WDH Response to WCAA Title 25 Changes

Background

September 1, 2020

The Wyoming Department of Health (WDH) was asked to provide feedback on recent bill drafts prepared by the Wyoming County Attorneys Association (WCAA) regarding change to the Title 25, Chapter 10 statute. We prepared our initial feedback based both on the bill language and the summary document provided by WCAA.

WDH Feedback on WCAA Title 25 Bill Drafts

1. Repeals all of the current Chapter 10 Articles and replaces with new Articles 5-10.

   WDH Feedback:

   a. The WDH believes that updates to the existing statute are sufficient to provide clarification and efficiencies to the process of hospitalization of mentally ill persons, without a full-scale overhaul.

2. Change to definition of "Mental Illness." Lists of common diagnoses; adds autism to the disorders that cannot be the primary diagnosis.

   WDH Feedback:

   a. The definition of mental illness, as much as possible, should remain consistent with clinical standards to avoid issues with conflicting standards. The draft bill adds physical brain disorders like dementia and acquired brain injuries to the definition of mental illness, which conflicts with Wyoming Life Resource Center Statutes. See 25-2-102(b)(xxxiv) "Organic brain syndrome." Muddling the definition of mental illness in Title 25 in this way could complicate the way the WLRC census is counted towards the Institute for Mental Diseases criteria.

   b. In addition, adding physical brain disorders to definitions of "mental illness" or "serious mental illness" could greatly expand the number of individuals going through the Title 25 process, which will generate financial and operational pressure on the system.

Commented [CR1]: County attorneys strongly feel that continuing to patch W.S. §§ 25-10-101, et seq. ("T-25") will not result in clear law or moving towards destigmatizing mental illness.

Consider that all of the current *Hospitalization of Mentally Ill Persons* statutes are in one Article, *General Provisions*. Whereas, for clarity and easy reference, the proposed law is divided into six articles – (1) Short Title, (2) Purpose and Patients' Rights, (3) Definitions and Process, (4) Responsibilities, (5) Minors, and (6) Liability for Costs. Having divided sections would also help target future amendments.

Throughout the proposed law, the language is updated to reduce the stigma of mental illness. For example, the current definition of *mental illness* connotes that mental illness is inextricably linked to being dangerous. Please see the endnotes for the current definition and the proposed definition.

Additionally, the proposed statutes are interrelated. Amending the current statutes with parts of the proposed statutes could affect clarity and not achieve the purpose of the proposed statutes – particularly proposed Article 7. *Definitions and Process*.

Commented [CR2]: The current definition of mental illness includes physical brain disorders. Specifically, the first line of the definition - ***(ix)*** *"Mental illness" and "mentally ill" mean a physical, emotional, mental or behavioral disorder which causes a person to be dangerous to himself or others . . .*

Commented [CR3]: Under statutory construction and as the current definitions demonstrate, when mental illness is defined in other acts, a different definition in Title 25, Chapter 10 does not affect those acts.

Commented [CR4]: As previously stated, "physical" is part of the current definition and will not expand the number of T-25 cases. The proposed definition clarifies and simplifies what disorders are covered by Title 25, Chapter 10. Additionally, if the legislature wants to exclude dementia or any other disorder, it could easily add the disorder(s) to proposed § 25-10-701(a)(ii).

Further, the proposed definition was drawn from relatively recently amended involuntary hospitalization statutes from other jurisdictions.

3. Adds definition of "Serious Mental Illness" that includes the current three concepts comprising danger to self or others and adds a fourth concept: unwilling or unable to obtain necessary mental health treatment.

    WDH Feedback:

    a. This definition conflicts with an established clinical definition. The introduction of a new defined term may create confusion and inconsistencies in application as Examiners and treating providers are not accustomed to using this term.
    b. From NIMH: "Serious mental illness (SMI) is defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. The burden of mental illnesses is particularly concentrated among those who experience disability due to SMI." SMI does not automatically make someone a danger to self or others.

4. Changes the term "emergency detention" to "emergency custody."

    WDH Feedback:

    a. The WDH has no concerns with this change in language.

5. Changes the term "gatekeeper" to "treatment coordinator." (Everybody hates the term "gatekeeper.") Re-characterizes their input to court as "recommendations" rather than "testimony."

    WDH Feedback:

    a. This is positive development, and comports with the intent of the reformed "gatekeeper" provisions of statute from 2016-2017. Gatekeepers were intended to be "coordinators" or "case managers" so changing this terminology could add clarity.

6. Adds the concept of "process continuum" to break down the barriers among court hearings for emergency custody, involuntary hospitalization, and outpatient treatment. (Designed to aid in judicial efficiency.)
    a. **No feedback from WDH.**

7. Places responsibility to distribute the emergency custody report on the individual examiner or officer preparing the report.
    a. **No feedback from WDH.**

Commented [CR5]: Examiners and treating providers would welcome a clearer definition and very likely are dynamic enough to adjust.

Commented [CR6]: Other jurisdictions have used the term "serious mental illness" (and "severe mental illness") to distinguish a mental illness from an illness serious enough to warrant involuntary hospitalization. The current statutes have no such distinction.

8. Changes the 72-hour initial custody period to 48-hours. Thus, initial court hearings must occur within 48 hours.

WDH Feedback:

a. Note a potential financial issue between county responsibility and state responsibility.

9. Clarifies that for emergency custody commencing on weekends or holidays, the clock starts at 8 AM the next business day.
   a. **No feedback from WDH.**

10. Changes the 10-day limit on continued emergency custody to 21 days.

WDH Feedback:

a. This is very concerning. An extended timeline of "emergency custody" while an individual awaits adjudication/civil commitment generates civil rights concerns. The WDH is interested in listening to, and understanding the rationale for a statutory change of this nature.

11. Adds requirement that examiner evaluate patient every 7 days and report to CA, Patient's attorney, and the treatment coordinator.
   a. No feedback from WDH, but since this functions within the newly proposed emergency custody timeline, we would articulate similar concerns as noted above.

12. Adds requirement for treatment coordinator to report on outpatient treatment patients every 6 months to the CA. CA files the reports with the court.

WDH Feedback:

a. This seems largely positive, and similar to what is currently in the directed outpatient commitment section of statute (W.S. § 25-10-110.1). Any clarity on outpatient commitment could aid in furthering the evolution of these programs.

13. Adds requirement for court to hold outpatient treatment review hearing every 12 months.
   a. **No feedback from WDH.**

14. Adds responsibility for DoH to establish a "medication review committee" to respond to requests from patients' psychiatrists for authorization to administer medications without patients' consent.

Commented [CR7]: The comments don't recognize the last sentence in proposed § 25-10-709(c) which states: "If either party requests a hearing to consider involuntary hospitalization prior to the expiration of 21 days, the court must as soon as practicable hold a hearing."

The maximum time a person could be held in emergency custody is 21 days, but either party could request a hearing any time after the emergency custody hearing. A party could request a hearing within ten days if that party wanted to follow the current timeline.

To some degree this puts a burden on a patient's attorney to request a hearing sooner if the attorney deems it appropriate. It also allows a county attorney to request a hearing sooner if it is clear the patient won't stabilize within 21 days and will need involuntary hospitalization.

The benefit is avoiding a ten day hearing when a patient's treatment provider anticipates the patient will stabilize in eleven days or twelve days . . .

Some other jurisdictions don't require a second/involuntary hospitalization hearing for even longer periods and don't provide the option of requesting a hearing sooner.

Commented [CR8]: This is part of the interrelated process continuum in proposed Article 7. Definitions and Process. The process eliminates the statutory distinction between directed outpatient commitment and convalescent leave.

WDH Feedback:

a. The authority for medical professionals to administer psychotropic medications to individuals in the Title 25 civil commitment process already exists in statute. The WDH is interested to hear from county and local officials on the need for a statutory change in this area. Creation of a medical review committee will come with its own operational and logistical hurdles, and could potentially remove medical decision-making and local control from our communities.

15. Adds to responsibility to DoH to adopt rules governing transportation of patients between treatment facilities.

WDH Feedback:

a. If clarification through administrative rule would be beneficial, the WDH is happy to have this conversation. Transportation requirements is articulated in current statute and also in WDH policy for Title 25 reimbursement (e.g., processing claims for transportation services or providing transportation services directly through State Hospital staff).

16. Grants immunity from liability for those transporting patients by reasonable means.

a. **No feedback from WDH.**

17. Adds responsibility to CAs to represent the State in the case as long as it lasts. Thus, the CA would replace the AG for patients at the WSH.

WDH Feedback:

a. The WDH is working with the Attorney General's office to analyze positive and negative impacts of this suggested change to statute. If a patient has been committed to the State Hospital and is truly in state, not county, custody, then it makes operational sense for the state's attorneys to represent the State Hospital or any state agency in legal proceedings. The WDH is interested to hear additional rationale from the WCAA on this suggested change.

18. Clarifies that parents/guardians must obtain mental health treatment for a minor. Adds obligation for treatment facilities to notify DFS if a minor's parent/guardian does not contact the treatment facility holding their child/ward.

a. **No feedback from WDH.**

19. Changes liability for all treatment costs from the current county/state split to all DoH responsibility. (NOTE: Option B draft bill would keep a county/state split.)

Commented [CR9]: Agreed. However, I have had several cases in which an assistant AG has INSISTED, despite me arguing otherwise, that in order for the WSH to administer psychotropic medication without consent, the county attorney had to file a motion and obtain an order for such administration. CAR

Commented [CR10]: Both treatment providers and law enforcement voiced a need to address transportation.

Proposed § 25-10-801(c) specifically says the rules must be adopted in accordance with the WAPA to allow the interested stakeholders to submit comments and be heard in the rulemaking process.

Commented [CR11]: This was added to address potential conflicts with the AG's Office representing the WSH and handling cases where what is most appropriate for the case may not be what WSH wants. Coincidentally, within the last several months this issue came up when there was a court order sending a patient to the WSH, and the WSH refused to admit the patient.

a. Option A: WDH is responsible for all costs.

i **WDH Feedback**: Counties have local control and are better situated to direct placement and control costs in the first 72 hours of placement. Having WDH responsible for costs without any authority regarding placement will induce some amount of moral hazard, leading to potentially escalating cost to the State.

b. Option B: WDH will reimburse counties for costs exceeding 25% of all counties cost

i **WDH Feedback**: The Department is supportive of cost-sharing with the counties. The Department is also willing to pursue leveraging its Medicaid claims processing infrastructure under a "Chart B" program to receive and pay all bills from designated hospitals, sending periodic invoices to the counties for their share of the costs. This would offer several advantages:

1. It is administratively simpler on counties (paying a consolidated monthly or quarterly invoice rather than individual claims);
2. Costs for counties will likely decrease, as they won't be subject to negotiating down billed charges from hospitals -- rather, they will just pay some share of the stay based on the Department's established per-diem rate.
3. The Department will collect better and more longitudinal data on Title 25 stays and emergency detentions.

Note that this would be a large project and significant undertaking. The Department has had initial discussions with several counties on potentially piloting a project like this. However, COVID-19 and current budget/revenue constraints have tabled discussions.

Commented [CR12]: The assertion of who is best situated to direct placement is largely hollow and irrelevant. Many of the communities that are lucky enough to have a placement option don't have more than one option. Further, the State has the ability to (1) negotiate with treatment facilities to make sure each facility is charging reasonable rates and all counties are charged the same rates; (2) establish a process for all counties to have equitable access to treatment facilities; and (3) utilize its infrastructure for medical billing.

Example- Multiple counties send their T-25 patients to the Wyoming Behavioral Institute (WBI) in Natrona County. The State could ascertain that each county was charged the same rate and the county had equitable access for T-25 patients.

Commented [CR13]: We recognize that there are many more challenges than usual to implementing parts of proposed Article 10. Liability for Costs.

i

Current definition of *mental illness* – W.S. § 25-10-101(a)	**Proposed** definition of *mental illness* and *severe mental illness* –
(ix) "Mental illness" and "mentally ill" mean a physical, emotional, mental or behavioral disorder which causes a person to be dangerous to himself or others and which requires treatment, but do not include addiction to drugs or alcohol, drug or alcohol intoxication or developmental disabilities, except when one (1) or more of those conditions co-occurs as a secondary diagnosis with a mental illness; **(ii)** "Dangerous to himself or others" means that, as a result of mental illness, a person: (A) Evidences a substantial probability of physical harm to himself as manifested by evidence of recent threats of or attempts at suicide or serious bodily harm; or (B) Evidences a substantial probability of physical	**25-10-701. Definitions.** As used in this act: **(a)** "**Mental illness**" means a medical condition that disrupts a person's thinking, mood, and/or behavior associated with distress and/or impaired functioning. **(i)** Mental illness includes, but is not limited to: **(A)** mood and thought disorders such as depression, schizophrenia, and bipolar disorder; **(B)** personality disorders such as paranoid, antisocial, and borderline personality disorders; **(C)** anxiety disorders and phobias; **(D)** degenerative brain disorders; and **(E)** traumatic brain injuries. **(ii)** The patient may have one or more of the following disorders co-occurring, however, the disorders listed in subsections (a)(ii)(A), (B), and (C)

harm to other individuals as manifested by a recent overt homicidal act, attempt or threat or other violent act, attempt or threat which places others in reasonable fear of serious physical harm to them; or (C) Evidences behavior manifested by recent acts or omissions that, due to mental illness, he is unable to satisfy basic needs for nourishment, essential medical care, shelter or safety so that asubstantial probability exists that death, serious physical injury, serious physical debilitation, serious mental debilitation, destabilization from lack of or refusal to take prescribed psychotropic medications for a diagnosed condition or serious physical disease will imminently ensue, unless the individual receives prompt and adequate treatment for this mental illness. No person, however, shall be deemed to be unable to satisfy his need for nourishment, essential medical care, shelter or safety if he is able to satisfy those needs with the supervision and assistance of others who are willing and available; (D) While this definition requires evidence of recent acts or omissions of endangerment, either to self or others, a court may consider a person's mental health history in determining whether directed outpatient commitment or involuntary hospitalization is warranted.	cannot be the primary cause of the condition necessitating placing patient in emergency custody, involuntary hospitalization, or outpatient treatment. **(A)** intellectual disability; **(B)** drug and alcohol intoxication and addiction; and **(C)** autism. **(b)** "**Serious mental illness"** means a mental illness where there is a substantial probability, manifested by a recent act, attempt to act, or failure to act and the person's mental illness and treatment history, that the person is or in the reasonably foreseeable future will be a danger in one or more of the following ways: **(i)** The person will intentionally act or attempt to act to commit suicide or otherwise cause serious bodily harm to the person; **(ii)** The person will act or attempt to act to kill or otherwise cause serious bodily harm to another person; **(iii)** The person will be unable to make rational decisions to meet the person's need for basic food, essential medical care, shelter, or safety causing death or serious bodily harm to the person and no competent adult is willing and able to assist the person meet those basic needs; or **(iv)** The person will be unable or unwilling to obtain treatment necessary to prevent the person's mental destabilization causing one or more of the conditions in (b)(i), (ii), or (iii) of this subsection .