TASK FORCE on INVOLUNTARY HOSPITALIZATION

Report of the

Task Force on Involuntary Hospitalization

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Chairperson

DATE Month, YYYY

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Introduction

BACKGROUND

In 2015, behavioral health disorders represented the leading cause of disease burden in the U.S., surpassing cancer and cardiovascular disease.[1] Approximately one in five adults in the U.S. experience mental illness in a given year.[2] An increase in psychiatric boarding challenges, escalating healthcare costs, public safety concerns around behavioral health and higher rates of incarceration for individuals experiencing behavioral health issues has solidified a desire to change how we address acute behavioral health needs within our communities. Although the rates of homelessness have declined almost 10% since 2017, per capita, Hawaii is tied for the highest rate of homelessness in the nation.[3] The overlapping issues of homelessness, substance use, and behavioral health disorders present complex problems within our communities.

House Bill 1013 was signed into legislation as Act 090 on June 7th, 2019 by Governor David Ige, formally creating the Involuntary Hospitalization Task Force and which assigned primary responsibility for convening the task force to the Hawaii State Department of Health. The task force aims to examine existing laws and practices pertaining to involuntary hospitalization. Chapter 334, Hawaii Revised Statutes requires that individuals at risk of harm to self or others, as determined by mental health emergency workers in consultation with law enforcement officers, be transported by law enforcement to facilities designated by the director of health for further evaluation and potential involuntary hospitalization, a process referred to as “MH-1.” [4]

The current process for MH-1 patients has been to transport individuals experiencing a mental health emergency to a hospital’s emergency department where they often require involuntary hospitalization. There is a significant burden on hospitals with

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[1] Rabah Kamal et al. Journal of the American Medical Association. Costs and Outcomes of Mental Health and Substance Use Disorders in the U.S. 2017; 318 (5):415
[2] NAMI. Mental Health by the Numbers.https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers.
[3] Henry, Meghan, Anna Mahathey, Tyler Morrill, Anna Robertson, Azim Shivji, and Rian Watt. “The 2018 Annual Homeless Assessment Report (AHAR) to Congress.” https://files.hudexchange.info/resources/documents/2018-AHAR-Part-1.pdf. The U.S. Department of Housing and Urban Development Office Of Community Planning And Development, 2018.
[4] Hawaii Revised Statutes §§334-59 - 334-62

psychiatric facilities in emergency departments given that these facilities receive the bulk of MH-1 patients. For example, an analysis of Oahu's MH-1 consults revealed that Queens Medical Center and Adventist Health Castle receive over 90% of the MH-1 emergency department visits on Oahu. Queens admits approximately 30% of their cases while Castle admits approximately 50%. Emergency facilities have simultaneously experienced a substantial increase in psychiatric emergency admissions which has resulted in overcrowding and unsafe environments for medical staff and patients.

One testimony from a local hospital reported it had experienced a disproportionate increase in the number of MH-1 patients brought into its facility, despite the expansion of designated receiving facilities. In 2018, a reported 60% of the MH-1 patients transported to the facility's emergency department did not require a psychiatric evaluation and could have been transported to another medical facility with a more appropriate level of care. Because emergency departments serve individuals with acute needs, they often do not have the appropriate setting for meeting the long-term needs of these patients.

The harsh reality of this current process is that individuals are not able to receive the appropriate care they need. Consequently, this results in costly hospital admissions and high utilization hospital stays. The Oahu Coordinated Entry System Homeless data from August - October 2017 revealed that the average cost per emergency department visit including ambulance transportation is $3,633 while the average cost of Hospital stay per day including the initial visit is $6,952. On average, the length of stay for MH-1 emergency department admission is 3 days. In addition to costly emergency department visits, those who do not receive appropriate care are not afforded crucial diversion opportunities. Over 2 million people with serious mental illnesses are booked into jail each year.[5] Evidence shows that the prevalence of mental illness in jails is 3-4x higher than the general population. Furthermore, people with mental illness in jail are more likely to be homeless post release. Given the multiple behavioral health and social risk factors, this population is especially at risk of hospital readmissions. A "Revolving Hospital Door" study which measured the rate of hospital readmissions among homeless individuals revealed that half (50.8%) of all hospitalizations resulted in a 30-day hospital inpatient readmission and 70.3% resulted in either an inpatient readmission, observation status stay, or emergency department visit within 30 days of

[5] "NAMI." NAMI, 2019. https://www.nami.org/learn-more/public-policy/jailing-people-with-mental-illness.

hospital discharge.[6] The lack of adequate behavioral health settings to serve this population, along with siloed services, creates a considerable cyclical systemic burden.

Comprehensive crisis response and stabilization services are a crucial element of the continuum of care. Reducing unnecessary emergency transportation and more appropriately placing clients in suitable levels of care will improve outcomes for consumers, reduce inpatient hospital stays and costs, and facilitate access to other necessary behavioral health services and community supports.

PURPOSE

The purpose of this task force was to unite a multidisciplinary team of stakeholders to form a collaborative task force which was tasked to examine the existing laws and systems surrounding involuntary transportation and hospitalization of individuals who are at risk of harm to themselves or others. Five working groups established within the task force examined sections of chapter 334, Hawaii Revised Statutes, recommended how to reduce unnecessary emergency department admissions, and explored ways to improve access for involuntarily hospitalized (MH-1) patients to the most appropriate level of care.

Through this task force, the legislature sought to identify action steps in which the state can adopt in order to improve and construct a more comprehensive system of care and flow of patients through the continuum of care. Furthermore, the task force is committed to reviewing the progress that has been made thus far and ensuring that previous work on this issue is organized in a cohesive way in order to identify gaps and operationalize policies more effectively, for the overall enhancement of the behavioral healthcare system.

The recommendations of the Involuntary Hospitalization Task Force is a collaborative initiative that seeks to reform the current continuum for involuntary commitment and intervention for people in mental health crisis as well as confront the need for a more robust voluntary crisis response system. The central goal is to improve efficiencies within the system and increase efficacy and maximization of current resources by reducing unnecessary emergency department admissions and improving standardized access for MH-1 patients.

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[6] Doran, Kelly M., Kyle T. Ragins, Andrea L. Iacomacci, Alison Cunningham, Karen J. Jubanyik, and Grace Y. Jenq. "The revolving hospital door: hospital readmissions among patients who are homeless." *Medical care* 51, no. 9 (2013): 767-773.

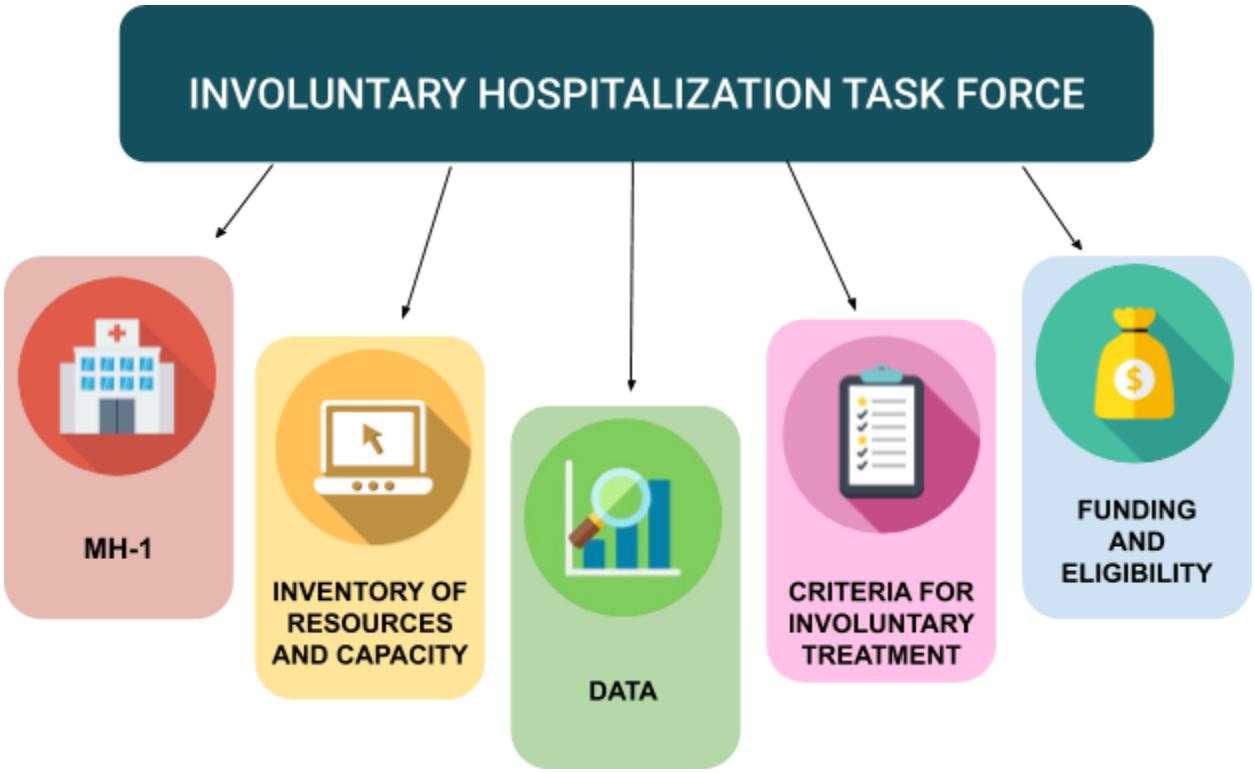
TASK FORCE MANDATE

The issues surrounding involuntary hospitalization and the gaps in the continuum of care have been a longstanding topic among stakeholders. Incremental improvements have been made for decades in an effort to restructure behavioral health treatment within the state. Through acknowledging the abundance of information and previous work that has been accomplished within the community, the mobilization and coordination of these key stakeholders was essential to constructing a collaborative framework to address these challenges.

By examining the success of previous task force planning strategies, it was necessary to involve a multidisciplinary group of individuals who were all committed and actively engaged in finding effective ways to address the issue. Utilizing this collaborative framework provided a structured approach to coordinating efforts across various state and community systems. Additionally, it provided an opportunity to place key stakeholders into subcommittees that were synonymous with their areas of expertise. Within each of these working groups, specific sets of action items were assigned which included: reviewing existing laws and policies, standardizing criteria for designated facilities, assessing gaps in current law enforcement and health care facilities, examining funding and reimbursement, and developing recommendations for a more robust coordinated system of care throughout the State.

Focus Areas

WORKING GROUPS



Focus Area Findings

Involuntary Hospitalization Task Force Working Group : MH-1

Objective # 1

Objective # 2

Objective # 3

Objective # 4

Core Recommendations of the Task Force

The Task Force largely organized its recommendations around the structure of its subcommittees on Data, MH-1, Post-stabilization Community Support and Inventory of Resources and Capacity, Criteria for Involuntary Treatment, and Funding and Eligibility. The Task Force will target all recommendations to the appropriate legislative audience and request necessary resources for the implementation of all Task Force recommendations.