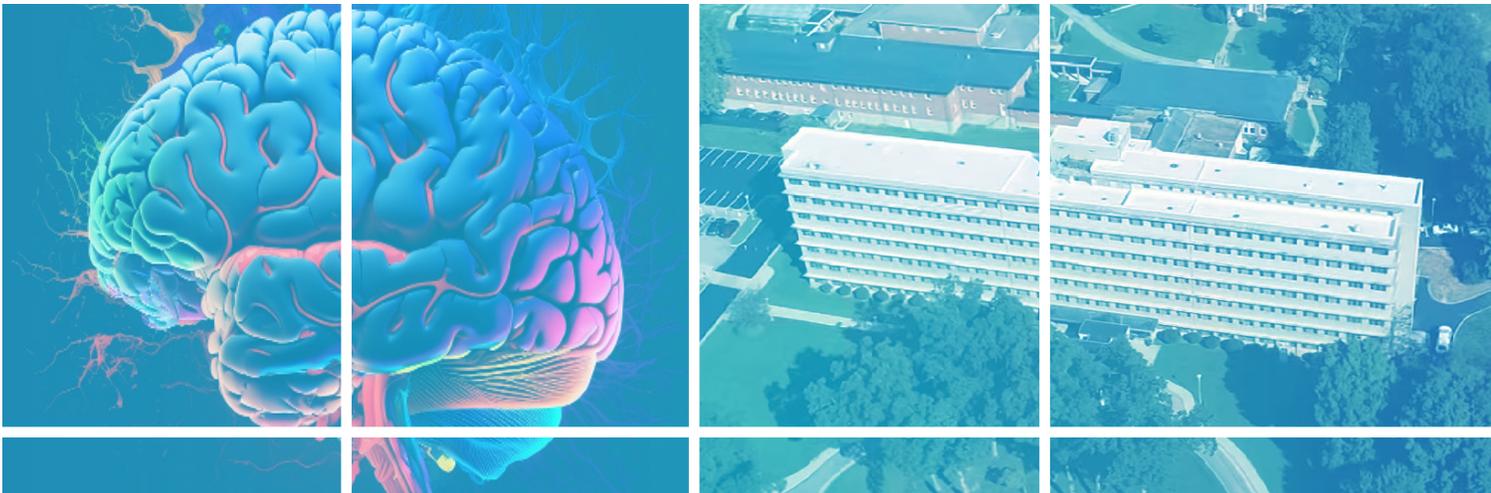


Report to the Governor and the General Assembly of Virginia

Virginia's State Psychiatric Hospitals

2023



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Summary: Virginia's State Psychiatric Hospitals

WHAT WE FOUND

Virginia's state-run psychiatric hospitals face numerous challenges to effectively treating patients with especially acute psychiatric needs, and one of the greatest challenges is recruiting and retaining staff willing to work in an unpredictable environment that poses personal safety risks daily. The state psychiatric hospital work environment is difficult for nursing and clinical staff, but also the many support staff who are integral to hospital operations. Despite the difficulties inherent in working in such an environment, it is clear that state psychiatric hospital employees are highly committed to providing effective care to patients and providing needed support to their colleagues.

State psychiatric hospitals' lack of control over their admissions jeopardizes patient safety

Around half of Virginia's state psychiatric hospital patients are individuals from the community who have been determined to be a threat to themselves or others as a result of a mental illness (i.e., civil patients) and have been admitted involuntarily. Since 2014, state law has required state hospitals to admit individuals who magistrates have placed under a temporary detention order (TDO) if no other placement can be found for them. The legislation was intended to ensure that individuals in need of acute psychiatric services receive treatment, and it removed state hospitals' ability to deny admissions. Since then, state hospitals have experienced significant ongoing capacity constraints and have regularly admitted more patients than they can safely accommodate

During FY23, seven of the nine state hospitals filled 95 percent or more of their staffed beds, and three regularly filled 100 percent of their beds. According to industry standards, inpatient psychiatric hospitals should not exceed 85 percent of staffed bed capacity to maintain a safe environment. Operating at higher occupancy levels limits hospitals' ability to respond to changing patient needs, such as moving patients to a different room or unit if needed to protect their safety, or protect the safety of other patients and staff, because there is no available extra space. Additionally, being responsible for so many patients limits staff's ability to intervene quickly and effectively in confrontations between patients or between patients and other staff.

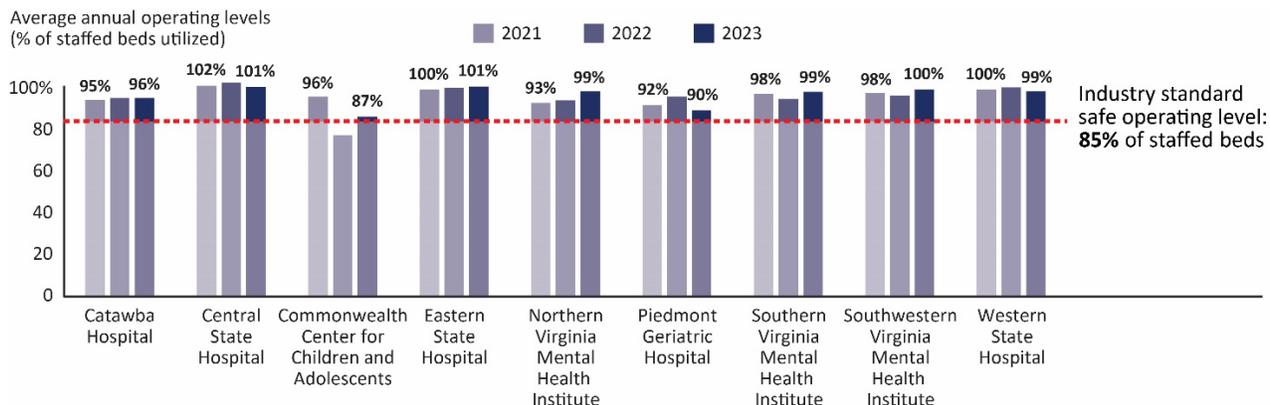
WHY WE DID THIS STUDY

In 2022, the Joint Legislative Audit and Review Commission directed staff to review the inpatient psychiatric hospitals operated by the state.

ABOUT VIRGINIA'S STATE PSYCHIATRIC HOSPITALS

The state operates nine psychiatric hospitals across Virginia, which provide psychiatric treatment services to individuals who are a threat to themselves or others because of mental illness. State hospitals also serve individuals in the criminal justice system, including jail inmates who require inpatient psychiatric treatment and defendants who need inpatient treatment to be able to understand the criminal charges against them. In FY23, about 5,000 individuals were admitted to state psychiatric hospitals, and the largest proportion were under a civil temporary detention order.

All state hospitals have been regularly operating above the industry standard for safe operating levels



SOURCE: JLARC analysis of DBHDS data on utilization of staffed beds at each hospital.

NOTE: Figures reflect each facility's average staffed bed operating levels and are based on monthly snapshots reported for each facility throughout each fiscal year.

State hospitals also have seen an increase in the number of inappropriate admissions. If an individual has been determined to meet the criteria for a TDO, but does not actually have a condition that requires psychiatric treatment, statute still requires state hospitals to admit them, which is counterproductive for these individuals' treatment and unsafe for them. These inappropriate admissions include individuals with neurocognitive disorders (i.e., dementia) and neurodevelopmental disorders (i.e., autism spectrum disorder), who accounted for 10 percent of state psychiatric hospital discharges in FY23. While they are a small percentage of state hospital patients, they stay for relatively long periods even though state hospital staff generally do not have the expertise to appropriately care for them. In addition, state psychiatric hospital staff frequently reported concerns regarding the safety and well-being of patients with neurocognitive and neurodevelopmental diagnoses.

Some state hospitals also have seen an increase in individuals who are dropped off by law enforcement before they are admitted, which is unsafe, especially for patients with urgent medical needs. Between FY22 and FY23, law enforcement dropped off 1,432 individuals at state hospitals before they were admitted. Some of these individuals were experiencing urgent medical needs, which state psychiatric hospitals are not equipped to treat. In January 2023, Virginia's attorney general issued an official opinion concluding that law enforcement "dropoffs" at psychiatric hospitals are not permissible under state law. However, more than 450 individuals have been dropped off at state psychiatric hospitals since the issuance of that opinion.

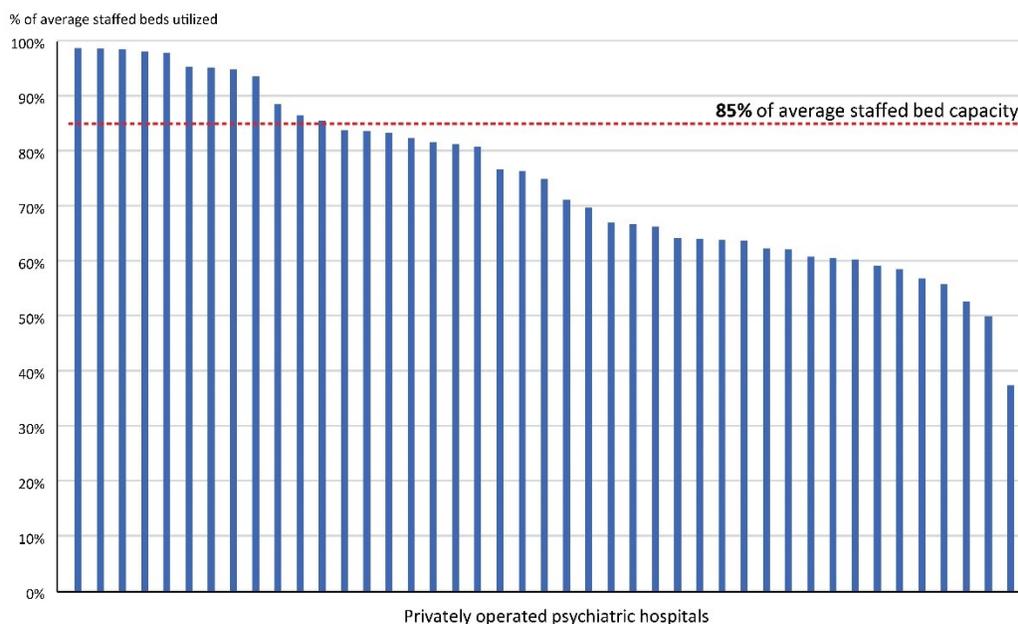
Many private psychiatric hospitals could admit more patients without exceeding safe operating levels

Underutilization of privately operated psychiatric hospital beds places an unnecessary overreliance on state hospitals and can delay or prevent individuals' receipt of needed

treatment. Neither state law, regulations, nor state licensing standards obligate private hospitals to accept any patient. However, greater utilization of privately operated hospitals would serve a clear public interest and meet a present and growing need to more quickly respond to Virginians who require inpatient psychiatric treatment, reduce the need for law enforcement to wait with patients who need involuntary treatment, and allow state hospitals to operate at safer levels. In FY23, 8,538 individuals under a civil TDO were on a waitlist for admission to a state psychiatric hospital, averaging around 700 individuals per month. Some of these individuals were never admitted to an inpatient facility for further evaluation or treatment, some were dropped off at a state hospital before being accepted by the facility, and some were arrested.

Private psychiatric hospital representatives have previously reported on underutilization of their inpatient psychiatric beds, and the majority of privately operated hospitals operate below the 85 percent staffed capacity level deemed safe for inpatient psychiatric facilities. If private psychiatric hospitals had used a portion of their unused staffed beds in FY22, enough patients would have been diverted from state hospitals to allow both state and private psychiatric hospitals to operate at a safe level.

About two-thirds of private psychiatric hospitals operated below 85 percent of staffed capacity (end of FY22)



SOURCE: JLARC analysis of Virginia Health Information (VHI) data regarding the staffed capacity and patient utilization of private psychiatric hospitals (2022).

NOTE: Four private psychiatric hospitals operated above their average staffed bed capacity. VHI utilization data for 2022 includes private psychiatric hospitals' average staffed bed capacity in the facility's 2022 fiscal year. The fiscal year for each privately operated psychiatric hospital may vary.

Increase in forensic patients has significantly reduced beds available for civil admissions and exacerbated patient and staff safety risks

One reason for the current civil TDO waitlists is the growing number of forensic patients at state hospitals, who are criminal defendants a court has ordered to receive inpatient psychiatric evaluations and/or treatment. Increasing forensic patient admissions have affected all eight state hospitals for adults. Forensic admissions accounted for 47 percent of all admissions to state psychiatric hospitals in FY23. In addition, forensic patients remain hospitalized for about three times longer than civil patients, on average, so increased forensic admissions have substantially reduced state hospital bed capacity for civil admissions, and this trend is expected to continue. Moreover, because the costs of serving forensic patients cannot generally be billed to Medicaid, Medicare, or commercial insurance, growing forensic admissions has increased the state's costs to operate state psychiatric hospitals.

The largest percentage of forensic patients are pre-trial defendants who judges find to be incompetent to stand trial and who must receive services to restore their competency. While many defendants receive outpatient competency restoration services, the majority receive these services on an inpatient basis at the state's psychiatric hospitals. State hospitals have delayed admitting some defendants for competency restoration because of capacity limitations, creating risks that the state will be sued for violating defendants' due process rights, which has happened in at least 16 states. In Virginia, from March through July 2023, 508 defendants were delayed admission to state hospitals for competency restoration. The other categories of forensic patients at state hospitals include individuals in jails or correctional centers who are determined to need inpatient psychiatric treatment under a TDO and individuals found not guilty by reason of insanity.

If state hospitals remain the only inpatient setting for treating forensic patients and no other action is taken to prioritize who is admitted for competency restoration, the capacity pressures they place on state hospitals are likely to worsen. This increasing forensic patient population exacerbates existing staff and patient safety risks because some forensic patients can be especially aggressive, according to state hospital staff. This is particularly concerning in state hospitals that mix civil and forensic patients in the same treatment unit or in the same room.

State hospitals are difficult to staff because of the unsafe working environment and uncompetitive pay for some positions

Statewide turnover across all state hospitals was 30 percent in FY23—over twice as high as the overall state government turnover rate. High turnover rates among state psychiatric hospital staff are a longstanding problem, but turnover has worsened over the past decade. As turnover has increased, positions have become more difficult to fill, leading to higher vacancy rates. The total state hospital staff vacancy rate doubled between June 2013 and June 2022 from 11 percent to 23 percent.

State hospital staff conveyed on a JLARC survey and through interviews that their facilities do not have enough staff to provide adequate care for patients. The majority of nursing and clinical staff responding to a JLARC survey observed their hospitals were insufficiently staffed. Twenty-eight percent of nursing and clinical staff reported that they usually lack enough time to give patients the attention they need, and this was especially common among social workers, case managers, and psychologists.

Virginia does not have specific staffing standards for either its state or privately operated psychiatric hospitals, and there is no industry consensus or federal requirement regarding the ratio of direct care staff to psychiatric hospital patients. A 2022 workgroup composed of chief nurse executives from Virginia state psychiatric hospitals determined a minimum staffing standard for nursing staff, but only one hospital meets that standard, and DBHDS has set a staffing goal below the workgroup's recommendation because of funding constraints.

Most state psychiatric hospitals have increased their use of temporary contract staff to fill vacant positions, raising state hospital operating costs. On a per-staff basis, contractors are much more expensive—between two and three times the cost—than nurses and clinicians employed directly by the facility. In FY23, state hospitals spent at least 9 percent of their operating budget on contract staff (\$47 million), 13 times the amount spent in FY13. The amount of total state hospital employee compensation spent on overtime more than tripled over this same time period, from \$5.8 million in FY13 to \$20 million in FY23. Combined overtime and contracting costs (\$67 million) are more than six times higher than the previous decade.

Some state hospital roles are compensated at less-than-competitive rates, but working conditions also contribute to staffing shortages. Positions that were benchmarked to have the least competitive pay compared with the regional median pay were psychologists, social workers, housekeeping staff, and food services staff. While pay increases should be considered, pay is not the only factor making state hospitals difficult to staff. These facilities are some of the most physically dangerous work environments in all of state government; state hospitals have *seven times* the rate of successful workers' compensation claims as employees in other state government agencies.

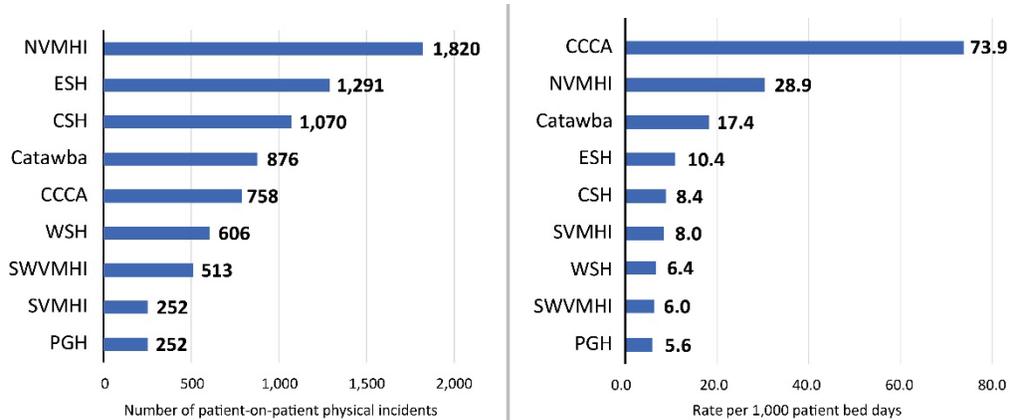
In addition to frustrations with pay and concerns over personal safety, state hospital nursing staff reported dissatisfaction with their hospital's shift schedules. One in four registered nurses who predicted that they would leave their jobs in the next six months cited scheduling as a top reason they were planning to leave. In particular, state hospital leadership and staff expressed frustration with their hospital's inability to offer 12-hour shifts to their employees, which is a standard healthcare industry practice.

Patient safety is a concern, and some Virginia state hospitals use patient seclusion and restraint more often than other states

All hospitals had at least 20 percent of their staff report that they did not believe that their hospital was a safe place for patients, and staff commonly attributed this belief

to high numbers of aggressive patients, increasing numbers of forensic patients, and the admission of patients with neurodevelopmental and neurocognitive disorders. There were about 7,400 known patient-on-patient physical incidents at state hospitals between January 2022 and May 2023 and 1,800 incidents of reported self-injurious behaviors. Across all of these incidents, over 1,400 resulted in patient injuries.

Rates of reported patient-on-patient physical incidents (Jan. 2022 to May 2023)



SOURCE: JLARC analysis of DBHDS Incident Tracker data and Avatar data.

NOTE: The denominator 'patient bed days' is used to measure incidence rates, because it bases incidence rates on the total number of days that patients received care in their hospital, allowing for comparability of incidents across facilities of various sizes. For example, if a facility has 100 beds and each bed is filled by a patient every day of the year, the facility would have 36,500 bed days that year.

State hospital staffing shortages and facility deficiencies, including weaponizable facility features, complicate state psychiatric hospitals' efforts to maintain a safe environment. Most state psychiatric hospitals were not originally designed as inpatient psychiatric hospitals, and various facility deficiencies contribute to safety incidents and hinder staff's ability to keep patients safe. Examples of facility deficiencies include ceramic tiles that can be removed and used as weapons; features like door handles and hinges that present risks to patients intent on harming themselves; hidden alcoves or poor lines of sight; shared rooms at seven hospitals, with at least two hospitals able to accommodate up to four patients in the same room; and lack of modern response mechanisms at four hospitals, which makes it more difficult for staff to efficiently de-escalate aggressive patient behavior or intervene quickly when patient incidents occur.

The use of seclusion and restraint is particularly high at some hospitals, and staff have reported that they and their colleagues are not well trained on how to properly use these methods or respond to patient aggression. State regulation requires all DBHDS-licensed and operated hospitals to use seclusion and restraint only as a last-resort intervention during an immediate crisis, with limits on the length of time adults and children can be subjected to either. Five of the nine state hospitals used higher rates of *restraint* relative to the national average. Six of the nine state hospitals used *seclusion*

at higher rates than national averages. The Commonwealth Center for Children and Adolescents (CCCA) restrains patients at a higher rate than any other state hospital and over 20 times higher than the reported national average. CCCA patients also generally spend a longer amount of time continuously in restraints compared with other hospitals. DBHDS central office made efforts in 2023 to reduce the use of restraint at the facility, including leadership changes and greater attention to de-escalation methods used by staff.

OSIG receives hundreds of complaints but independently investigates only a relatively small portion of them

State hospital staff have unmatched visibility into patients' care and potential safety risks, including possible violations of their personal safety or human rights. However, state hospital staff do not uniformly feel comfortable reporting patient safety concerns to their supervisor or hospital leadership. An independent complaint investigation process is critical to ensuring that patients, visitors, staff, or others have a safe and non-threatening means to raise concerns and can be confident that the investigation of their complaint will have integrity and lead to the proper resolution. The General Assembly has identified this need and assigned Virginia's Office of the State Inspector General (OSIG) to receive and investigate complaints about patient care and safety at state psychiatric hospitals.

OSIG's approach to handling complaints that it receives does not ensure that complaints are independently or thoroughly investigated, counter to the General Assembly's intent. In FY23, OSIG received 633 complaints about DBHDS facilities, but referred most of them back to DBHDS and state hospitals to investigate. OSIG itself reviewed just 117 of those complaints. Independent investigation of complaints regarding patient safety is essential because referring complaints made to OSIG back to DBHDS and the hospitals could result in complaints not being investigated thoroughly or, worse, being purposely ignored or concealed. It also makes it less likely that appropriate and effective remedies and sanctions will be pursued.

Independent review of a sample of patient records concluded that most sampled patients received satisfactory care, but there were exceptions

The quality of patient care can affect the likelihood of their readmission to an inpatient setting after discharge. Over the past decade, about one in five adults and one in four children discharged from a state psychiatric hospital under a civil status were readmitted within six months. Psychiatrists at VCU Health conducted an independent review of state hospital patient charts for this study. Psychiatrists collectively concluded that most patients in the sample appeared to have received satisfactory care, but there were exceptions. For example, VCU psychiatrists reported concerns about the medication given to 17 of the 45 patients from the sample who received medications during their

hospitalization, including the dosage, appropriateness of the medication for the patient's diagnosis, or adverse side effects. In several instances, reviewers noted concerns about the use of multiple medications simultaneously. Reviewers also observed little documentation by doctors or psychiatric nurse practitioners about the patient's progress or their visits with the patient.

During JLARC staff's visits to the state psychiatric hospitals, staff at several hospitals pointed out deficiencies in the hospitals' physical space that they believed hindered the hospital's ability to provide optimal patient care and treatment. For example, hospital staff highlighted that in some hospitals, there is not enough space to offer small group therapy sessions as often as needed.

Psychiatric hospital for children and youth has persistent operational and performance issues

CCCA is intended to be the facility of last resort for youth experiencing a severe mental illness and who are a threat to themselves or others. However, persistent operational and performance issues at CCCA justify considering whether CCCA should continue to operate. Through various metrics, CCCA stands out as the worst or among the worst performers compared with other state hospitals. For example, it has the highest rate of patient-on-patient and patient-on-staff physical safety incidents, the highest rate of patient self-harm, the highest number and percentage of substantiated human rights complaints, the highest use of physical restraint against patients, the highest staff turnover, nearly the highest staff vacancy rate, and the greatest dependence on expensive contract staff. In a recent unannounced inspection by a national accrediting agency (the Joint Commission), CCCA received 28 citations and was determined to be an immediate threat to the health and safety of patients, according to DBHDS.

CCCA has become more costly to operate, neither patient outcomes nor staffing challenges have improved, and additional investment in the facility is unlikely to result in further improvements. Additionally, most other states do not operate a youth psychiatric hospital.

DBHDS should develop a plan to close CCCA and find or develop alternative placements for the patients who would otherwise be placed there. Following approaches used in other states, including those that do not operate a state hospital for children, the state should contract for services that would better meet the needs of CCCA patients, including private psychiatric hospitals, residential crisis stabilization units, and residential psychiatric treatment facilities, and that are closer to their home communities. State funds used to operate CCCA, about \$18 million in FY23, could instead help fund placements for youth who would otherwise be admitted there. If CCCA were closed, at any given time the number of youth needing an alternative placement, such as at a private psychiatric hospital, a crisis stabilization unit, or residential psychiatric treatment facility, would be relatively low (two youths per day, on average).

WHAT WE RECOMMEND

The following recommendations include only those highlighted for the report summary. The complete list of recommendations is available on page xi.

Legislative action

- Exclude behaviors and symptoms that are solely the manifestation of a neurocognitive or neurodevelopmental disorder from the definition of mental illness for the purposes of TDOs and civil commitments so that they are not a basis for placing an individual under a TDO or involuntarily committing them to an inpatient psychiatric hospital, with an effective date of July 1, 2025.
- Grant state psychiatric hospitals the authority to deny admission to an individual under a TDO or civil commitment if the individual's behaviors are solely a manifestation of a neurocognitive or neurodevelopmental disorder and the individual does not meet the criteria for inpatient psychiatric treatment, with an effective date of July 1, 2025.
- Direct the secretary of health and human resources to evaluate the availability of placements for individuals with neurocognitive or neurodevelopmental disorders and identify and develop strategies to support these populations, including through enhanced Medicaid reimbursements or Medicaid waivers, and report results by October 2024.
- Grant state psychiatric hospitals the authority to delay the admission of an individual until it has been determined that they do not have urgent medical needs that the hospital cannot treat.
- Require the commissioner of the Virginia Department of Health to condition the approval of any certificate of public need (COPN) for a project involving an inpatient psychiatric facility on the applicant's agreement to admit individuals who are under a civil TDO.
- Provide funding to assist privately operated hospitals with accepting more individuals under a TDO and with discharging patients who face substantial barriers to discharge.
- Grant state psychiatric hospitals the authority to decline admission to an individual under a TDO if doing so will result in the hospital operating in excess of 85 percent of the hospital's staffed capacity, with an effective date of July 1, 2025.
- Provide salary increases for social workers, psychologists, and housekeeping and food services staff.
- Direct the Department of Human Resource Management to allow state hospitals to define nursing staff who work 36 hours per week as full-time staff to facilitate hospitals' ability to use 12-hour shifts.

- Create and fund the number of nursing positions DBHDS has determined are needed to provide quality care at the state's psychiatric hospitals.
- Direct OSIG to develop and submit a plan to fulfill its statutory obligation to fully investigate complaints of serious allegations of abuse, neglect, or inadequate care at any state psychiatric hospital, and develop and submit annually a report on the number of complaints it has received and fully investigated.
- Direct DBHDS to develop a plan to close CCCA and find or develop alternative placements for children and youth.

Executive action

- Virginia Department of Health should develop and implement a process to determine whether all providers granted a COPN based at least partially on their commitment to accept patients under a TDO are fulfilling this commitment and take appropriate remedial steps to bring them into compliance with this commitment, if necessary.
- DBHDS should seek clarification from the Office of the Attorney General regarding whether the DBHDS commissioner has the legal authority pursuant to 12VAC35-105-50.B to require providers of inpatient psychiatric services to admit patients under a TDO or civil commitment if the provider has the capacity to do so safely.
- DBHDS should formally solicit proposals from state-licensed psychiatric hospitals or units in Virginia to admit certain categories of forensic patients and work with those hospitals that respond to develop a plan and timeline to contract with them to admit forensic patients.
- DBHDS should study and propose designating certain state psychiatric hospitals or units within them as appropriate to treat only forensic patients.
- DBHDS should contract with a subject matter expert to assess the therapeutic environment for each state psychiatric hospital, prioritizing those with the highest rates of seclusion and restraint.
- DBHDS should develop and implement a process to conduct regular reviews of a sample of state psychiatric hospital patient records to evaluate the quality of care they provide, including procedures for holding hospitals accountable for correcting factors that are determined to cause the delivery of ineffective, unsafe, or generally substandard patient care.

Recommendations: Virginia’s State Psychiatric Hospitals

Recommendations

RECOMMENDATION 1

The General Assembly may wish to consider amending the Code of Virginia, which defines “mental illness” for the purpose of temporary detention orders and civil commitments, to specify that behaviors and symptoms that are solely a manifestation of a neurocognitive disorder, as determined through an appropriate evaluation by a mental health professional who is competent in the assessment of psychiatric illnesses in individuals with neurocognitive disorders, are excluded from the definition of mental illness, and therefore, are not a basis for placing an individual under a temporary detention order or committing them involuntarily to an inpatient psychiatric hospital. The legislation’s effective date should be delayed until July 1, 2025. (Chapter 2)

RECOMMENDATION 2

The General Assembly may wish to consider amending the Code of Virginia, which defines “mental illness” for the purpose of temporary detention orders and civil commitments, to specify that behaviors and symptoms that are solely a manifestation of a neurodevelopmental disorder, as determined through an appropriate evaluation by a mental health professional who is competent in the assessment of psychiatric illnesses in individuals with neurodevelopmental disorders, are excluded from the definition of mental illness, and therefore, are not a basis for placing an individual under a temporary detention order or committing them involuntarily to an inpatient psychiatric hospital. The legislation’s effective date should be delayed until July 1, 2025. (Chapter 2)

RECOMMENDATION 3

The General Assembly may wish to consider amending the Code of Virginia to give state psychiatric hospitals the authority to (i) have a licensed psychiatrist or other licensed mental health professional reevaluate an individual’s eligibility for a temporary detention order before they are admitted if the facility has reason to believe that their symptoms and behavior are solely a manifestation of a neurocognitive or neurodevelopmental disorder, and (ii) deny admission to individuals for whom this is found to be the case. The legislation’s effective date should be delayed until July 1, 2025. (Chapter 2)

RECOMMENDATION 4

The General Assembly may wish to consider including language in the Appropriation Act directing the secretary of health and human resources to (i) evaluate the current availability of placements for individuals with neurocognitive and neurodevelopmental disorders who would otherwise be placed in a state psychiatric hospital, (ii) identify and develop alternative strategies to support these patient populations, including through, but not limited to, enhanced Medicaid reimbursements and a Medicaid waiver for individuals with neurocognitive disorders, and (iii) report the results of its work to the House Appropriations and Senate Finance and Appropriations committees no later than October 1, 2024. (Chapter 2)

RECOMMENDATION 5

The General Assembly may wish to consider amending the Code of Virginia to allow state psychiatric hospitals to delay admission of an individual under a temporary detention order until the state psychiatric hospital has determined that the individual does not have urgent medical needs that the state hospital cannot treat. (Chapter 2)

RECOMMENDATION 6

The Department of Behavioral Health and Developmental Services should take immediate steps to expedite the development and implementation of an information technology system that will allow for the secure electronic transfer of patient documents between community services boards and inpatient psychiatric hospitals and provide monthly progress reports on this work to the Behavioral Health Commission. (Chapter 2)

RECOMMENDATION 7

The General Assembly may wish to consider including language and funding in the Appropriation Act directing the Department of Behavioral Health and Developmental Services to establish a program for state-licensed psychiatric hospitals (commonly referred to as “private psychiatric hospitals”) to provide funding for those hospitals that agree to increase the percentage of involuntary inpatient admissions they accept and demonstrate the need for funding to safely admit such patients. Funds could be provided to cover one-time and ongoing costs for creating and filling additional security positions, providing staff training on how to safely treat these patients, and making safety improvements to the facilities. (Chapter 3)

RECOMMENDATION 8

The General Assembly may wish to consider including language and funding in the Appropriation Act to expand the discharge assistance provided by the Department of Behavioral Health and Developmental Services (DBHDS) to individuals facing substantial barriers to discharge from inpatient psychiatric units and facilities licensed by DBHDS (commonly referred to as “privately operated”). (Chapter 3)

RECOMMENDATION 9

The Virginia Department of Health should develop and implement a process to (i) determine whether all healthcare providers that were granted a certificate of public need based at least partially on their commitment to accept patients under a temporary detention order (TDO) are fulfilling this commitment, and (ii) take appropriate remedial steps to bring providers who are determined to not be fulfilling their commitment into compliance. (Chapter 3)

RECOMMENDATION 10

The General Assembly may wish to consider amending § 32.1-102.4 of the Code of Virginia to require the commissioner of the Virginia Department of Health to condition the approval of any certificate of public need for a project involving an inpatient psychiatric service or facility on the agreement of the applicant to accept patients under a temporary detention order whenever the provider has the capacity and capability to do so. (Chapter 3)

RECOMMENDATION 11

The Department of Behavioral Health and Developmental Services (DBHDS) should seek clarification from the Office of the Attorney General regarding whether the commissioner of DBHDS has the legal authority pursuant to 12VAC35-105-50.B to require providers of inpatient psychiatric services to admit patients under a temporary detention order or civil commitment order if the provider has the capacity to do so safely. (Chapter 3)

RECOMMENDATION 12

The General Assembly may wish to consider amending the Code of Virginia to grant state psychiatric hospitals the authority to decline to admit any individual under a temporary detention order if doing so will result in the hospital operating in excess of 85 percent of its total staffed capacity. The legislation's effective date should be delayed until July 1, 2025. (Chapter 3)

RECOMMENDATION 13

The Department of Behavioral Health and Developmental Services should collect quarterly data on (i) the median length of time forensic patients in the state psychiatric hospitals have waited to be evaluated for discharge eligibility once the patient's treatment team has referred them for evaluation and (ii) the number of forensic patients who have been referred for a forensic evaluation but have not received one in a timely manner, and report such data to the State Board of Behavioral Health and Developmental Services and the Behavioral Health Commission. (Chapter 4)

RECOMMENDATION 14

The Department of Behavioral Health and Developmental Services should determine the number of additional forensic evaluator positions, if any, needed to prevent delays in forensic evaluations for patients in state psychiatric hospitals and the amount of funding needed for those positions and request that the additional positions and funding for them be included in the 2025–2026 budget introduced by the governor in December 2024. (Chapter 4)

RECOMMENDATION 15

The Department of Behavioral Health and Developmental Services should formally solicit proposals from state-licensed psychiatric hospitals or units in Virginia to admit (i) individuals placed under a temporary detention order while in a local jail and (ii) criminal defendants determined to need inpatient competency restoration services, and work with those hospitals that respond to develop a plan and timeline to contract with them to admit forensic patients. (Chapter 4)

RECOMMENDATION 16

The Department of Behavioral Health and Developmental Services should (i) work with the Department of Human Resource Management (DHRM) to annually measure, using available DHRM data on state hospital recruitment actions, the amount of time elapsed between when a state hospital position becomes vacant, when the position is advertised, and when the position is filled, (ii) use the results of this analysis to compare hospitals' performance in filling vacancies, especially for nursing and clinical positions that are critical to patient care, and (iii) identify hospitals that appear to be underperforming and provide technical assistance, oversight, and resources to improve such hospitals' ability to fill critical vacant positions in a timely manner. (Chapter 5)

RECOMMENDATION 17

The General Assembly may wish to consider including funding in the Appropriation Act to provide salary increases for psychologists, social workers, housekeeping, and food services staff at state psychiatric hospitals that will bring these positions' salaries within 10 percent of the median salary paid to these positions by other health care employers in the region. (Chapter 5)

RECOMMENDATION 18

The General Assembly may wish to consider including language in the Appropriation Act directing the Department of Behavioral Health and Developmental Services to report annually to the Behavioral Health Commission on average turnover and vacancy rates and salary competitiveness, by hospital and position type, for the state's psychiatric hospitals. (Chapter 5)

RECOMMENDATION 19

The General Assembly may wish to include language in the Appropriation Act directing the Department of Human Resource Management to allow state hospitals to define nursing staff (including psychiatric technicians) who work at least 36 hours per week as full-time staff and not require reductions in pay or other benefits among those staff who work at least 36 hours per week. (Chapter 5)

RECOMMENDATION 20

The General Assembly may wish to consider including funding in the Appropriation Act for the Department of Behavioral Health and Developmental Services to procure scheduling software to assist state hospitals in scheduling nursing shifts. (Chapter 5)

RECOMMENDATION 21

The General Assembly may wish to include language and funding in the Appropriation Act to (i) increase the number of nursing positions allocated to state psychiatric hospitals to a level that would ensure adequate and safe patient care, as determined in 2022 by the Department of Behavioral Health and Developmental Services (DBHDS) and (ii) appropriate the amount of funding necessary to fill those positions. (Chapter 5)

RECOMMENDATION 22

The General Assembly may wish to consider including language in the Appropriation Act to direct the Department of Behavioral Health and Developmental Services to (i) contract for an assessment of the adequacy of each hospital's planned and actual staffing levels for key positions affecting facility operations, patient and staff safety, and quality of care; (ii) conduct similar assessments of the adequacy of each state hospital staffing levels at least biennially; and (iii) report the results of the initial and ongoing assessments to the Behavioral Health Commission, and any additional funding needed to address any staffing level deficiencies, to the chairs of the House Appropriations and Finance and Senate Finance and Appropriations committees. (Chapter 5)

RECOMMENDATION 23

The Department of Behavioral Health and Developmental Services (DBHDS) should study and propose designating certain state psychiatric hospitals or units within them as appropriate to treat only forensic patients and identify the following: (i) which hospitals and units are the most feasible to be reserved for forensic patients, (ii) necessary changes to staffing and facilities, (iii) potential impacts on local law enforcement and jail resources, and (iv) any one-time and ongoing costs that the agency would incur. DBHDS should report the results of this study to the State Board of Behavioral Health and Developmental Services and the Behavioral Health Commission. (Chapter 6)

RECOMMENDATION 24

The General Assembly may wish to consider including language in the Appropriation Act to direct the Office of the State Inspector General (OSIG) to develop and submit a plan to fulfill its statutory obligation to fully investigate complaints received that contain serious allegations of abuse, neglect, or inadequate care at any state psychiatric hospital and to submit the plan to the chairs of the House Health, Welfare, and Institutions and Senate Rehabilitation and Social Services committees no later than June 20, 2024, and thereafter should provide an annual report on the number of complaints received by OSIG alleging abuse, neglect, or inadequate care at any state psychiatric hospitals along with the number fully investigated by OSIG. (Chapter 6)

RECOMMENDATION 25

The Department of Behavioral Health and Developmental Services should develop and implement a process to conduct ongoing reviews of the quality of the data reported by state psychiatric hospitals on patient safety and take action to address any deficiencies identified in hospitals' reporting of patient safety incidents. (Chapter 6)

RECOMMENDATION 26

The Department of Behavioral Health and Developmental Services should (i) contract with a subject matter expert to conduct an assessment of the therapeutic environment for each state psychiatric hospital including the extent to which staff are using evidence-based practices while interacting with patients, prioritizing those with the highest rates of seclusion and/or restraint, (ii) evaluate whether an alternative to the Therapeutic Options program for patient behavior management would improve staff's ability to safely and effectively prevent and de-escalate patient aggression and minimize the use of seclusion and restraint, (iii) use the results of the assessments to improve the ability of state hospital staff to interact effectively with patients, and (iv) replace current training if a better behavior management program is identified. (Chapter 6)

RECOMMENDATION 27

The Department of Behavioral Health and Developmental Services should develop and implement processes to (i) conduct regular reviews of a sample of state psychiatric hospital patient records to evaluate the quality of care patients receive at each state hospital, which should at least include an evaluation of the effectiveness and safety of pharmacological and non-pharmacological treatments; (ii) share observations and conclusions with state hospital leaders; (iii) issue recommendations to each hospital regarding needed improvements in patient care; and (iv) hold state hospitals accountable for correcting the factors that are determined to cause the delivery of ineffective, unsafe, or generally substandard care to patients. (Chapter 7)

RECOMMENDATION 28

The Department of Behavioral Health and Developmental Services should (i) develop and implement a plan to improve its oversight of discharge determination procedures and decision-making at state psychiatric hospitals, which, at a minimum, should include a process to review a sample of discharge determinations from each state hospital on an ongoing basis to ensure appropriate discharge decisions are being made for patients admitted to these facilities and (ii) provide technical assistance and guidance to state hospital staff when shortcomings are identified with discharge determinations. (Chapter 7)

RECOMMENDATION 29

The General Assembly may wish to consider amending (i) §37.2-837 of the Code of Virginia to assign responsibility for leading discharge planning to state psychiatric hospital staff rather than community services boards (CSBs) for patients who are determined to likely need hospitalization for 30 days or less, but stipulate that CSB staff should remain engaged in discharge planning for these patients, and (ii) §37.2-505 of the Code of Virginia to limit CSBs' responsibility for discharge planning to patients who remain in state hospitals more than 30 days. (Chapter 7)

RECOMMENDATION 30

The Department of Behavioral Health and Developmental Services should specify in its performance contracts with community services boards (CSBs) that CSB discharge liaisons are expected to complete the intake process for patients on their caseload before they are discharged from state psychiatric hospitals. (Chapter 7)

RECOMMENDATION 31

The Department of Behavioral Health and Developmental Services should contract with a provider to establish a telepsychiatry program and, as part of that contract, stipulate that individuals discharged from state psychiatric hospitals should receive a telepsychiatry appointment through the program within one week of discharge, unless the individual's community services board or other community-based psychiatric provider can offer an in-person psychiatrist appointment within that week. (Chapter 7)

RECOMMENDATION 32

The General Assembly may wish to consider including language in the Appropriation Act directing the Department of Behavioral Health and Developmental Services (DBHDS) to develop a plan to (i) close the Commonwealth Center for Children and Adolescents (CCCA) and (ii) find or develop alternative effective, safe, and therapeutic placements for children and youth who would otherwise be admitted to CCCA, and direct DBHDS to submit its plan to the House Appropriations and Senate Finance and Appropriations committees. (Chapter 8)

1 Virginia's State Psychiatric Hospitals

In November 2022, the Joint Legislative Audit and Review Commission (JLARC) directed its staff to review Virginia's state psychiatric hospitals. JLARC staff were directed to review state psychiatric hospital staffing and capacity, admissions and discharge approaches, barriers to discharge, and patient outcomes. Staff were also directed to review whether some patients could be more effectively served in an alternative setting to a state hospital. (See Appendix A for the study resolution.)

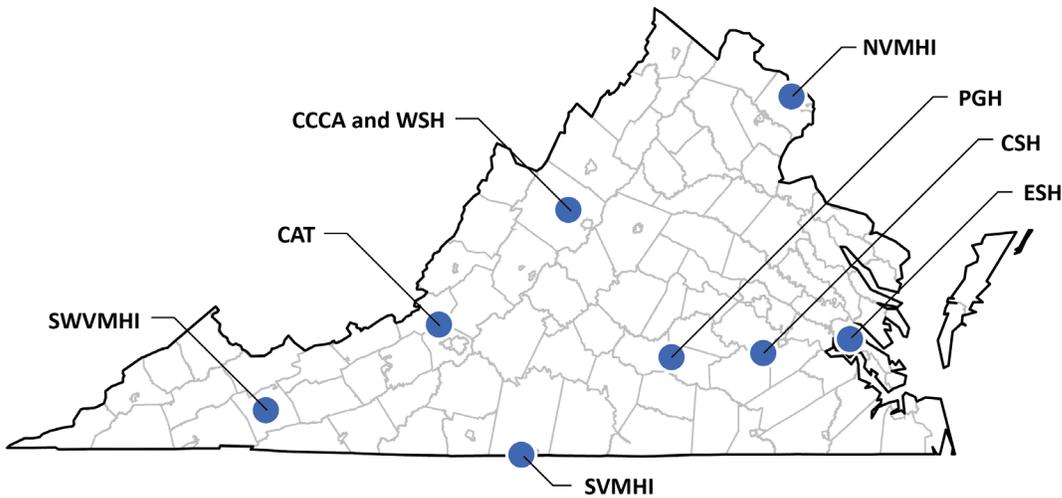
JLARC staff used various methods to address the study mandate, including site visits to all nine state psychiatric hospitals, surveys, and reviews of other states' approaches. Staff analyzed data on state psychiatric hospital patient characteristics, funding, staffing, and readmission rates. Staff also analyzed data on the utilization of beds in privately operated psychiatric hospitals. JLARC staff interviewed state psychiatric hospital staff, staff from the Department of Behavioral Health and Developmental Services (DBHDS) and other relevant state agencies, national subject-matter experts, and representatives of consumers and other stakeholders. Staff also conducted two statewide surveys and reviewed relevant documentation, including documents related to human rights investigations, state hospital discharge policies, and publications on other states' psychiatric hospital systems. Finally, JLARC staff contracted with VCU Health for an independent review of a sample of state hospital patient medical charts. (See Appendix B for a detailed description of research methods.)

State hospitals are intended to be placement of last resort for individuals with a severe mental illness

Virginia operates nine state psychiatric hospitals to provide short- and long-term inpatient treatment and services to individuals who have a serious mental illness and who cannot be treated with alternative or less restrictive treatment options available (Figure 1-1). Various sections of state law require that patients be admitted to state psychiatric hospitals only after all other treatment options have been considered, including state-licensed psychiatric hospitals, which are mostly privately operated, and outpatient treatment. Eight of Virginia's state psychiatric hospitals admit adult patients, and one admits children and adolescents (Table 1-1).

Nearly all individuals admitted to state psychiatric hospitals have been placed there involuntarily, and a majority of patients are admitted to state hospitals from the community ("civil patients"). A growing number and proportion of individuals admitted to state hospitals come from the criminal justice system ("forensic patients").

FIGURE 1-1
Virginia operates nine state psychiatric hospitals



SOURCE: JLARC analysis.

NOTE: CAT = Catawba Hospital, CCCA = Commonwealth Center for Children and Adolescents, CSH = Central State Hospital, ESH = Eastern State Hospital, NVMHI = Northern Virginia Mental Health Institute, PGH = Piedmont Geriatric Hospital, SVMHI = Southern Virginia Mental Health Institute, SWVMHI = Southwestern Virginia Mental Health Institute, WSH = Western State Hospital. CCCA and WSH are separate facilities located near each other.

TABLE 1-1
Virginia's state hospitals vary in capacity, and the largest hospitals primarily admit forensic patients

	Total facility bed capacity*	Patient populations	Total admissions (FY23)	% forensic admissions (FY23)
Eastern State Hospital (ESH)	302	Adult Geriatric	689	94%
Central State Hospital (CSH)	277	Adult	562	95%
Western State Hospital (WSH)	246	Adult	875	63%
Southwestern Virginia Mental Health Institute (SWVMHI)	175	Adult Geriatric	691	16%
Northern Virginia Mental Health Institute (NVMHI)	134	Adult	654	26%
Piedmont Geriatric Hospital (PGH)	123	Geriatric	245	18%
Catawba Hospital (CAT)	110	Adult Geriatric	586	18%
Southern Virginia Mental Health Institute (SVMHI)	72	Adult	270	48%
Commonwealth Center for Children and Adolescents (CCCA)	48	Children	409	12%
Total	1,487		4,981	50%

SOURCE: JLARC analysis of DBHDS Avatar data and reports.

NOTE: Facility capacity reflects the total allowable beds in the facility. It does not reflect the staffed capacities of each facility, which can fluctuate daily. Central State Hospital includes a 111-bed maximum-security forensic unit.

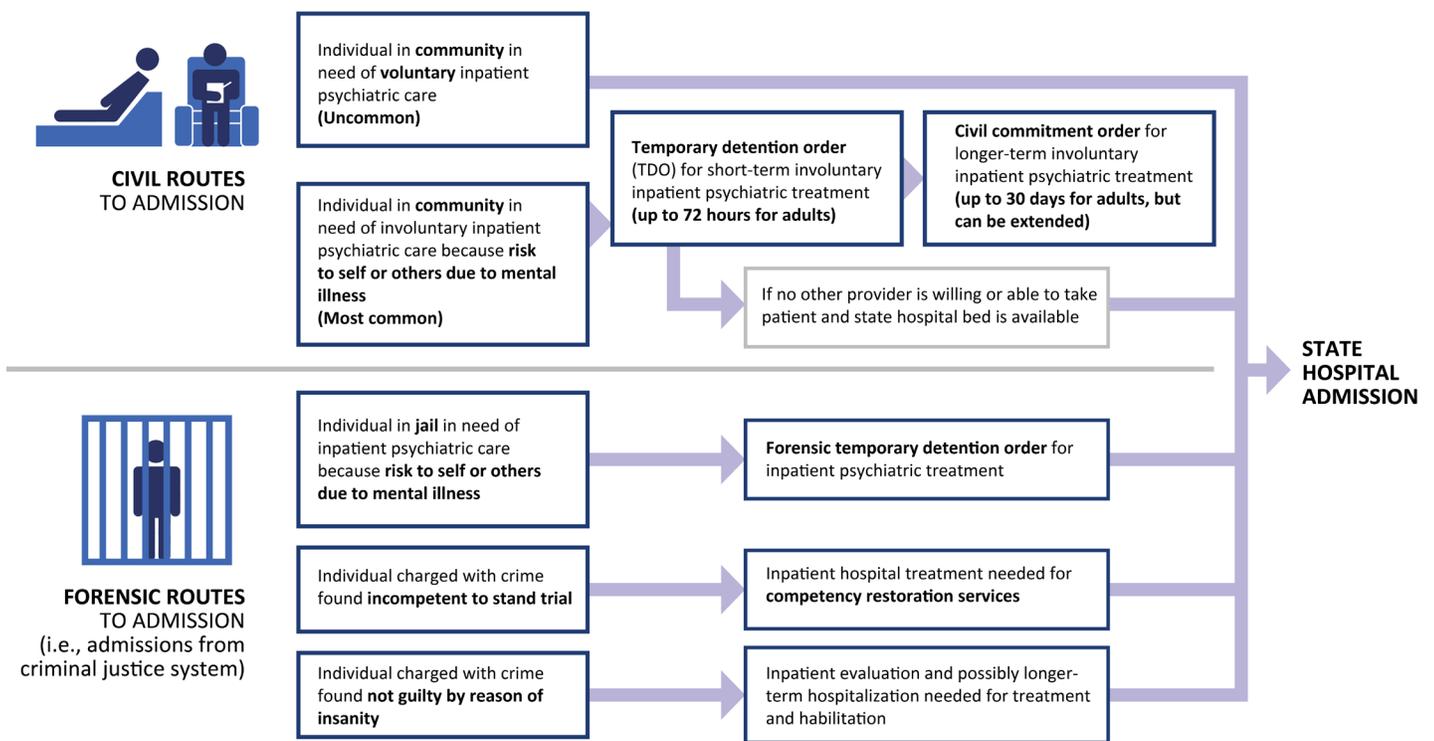
Generally, individuals may be admitted to state hospitals if they

- are an imminent threat to themselves or others because of a mental illness and need inpatient psychiatric treatment (sidebar);
- have been charged with a crime but are found incompetent to stand trial and need inpatient competency restoration services to become competent; or
- have been found not guilty by reason of insanity (NGRI) and need further treatment or habilitation to remain in the community safely (Figure 1-2).

State law also allows individuals to voluntarily commit themselves to a state psychiatric hospital if they are determined to need that level and type of care. However, voluntary admissions are relatively uncommon. For example, only 58 of the 5,047 admissions (1 percent) in FY22 were voluntary admissions.

In state law, "mental illness" is defined as "a disorder of thought, mood, emotion, perception, or orientation that significantly impairs judgment, behavior, capacity to recognize reality, or ability to address basic life necessities and requires care and treatment for the health, safety, or recovery of the individual or for the safety of others."

FIGURE 1-2
Individuals are admitted to state psychiatric hospitals through several routes



SOURCE: JLARC analysis of the Code of Virginia and DBHDS Avatar data.

NOTE: Figure simplified for illustrative purposes. Figure does not show circumstances where patients may receive services from other providers, such as outpatient competency restoration services or inpatient psychiatric treatment from a psychiatric hospital not operated by the state. Other, less common routes also exist, including admissions from correctional facilities, admissions for a competency evaluation, or transfers of non-forensic patients from psychiatric hospitals not operated by the state.

State hospitals admit patients with a serious mental illness who are likely a threat to themselves or others

Individuals placed under **temporary detention orders** are involuntarily held for up to 72 hours (adults) or 96 hours (youth) for further evaluation and, when available, to begin treatment.

Civil commitments are issued by judges or special justices as a result of an involuntary commitment hearing at the end of a TDO if it is determined the individual still meets the criteria for involuntary psychiatric treatment.

Individuals seeking voluntary admission to a state psychiatric hospital must also receive a preadmission screening through a CSB. In these circumstances, patients are not under an emergency custody order.

Over the past decade, most patients admitted to state hospitals have been determined by a court to be an imminent danger to themselves or others because of a mental illness. Most individuals admitted to a state psychiatric hospital are admitted from the community (rather than another institution, like a jail or a psychiatric hospital not operated by the state) either through a short-term temporary detention order (TDO) or a longer-term civil commitment order (sidebar). Jail inmates, whether pre- or post-trial, who meet the civil TDO criteria (imminent risk to self or others due to mental illness) and who cannot be treated in a correctional facility may be admitted to state psychiatric hospitals under a “forensic TDO.”

Before individuals may be admitted to a state hospital voluntarily or through a TDO, they must be evaluated by one of Virginia’s 40 community services boards (CSBs). This “preadmission screening” evaluation is conducted during the eight-hour emergency custody order period, during which CSB staff determine whether the individual needs to be placed under a TDO (sidebar). If inpatient psychiatric treatment is deemed necessary, CSBs must also locate an appropriate facility for the individual. CSB staff must search for and be unable to find an available inpatient psychiatric bed among state-licensed inpatient facilities, including privately operated hospitals, before they seek admission for the individual to a state psychiatric hospital.

State hospitals also provide services for criminal defendants who are found incompetent to stand trial or found not guilty by reason of insanity

State hospitals also serve as the location for court-ordered inpatient competency restoration services for individuals charged with a crime and determined to be incompetent to stand trial. State hospitals’ competency restoration services vary, but aim to bring the individual to a point where they can understand the proceedings against them or assist their attorney in their defense. To do this, patients admitted for competency restoration receive psychiatric treatment to stabilize their mental condition if needed and basic legal education programming, such as activities to help the patient understand the various individuals in the courtroom or basic court-related terminology. Before being released from a state psychiatric hospital, patients admitted for competency restoration must be evaluated by a specially trained psychiatrist or clinical psychologist, referred to as a forensic evaluator.

Additionally, a small number and proportion of state psychiatric hospital patients are admitted to state psychiatric hospitals after being found not guilty by reason of insanity. Individuals found not guilty by reason of insanity may be admitted to a state psychiatric hospital for an initial evaluation to determine whether they should be released to the community or should receive further treatment and habilitation. If the initial evaluation determines that they require further treatment before they can be released

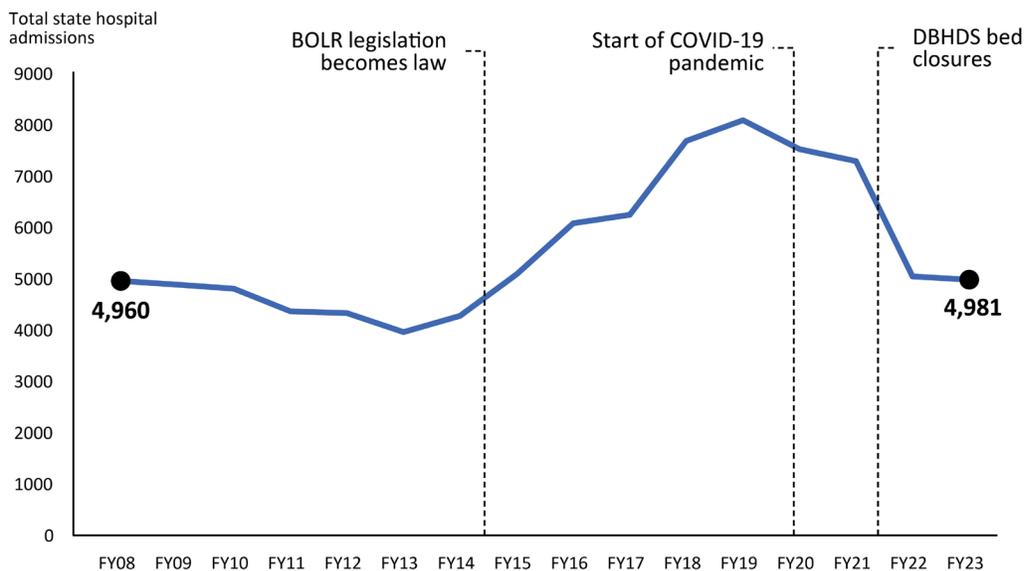
back into the community, they may be admitted to one of Virginia's eight adult psychiatric hospitals.

Between 5,000 and 7,000 individuals are admitted annually to state hospitals, and an increasing number come from the criminal justice system

Over the past decade, Virginia's state hospitals have experienced a dramatic shift in the number and characteristics of patients they admit. Following a decline in admissions from FY08 to FY13, state hospitals experienced a sharp increase in the total number of patients admitted (Figure 1-3). The increase in the number of patients admitted continued until the beginning of the COVID-19 pandemic during FY20. It declined further after DBHDS leadership temporarily closed several state hospitals to new civil admissions at the beginning of FY22 in response to staffing shortages.

State hospitals have gradually reopened most beds that were closed. As of August 2021, 303 of 1376 state hospital beds (22 percent) were reported offline across all state hospitals. As of October 2023, 69 of the 1376 beds (5 percent) were reported offline (45 beds at Eastern State and 24 beds at CCCA).

FIGURE 1-3
Virginia state psychiatric hospitals experienced a sharp increase in admissions after the passage of Bed of Last Resort legislation



SOURCE: JLARC analysis of DBHDS Avatar data.

NOTE: BOLR = Bed of Last Resort. Figure includes all admission statuses (i.e., civil and forensic).

2014 Bed of Last Resort legislation required state hospitals to admit patients under a TDO if no other facility accepted them

The leading driver of increased admissions between FY14 and FY20 was an increase in patients admitted from the community, especially patients under a civil TDO. Most of this increase occurred after the General Assembly passed legislation in 2014 that

required state hospitals to admit patients under a civil TDO if no other facility accepted them. This legislation, commonly referred to as the “Bed of Last Resort” law, was intended to ensure that individuals who needed inpatient psychiatric treatment because they were an imminent threat to themselves or others would not be denied inpatient treatment. To help CSB staff locate a needed inpatient bed quickly, the General Assembly also required DBHDS to establish a central electronic bed registry that CSBs could use to identify open inpatient beds across all of the state’s psychiatric hospitals, including those not operated by the state.

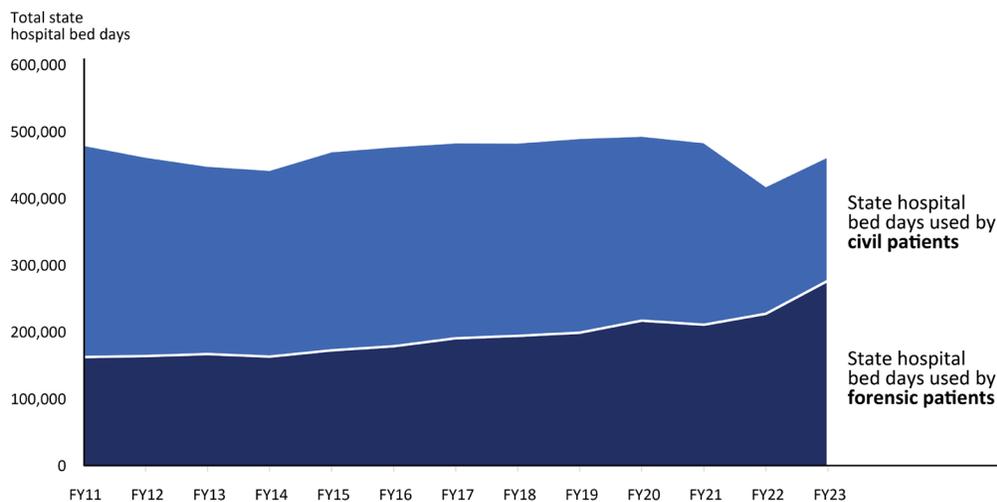
Forensic patients, particularly those admitted for competency restoration, use a larger proportion of available state hospital beds than a decade ago

“Bed days” is a commonly used metric that refers to the total number of days that patients have occupied hospital beds. For example, if all 100 beds at a hospital were occupied every day of the year, the hospital would have 36,500 bed days for that year. The measure can help to assess the use of available beds and total hospital workload.

Although there has been a decrease in state hospital admissions since FY20, a larger proportion of patients admitted are forensic patients, who typically have longer hospital stays. As a result, the total number of bed days, a measure of total state hospital workload and utilization, has not declined at the same rate as admissions (Figure 1-4).

The largest driver of increased forensic admissions over the past decade has been admissions for competency restoration. This is not unique to Virginia; there has been an increase in competency restorations nationwide. Between FY08 and FY23, the number of patients admitted for competency restoration each year more than tripled, from 389 to 1,240. Patients admitted for competency restoration represented only 9 percent of admissions in FY08 but almost a third in FY23. Admissions of other forensic patients, including NGRI and forensic TDOs, have remained stable or comprise a relatively small proportion of total admissions.

FIGURE 1-4
Forensic patients now use a majority of all state hospital bed days



SOURCE: JLARC analysis of DBHDS Avatar data.
 NOTE: Forensic patients represented 50 percent of FY23 admissions to state psychiatric hospitals.

Most state psychiatric hospital patients have a mental illness, but a growing number and proportion do not

In FY22, nearly half of the patients discharged from a state psychiatric hospital (45 percent) had a primary diagnosis considered to be a schizophrenia spectrum disorder or other psychotic disorder (Table 1-2). The next most prevalent primary diagnosis among discharged patients was bipolar disorder or a related disorder. Both groups of diagnoses are considered serious mental illnesses, as they can be very disruptive to individuals' day-to-day functioning. They are also currently considered chronic conditions for which there are no permanent cures at this time. However, medications and psychotherapies can help many people with these conditions manage their symptoms.

Compared with FY13, a higher number and proportion of patients in FY22 had behavioral or personality disorders, conditions for which there are, at present, no medications specifically approved to treat. Individuals with these conditions may sometimes require short-term inpatient treatment for their safety or the safety of others. However, because treating these conditions involves changing an individual's behavior or thought patterns, these conditions are most commonly treated through longer-term psychotherapies provided on an outpatient basis. Examples of such therapies include cognitive behavioral therapy, dialectical behavioral therapy, and multi-systemic therapy. According to DBHDS, state hospital patients with behavioral or personality disorders tend to have extended stays in state hospitals due to a lack of available alternative treatment and resources, like housing, in their communities rather than their need for continual inpatient psychiatric treatment.

Bipolar disorder is a serious mental illness that causes unusual shifts in mood. Individuals with bipolar disorder may experience extreme highs ("manic episodes") and extreme lows ("depressive episodes").

Schizophrenia is a serious mental illness that causes people to interpret reality abnormally. It may involve delusions, hallucinations, unusual behavior, and disorganized thinking and speech.

TABLE 1-2

About three-fourths of patients admitted to state hospitals have either a psychotic disorder, a bipolar disorder, a substance-related disorder, or a depressive disorder

Primary Diagnosis	# of patients discharged in FY13	# of patients discharged in FY22	% of patients discharged in FY13	% of patients discharged in FY22
Schizophrenia spectrum and other psychotic disorders	1,724	2,223	42%	45%
Bipolar and related disorders	573	643	12%	13%
Substance-related disorders	534	416	8%	8%
Depressive disorders	870	376	19%	8%
Trauma- and stressor-related disorders	396	279	7%	6%
Disruptive, impulse-control, and conduct disorders ^a	157	242	3%	5%
Personality disorders ^a	89	221	1%	4%
Neurocognitive disorders ^a	109	182	2%	4%
Neurodevelopmental disorders ^a	66	115	1%	2%
Other	170	219	4%	4%

SOURCE: JLARC analysis of DBHDS Avatar patient-level data and the American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders, Fifth Edition.

NOTE: Includes all admission statuses (forensic and civil). Figures do not sum to 100 percent because of rounding. Figure includes only the patient's primary diagnosis upon discharge. Patients may have multiple diagnoses. ^aNo medication exists to treat these conditions, and patients with these conditions typically need different and longer-term supports or services than inpatient psychiatric hospitals can provide.

The total number of patients with neurodevelopmental disabilities served in state facilities, including state psychiatric hospitals and state training centers for individuals with neurodevelopmental disabilities, has decreased over the past decade. Since 2014, the state has closed four of the five state-operated training centers.

Although still a relatively small proportion of total patients, a growing number of individuals admitted to state hospitals have a primary diagnosis that is not typically treated in an inpatient psychiatric setting. Most notably, compared to a decade ago, state psychiatric hospitals are admitting more individuals with neurodevelopmental disorders, such as autism spectrum disorders and intellectual disabilities, or neurocognitive disorders, including dementia (sidebar).

State hospitals have been operating at levels considered within the industry to be unsafe

According to industry standards, psychiatric hospitals generally should not operate at more than 85 percent of their “staffed bed capacity,” or the number of beds hospitals can make available and support with the staff they have. The additional unused 15 percent of staffed bed capacity allows facilities to respond rapidly to changing needs, such as the admission of a patient who is very aggressive and who needs a single room or the need for a staff member to be exclusively assigned to a patient for monitoring.

In recent years, all state hospitals have been operating above 85 percent of their staffed bed capacity, and several have regularly exceeded their staffed bed capacity. During FY23, seven state hospitals had an average annual operating level of at least 95 percent of staffed beds, and three regularly filled all their staffed beds.

Forensic patients have longer state hospital stays than civil patients

The average length of stay also decreased for all primary diagnosis categories for civil patients between FY13 and FY21. Examples of primary diagnosis categories include schizophrenia spectrum and other psychotic disorders, personality disorders, bipolar and related disorders.

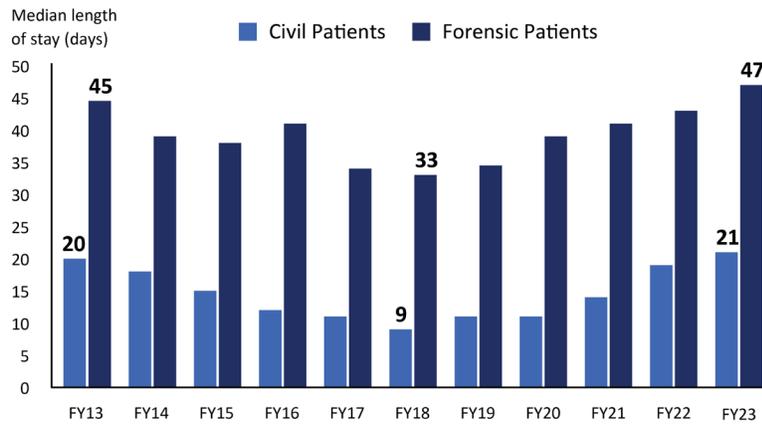
The median length of time patients stay at a state psychiatric hospital varies substantially based on their legal status upon admission. Individuals admitted under a forensic status tend to have longer lengths of stay than those admitted under a civil status. The length of stay is expected to differ between admission statuses because treatment goals and discharge legal requirements differ based on an individual's admissions status.

The median length of stay decreased during the years immediately following the passage of the Bed of Last Resort legislation in 2014, especially for civil patients. The median length of stay among civil patients decreased from 20 in FY13 to nine days in FY18, rising to 21 days in FY23 (Figure 1-5). The decrease was likely driven partially by the passage of the Bed of Last Resort legislation, after which there was a substantial increase in patients admitted under a temporary detention order instead of a longer-term civil commitment.

The average length of stay for inpatient competency restoration in other states was 144 days based on data from the National Research Institute (2020).

The only group of individuals who experienced longer stays than a decade ago are patients admitted for competency restoration, contributing to the overall increase in the lengths of stay for forensic patients. The median length of stay increased from 54 days in FY13 to 76 days in FY23. Despite this increase, Virginia's length of stay for inpatient competency restoration remains shorter than other states, based on available national data (sidebar).

FIGURE 1-5
Median lengths of stay have begun to increase



SOURCE: JLARC analysis of DBHDS AVATAR data.

NOTE: Includes patients discharged from a state hospital within the fiscal year.

State psychiatric hospitals are operated and funded by DBHDS

State law requires that DBHDS supervise and manage the state psychiatric hospitals. DBHDS oversees various aspects of the state psychiatric hospitals, including their operations, staffing, finance, and compliance with human rights regulations. Unlike privately operated psychiatric hospitals, however, state psychiatric hospitals are not required to be licensed and are therefore not overseen by DBHDS's licensing department. They are, however, overseen by DBHDS's Office of Human Rights, which monitors critical safety incidents and patient rights violations.

State law also gives the Office of the State Inspector General (OSIG) and the Disability Law Center of Virginia (dLCV) responsibility for monitoring and investigating complaints regarding abuse, neglect, inadequate care, and human rights violations at state psychiatric hospitals. OSIG is responsible for conducting inspections of state psychiatric hospitals, monitoring and reporting on the quality of services provided in state psychiatric hospitals, and responding to complaints of abuse, neglect, or inadequate care. It is also responsible for keeping the General Assembly fully informed of significant problems, abuses, and deficiencies relating to programs and services at state hospitals. The dLCV is Virginia's state-designated protection and advocacy system for individuals with disabilities. Its existence is federally mandated, and state law requires dLCV to provide advocacy, legal, and ombudsman services to individuals with disabilities, including patients at state psychiatric hospitals.

As of October 2023, all of Virginia's state psychiatric hospitals are accredited by the Joint Commission, a national accreditation organization, which requires that they meet certain standards related to patient safety and patient care quality. Accreditation by the

Joint Commission is not required under state law, but is one way state hospitals can become eligible to receive federal Medicaid and Medicare dollars for patient care.

State hospitals are heavily reliant on state general funds

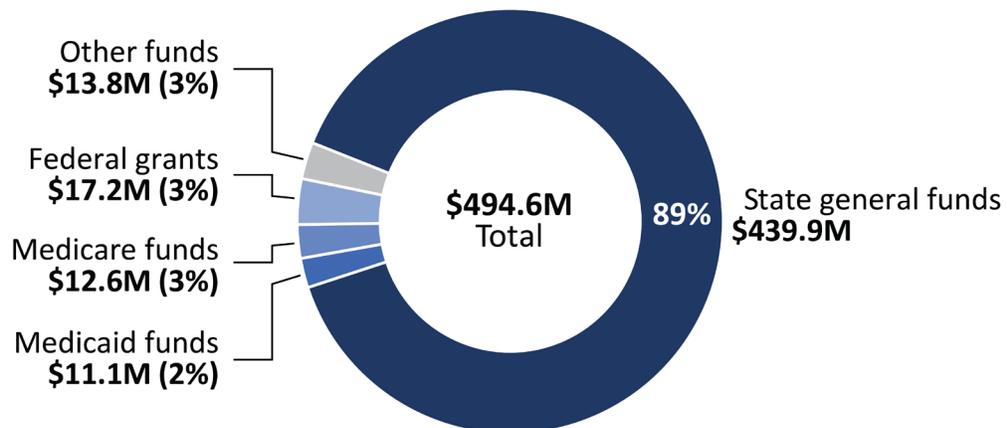
Most funding for state psychiatric hospitals comes through non-Medicaid state general funds, and state funding has increased considerably over the past decade. In FY23, 89 percent of all funding for state hospitals was from state general funds (Figure 1-6). The remaining 11 percent of funding was through Medicaid, Medicare, federal grants, or other funds, which include commercial insurance and private payments (sidebar). Adjusted for inflation, state funding in FY23 (\$440 million) was almost double what it was in FY11 (\$235 million) (Figure 1-7).

On an inflation-adjusted and per-patient basis, total funding for state hospitals declined in the years immediately following the passage of the Bed of Last Resort legislation in 2014 but has since increased. Whereas per-patient funding in FY11 was \$65,454 per hospital stay, it had decreased to \$48,221 in FY18. A combination of reduced admissions and increased state general funding caused the per-patient funding to grow to \$99,294 in FY23. In nominal terms, the largest funding increases for state hospitals were for salaries and benefits, contractual services, and employee overtime. On a per-bed day basis, funding has also increased from \$593 in FY11 to \$1,065 in FY23.

State funding for state psychiatric hospitals is higher than in most other states. In federal fiscal year 2019, Virginia ranked 13th in per-capita expenditures for state psychiatric hospitals, according to data from the National Research Institute.

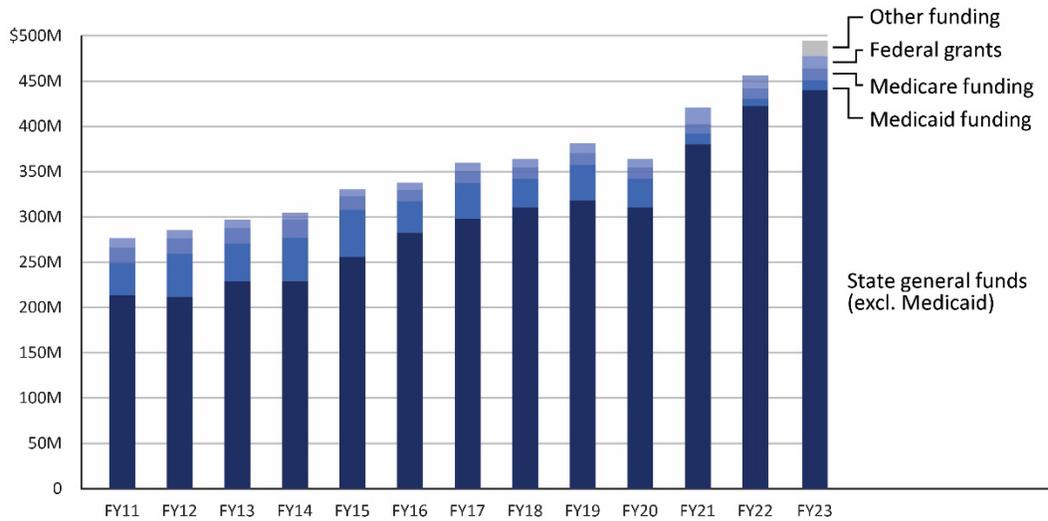
Hospitals may receive both Medicaid and Medicare payments on behalf of individuals enrolled in these programs. However, hospitals must first be certified by the Centers for Medicare and Medicaid Services. There are also limits to how much funding they can receive through each of these programs.

FIGURE 1-6
State hospitals are mostly funded through state general funds (FY23)



SOURCE: JLARC analysis of DBHDS annual reports and revenue data, and state Appropriation Acts.
NOTE: Other funds include commercial insurance and private payments.

FIGURE 1-7
State funding for state psychiatric hospitals has increased considerably over the past decade



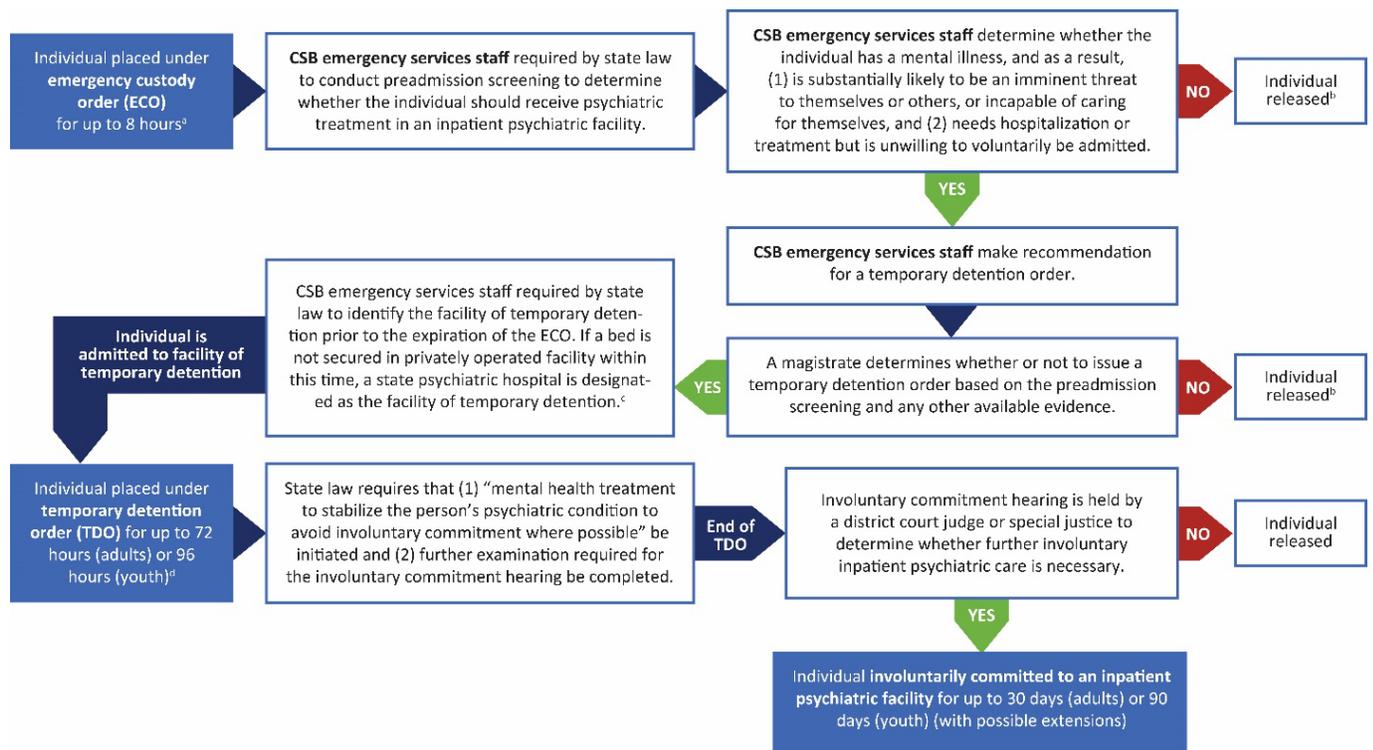
SOURCE: JLARC analysis of DBHDS annual reports and revenue data, and state Appropriation Acts.

NOTE: Figure adjusted for inflation using Medical Care CPI-U. According to DBHDS, declines in Medicaid funding were primarily due to the decertification of several facilities (or units within facilities) over the past five fiscal years. One facility (the Commonwealth Center for Children and Adolescents) experienced a large drop in Medicaid revenue from FY20 to FY21 due to its inability to bill Medicaid until it was certified as a psychiatric hospital. This certification occurred in August 2022.

2 Civil Admissions to State Psychiatric Hospitals

Civil patients account for around half of admissions to state hospitals and, in almost all cases, these patients have been determined to need involuntary inpatient psychiatric treatment. For an individual to be involuntarily admitted to a psychiatric hospital, a magistrate or law enforcement officer, in consultation with community services board (CSB) staff, must determine that it is “substantially likely” the individual is an imminent risk to themselves or others because of a mental illness, needs hospitalization, and is unwilling to receive such treatment (Figure 2-1).

Figure 2-1
Civil state hospital admissions generally occur through the involuntary commitment process



SOURCE: JLARC staff review of the Code of Virginia and interviews with CSB and DBHDS staff.

NOTE: Figure simplified for clarity purposes. ^a An individual may also request a preadmission screening voluntarily. ^b An individual may be released with or without a referral to other services. ^c The facility of temporary detention can be a state- or privately operated hospital, training center, or other type of residential or outpatient mental health or developmental services facility that can accept custody of an individual. ^d An individual can be released before an involuntary commitment hearing if (1) a court judge or other authorized judicial officer, or (2) the director of the facility of temporary detention finds that the individual does not meet the criteria for involuntary commitment.

Prior to the enactment of Virginia's Bed of Last Resort law in 2014, civil admissions to state hospitals were declining. However, admissions almost doubled between FY14 and FY21 after the law's enactment. The law requires state psychiatric hospitals to accept individuals under a TDO if they were not admitted to a privately operated psychiatric hospital before the TDO's expiration. The purpose of the Bed of Last Resort law was to ensure that individuals in a psychiatric emergency would receive needed inpatient treatment instead of being unsafely released from law enforcement custody when no inpatient psychiatric bed could be located for them. Circumstances in which individuals were released without receiving needed psychiatric treatment had resulted in tragic situations for the individuals and their families, and the Bed of Last Resort law was designed to prevent these situations from occurring.

Increased admissions to state hospitals likely mean the law has served as a safety net for many Virginians experiencing psychiatric emergencies. However, the law has also contributed to the increase in inappropriate admissions to state hospitals, such as patients with dementia or intellectual disabilities, whom state hospitals are not equipped to treat. The Bed of Last Resort law does not allow state hospitals to deny admission to an individual under a TDO, even if it does not have sufficient numbers of staff, staff with the right types of expertise or training to treat them, or adequate physical space or equipment for use in treating them.

For state hospitals to be an effective and reliable safety net for individuals in psychiatric emergencies, admissions to these facilities must be restricted to individuals with a mental illness who need inpatient psychiatric treatment and who cannot be treated in any other setting or through other services, such as a crisis stabilization facility or a privately operated psychiatric hospital.

State hospitals' lack of control over civil TDO admissions allows unsafe operating levels and inappropriate admissions

State hospitals do not have the authority to deny admission to an individual under a TDO. When an individual needs temporary detention, the Bed of Last Resort law specifically requires that

if a facility of temporary detention cannot be identified by the time of the expiration of the period of emergency custody, the person shall be detained in a [state psychiatric hospital].

Even if an individual placed under a TDO has a condition that does not require psychiatric treatment or has urgent medical needs that a state psychiatric hospital cannot meet, state law requires the state hospital to admit them. Forcing hospitals to admit these individuals negatively affects state hospitals' operations and contributes to unsafe numbers of patients in state hospitals.

For an individual who is under a TDO but who requires urgent medical treatment or does not need psychiatric treatment, being placed in a psychiatric hospital where they will not receive effective treatment for their primary diagnoses is both counterproductive and unsafe. Especially with state hospitals operating above what is considered a safe capacity level, in many instances their condition makes them especially vulnerable to physical injury by other patients. For the safety of all patients and to ensure the most effective use of the state's limited state hospital beds, these facilities should be able to deny admission to patients with non-psychiatric conditions and delay admissions to patients with urgent medical needs that are best addressed in a medical setting.

Individuals who do not need psychiatric treatment are being placed under TDOs and admitted to state psychiatric hospitals, risking their safety and complicating hospital operations

Individuals with neurocognitive disorders (e.g., dementia or traumatic brain injuries) or neurodevelopmental disorders (e.g., autism)—conditions that do not benefit from psychiatric treatment—are being placed in state hospitals through the civil admissions process (sidebar). State hospitals are intended to provide psychiatric treatment to address symptoms of an individual's mental illness, but neurocognitive and neurodevelopmental disorders require different treatments and care. For example, individuals with neurocognitive disorders require long-term custodial care, neuropsychology, and palliative care, and individuals with neurodevelopmental disorders require rehabilitative services and therapies specifically targeted to help manage behavioral symptoms. State hospital staff generally do not have the expertise or capacity to provide these services. Additionally, state psychiatric hospitals often include small living spaces and overstimulating and noisy environments, all of which are known triggers for undesirable behaviors and worsening conditions among these patient populations.

These inappropriate admissions take up hospital beds, making them unavailable for Virginians who require inpatient hospitalization. In FY23, 178 civil patients with a neurocognitive primary diagnosis and 79 civil patients with a neurodevelopmental primary diagnosis were discharged from a state hospital—accounting for 10 percent of civil discharges. While not a large percentage of state hospital patients, these patients stay for relatively long periods of time, reducing hospitals' capacity. In FY23, individuals with neurocognitive disorders accounted for 20 percent of state hospital bed days used by civil patients statewide. At one state hospital, these individuals accounted for 44 percent of civil patient bed days. Individuals with neurodevelopmental disorders accounted for 3 percent of bed days used by civil patients statewide, and, at most 10 percent of bed days at one state hospital.

State hospital admissions of patients with neurocognitive and neurodevelopmental disorders have increased over the past decade (Figure 2-2). Between FY09 and FY21, bed days used by these patients more than tripled statewide, driven by both increased admissions and lengths of stay. After FY21, utilization by these patients decreased somewhat, likely because of increased bed utilization by forensic patients and

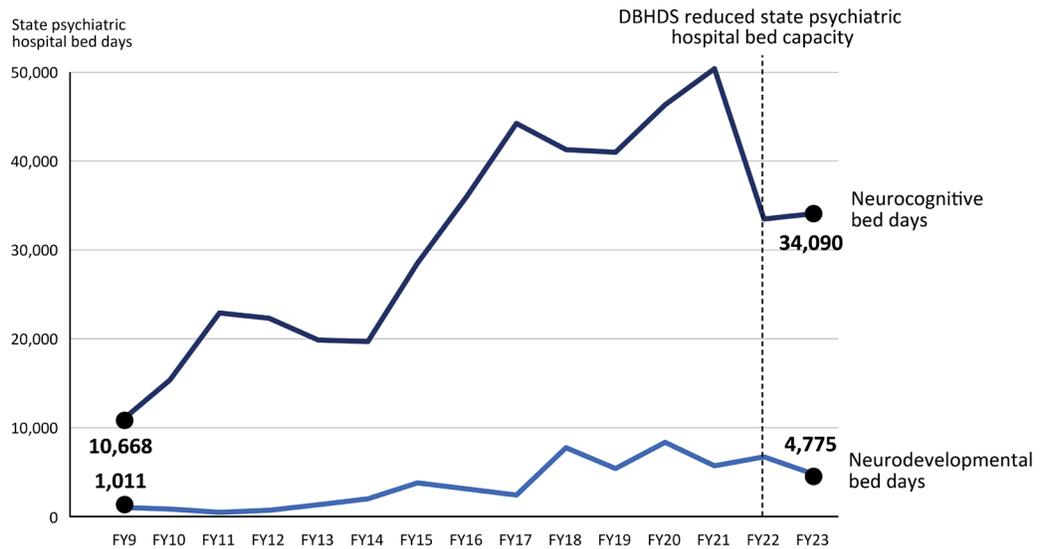
Neurodevelopmental disorders are a group of conditions that are characterized by developmental deficits that impair an individual's personal, social, academic, and occupational functioning.

Neurocognitive disorders are a group of disorders where the primary clinical deficit is decreased cognitive functioning.

Some patients with neurocognitive and neurodevelopmental primary diagnoses may have co-occurring mental illnesses that warrant psychiatric hospitalization. JLARC was not able to quantify this as part of its analysis of DBHDS Avatar data.

DBHDS’s temporary closure of some hospital beds. Most state hospitals experienced these trends.

Figure 2-2
Bed days utilized by neurocognitive and neurodevelopmental patients have generally increased over time (FY09 to FY23)



SOURCE: JLARC analysis of DBHDS data regarding patients discharged from state hospitals (FY09 to FY23).

NOTE: Data includes only civil patients with neurocognitive and neurodevelopmental primary diagnoses who had been discharged from a state hospital. Additional bed days may have been utilized by individuals with these primary diagnoses who (i) had been admitted to a state hospital but had not been discharged or (ii) were in a state hospital under a forensic status.

Admissions of patients with neurocognitive and neurodevelopmental disorders can worsen their conditions and create staffing challenges

Placing patients with neurocognitive and neurodevelopmental disorders in state hospitals is counterproductive and unsafe. The psychiatric hospital environments and lack of appropriate treatment can trigger undesirable behaviors and worsen conditions for these patients. As they interact with other patients with serious mental illnesses, they are placed at increased risk of victimization and can, in some cases, contribute to unsafe conditions for other patients. In interviews and survey responses, state psychiatric hospital staff frequently reported concerns regarding the safety and well-being of neurocognitive, neurodevelopmental, and other patients because they are all placed in the same facility and units. The following were expressions of concern reported through the survey:

For someone who has dementia who’s already confused and easily agitated, to come into an environment like this that can be loud and chaotic and is not super

comfortable, and they're surrounded by unfamiliar people, it can really exacerbate their confusion and agitation and lead to pretty rapid deterioration of their cognitive functioning.

Individuals with intellectual and developmental disabilities should not be here. They are preyed upon by forensic and civil patients.

Vulnerable patients such as individuals with intellectual disabilities, autism spectrum disorders,... and even geriatric patients... are often [mixed on the same units with] a population that comprises of inmates, convicted sexual offenders, and other physically aggressive or patients considered "violent."

Individuals with neurocognitive or neurodevelopmental disorders are also at risk for remaining in psychiatric hospitals for especially long stays because, once an individual is placed in one of these facilities, they can reportedly earn a reputation among other providers for being especially difficult to care for. This perception can be a result of (1) the "stigma" associated with having been a state psychiatric hospital patient or (2) undesirable behaviors or worsening conditions of the patient that are reported during the psychiatric hospitalization. Both reportedly make it more difficult for state hospitals to discharge these patients to more appropriate placements and providers.

In addition to the adverse effects on the individuals, these inappropriate placements also increase staff workload to ensure patient safety and treatments. Constant observation of individuals with neurocognitive and neurodevelopmental disorders may be necessary, according to state psychiatric hospital staff. This requires that staff be designated specifically to observe and care for a single patient, resulting in higher staffing levels on a unit than would otherwise be required. Additionally, supporting a diverse population makes it more difficult to address all patients' treatment needs effectively and further contributes to serious incidents and staff burnout:

As units are filled with mixed populations without full planned capacity for care, neither population gets their needs met fully. Acute psychiatric patients are receiving a less therapeutic milieu... and individuals with dementia are being emotionally impacted and having individual rights restricted because of the presence of angry, sometimes aggressive, and unstable psychiatric patients. (DBHDS-hired consultant report on the geropsychiatric system of care in Virginia [2017])

It is an unsafe environment for [individuals with intellectual disabilities and dementia], so we have to put them on a 1:1 to keep them safe, whereas if they were put in the appropriate facility or residential placement, a 1:1 wouldn't be needed. (state hospital staff)

Direct care staff feel pushed into being a 'jack of all trades and master of none,' doing their best but can't get as proficient as they would like. (state hospital staff)

State law should clarify that neither neurocognitive nor neurodevelopmental disorders are mental illnesses

The Code of Virginia is inconsistent in defining what mental conditions constitute a mental illness. As it applies to the criteria for civil TDOs and civil commitments, the Code of Virginia defines a mental illness as

a disorder of thought, mood, emotion, perception, or orientation that significantly impairs judgment, behavior, capacity to recognize reality, or ability to address basic life necessities and requires care and treatment for the health, safety, or recovery of the individual or the safety of others.

Because behaviors exhibited by individuals with neurocognitive and neurodevelopmental conditions may meet these criteria, individuals with these conditions can be characterized as having mental illnesses under this definition.

However, a separate section of state law specifies that neurodevelopmental disorders should *not* be considered a mental illness, but this is not directly referenced in the TDO or civil commitment criteria or the definition of mental illness. This section of state law defines a developmental disability as a distinctly separate condition from a mental illness:

“Developmental disability” means a severe, chronic disability of an individual that is attributable to a mental or physical impairment, or a combination of mental and physical impairments, *other than a sole diagnosis of mental illness...*

State statute does not similarly define neurocognitive disorders in statute or specify whether these conditions should be considered mental illnesses. However, before the Bed of Last Resort law, DBHDS had developed a list of conditions state psychiatric hospitals were not equipped to treat and that should be excluded from involuntary admissions, including primary diagnoses of dementia, traumatic brain injuries, and delirium—all of which are neurocognitive disorders. Still, the Bed of Last Resort law for involuntary psychiatric treatment supersedes these exclusionary criteria and eliminates state hospitals’ ability to enforce this policy.

Given the substantial safety risks to patients and implications on state hospital operations, conditions that are solely a manifestation of neurocognitive or neurodevelopmental disorders should not be considered mental illnesses and should be excluded from the Code of Virginia’s definition of mental illness. These exclusions should be reflected in the statutory criteria for temporary detention orders and civil commitments to help ensure they are considered and applied consistently in both circumstances.

DBHDS staff have suggested that inappropriate placements of individuals with neurocognitive and neurodevelopmental disorders may occur during the TDO assessment process. According to subject matter experts, it can be especially challenging to determine whether the behaviors and symptoms exhibited by individuals with neurocognitive and neurodevelopmental disorders are due to a co-occurring mental health condition. State law could further specify that mental health professionals making the TDO

determination must be competent in the assessment of psychiatric illnesses for individuals with neurocognitive and neurodevelopmental disorders. This would follow recommendations in JLARC’s 2022 report *CSB Behavioral Health Services* for DBHDS to improve the training provided to preadmission screening clinicians.

If legislation is introduced to grant state hospitals the authority to deny admission to individuals whose symptoms and behavior are solely a manifestation of a neurocognitive or neurodevelopmental disability, the General Assembly should specify that it will not go into effect until 2025. Delaying enactment would give state and local agencies adequate time to prepare to more effectively meet the needs of individuals with neurocognitive and neurodevelopmental disorders who would otherwise be inappropriately placed in state psychiatric hospitals. As discussed later in this chapter, a lack of alternative services was commonly cited as a key driver in the inappropriate placements of these populations in state psychiatric hospitals.

RECOMMENDATION 1

The General Assembly may wish to consider amending the Code of Virginia, which defines “mental illness” for the purpose of temporary detention orders and civil commitments, to specify that behaviors and symptoms that are solely a manifestation of a neurocognitive disorder, as determined through an appropriate evaluation by a mental health professional who is competent in the assessment of psychiatric illnesses in individuals with neurocognitive disorders, are excluded from the definition of mental illness, and therefore, are not a basis for placing an individual under a temporary detention order or committing them involuntarily to an inpatient psychiatric hospital. The legislation’s effective date should be delayed until July 1, 2025.

RECOMMENDATION 2

The General Assembly may wish to consider amending the Code of Virginia, which defines “mental illness” for the purpose of temporary detention orders and civil commitments, to specify that behaviors and symptoms that are solely a manifestation of a neurodevelopmental disorder, as determined through an appropriate evaluation by a mental health professional who is competent in the assessment of psychiatric illnesses in individuals with neurodevelopmental disorders, are excluded from the definition of mental illness, and therefore, are not a basis for placing an individual under a temporary detention order or committing them involuntarily to an inpatient psychiatric hospital. The legislation’s effective date should be delayed until July 1, 2025.

Other states have recognized the distinction between a mental illness, a neurodevelopmental disorder, and a neurocognitive disorder in their statutory definitions of mental illness and/or involuntary psychiatric treatment criteria. Many of these states have excluded individuals with conditions that are a manifestation of neurodevelopmental disorders (24 states) or neurocognitive disorders (nine states) from involuntary inpatient psychiatric treatment. At least some of these states have also taken steps to provide needed support to these populations through alternative services and settings. For example, Idaho excludes individuals who have a “neurological disorder, neurocognitive

disorder, a developmental disability, a physical disability or any medical disorder that includes psychiatric symptomology” from being eligible for involuntary psychiatric treatment and has established an enhanced reimbursement rate for nursing homes that use a certain proportion of beds for individuals with behavioral care needs. Washington excludes developmental disabilities, impairments due to substance use, and dementia from diagnoses eligible for involuntary psychiatric treatment. The state also contracts with assisted-living facilities to provide specialized dementia care services for individuals with dementia who no longer can live at home and who have or are eligible for Medicaid.

Shortcomings with CSB preadmission screening efforts, as described in JLARC’s 2022 report *CSB Behavioral Health Services*, may continue to result in TDOs for individuals whose symptoms and behaviors are manifestations of a neurocognitive or neurodevelopmental disorder, and therefore, state psychiatric hospitals should have the authority to deny such admissions. For individuals with these disorders who are recommended for or placed under a TDO by a CSB or magistrate, state psychiatric hospitals should be able to require that a second assessment be conducted by a licensed psychiatrist or other licensed mental health professional to ensure that an individual’s symptoms and behavior are a manifestation of a mental illness. If it is found that this is not the case, the state psychiatric hospitals should have the authority to deny admission. As with the previous two recommendations, the General Assembly should specify that this change will not go into effect until 2025.

RECOMMENDATION 3

The General Assembly may wish to consider amending the Code of Virginia to give state psychiatric hospitals the authority to (i) have a licensed psychiatrist or other licensed mental health professional reevaluate an individual’s eligibility for a temporary detention order before they are admitted if the facility has reason to believe that their symptoms and behavior are solely a manifestation of a neurocognitive or neurodevelopmental disorder, and (ii) deny admission to individuals for whom this is found to be the case. The legislation’s effective date should be delayed until July 1, 2025.

CSB preadmission screening clinicians report that they recommend inpatient psychiatric placements for some adults, even though an alternative placement would be more appropriate because there are no alternative placements available. About one in five surveyed preadmission screening clinicians reported that half or more of the adults they recommended for inpatient psychiatric treatment could have been served in an alternative setting had one been available. State psychiatric hospital staff reported that this most commonly occurs for adults with dementia or intellectual or developmental disabilities, as well as other conditions such as impairments due to substance abuse or non-psychiatric physical conditions.

In 2012, Virginia entered a settlement agreement with the U.S. Department of Justice (DOJ) after the DOJ concluded that Virginia was not providing services to individuals with neurodevelopmental disabilities in the most integrated setting appropriate to meet

their needs. Over the past decade, the state has taken steps to reform Virginia’s approach to serving individuals with neurodevelopmental disorders, including closing four of five state-operated training centers for individuals and implementing the Medicaid Home and Community Based waiver system to help serve individuals who would otherwise receive care in an institution (sidebar).

The state has already taken several steps to help ensure individuals with neurocognitive and neurodevelopmental disorders are connected with services they need that are more appropriate than state hospital placements, and such efforts should continue. For example, DBHDS has provided state general funds (~\$3 million in FY23) to three CSBs to develop memory care beds and community-based crisis services for individuals with dementia and to provide specialized staff in nursing homes to allow them to use more beds for individuals with extraordinary behavioral health needs. In FY22, these efforts diverted 105 individuals from state hospitals by the third quarter of that year, according to DBHDS. These programs are provided at only two of Virginia’s 40 CSBs, and more widespread implementation could support more individuals with neurocognitive and neurodevelopmental disorders.

With respect to crisis intervention and diversion from state hospitals, DBHDS has also created the REACH program to support individuals with neurodevelopmental diagnoses who are facing crises, but this program also likely needs to be expanded. REACH services include crisis stabilization, intervention, and prevention services and are intended to reduce the use of training centers to provide needed care. However, various stakeholders have indicated that these services are underdeveloped and insufficient to meet current demand. These services are funded through general funds (~\$13 million in FY24) and Medicaid reimbursements.

According to DBHDS staff, although these changes have been impactful, as of December 2023 Virginia remains in non-compliance with the DOJ settlement agreement because the state is not adequately meeting the needs of individuals with neurodevelopmental disorders.

The General Assembly could use other strategies to expand services for individuals with these disorders, including approaches used in other states that have excluded neurocognitive and neurodevelopmental disorders from their criteria for involuntary psychiatric treatment. Other states’ approaches for improving placements and services for these populations that Virginia could consider include

- providing enhanced Medicaid reimbursements to facilities that provide care for individuals with behavioral challenges (e.g., Delaware, Georgia, Idaho), neurocognitive conditions (e.g., Indiana, Missouri, and Colorado), or who have been discharged from a state psychiatric hospital (e.g., Vermont); and
- applying for a Medicaid Home and Community-Based Services waiver to establish services targeted for individuals with neurocognitive conditions (sidebar).

The Southeastern Virginia Training Center is Virginia’s only remaining state-operated training center for individuals with neurodevelopmental disabilities.

The Department of Medical Assistance Services (DMAS) is developing a brain injury waiver program that will aim to improve the availability of home and community-based services for individuals with traumatic brain injury. This will include increasing the number of facilities that specialize in neurobehavioral care, which could also benefit individuals with other neurocognitive disorders.

(See Appendix D for more information on other states' approaches to serving individuals with neurocognitive and neurodevelopmental disorders.)

In 2021, staff of the Virginia Joint Commission on Health Care (JCHC) developed a policy option the commission could consider to direct the Department of Medical Assistance Services through the Appropriation Act to “develop a plan for an enhanced reimbursement rate to nursing homes for residents with behavioral health diagnoses.” The proposed policy option was identified as a strategy to enable nursing homes to admit more individuals with behavioral health diagnoses and “relieve some of the pressure on the struggling state psychiatric facilities.” The JCHC report cites Delaware as an example of a state that has adopted a similar strategy; nursing homes in Delaware receive an additional 10 percent of the primary care rate for residents “exhibiting disruptive psychosocial behaviors on a frequent basis.”

Prior to the effective date of changes recommended in Recommendations 1 through 3, the General Assembly should direct the secretary of health and human resources to work with relevant state and local behavioral health and social services agencies to identify and develop strategies to ensure individuals with neurocognitive and neurodevelopmental disabilities, who would otherwise be inappropriately placed in state psychiatric hospitals, receive appropriate services and placements. Strategies that should be considered include, but should not be limited to, establishing enhanced Medicaid reimbursement for providers that serve these patient populations and developing targeted Medicaid waivers for individuals with neurocognitive disorders. The chosen strategies and needed changes to state law, regulations, or funding should be reported and initiated before the changes in Recommendations 1, 2, and 3 go into effect.

As part of this effort, the secretary should direct DBHDS to develop formal guidance and direction for CSB preadmission screeners that specifies preadmission screeners' role in connecting individuals with neurocognitive or neurodevelopmental disorders with more appropriate services or placements, the other state and local agencies that should be involved in securing alternative services or placements, and the actions preadmission screeners should take to connect these individuals with those agencies.

RECOMMENDATION 4

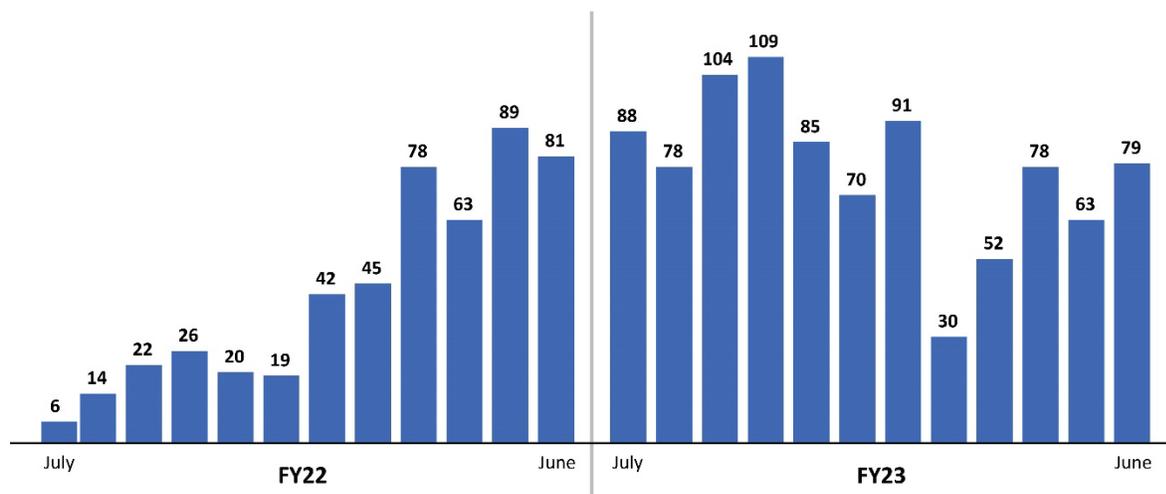
The General Assembly may wish to consider including language in the Appropriation Act directing the secretary of health and human resources to (i) evaluate the current availability of placements for individuals with neurocognitive and neurodevelopmental disorders who would otherwise be placed in a state psychiatric hospital, (ii) identify and develop alternative strategies to support these patient populations, including through, but not limited to, enhanced Medicaid reimbursements and a Medicaid waiver for individuals with neurocognitive disorders, and (iii) report the results of its work to the House Appropriations and Senate Finance and Appropriations committees no later than October 1, 2024.

Law enforcement dropoffs are placing patients and state hospital staff at risk

One of the most serious concerns expressed by state hospital leadership was increasing incidents where law enforcement transported individuals who were deemed to need temporary detention to state hospitals and left them there before they had been accepted for admission. These instances are referred to as law enforcement “dropoffs.”

Between FY22 and FY23, 1,432 individuals were dropped off at a state hospital before the facility accepted them for admission (Figure 2-3). Nearly all these dropoffs occurred at Southwestern Virginia Mental Health Institute, Western State Hospital, and Catawba Hospital.

Figure 2-3
Law enforcement dropoffs have become more prevalent since the beginning of FY22



SOURCE: JLARC analysis of DBHDS law enforcement dropoff data (FY22 and FY23).

Some of the individuals law enforcement left at state psychiatric hospitals were experiencing urgent medical needs, placing their physical health at risk because state psychiatric hospitals are not equipped to treat these medical needs, according to state hospital staff. State hospital staff told JLARC that individuals dropped off by law enforcement had experienced medical emergencies such as severe alcohol withdrawal, strokes, and cardiac arrests, which they were not prepared to treat.

State psychiatric hospital staff reported serious concerns about patient dropoffs in interviews and survey responses:

There have been no deaths as a result of dropoffs, but it’s been very close. Had a patient who we sent out 15 minutes after arrival who was very close to death. We feel lucky that there hasn’t been a catastrophic outcome.

While there is a system that has worked for years, law enforcement has taken it upon themselves to circumvent it. These admissions put the state at a huge medical liability, and at some point, someone is going to die due to negligence of this.

Dropoff of patients by law enforcement is a frequent event at [Southwestern Virginia Medical Health Institute]. Absolutely nothing has been done to prevent this action by law enforcement officers, and I fear a patient will pay for this reckless behavior with their life.

A huge stressor on our hospital is dropoffs. Most of the time patients are not even medically cleared... I have a patient who passed away 10 days after being admitted to Catawba State Hospital as a dropoff who was internally bleeding and had labs that indicated [they had] a medical problem that law enforcement said was 'medically cleared.'

The police drop-offs are dangerous. Staff are given a patient that sometimes has not been medically cleared and at times has no paperwork. It is very unsafe for the patients. Recently there has been a patient in active withdrawal...from alcohol and another with a gunshot wound. Eventually there will be a bad outcome...

In January 2023, Virginia's attorney general issued an official opinion that concluded that dropoffs are not permissible under state law. Still, the dropoffs continue to occur. The opinion notes:

It is my opinion that if a magistrate designates law enforcement to execute a TDO and provide transportation, law enforcement must execute the order without delay *and maintain custody of the individual until custody is accepted by the temporary detention facility*. Further, it is my opinion that the law does not permit law enforcement to transfer an individual under a TDO to the temporary detention facility *unless the facility accepts custody of the individual for admission*. (emphasis added)

Between the issuance of that opinion and August 2023 (the most recent date for which data is available), an additional 452 individuals were dropped off by law enforcement at state hospitals.

For the safety of all patients, but particularly those who are being dropped off by law enforcement, the Bed of Last Resort law should be amended to ensure that it is clear to all stakeholders that state hospitals are not required to admit an individual under a TDO until certain conditions are met. Although state hospitals cannot *deny* admissions to individuals needing temporary detention, state hospitals should be able to *delay* admission until the hospital has determined that the individual does not have urgent medical issues that must first be addressed in a non-psychiatric hospital.

RECOMMENDATION 5

The General Assembly may wish to consider amending the Code of Virginia to allow state psychiatric hospitals to delay admission of an individual under a temporary detention order until the state psychiatric hospital has determined that the individual does not have urgent medical needs that the state hospital cannot treat.

“ Many partners believe we are more of a ‘hospital’ than we are: We have no in house lab; we have no medical staff on-site after hours; we have limitations about what medical conditions we can treat given our staff education and training as well as on-site medical equipment and assets as we are psychiatrically focused and not acute medical care.”

— State psychiatric hospital director

DBHDS should prioritize implementing an electronic patient information exchange system to improve the use of privately operated psychiatric beds

CSB staff's process to search for an inpatient psychiatric placement for individuals under an emergency custody order or temporary detention order is grossly inefficient and increases the likelihood that individuals will be placed in a state psychiatric hospital rather than a private psychiatric hospital. An emergency custody order expires after eight hours, and during that time CSB staff must determine whether the individual is eligible to be placed under a TDO. They must also find a placement for the individual to receive treatment while under the TDO. If CSB staff cannot find a bed in a private psychiatric hospital within eight hours, a state psychiatric hospital must accept the individual, according to the Bed of Last Resort law (sidebar). Because of time constraints, creating a highly efficient bed search process is essential to CSB staff's ability to identify privately operated beds for individuals needing temporary detention and avoid unnecessary state hospital placements.

JLARC previously reported that the current bed search process is unnecessarily cumbersome and requires sharing patient information with private psychiatric hospitals across the state, typically by fax. CSB staff also must make repeated phone calls to find a placement. A single CSB staff person searching for a bed communicates with a median of 32 inpatient facilities for every individual deemed to need temporary detention. State law requires DBHDS to maintain a bed registry for CSB staff to identify available beds in privately operated hospitals easily, but the existing registry has never provided accurate, real-time data on bed availability. CSB staff tend to not even use the bed registry because of its unreliability.

DBHDS began developing a new bed registry in 2022 that is supposed to address the current registry's shortcomings, but this is a protracted effort that appears unlikely to improve the efficiency of the bed search process in the near term. DBHDS staff have indicated that many complicating factors must be addressed before the new bed registry is fully operational. DBHDS has not determined with certainty when the new bed registry will be operational but has projected that it could take until the end of 2024.

To vastly improve the efficiency of the bed search process, JLARC recommended in its 2022 report, *CSB Behavioral Health Services*, that DBHDS enter into a contract with a vendor for a secure, HIPPA-complaint online portal through which CSBs could share patient documents with inpatient psychiatric facilities. While this would not fix the entire bed registry system, it would eliminate the need for CSB staff to fax pages of patient records to many different facilities and conduct numerous follow-up phone

During the eight-hour emergency custody order (ECO), CSB staff evaluate an individual to determine if they meet the TDO criteria. When a TDO is recommended, a bed for the individual must be secured before the end of the ECO. If no privately operated hospital bed or an alternative placement accepts the individual before the end of the ECO, a state hospital is required to admit them.

calls with facility staff, all within eight hours. Several CSBs in Virginia have already contracted with such vendors to expedite their search for inpatient psychiatric beds.

One year has passed since JLARC staff issued that recommendation, and DBHDS has not pursued such a contract because agency staff assert that it would be duplicative of their efforts to implement a new bed registry. In November, DBHDS staff indicated a willingness to expedite work on the feature of the new bed registry that they report would allow for the electronic transfer of patient documents between CSBs and inpatient psychiatric hospitals, thereby meeting the intent of JLARC's 2022 recommendation. The need for a more efficient document exchange system is urgent, and DBHDS should take immediate steps to expedite the implementation of this functionality in the new system. DBHDS should enable CSBs to electronically transmit patient documents to inpatient psychiatric hospitals as soon as practicable, but no later than June 30, 2024. DBHDS should also provide monthly progress reports to the Behavioral Health Commission.

RECOMMENDATION 6

The Department of Behavioral Health and Developmental Services should take immediate steps to expedite the development and implementation of an information technology system that will allow for the secure electronic transfer of patient documents between community services boards and inpatient psychiatric hospitals and provide monthly progress reports on this work to the Behavioral Health Commission.

If DBHDS determines that this effort will not be successful, it could instead pursue entering into a contract with another vendor solely for this service, as JLARC recommended in 2022. This could be a short-term contract if DBHDS determines that it would eventually be rendered unnecessary by the new bed registry. DBHDS should consult with the Virginia Information Technologies Agency to determine if an “emergency procurement” is possible, which would significantly reduce the steps and time needed to reach an agreement with a vendor.

3 Civil Admissions to Private Hospitals

Privately operated, state-licensed psychiatric hospitals (“private psychiatric hospitals”) play an integral role in Virginia’s overall behavioral health system and serving individuals in need of inpatient treatment (sidebar). In FY22, 49,350 adults were discharged from a private psychiatric hospital in Virginia—about 10 times as many as the number of people discharged from state hospitals in the same year (~5,000). CSB staff must attempt to place individuals under a temporary detention order (TDO) in private psychiatric hospitals before placing them in a state psychiatric hospital, and the best available data indicate that the majority of patients under a civil TDO are served by a private hospital (sidebar, next page).

According to data maintained by Virginia Health Information (VHI) and the Department of Behavioral Health and Developmental Services (DBHDS), Virginia has approximately 1,660 adult and 550 youth inpatient beds across 47 private psychiatric hospitals. These beds account for just over half of Virginia’s total adult inpatient bed capacity and almost all of its youth bed capacity.

Designating state hospitals as the safety net providers through the Bed of Last Resort law appears to have unintentionally allowed service providers to be more selective in who they admit and avoid admitting, treating, and managing the needs of some Virginians in need of inpatient treatment. Selectivity on the part of many providers has resulted in state psychiatric hospitals being required to admit individuals who could have been served by privately operated hospitals. This is evidenced by excess staffed bed capacity in some privately operated psychiatric hospitals.

Many private psychiatric hospitals could admit more patients without exceeding safe operating levels

While state hospitals have been operating at or near their staffed capacity, the majority of adult private psychiatric hospitals operate below their staffed capacity (Figure 3-1). Adult state psychiatric hospitals have consistently operated at a median of 99 percent of their staffed capacity on a given day between July 2021 and October 2023. Several of these hospitals operated between 100 and 102 percent of their total staffed capacity during this period. According to the most recent available VHI data, 31 of the 43 private psychiatric hospitals for adults used less than 85 percent of their average staffed bed capacity in 2022, which is the industry standard for a safe operating level (sidebar). Many of the hospitals operated far below that level. In the 31 hospitals that operated below 85 percent of staffed capacity, a substantial number of additional inpatient bed days—67,884—could have been used before the hospitals reached 85 percent of staffed capacity.

For simplicity, this report will refer to all non-state operated psychiatric hospitals as “**privately operated hospitals.**” These are freestanding psychiatric hospitals and psychiatric units in general hospitals that are licensed by DBHDS to provide inpatient psychiatric care. These include teaching hospitals that receive public funding for their operations (e.g., University of Virginia Medical Center), but that are not state-operated facilities.

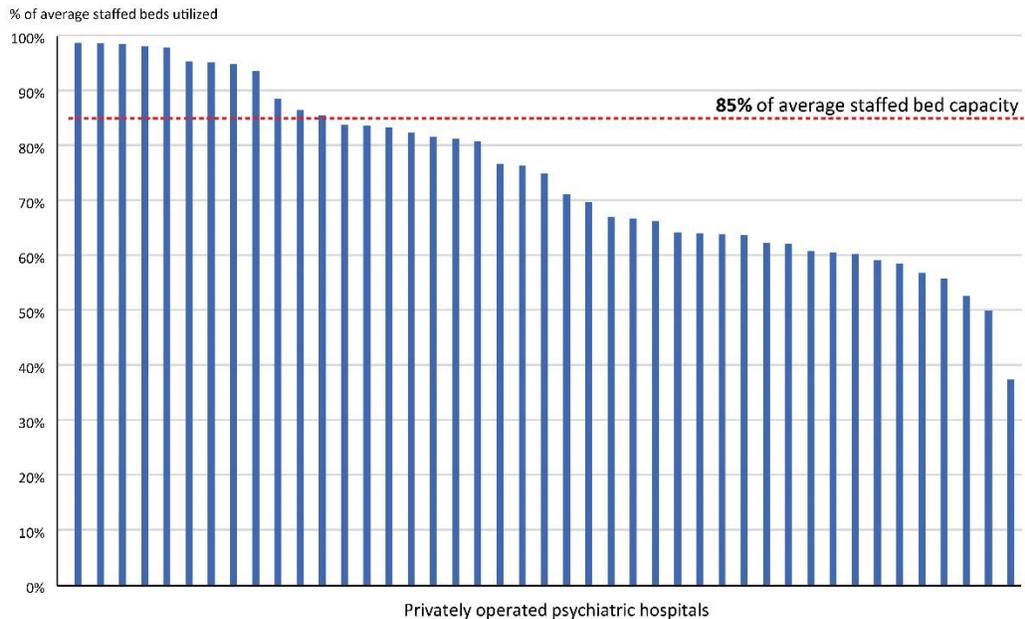
Information on **private psychiatric hospital beds for children and adolescents** is also reported to VHI but includes residential psychiatric placements. Therefore, a similar analysis to the one presented in this chapter for youth beds is not possible.

FIGURE 3-1
About two-thirds of adult private psychiatric hospitals operated below 85 percent of staffed capacity (FY22)

Previous reports to the General Assembly on TDO admissions to private psychiatric hospitals overstated the admissions because the admission figures assumed that any TDO patient not admitted to a state hospital was admitted to a private hospital, but some of those not admitted to a state hospital were never admitted to any inpatient setting.

In the third quarter of FY22, VHI began tracking the TDO status of individuals discharged from private psychiatric hospitals. This data could provide more accurate information on the number of TDO patients admitted to private hospitals than is currently being reported.

Fewer adult private hospital beds than JLARC's estimates may be needed for state hospitals to operate at safer levels. Reducing forensic admissions to state hospitals and preventing inappropriate TDOs would both increase state hospitals' capacity to accept civil patients and reduce the number of individuals needing temporary detention. (More discussion in Chapters 2 and 4).



SOURCE: JLARC analysis of VHI data regarding the staffed capacity and patient utilization of private psychiatric hospitals (FY22).

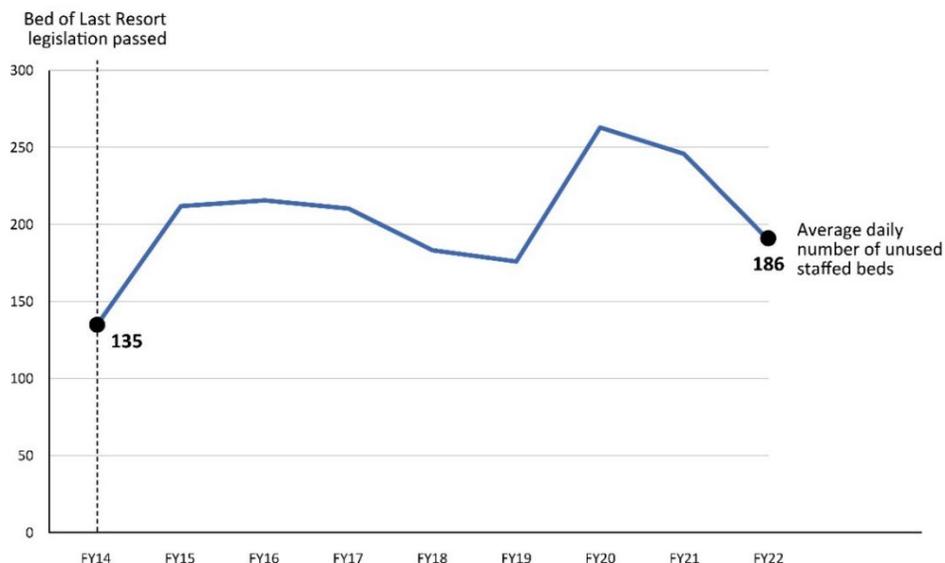
NOTE: VHI utilization data for 2022 includes private psychiatric hospitals' average staffed bed capacity in the facility's 2022 fiscal year. The fiscal year for each privately operated psychiatric hospital may vary.

Private psychiatric hospital beds' underutilization has previously been reported by representatives of these facilities. In 2019, the Virginia Hospital and Healthcare Association (VHHA) surveyed its members and reported that 46 percent of private psychiatric hospitals operated below 85 percent of their staffed capacity.

The number of *unused staffed beds* at adult private psychiatric hospitals increased 38 percent between FY14 and FY22. Some of this increase could at least partially be explained by reduced admissions during the COVID-19 pandemic. However, the largest increase in the number of unused beds occurred around the implementation of the Bed of Last Resort law in 2014 (Figure 3-2).

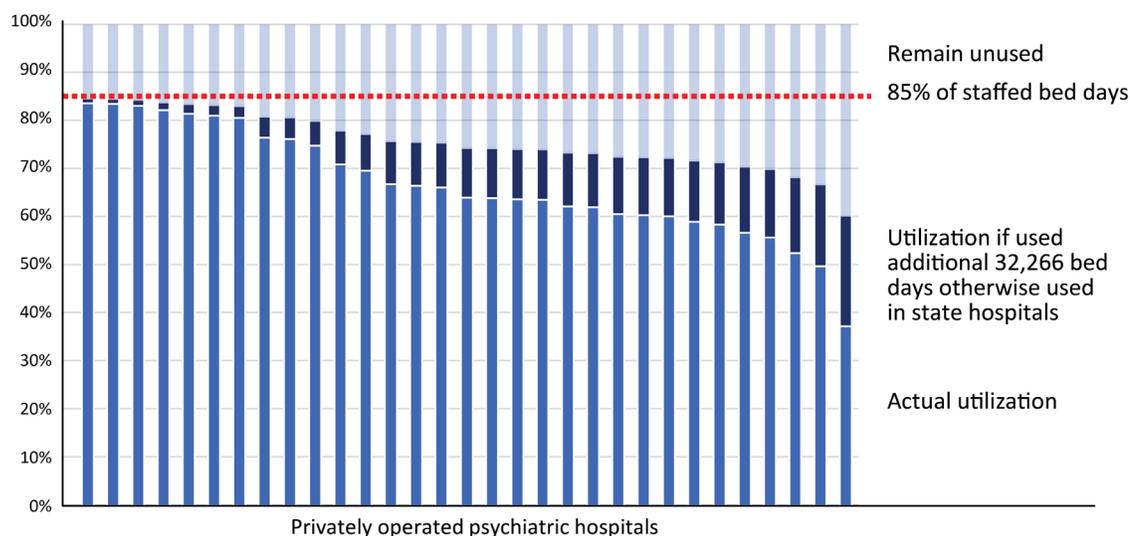
If adult private psychiatric hospitals had used around half of these unused beds in FY22, enough patients would have been diverted from adult state hospitals to allow them to operate at a safe capacity level. If an additional 32,266 bed days in private hospitals had been used to treat adult patients who were ultimately admitted to state hospitals in FY22, state hospitals could have operated at 85 percent of their capacity. At the same time, adult private hospitals would have continued to operate below 85 percent of their average staffed capacity (sidebar). (This analysis assumes that these additional bed days were distributed across all of the adult private psychiatric hospitals that were operating under 85 percent of their staffed bed capacity) (Figure 3-3).

FIGURE 3-2
The statewide average number of unused staffed beds in adult private psychiatric hospitals has increased over time



SOURCE: JLARC analysis of VHI data regarding the staffed capacity and patient utilization of private psychiatric hospitals.
 NOTE: Only unused beds that were within 85 percent of the facilities' average staffed bed capacity were counted in this estimate. Additional unused beds exist. See Appendix B for more details.

FIGURE 3-3
Distributing additional bed days across adult private psychiatric hospitals operating below 85 percent capacity would have allowed them to continue operating within safe levels (FY22)



SOURCE: JLARC analysis of VHI data.
 NOTE: Additional bed days were distributed across facilities based on the proportion of total unused staffed bed days statewide that they accounted for. Unused staffed bed days included only unused beds that were within 85 percent of a facility's total operating capacity. Thirty-one facilities had unused staffed bed days within 85 percent of their average staffed bed capacity. The fiscal year for each privately operated psychiatric hospital may vary.

This increase in adult private hospital utilization would have had a large positive impact on state hospitals' operations while allowing the private hospitals to continue to operate at safe levels. Many of the challenges discussed throughout this report—safety concerns, staff burnout and turnover, and discharge pressures—stem from high utilization and admission pressures placed on state hospitals.

Private psychiatric hospitals are justifiably concerned about risks that high-need patients create for staff and patient safety

Regardless of funding, general concerns regarding the safety of patients and staff will continue to affect private psychiatric hospitals' willingness or ability to accept additional patients for involuntary admissions. Private psychiatric hospital staff indicated that safety risks to their staff are a key consideration when considering whether to admit additional patients, and some indicated that they felt ill-equipped to protect their staff from especially aggressive or volatile patients.

Private psychiatric hospitals could take several steps to improve their ability to protect their staff from more aggressive and volatile patients. Additional security staff, staff training, and facility improvements were all resources that private hospital staff reported they would need to accept more patients under TDOs or civil commitments. State funding to help cover these costs could incentivize these hospitals to accept more civil TDOs and civil commitments, even if the hospitals could afford to do so without financial incentives. The state already reimburses private hospitals for taking some uninsured patients who would have been admitted to state hospitals from the Local Inpatient Purchase of Services (LIPOS) fund. In FY22, the state allocated around \$8.8 million from this fund to cover the costs of serving 993 individuals in private hospitals.

RECOMMENDATION 7

The General Assembly may wish to consider including language and funding in the Appropriation Act directing the Department of Behavioral Health and Developmental Services to establish a program for state-licensed psychiatric hospitals (commonly referred to as “private psychiatric hospitals”) to provide funding for those hospitals that agree to increase the percentage of involuntary inpatient admissions they accept and demonstrate the need for funding to safely admit such patients. Funds could be provided to cover one-time and ongoing costs for creating and filling additional security positions, providing staff training on how to safely treat these patients, and making safety improvements to the facilities.

Another approach to incentivizing private hospitals to accept more involuntary admissions would be to provide higher Medicaid reimbursements for involuntary patients. Medicaid is an increasingly important source of revenue for private hospitals; in FY21 (most recent data available), a median of 42 percent of each hospital's patients were enrolled in Medicaid, more than double the proportion in FY18. Policymakers could also explore making eligibility for Medicaid reimbursement contingent on private hos-

pitals' increasing the number of involuntary admissions by a specified order of magnitude, but the permissibility of this approach would need to be reviewed by the Centers for Medicare and Medicaid Services (CMS).

Insufficient funding to support patient discharges from psychiatric hospitals deters private hospitals from admitting certain patients

Various stakeholders indicated that individuals who are likely to face barriers to discharge, including individuals with longer stays and complex conditions, were commonly placed on state hospital civil admission waitlists. One of the most common reasons private psychiatric hospitals reported for denying admission to patients needing involuntary treatment was concern with patients that are challenging to discharge.

Patients who are difficult to discharge cost hospitals more because commercial insurers, Medicaid, and Medicare do not reimburse the costs of their stays after they have been determined to no longer need inpatient treatment. Additionally, hospitals tend to spend more staff time and other resources locating appropriate discharge placements for these patients.

The General Assembly allocates funding to DBHDS for post-discharge services and support for patients in state hospitals who are difficult to discharge through the Discharge Assistance Program (DAP). DAP funding is used to (1) assist with the costs of post-discharge services and placements and (2) develop new post-discharge services and placements when none are available for patients in state psychiatric hospitals who face barriers to discharge. DAP funding is used for supports and services such as in-home services, transportation, medications, and placements in nursing homes, assisted-living facilities, and other less intensive facilities.

In contrast, discharge assistance funding has not been available for patients in private psychiatric hospitals, and these hospitals have been requesting access to these funds to help discharge individuals in a timely manner and reduce the costs of securing post-discharge services and placements for difficult-to-discharge patients. Without access to discharge assistance funding, private hospitals are disincentivized from accepting patients who may be challenging to discharge because they must absorb the cost to arrange the discharge and the cost of the portion of the inpatient stay that extends beyond what is determined to be clinically necessary. In its FY25–26 operating budget request, DBHDS has asked that private psychiatric hospitals have access to available discharge assistance funds.

Allowing discharge assistance funding to support discharges from private psychiatric hospitals could help ensure that they are not disincentivized from admitting patients that they believe will be challenging to discharge.

RECOMMENDATION 8

The General Assembly may wish to consider including language and funding in the Appropriation Act to expand the discharge assistance provided by the Department of Behavioral Health and Developmental Services (DBHDS) to individuals facing substantial barriers to discharge from inpatient psychiatric units and facilities licensed by DBHDS (commonly referred to as “privately operated”).

Underutilization of private hospital beds places avoidable burdens on patients, law enforcement, and state hospitals

In FY23, 8,538 individuals under a TDO experienced delays receiving needed psychiatric treatment after they had been deemed an imminent risk to themselves or others because no private psychiatric hospital bed was found for them, and a state hospital bed was not immediately available. Of those individuals, *at least*

- 235 were never admitted to an inpatient facility for further evaluation or treatment—instances the Bed of Last Resort law was intended to prevent;
- 927 were dropped off at a state hospital before being accepted by the facility; and
- 36 were arrested before an inpatient bed was secured because of incidents that occurred while waiting for a bed.

The underutilization of private hospital capacity also prolongs law enforcement officers’ involvement in TDO cases and unnecessarily occupies emergency department beds.

The underutilization of private psychiatric hospitals is at least partially due to a reluctance by these facilities to serve certain populations. Current and former leadership and staff of private psychiatric hospitals reported knowing that some *other* privately operated facilities in Virginia do not admit patients they *could* treat. For example, individuals with potential barriers to future discharge were commonly reported to be denied admission to private psychiatric hospitals.

The Bed of Last Resort law likely exacerbates the overreliance on state hospitals to provide inpatient care to individuals needing involuntary psychiatric treatment because it requires state hospitals to accept any individual under a TDO if another placement cannot be secured. The Bed of Last Resort law requires other placements to be sought first, and so its intent is to avoid the use of state psychiatric hospitals unless absolutely necessary. However, neither state law, regulations, nor state licensing standards obligate private hospitals to accept any patient. Multiple national subject matter experts raised concerns that the existing law places undue pressure on Virginia’s state psychiatric hospitals because it allows private psychiatric hospitals to be selective in their admissions.

Hospitals are already required to treat individuals in emergencies if they have the capability to do so. Under the federal Emergency Medical Treatment and Labor Act (EMTALA), a hospital is required to treat individuals who need to be stabilized because of an emergency medical condition, either on an inpatient or outpatient basis, when a hospital has the staff and physical capacity to do so. The federal definition of “emergency medical condition” includes individuals experiencing “psychiatric disturbances” that, without immediate attention, “could reasonably be expected to result in placing the health of the individual...in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.” This definition includes individuals who are substantially likely to be an imminent risk to themselves because of mental illness—one of the three circumstances by which an individual may meet the criteria for involuntary psychiatric treatment in Virginia. At least in some circumstances, private hospitals that do not admit TDO patients whom they have the ability to treat into their psychiatric units would be in violation of EMTALA.

State could use the certificate of public need process to ensure that privately operated hospitals accept TDO patients

State law requires that healthcare providers receive a certificate of public need (COPN) from the state health commissioner before undertaking a project to establish, expand, or relocate certain types of medical facilities, including inpatient psychiatric facilities or units within general hospitals. Most states (35), including Virginia, operate a COPN process, and the general purposes of such a process are to control costs by avoiding unnecessary expansion or duplication of services in an area and to improve access to underserved areas or populations.

To receive a COPN in Virginia, a healthcare provider must demonstrate through an application process that the proposed project meets a public need, according to criteria specified in state law. State law also requires the state health commissioner to condition the approval of any COPN on the applicant’s agreement to meet certain conditions. These conditions include “to provide a specified level of charity care to indigent persons” or to “accept patients requiring specialized care.” If the COPN is issued, the provider must meet those conditions annually or be subject to a civil penalty. Furthermore, when a provider applies for a COPN to operate psychiatric inpatient beds, state regulations require the Virginia Department of Health to give preference to proposals “demonstrating a willingness to accept persons under a temporary detention order.”

State law does not specify who should be considered “patients requiring specialized care” in the COPN process.

In their COPN application, some private psychiatric hospitals have committed to accepting TDO patients. Between January 2021 and September 2022, the state health commissioner granted approval to nine projects seeking to add inpatient psychiatric beds, and in four of them, the approval was partially based on the applicant’s commitment to accepting TDO patients.

To improve access to inpatient care for TDO patients, the state health commissioner should develop and implement a process to ensure that providers who have committed in their COPN application to serve TDO patients are fulfilling this commitment. If

providers are found not to be meeting their commitment to serve TDO patients, the commissioner, using the authority granted in state law, should take appropriate steps to bring the provider into compliance. State law authorizes the commissioner to impose civil penalties if providers refuse, fail, or neglect to honor agreed-upon conditions.

The VHI, which reports to the Virginia Department of Health, now collects information to identify the number and proportion of patients admitted to each hospital who were under a TDO at the time of admission. The Virginia Department of Health should use this information as part of its review process to determine the extent to which hospitals are meeting their commitments.

RECOMMENDATION 9

The Virginia Department of Health should develop and implement a process to (i) determine whether all healthcare providers that were granted a certificate of public need based at least partially on their commitment to accept patients under a temporary detention order (TDO) are fulfilling this commitment, and (ii) take appropriate remedial steps to bring providers who are determined to not be fulfilling their commitment into compliance.

The General Assembly should establish in state law that providers must agree to accept TDO patients as a condition of *future* COPN approvals related to inpatient psychiatric beds. This change would apply to projects seeking to open a new inpatient psychiatric hospital or add inpatient psychiatric beds to an existing facility. State law already has a precedent for requiring a COPN applicant to commit to serving certain categories of patients (i.e., providing charity care or serving individuals who require specialized care), and accepting patients under a TDO follows this precedent.

RECOMMENDATION 10

The General Assembly may wish to consider amending § 32.1-102.4 of the Code of Virginia to require the commissioner of the Virginia Department of Health to condition the approval of any certificate of public need for a project involving an inpatient psychiatric service or facility on the agreement of the applicant to accept patients under a temporary detention order whenever the provider has the capacity and capability to do so.

Because the previous two recommendations would only affect *new inpatient psychiatric beds* or *providers that previously committed to serving TDOs*, the General Assembly could consider and evaluate other options to require existing inpatient facilities to accept patients under a TDO, even if they did not previously commit to doing so as part of their COPN application. For example, the General Assembly could consider requiring that projects seeking to expand inpatient psychiatric services only be considered by the Virginia Department of Health commissioner if either they (1) previously agreed to accept TDO patients in their prior COPN application(s) or (2) agree to accept TDO

patients in at least some of their existing facilities going forward. However, these legislative changes and their impacts would need to be further evaluated and may not be necessary if DBHDS already has the authority to require providers to accept TDO patients, as described below.

DBHDS may already have the authority to require that private psychiatric hospitals serve TDO patients

Another option that the executive branch could consider to help patients under a TDO receive the care they need and alleviate pressures on emergency rooms, law enforcement officers, and state hospitals is for the DBHDS commissioner to use existing authority granted to him under state provider licensure requirements. DBHDS licenses providers of inpatient psychiatric services, including private psychiatric hospitals and psychiatric units within general hospitals, and state regulations authorize the DBHDS commissioner to impose additional requirements on licensed providers:

The commissioner may add stipulations on a license issued to a provider...to impose additional requirements on the provider (*12VAC35-105-50.B*)

Because DBHDS-issued licenses must be renewed at least once every three years, DBHDS could potentially use this authority to prohibit licensed providers from denying admission to an individual under a TDO when the provider is operating below 85 percent of staffed capacity. Exceptions could be allowed when a provider demonstrates that accepting the individual would jeopardize the individual's safety or the provider's ability to care for their existing patients. DBHDS has the authority to implement sanctions for non-compliance, including issuing fees, prohibiting new admissions, and reducing the licensed capacity of a facility.

Such a requirement would be consistent with the expectations under EMTALA, which specify that hospitals should not deny admission to patients experiencing an emergency condition if they have the capability and capacity to treat them.

Massachusetts has used its licensing authority to take such action. The Massachusetts Department of Mental Health specifies in its licensing regulations that privately operated psychiatric hospitals, which are licensed by the department, cannot deny admission of involuntary patients when they have the capability and capacity to treat them. This provision was promulgated to address the recurring problem of involuntarily detained mental health patients spending protracted amounts of time in emergency rooms waiting to be admitted to an inpatient unit or facility for mental health treatment. The requirement is consistent with EMTALA's requirements, according to Massachusetts department staff. Staff reported that the provision has helped increase the rate at which private hospitals admit involuntary patients, including those with more challenging conditions and behaviors.

Because DBHDS licensure regulations are generally related to patients who are receiving services through licensed providers (rather than those who *could* be receiving services), DBHDS should seek clarification from the Office of the Attorney General

about this authority. If the Office of the Attorney General determines that the DBHDS commissioner has the legal authority pursuant to 12VAC35-105-50.B to require providers of inpatient psychiatric services to accept TDO patients if they can do so safely, then the commissioner should use this authority and develop and implement processes to ensure compliance with it.

RECOMMENDATION 11

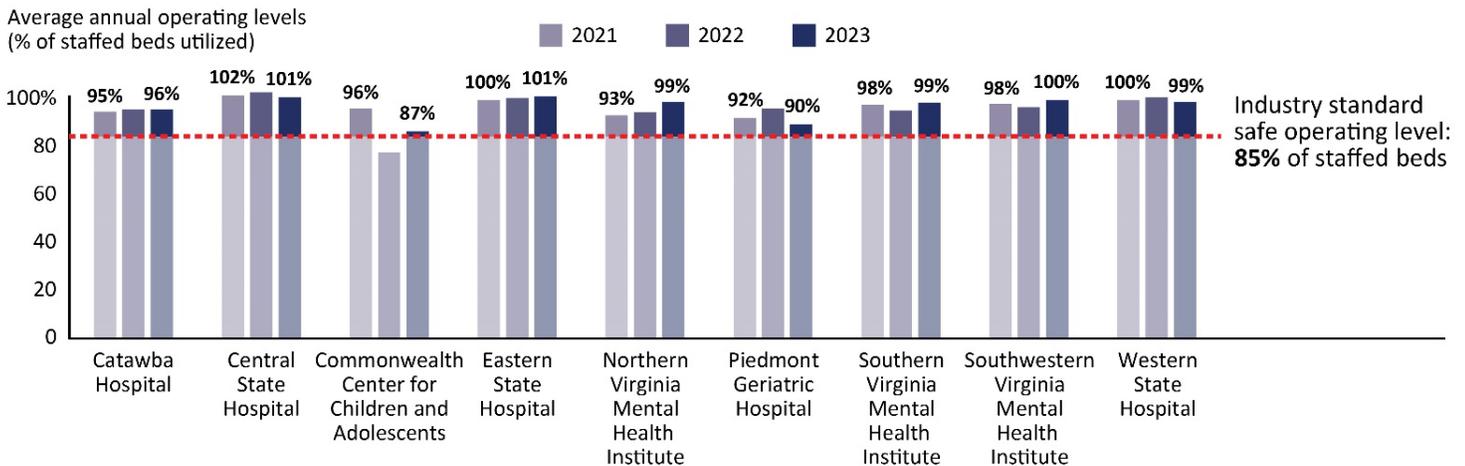
The Department of Behavioral Health and Developmental Services (DBHDS) should seek clarification from the Office of the Attorney General regarding whether the commissioner of DBHDS has the legal authority pursuant to 12VAC35-105-50.B to require providers of inpatient psychiatric services to admit patients under a temporary detention order or civil commitment order if the provider has the capacity to do so safely.

State hospitals should be given the authority to deny admissions based on their staffed capacity

In recent years, all state hospitals have been operating above 85 percent of their staffed bed capacity, and several have regularly exceeded their staffed bed capacity. During 2023, seven state hospitals had an average annual operating level of at least 95 percent of staffed beds, and three regularly filled all their staffed beds (Figure 3-4).

FIGURE 3-4

All state hospitals have been regularly operating above the industry standard for safe operating levels



SOURCE: JLARC analysis of DBHDS data on utilization of staffed beds at each hospital.

NOTE: Figures reflect each facility's average staffed bed operating levels and are based on monthly snapshots reported for each facility throughout each fiscal year. Information on staffed beds was available from July 2021 through October 2023.

Operating at these high levels limits the facilities' ability to respond to changing patient needs, in terms of providing appropriate bed placements, treatment, and staff supervision. As expected, DBHDS and state hospital staff reported that it has had detrimental impacts on staffing, the safety of patients and staff, and the quality of care provided—concerns discussed in more detail throughout this report:

Unsafe staffing conditions are exacerbated when we are forced to go over census. This is a significant risk for staff and patients and ultimately a risk for the system overall. It seems like just a matter of time until a related sentinel event occurs somewhere in the system. (state hospital staff)

Having a hospital at 100% capacity for several years on end is not sustainable; results in poor care, unsafe working conditions, and staff leaving. (state hospital staff)

The admissions policy that requires this facility to take in more clients regardless of our facility's ability (or lack thereof) due to staffing and bed availability, is not only dangerous for all involved but sends a clear message to the employees that they are not important or valued. Something has to give! People are frustrated and many are getting hurt or worse. (state hospital staff)

State psychiatric hospitals should have the ability to deny civil admissions, at least temporarily, if they are operating at levels that are generally considered unsafe. However, state hospitals currently have no authority to deny admission for civil patients under state law:

Under no circumstances shall a state facility fail or refuse to admit an individual who meets the criteria for temporary detention... unless an alternative facility that is able to provide temporary detention and appropriate care agrees to accept the individual for temporary detention

This is much more prescriptive than the regulatory admissions requirements for privately operated psychiatric hospitals, which shall only admit individuals “for which staffing levels and types meet the needs of the individuals receiving services.” Providing similar flexibility for state psychiatric hospitals is necessary to improve the safety of these facilities and the ability of staff to properly care for patients.

Two equally important goals should guide efforts to provide needed treatment for Virginians placed under TDOs: ensure that the hospitals offer an environment that is as safe and therapeutic as possible *and* ensure that all Virginians who meet TDO criteria and need inpatient psychiatric treatment are placed, without delay, in an appropriate inpatient setting. To achieve the first goal, state psychiatric hospitals should have the statutory authority to pause new admissions when they are operating at 85 percent of their staffed capacity. However, doing this alone will increase the risk that individuals experiencing a mental health crisis will not receive needed inpatient care (although this already occurs because of civil admission waitlists and the expiration of TDOs before treatment can be provided.) Therefore, DBHDS and the General Assembly should also follow the recommendations provided earlier in this chapter to expand access to other existing inpatient beds in privately operated psychiatric hospitals.

Virginia also needs to build out new community-based resources, like crisis receiving centers that can accept TDO patients, which the General Assembly, DBHDS, and community services boards have already begun to do. However, this cannot be the sole strategy for helping Virginians experiencing a mental health crisis because it will take time and significant financial resources. Further utilizing state-licensed privately operated hospitals with unused capacity can help in the near term to provide more Virginians placed under TDOs with timely care.

Allowing state hospitals to deny involuntary admissions based on their staffed capacity is an essential component of ensuring that state hospitals can provide environments that are safe and therapeutic for patients and safe and more predictable for staff. (See Chapters 5 and 6 for further discussion of patient and staff safety.) However, it is prudent to give the state time to prepare for this change and allow state officials and other stakeholders to take steps to avoid unintended consequences. For example, waitlists for admissions to inpatient facilities, which are already a concern, could grow if other resources for patient treatment are not identified or developed. Therefore, if legislation is enacted to grant state hospitals the authority to deny admission to individuals under a TDO when they reach 85 percent of their staffed capacity, its effective date should be delayed by the General Assembly until 2025.

RECOMMENDATION 12

The General Assembly may wish to consider amending the Code of Virginia to grant state psychiatric hospitals the authority to decline to admit any individual under a temporary detention order if doing so will result in the hospital operating in excess of 85 percent of its total staffed capacity. The legislation's effective date should be delayed until July 1, 2025.

4 Forensic Admissions to State Psychiatric Hospitals

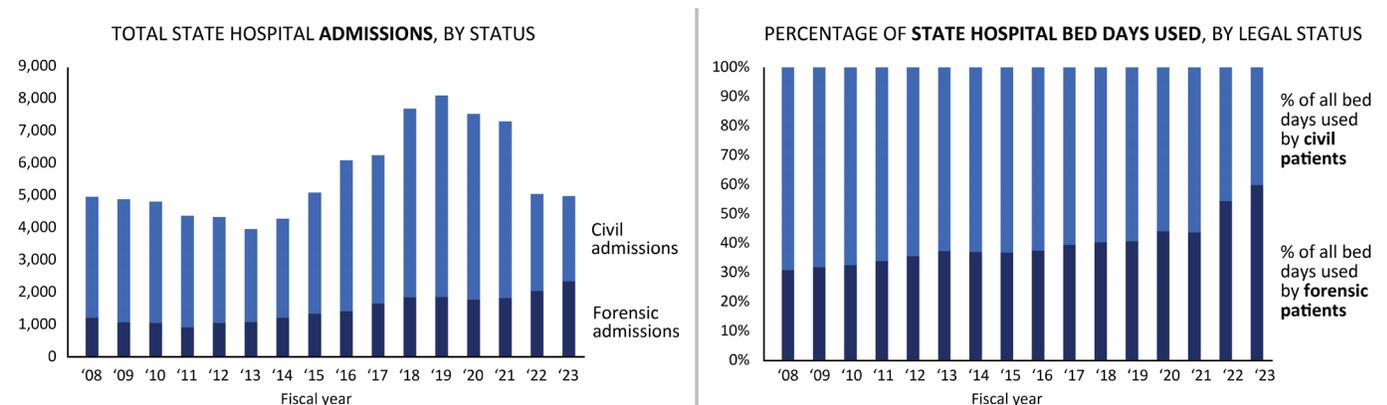
Over the past 15 years, the number and proportion of criminal defendants whom a court has ordered to receive inpatient psychiatric evaluations and/or treatment (“forensic patients”) has risen steadily. Between FY08 and FY23, annual forensic admissions to state hospitals nearly doubled—from 1,211 to 2,339. Forensic admissions accounted for 47 percent of all admissions to state psychiatric hospitals in FY23, compared with 24 percent in FY08.

This trend is affecting all adult psychiatric hospitals. All eight of Virginia’s adult state psychiatric hospitals serve more forensic patients now than they did 15 years ago. In FY23, forensic patients used the majority of all available state psychiatric bed days (60 percent)—almost double the proportion used in FY08 (Figure 4-1, sidebar).

Forensic patients remain hospitalized for about three times longer than civil patients, on average, so increased forensic admissions have substantially reduced state hospital bed capacity for civil admissions, and this trend is expected to continue. Lower capacity for civil admissions undermines the General Assembly’s goal of using state hospitals as the safety net for Virginians who require hospitalization but are denied admission to privately operated psychiatric hospitals. Moreover, because the costs of serving forensic patients cannot generally be billed to Medicaid, Medicare, or commercial insurance, increasing forensic admissions to state psychiatric hospitals will increase the state’s costs to operate these hospitals (sidebar).

The costs of serving forensic patients may not be reimbursable for various reasons. For example, (1) certain patients are not responsible for the cost of their treatment and (2) treatments that are eligible for Medicaid reimbursement can only be reimbursed for up to 15 days of a patient’s stay in a state psychiatric hospital under federal law, but forensic patients generally have much longer stays.

Figure 4-1
State hospitals are admitting more forensic patients than in FY08, and forensic patients now use a majority of bed days



SOURCE: JLARC analysis of DBHDS Avatar data.

Increase in competency restoration patients at state hospitals has delayed forensic patient discharges and worsened civil admission waiting lists

Competency restoration treatment and services vary depending on the defendant's needs and may entail psychiatric stabilization, symptom management, and legal education.

The U.S. Supreme Court in *Dusky v. U.S. (1960)* held that for a defendant to be found competent to stand trial, he must have "sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding" and a "rational as well as factual understanding of the proceedings against him."

Under state and federal law, pre-trial defendants who judges find are incompetent to stand trial ("incompetent defendants") must receive competency restoration treatment and services (sidebar). Court proceedings for these defendants can continue only after it has been determined that these services and interventions have allowed them to understand the legal proceedings and consult with their attorney (sidebar).

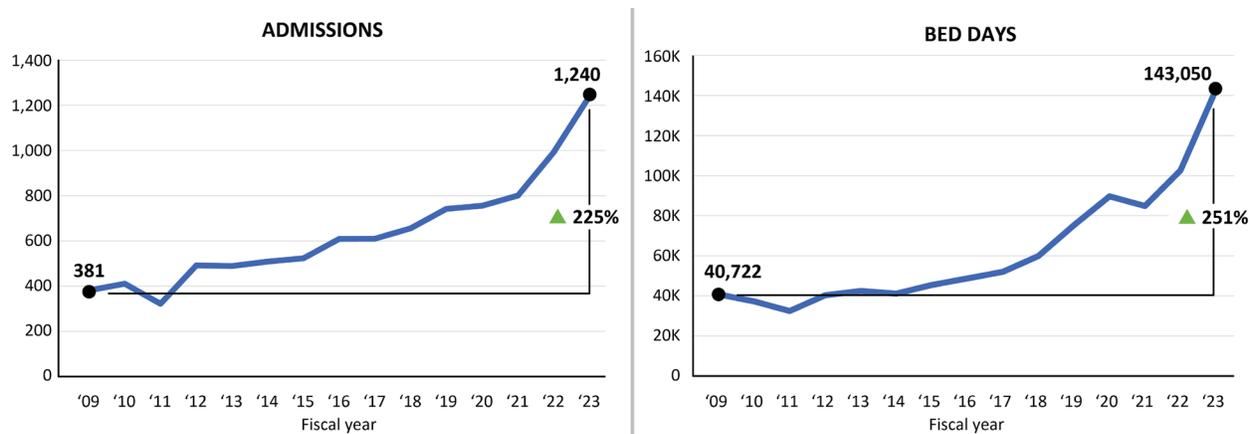
In Virginia, incompetent defendants must receive competency restoration services in an outpatient setting unless a defendant needs inpatient hospitalization or the individual meets the criteria to be diverted from the criminal justice system so that they may receive involuntary psychiatric treatment. Specially trained psychiatrists and clinical psychologists, called forensic evaluators, (1) recommend whether defendants should receive competency restoration services and in what settings those services should be provided, and (2) confirm whether or not an individual's competency has been restored because of those services. However, a judge ultimately decides whether a defendant is admitted to a state hospital for inpatient competency restoration services and when the defendant can continue with court proceedings. The median length of stay in a state hospital for defendants receiving these services is 76 days.

Competency restoration admissions have increased substantially, and delays in admissions create state legal exposure for potential due process violations

Competency restoration admissions to state psychiatric hospitals have tripled over the past 15 years, as have the number of bed days used by these patients (Figure 4-2). While all eight adult state hospitals experienced increases in competency restoration admissions and bed utilization, Eastern State Hospital, Central State Hospital, and Western State Hospital experienced the greatest increases.

State hospitals have delayed admitting some defendants for competency restoration because of capacity limitations, which creates risks that the state will be sued for violating defendants' due process rights. At least 16 states have been sued because of delayed inpatient competency restoration services for defendants. In Virginia, from March through July 2023, 508 defendants were delayed admission to state hospitals for competency restoration, further delaying their court proceedings.

FIGURE 4-2
State hospital admissions and bed days for competency restorations have increased significantly over time



SOURCE: JLARC analysis of DBHDS Avatar data (FY09 to FY23).

Virginia could reduce its reliance on state hospital admissions for competency restoration, particularly for misdemeanors

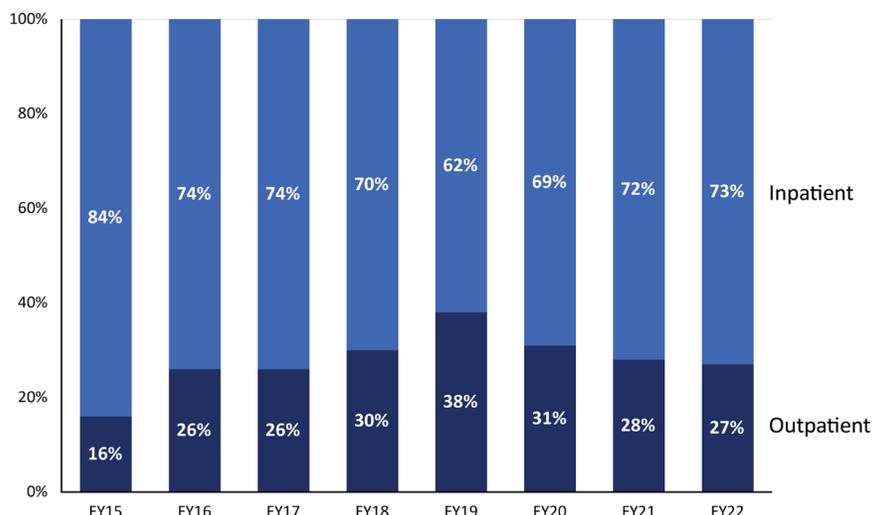
Virginia relies heavily on state psychiatric hospitals to provide competency restoration services to defendants, which is more expensive than providing competency restoration through outpatient services (sidebar). In FY22, 73 percent of individuals ordered to receive competency restoration were placed in a state psychiatric hospital (Figure 4-3). The proportion has fluctuated, but most competency restorations have consistently taken place in state hospitals since 2015 (when DBHDS began tracking outpatient placements). Recent estimates from the Behavioral Health Commission indicate that the cost of inpatient competency restoration (\$110,000 per person) is about 100 times higher than the cost of outpatient competency restoration services conducted in the community (\$1,190 per person) (sidebar).

Using outpatient competency restoration and diverting more cases from the criminal process are the two primary ways to (1) reduce the unnecessary use of state hospitals for competency restoration, (2) reduce the state’s costs of providing competency restoration, and (3) improve the timeliness of competency restoration services in the interest of defendants’ due process rights.

Outpatient competency restoration services are provided by community services board staff either in the community or in a jail. Individuals can receive many of the same services that are provided on an inpatient basis, including legal education and mental health services.

Jail-based competency restoration services are more costly than restoration services delivered in the community because of the additional costs associated with being held in a jail. Virginia’s Compensation Board reported the average jail operating cost per inmate was \$107 per day in FY21. Still, the combined cost of a jail stay and outpatient restoration services is substantially less than an inpatient restoration stay.

FIGURE 4-3
Most defendants receive competency restoration services in state psychiatric hospitals



SOURCE: JLARC analysis of DBHDS competency restoration data (FY15 to FY22).

NOTE: Outpatient data is based on reimbursement requests from CSBs and may not reflect all outpatient restorations in a given year.

Some states more clearly articulate the most appropriate setting for competency restoration services

Incompetent defendants should not receive inpatient competency restoration unless they require hospitalization to restore competency successfully. However, incompetent defendants are unnecessarily admitted to state hospitals, according to various stakeholders, including state psychiatric hospital leadership and staff, DBHDS central office staff, and subject matter experts in Virginia. The number of defendants unnecessarily hospitalized for restoration is unknown, but they reportedly either have conditions that do not require psychiatric treatment at all or have psychiatric conditions mild enough to be treated through outpatient services.

Subject matter experts indicate that decision-makers are likely to err toward hospitalization for competency restoration without specific criteria to guide placement decisions. State law is unclear regarding the conditions or circumstances under which inpatient restoration services should be considered, which likely contributes to some unnecessary hospitalizations. Clearer parameters in state law could help forensic evaluators and judges make appropriate recommendations and decisions for the most suitable setting for a defendant’s competency restoration.

Laws in several other states specify criteria that are used to determine whether a defendant should receive competency restoration through inpatient or outpatient services. Some states require that defendants meet civil commitment criteria (Maryland, Florida, New Jersey, Massachusetts) to be eligible for inpatient competency restoration,

while others, including Washington and Texas, specify circumstances under which outpatient restoration should be considered.

Some states exclude misdemeanors from inpatient competency restoration

DBHDS estimates that 34 percent of defendants admitted to state hospitals for competency restoration in FY22 had *only* misdemeanor charges. National subject matter experts believe that competency restoration for individuals charged with misdemeanors should be limited because it can prolong detention and delay court proceedings. For defendants accused of relatively minor offenses, the wait to begin restoration services combined with the services' duration can result in involuntary commitments that exceed the length of a defendant's potential criminal sentence if found guilty.

Virginia has already taken steps to reduce the use of competency restoration services for some alleged misdemeanors, but some states have developed broader policies to reduce the use of inpatient competency restoration services for defendants charged with misdemeanors (sidebar). The General Assembly could consider adding to the types of misdemeanors that should not require inpatient competency restoration services or competency restoration services at all. For example:

- Minnesota prohibits the use of inpatient competency restoration services for defendants with only misdemeanor charges. Further, unless an incompetent defendant's charge is a targeted or gross misdemeanor (i.e., the most serious misdemeanors), the charges must be dismissed.
- Florida, New Mexico, and New York require their courts to dismiss charges against an incompetent defendant if the defendant is charged with only misdemeanors.
- California requires incompetent defendants charged with misdemeanors and found to have a mental illness to be diverted from court proceedings to receive mental health treatment and other needed services, or to be dismissed without any further action.

Shortage of forensic evaluators at state hospitals contributes to prolonged hospitalizations for competency restoration

Once a treatment team determines that a competency restoration patient has completed treatment, a forensic evaluator must confirm that they are competent to stand trial before they can be discharged. Forensic evaluators are psychiatrists or clinical psychologists who have undergone the state's forensic evaluator training and have been approved by DBHDS to conduct forensic evaluations. As competency restoration admissions to state hospitals have increased, staff at most state hospitals have reported in interviews and survey responses that they do not have enough forensic evaluators to make timely discharge eligibility determinations.

Delays in forensic evaluations reportedly result in some forensic patients remaining in state hospitals after their treatment team has determined they are ready for discharge.

Steps taken in Virginia to reduce the use of competency restoration services for some alleged misdemeanors include:

- Limiting restoration services to 45 days. If competency has not been restored, the individual must be released or civilly committed.
 - Requiring individuals to be diverted from the criminal justice system to receive involuntary psychiatric treatment if they meet the criteria for a temporary detention order or are likely to remain incompetent for the foreseeable future.
-

“
Completion of forensic
evaluation is one of the
main barriers to timely
patient discharge
”

– Western State
Hospital staff

“
Lagging forensic
evaluations have been
bottlenecking discharges
and treatment staff feel
hopelessly at the mercy
of the forensic team
evaluation schedule,
”

– Central State
Hospital staff

Not only does this contribute to unnecessary utilization of state hospital beds, but untimely discharges further delay court proceedings for these patients. Similar to extensive wait times for *admission*, delays in discharge for pre-trial defendants may infringe on an individual’s due process rights, putting the state at risk of litigation.

State hospitals and DBHDS have attempted to increase the staff dedicated to forensic evaluations, but state hospitals still report an inability to provide timely forensic evaluations consistently. Some hospitals have required staff with other primary job responsibilities to assist with forensic evaluations, and others have established additional forensic evaluator positions. The General Assembly has also funded three DBHDS forensic evaluator positions that state hospitals can use, as needed, to supplement their existing staff resources.

DBHDS does not collect data from the state hospitals to determine the timeliness of forensic evaluations or the number of forensic patients who have not been discharged because of delays in their evaluations. Doing so will inform whether and how many additional forensic evaluator positions are needed. With this information, DBHDS should develop a plan to address inadequate forensic evaluator staffing across state hospitals.

RECOMMENDATION 13

The Department of Behavioral Health and Developmental Services should collect quarterly data on (i) the median length of time forensic patients in the state psychiatric hospitals have waited to be evaluated for discharge eligibility once the patient’s treatment team has referred them for evaluation and (ii) the number of forensic patients who have been referred for a forensic evaluation but have not received one in a timely manner, and report such data to the State Board of Behavioral Health and Developmental Services and the Behavioral Health Commission.

RECOMMENDATION 14

The Department of Behavioral Health and Developmental Services should determine the number of additional forensic evaluator positions, if any, needed to prevent delays in forensic evaluations for patients in state psychiatric hospitals and the amount of funding needed for those positions and request that the additional positions and funding for them be included in the 2025–2026 budget introduced by the governor in December 2024.

Forensic TDO admissions have also increased but remain a small proportion of bed days

Local jail inmates who have been determined to need hospitalization for a mental illness are admitted to a state psychiatric hospital for treatment (a “forensic TDO”). As with civil TDOs, these determinations are made by certified community services board (CSB) pre-admission screeners and magistrates. Virtually all forensic TDOs are issued

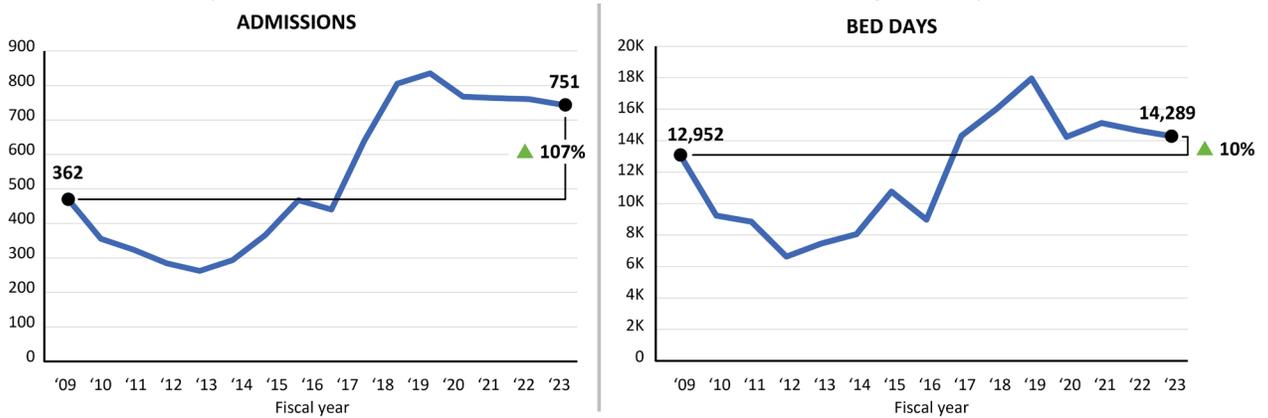
for pre-trial defendants. (These admissions are separate from competency restoration admissions.) According to state hospital staff, these patients receive the same types of treatments as patients admitted under civil statuses and have similar lengths of stay as civil TDO patients.

Forensic TDOs account for a relatively low proportion of state psychiatric hospital admissions (15 percent) and used bed days (3 percent), but these admissions have increased over the past 15 years. Forensic TDO admissions have more than doubled, and the number of bed days used has increased 10 percent (Figure 4-4). Inadequate mental health services in jails for pre-trial defendants are reportedly a primary cause. The proportion of jail inmates diagnosed with a serious mental illness has increased from 6 percent in FY11 to 18 percent in FY22, and many jails report not having adequate staff to provide needed mental health services.

An insufficient supply of community-based behavioral health services has also reportedly contributed to the increase in forensic TDOs. For example, available civil waitlist data and stakeholders interviewed indicate that at least some individuals waiting for an available inpatient psychiatric bed commit criminal offenses during their wait. As a result, some of these individuals end up in jail and become a “forensic TDO” if they meet the statutory criteria for temporary detention. Improving access to community-based behavioral health crisis services and emergency psychiatric treatment, in particular, could reduce the number of Virginians who end up in a state psychiatric hospital through a forensic TDO.

The growing number of forensic TDOs contributes to the decreasing number of state psychiatric beds available for patients who are determined to need hospitalization under a civil TDO process. In FY23, 8,538 civil TDO patients were placed on the state hospitals’ waitlist because no bed was available for them in these facilities—an average of 710 individuals per month. Continued efforts by the General Assembly to expand community-based behavioral health services could help reduce the number of forensic TDO admissions to state psychiatric hospitals and free up state hospital capacity for civil patients.

FIGURE 4-4
Bed days and admissions for forensic TDO patients have generally increased over time



SOURCE: JLARC analysis of DBHDS Avatar data (FY09 to FY23).

DBHDS could designate some private hospitals to admit forensic patients

There is a widespread perception that all inpatient psychiatric forensic patients must be admitted to Virginia’s state psychiatric hospitals, but state law does not require that forensic patients be treated at state hospitals. State law gives the DBHDS commissioner the ability to designate certain hospitals for these forensic patients but does not limit the hospitals that can be used. It does not appear that any hospitals—state run or privately run—have been formally designated as appropriate facilities to place competency restoration and forensic TDO patients. State law says, “any inmate of a local correctional facility may be hospitalized for psychiatric treatment *at a hospital designated by the Commissioner of Behavioral Health and Developmental Services as appropriate* for treatment of persons under criminal charge.” Regarding competency restoration, state law states that once a defendant is determined to be incompetent, “the court shall order that the defendant receive treatment to restore his competency on an outpatient basis or...*at a hospital designated by the Commissioner of Behavioral Health and Developmental Services as appropriate* for treatment of persons under criminal charge.”

If state hospitals remain the only inpatient setting for treating forensic patients, the capacity pressures on state hospitals are likely to worsen. The increasing prevalence of mental illness among individuals charged with a crime is well documented. This increasing forensic population creates staff and patient safety risks because state hospitals are already operating at unsafe capacity levels, and some forensic patients can be especially aggressive, according to state hospital staff.

State law gives the DBHDS commissioner the authority and discretion to ensure that the burden of treating these patients does not fall exclusively on state-run hospitals, but no commissioners appear to have exercised this authority in recent years. The

commissioner could lessen, although not eliminate, these risks by exercising this authority.

Leaders at private psychiatric hospitals and stakeholders are likely to express several concerns about taking forensic patients. For example, they likely will have concerns about whether these facilities are equipped with the staff or security measures and precautions to accept and treat individuals with a mental illness who have, or who are alleged to have, committed a crime. They are also likely to express concerns about the difficulty of receiving reimbursements from private insurance or Medicaid for treating criminally involved patients.

Nevertheless, as described in Chapter 3, some private hospitals have unused bed capacity, and the commissioner should work with one or more privately operated hospitals to receive a limited number of forensic patients, potentially limited to certain types of forensic patients, such as those charged with misdemeanors. The commissioner should work with hospital leadership to determine what, if any, additional one-time and ongoing resources would be needed to accommodate some forensic patients, such as for security staff or facility modifications, and develop a plan to secure these resources and a timeline for when admissions can begin.

DBHDS could issue a request for proposals (RFP) to private hospitals that specifies the numbers and types of forensic patients the state designates as appropriate for admission to private hospitals. The RFP could also specify other parameters, such as hospital security and staffing requirements and treatment capabilities. The RFP would allow the state and interested private hospitals to negotiate the terms of a contractual arrangement.

RECOMMENDATION 15

The Department of Behavioral Health and Developmental Services should formally solicit proposals from state-licensed psychiatric hospitals or units in Virginia to admit (i) individuals placed under a temporary detention order while in a local jail and (ii) criminal defendants determined to need inpatient competency restoration services, and work with those hospitals that respond to develop a plan and timeline to contract with them to admit forensic patients.

NGRI admissions have remained relatively stable over the past decade but still make up a large proportion of total bed days

Individuals who have been acquitted of criminal charges after being found “not guilty by reason of insanity” (NGRI) are admitted to a state psychiatric hospital for an evaluation to determine whether they should be released to the community or remain in a state hospital for treatment and monitoring. A judge ultimately determines whether NGRI individuals remain in a state hospital after this evaluation based on whether they

(1) have a mental illness or intellectual disability, (2) are likely to present an imminent risk of harm to themselves or others, and (3) are likely to receive adequate supervision and outpatient treatment in the community.

Relatively few individuals are admitted to state hospitals under an NGRI status, but NGRI patients comprise a considerable amount of bed days. In FY23, 164 individuals were committed to a state hospital under an NGRI status, which accounted for only 3 percent of total admissions. However, NGRI patients discharged in FY23 spent a median of 466 days in state hospitals, compared with a median of 21 days for civil patients and 76 days for competency restoration patients. Since FY09, NGRI patients have used an annual average of 20 percent of total state hospital bed days.

Increasing the number of forensic evaluators would reportedly reduce the length of stay for some NGRI patients because, like competency restoration patients, a forensic evaluator must confirm that an NGRI patient meets the criteria for discharge before a judge will approve their release. More timely discharge evaluations for NGRI patients would not substantially reduce the length of stay for these patients, but, given the state hospital capacity challenges discussed in this and previous chapters, any reduction would better ensure patients requiring emergency psychiatric treatment receive it as soon as possible.

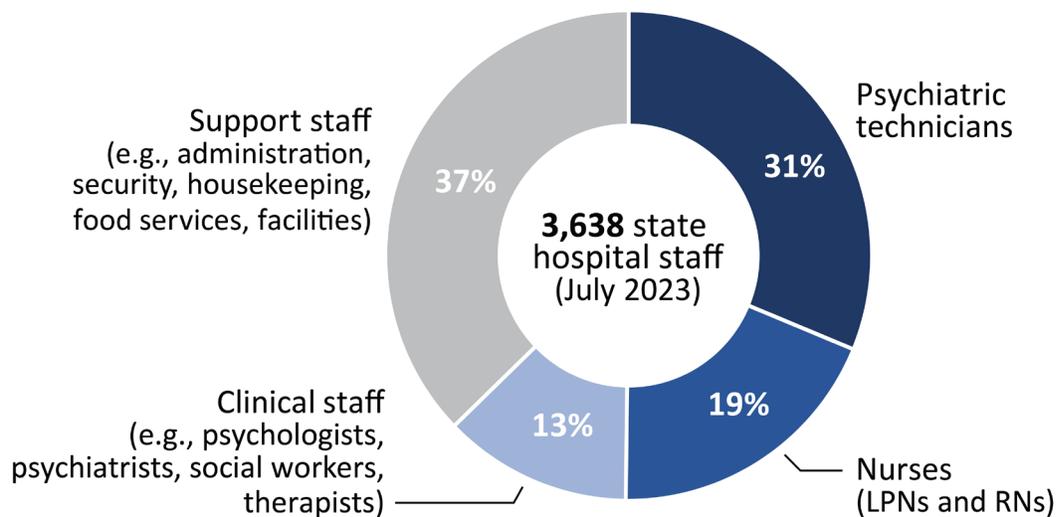
5 Staffing for State Psychiatric Hospitals

Having sufficient qualified staff is critical for state psychiatric hospitals' ability to provide patients with effective psychiatric treatment and maintain a safe environment for patients and employees. Hospitals also need to have sufficient staff to maximize the use of the facility's physical capacity while maintaining safe patient levels. In addition, sufficient staffing gives hospitals the flexibility to adjust appropriately to variations in admissions and patient conditions.

State psychiatric hospitals employ about 3,600 full-time staff, and most staff directly care for patients (Figure 5-1). State hospital *nursing staff*, including psychiatric technicians, licensed practical nurses, and registered nurses, are responsible for the day-to-day monitoring and caring of patients (sidebar). Patients at state hospitals also interact with *clinical staff*, including psychologists, psychiatrists, social workers, and therapists, during their stay, but less frequently than they interact with nursing staff. About a third of all state hospital staff support the operations of facilities. These *support staff* positions vary widely and include roles such as food services staff, human resources staff, and facility operations and maintenance staff. An additional 754 part-time staff, mostly psychiatric technicians and nurses, were employed by state hospitals in June 2023, totaling 4,336 full-time equivalent staff.

Job responsibilities of psychiatric technicians include assisting patients with tasks such as dressing, organizing group social activities, monitoring patients' safety throughout the day, and administering seclusion and restraint when needed.

FIGURE 5-1
State hospitals employ about 3,600 full-time staff (June 2023)



SOURCE: JLARC analyses of DBHDS human resources data.

NOTE: Limited to filled, full-time, salaried positions. Psychiatric technicians include certified nurse assistants. Nurse practitioners are classified as clinical. Some hospitals also employ contract staff. Contract staff not included in figure.

State hospitals struggle to recruit and retain staff, especially for certain clinical and nursing positions

Almost all states (41) reported experiencing substantial staffing shortages in their state-operated psychiatric hospitals and residential treatment centers, according to a 2022 report by the National Association of State Mental Health Program Directors.

Statewide and nationally, healthcare organizations are experiencing substantial challenges in recruiting and retaining sufficient numbers of qualified staff. According to the Virginia Health Workforce Development Authority, various factors contribute, including high patient-to-provider ratios, burnout, low wages, and violence in the workplace. In recent years, the General Assembly has taken steps to help state psychiatric hospitals with their staffing challenges, but recruiting and retaining staff for certain positions remains difficult for most hospitals.

Most state hospitals have experienced substantial turnover in recent years, especially among nursing and clinical positions

Prior JLARC reports found that key roles at state hospitals were among the most difficult to retain. In 2008, for example, JLARC staff found that registered nurses and licensed practical nurses had among the top five highest turnover rates of any state job role.

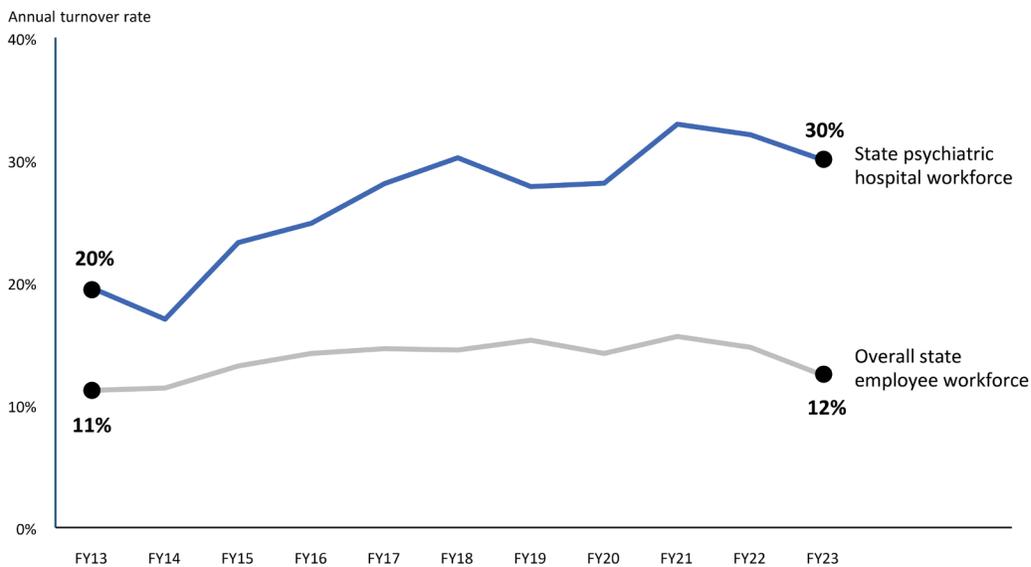
Statewide turnover across all state hospitals was 30 percent in FY23—over twice as high as the overall state government turnover rate. High turnover rates among state psychiatric hospital staff are a longstanding problem, but turnover has worsened over the past decade (sidebar). Annual state hospital turnover increased by 10 percentage points, from 20 percent in FY13 to 30 percent in FY23. Although state hospitals have consistently experienced higher turnover than the broader state government workforce, the gap between the turnover rate among state hospital employees and employees at other state agencies has steadily widened (Figure 5-2).

State hospitals' turnover rates in recent years have varied, but all have lost a considerable amount of staff. Four state hospitals turned over at least 45 percent of their staff between FY20 and FY23, including the Commonwealth Center for Children and Adolescents (CCCA), which turned over 63 percent of its staff during this period (Figure 5-3).

Across state hospitals, turnover has generally been the highest among nursing staff and social workers in recent years. Compared with all other staff roles, turnover between FY20 and FY23 was highest among psychiatric technicians, licensed practical nurses, registered nurses, and social workers. (Figure 5-4).

FIGURE 5-2

State hospitals have experienced higher annual turnover rates in recent years compared with prior years and with the overall state employee workforce

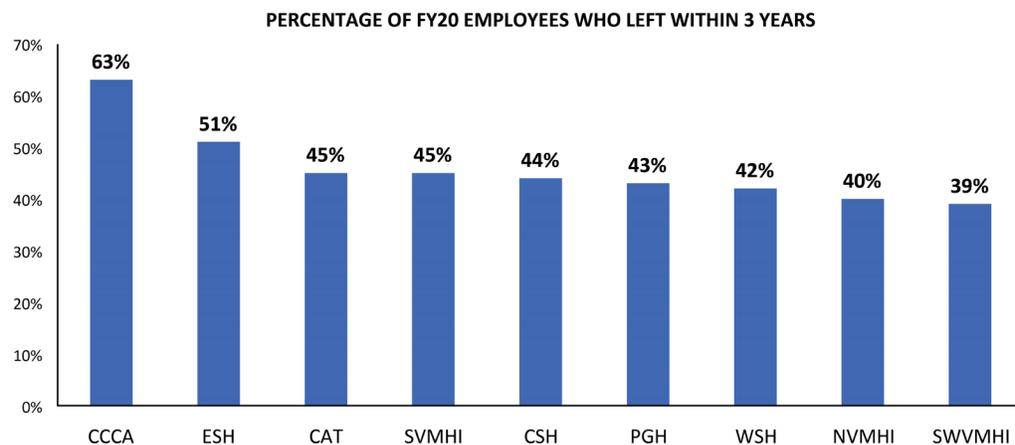


SOURCE: JLARC analysis of DHRM and DBHDS human resources data.

NOTE: Limited to full-time salaried staff. "Overall state employee workforce" includes state psychiatric staff, which comprise an estimated 6 percent of the total full-time classified state employee workforce. Actual turnover among the overall state employee workforce would be slightly lower if these positions were not included. The turnover rate for a fiscal year is defined as the number of staff departures during the year divided by the number of positions.

FIGURE 5-3

At most hospitals, nearly half or more of those employed in FY20 were no longer employed by the hospital in FY23

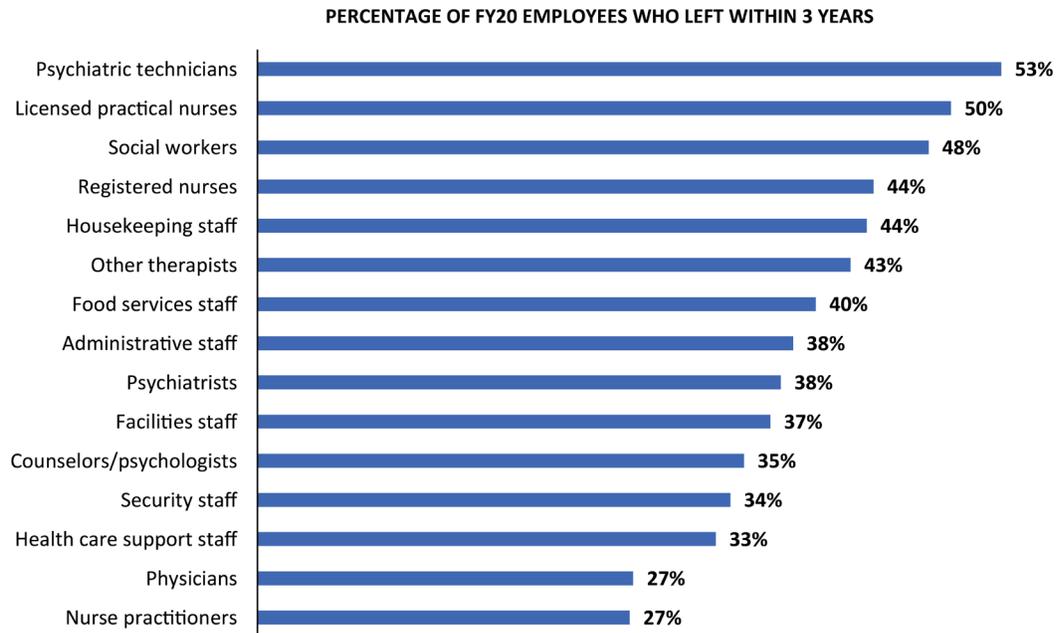


SOURCE: JLARC analysis of DHRM and DBHDS human resources data.

NOTE: Limited to full-time salaried staff. Figure represents the proportion of employees who were employed on June 30, 2020 but who were no longer employed by June 30, 2023.

FIGURE 5-4

Across state hospitals, turnover was generally highest among nursing and clinical staff, although some support staff roles had relatively high turnover



SOURCE: JLARC analysis of DHRM and DBHDS human resources data.

NOTE: Limited to full-time salaried staff. Figure represents the proportion of employees who were employed on June 30, 2020, but who were no longer employed by June 30, 2023. "Psychiatric technicians" include certified nurse assistants. "Other therapists" include positions such as occupational and recreational therapists. "Health care support staff" include positions such as pharmacists and health care compliance managers.

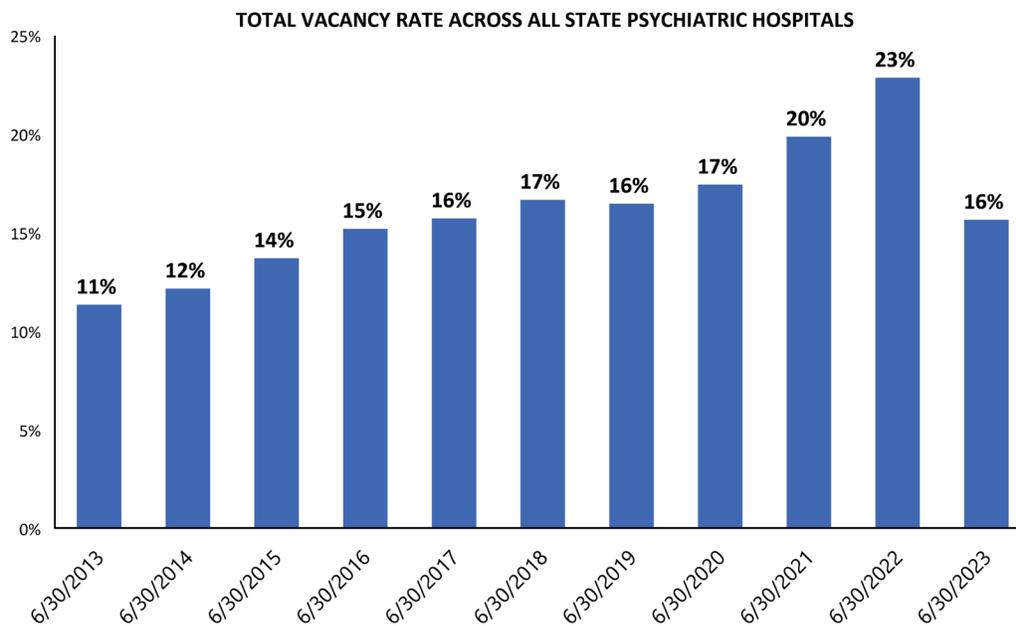
State hospitals have struggled to fill vacant positions

As turnover has increased, positions have become more difficult to fill, leading to higher vacancy rates. The total state hospital vacancy rate doubled between June 30, 2013 and June 30, 2022, from 11 percent to 23 percent. By June 30, 2023, vacancy rates had declined somewhat but were still notably higher than a decade prior and would have been 6 percentage points higher without contract staff (Figure 5-5).

By June 30, 2023, vacancy rates across hospitals varied considerably, from 9 percent at Southwestern Virginia Mental Health Institute to 19 percent at Eastern State Hospital. If contractor positions are excluded, vacancy rates would have been the highest at the Commonwealth Center for Children and Adolescents (43 percent) and Eastern State Hospital (33 percent).

Certain full-time staff positions at state hospitals are also more likely to be vacant than a decade ago. Vacancy rates among full-time classified staff positions at the end of FY23 were the highest among licensed practical nurses (49 percent), psychiatrists (28 percent), psychiatric technicians (25 percent), housekeeping staff (25 percent), registered nurses (24 percent), facilities staff (22 percent), and food services staff (17 percent). All of these positions had higher vacancy rates than at the end of FY13.

FIGURE 5-5
State hospital system has experienced higher vacancy rates, especially during the COVID-19 pandemic



SOURCE: JLARC analysis of DHRM and DBHDS human resources data.

NOTE: Figure shows vacancy rates among full-time staff positions that were not filled by either full-time staff or a temporary contract position. Part-time positions are not included in this analysis.

Delays in hiring process may unnecessarily prolong vacancies

Some state hospitals are slower to fill positions than other state government agencies. Of positions that became open in 2023 in other state government agencies, 26 percent took more than 100 days to fill. In aggregate, state hospitals were similar, with 25 percent of jobs taking more than 100 days to fill. However, the percentage of jobs taking more than 100 days to fill was especially high for Eastern State Hospital (48 percent), Commonwealth Center for Children and Adolescents (41 percent) and Western State Hospital (34 percent).

Staff from several state hospitals reported frustration with delays in the hiring process. For example, one state hospital chief nursing executive reported having recently interviewed an individual who had applied two months prior. An employee at a different state hospital noted that, “[The] hiring process needs to be better, no waiting a month to get an interview, and no waiting a month to get accepted.” According to another state hospital employee, “I applied for a position which would be mission critical for addressing growing numbers of competency restoration admissions, and HR has yet to inform me either way...now over two months later.”

According to state hospitals, manual and inefficient human resources processes slow recruiting. One hospital described 35 paper forms that need to be completed for new

Days to fill means the number of calendar days between a job being posted and filled. This metric is limited to jobs that were eventually filled.

hires, and stated some individuals who were offered jobs left because the onboarding process took so long. The human resources director at another hospital noted that their recruitment processes take twice as long as the state agency where she previously worked.

DBHDS central office staff have observed that at least some state hospitals need to respond more quickly to applicants for open positions because healthcare recruiting is highly competitive. DBHDS has increased its support and scrutiny of state hospital recruitment in the last year. The central office began holding quarterly meetings to discuss staffing metrics in September 2022, including vacancy rates and recruiting timeliness. Additionally, DBHDS staff help the state hospitals by occasionally assisting with recruitment activities, such as interviewing applicants. Given the importance of filling staff vacancies quickly, DBHDS should provide ongoing, proactive support to each state psychiatric hospital's human resources office and identify ways to streamline the hiring process. DBHDS should also work with the Department of Human Resource Management to measure the amount of time elapsed between when a position becomes vacant, when the state hospital first advertises hiring for the position, and when it is filled. This would allow DBHDS to provide targeted oversight and technical assistance to state hospital human resources departments that take relatively longer to advertise for and fill open positions that are critical to hospital operations and patient care.

RECOMMENDATION 16

The Department of Behavioral Health and Developmental Services should (i) work with the Department of Human Resource Management (DHRM) to annually measure, using available DHRM data on state hospital recruitment actions, the amount of time elapsed between when a state hospital position becomes vacant, when the position is advertised, and when the position is filled, (ii) use the results of this analysis to compare hospitals' performance in filling vacancies, especially for nursing and clinical positions that are critical to patient care, and (iii) identify hospitals that appear to be underperforming and provide technical assistance, oversight, and resources to improve such hospitals' ability to fill critical vacant positions in a timely manner.

State hospital staffing problems contribute to increased costs

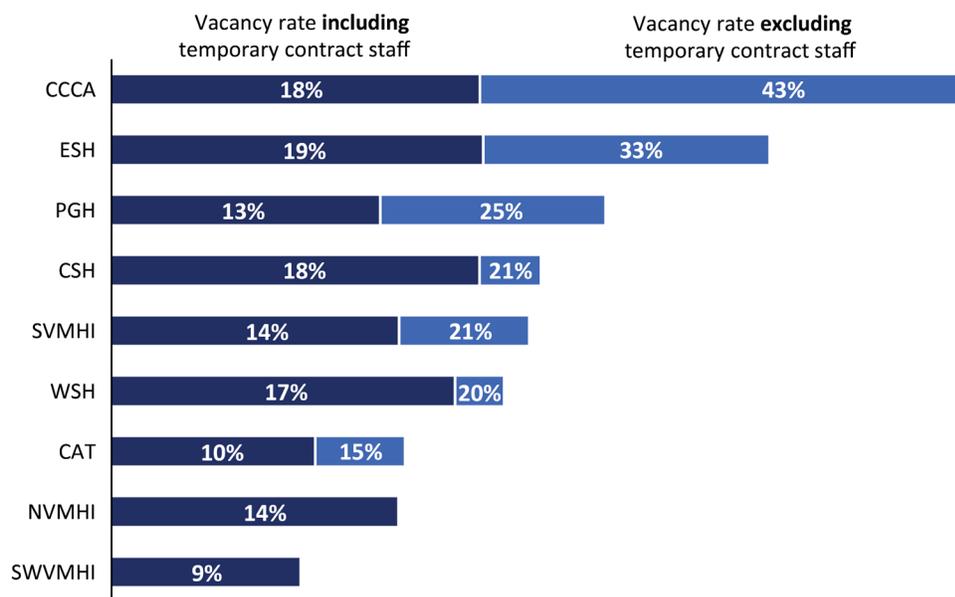
Recruitment and retention challenges have had several implications for state hospital costs and operations. In recent years, some state hospitals have significantly increased their reliance on overtime and temporary contractors, which has increased operating costs. Furthermore, state hospital leadership and other staff attributed their concerns about patient care and safety to staffing shortages.

In response to staffing shortages, most state hospitals are using contractors and overtime, which increase costs

Most state psychiatric hospitals have increased their use of temporary contract staff to fill vacant positions, and these contract staff have increased state hospital operating costs. In FY23, 10 percent of total nursing hours (including hours worked by both nurses and psychiatric technicians) were worked by contractors, and this was 18 times higher than in FY15 (0.6 percent).

Some state hospitals are much more dependent on contract staff than others. At the end of FY23, the Commonwealth Center for Children and Adolescents, Eastern State Hospital, and Piedmont Geriatric Hospital were heavily reliant on contractors to reduce vacancy rates (Figure 5-6). In contrast, Southwestern Virginia Mental Health Institute and Northern Virginia Mental Health Institute did not employ any contract staff at the end of FY23.

FIGURE 5-6
Certain state hospitals are heavily reliant on contract staff to keep vacancy rates lower (June 2023)



SOURCE: JLARC analysis of DBHDS human resources data.
 NOTE: Limited to full-time salaried staff and temporary contract positions.

Although the use of contract staff has helped reduce vacancy rates, they are expensive, and state hospital costs for contractors have increased substantially over the past several years. Across state hospitals, at least \$47 million was spent on contractual labor in FY23, 13 times the amount in FY13 (\$4 million, adjusted for inflation). Spending on contractors rose as a share of total state hospital spending, from 1 percent in FY13 to 9 percent in FY23.

On a per-staff basis, contractors are much more expensive. State hospitals spent between two to three times as much on each contract psychiatric technician, nurse, and psychiatrist than if they were employed directly by the facility.

Aside from costs, state hospital leadership and staff expressed concerns about the growing reliance on contractors for their hospitals' operations. The temporary nature of these positions (typically no more than 13 weeks) guarantees the need to train new staff on state hospital policies and procedures regularly. In interviews and a survey, staff also expressed frustration with some contractors' quality of care or commitment to their roles, given their temporary nature and their relatively high pay compared with full-time staff.

DBHDS central office has also reported concerns about the state's growing reliance on contract staff. In a recent decision package, DBHDS reported that contract staff "have proven in many instances to be a disruption to the continuity of care, unreliable and extremely expensive" and that "the use of contract labor is costly and is not a long-term solution to [fill vacancies], nor an efficient use of taxpayer resources."

State hospital staff are also being asked to work more overtime, both on a mandatory or volunteer basis, than a decade ago to help address staffing shortages, and the additional overtime has added to state psychiatric hospital costs. Over the last decade, the amount of total state hospital employee compensation spent on overtime more than tripled, from \$7.6 million in FY13 (adjusting for inflation) to \$20 million in FY23. Overtime spending as a percentage of total spending varied by state hospital, from 1 percent at Southwest Virginia Mental Health Institute to 8 percent at Northern Virginia Mental Health Institute.

In total, the amount spent on overtime and contracting has increased significantly in the last decade. Combined overtime and contracting costs are more than six times higher than a decade prior, rising from \$11 million in FY13 (adjusting for inflation) to \$67 million in FY23.

Staffing shortages are contributing to decreased quality of care and increased safety risks, according to state psychiatric hospital staff

Perhaps most importantly, patients are experiencing the effects of staffing shortages, according to leadership and staff of state hospitals. In response to JLARC's survey, the most common reason cited by state hospital staff who believed their hospital was unsafe for patients was that there were not enough nursing and clinical staff. Similarly, among staff who rated the quality of care in their facility as less than excellent, "inadequate nursing and clinical staff" was cited most commonly as the reason for their lower rating.

(See Chapters 6 and 7 for more information on the effects of staffing on safety and quality of care.)

Many staff who are not in leadership roles also believe there is an inadequate number of staff to care for patients appropriately. When asked in a JLARC survey whether

"[This state hospital] would be a great place to work if we had enough staff to make it more safe for the patients and staff and be able to have time to work with the patients more."

— State hospital nursing staff

there were enough staff in their hospital over the past five days, the majority (57 percent) of nursing and clinical staff responded that they lacked enough staff on three or more of those days. Twenty-eight percent of nursing and clinical staff believe they usually lack enough time to give patients the attention they need, and this belief was especially common among social workers, case managers, and psychologists. At least 20 percent of nursing and clinical staff at each hospital believed that they usually lacked adequate time for patients.

Concerns related to pay, scheduling, personal safety, and support are driving state hospital staffing difficulties

Various factors make it challenging for state hospitals to recruit and retain sufficient numbers of qualified staff. Some factors outside the direct control of the state or state hospitals, including a broader hospital and behavioral health workforce shortage, contribute to recruitment and retention challenges. However, steps can be taken by state hospitals, DBHDS, and the General Assembly to mitigate those factors that are within the state's direct control.

In response to JLARC's survey, about 20 percent of staff (263) reported that they were considering leaving within the next six months, and about 60 percent of these staff reported they were "strongly considering" leaving. Inadequate pay, unsafe working conditions, inflexible and unpredictable schedules, and a lack of support from leadership and supervisors appear to be the primary drivers of state hospital recruitment and retention issues.

Hospital leadership and staff who are planning to leave identify uncompetitive pay as a problem

Uncompetitive pay among certain positions appears to be a key reason for staffing difficulties, according to JLARC's survey of state hospital staff and interviews with state hospital leadership. Some positions may be compensated competitively, relative to the market, but staff in these positions remain dissatisfied with their pay given the stressful, unpredictable, and often dangerous working conditions at state hospitals.

About 46 percent of all surveyed state hospital staff reported being dissatisfied with their salary or wages. Housekeeping staff, therapists, certain support staff positions, pharmacy staff, and psychiatric technicians reported the highest levels of dissatisfaction (Figure 5-7).

Uncompetitive pay is the leading reason staff reported they were planning to leave. Among the surveyed staff who reported plans to leave their job at their state hospital within the next six months, the most common reason cited was, "I believe other employers offer higher pay (salaries or wages)" (47 percent).

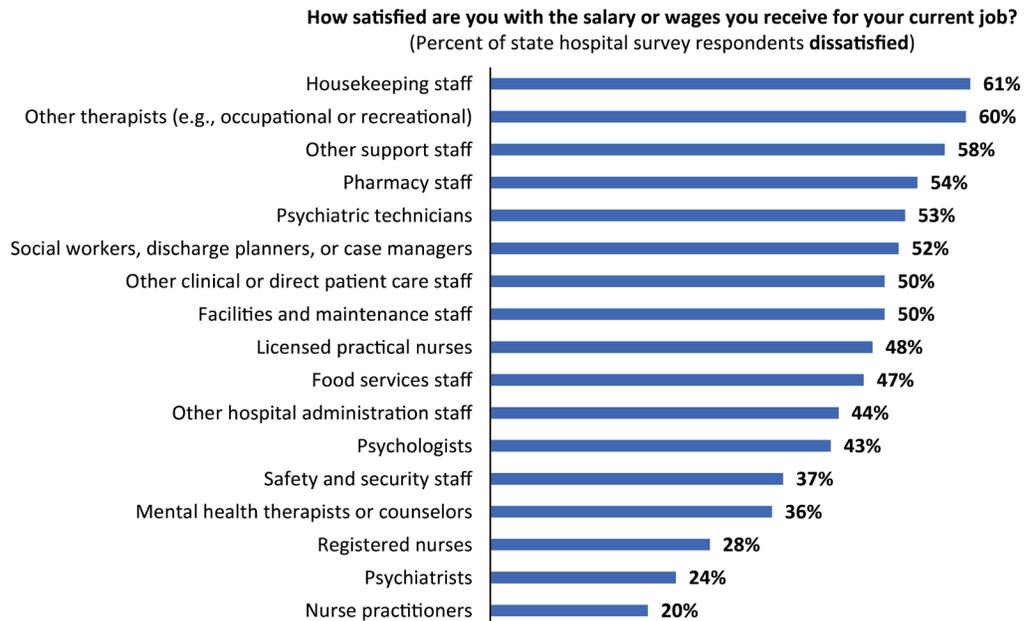
“
[When staff don't have time, their role] turns into custodial – we are watching them – as opposed to engaging them.
”

– State hospital psychosocial rehabilitation director

The source of DBHDS's reserves funds are general funds not spent in prior years. DBHDS central office uses these funds on an as-needed basis to meet specific needs at state hospitals on a case-by-case basis.

The primary source of funds available to state hospitals to increase compensation when needed to hire or retain staff, through actions such as bonuses, is “vacancy savings” (funds that they had planned to spend but did not because of staff turnover and unfilled positions). However, reliance on vacancy savings for supplemental compensation actions may disincentivize hospitals to fill vacant positions, which is counterproductive under the current circumstances. DBHDS can also use “reserve funds” (sidebar) for compensation actions, but these funds are generally used for critical non-personnel needs (e.g., the replacement of an HVAC system or pharmaceutical supplies).

FIGURE 5-7
Satisfaction with pay varied across surveyed state hospital positions (August 2023)



SOURCE: JLARC survey of state psychiatric hospital staff (N = 1,283).

NOTE: Excludes contract staff and roles for which there were 10 or fewer responses. “Other hospital administration staff” includes staff for functions such as human resources, finance, and information technology. “Patient care technician,” “psychiatric technician,” and “direct service associate” are all psychiatric technician positions.

Available benchmarking data indicates at least some state hospital roles are paid at less-than-competitive rates, and some of the roles most commonly reporting dissatisfaction with pay on the survey pay salaries below benchmarks. Positions that were benchmarked to have the least competitive pay compared to the regional median pay are psychologists, social workers, housekeeping staff, and food services staff, according to data from Mercer (Table 5-1). In contrast, nursing staff, including nurses and psychiatric technicians, are paid more competitively, which could be the outcome of recent targeted actions by the General Assembly (sidebar).

The General Assembly should appropriate funds for targeted salary increases for state hospital staff and require DBHDS to report annually on turnover, vacancy rates, and salary competitiveness across state hospitals to monitor changes in their workforce challenges. Salary increases should be prioritized for psychologists, social workers, and housekeeping and food services staff.

The General Assembly appropriated \$46 million for state hospital nursing staff in FY23. These actions, in addition to across-the-board state employee raises appropriated by the General Assembly, have helped make the salaries for nurses and psychiatric technicians more competitive.

TABLE 5-1
State hospitals pay nursing staff competitively, but pay for psychologists, social workers, food services, and housekeeping is less than the regional median

State hospital role	Comparable roles	State hospital pay compared with regional market median	
Nurse practitioner	Nurse practitioner	↑	+20%
Psychiatric technician, with CNA	Long-term care CNA	↑	+18
Registered nurse	Long-term care RN	↑	+18
	Psychiatric RN	↑	+17
Psychiatric technician, without CNA	Mental health assistant	↔	+6
Psychiatrist	Psychiatrist	↔	+5
LPN	Long-term care LPN	↔	+3
Recreation therapist	Long-term care recreation therapist	↔	0
Pharmacist	Pharmacist	↔	-5
Social worker	Social worker with Masters'	↓	-10
	Social worker with LCSW	↓	-17
Psychologist	Psychologist	↓	-20
Food services staff	Hospital food services worker	↓	-21
Housekeeping staff	Hospital housekeeper	↓	-23

Key:
 ↔ State hospital median within 10% of regional median
 ↑ State hospital median more than 10% above regional median
 ↓ State hospital median more than 10% below regional median

SOURCE: JLARC analysis of DBHDS human resources data and Mercer 2023 Healthcare Individual Contributors and Senior Living/Nursing Homes/Long-Term Care Facilities surveys.

NOTE: There is no statutory or policy guidance about what Virginia considers “comparable” compensation, but JLARC staff considered between 90 percent and 110 percent of the market median to be a competitive range. Regional median is the Southeast United States median. DBHDS data reflects state hospital compensation as of March 31, 2023; Mercer data reflects compensation as of March 1, 2023.

RECOMMENDATION 17

The General Assembly may wish to consider including funding in the Appropriation Act to provide salary increases for psychologists, social workers, housekeeping, and food services staff at state psychiatric hospitals that will bring these positions’ salaries within 10 percent of the median salary paid to these positions by other health care employers in the region.

RECOMMENDATION 18

The General Assembly may wish to consider including language in the Appropriation Act directing the Department of Behavioral Health and Developmental Services to report annually to the Behavioral Health Commission on average turnover and vacancy rates and salary competitiveness, by hospital and position type, for the state’s psychiatric hospitals.

Unsafe working conditions are also cited as a key reason for turnover, and staff injuries far exceed other state government jobs

Salary increases are important but are unlikely to improve staffing levels without addressing other root causes of understaffing. State psychiatric hospitals are stressful and unsafe environments, which will inevitably cause many staff to seek employment in environments that offer better working conditions. This is likely true even if the pay offered by other employers is the same or less than state hospitals’ pay.

Unsafe working conditions appear to more frequently be a concern among front-line nursing and clinical staff at state psychiatric hospitals. In survey responses, front-line staff with the most frequent interactions with patients, including nurses, psychiatric technicians, psychologists, and social workers, were more likely than other staff to report that they felt their hospital was unsafe for staff (Figure 5-8). Staff at Southern Virginia Mental Health Institute, Western State Hospital, and the Commonwealth Center for Children and Adolescents were the most likely to disagree that their hospital was a safe place for staff.

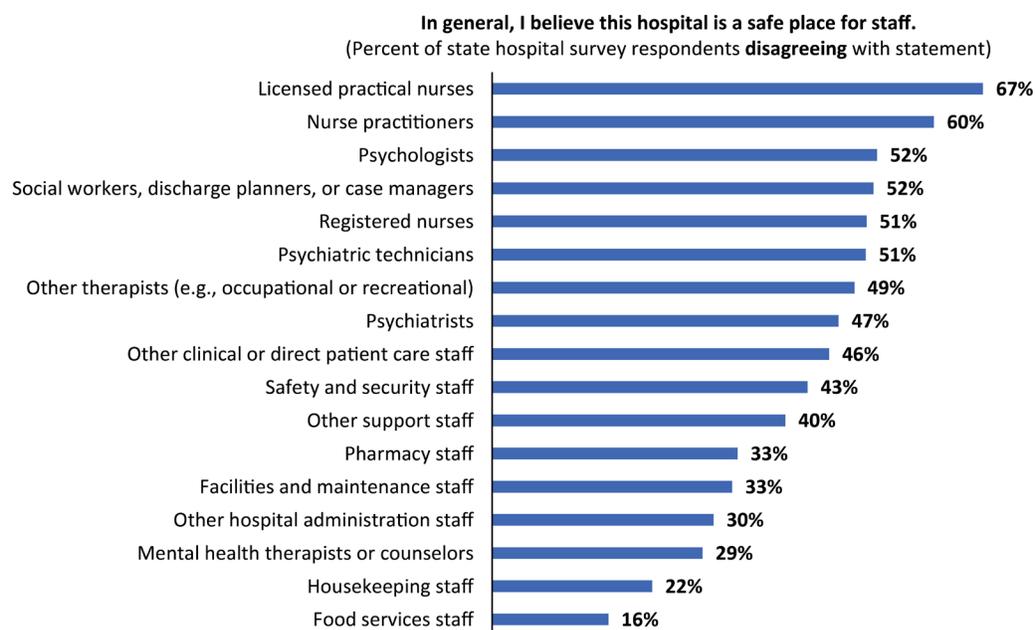
Many staff do not believe hospital leaders do enough to mitigate risks. About half of nursing and clinical staff disagreed that their hospital “does everything it can to protect staff from physical harm caused by patients.” These concerns were widespread, expressed by a majority of either registered nurses or psychiatric technicians at eight of nine hospitals.

In interviews, state hospital human resources staff and chief nurse executives described how the unsafe work environment contributes to staffing challenges. For example, one human resources director noted, “If [employees] don’t feel safe on the

National data indicates that private-sector inpatient psychiatric settings are also risky work environments. Behavioral health hospitals reported more than twice the staff injury rate of the other private sector establishments in 2021.

unit, then it doesn't matter how much you pay them." Another human resources director described how some severe staff injuries were well known in the local area, and that these reports have exacerbated their hospital's recruitment challenges. A chief nurse executive at another hospital reported that new hires "go to the unit and feel unsafe, [and] that is when they decide they cannot work here. That is why we have a lot of turnover."

FIGURE 5-8
Front-line nursing and clinical staff were more likely to disagree that their hospital was a safe place for staff (August 2023)



SOURCE: JLARC survey of state psychiatric hospital staff (N = 1,283).

NOTE: Excludes contract staff and roles for which there were 10 or fewer responses. "Other hospital administration staff" includes staff for functions such as human resources, finance, and information technology. "Patient care technician," "psychiatric technician," and "direct service associate" are all psychiatric technician positions.

Available workers' compensation data indicates that staff injuries occur at state hospitals much more frequently than other state agencies. In FY22, Virginia's state hospitals had *seven times* the rate of paid workers' compensation claims as employees in other state government agencies. Workers' compensation claims at state hospitals exceeded those at other agencies, even when compared with similar occupations.

Recommendations in this chapter intended to mitigate staffing shortages will help make state hospitals a safer environment for staff. In addition, other chapters of this report include recommendations that, if implemented, will help improve staff safety.

Examples of such recommendations include allowing state hospitals to operate at capacity levels generally considered safe in the industry and requiring and supporting the admission of patients to privately operated hospitals. (See Chapters 3 and 4 for more information on these recommendations.)

Inflexible or unpredictable scheduling is also a substantial contributor to nursing staff dissatisfaction

Another common concern that state hospital nursing staff reported was their hospital's work scheduling. In response to JLARC's survey, one in five state hospital nursing staff (i.e., nurses and psychiatric technicians) reported being dissatisfied with their work schedule, and one in four registered nurses who predicted that they would leave their jobs in the next six months cited schedules as a top reason they were planning to leave. More than half (55 percent) disagreed that their state hospitals' strategy for scheduling nursing and clinical staff makes the best use of staff resources.

“Our inability to offer solely 12-hour shifts] has been a deal breaker for some of the people we offer positions to.”

— State hospital chief nurse executive

In interviews and survey responses, leadership and staff at some hospitals expressed frustration with their hospital's inability to offer 12-hour shifts to their employees. Offering staff 12-hour shifts, totaling 36 hours per week, is a common practice in the healthcare industry and can support a better work-life balance among staff. Several state hospitals that have operated on 12-hour shifts reported to JLARC staff that it has helped with their recruitment and retention efforts.

Technically, state hospitals can already offer 12-hour shifts to employees, but current state policy makes doing so less practical for hospitals and desirable for staff. Department of Human Resource Management (DHRM) policy currently allows state employees to work fewer than 40 hours per week. However, if employees do so, they must have their pay and leave reduced proportionally (e.g., working 36 hours is a 10 percent reduction in hours and requires a 10 percent reduction in pay). The reduction in pay also reduces the employee's retirement benefits, which are based on the employee's actual compensation levels.

Although a policy that requires pay and leave to be reduced proportionately to hours worked appears reasonable for most state agencies, it places the state hospitals at a disadvantage in competing against other employers who can offer 12-hour shifts, which is a common industry practice. State policy should be amended to provide an exception to allow state hospitals to offer 12-hour shifts where it is practicable and desired among staff.

RECOMMENDATION 19

The General Assembly may wish to include language in the Appropriation Act directing the Department of Human Resource Management to allow state hospitals to define nursing staff (including psychiatric technicians) who work at least 36 hours per week as full-time staff and not require reductions in pay or other benefits among those staff who work at least 36 hours per week.

State hospitals rely on manual processes or poorly designed software to schedule nursing staff, and staff scheduling at state hospitals is complex. Developing nursing staff schedules is complicated because of the unpredictability of patient needs and acuity during any given week, nursing staff shortages, staff availability and preferences, and internal policies such as the number of consecutive hours an employee can work. State hospital staff reported that it is common for new patients to arrive with little notice. They also reported that it is common for one or more patients to suddenly need a nursing staff member to monitor them exclusively (a “one-on-one monitor”), which reduces the number of nursing staff available to the rest of the patients.

Scheduling software can facilitate changes to planned staffing schedules in response to such situations and send text notifications to multiple off-duty staff to offer them an additional shift. This latter feature is far more efficient than having a scheduling coordinator phone each off-duty staff member individually. Several hospitals have explored the possibility of procuring scheduling software but were reportedly deterred by the cost, DBHDS’s response, and the state’s IT security requirements. DBHDS estimated the cost of new time-keeping software (including scheduling) to be approximately \$815,000 over two years.

RECOMMENDATION 20

The General Assembly may wish to consider including funding in the Appropriation Act for the Department of Behavioral Health and Developmental Services to procure scheduling software to assist state hospitals in scheduling nursing shifts.

Staffing committees are another approach that could improve nursing staff satisfaction with their schedules. The American Nurses Association recommends that hospitals use staffing committees to create staffing plans and that line-level nurses comprise at least half of the committee members. Eight states have statutory requirements that hospitals maintain staffing committees.

Virginia’s state hospitals could organize staffing committees to ensure employee perspectives on schedule design and implementation are considered. For example, these committees could collect staff preferences for shift length and review data on overtime to evaluate ways to expand 12-hour shifts. These committees could also support nursing retention efforts by providing line-level staff feedback and involvement with initiatives to reduce turnover.

Inadequate support from supervisors and leadership was also cited as a key reason why front-line staff are considering leaving

Lack of support from supervisors and leadership also contributes to high rates of staff turnover. A feeling of inadequate support reflects a wide continuum of grievances, such as perceptions that managers are unqualified, lack leadership skills, make unfair salary decisions, and enforce internal rules inconsistently (sidebar). About one-fifth of all nursing and clinical staff described the support they receive from their

Examples of staff complaints included:

- “Over the years I have [seen] a lot of hard-working and dedicated staff ... leave because of the raises not being fairly distributed.”
 - “The favoritism needs to stop or more people will be leaving.”
 - “Clinical staff are leaving due to lack of leadership.”
-

supervisor as inadequate. Of all nursing and clinical staff who reported planning to leave their jobs in six months, 39 percent cited inadequate support from supervisors and hospital leaders as a top reason.

As described in other chapters of this report, most state hospitals have more patients than they can safely accommodate, and the combination of high patient volumes and low staffing levels inherently limits the time hospital leaders and supervisors can spend on activities to support direct care staff. In JLARC’s survey, about one-quarter of supervisors to direct care staff said that they lack enough time to “provide effective guidance and support” to their direct reports. Implementing recommendations to reduce state hospital operating levels to manageable and safe levels would likely enable more supportive environments for staff.

DBHDS central office needs to assess the adequacy of hospital staffing levels on an ongoing basis

The recommendations in this chapter will help state hospitals’ recruitment and retention efforts, but the state needs a better understanding of state hospital staffing needs. The number and type of positions at state hospitals are not a result of intentional planning but are rather based on historical staffing levels and available funding.

Virginia does not have specific staffing standards for either its state or privately operated psychiatric hospitals, and there is no industry consensus or federal requirement regarding the ratio of direct care staff to psychiatric hospital patients (sidebar). The lack of mandatory staffing standards or ratios in the industry is partly because “adequate staffing levels” for any facility will depend on various factors, including patient characteristics, facility features, and even the time of day. For example, facilities with high numbers of acutely ill or aggressive patients need more staff than those with more stabilized conditions or who are not aggressive. Facilities with units that have poor lines of sight require more staff than those where nursing staff can readily monitor patients. Generally, night shifts require fewer front-line staff than day shifts.

DBHDS has taken steps to define adequate staffing levels at state psychiatric hospitals. A workgroup composed of chief nurse executives from Virginia state psychiatric hospitals determined in 2022 that state hospitals needed to operate at 9.1 to 13.2 nursing hours per patient day (HPPD), depending on the type of unit (ranging from 9.1 for geriatric care units to 13.2 for acute care/admissions units) (sidebar). However, in practice, the actual statewide HPPD in FY23 was 6.8—lower than the staffing levels needed to provide adequate care for patients in the *least* intensive unit, and about half the staff hours needed to care for patients in the most intensive units adequately.

Only one state hospital (Commonwealth Center for Children and Adolescents) had an HPPD that exceeded the 9.1 HPPD minimum in FY23. Notably, the state hospital with the *lowest* HPPD in FY23 (Southern Virginia Mental Health Institute) was also the one where surveyed staff were the most likely to report that they did not believe their hospital was a safe place for either patients or staff.

Virginia’s licensing requirements for private psychiatric hospitals do not mandate a minimum number of staff. DBHDS regulations require private psychiatric hospitals or hospital units to have a “written staffing plan that includes the types, roles, and numbers of employees and contractors that are required to provide the service.”

Nursing hours per patient day (HPPD) means the total number of hours worked by nurses and psychiatric technicians *divided* by the number of patients in the same time period. Consider a theoretical Monday with 20 patients, an eight-hour day shift of 10 staff (nurses plus psychiatric technicians), an eight-hour evening shift of eight staff, and an eight-hour night shift of four staff. That 24-hour period HPPD is:

$$\frac{(10 \times 8) + (8 \times 8) + (4 \times 8)}{20} = 8.8$$

DBHDS has directed state hospitals to set a staffing goal below the workgroup's estimates—at seven hours per patient day—because of funding constraints. DBHDS does not have the funding for hospitals to meet the minimum workgroup-recommended 9.1 HPPD and has not requested funding to achieve the recommended minimum.

The DBHDS workgroup included chief nurse executives from the state hospitals and several DBHDS central office subject experts. The workgroup reviewed research literature on staffing and relied on their own subject-matter expertise to develop recommended ratios of patients per psychiatric technician, licensed practical nurse, and registered nurse, and the ratios accounted for various types of patients. The workgroup's recommendations reflected realistic assumptions for bed utilization and the number of patients needing one-on-one monitors and accounted for overtime hours.

The General Assembly should provide funding to allow state hospitals to increase the number of nursing positions to help state hospitals get closer to the workgroup's HPPD recommendations. This may require additional funding to attract prospective employees to vacant positions and the creation of additional nursing positions. Because of state hospitals' recruitment challenges, it is unrealistic to expect additional funding to yield a near-term increase in the number of staff hired for any newly created positions.

RECOMMENDATION 21

The General Assembly may wish to include language and funding in the Appropriation Act to (i) increase the number of nursing positions allocated to state psychiatric hospitals to a level that would ensure adequate and safe patient care, as determined in 2022 by the Department of Behavioral Health and Developmental Services (DBHDS) and (ii) appropriate the amount of funding necessary to fill those positions.

Recommendation 21 focuses on nursing staff, but other staff roles can also greatly affect facility operations, patient and staff safety, quality of care, and timeliness of discharge. A broader assessment of the adequacy of each hospital's planned and actual staffing levels beyond only nursing staff, including numbers of food services staff, social workers, psychiatrists, and psychologists, would provide more transparency into the needs of each hospital. It would also allow the General Assembly to understand where to target funding.

Currently, the General Assembly relies on ad-hoc requests by DBHDS for funding. Regular, rigorous assessments of state hospitals' staffing needs would ensure that state hospital leadership, DBHDS, and the General Assembly are aware of the need to increase, reduce, or repurpose positions at state hospitals.

DBHDS should hire a contractor with expertise in psychiatric hospital staffing to conduct the initial assessment and provide DBHDS with sufficient information to allow it to conduct similar assessments at least biennially. Reports from both the initial and

Two states for which data on HPPD in their state psychiatric hospitals were available had higher reported HPPD than DBHDS's goal. Minnesota reported 11 HPPD in their psychiatric hospital, and Washington reported eight HPPD across both of their psychiatric hospitals.

ongoing assessments should be provided to the General Assembly through the Behavioral Health Commission.

RECOMMENDATION 22

The General Assembly may wish to consider including language in the Appropriation Act to direct the Department of Behavioral Health and Developmental Services to (i) contract for an assessment of the adequacy of each hospital's planned and actual staffing levels for key positions affecting facility operations, patient and staff safety, and quality of care; (ii) conduct similar assessments of the adequacy of each state hospital staffing levels at least biennially; and (iii) report the results of the initial and ongoing assessments to the Behavioral Health Commission, and any additional funding needed to address any staffing level deficiencies, to the chairs of the House Appropriations and Finance and Senate Finance and Appropriations committees.

6 Ensuring State Hospital Patient Safety

Patients in state psychiatric hospitals are entitled to an environment that protects them from harm caused by staff, peer patients, and themselves. According to state law, state hospital facility directors are responsible for the safe operations of their facility. State and federal law entitles patients to specific human and legal rights and requires timely, impartial investigations of alleged violations of these rights. Federal civil rights law also requires state psychiatric hospitals to adequately protect patients from unconstitutional conditions, including abuse, inappropriate use of seclusion and restraint, and other substandard forms of care (sidebar). State psychiatric hospitals across the U.S. have been subjected to federal investigations and lawsuits for violations of patient rights and inadequate safeguards from dangerous conditions.

Virginia does not “license” state psychiatric hospitals, as it does privately run psychiatric hospitals, but does oversee patient safety at state hospitals. DBHDS’s Office of Human Rights oversees the hospitals and assigns five staff members to review human rights investigations that are conducted by state hospital staff (sidebar).

As of October 2023, all state hospitals are accredited by the Joint Commission (tJC), a national accrediting agency. Accreditation by tJC is one way hospitals can achieve and maintain Centers for Medicare and Medicaid Services (CMS) certification to receive Medicaid and Medicare funding. The commission performs periodic reviews of state hospital operations and is notified of severe events, such as patient suicides (sidebar). When tJC identifies problems, state hospitals are required to correct them to remain accredited, although accreditation is not required by state or federal law.

Two other entities responsible for monitoring patient safety at state hospitals are the disAbility Law Center of Virginia (dLCV) and the Office of the State Inspector General (OSIG). States are required by federal law to maintain a patient advocacy organization to protect the legal and human rights of disabled individuals, and Virginia state law assigns this role to the disAbility Law Center. Although the disAbility Law Center’s focus is broader than just state hospitals, the center is required by state law to report on critical incidents at state facilities, including state psychiatric hospitals, annually. State law requires OSIG to conduct annual inspections of state hospitals and operate a complaint line to receive complaints about patient safety and care at state psychiatric hospitals and other behavioral health providers. A prior JLARC report identified shortcomings in OSIG’s oversight of DBHDS facilities.

The Civil Rights of Institutionalized Persons Act is the main federal statute that protects the rights of individuals in state-operated facilities.

Human rights complaints are only substantiated if a staff member was abusive, neglectful, and/or exploitative in connection to an incident. Severe harm to a patient does not on its own make a human rights complaint substantiated.

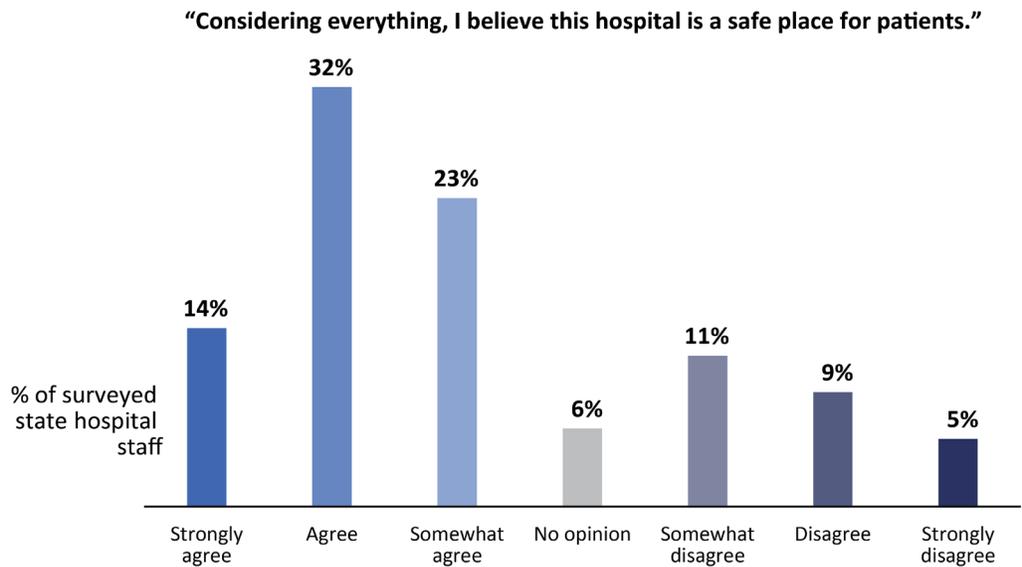
The Joint Commission’s accreditation surveys are conducted triennially by tJC staff and include document reviews, building inspections, and staff interviews, among other methods. Facilities may receive more frequent reviews by tJC as needed.

Patient safety incidents occur at every state hospital, and some may not receive sufficient scrutiny

State hospital leadership and staff commonly described through interviews and survey responses the challenges they face in trying to keep patients safe. About a quarter of state hospital staff responding to a JLARC survey disagreed to some extent that their hospital is a safe place for patients (Figure 6-1). All hospitals had at least 20 percent of their staff report that they did not believe that their hospital was a safe place for patients. Concerns about patient safety were highest among Southern Virginia Mental Health Institute staff, 42 percent of whom did not believe the hospital was a safe place for patients.

Most patients who are admitted to a state psychiatric hospital have been determined to be a threat to themselves or others. Serving these populations is inherently risky, and no national benchmarks identify an “acceptable” number or rate of patient-related safety incidents. Still, it is important to examine the numbers of safety incidents—and hospitals’ responses and investigations to them—to determine whether any could have been prevented.

FIGURE 6-1
Only about half of surveyed state psychiatric hospital staff agree or strongly agree that their hospital is a safe place for patients



SOURCE: JLARC survey of state psychiatric hospital staff (August 2023) (N=760).

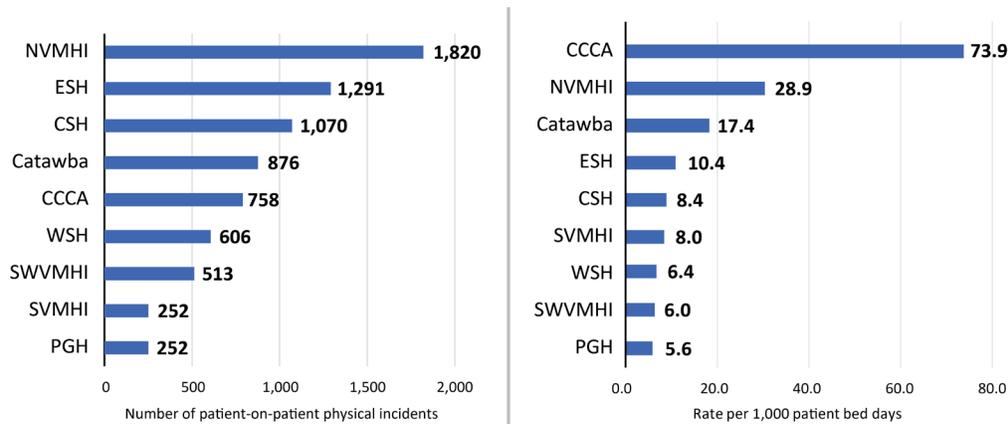
NOTE: Results of this question reflect the perspectives of nursing staff (e.g., psychiatric technicians and registered nurses), clinical staff (e.g., social workers, psychiatrists, psychologists), and facility directors. Other types of staff with less direct knowledge of patients’ day-to-day experiences, such as food services and maintenance staff, were not asked this question.

Between January 2022 and May 2023, around 7,400 known physical incidents occurred between state psychiatric hospital patients

There were around 7,400 known patient-on-patient physical incidents at state hospitals between January 2022 and May 2023. Patient-on-patient physical incidents varied in severity, but at least 898 (12 percent) resulted in a patient injury (sidebar). Seventy-three of these 898 incidents resulted in a patient injury that required medical treatment beyond first aid, such as a loss of consciousness, and five resulted in a patient being hospitalized. The highest rates of patient-on-patient physical incidents were at the Commonwealth Center for Children and Adolescents, Northern Virginia Mental Health Institute, and Catawba Hospital, according to DBHDS data (Figure 6-2).

During the same timeframe, 1,800 known incidents of self-injurious behavior were reported across facilities, at least 576 (32 percent) of which resulted in a patient injury. The severity of self-injurious behaviors ranged from minor cuts to more severe forms of harm and suicide attempts. The highest rates of self-injurious behaviors occurred at the Commonwealth Center for Children and Adolescents, Northern Virginia Mental Health Institute, and Western State Hospital (Figure 6-3).

FIGURE 6-2
CCCA, Northern Virginia Mental Health Institute, and Catawba have the highest rates of reported patient-on-patient physical incidents (Jan. 2022 to May 2023)



SOURCE: JLARC analysis of DBHDS Incident Tracker data and Avatar data.

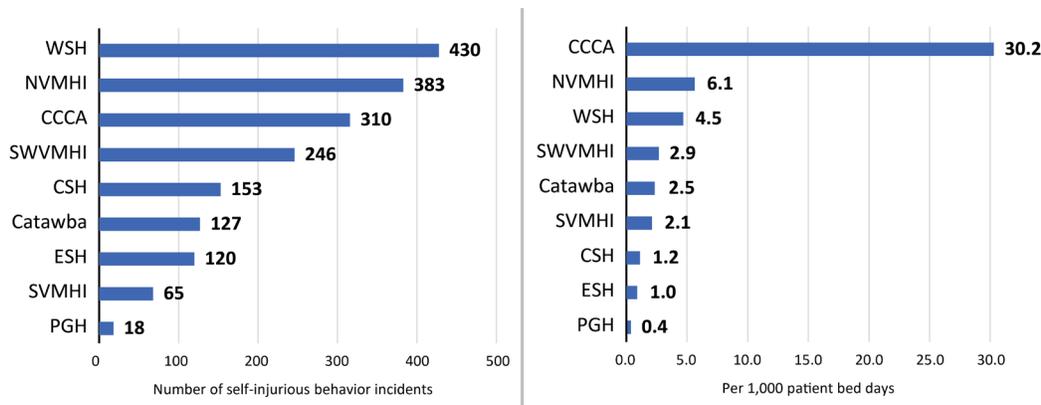
NOTE: The denominator 'patient bed days' is used to measure incidence rates, because it bases incidence rates on the total number of days that patients received care in their hospital, allowing for comparability of incidents across facilities of various sizes. For example, if a facility has 100 beds and each bed is filled by a patient every day of the year, the facility would have 36,500 bed days that year.

Severity of incidents is determined using a severity score system, which ranges from 00–06. Incidents with a score higher than 00 indicate a patient was injured, and higher scores indicate more severe injuries.

During the time period reviewed, 898 reported patient-on-patient physical incidents were assigned a severity score greater than 00. This is likely an undercount as most facilities do not assign severity scores to all incidents.

In addition, 576 reported incidents of self-injurious behavior were given a score higher than 00. Like patient-on-patient physical incidents, this is likely an undercount due to documentation inconsistencies.

FIGURE 6-3
Rates of self-injurious behaviors have been the highest at CCCA, Northern Virginia Mental Health Institute, and Western State (Jan. 2022 to May 2023)



SOURCE: JLARC analysis of DBHDS Incident Tracker data and Avatar data.

NOTE: The denominator 'patient bed days' is used to measure incidence rates because it bases incidence rates on the total number of days that patients received care in their hospital, allowing for comparability of incidents across facilities of various sizes. For example, if a facility has 100 beds and each bed is filled by a patient every day of the year, the facility would have 36,500 bed days that year.

Ensuring patient safety at state hospitals has many significant challenges

In interviews and survey responses, state psychiatric hospital staff reported various factors that make it challenging to keep patients safe. However, staff reported certain common factors, including operating at such high levels of their staffed capacity, high numbers of aggressive patients, increasing numbers of patients with criminal justice system involvement (“forensic patients”), and the mixing of patients with neurodevelopmental and neurocognitive disorders with other patients. These factors would likely make it difficult for any facility to keep patients safe, especially when multiple factors are present at the same time. State hospital staffing shortages and facility deficiencies, including weaponizable facility features, further complicate state psychiatric hospitals’ efforts to maintain a safe environment.

High numbers of aggressive patients

State hospitals’ patient populations present inherent safety risks. State psychiatric hospitals are intended to be the facilities of last resort for patients with severe mental illnesses, and state law requires them to serve patients that private psychiatric hospitals are unwilling or unable to serve. Additionally, an increasing proportion and number of patients at state hospitals are being referred from the criminal justice system.

Perhaps unsurprisingly, state psychiatric hospital staff at all eight adult psychiatric hospitals who felt their hospital was not a safe environment for patients reported “high numbers of patients with aggressive or threatening behaviors” as a top reason why it was unsafe (Table 6-1).

State psychiatric hospitals are likely to continue to serve patients with aggressive behaviors. However, the state can better enable state hospitals to accommodate aggressive patients by allowing state hospitals to reduce their patient populations to safe levels and finding alternative placements for patients who are more appropriately and safely treated in other settings. (See Chapters 2 and 3.)

TABLE 6-1
Staffing challenges and patient aggression reportedly contribute the most to state hospitals being an unsafe environment for patients

State Psychiatric Hospital	Top 3 factors contributing the most to the hospital being an unsafe environment for patients, according to staff			
	Not enough direct care or clinical staff	Too many patients with aggressive or threatening behaviors	Low staff morale	Other
Catawba Hospital	√	√		√
Central State Hospital	√	√		√
Commonwealth Center for Children and Adolescents	√		√	√
Eastern State Hospital	√	√	√	
Northern Virginia Mental Health Institute	√	√	√	
Piedmont Geriatric Hospital	√	√		
Southern Virginia Mental Health Institute	√	√	√	
Southwestern Virginia Mental Health Institute	√	√		√
Western State Hospital	√	√	√	
Total number of state hospitals where factor was most commonly cited	9	8	5	4

SOURCE: JLARC survey of state psychiatric hospital staff (August 2023) (N=760).

NOTE: Reflects only responses from staff who disagreed that their hospital was a safe place for patients. "Other" includes "Too many forensic patients" (Catawba Hospital and Southwestern Virginia Mental Health Institute), "Not enough security staff (Central State Hospital), "Not enough flexible space that can be used to separate patients when needed" (Piedmont Geriatric Hospital), and "Staff are not as well trained as they should be" (Commonwealth Center for Children and Adolescents). Results of this question reflect the perspectives of nursing staff (e.g., psychiatric technicians and registered nurses), clinical staff (e.g., social workers, psychiatrists, psychologists), and facility directors. Other types of staff with less direct knowledge of patients' day-to-day experiences, such as food services and maintenance staff, were not asked this question.

Mixing of civil and forensic patients in the same room or unit

Some state hospitals mix forensic and civil patients in the same unit and sometimes in the same room. As discussed in Chapter 4, all state psychiatric hospitals have experienced an increase in patients who have been charged with or convicted of a crime, and several hospitals are now primarily serving forensic patients. All state hospitals serve a mix of civil and forensic patients.

The mixing of civil and forensic patients was mentioned in interviews and surveys as a significant challenge to patient safety. Survey responses illustrate some of the safety concerns raised by state hospital staff about this practice:

We have a very diverse set of patients, they are often mixed together on the same units... vulnerable patients such as [ID/DD patients], females that have a traumatic past of sexual assault, and even geriatric patients (depending on bed space) are often in an environment comprised of inmates, convicted sex offenders, and other physically aggressive patients.

Especially on admissions wards, the mix of patients includes very volatile and forensic patients along with patients who lack ability to discern safety risks for themselves. It is often extremely difficult to keep less able patients from being targeted.

The National Association of State Mental Health Program Directors (NASMHPD) is a national organization representing state agencies equivalent to Virginia's Department of Behavioral Health and Developmental Services.

The separation of forensic and civil patients is considered a best practice for state hospitals, according to the National Association of State Mental Health Program Directors (NASMHPD) (sidebar). In a 2014 report, NASMHPD recommended the separation of individuals with criminal behavior and those only with a mental illness:

State psychiatric hospitals include people with mental illness, people with criminal behavior driven by mental illness, and people with criminal and predatory behavior with no mental illness. These populations should be served in discrete locations.

Virginia's current practice of serving civil and forensic patients in the same hospital is not uncommon, but many states have entirely separate facilities to serve forensic patients. As of 2020, 22 states had at least one state psychiatric hospital solely for forensic patients, according to the National Research Institute.

State law prohibits *jails* from confining mentally ill individuals with others. Sheriffs and police offices cannot confine "any person with mental illness in a cell or room with prisoners charged with or convicted of crimes."

Logistically, serving civil and forensic patients in the same hospital can be challenging because forensic patients require some specific services. For example, forensic patients admitted for competency restoration and those who have been adjudicated not guilty by reason of insanity have treatment needs and court requirements that differ from civil patients. To serve patients well and efficiently, state hospitals must have the staff necessary to serve both populations, and staff must be aware of the various programming and court-related requirements for each type of admission status.

Because of the challenges serving these patient populations together, the differing treatment needs of the patient populations, and the opportunity for facilities to specialize in serving forensic populations, DBHDS should review whether changes should be made to the state's approach of serving forensic and civil patients in the same rooms, units, or hospitals.

RECOMMENDATION 23

The Department of Behavioral Health and Developmental Services (DBHDS) should study and propose designating certain state psychiatric hospitals or units within them as appropriate to treat only forensic patients and identify the following: (i) which hospitals and units are the most feasible to be reserved for forensic patients, (ii) necessary changes to staffing and facilities, (iii) potential impacts on local law enforcement and jail resources, and (iv) any one-time and ongoing costs that the agency would incur. DBHDS should report the results of this study to the State Board of Behavioral Health and Developmental Services and the Behavioral Health Commission.

Mixing patients with neurocognitive and neurodevelopmental disorders with other patients

State hospital staff cited two patient populations that are particularly vulnerable to patient-on-patient aggression as patients with a primary diagnosis of a neurocognitive disorder (such as dementia) or a neurodevelopmental disorder (such as autism spectrum disorder or an intellectual disability). Patients with these conditions do not require psychiatric treatment, can become safety risks for state psychiatric hospitals, and can exacerbate staffing challenges.

The following quotes illustrate concerns relayed to JLARC staff in interviews and surveys regarding patient aggression directed at patients with neurocognitive disorders:

For our patients coming from jails or who are pre-trial, they have lengthy correctional experiences. So a dementia patient crossing into their space becomes seen as very disrespectful by these forensic patients. Which leads to peer-on-peer aggression.

Admission to a place like this for someone who has cognitive decline and confusion will increase [the] rate of their decline. It is an overwhelming, destabilizing, and unsafe environment for them.

There are too many mixed patients on geriatrics (Alzheimer's or dementia patients mixed with forensic or acute psychiatric diagnoses) for patient safety.

Similarly, leadership and staff of state psychiatric hospitals expressed concerns about the safety of patients with neurodevelopmental disorders:

ID/DD [patients] should not be here. They get preyed upon by forensics and some civil patients. They will mess with them. ID/DD needs a special program.

The ID/DD population is not very safe here with the forensic population.

We are not trained to work with individuals with ID/DD diagnoses. They are placed on the general unit, which is not safe for them and also disturbs the other patients who don't understand why the individual is acting the way they are.

The vulnerability of patients with neurocognitive disorders in state psychiatric hospitals has been known, and state hospitals have had admission policies intended to help minimize these inappropriate admissions (sidebar). However, the Bed of Last Resort law, which requires state hospitals to accept any individual placed under a temporary

State hospitals' admission policy identifies individuals with a primary diagnosis of a neurocognitive disorder as a population that should not be admitted. It notes that this population is "at risk of victimization."

detention order when no other facility is willing or able to admit them, supersedes this policy.

Unsafe conditions for patients with neurodevelopmental disorders may place the Commonwealth at risk of losing federal funding or being sued if these environments are deemed less safe than for the general population. The Developmentally Disabled Assistance and Bill of Rights Act of 2000 states that “the federal government and states must ensure that public funds are provided only to institutional programs... in which individuals with developmental disabilities participate that... subjects individuals with developmental disabilities to no greater risk of harm than others in the general population.”

(See Chapter 2 for approaches to reduce the inappropriate admission of individuals with neurocognitive and neurodevelopmental disorders to state psychiatric hospitals.)

Staffing challenges and facility deficiencies

Considering the high number of aggressive patients at state hospitals, as well as the mixing of civil, forensic, and vulnerable populations, adequate direct care staffing is necessary to ensure patient safety. According to the research literature, staffing-related factors, including inadequate staff (or high utilization of staff), use of temporary staff, turnover, and low morale, all can contribute to higher rates of aggressive acts between patients. Two of the top three most commonly reported reasons why state hospital staff believed that their hospital was not a safe place for patients were related to staffing, according to JLARC’s survey of state psychiatric hospital staff (Table 6-1).

In addition to staffing challenges, most state psychiatric hospitals were not originally designed as inpatient psychiatric hospitals, and various facility deficiencies contribute to safety incidents and hinder staff’s ability to keep patients safe. Examples of facility deficiencies include:

- ceramic tiles at eight hospitals that can be removed and used as weapons;
- furniture and features, such as loopable door handles and hinges, that present risks to patients intent on harming themselves at all hospitals;
- hidden alcoves or poor lines of sight at all hospitals, which present risks to both patients and staff and can allow incidents to occur without staff noticing;
- shared rooms at seven hospitals, with at least two hospitals able to accommodate up to four patients in the same room; and
- a lack of modern response mechanisms at four hospitals, which complicates an efficient staff response to de-escalate patients or intervene quickly when patient incidents occur.

DBHDS and state hospitals have recently taken steps to identify and address safety risks at hospitals and should continue to do so. If necessary, DBHDS should request

additional appropriations to address critical facility deficiencies that present a severe risk of harm to patients or staff.

OSIG receives hundreds of complaints but independently investigates only a relatively small portion of them

State hospital staff have unmatched visibility into patients' care and potential safety risks, including possible violations of their personal safety or human rights. At least 20 percent of surveyed staff at each state hospital reported that they disagreed that the hospital they work in is a safe place for patients. However, state hospital staff do not uniformly feel comfortable reporting patient safety concerns to their supervisor or hospital leadership. The facility with the greatest proportion of staff (26 percent) who reported *not* feeling comfortable reporting patient safety concerns is also the facility with the greatest proportion of staff who disagreed that their hospital was a safe place for patients (Southern Virginia Mental Health Institute).

The General Assembly has identified the need for an independent entity to receive and investigate complaints about patient care and safety in the state's psychiatric hospitals and has assigned OSIG to perform this critical function. State law requires OSIG to receive and investigate complaints reported to it about abuse, neglect, or inadequate patient care at state psychiatric hospitals. Anyone, including state hospital patients, visitors, and staff, can anonymously report their concerns about patient safety due to abuse or neglect to OSIG. An independent complaint investigation process is critical to ensuring that patients, visitors, staff, or others have a safe and non-threatening means to raise concerns and can be confident that the investigation of their complaint will have integrity and lead to the proper resolution.

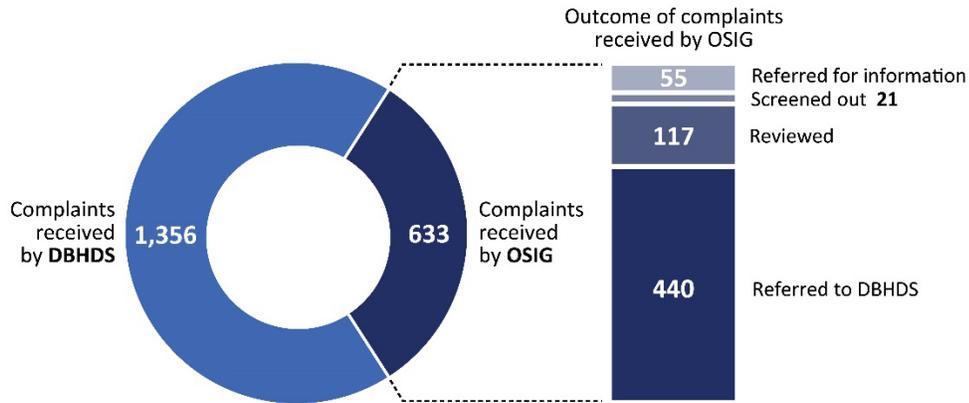
OSIG's approach to handling complaints that it receives does not ensure that complaints are independently or thoroughly investigated, counter to the General Assembly's intent. In FY23, OSIG received 633 complaints about DBHDS facilities, but referred most of them back to DBHDS and state hospitals to investigate. OSIG itself reviewed just 117 of those complaints (Figure 6-4) (sidebar). OSIG's heavy reliance on DBHDS to review complaints that were received by OSIG was reported previously in 2019 by JLARC staff.

Independent investigation of complaints that involve concerns regarding patient safety is essential because in potential cases of improper or ineffective conduct by DBHDS or state hospital leadership, the practice of referring complaints made to OSIG back to DBHDS and the hospitals could result in complaints not being investigated thoroughly or, worse, being purposely ignored or concealed. It also makes it less likely that appropriate and effective remedies and sanctions will be pursued.

Facilities can also receive complaints and conduct investigations, but these investigations are handled by facility staff members.

Facility investigators must undergo training provided by the DBHDS Office of Human Rights. Training covers methods for information gathering, planning investigation activities, and determining investigation outcomes.

FIGURE 6-4
Out of all state hospital complaints received by OSIG in FY23, most were referred back to DBHDS



SOURCE: JLARC analysis of OSIG healthcare compliance unit complaint data.

NOTE: 'Reviewed' does not mean that OSIG conducted a full investigation. According to OSIG staff, reviews can range from a follow-up phone call to a more in-depth investigation.

The General Assembly should direct OSIG to develop a plan to more effectively respond to and resolve complaints it receives, as required in statute, and reduce its reliance on DHBDS and state hospitals to investigate complaints that involve serious allegations or concerns regarding patient safety. The plan should describe (i) strategies for recruiting the needed investigators to fully investigate the complaints, and (ii) an improved process to investigate the most serious complaints instead of referring them back to DBHDS. OSIG should submit this plan to the General Assembly along with annual status reports detailing the number of complaints received and investigated by OSIG so that the General Assembly can monitor whether OSIG is fulfilling its statutory obligation.

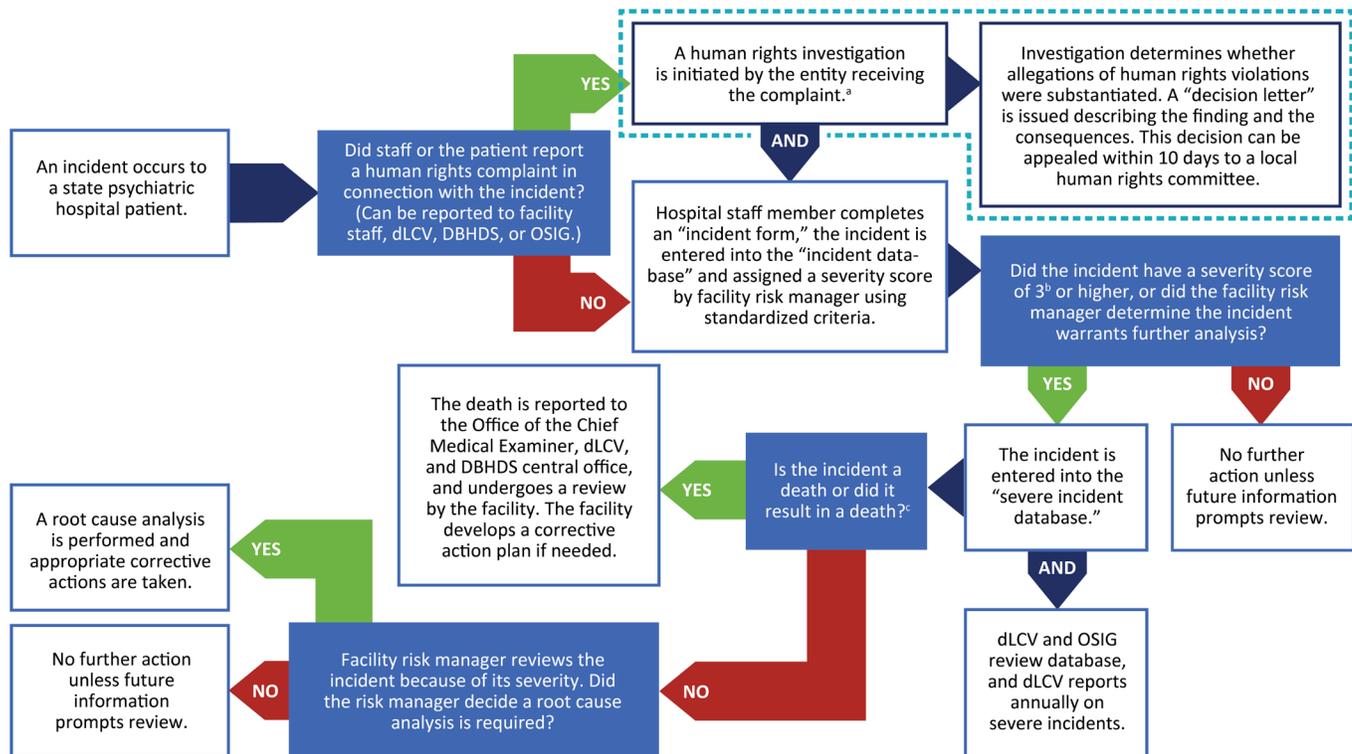
RECOMMENDATION 24

The General Assembly may wish to consider including language in the Appropriation Act to direct the Office of the State Inspector General (OSIG) to develop and submit a plan to fulfill its statutory obligation to fully investigate complaints received that contain serious allegations of abuse, neglect, or inadequate care at any state psychiatric hospital and to submit the plan to the chairs of the House Health, Welfare, and Institutions and Senate Rehabilitation and Social Services committees no later than June 20, 2024, and thereafter should provide an annual report on the number of complaints received by OSIG alleging abuse, neglect, or inadequate care at any state psychiatric hospitals along with the number fully investigated by OSIG.

Many state hospitals’ reports of serious patient safety incidents are incomplete, which can prevent necessary review and follow up

Oversight entities, including DBHDS central office, OSIG, and dLCV, need reliable and accurate information about patient safety incidents at state hospitals (Figure 6-5). Without reliable information, understanding and responding appropriately to serious incidents and improving patient safety systemwide will remain difficult.

FIGURE 6-5
Incidents are handled differently depending on their nature and severity, and external entities may be involved in certain circumstances



SOURCE: JLARC analysis of DBHDS departmental instructions 201, 401, and 315, and the Code of Virginia.

NOTE: Incidents include any event that deviates from the normal routine of care, ranging from medication errors to assaults. At any time throughout the incident review process, an incident can be referred for a human rights investigation if evidence suggests that a violation may have occurred, including alleged abuse, neglect, or exploitation by staff or infringement upon other rights guaranteed by state and federal law to individuals receiving services at state facilities. dLCV and OSIG also may investigate any incident in the incident database or severe incident database if determined to warrant further attention. ^a Even if a complaint is reported to an external entity initially, it may be referred back to DBHDS for investigation. ^b A severity score of 3 or higher indicates incidents requiring care beyond first aid and any death of a patient. ^c Death includes deaths occurring at the facility, during trips off-premises (such as hospitalizations), or 21 days after discharge.

dLCV and OSIG both have access to incident databases for oversight purposes. dLCV uses incident data for its yearly Critical Incident Report to the DBHDS commissioner. dLCV's annual report is both a state and federal requirement.

Based on a review of state hospital incident data, state hospitals are not consistently reporting the required incident information necessary to prompt more thorough scrutiny by DBHDS, OSIG, and dLCV (sidebar). For example, around a third of all incident reports by staff of the Commonwealth Center for Children and Adolescents were missing “severity indicators.” These severity indicators are the basis on which DBHDS decides when to report incidents to dLCV and the only data point DBHDS has to understand and track the frequency of very severe patient incidents, including those that involve patient hospitalization.

OSIG also uses incident documentation to monitor safety data and potentially investigate and report on serious incidents as required by state law. OSIG has previously reported on the unreliability of state psychiatric hospitals’ incident data, and dLCV has identified concerns with data integrity and underreporting in the two most recent critical incident reports to the DBHDS commissioner.

To ensure state hospitals are reporting all required information and that incidents are receiving appropriate attention, DBHDS should develop a process to regularly and rigorously analyze the quality and completeness of the incident and human rights data submitted by state hospitals. The agency should then take appropriate action to improve hospitals’ reporting of patient safety incidents.

RECOMMENDATION 25

The Department of Behavioral Health and Developmental Services should develop and implement a process to conduct ongoing reviews of the quality of the data reported by state psychiatric hospitals on patient safety and take action to address any deficiencies identified in hospitals’ reporting of patient safety incidents.

State hospitals’ appear to follow appropriate steps in investigating human rights allegations and take reasonable corrective actions

When incidents involving alleged patient human rights violations are reported, including those alleging abuse or neglect by staff, it is important to have a strong and impartial process for determining whether the allegation is true, and, if so, why it happened, and what corrective actions are necessary. Without such a process in place, human rights complaints may be handled ineffectively or with bias potentially compromising systems of protection for patients.

JLARC reviewed documentation and video for a stratified sample of 45 human rights investigations, five from each state hospital. All allegations occurred between January 2022 and May 2023.

Like other types of behavioral health providers in Virginia, state hospitals are required to investigate any incident involving an alleged human rights violation at their facility if the incident is reported to staff at the facility or to DBHDS Office of Human Rights staff. While some state hospitals have full-time investigators, other hospitals assign these responsibilities to staff who have other responsibilities, such as social workers. In either case, state hospitals are required to assign an objective staff person to conduct these investigations, and the staff person must be specifically trained to conduct human rights investigations.

State hospital staff who conduct human rights investigations report the decisions of their investigations to the central office human rights advocate assigned to monitor the facility's compliance with state human rights regulations. The central office human rights advocate is responsible for reviewing the thoroughness of the investigations conducted by hospital staff, intervening where necessary to ensure a thorough investigation, and monitoring hospitals' compliance with corrective actions.

In reviewing a limited sample of human rights investigations conducted by state hospital staff, JLARC staff did not identify any significant shortcomings in how the investigations were carried out or the corrective actions taken in response (sidebar). In these investigations, hospital investigators interviewed patients and staff, reviewed relevant documentation, and reviewed any available photographic or video evidence. In response to substantiated complaints, state hospitals took corrective actions that generally appeared reasonable, including terminating staff in some substantiated cases (sidebar).

Out of 22 substantiated cases, 13 resulted in the termination or pre-emptive resignation of the staff member. All others resulted in a plan for corrective action, including policy changes and additional training.

Utilization of seclusion and restraint at some hospitals warrants ongoing attention and intervention by DBHDS

When seclusion and restraint are used inappropriately, a patient's recovery can be undermined, and they could be physically injured. All DBHDS-licensed and operated hospitals are required by state regulation to use seclusion and restraint only as a last-resort intervention during an immediate crisis, with time limits before reassessment by a medical professional is required (sidebar). Furthermore, state law says that each individual admitted to a hospital operated, funded, or licensed by DBHDS should not be subjected to unnecessary physical restraint and isolation. Bed occupancy rates at or above hospitals' staffed capacity, the increasing numbers of forensic patients and hospitals' practices of mixing forensic and civil patients, and the high rates of staff turnover and position vacancies may lead to an overuse of seclusion and restraint. The use of seclusion and restraint is particularly high at some facilities, and staff have reported that they and their colleagues are not well trained on how to use these methods to properly and safely respond to patient aggression.

Five of the nine state hospitals used higher rates of *restraint* than national benchmarks (Figure 6-6). The Commonwealth Center for Children and Adolescents (CCCA) restrains patients at a higher rate than any other state hospital and over 20 times higher than tJC's reported national average.

Six of the nine state hospitals used *seclusion* at higher rates than national averages (Figure 6-7). Western State Hospital has the highest rate of seclusion, with a rate seven times higher than the tJC-reported national average.

A 2021 OSIG report found CCCA and Western State Hospital overused seclusion and restraint, and DBHDS has targeted some improvements at Western State. DBHDS

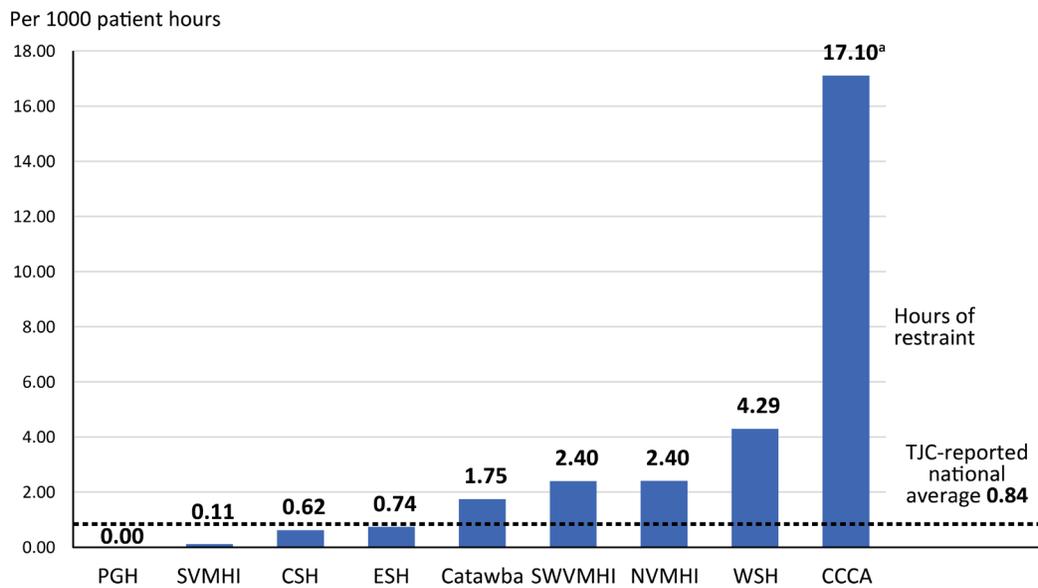
State regulations require an assessment by a medical professional to be conducted within strict time limits before the use of seclusion or restraint can be re-ordered on a patient. Adults must be reassessed every four hours, children ages 9–17 must be reassessed every two hours, and children under 9 must be reassessed every hour.

Seclusion and restraint cannot be ordered on an as-needed basis, as a form of treatment, or for punitive or coercive purposes.

staff provided evidence that Western State Hospital has improved its usage rates of both seclusion and restraint since 2022 through enhanced staff training developed by Western State Hospital. However, Western State Hospital staff survey responses show that there is still insufficient knowledge about the appropriate use of seclusion and restraint and that staffing shortages have caused improvements to stall recently.

JLARC surveyed state hospital staff about their degree of satisfaction with the training they had received on the use of seclusion and restraint. Hospitals with the greatest use of seclusion and restraint tended to have the highest levels of dissatisfaction with the training and were more likely to agree that they had witnessed inappropriate use of seclusion and restraint within the past month. Twelve percent of survey respondents indicated that they had observed inappropriate use of restraint within the past month, and 8 percent indicated they had observed inappropriate use of seclusion.

FIGURE 6-6
Five facilities exceed national benchmark for restraint usage rates (Jan. 2022 to May 2023)



SOURCE: JLARC analysis of DBHDS restraint database and Avatar data.

NOTE: Restraint rate is reported using a measure of 1,000 patient hours, which is a conversion of all patient bed days in a given time period to hours, standardized to a rate per 1,000. TJC rates are based on the reported national average rate for adults. TJC benchmark includes both forensic and civil patients. ^a DBHDS provided data as of October 2023 that indicated that the average rate of restraint use in 2023 was lower than in 2022 and attributed this to recent efforts taken by DBHDS central office staff to reduce restraint use at CCCA. As with other hospitals, the presented rate includes data from 2022 and the first five months of 2023.

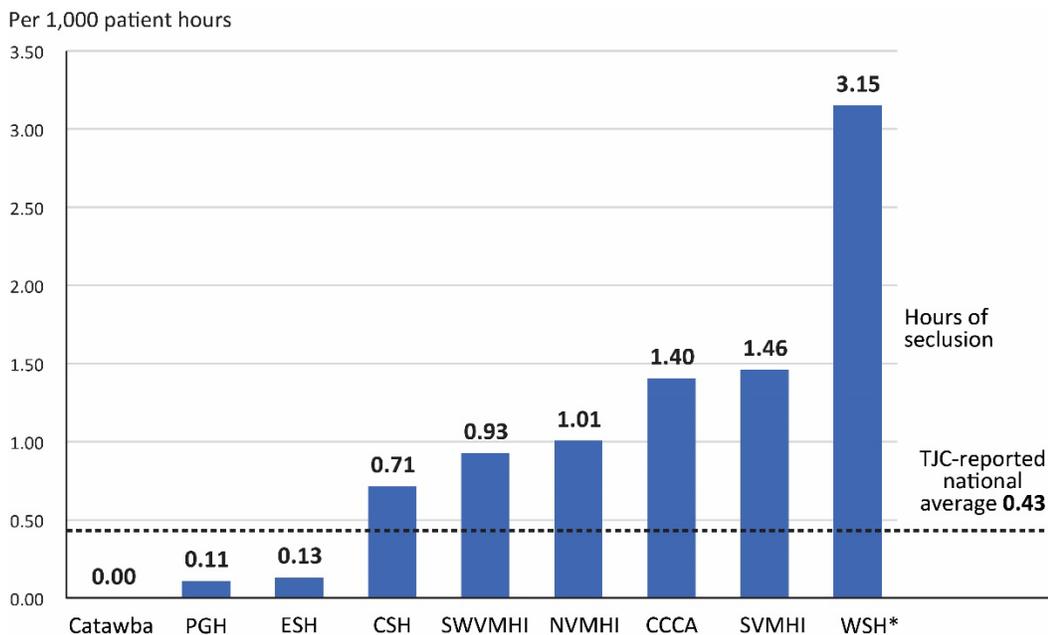
As a provider of behavioral health services to youth, CCCA’s rates of seclusion and restraint should be lower than Virginia’s adult state hospitals’ rates. TJC’s reported national average of seclusion and restraint for youth is many times lower than the rates of seclusion and restraint at CCCA (sidebar). CCCA staff were also more likely than the staff at other state hospitals to report dissatisfaction with training on seclusion and restraint and to report that they had observed inappropriate use of seclusion and restraint within the past month in their hospital. CCCA patients also generally spend a longer amount of time continuously in restraints compared with other hospitals, with a median restraint episode length of 229 minutes, the highest of any hospital.

Although restraint usage at CCCA has been similarly high over the past several years, DBHDS central office made efforts in 2023 to reduce the use of restraint at the facility, including leadership changes and greater attention to de-escalation methods used by staff. While these efforts appear to have resulted in decreased use of restraint during some months in 2023, the 2023 rate of restraint reported by DBHDS (8 hours per 1,000 patient hours) remains almost 20 times higher than the tJC-reported average for adolescents aged 13–17. Additionally, although the use of restraint at CCCA was lower during the first three months of 2023, restraint rates through October (most recent available data) were higher.

The tJC-reported national average restraint usage rate for adolescents aged 13–17 years, is 0.42 hours, about 40 times lower than the average restraint usage rate at CCCA (17.1 hours).

The tJC-reported national average reported seclusion rate for adolescents aged 13–17 years is 0.16 hours, significantly lower than CCCA’s average seclusion rate (1.4 hours).

FIGURE 6-7
Six facilities exceed national benchmark for seclusion usage rates (Jan. 2022 to May 2023)



SOURCE: JLARC analysis of DBHDS seclusion database and Avatar data.

NOTE: Seclusion rate is reported using a measure of 1,000 patient hours, which is a conversion of all patient bed days in a given time period to hours, standardized to a rate per 1,000. TJC rates are based on the reported national average rate for adults. TJC benchmark includes both forensic and civil patients. Catawba does not use seclusion per its own policy. *Excludes one patient with approved variance for voluntary seclusion.

DBHDS should contract with a subject matter expert to assess and improve the therapeutic environment among patients and staff at facilities, prioritizing those with higher rates of seclusion and restraint. This type of assessment (a “milieu” improvement) looks comprehensively at how staff interact with patients and uses strategies that prioritize hands-off interventions, structured programs, and positive interaction to reduce rates of conflict, seclusion, and restraint. For example, these assessments can focus on improving staff’s de-escalation skills, therapeutic communication, and workplace culture.

As part of this assessment, the subject matter expert should also re-evaluate and potentially recommend a replacement program for patient behavior management that all state hospital staff are trained to use for reducing seclusion and restraint. Many state hospital staff reported concerns about the effectiveness of the current training (“Therapeutic Options”) on how to respond to and de-escalate patient aggression.

RECOMMENDATION 26

The Department of Behavioral Health and Developmental Services should (i) contract with a subject matter expert to conduct an assessment of the therapeutic environment for each state psychiatric hospital including the extent to which staff are using evidence-based practices while interacting with patients, prioritizing those with the highest rates of seclusion and/or restraint, (ii) evaluate whether an alternative to the Therapeutic Options program for patient behavior management would improve staff’s ability to safely and effectively prevent and de-escalate patient aggression and minimize the use of seclusion and restraint, (iii) use the results of the assessments to improve the ability of state hospital staff to interact effectively with patients, and (iv) replace current training if a better behavior management program is identified.

DBHDS has taken steps to improve its oversight of patient deaths at state hospitals

Thoroughly and objectively reviewing deaths that occur in government facilities caring for vulnerable populations is one of the most important oversight objectives for these facilities. These investigations are vital to understanding the cause of death and whether and how the deaths could have been prevented.

Patients of Virginia state psychiatric hospitals have died while under the hospitals’ care, and the Office of the Chief Medical Examiner has determined that the majority were the result of natural causes and occurred among patients age 65 or older (sidebar). In the past two fiscal years, the most common cause of death was cardiovascular disease.

Although deaths increased to a total of 68 in FY21 during the height of the COVID-19 pandemic, the number of patient deaths has declined in the past two years, with 38 deaths in FY22 and 50 in FY23 (about 1 percent of all patients served by state psychiatric hospitals per year).

The Virginia Department of Health’s Office of the chief medical examiner is required by state law to determine the cause of all patient deaths at state mental health facilities.

In 2019, OSIG investigated how state hospitals review the circumstances surrounding patient deaths and had concerns. Notably, despite DBHDS having procedures for hospital staff to review all deaths, some hospitals' committees followed their own policies and reviewed only unexpected deaths (sidebar).

DBHDS has taken steps to improve reporting and standardize the process state hospitals use to review patient deaths. Each hospital has a committee that conducts its own reviews to determine whether a death was expected or unexpected. All preliminary findings by the facility, regardless of this determination, are then reviewed by a DBHDS central office committee for quality and compliance in the review process. If the central office committee disagrees with a hospital's determination of whether the death was expected or unexpected, the case is sent back to the hospital's committee, which will then engage in further fact-finding and review of the death. The central office committee may also refer certain cases for a human rights investigation if the circumstances of death or health record information indicate potential abuse or neglect.

Deaths are also reviewed to determine whether they were potentially preventable for risk management purposes. A death is considered potentially preventable if the facility or central office determines that reasonable medical, social, psychological, or legal intervention would have likely prevented the death from occurring. The facility must identify areas of quality improvement in these cases and include documentation of this in their reports to the central office committee. Four of 88 deaths (5 percent) at state psychiatric hospitals were determined to be potentially preventable in the past two fiscal years.

Unexpected deaths are deaths that occur as a result of an acute medical event and are not attributable to a known medical condition. Determinations of expected and unexpected death rely upon a review of records, patient charts, and other documentary information.

7 State Hospital Treatment Quality and Discharge Process

State psychiatric hospitals are responsible for determining when a patient is clinically ready for discharge. The Code of Virginia stipulates criteria that a patient must meet, as determined by their treatment team, to be eligible for discharge. For some forensic patients, including those admitted under a Not Guilty by Reason of Insanity (NGRI) status, state hospitals make discharge recommendations, and a judge must approve the discharge recommendation before the individual can be discharged to the community or jail.

In addition to being determined clinically ready for discharge, the Code of Virginia requires that patients have a discharge plan before a state hospital can discharge them. The plan must identify the services the individual will need upon reentry into the community and the entities that have agreed to provide the service(s) for the individual. The discharge plan must be completed by community services board (CSB) staff from the locality of the patient's residence.

Many factors outside state hospitals' control affect their use, but the quality of care provided and the discharge process play a key role in managing state hospitals' capacity. Appropriate and effective treatment, discharge determinations, and discharge planning make it more likely that state hospital patients can remain in the community after release without requiring re-hospitalization. Timely discharge decisions ensure that patients are not using a bed that could otherwise be made available for an individual with urgent and more acute psychiatric treatment needs.

About 20 percent of discharged patients are readmitted within six months, and readmission rates are higher for children and at certain hospitals

One indicator of the effectiveness of state psychiatric hospitals in treating patients and supporting their successful discharges is the rate at which patients are readmitted to the state hospital system (sidebar). Over the past decade, about one in five adults and one in four children discharged from a state psychiatric hospital under a civil status (e.g., civil temporary detention order or civil commitment) were readmitted within six months.

Systemwide, overall readmission rates among adults appear to have remained generally steady or declined slightly, while readmissions among children have increased. Virginia's state psychiatric hospital readmission rates among adults are generally comparable to other states, but readmission rates among children are higher. In recent years, several hospitals, including the Commonwealth Center for Children and Adolescents,

Examples of factors outside the control of state hospitals that may affect whether an individual is re-hospitalized include the individual's continued willingness to take needed medications after discharge and the availability and effectiveness of other behavioral health services in their community.

Readmission rates include a readmission to any state psychiatric hospital, not only readmissions to the same facility.

Central State Hospital, Eastern State Hospital, Northern Virginia Mental Health Institute, and Southwestern Virginia Mental Health Institute, have had relatively high readmission rates among patients admitted under a civil status (sidebar).

Various factors, including factors within and outside of the control of state hospitals, can affect whether patients are readmitted to a psychiatric hospital. Still, appropriate and adequate treatment during the patient's stay at the hospital, paired with discharge processes that effectively support the patient's transition back to their communities, may prevent avoidable re-hospitalizations.

Some readmissions should be expected and may be appropriate, particularly among the most severely ill and when outpatient care has been unsuccessful. Certain conditions, including schizophrenia and bipolar disorder, may be managed through both pharmacological and non-pharmacological therapies, but there is currently no permanent cure for them.

Independent review of a sample of patient records concluded that most sampled patients received satisfactory care, but there were exceptions

One factor that can affect the likelihood of patients' readmissions to a state psychiatric hospital is the quality of care provided during their stay. Inappropriate or inadequate care while at a state psychiatric hospital can be detrimental to a patient's health and well-being. Gaps in pharmacological and non-pharmacological treatments can also waste limited time available to help patients understand and manage their mental illness after they are discharged.

Evaluating and drawing conclusions about the overall quality of care delivered across all nine of the state's psychiatric hospitals is extremely difficult and requires clinical expertise. To provide the General Assembly with some insight into the quality of care state hospitals provide, JLARC staff obtained first-hand observations of state psychiatric hospital staff about patient care quality through the JLARC survey.

Patients whose records were reviewed by consultants were discharged between March 2022 and May 2023. Patient records were selected from each state hospital.

Additionally, to obtain an external clinical perspective on the quality of patient care at state psychiatric hospitals, JLARC staff contracted with psychiatrists at VCU Health System for an independent review of a sample of 50 patient records across the state hospitals (sidebar). Consultants were asked to review patient records and provide feedback on the quality of care provided to patients at the state hospital, including the effectiveness of pharmacological and non-pharmacological treatments and recommendations for how to improve patient care. (See Appendix B for more details on this method and the sample selection.)

Psychiatrists collectively concluded that most patients in the sample appeared to have received satisfactory care, but there were exceptions. After reviewing each patient's treatment records, reviewers were asked, "Based on the indications in the patient's

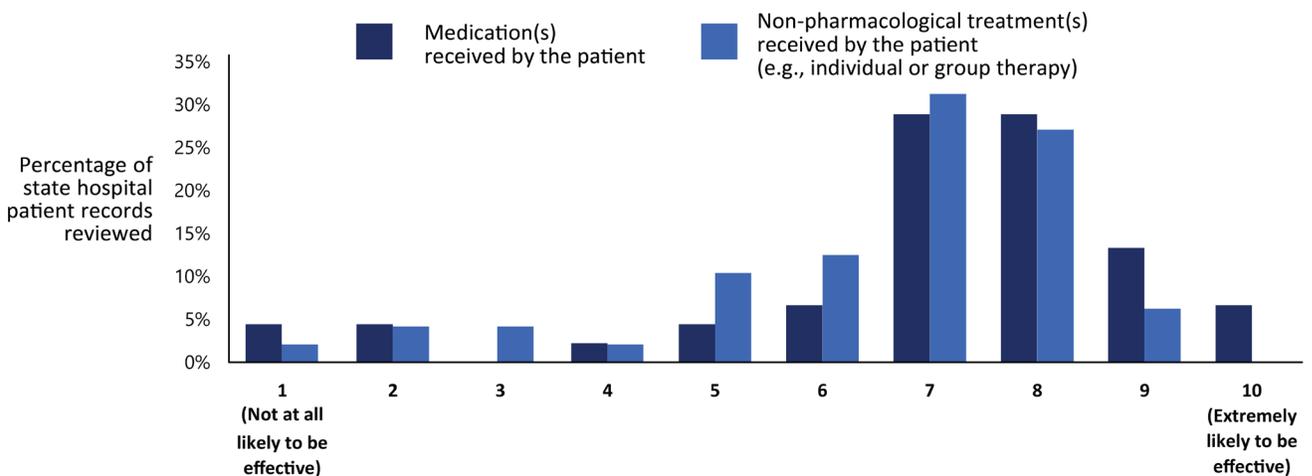
record of the quality of care received, does the reviewer believe the patient’s care reflects generally accepted criteria for high-quality care?” To this question, the reviewers responded “Yes” for about 80 percent of reviewed records and “No” for about 20 percent.

The psychiatrists also concluded that both the pharmacological and non-pharmacological treatments patients received were likely to be effective at treating the patient’s specific psychiatric condition (Figure 7-1). However, exceptions were noted.

The exceptions to quality care and treatment that VCU’s psychiatrists identified were notable and suggest that the state should conduct a similar review of patients’ charts periodically. For 17 of the 45 patients who were given medications during their hospitalization, VCU psychiatrists reported concerns about the medication, including the dosage, appropriateness of the medication for the patient’s diagnosis, or adverse side effects. In several instances, reviewers noted concerns about the use of multiple medications simultaneously.

- In one record, the reviewer noted that the patient’s diagnosis did not reflect their symptoms, and the patient was prescribed a large amount of multiple medications simultaneously, including two antipsychotics without justification.
- In another record, the reviewer noted that the use of multiple medications initially caused a patient to have seizures and that a higher dose of one medication should have been considered first.

FIGURE 7-1
Most sampled cases indicated that the pharmacological and non-pharmacological treatments patients received were likely to be effective



SOURCE: Analyses of results from consultant reviews of 50 patient records across state psychiatric hospitals.

NOTE: Respondents were asked only to comment on the likely effectiveness of medications if the patient received medications during their stay. However, almost all patients in the sample (45 of 50) received medications.

Other concerns were reported about patient safety, discharge planning, and adequate documentation.

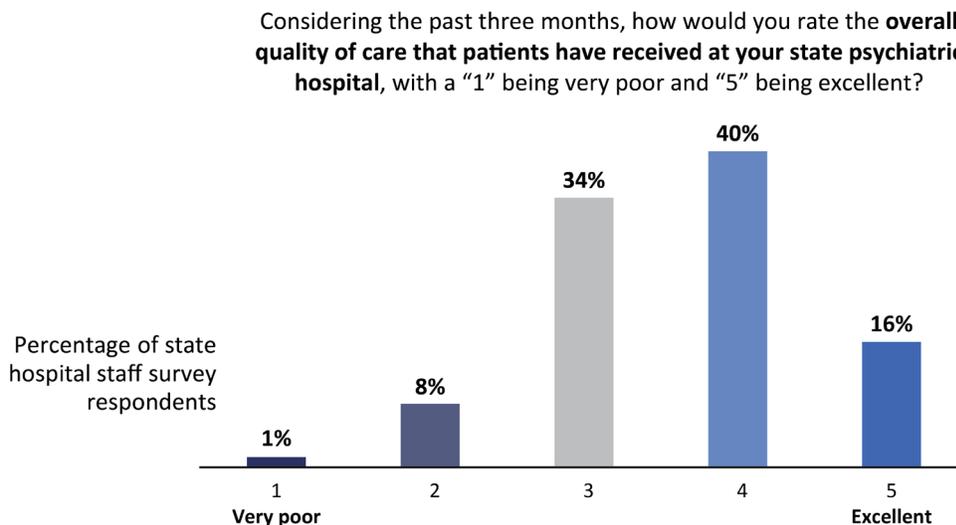
- In one record, it was unclear why a patient stayed more than five weeks at the state hospital with no persisting psychiatric symptoms other than dementia, and there was very little documentation by a doctor or psychiatric nurse practitioner throughout the patient's stay, especially to indicate why the patient was kept for so long at the hospital.
- In another record reviewed, a 74-year-old man was admitted with no psychiatric history but had dementia and behavioral problems. According to the reviewer, the patient was managed with antipsychotics and mood stabilizers, but the record included no mention of dementia medications. The reviewer noted that the patient might have been better served in a different placement, at least initially for an assessment, as new-onset psychosis in the geriatric population is uncommon.
- In five records, reviewers observed very little documentation by doctors or psychiatric nurse practitioners about the patient's progress or their visits with the patient.

In response to a JLARC survey of state hospital staff, most clinical and nursing staff reported feeling that the quality of care that patients received was neither very poor nor excellent (Figure 7-2). Staff were asked to rate the overall quality of care patients received at their state hospital over the past three months on a scale of one to five (with "one" being very poor and "five" being excellent), and 75 percent of staff rated the quality of care at their facility to be either a three or a four. There was no pattern in how staff within different roles (e.g., nurses or psychiatrists) viewed the quality of care at their hospital.

Among the state psychiatric hospital staff who rated the quality of care as not being "excellent," the most commonly reported factors preventing their hospital from providing better patient care were typically related to staffing levels or patient characteristics. The most commonly reported factors preventing better care for patients included insufficient nursing or clinical staff (66 percent), too many patients with aggressive or threatening behaviors (54 percent), high staff turnover (51 percent), and low staff morale (36 percent). Other commonly reported factors included patients not receiving enough medications (25 percent), insufficient staff training (21 percent), and patients not receiving enough one-on-one therapy (20 percent).

During JLARC staff's visits to the state psychiatric hospitals, staff at several hospitals pointed out deficiencies in the hospitals' physical space that they believed hindered the hospitals' ability to provide optimal patient care and treatment. For example, hospital staff highlighted that in some hospitals, there is not enough space to offer small group therapy sessions as often as needed, and in some hospitals, there is insufficient safe and secure outdoor space.

FIGURE 7-2
Nurses, clinicians, and physicians ratings of the quality of care provided at state hospitals



SOURCE: JLARC survey of state psychiatric hospital staff (August 2023) (N=583).

NOTE: Results of this question reflect the perspectives of licensed practical nurses, registered nurses, and clinical staff (e.g., social workers, psychiatrists, psychologists, and physicians) at all state psychiatric hospitals. Percentages do not sum to 100 because of rounding.

Because patient care concerns were identified in just a small sample of patient records and staff expressed concerns about patient care through JLARC’s survey, DBHDS should monitor the quality of care provided at all nine state psychiatric hospitals through regular reviews of a sample of patient records. DBHDS has made substantial efforts to collect and analyze more information about state hospital operations systematically, including data on staffing, patient and staff safety, and finances, and undertaking regular reviews of patient records would ensure that their oversight is also focused on patient care. DBHDS could use the patient chart review tool JLARC staff developed, in collaboration with clinical experts at DBHDS and VCU Health, as a resource for this new effort, modifying it if necessary to prioritize different or additional aspects of patient care.

RECOMMENDATION 27

The Department of Behavioral Health and Developmental Services should develop and implement processes to (i) conduct regular reviews of a sample of state psychiatric hospital patient records to evaluate the quality of care patients receive at each state hospital, which should at least include an evaluation of the effectiveness and safety of pharmacological and non-pharmacological treatments; (ii) share observations and conclusions with state hospital leaders; (iii) issue recommendations to each hospital regarding needed improvements in patient care; and (iv) hold state hospitals accountable for correcting the factors that are determined to cause the delivery of ineffective, unsafe, or generally substandard care to patients.

Key stakeholders report concerns about some patients being discharged before they are ready

Discharge liaisons are CSB staff responsible for leading and conducting discharge planning efforts for patients in state psychiatric hospitals.

Key stakeholders have raised concerns about state psychiatric hospital patients being discharged before they should have been. In response to JLARC's surveys,

- 74 percent of CSB discharge liaisons for adults believed that at least some of the patients on their caseloads were discharged before they should have been (sidebar). Liaisons most commonly reported that these instances occurred at Northern Virginia Mental Health Institute, Southwestern Virginia Mental Health Institute, and Central State Hospital.
- 27 percent of CSB discharge liaisons for youth believed that at least some of the patients on their caseloads were discharged from CCCA before they should have been.
- 10 to 38 percent of nursing and clinical staff at adult state hospitals and 24 percent at CCCA believed that some patients under their care were discharged before they should have been (Figure 7-3).

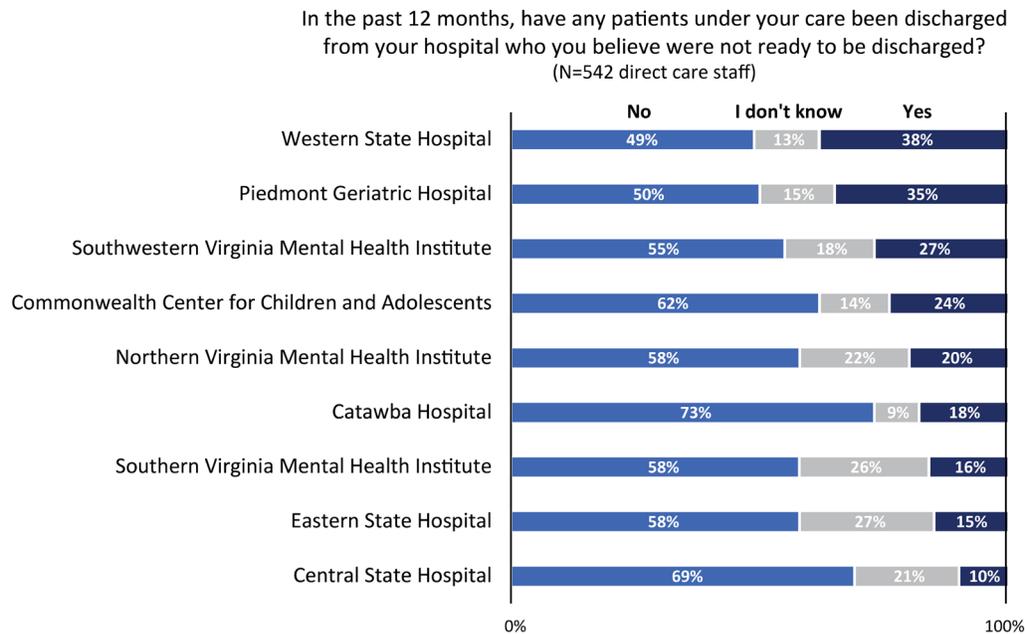
The most common reason why stakeholders believed patients were prematurely discharged was that patients had not been stabilized before discharge and were not placed in a setting that would help them stabilize after discharge (such as a crisis stabilization unit or private psychiatric hospital). CSB and state hospital staff indicated that discharging individuals before they are ready has led to multiple cases of readmissions, arrests, and homelessness. They also raised concerns that some patients who had been discharged still presented an imminent risk to themselves or others.

VCU Health's psychiatrists also conducted an independent review of DBHDS discharge determination guidance in addition to the review of patient charts discussed above.

DBHDS has established statewide guidance to determine when an individual is ready for discharge, but VCU Health's psychiatrists uniformly described the current guidance as overly complicated. This complex guidance makes it unlikely that the criteria are used consistently across state hospitals to make discharge decisions (sidebar). VCU Health psychiatrists suggested that DBHDS develop simplified criteria, potentially a checklist that more succinctly and clearly identifies the criteria for discharge readiness.

In addition, DBHDS has limited oversight of discharge determinations. DBHDS transition specialists participate in treatment team meetings where they can provide suggestions about discharge readiness decisions. However, there is no structured approach for transition specialists to assess the appropriateness of discharge decisions.

FIGURE 7-3
A significant proportion of nursing and clinical staff at state hospitals believed that some patients were discharged before it was safe



SOURCE: JLARC survey of state psychiatric hospital staff.

To ensure the discharge criteria are being used by state hospital staff and at all state hospitals, and that appropriate discharge determinations are made, DBHDS should improve its oversight of state hospitals' discharge determination procedures and decision-making. As part of its annual review of patient records (recommended earlier in this chapter), DBHDS should review the discharge determinations made for patients and assess whether appropriate decisions were made based on their treatment records, discharge criteria, and the discharge requirements prescribed in state law. DBHDS should also conduct regular case reviews for individuals who are repeatedly readmitted to state hospitals within a short period to determine whether factors within a state hospital's control, including the treatment provided or the discharge determinations, likely contributed to an individual's re-hospitalization.

Findings of inappropriate discharge determinations should result in training and technical assistance for state psychiatric hospital staff and sometimes may require additional corrective actions. When problems with discharge determinations persist, DBHDS could play a more active role in discharge decision-making and require that central office staff approve discharges before patients are released.

RECOMMENDATION 28

The Department of Behavioral Health and Developmental Services should (i) develop and implement a plan to improve its oversight of discharge determination procedures and decision-making at state psychiatric hospitals, which, at a minimum, should include a process to review a sample of discharge determinations from each state hospital on an ongoing basis to ensure appropriate discharge decisions are being made for patients admitted to these facilities and (ii) provide technical assistance and guidance to state hospital staff when shortcomings are identified with discharge determinations.

If individuals are found to have been discharged prematurely, DBHDS could contact the former patient's CSB to learn whether and how consistently the patient received post-discharge treatments and services. If DBHDS determines that the former patient did not receive needed post-discharge treatments and services, it could request that the individual's CSB attempt to re-engage them in treatment.

Shift from regional to statewide admissions has made discharge planning more challenging for CSBs and state hospitals

Timely and effective discharge planning helps ensure individuals are released from state psychiatric hospitals as soon as they are deemed ready and that they receive needed follow-up care upon discharge, reducing the likelihood of re-hospitalization.

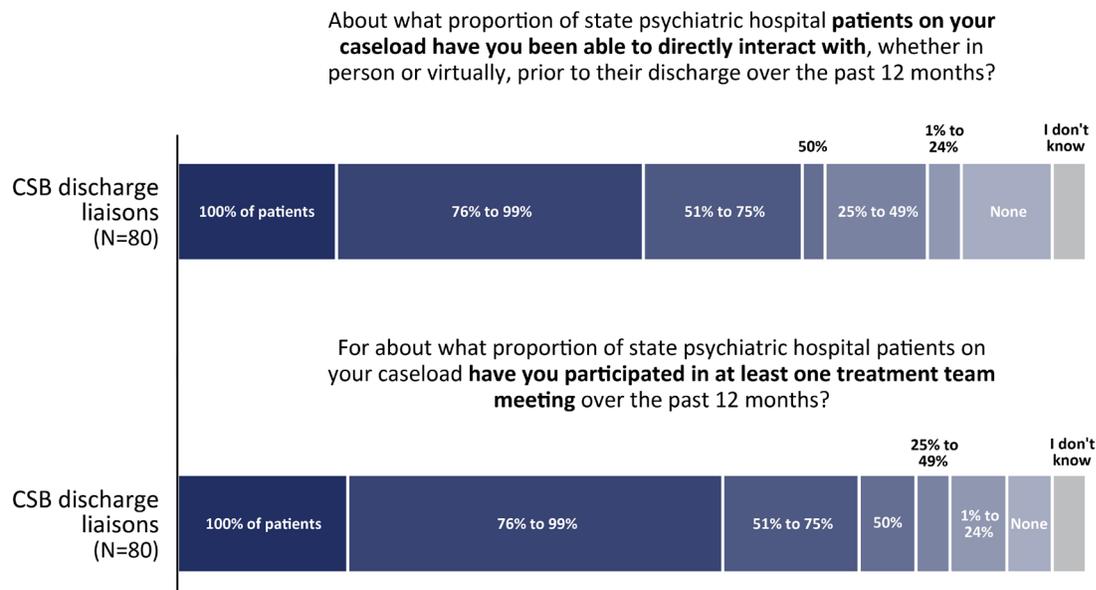
CSB discharge liaisons are ultimately responsible for completing discharge plans, and doing so requires close coordination with state psychiatric hospital staff. DBHDS policies require state hospital staff to notify CSB discharge liaisons of new admissions to their facilities and relay patients' post-discharge needs and progress toward discharge. CSB discharge liaisons are responsible for developing a patient's discharge plan based on their post-discharge needs, as determined by state hospital staff, and identifying the entities that agree to provide those service(s) for the individual after release.

Various concerns about the effectiveness of discharge planning have been previously reported. In 2022, JLARC reported that CSB discharge liaisons do not consistently fulfill their discharge planning obligations, which results in discharge delays and ineffective post-discharge services (sidebar).

CSB staff, counter to best practice, do not consistently engage with patients or participate in treatment team meetings while patients are hospitalized (Figure 7-4). Patient involvement in the discharge planning process is considered best practice because it helps ensure individuals are invested in their discharge plan and are likely to adhere to it. Additionally, treatment team meetings allow discharge liaisons and state hospital staff to coordinate. CSB discharge liaisons' participation in these meetings is necessary to ensure discharge plans reflect patients' post-discharge needs and that liaisons are updated on patients' discharge readiness so they can ensure supports are available when the patient is released.

In the CSB Behavioral Health Services report (2022), JLARC recommended that DBHDS improve its oversight of CSB discharge efforts to ensure they are fulfilling their discharge planning responsibilities.

FIGURE 7-4
CSB discharge liaisons report not consistently engaging with at least half of the patients on their caseload



SOURCE: Responses to JLARC survey of CSB discharge liaisons.

NOTE: The size of each section of the chart reflects the proportion of respondents in each response category.

Discharge planning and coordinating with CSBs has become more complicated as the state hospital system has moved from regional to statewide admissions. Prior to the enactment of the Bed of Last Resort law in 2014, most state hospitals generally served patients residing within their respective regions. Since then, all state hospitals have moved to statewide admissions to help address the state hospital waitlist and census pressures. Accordingly, most state hospitals experienced a substantial increase in the number of CSBs they have had to work over the past decade (Figure 7-5).

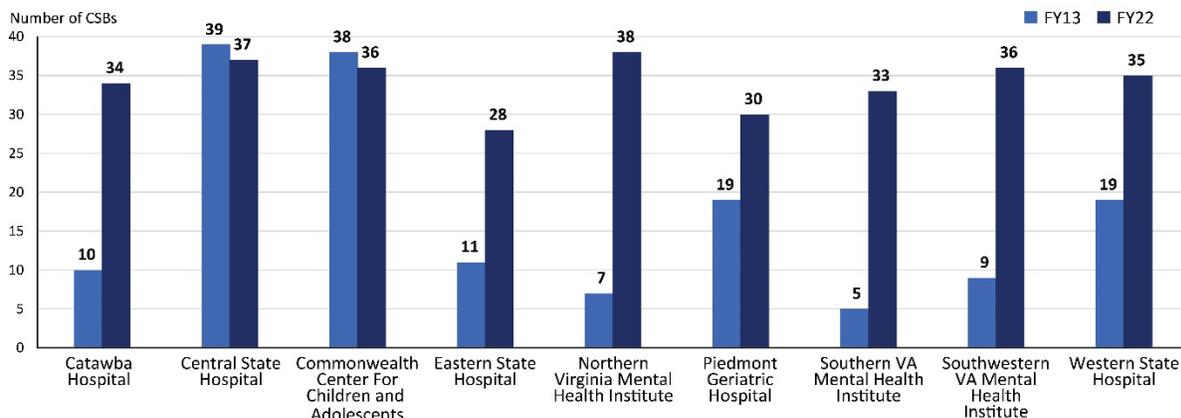
CSBs need to remain engaged in the discharge planning process, but social workers at the state psychiatric hospitals are likely better suited to lead discharge planning for patients with shorter stays (~30 days or less). Social workers at hospitals, unlike CSB staff, engage with patients and treatment team members daily (sidebar). A DBHDS workgroup on discharge planning also recently suggested shifting responsibility for discharge planning from CSBs to state hospitals.

However, patients with longer stays could benefit more from discharge planning led by CSB discharge liaisons. These patients are likely to require greater post-discharge support, such as residential placements and intensive community treatment services. CSBs typically have a strong connection with and awareness of such resources.

Facility-led discharge planning is a common practice in many other facilities. Licensed psychiatric hospitals in Virginia and at least some other states' public psychiatric hospitals are responsible for leading these efforts.

FIGURE 7-5

As the state has shifted from regional to statewide admissions, state hospitals have to coordinate with more CSBs than a decade ago



SOURCE: JLARC analysis of DBHDS Avatar data (FY13 to FY22).

Giving state hospitals the responsibility for developing discharge plans for patients with stays of 30 days or less would reduce the workload for CSB discharge liaisons and allow them to spend their time on effective discharge planning for patients who are most likely to benefit from their community connections and expertise. Smaller discharge plan workloads should allow the liaisons to more effectively engage with patients and their state hospital treatment teams and ensure appropriate post-discharge services are arranged before a patient's discharge from a state hospital.

RECOMMENDATION 29

The General Assembly may wish to consider amending (i) §37.2-837 of the Code of Virginia to assign responsibility for leading discharge planning to state psychiatric hospital staff rather than community services boards (CSBs) for patients who are determined to likely need hospitalization for 30 days or less, but stipulate that CSB staff should remain engaged in discharge planning for these patients, and (ii) §37.2-505 of the Code of Virginia to limit CSBs' responsibility for discharge planning to patients who remain in state hospitals more than 30 days.

Gaps in community services reduce the likelihood of successful transitions and timely discharges

Securing timely and appropriate post-discharge support is necessary to keep former state psychiatric hospital patients engaged in treatment, prevent the re-escalation of psychiatric symptoms, and reduce the likelihood of re-hospitalization. Examples of post-discharge support include psychiatric appointments, medication management, step-down placements, residential placements, and outpatient therapy. Inadequate

post-discharge support appears to contribute to many untimely and unsuccessful discharges from state hospitals.

Increasing the availability of these supports will have benefits in addition to improving discharge outcomes for individuals admitted to state hospitals. As discussed in Chapters 2, 3, and 4, many individuals could be diverted from state hospitals if community services were expanded, and many of the services needed to increase diversions are the same as those needed to improve discharge outcomes.

Few CSBs report being able to provide psychiatrist appointments within a week of discharge to most patients, as required by DBHDS

Receiving a psychiatric appointment soon after an individual is discharged from an inpatient facility can prevent the need for future psychiatric hospitalizations. Prompt psychiatric appointments help ensure individuals adhere to needed treatment, remain on necessary psychiatric medication, and understand how to manage their psychiatric condition.

In CSB performance contracts, DBHDS requires that individuals discharged on psychiatric medication receive an appointment with a psychiatrist within a week of discharge, but CSB and state hospital staff commonly reported significant lags in the timing of such appointments. In response to JLARC’s survey, only 19 percent of discharge liaisons reported that all patients on their caseload who were discharged on psychiatric medication received a psychiatric appointment within a week of discharge (Figure 7-6). State hospitals also observed lags in needed appointments, noting that sometimes individuals received only an intake appointment, rather than a psychiatric appointment, within the first week of discharge.

FIGURE 7-6
Many patients discharged on psychiatric medication do not receive psychiatric appointments within the time required



SOURCE: Responses to JLARC survey of CSB discharge liaisons.

NOTE: The size of each section of the chart reflects the proportion of respondents in each response category.

CSBs’ intake process for state hospital patients does not start until after patients are discharged in many cases, which delays patients’ receipt of needed CSB services. Before an individual can begin receiving services at a CSB, they must complete the CSB’s

CSB intake procedures include completing patient registration paperwork and clinical assessments to determine treatment needs. This is necessary to determine what services an individual is eligible for and to receive an appointment for needed services.

intake procedures (sidebar). The majority (68 percent) of CSB discharge liaisons who responded to JLARC’s survey indicated that at least half of the patients on their caseload had not completed CSB intake procedures before being discharged by the state hospital. It is especially important for patients with complex needs, higher risk of readmissions, and psychiatric medication prescriptions to complete intake with the CSB before being discharged from a state hospital. According to DBHDS, it can be difficult for CSBs to complete intake before discharge because CSBs cannot be reimbursed for tasks conducted while the patient remains in the hospital. DBHDS should work with the Department of Medical Assistance Services to determine whether reimbursement policies can be amended to make exceptions for intake work and, if not, identify other feasible strategies to remove this impediment.

RECOMMENDATION 30

The Department of Behavioral Health and Developmental Services should specify in its performance contracts with community services boards (CSBs) that CSB discharge liaisons are expected to complete the intake process for patients on their caseload before they are discharged from state psychiatric hospitals.

The general shortage of psychiatrists in Virginia contributes to delays in receiving post-discharge psychiatric appointments, but telepsychiatry is a viable solution to overcoming this shortage. The American Psychiatry Association supports the use of telepsychiatry as a means of connecting patients with providers, noting:

Telepsychiatry’s evidence base is substantial, and satisfaction is extremely high among patients, psychiatrists, and other professionals. Its effectiveness is comparable to in-person care in terms of therapeutic engagement, quality of care, validity/reliability of assessment, and clinical outcomes.

Other states’ mental health agencies have established statewide telepsychiatry programs to overcome shortages in needed psychiatric care (sidebar). In addition, telepsychiatry is currently allowed at residential crisis stabilization units in Virginia.

To address known and serious gaps in state hospital patients’ access to psychiatry appointments soon after discharge, DBHDS should contract with a provider to establish a statewide telepsychiatry program. This program should prioritize appointments for patients discharged from state hospitals when CSBs are unable to provide needed appointments within the first week of an individual’s discharge.

RECOMMENDATION 31

The Department of Behavioral Health and Developmental Services should contract with a provider to establish a telepsychiatry program and, as part of that contract, stipulate that individuals discharged from state psychiatric hospitals should receive a telepsychiatry appointment through the program within one week of discharge, unless the individual’s community services board or other community-based psychiatric provider can offer an in-person psychiatrist appointment within that week.

At least five **other states** have developed **statewide telepsychiatry services** including Illinois, North Carolina, New York, Tennessee, and Vermont.

Lack of appropriate step-down placements causes some longer than necessary state hospital stays and unsuccessful discharges

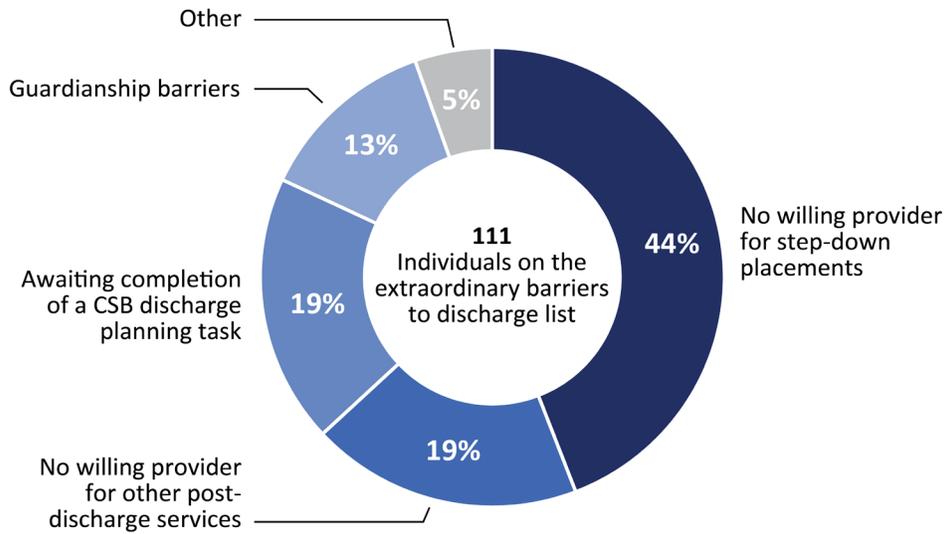
Key stakeholders frequently reported that the lack of appropriate step-down placements is a primary driver of unsuccessful transitions back into the community. One of the most common reasons CSB discharge liaisons and state hospital clinical and nursing staff believed that individuals were discharged before they were ready was that step-down and long-term residential placements were not available. Appropriate step-down placements can help prevent the re-escalation of an individual's symptoms and need for future hospitalization. Eighty percent of CSB discharge liaisons also indicated that improving the availability of long-term care facilities for adults with behavioral health needs was the most common post-discharge support needed to increase the likelihood of successful transitions.

The majority of individuals who remain in state hospitals longer than necessary experience discharge delays because needed step-down placements or other types of needed community-based services had not been found or were unavailable (Figure 7-7). Forty-nine of the 111 individuals on the extraordinary barriers to discharge list (EBL) in April 2023 had not been discharged for this reason and had already spent a median of 60 days in state hospitals after it had been determined they were clinically ready to be discharged. Among the most common needed placements that were unavailable were nursing homes and assisted-living facilities.

DBHDS has various initiatives focused on improving access to post-discharge placements, and these efforts could be further expanded. For example, DBHDS has contracted with private providers and CSBs to develop transitional group homes, assisted-living facilities, and permanent supportive housing to support individuals discharged from state hospitals.

CSB discharge liaisons reported that the **most common post-discharge supports needed for youth** to increase the likelihood of successful transitions were (1) 23-hour crisis stabilization facilities, (2) intensive in-home services, and (3) outpatient services, including applied behavioral analysis and therapeutic day treatment.

FIGURE 7-7
Nearly half of individuals placed on the extraordinary barriers to discharge list lack willing providers of needed step-down placements (April 2023)



SOURCE: JLARC analysis of DBHDS EBL data (April 2023 snapshot).

NOTE: These statistics are for adults and geriatric patients only. Examples of "other" reasons include delays due to the developmental disability waiver process and patient or family/authorized representatives resisting discharge. JLARC excluded certain individuals from its analysis of the extraordinary barriers to discharge list (EBL). These exclusions include individuals who had not yet been released but were completing the NGRI process or who had a discharge date scheduled.

8 The Commonwealth Center for Children and Adolescents

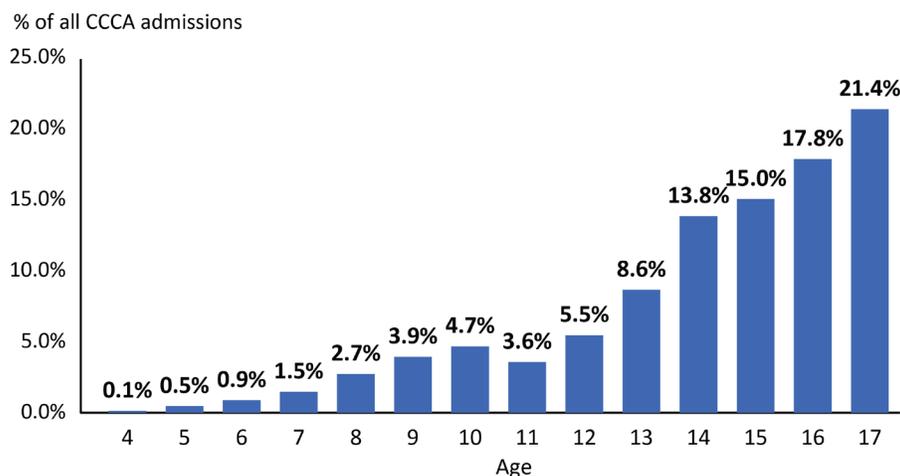
The Commonwealth Center for Children and Adolescents (CCCA) in Staunton is intended to be the facility of last resort for youth experiencing a severe mental illness and who are a threat to themselves or others. However, persistent operational and performance problems at CCCA justify reconsidering whether CCCA should continue to operate. Most other states do not operate a youth psychiatric hospital, and the beds at CCCA represent only a small proportion of all inpatient psychiatric beds for children and adolescents available in the state.

Most patients admitted to CCCA are teenagers, and most are diagnosed with one of three general psychiatric conditions. Of all patients admitted to CCCA between FY20 and FY22, 82 percent were between the ages of 12 and 17, and the average age of CCCA patients was 14 (Figure 8-1). Most were diagnosed with a psychiatric condition either classified as (1) a trauma- or stressor-related disorder, (2) a disruptive, impulse-control, or conduct disorder, or (3) a depressive disorder (Table 8-1).

Most patients stay at CCCA for a relatively short period, especially compared with adult patients. The median length of stay among youth discharged from CCCA has decreased over the past decade, from 10 days in FY13 to seven days in FY22. In contrast, the average length of stay among adult patients admitted under a civil status was 23 days in FY22.

The term “youth” is used in this chapter because most of the patients served through CCCA are between the ages of 12 and 17 years old. Children as young as four years old have been admitted to CCCA in recent years, however.

FIGURE 8-1
About two-thirds of patients admitted to CCCA between FY20 and FY22 were at least 14 years old



SOURCE: JLARC analyses of DBHDS Avatar Data

TABLE 8-1**Most patients discharged from CCCA between FY20 and FY22 had trauma- and stressor-related disorders, conduct disorders, or depressive disorders**

Primary Diagnosis	# of CCCA patients discharged (FY20–FY22)	% of CCCA patients discharged (FY20–FY22)
Trauma- and stressor-related disorders	690	32%
Disruptive, impulse-control, and conduct disorders	630	29%
Depressive disorders	533	24%
Schizophrenia spectrum and other psychotic disorders	94	4%
Personality disorders	66	3%
Bipolar and related disorders	50	2%
Substance-related disorders	37	2%
Anxiety disorders	27	1%
Neurodevelopmental disorders	24	1%
Other	27	1%

SOURCE: JLARC analysis of DBHDS Avatar patient-level data and the American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders, Fifth Edition.

NOTE: Figures do not sum to 100 percent because of rounding. Figure includes only the patient's primary diagnosis upon discharge. Patients may have multiple diagnoses.

Most CCCA patients are admitted under a civil status (“civil patients”) rather than from the juvenile justice system (“forensic patients”). Between FY20 and FY22, an average of only 37 forensic patients were admitted to CCCA per year, comprising only 7 percent of all admissions during this period.

Over the past decade, CCCA costs have tripled, and readmission rates have worsened

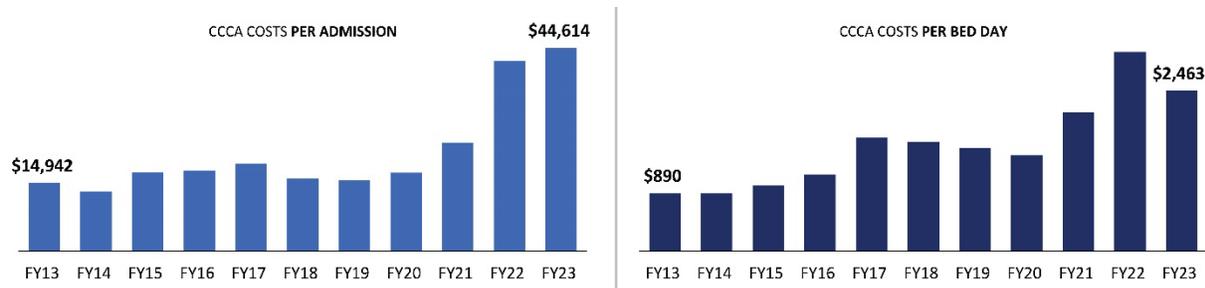
Since FY13, the overall costs to operate and maintain CCCA have increased substantially, both in total and per admission. Adjusted for inflation, total CCCA operating costs increased 77 percent, from \$10.3 million in FY13 to \$18.2 million in FY23. Per-admission costs increased nearly 200 percent, from \$14,942 per admission in FY13 to \$44,614 per admission in FY23. Similarly, on a per-bed-day basis, overall facility costs increased 177 percent from \$890 per bed day in FY13 to \$2,463 in FY23 (Figure 8-2).

Despite the increased spending, children admitted to CCCA are more likely to be re-admitted than a decade ago. Between FY13 and FY20, 30-day readmission rates (counts of youth who were readmitted within 30 days of discharge) doubled, from 9 percent to 18 percent. Thirty-day readmission rates declined in FY21 and FY22, but this decline is likely partially attributable to DBHDS's closure of half of CCCA's beds starting in FY21 due to staffing shortages. Longer-term (180-day) readmission rates have also increased.

Both short-term and long-term readmission rates among children discharged from CCCA remain higher than readmission rates among children discharged from state psychiatric hospitals in other states, and the gap has widened over the past decade (Figures 8-3 and 8-4). In contrast, Virginia’s readmission rates for adult patients have remained relatively stable over time and comparable to national rates.

FIGURE 8-2

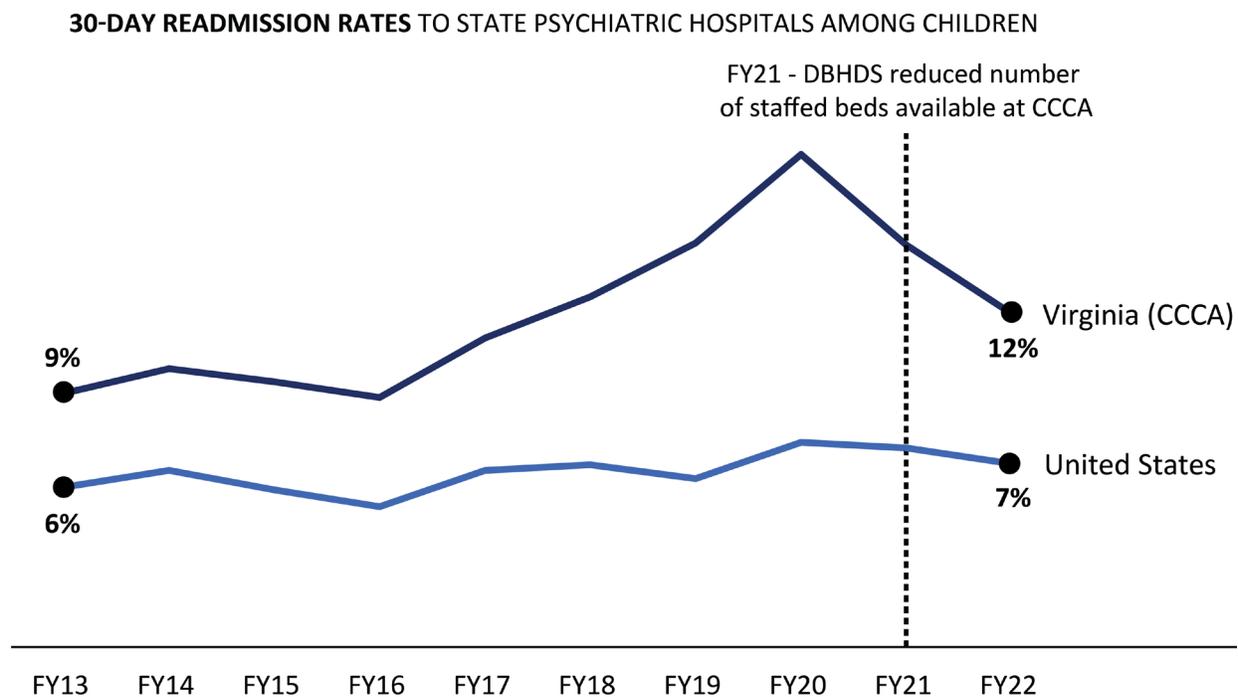
Total CCCA costs have increased substantially on both a per-admission and per-bed-day basis



SOURCE: JLARC analyses of DBHDS state hospital expenditure data and AVATAR state hospital utilization data.
 NOTE: Figure adjusted for inflation using Medical Care CPI-U.

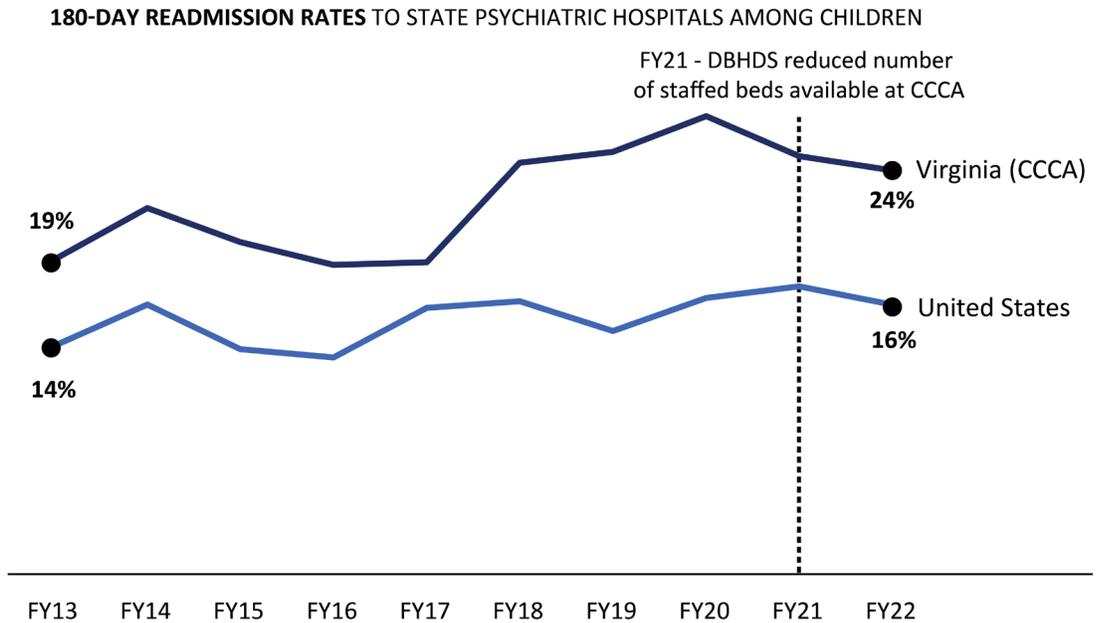
FIGURE 8-3

CCCA 30-day readmission rates have remained higher than national rates and have worsened over the past decade



SOURCE: JLARC analyses of SAMHSA Uniform Reporting System reports.
 NOTE: United States data uses federal fiscal year. Virginia data uses state fiscal year.

FIGURE 8-4
CCCA 180-day readmission rates have remained higher than national rates and have worsened over the past decade



SOURCE: JLARC analyses of SAMHSA Uniform Reporting System reports.

NOTE: United States data uses federal fiscal year. Virginia data uses state fiscal year.

CCCA is experiencing persistent operational and performance issues

As discussed in other chapters of this report, CCCA is among the state hospitals that have experienced some of the most significant staffing challenges and patient safety incidents. Across various metrics discussed in other chapters of this report, CCCA stands out as the poorest performer compared with all other state psychiatric hospitals in Virginia (Table 8-2).

The CCCA facility was not designed to serve acutely mentally ill patients but rather patients who needed longer-term residential care. Certain facility deficiencies exacerbate staffing and safety challenges, including

- (1) poor lines of sight that make it difficult for staff to monitor patient activities and safety;
- (2) areas where staff and patients can become isolated;
- (3) undersized spaces that present a risk to patients and staff if a patient becomes aggressive; and
- (4) many weaponizable building features and materials.

TABLE 8-2

CCCA performs poorly on most metrics compared with other Virginia state psychiatric hospitals

	CCCA performance	CCCA performance relative to the other eight state psychiatric hospitals in Virginia
Turnover (Chapter 5)		
Average annual turnover rate (FY21 to FY23)	88%	Highest
Percentage of <u>all staff</u> employed in June 2020 who left within three years	63%	Highest
Percentage of <u>all nursing and clinical staff</u> employed in June 2020 who left within three years	69%	Highest
Vacancy and contractors (Chapter 5)		
Vacancy rate (excluding contractors) (June 2023)	43%	Highest
Vacancy rate (including contractors) (June 2023)	18%	2 nd highest
Percentage of all staff who are contractors (June 2023)	37%	Highest
Total spending on contractors as a percentage of total hospital spending	24%	Highest
Total spending on contractors (FY23)	\$4.4 million	3 rd highest
Staff safety (Chapter 5)		
Patient-to-staff physical incident rate	99.2 incidents per 1,000 patient days	Highest
Use of seclusion and restraint (January 2022 to May 2023) (Chapter 6)		
Patient seclusion rate	1.4 hours per 1,000 patient hours	3 rd highest <i>(8 times the national average rate of use among children ages 13–17 at inpatient psychiatric facilities)</i>
Patient restraint rate	17.1 hours per 1,000 patient hours	Highest <i>(40 times the national average rate of use among children ages 13–17 at inpatient psychiatric facilities)</i>
Patient safety (Chapter 6)		
Patient-to-patient physical incident rate	73.9 incidents per 1,000 patient bed days	Highest
Patient self-injurious behavior rate	30.2 incidents per 1,000 patient bed days	Highest
Human rights complaints (January 2022 to May 2023) (Chapter 6)		
Number of human rights complaints	84	3 rd highest
Number of substantiated human rights complaints	27	Highest
Percentage of human rights complaints that were substantiated	32%	Highest

SOURCE: JLARC analysis of DBHDS staffing, expenditure, human rights, incident tracker, seclusion, and restraint data.

NOTE: Average annual turnover rate represents the total number of departures during the fiscal year divided by the total number of positions at CCCA. This approach to measuring turnover is used by the Department of Human Resources Management in its typical analyses of agency and statewide turnover. National average seclusion and restraint rates are based data reported by the Joint Commission.

Additionally, CCCA also has very few physical spaces for therapeutic programming for youth. During JLARC’s site visit to CCCA, for example, staff noted having to use a repurposed closet to provide music therapy for patients.

In a May 2023 unannounced inspection by the Joint Commission, a national accreditation organization, CCCA received 28 citations and was determined to be an immediate threat to the health and safety of patients and at imminent risk of losing accreditation, according to DBHDS.

DBHDS leadership has taken steps to improve conditions at CCCA, but the facility continues to struggle

DBHDS central office leadership and staff have recently undertaken several efforts to address operational and performance issues at CCCA. Efforts in 2023 have included making changes to CCCA’s leadership, assisting CCCA human resources staff on site with efforts to fill vacant positions, and making changes to CCCA staff training. According to DBHDS staff, these efforts and others helped the facility maintain Joint Commission accreditation.

Despite these efforts, DBHDS leadership has recognized that more needs to be done. DBHDS has requested that the governor and General Assembly consider a “restructuring” of CCCA. In its “decision package” for consideration in the FY24–FY25 budget process, DBHDS notes that “despite work towards improvement, CCCA continues to struggle to meet minimum operating clinical quality standards” and that “despite the low hospital census, current staff still struggle to meet minimum expectations for patient care and documentation.” As noted by DBHDS, without a reconsideration of Virginia’s approach to serving children, “the Commonwealth will continue to be at risk of non-compliance with state and federal regulations.”

DBHDS should develop a plan to close CCCA and find or develop alternative appropriate placements

Virginia needs a better approach to serving youth who need the most intensive psychiatric care. While CCCA has become more costly to operate, patient outcomes and staff vacancy and turnover rates have not improved, and it appears highly unlikely that these conditions will improve with the existing facility.

To ensure that youth who need the most intensive psychiatric care are able to receive effective services in a safe and therapeutic environment, the state should develop a plan to (i) close CCCA and (ii) find or develop alternative services or placements for CCCA patients. The state could follow approaches used in other states that do not

operate state psychiatric hospitals for youth to better support youth who would otherwise be placed at CCCA. These include developing contracts with private hospitals and psychiatric residential treatment centers to admit and treat youth (Georgia, Louisiana, and Tennessee). (See Appendix E for more information on other states' approaches to supporting children and youth who need psychiatric services.)

The state is also investing additional resources in crisis stabilization centers for patients who need only short-term psychiatric treatment, and which would be appropriate placements for some CCCA patients considering their relatively short, average lengths of stay at CCCA. Virginia could repurpose the state funds currently being used to operate CCCA toward the costs of securing alternative placements.

Closing the state's only youth psychiatric hospital would also allow more youth needing inpatient psychiatric to receive care closer to their homes and reduce the burden on law enforcement who must travel far to bring patients to CCCA. Treating youth closer to home would allow parents and guardians to maintain contact with their children. This would also reduce the need for law enforcement in southwestern, northern, southern, and eastern Virginia to drive long distances to transport patients to Staunton. Often, according to CCCA staff, youth are transported long distances in the back of law enforcement vehicles and are handcuffed the entire time.

CCCA staff could be reassigned to Western State Hospital, which has a substantial number of staff vacancies. Western State is only 2.5 miles from CCCA and already carries out some of CCCA's administrative functions, like human resources.

If CCCA were closed, the total number of youth needing a bed at a private psychiatric hospital or another psychiatric facility, such as a crisis stabilization unit or residential psychiatric treatment facility, at any given time would be relatively low. Although the number of admissions to CCCA fluctuates throughout the year, CCCA admitted only an average of 1.5 patients per day between FY21 and FY23. Therefore, the state would have needed to find alternative placements for only two youths per day, on average, and there are 552 privately operated inpatient psychiatric beds for youth in Virginia.

RECOMMENDATION 32

The General Assembly may wish to consider including language in the Appropriation Act directing the Department of Behavioral Health and Developmental Services (DBHDS) to develop a plan to (i) close the Commonwealth Center for Children and Adolescents (CCCA) and (ii) find or develop alternative effective, safe, and therapeutic placements for children and youth who would otherwise be admitted to CCCA, and direct DBHDS to submit its plan to the House Appropriations and Senate Finance and Appropriations committees.

Appendix A: Study resolution

Review of Virginia's State-Operated Inpatient Psychiatric Hospitals

Authorized by the Commission on November 7, 2022

WHEREAS, Virginia operates eight inpatient psychiatric hospitals for adults and one for children and youth in various locations throughout the state; and

WHEREAS, these hospitals are overseen by the Department of Behavioral Health and Developmental Services; and

WHEREAS, it is critical to the health and well-being of patients that the services and treatment provided in state psychiatric hospitals is evidence-based and effective; and

WHEREAS, delivering evidence-based and effective services and treatment requires a sufficient number of qualified and experienced clinicians and staff; and

WHEREAS, the number of admissions to inpatient psychiatric hospitals has increased dramatically in recent years and there are currently waitlists for each state hospital; and

WHEREAS, there is evidence that some patients do not require the level or type of services or treatment provided by psychiatric hospitals but are still admitted due to a lack of alternatives; and

WHEREAS, some patients remain in state psychiatric hospitals for longer than necessary due to barriers to discharging them into community-based services; now, therefore be it

RESOLVED by the Joint Legislative Audit and Review Commission that staff be directed to review the state's inpatient psychiatric hospitals. In conducting its study, staff shall (i) evaluate whether the state hospitals have sufficient space and staff to meet demands for admissions, (ii) evaluate hospitals' staffing strategies and hiring practices, especially for clinicians and other direct care staff, (iii) evaluate the criteria and policies used by state hospitals for admitting and discharging patients, (iv) identify the most common and substantial barriers to discharging patients, including forensic patients, who are clinically ready to be discharged, (v) evaluate the development and execution of treatment plans for patients, (vi) evaluate the outcomes of patients, (vii) determine whether a portion of patients could be more effectively served in a setting different from a state hospital, and (viii) evaluate DBHDS's oversight of the state hospitals.

JLARC shall make recommendations as necessary and review other issues as warranted.

All agencies of the Commonwealth, including each of the state's inpatient psychiatric hospitals, the Department of Behavioral Health and Developmental Services, all community services boards, and the Office of the Executive Secretary of the Supreme Court shall provide assistance, information, and data to JLARC for this study, upon request. JLARC staff shall have access to all information in the possession of agencies pursuant to § 30-59 and § 30-69 of the Code of Virginia. No provision of the Code of Virginia shall be interpreted as limiting or restricting the access of JLARC staff to information pursuant to its statutory authority.

Appendix B: Research activities and methods

Key research activities JLARC performed for this study include:

- structured interviews with leadership and staff of the Virginia Department of Behavioral Health and Developmental Services (DBHDS) and other state agencies, leadership and staff of Virginia's nine state psychiatric hospitals, other behavioral health stakeholders, and subject-matter experts in the nation and Virginia;
- site visits to all nine state psychiatric hospitals and several private psychiatric hospitals;
- surveys of state psychiatric hospital staff and CSB discharge liaisons;
- analysis of DBHDS data, other state agencies' data, and national data;
- reviews of patient records and DBHDS discharge determination guidance;
- reviews of previous reports on Virginia's state psychiatric hospital system;
- reviews of national research; and
- reviews of relevant documentation, such as those related to laws, regulations, and policies relevant to the provision of public psychiatric hospital services in Virginia.

Structured interviews

Structured interviews were a key research method for this report. JLARC conducted more than 100 interviews. Key interviewees included:

- central office staff of DBHDS and other state agencies;
- leadership and staff of DBHDS's state psychiatric hospitals; and
- stakeholders and subject-matter experts in Virginia and nationally.

Central office staff of DBHDS and other state agencies

JLARC conducted around 40 structured interviews with DBHDS central office staff. Topics varied across interviews but were primarily designed to understand DBHDS's oversight and administrative functions, including ongoing monitoring, training, and technical assistance efforts, among other activities. DBHDS staff were also asked for their perspectives on opportunities to improve Virginia's state psychiatric hospital system.

JLARC also interviewed staff of the Virginia Department of Health (VDH), Department of Medical Assistance Services (DMAS), Virginia Retirement System (VRS), Office of the State Inspector General (OSIG), Department of Human Resource Management (DHRM), Department of Corrections (DOC), the Office of the Attorney General (OAG), and the Behavioral Health Commission (BHC).

Leadership and staff of DBHDS's state psychiatric hospitals

JLARC staff conducted around 25 individual and group interviews with executive directors, clinical and social work directors, supervisors, and other staff from all nine state psychiatric hospitals in Virginia, including:

- Catawba Hospital;

- Commonwealth Center for Children and Adolescents;
- Central State Hospital;
- Eastern State Hospital;
- Northern Virginia Mental Health Institute;
- Piedmont Geriatric Hospital;
- Southern Virginia Mental Health Institute;
- Southwestern Virginia Mental Health Institute; and
- Western State Hospital.

Interview topics focused on staff's perspectives on admissions and utilization; discharge planning; staffing ratios, scheduling, and recruitment initiatives; treatment capabilities and programming; facility design and deficiencies; and safety of patients and staff. Leadership and staff were also encouraged to share ideas for improving state psychiatric hospital operations and services based on their own experiences and expertise.

Stakeholders and subject-matter experts in Virginia and nationally

JLARC staff interviewed various Virginia stakeholder groups and subject-matter experts, including representatives of:

- Virginia Hospital & Healthcare Association
- Virginia College of Emergency Physicians
- University of Virginia Institute of Law, Psychiatry, and Public Policy
- Virginia Tech Carilion School of Medicine
- Virginia Commonwealth University School of Medicine
- Mental Health America of Virginia
- disAbility Law Center Virginia

JLARC staff also interviewed national subject-matter experts, including representatives of:

- University of Michigan, Program in Psychiatry, Law, and Ethics
- American Association of Psychiatric Technicians
- American Psychiatric Nurses Association, Taskforce on Staffing Inpatient Psychiatric Units
- National Association of State Mental Health Program Directors
- American Psychiatric Association

These interviews were used to gather stakeholder perspectives on a variety of topics, including satisfaction with state psychiatric hospital services, challenges, and concerns regarding the provision of those services, ideas for addressing those concerns, and actions taken in other states to address similar challenges.

Other states

Additionally, JLARC interviewed staff at state mental health agencies in Illinois, Massachusetts, Texas, and Washington and corresponded with staff at state mental health agencies in Arizona, Arkansas,

Colorado, Illinois, Kansas, Mississippi, Missouri, Nevada, Ohio, Pennsylvania, Tennessee, and Texas. These efforts focused on publicly operated psychiatric hospital operations in these states, including the patient populations served, staffing, safety, and initiatives related to increasing the use of alternative placement options for patients placed in these facilities.

Site visits

JLARC staff visited all nine state psychiatric hospitals:

- Catawba Hospital;
- Commonwealth Center for Children & Adolescents;
- Central State Hospital;
- Eastern State Hospital;
- Northern Virginia Mental Health Institute;
- Piedmont Geriatric Hospital;
- Southern Virginia Mental Health Institute;
- Southwestern Virginia Mental Health Institute; and
- Western State Hospital.

JLARC staff also visited several private psychiatric facilities:

- Virginia Commonwealth University- adult inpatient psychiatry unit
- Poplar Springs Hospital
- Virginia Treatment Center for Children

Surveys

For this study, JLARC staff conducted surveys of (1) CSB discharge liaisons and (2) DBHDS state psychiatric hospital staff.

Survey of CSB discharge liaisons

The survey of community services board discharge liaisons was administered electronically to adult and youth discharge liaisons of all 40 CSBs. The survey was designed to gather discharge liaisons' perspectives on communication between state psychiatric hospital staff and CSB discharge liaisons, their discharge planning responsibilities, state psychiatric hospital discharge determinations, and the provision of post-discharge placements and services. JLARC received 82 responses from discharge liaisons at 38 of the 40 CSBs.

Survey of state psychiatric hospital staff

The survey of state psychiatric hospital staff was administered electronically to staff at all nine facilities who were employed as of August 2023, including contract staff. Staff were asked to give their perspectives on job satisfaction, hospital management, overtime and scheduling, and workforce retention.

Direct care staff and clinical staff, including nursing staff, techs, aides, physicians, psychiatrists, psychologists, social workers, and counselors, were asked for their perspectives on training adequacy, staffing adequacy, patient safety, staff safety, and treatment.

The estimated survey response rate was 36 percent, with a total of 1,284 responses. JLARC received responses from 758 clinical and nursing staff.

Data collection and analysis

JLARC collected data from DBHDS, DHRM, DMAS, OSIG, and Virginia Health Information (VHI) to analyze for this study. JLARC staff also analyzed publicly available data from the Substance Abuse and Mental Health Services Administration (SAMHSA) and proprietary data from Mercer.

Analysis of state psychiatric hospital patient and utilization trends (Chapters 1, 2, 3, 4, and 8)

JLARC used DBHDS Avatar data to analyze admission and bed day utilization trends across state psychiatric hospitals, overall and by patients' demographics, legal status, primary diagnoses, and lengths of stay. Data was available from FY08 to FY23.

JLARC also received data on state psychiatric hospitals' maximum and staffed bed capacity. Maximum bed capacity data was available for FY08 through FY23 and staffed bed capacity data was available for July 2021 through October 2023.

To support the analysis of competency restoration trends, JLARC used DBHDS data on (1) the number of outpatient competency restoration services between FY16 and FY22 and (2) the types of offenses (e.g., misdemeanor only, felony) individuals who were admitted to a state psychiatric hospital were charged with between FY13 and FY22.

Analysis of privately operated psychiatric hospital trends (Chapter 3)

JLARC used VHI Annual Licensure Survey Data (ALSD) to analyze licensed and staffed bed capacities, and bed utilization of privately operated psychiatric hospitals, including both freestanding psychiatric hospitals and psychiatric units in general hospitals. This data included information on psychiatric beds for both adults and youth. All licensed hospitals in Virginia are required to self-report information for the ALSA to VHI on an annual basis under state law. This VHI data was available for FY08 to FY21. It should be noted that the reporting period for each fiscal year varied across privately operated hospitals, but this was accounted for in the analysis.

JLARC estimated the number of bed days that were unused in privately operated hospitals through multiple steps. First, JLARC estimated the staffed bed days available for each facility's full fiscal year using the average daily staffed bed capacity. The utilization rate for each facility was then calculated using this estimate and the total bed days used by patients. For facilities found to have used less than 85 percent of their available staffed bed days, JLARC calculated the total number of bed days unused that were within 85 percent of their available staffed bed days.

This analysis was then combined with DBHDS Avatar data on state psychiatric hospital bed utilization to determine the impact of distributing additional bed days across privately operated psychiatric hospitals that would have allowed state psychiatric hospitals to operate at 85 percent of their staffed bed capacity. Data on the staffed bed capacity of state psychiatric hospitals is generally limited to once-

monthly snapshots, which JLARC used to estimate the average staffed bed capacity for FY22. Staffed bed capacity data was not collected by DBHDS before FY22.

JLARC used VHI Patient Level Data (PLD) to analyze demographics, diagnoses, and lengths of stay for patients who were discharged from privately operated psychiatric hospitals and compare the patient population to that of state psychiatric hospitals. This data was available for FY08 through FY21.

State psychiatric hospital waitlist data (Chapters 3 and 4)

JLARC received waitlist data from DBHDS to analyze trends in the number of people delayed admission to a state psychiatric hospital for treatment under a civil status or for competency restoration services. Civil waitlist data was available for July 2021 through August 2023. JLARC also received incident data for individuals who were on the civil waitlist between FY22 and FY23. Competency restoration waitlist data was available for March to July 2023.

Analysis of contracting use by private psychiatric hospitals in Virginia (Chapter 5)

JLARC obtained VHI Hospital Detail reports for CY21 (the most recent available). Data was available for six private hospitals in Virginia. Data was not available for private hospitals with psychiatric units. To calculate the proportion of nursing contracting hours, JLARC analyzed full-time equivalent (FTE) data for “nurse aide/patient technicians,” LPNs, and registered nurses. Contractor status was reported by role, but not by function within the role. Therefore, a small share of reported FTE staff represent staff who do not work directly with patients (e.g., administrators).

Benchmarking state hospital salaries against Mercer data (Chapter 5)

Mercer salary surveys were used by JLARC to benchmark state hospital salaries. JLARC used Mercer’s Healthcare Individual Contributors survey and Senior Living/Nursing Homes/Long-Term Care Facilities survey, in which employers were asked about compensation for March 1, 2023. Mercer provided the median hourly base salary, which JLARC multiplied by 2,080 to annualize. This method did not account for other compensation such as shift-specific supplements (e.g., for evening or weekend), overtime, or bonuses. JLARC compared Mercer data to salaries at filled, salaried, full-time positions at Virginia state hospitals.

For all roles, JLARC compared the median state hospital salary to the median salary in the Southeast United States region. Usually, multiple Mercer jobs were comparable to a particular state hospital job. For example, JLARC compared psychiatric technicians without a CNA to four jobs in Mercer reports: mental health technician, mental health assistant, long-term care facility assistant/caregiver, and long-term care facility activity aide.

Analysis of workers compensation (Chapter 5)

JLARC analyzed workers’ compensation claims and state employee data obtained from DHRM. Workers’ compensation claims were limited to claims with financial payments. This resulted in 2,351 claims for incidents that occurred in FY22, the most recent year available. JLARC calculated claims per full-time equivalent employee as of December 31, 2022, and multiplied that number by 100 for easier interpretation. JLARC used the same data to calculate the total amount of workers’ compensation paid per employee.

To compare workers' compensation claims for similar occupations, JLARC focused on nursing staff. Specifically, JLARC compared workers' compensation claims per employee at state hospitals versus all other state government agencies for two job types: (1) direct service associate (including certified nursing assistants) and (2) licensed nurses (e.g., licensed practical nurses, registered nurses, nurse practitioner).

Comparison of contractor to employee costs (Chapter 5)

JLARC used data on hours worked and expenditures from DBHDS to calculate the relative cost of contractors. This analysis was limited to psychiatric nurses, LPNs, registered nurses, physicians, and psychiatrists because they comprise the vast majority of contractors, according to DBHDS.

To identify hours worked by contractors, JLARC analyzed employee-level data. JLARC used cost center and role codes recommended by DBHDS and also used job titles to improve accuracy. JLARC divided the total hours worked by contractors by 2,080 (the number of work hours in a standard year) to convert to full-time equivalents (FTE).

To identify contractor costs in expenditure data, JLARC used object and cost center codes recommended by DBHDS. This expenditure data did not differentiate between physicians and psychiatrists, and likewise did not differentiate between nursing roles (psychiatric nurses, LPNs, and registered nurses). Because DBHDS indicated that psychiatrist contractors were more common than physician contractors, JLARC assumed all costs represented psychiatrists. For nursing staff, JLARC assumed that the proportional cost difference between the three nursing roles was the same for contractors as for employees.

Lastly, JLARC compared the per-FTE costs of contractors to employees with the same role in FY23. For contractors, JLARC calculated the per-FTE cost as total FY23 costs divided by total FY23 FTE. For employees, JLARC used the median annual salary as of June 30, 2023 for full-time salaried employees. JLARC added that salary to an estimated costs of benefits to identify the per-FTE cost of state employees.

Analysis of incident data on peer-to-peer physical aggression and self-injurious behaviors (Chapter 6)

JLARC received data from DBHDS's Incident Tracker database and utilization data from the Avatar database to calculate each facility's total number and incidence rate of peer-to-peer physical aggression and self-injurious behaviors per 1,000 patient bed days. Incident Tracker data included documentation of all known incidents by facility. Avatar data included total patient bed days by month for each facility. Data was requested for January 2022 to May 2023.

Facilities did not all consistently report these incidents with the same categories, prompting the use of multiple categories to analyze safety incidents. Peer-to-peer physical aggression incidents included incidents categorized as 'Physical Aggression – Against Another Client' and 'By Another.' Self-injurious behavior incidents included incidents categorized as 'Intentional,' 'To Self,' and 'Suicidality.'

The incidence rates of peer-to-peer physical aggression and self-injurious behavior were calculated by dividing the total number of incidents by the total patient bed days for each facility, then multiplied

by 1,000 for a rate per 1,000 patient days. This method was based on CMS guidance for reporting other types of safety incidents, such as falls.

Analysis of OSIG and DBHDS human rights complaint data (Chapter 6)

JLARC requested a sample of human rights cases to review investigation methods and outcomes. A sample of 45 cases, five from each hospital, were reviewed. Cases were chosen by JLARC staff to ensure review of an equitable number of substantiated and unsubstantiated cases, as well as a mix of cases alleging abuse, neglect, or exploitation. At least one substantiated case was reviewed for each facility. Documentation reviewed included the initial human rights database entry, incident report form, notes on witness interviews, written statements, video evidence (when available), employee schedules, staff emails, shift notes, patient charts, and any evidence of corrective action taken by the facility when warranted. Cases in the sample were selected from database entries between January 2022 and May 2023.

JLARC also requested human rights complaint totals and outcomes from OSIG as well as complaint totals from DBHDS. Complaint totals were used to determine the total number of complaints received by both entities, and outcomes were used to determine how many complaints were internally reviewed or referred back to DBHDS by OSIG. Data was requested for fiscal years 2022 and 2023.

Analysis of state psychiatric hospital seclusion and restraint use (Chapter 6)

JLARC received data from DBHDS's seclusion and restraint database and utilization data from the Avatar database to calculate each facility's seclusion and restraint usage rates per 1,000 patient hours. Seclusion and restraint data included recorded times of all episodes of seclusion and restraint use on patients, and Avatar data included total patient bed days by month for each facility. Data was requested for January 2022 to May 2023.

The usage rates of seclusion and restraint were calculated by converting all episode lengths (originally reported as a mix of hours and minutes) to total minutes. Total minutes were converted to total hours, which were then divided by the total patient bed hours (converted to hours from patient bed days) for each facility and multiplied by 1,000 for a rate per 1,000 hours. This method was based on CMS guidance for reporting seclusion and restraint rates.

Analysis of state psychiatric hospital readmission rates (Chapter 7)

JLARC used patient-level data from DBHDS to calculate 30- and 180-day readmission rates for individuals who have been discharged from state psychiatric hospitals between FY08 and FY22. Annual readmission rates are based on the cohort of patients who were discharged from a state psychiatric hospital that year. For example, FY22 30-day readmission rates for adult forensic TDO patients were calculated as follows:

$$\frac{\text{\# adult forensic TDO patients discharged from a state psychiatric hospital in FY22 who were readmitted within 30 days}}{\text{total \# of adult forensic TDO patients discharged from a state psychiatric hospital in FY22}}$$

Overall readmission rates were calculated as well as readmission rates by state psychiatric hospital, legal status (e.g., civil status, forensic TDO, competency restoration, NGRI), and diagnosis category (e.g., bipolar and related disorders, depressive disorders, neurocognitive disorders). Readmission rates do not include all instances of re-hospitalization because they include only readmissions to the state

psychiatric hospital system. Individuals who were discharged from a state psychiatric hospital may have been readmitted to a privately operated psychiatric hospital shortly after discharge but data is not collected on those instances.

JLARC used publicly available 30- and 180-day readmission rates data from SAMHSA's Uniform Reporting System to analyze Virginia's state psychiatric hospital readmission rates and compare Virginia's trends to those nationally. These rates included only individuals who had previously been placed in a state psychiatric hospital and were readmitted to such facilities within 30 or 180 days. This data was available from 2008 to 2021.

Analysis of state psychiatric hospital discharge trends (Chapter 7)

JLARC received consumer-level snapshot data on the extraordinary barriers to discharge list (EBL) from DBHDS to analyze (1) the number of individuals placed on this list over time and (2) the primary barriers to discharge in April of each year. The April "snapshot" numbers of EBL placements were available between 2015 and 2023, while April "snapshots" of the primary barriers for discharge were only available between 2019 and 2023.

Review of patient records and discharge determination guidance

JLARC staff contracted with psychiatrists at VCU Health System for an independent review of a sample of 50 patient records for patients discharged from state psychiatric hospitals between March 2022 and May 2023. Patient records were selected from each state psychiatric hospital. Consultants were asked to review patient records and provide feedback on the quality of care provided to patients at the state hospital, including the effectiveness of pharmacological and non-pharmacological treatments and recommendations for how to improve patient care.

In addition, psychiatrists at VCU Health System also conducted an independent review of DBHDS's discharge determination guidance to assess the appropriateness and clarity of the guidance and to provide recommendations on how to improve the discharge determination guidance for state psychiatric hospital staff.

The findings of these reviews are reflected in Chapter 7.

Review of previous reports on Virginia's state psychiatric hospitals

JLARC staff reviewed a variety of previous reports, audits, presentations, and other materials published in recent years pertaining to public behavioral healthcare. The review of these materials helped inform the team's understanding of previous challenges identified in the state psychiatric hospital system and understand how the current structure of this system contributes to challenges affecting the delivery and quality of psychiatric services in Virginia.

Materials reviewed included:

- previous JLARC reports on or relating to state psychiatric services and operations, including the 2022 *CSB Behavioral Health Services* report, the 2019 *Operations and Performance of the Office of the State Inspector General* report, and the 2007 *Availability and Costs of Licensed Psychiatric Services in Virginia* report;
- OSIG's annual reports and topic-specific reports to the General Assembly;

- dLCV's annual critical incident reports to the DBHDS commissioner;
- materials on the Prompt Placement Taskforce;
- the governor's 'Right Help, Right Now' plan;
- various DBHDS annual reports and topic-specific reports to the General Assembly including reports on the implementation of SB 260, bed utilization, bed registry, and funding and staffing;
- a selection of DBHDS monthly operational reviews from FY23; and
- relevant presentations by the Behavioral Health Commission.

Review of national research

JLARC staff reviewed publications and resources on behavioral health services from national organizations, including resources from:

- American Nursing Association;
- American Psychiatric Nurses Association;
- American Psychiatric Association;
- Mental Health America;
- The National Association of State Mental Health Program Directors;
- The National Association of State Mental Health Program Directors Research Institute (NRI);
- The Occupational Information Network;
- SAMHSA; and
- The Treatment Advocacy Center.

Document review

JLARC also reviewed numerous other documents and literature pertaining to public behavioral health services in Virginia and nationwide, such as:

- Virginia laws, regulations, and policies relating to state psychiatric hospital operations and utilization, including the civil commitment process, forensic admission processes, privately operated psychiatric hospital licensing, full-time employee classification, human rights protections and investigations, incident reporting, and costs and reimbursement;
- federal laws, regulations, and policies pertaining to psychiatric hospitalization, competency restoration, CMS certification, Medicaid and Medicare reimbursements for inpatient psychiatric services, staffing, patient rights, seclusion and restraint, full-time employee classification;
- other states' laws, regulations, policies and processes related to involuntary psychiatric treatment, competency restorations, the roles and responsibilities of publicly and privately operated psychiatric hospitals, staffing, and patient rights;
- journal articles and government reports on trends in behavioral health conditions and publicly and privately operated psychiatric hospitalization; and

- the Joint Commission accreditation manual for hospitals and the most recent accreditation survey results for Virginia's state psychiatric hospitals.

Appendix C: Agency responses

As part of an extensive validation process, the state agencies and other entities that are subject to a JLARC assessment are given the opportunity to comment on an exposure draft of the report. JLARC staff sent an exposure draft of the full report to the Virginia Department of Behavioral Health and Developmental Services (DBDHS), the Virginia Department of Health (VDH), the Virginia Department of Human Resource Management (DHRM), the Virginia Office of the State Inspector General (OSIG), and the secretary of health and human resources.

Appropriate corrections resulting from technical and substantive comments are incorporated in this version of the report. This appendix includes response letters from DBDHS, DHRM, OSIG, and the secretary of health and human resources. VDH provided technical comments that have been incorporated.



COMMONWEALTH of VIRGINIA

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December 4, 2023

Hal E. Greer, Director
Joint Legislative Audit and Review Commission
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Richmond, VA 23219

Dear Mr. Greer,

Thank you for the opportunity to review the Joint Legislative Audit and Review Commission (JLARC) report on Virginia's State Psychiatric Hospitals. We appreciate the professionalism, hard work, and the comprehensive analysis of your staff to develop some valuable recommendations to improve the state hospital system.

It is important to note Virginia's eight adult mental health hospitals and one child and adolescent mental health hospital have been struggling for years under the weight of increasing temporary detention order (TDO) admissions, increasing forensic admissions, and a staffing crisis exacerbated by COVID-19. As you know, five of Virginia's hospitals were temporarily closed to admissions in July 2021 because staffing levels were so low the environments became unsafe for patients and staff.

Since the start of this Administration, DBHDS has pushed to make critical improvements to state hospital patient care and operations, along with strengthening oversight and management of the state facility system by the DBHDS Central Office. Currently, all available adult state beds have reopened, except for 22 beds at Eastern State Hospital that are closed for a construction project. In August 2022, a new DBHDS Facility Services Division structure was developed to improve operations and ensure the 5,500 state employees who work in the state facility system were well-trained and fully capable of delivering quality services. The new DBHDS structure was implemented over the course of the following year and greatly extended the ability of Virginia's state hospital system to deliver higher quality services, including:

- Development and Implementation of Systemic Policies, Procedures, and Workflows
- Identify, Monitor, and Analyze Performance Measures
- Monthly Operational Review Meetings with Decision-Making
- Enhanced, Standardized Utilization Review
- Monitor Patient Outcomes and Quality Measures

- Quality and Risk Framework
- Standardized Training Modules, and Monitor Compliance
- Mock Surveys with Performance Management
- Compliance Expectations for Facility Leadership

Along with salary increases for targeted staff from the Governor and General Assembly, the new division has been able to reduce staffing vacancies for direct care staff from 36 percent in 2022 to 23 percent currently and reduce vacancies for housekeeping and food services from 28 percent in 2022 to 16 percent currently. This has allowed DBHDS to restore all the inpatient beds that closed during the previous Administration.

Importantly, Governor Youngkin's *Right Help, Right Now* plan targets areas through its Workstreams that will provide major relief to state hospitals. The building of Virginia's crisis system to ensure Virginians have someone to call, someone to respond, and a place to go, will divert people from state hospital admission and allow them to get critical help closer to home. Workstream 3's goal to build capacity will give Virginians much needed access to quality services to help people manage their symptoms before they reach a crisis level requiring inpatient care. In addition, Workstream 4's efforts to strengthen Virginia's behavioral health workforce will bolster staffing across the behavioral health system and create a staffing pipeline to benefit both public and private providers of behavioral health services.

Many of the changes in *Right Help, Right Now* are designed for meaningful, enduring system change and it will take some time for better outcomes to be realized. For example, the improvements championed by *Right Help, Right Now* for crisis system transformation may be apparent in FY 2024, but more likely, will become more evident starting in FY 2025 as new crisis centers are being built. Through the work of the *Right Help, Right Now* plan, the Administration, DBHDS and other HHR agencies remain fully committed to ensuring Virginians with behavioral health disorders and their families can access the full services continuum to meet their needs.

The JLARC report recognizes that Virginia's state mental health hospitals cannot control their own admissions. Specifically, we agree with your analyses and findings that a lack of control over admissions jeopardizes patient safety, that private hospitals could admit more patients, that the increase in forensic patients results in a significant impact, and that certain challenges lead to difficulties in state hospital staffing. Upon reviewing the exposure draft, DBHDS still had several areas of concern. We appreciate you taking the time to discuss these items and we are grateful for the adjustments made to the report as a result of these conversations. We look forward to reviewing the recommendations in the final report. Several recommendations may benefit from response at this time as shown below. (Only the chapter is noted for each recommendation as the final report may contain different numbering than the exposure draft.)

- **JLARC Recommendation** – The General Assembly may wish to direct DBHDS to develop a plan to close CCCA. (Chapter 8)

DBHDS, through its own discovery, identified operational concerns within CCCA and began to analyze the mitigating factors and implement strategies to sustain and enhance operations. During this time of change management, CCCA was surveyed by The Joint Commission (TJC) on May 16 – 17, 2023, which yielded 28 findings and

considered the facility to be at an immediate risk of losing accreditation if deficiencies were not remediated within 15 days. CCCA staff, in conjunction with support from Central Office and several other facilities, quickly worked to develop and execute an action plan. The strategies that were implemented were approved by TJC who then acknowledged CCCA for their work which was evident by reducing the deficiencies from 28 to only two. CCCA also had lookbehinds conducted by the Virginia Department of Health (VDH) and Centers for Medicare & Medicaid Services (CMS) on June 2, 2023, and June 5, 2023, respectively, which concluded with zero findings. TJC returned again on June 7, 2023, and noted zero additional findings. Today, CCCA continues to sustain compliance and since the quality audits were implemented in June 2023, the hospital has averaged the following compliance scores: (1) Safety – 100 percent, (2) Treatment Planning – 92 percent, (3) Clinical Documentation – 86 percent; and (4) Environment of Care – 100 percent.

Furthermore, more recent analysis on CCCA's seclusion and restraint data shows marked improvements. Although the 2023 year-to-date seclusion usage was equal to the 2019-2022 average, the restraint usage reduced by 116 percent. DBHDS' goal is for CCCA to be restraint-free and we will continue to work with CCCA and the adult state hospitals to ensure instances of seclusion and restraint continue to trend downwards.

Finally, it is important to note bed-day cost is indeed higher at CCCA because the hospital has lower admissions overall compared to prior years as beds have been offline, i.e. fixed costs become more pronounced in a smaller facility.

JLARC Recommendation – The General Assembly may wish to consider including language in the Appropriation Act directing the Secretary of Health and Human Resources to (i) evaluate the current availability of placements for individuals with neurocognitive and neurodevelopmental disorders who would otherwise be placed in a state psychiatric hospital, (ii) identify and develop alternative strategies to support these patient populations, including through, but not limited to, enhanced Medicaid reimbursements and a Medicaid waiver for individuals with neurocognitive disorders, and (iii) report the results of its work to the House Appropriations and Senate Finance and Appropriations committees no later than October 1, 2024. *The report also says:* As part of this effort, the Secretary should direct DBHDS to develop formal guidance and direction for CSB preadmission screeners that specifies preadmission screeners' role in connecting individuals with neurocognitive or neurodevelopmental disorders with more appropriate services or placements, what other state and local agencies should be involved in securing alternative services or placements, and what actions preadmission screeners should take to connect these individuals with those agencies. (Chapter 2)

We appreciate JLARC working with us on this recommendation as this area will require further examination to avoid unintended consequences. There is a high mental illness co-occurrence rate for individuals with intellectual and developmental disabilities (DD). Determining whether an individual's behaviors and symptoms are because of DD or a co-occurring mental illness can be extremely challenging and complex, especially for those with more severe DD. Pre-screeners may not have the competency to make this clinical determination, particularly during the relatively short emergency custody period in

Virginia. There may be situations when an involuntary commitment is an appropriate outcome for an individual with a sole DD diagnosis. In addition, this is an area cited in the DOJ settlement agreement and Virginia needs to align with how we approach this issue, not through exclusion, but rather through building competency and the appropriate supports and services in every community.

- **JLARC Recommendation** – Delay admission of TDO for individuals with urgent medical needs. (Chapter 2)

If changes are made to the civil code, the criminal codes should also be changed to allow for delay due to urgent medical needs. The code sections would be §19.2-169.6, §19.2-169.1, §19.2-169.5, §19.2-168.1, §19.2-169.2, §19.2-169.3, §19.2-182.2, §19.2-182.8, §19.2-182.9, §53.1-40.9, and §16.1-356.

- **JLARC Recommendation** – DBHDS should take immediate steps to expedite the development and implementation of an information technology system that will allow for the secure electronic transfer of patient documents between CSBs and inpatient psychiatric hospitals and provide monthly progress reports on this work to the Behavioral Health Commission. *The report also says:* If DBHDS determines that this effort will not be successful, it could instead pursue entering into a contract with another vendor solely for this service, as JLARC recommended in 2022. This could be a short-term contract if DBHDS determines that it would eventually be rendered unnecessary by the new bed registry. DBHDS should consult with VITA to determine if an “emergency procurement” is possible, which would significantly reduce the steps and time needed to reach an agreement with a vendor. (Chapter 2)
- The existing Virginia Crisis Connect platform has this functionality and we will be rolling it out in the coming months; however, for this tool to be valuable, private facilities will need to integrate their systems.
- **JLARC Recommendation** – DBHDS should seek an official opinion from the Office of the Attorney General on whether 12VAC35-105-50.B grants the DBHDS commissioner the legal authority to require providers of inpatient psychiatric services to admit patients under a TDO if the provider has the capacity to do so safely. (Chapter 3)

DBHDS has contacted the Office of the Attorney General to seek this opinion.

- **JLARC Recommendation** – DBHDS should (i) work with DHRM to annually measure, using available DHRM data on state hospital recruitment actions, the amount of time elapsed between when a state hospital position becomes vacant, when the position is advertised, and when the position is filled, (ii) use the results of this analysis to compare hospitals’ performance in filling vacancies, especially for nursing and clinical positions which are critical to patient care, (iii) identify hospitals that appear to be underperforming and provide technical assistance, oversight, and resources to improve such hospitals’ ability to fill critical vacant positions in a timely manner. (Chapter 5)

This recommendation is already complete. DBHDS has implemented a hiring process with expectations and management oversight reports per facility and systemically through PageUp via POWER BI. Additional consultation is not needed through DHRM as this information is readily available internally for reporting and executive actions.

- **JLARC Recommendation** – The General Assembly may wish to direct DBHDS to report annually on average turnover and vacancy rates and salary competitiveness, by hospital and position type, for the state’s psychiatric hospitals. (Chapter 5)

DBHDS already tracks and displays publicly available Strategic Plan Dashboard turnover and vacancy information for direct care and clinical positions on its website.

- **JLARC Recommendation** – The General Assembly may wish to direct the Office of the State Inspector General to develop and submit a plan to fulfill the requirements to oversee DBHDS facilities as required in § 2.2-309.1 and develop and submit annually a report detailing the activities and results of its DBHDS facility oversight. (Chapter 6)

Of note, the JLARC report focused on the complaint process. OSIG reviews all complaints or conducts an independent investigation based on the findings of the facility and on the validity and severity of the complaint. In addition, OSIG conducts announced and unannounced site visits yearly to all state facilities and requires a written plan of action for each recommendation, as well as follow-up for completion of actionable items. OSIG has increased its focus on oversight of other regulatory requirements such as the Americans with Disabilities Act, mandatory overtime procedures, mortality reviews, electronic health record review implementation, and utilization in conjunction with standard oversight of complaints, to name a few. Finally, clarification is needed regarding OSIG "oversight of state facilities" based in code language interpretation.

In addition, there are recommendations that carry a fiscal impact, such as an assessment of the therapeutic environment at state hospitals, contracting for telepsychiatry for transitioning state hospital patients, and recommendations around additional discharge planners.

Again, thank you for the opportunity to comment on the report and for the work of your staff to understand this system and make many meaningful recommendations for improvements. We look forward to partnering with you to improve the behavioral health system for Virginians who rely on these services throughout the Commonwealth.

Sincerely,



Nelson Smith
Commissioner



JANET L. LAWSON
DIRECTOR

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December 1, 2023

Hal E. Greer
Director
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Richmond, VA 23219

Dear Mr. Greer,

Thank you for providing the exposure draft JLARC report of the *Virginia's State Psychiatric Hospitals* for review by DHRM. My review is complete, and I have found the draft report to be very thorough with sound recommendations.

We appreciate the opportunity to assist you with this review, and remain available to provide further assistance as needed.

Best regards,

A handwritten signature in cursive script that reads "Janet L. Lawson".

Janet L. Lawson
Director



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November 30, 2023

Hal E. Greer, Director
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Dear Mr. Greer,

The Office of the State Inspector General (OSIG) has reviewed the exposure draft on Virginia's State Psychiatric Hospitals provided by the Joint Legislative Audit and Review Commission (JLARC). We appreciate the opportunity to provide a written response and look forward to continued systemic improvements in the future.

OSIG is the only Inspector General office in the nation that operates a statewide healthcare compliance unit to address mental health concerns. Our Healthcare Compliance Unit (HCU) consists of three full-time staff, which we have frequently supplemented with part-time staff and qualified contractor assistance. In addition, we have incorporated the assistance of our performance audit staff to provide additional oversight (i.e., we are currently working on an Electronic Health Records audit at the Department of Mental Health and Behavioral Services (DBHDS)).

JLARC noted that the 2022 unannounced inspections focused on follow-up of facilities' implementation of prior OSIG recommendations and compliance with fire drills, and that OSIG's unannounced inspection project scope was "narrowly focused." OSIG followed-up on 73 prior open recommendations and identified two findings related to fire drills. Further, JLARC did not note the scope topics for prior year unannounced inspections. The 2021 unannounced inspections scope topics included the following:

- Sexual assault allegations.
- Public safety and facility management.
- Seclusion and restraint.
- Patient procedures.

- Patient administration.
- Dietary compliance and food safety.

This unannounced inspection resulted in 39 findings and 40 recommendations. OSIG did not conduct a limited scope in 2020 due to the pandemic and difficulty conducting onsite fieldwork. The 2018/2019 unannounced inspection report reviewed the impact that the *Code of Virginia* “bed of last resort” legislation had on DBHDS and evaluated the following topics:

- Changes in staffing protocols related to safety of the patient, managing proper nursing staff-to-patient ratio, and maintaining proper support staff.
- Staff safety programs oversight.
- DBHDS training requirements for direct care staff.
- DBHDS reporting requirements related to key facility reporting data for Central Office review and oversight.

This unannounced inspection resulted in six findings and 17 recommendations. OSIG’s annual unannounced inspections have been significantly more comprehensive than the one year noted in the JLARC report.

Prior to a 2019 JLARC review, OSIG voluntarily implemented a Complaint Line to respond to calls of abuse, neglect and inadequate care by patients, advocates and staff within DBHDS. After a 2019 JLARC review and recommendation, the Complaint Line was codified in 2020. OSIG now staffs this complaint line full-time without additional state-funded resources. OSIG also receives complaints via mail, email, in-person, and through a website form to provide multiple avenues for submitting complaints.

In FY 2023, OSIG restructured HCU to align with the State Fraud, Waste and Abuse Hotline Unit that has run successfully and efficiently for over thirty years. Unannounced inspections are now conducted by the Audit Division under Government Auditing Standards issued by the U.S. Government Accountability Office, leaving HCU with more time to intake, process and review calls received on our *Code*-mandated Complaint Line. In accordance with our Complaint Manual, based on the severity of the complaint, OSIG determines the appropriate process to resolve the complaint, including whether OSIG should complete the complaint review. Results of complaints referred to and completed by DBHDS facility staff are reviewed by OSIG for propriety, and follow-up is conducted where warranted. OSIG encourages and supports continuing education and certifications for all staff. Specifically within HCU, staff have obtained and maintained a doctorate degree, Licensed Practical Nurse certification, Health Insurance Portability and Accountability Act compliance certification, and Certified Professional in Healthcare Quality certification.

OSIG’s 2019 unannounced inspection noted deficiencies in training related to care of ID/DD patients. These deficiencies were also noted in the JLARC report. In addition to reviewing JLARC studies, OSIG works with the disAbility Law Center of Virginia, Joint Commission on

Health Care, DBHDS Office of Human Rights, and other oversight entities to ensure non-duplication of efforts and an awareness of other oversight activities statewide.

While OSIG has incorporated HCU and DBHDS facility oversight into our annual work plan every year since HCU inception, OSIG acknowledges that improvements can always be made, and we continue to evaluate and assess our operations, procedures and staffing. Thank you for the opportunity to provide a response to this report.

Sincerely,

A handwritten signature in black ink, appearing to read "Michael C. Westfall", written over a light-colored rectangular background.

Michael C. Westfall, CPA
State Inspector General



COMMONWEALTH of VIRGINIA

Office of the Governor

John E. Littel

Secretary of Health and Human Resources

December 4, 2023

Hal E. Greer, Director
Joint Legislative Audit and Review Commission
919 East Main Street; Suite 21010
Richmond, VA 23219

Dear Mr. Greer:

Thank you for providing the opportunity to examine the JLARC report on Virginia's State Psychiatric Hospitals. The report underscores the urgent need for a transformation in the Commonwealth's mental health system, as clearly demonstrated by the comprehensive analysis conducted by you and your team.

From the first day of his Administration, Governor Youngkin has been committed to transforming mental health and substance use system. Since the unveiling of his *Right Help, Right Now* Behavioral Health Transformation plan in December 2022, Virginia has prioritized the swift expansion and investment in the community mental health system. The plan is structured around six strategic pillars, each aiming to address crucial aspects of the mental health landscape:

1. Same day care for individuals experiencing a behavioral health crisis;
2. Reducing criminalization of behavioral health and relieving local law enforcement burden to respond to behavioral health crises;
3. Developing more capacity throughout the system, beyond hospital-based care, and enhancing community based services;
4. Targeted support for substance use disorders and efforts to prevent overdose;
5. Prioritizing the behavioral health workforce; and,
6. Identifying service innovations and best practices to close capacity and service gaps.

The JLARC report rightly points out the system's overreliance on state psychiatric hospitals for all levels of care, emphasizing the need for a shift towards putting individuals first. The outdated approach disproportionately allocates limited resources to inpatient treatment, rather than meeting individuals where they are. The *Right Help, Right Now* initiative strives to establish high-quality, evidence-based, trauma-informed services as viable alternatives to inpatient treatment.

The JLARC report highlights specific populations, beginning with individuals with neurodevelopmental disorders in state psychiatric hospitals. The Commonwealth is steadfast in its commitment to ensuring that individuals with developmental disabilities can reside in integrated settings that cater to their needs, allowing them to lead fulfilling lives. Stakeholder surveys and discussion groups conducted during the development of the *Right Help, Right Now* plan revealed dissatisfaction among individuals with developmental disorders in the Commonwealth, with 60% expressing dissatisfaction with the adequacy of available behavioral health services and 70%

dissatisfied with their accessibility.¹ The JLARC report emphasizes that state psychiatric hospitals do not optimally serve individuals with neurodevelopmental disorders and emphasizes the need for tailored treatment. This underscores the Governor's substantial investment in Virginia's comprehensive crisis system, recognizing the importance of meeting the needs of individuals in mental health crises within the community. For the developmental disabilities' population, our data indicates that community crisis assessments have a significant impact, with 93% avoiding hospitalization compared to only 58% through crisis assessments in emergency departments.² The report also stresses the significance of addressing the behavioral health needs of Virginia's youth. According to the 2023 Mental Health America report, Virginia ranks 48th among the 50 states for youth mental health. Notably, Virginia stands among a limited number of states that still operate a state psychiatric hospital for youth. Despite substantial financial investments in the Commonwealth Center for Children and Adolescents, the absence of a comprehensive plan and guiding principles for the care of youth with mental health and developmental disabilities hinders the realization of significant positive impacts on youth mental health. Given that young individuals rely on adults for support, tools, and an enabling environment for success, it is crucial that youth receive care within the communities where they live, learn, and play—spanning from preventive services to inpatient care. In alignment with this imperative, the Governor's year two plan for *Right Help, Right Now* prioritizes youth, shielding them from the adverse effects of social media and ensuring every child has the opportunity to fulfill their God-given potential.

Through our Prompt Placement Task Force, we have worked with state, community-based, private hospitals, community law enforcement, community service boards and others to better understand the challenges facing involuntary placement. While there is certainly more work to be done, we have found the private psychiatric hospitals, to have been good faith partners. The crisis infrastructure envisioned in *Right Help, Right Now* ultimately will positively address demand and ensure that individuals receive the correct care in a more timely fashion.

In closing, it is essential to recognize the large, complex, and ever-changing nature of the behavioral health system. The dedicated staff at our state hospitals tirelessly care for some of Virginia's most vulnerable citizens. As we work towards improving our state hospital system, let us not forget to prioritize the well-being of those who provide care. By supporting and uplifting the individuals who dedicate themselves to this challenging and rewarding profession, we can expect to see positive impacts on the lives of the Virginians we serve.

Sincerely,



John E. Littel

¹ Source: Virginia HHR BHJ Services Survey, launched November 9, 2022, results as of November 30, 2022.

² REPORT OF THE INDEPENDENT REVIEWER ON COMPLIANCE WITH THE SETTLEMENT AGREEMENT. UNITED STATES v. COMMONWEALTH OF VIRGINIA. United States District Court for Eastern District of Virginia. Civil Action No. 3:12 CV 059. October 1, 2022 – March 31, 2023

Appendix D: Other states’ involuntary psychiatric treatment exclusions

JLARC reviewed mental illness definitions and involuntary psychiatric treatment criteria for the 49 other states and Washington, D.C., to identify those that exclude certain diagnoses or conditions from eligibility for involuntary psychiatric treatment (Table D-1).

JLARC also reviewed other states’ approaches to providing services and placements for individuals with neurocognitive and neurodevelopmental disabilities outside of psychiatric hospitals. The identified approaches were those that JLARC staff could identify readily, including through interviews or correspondence with staff in other states and reviews of publicly available information on state programs for these populations. The absence of alternative approaches in Table D-1 for some states should not be interpreted to mean a state has not implemented any approaches to meet these individuals’ service and placement needs.

Additionally, some approaches to support individuals with neurocognitive or neurodevelopmental disorders were identified among states *without* exclusion criteria for these conditions.

TABLE D-1
Other states’ involuntary treatment exclusions and alternative approaches to supporting individuals with neurocognitive and neurodevelopmental disorders

State	Neurodevelopmental exclusions	Neurocognitive exclusions	Other exclusions	Source	Alternative approaches identified by JLARC staff
Alabama	Intellectual and developmental disabilities		Epilepsy, and substance abuse	AL Code §22-52-1.1	
Arizona	Intellectual disabilities		Substance abuse; declining mental ability due to impending death; character and personality disorders	AZ Revised Statutes §36-501	
Arkansas	Intellectual and developmental disabilities		Epilepsy, and substance abuse	AR Code §20-47-202	
California	Intellectual disabilities			CA Welf & Inst Code §5008	
Colorado	Developmental disabilities			CO R.S. §27-65-102	<ul style="list-style-type: none"> Enhanced Medicaid reimbursements to nursing homes for individuals with moderate to severe mental health conditions, cognitive dementia, or acquired brain injury.

State	Neurodevelopmental exclusions	Neurocognitive exclusions	Other exclusions	Source	Alternative approaches identified by JLARC staff
Florida	Developmental disabilities	Dementia and Traumatic Brain Injury	Substance abuse and antisocial behavior	FL Stat §394.455	
Idaho	Developmental disabilities	Neurocognitive disorders	Neurological disorders, physical disabilities, any medical disorder that includes psychiatric symptomology, substance abuse	ID Code §66-329	<ul style="list-style-type: none"> Enhanced Medicaid reimbursement for nursing facilities that designated 20 percent more of their beds for behavioral care.
Illinois	Developmental disabilities	Dementia absent psychosis	Substance use or abnormality manifesting only from repeated criminal or antisocial conduct	405 IL C.S. 5/1-129	<ul style="list-style-type: none"> Provide Home and Community-Based Services waiver for supportive living care. Eligible adults in care homes, assisted-living facilities, or residential memory care. Memory care placements are specifically for individuals with dementia.
Iowa	Intellectual disabilities			IA Code §4.1 & §229.1	
Kansas	Intellectual disabilities	Organic mental disorders ^a	Organic mental disorders ^a , organic personality disorder, antisocial personality disorder, substance abuse	KS Stat. §59-2946	
Maine	Developmental disabilities		Antisocial personality disorder	ME R.S.A. Title 34-B §3801	
Maryland	Intellectual disabilities			MD Code Health-Gen. §10-101	<ul style="list-style-type: none"> Provide Home and Community-Based Service waiver for adults needing assisted living facility services, including individuals with Alzheimer's disease. State operates nursing home and long-term care facilities.
Minnesota	Developmental disabilities		Epilepsy, substance abuse	MN Stat. §253B.02, subd. 17a	
Mississippi	Intellectual disabilities	Dementia	Epilepsy, substance abuse	MS Code §41-21-61	<ul style="list-style-type: none"> Enhanced Medicaid reimbursement to nursing homes for residents of Alzheimer's disease units
Montana	Intellectual disabilities		Epilepsy, substance abuse	MT Code §53-21-102	<ul style="list-style-type: none"> State operates short-term crisis transition homes for individuals with intellectual or developmental disabilities (ID/DD) who need services and support to maintain safety and to address physical, behavioral, and mental health needs.
Nevada	Intellectual disabilities	Dementia	Substance abuse, delirium	NV Rev. Stat. §433.164	
New Hampshire	Intellectual disabilities		Epilepsy, substance abuse	NH Rev. Stat. Ann. §135-C:2	

State	Neurodevelopmental exclusions	Neurocognitive exclusions	Other exclusions	Source	Alternative approaches identified by JLARC staff
New Mexico	Developmental disabilities			NM Stat. Ann. §43-1-3	
North Carolina					<ul style="list-style-type: none"> State operates a neuro-medical center that provides specialized neurocognitive care.
North Dakota	Intellectual disabilities		Substance abuse	ND Cent. Code §25-03.1-02	
Oklahoma	Intellectual and developmental disabilities	Dementia, traumatic brain injury	Seizure disorder, Homeless	43A OK Stat. §1-103	
South Dakota	Intellectual and developmental disabilities		Epilepsy, substance abuse, criminal behavior	SD Codified Laws §27A-1-1	<ul style="list-style-type: none"> Enhanced Medicaid reimbursement to nursing homes for behaviorally challenging residents.
Texas	Intellectual disabilities	Dementia	Epilepsy, substance abuse	TX Health & Safety Code §571.003	<ul style="list-style-type: none"> State operates 13 supported living centers that provide respite (initially up to 30 days), emergency (up to 12 months), and long-term placements for individuals with intellectual or developmental disabilities, medically fragile individuals, or those with behavioral problems.
Vermont					<ul style="list-style-type: none"> Enhanced Medicaid reimbursement for individuals discharged from a state psychiatric hospital with persisting significant behavior management challenges.
Washington	Developmental disabilities	Dementia	Substance abuse	Rev. Code WA §71.05.040	<ul style="list-style-type: none"> Enhanced Medicaid reimbursement to nursing homes for residents who need psychiatric care and have significant behaviors that cannot be safely cared for at standard staffing levels or without other accommodations State covers costs associated with stays in assisted-living facilities (ALFs) for individuals with dementia who no longer can live at home and need state support to cover the costs of long-term services in a facility. The state contracts with ALFs to provide specific dementia care programming.
Wyoming	Developmental disabilities		Substance abuse	WY Stat. Ann. §25-10-101	

SOURCE: JLARC analysis of other states' laws, and publicly available reports and documentation on other states' approaches to providing services and supports for individuals with neurocognitive and neurodevelopmental disorders.

Appendixes

NOTE: These exclusions do not preclude individuals from involuntary psychiatric treatment if they have a co-occurring mental illness that meets the criteria for such treatment. Some states do not have separate definitions of intellectual and developmental disabilities.^a Organic mental disorders include neurocognitive disorders, mental disorders due to general medical conditions, and substance-related disorders.

Appendix E: Other states’ psychiatric alternatives to state hospitals for youth

JLARC analyzed national data on the role state-operated psychiatric hospitals play in each state and found that many states do not operate psychiatric hospitals for children and adolescents. These states include AL, AZ, CA, DE, DC, FL, GA, HI, IL, KS, KY, LA, ME, MT, NJ, NM, ND, OH, OR, PA, RI, TN, UT, VT, WV, WY.

JLARC reviewed approaches used by larger states that do not operate state psychiatric hospitals for children and adolescents to understand how these populations are served in alternative settings. These findings are presented in Table E-1. The identified approaches were those that JLARC staff could identify readily, including through interviews or correspondence with staff in other states and reviews of publicly available information on state programs for these populations. There may be additional approaches used in the other states JLARC reviewed that were not identified. The information presented in Table E-1 should not be interpreted as an exhaustive list of these states’ efforts to support children and adolescents otherwise placed in psychiatric hospitals.

TABLE E-1
Approaches used in other states to serve children and adolescents who need inpatient psychiatric treatment involuntary

State	Crisis stabilization units (CSU)	Psychiatric residential treatment services	Private psychiatric hospitals	Other	Additional information
California	✓	✓	✓		<ul style="list-style-type: none"> State is implementing a Children and Youth Behavioral Health Initiative to improve behavioral health services for children. As part of this, the state awarded grant funding to provider networks to develop new inpatient psychiatric beds, crisis stabilization units, transitional housing, and outpatient services.
Florida	✓	✓	✓		<ul style="list-style-type: none"> State gives preference through its certificate of need process to hospitals providing inpatient psychiatric services that commit to providing a continuum of psychiatric services for children and adolescents (Fla. Admin. Code R. 59C-1.040).
Georgia	✓	✓	✓		<ul style="list-style-type: none"> State regulations require crisis stabilization units to evaluate and accept referred children if they have the capacity to accept them. (Ga. Comp. R. & Regs. R. 82-4-1-.07 (1)). State contracts with private hospitals across the state for inpatient psychiatric beds.
Louisiana		✓	✓		<ul style="list-style-type: none"> State contracts with private hospitals to provide longer-term inpatient psychiatric care for children and adolescents. The contracts secure beds for children/adolescents who are either (1) uninsured or underinsured or (2)

Appendixes

<p>whose stay no longer qualifies for insurance reimbursement because the court order for treatment or barriers to discharge extends their stay beyond what is deemed medically necessary.</p>					
<p>New Jersey</p>	✓	✓	✓	✓	<ul style="list-style-type: none"> • Mobile response stabilization services • State established specialized managed care program for youth with complex behavioral health needs, which is intended to increase capacity and access to in-home and community-based services.
<p>Ohio</p>	✓	✓	✓	✓	<ul style="list-style-type: none"> • Partial hospitalization • State recently awarded funding to five private hospitals to establish new and increase existing psychiatric services for children, including inpatient psychiatric treatment, partial hospitalization, and severe behavioral day treatment. • Severe behavioral day treatment
<p>Pennsylvania</p>	✓	✓	✓	✓	
<p>Tennessee</p>	✓	✓	✓	✓	<ul style="list-style-type: none"> • State contracts with private psychiatric hospitals for inpatient psychiatric beds for uninsured children and adolescents.

SOURCE: JLARC analysis of publicly available reports and documentation on other states' approaches to providing services and support for children and adolescents who need inpatient psychiatric treatment.



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