MINUTES
Reduce the Overall Use of Acute Mental Health Hospitalizations Task Force

Senator Alan Solano, Chair
Representative Erin Healy, Vice Chair

Third Meeting, 2019 Interim
Monday, September 30, 2019

Room 362 – State Capitol
Pierre, South Dakota

The third meeting of the SCR 2 Task Force 2, Reduce the Overall Use of Acute Mental Health Hospitalizations, was called to order by Senator Alan Solano at 10:00 AM (CDT) in room 362 of the State Capitol in Pierre. A quorum was determined with the following members answering roll call: Senator Margaret Sutton, Representative Steven Haugaard, Jill Franken, Amy Iversen-Pollreisz, Jim Kinyon, Steve Lindquist, Dianna Marshall, Tom Stanage, Barry Tice, Representative Erin Healy, Vice Chair, and Senator Alan Solano, Chair. Excused: Teri Corrigan.

Staff members present included Wenzel Cummings, Code Counsel; and Cindy Tryon, Senior Legislative Secretary.

NOTE: For purpose of continuity, the following minutes are not necessarily in chronological order. Also, all referenced documents distributed at the meeting are attached to the original minutes on file in the Legislative Research Council office. This meeting was webcast live. The archived webcast is available at the LRC website at sdlegislature.gov.

Welcome and Introductions

Senator Solano welcomed the task force members, audience members, and those listening on the internet.

Approval of Minutes

A motion was made by Representative Haugaard, seconded by Representative Healy, to approve the minutes of the Thursday, August 22, 2019, Reduce the Overall Use of Acute Mental Health Hospitalizations Task Force meeting. Motion prevailed on a voice vote.

Subgroup Report

Senator Solano reported on the subgroup meeting regarding the definition of "appropriate regional facility." The subgroup discussed the need to broaden the scope of the definition.

Ms. Iversen-Pollreisz said currently the Department of Social Services (DSS) considers "appropriate regional facility" as the inpatient psychiatric providers within the state including Avera Behavioral Health in Sioux Falls, Avera St. Luke's in Aberdeen, and Rapid City Regional West in Rapid City. The Veterans Affairs facilities could also be used. The DSS does not have set criteria at this time in regard to other facilities that might qualify as an appropriate regional facility.

Senator Solano said the subgroup met to discuss how to best broaden the scope and still allow DSS to designate which facilities are designated as appropriate regional facilities. One suggestion is to have a facility that wants to have that designation go through an application process.

Dr. Stanage described the loss of 110 adult psychiatric beds due to tornado damage to a Sioux Falls hospital and how that recent crisis is being addressed. Dr. Stanage said the subgroup discussion demonstrated an understanding that in determining the definition of appropriate regional facility it is important to consider the need in South Dakota for a level of care between mobile crisis intervention and inpatient care. The availability of 24-hour staffing, the ability to admit a patient 24/7, some availability of medical care by phone or in person, a crisis stabilization plan,

and daily contact with a QMHP would be some of the issues that need to be addressed when accepting an application. This discussion has been about facilities for adults and does not include juveniles.

Mr. Lindquist said the definition is intended to give DSS guidance as to the requirements for accepting a facility as an appropriate regional facility. The definition needs to be cautious making sure the facility has the ability to say no when a person needing care is beyond the capability of that location or has a diagnosis beyond the scope of the facility; but be inclusive enough so people will utilize the facility as a way to stay local and not have to go to higher levels of care.

Senator Solano said this definition will be included in statute and the things to be included in the requirements are: application to be made to DSS and DSS would make final determination of designation; include the ability for the facility to refuse treatment; need for the location to meet the Department of Health's life-safety codes; the QMHP could initiate an immediate hold if the person is at the facility voluntarily but the condition continues to worsen; and liability protections for the programs.

Dr. Stanage said the goals for this is to increase voluntary admissions and decrease commitments by having this intermediate level of service.

Representative Haugaard said the application needs to be written in a way to encourage facilities across the state to take part in this process and not have the application so cumbersome they don't want to apply. Agencies around the country have shown if there is a voluntary facility available many involuntary commitments are avoided.

Representative Healy asked if increasing the number of facilities will lead to the need for more QMHPs. Mr. Lindquist gave some history of the QMHP program saying the gradual expansion of the program has led to many more QMHPs than there were 10 years ago. There has been some discussion about using video examinations by the QMHP to put a hold on someone. There is nothing in statute saying if this can or cannot be done and perhaps this issue should be addressed.

Dr. Stanage and Representative Haugaard said evaluations are frequently being conducted via video conferencing. Senator Solano said that option should be made clear in statute.

Senator Solano said the goal of the subgroup meeting is to encapsulate the "appropriate regional facility" definition changes into statute in order to broaden the resources of the regional facilities so they are not just inpatient psychiatric hospitalizations.

Statute Analysis: SDCL Chapter 27A-10 (Emergency Commitment)

Mr. Wenzel Cummings, Code Counsel, explained the work he is doing revising SDCL Chapter 27A based on the work of this task force. Mr. Cummings will put the chapter revisions into bill form and will email the draft bill to the task force members for review, revisions, and action at the next task force meeting.

SDCL 27A-10-9.1. Ninety-day initial commitment to facility or outpatient treatment program—Release—Transportation—Notice of right to appeal. Senator Solano said the task force may want to consider if the ninety-day commitment should include allowing the Board of Mental Illness to do a dual commitment to be inclusive of both inpatient and outpatient treatment. The dual commitment may need to be put in statute so the process of going between inpatient and outpatient treatment is more seamless.

Senator Haugaard said the statutes allow the Board of Mental Illness the latitude to order dual commitment but it is not often put into practice. There may need to be better coordination of services with those outpatient facilities as this type of order would require follow-up and someone checking on that follow-up. The statutes may not need to change but rather the practice may need to change. There needs to be incentives for the facilities to accept the patients on an outpatient basis and compensation may be part of the issue of this option not being put into practice.

Mr. Tice said building the capacity within the communities to accept those commitments may be a key component in making the dual commitment successful.

Representative Haugaard said some type of opportunity for a mental health tech who does not need the full QMHP credentialing but can meet with individuals could help address some of the staffing issues. It would be great to have more outpatient facilities to accept these patients, but the money would need to follow the patient. Many patients are past the crisis within 10 days to 2 weeks and the full 90 days is not often needed. There must be an end date to the patient's need for care.

Senator Solano asked about patient evaluations. Mr. Lindquist said an inpatient is continually evaluated by the physician as to whether they meet the criteria or not, and the board has oversight during that entire time.

Mr. Kinyon shared his concerns regarding how these changes may not benefit rural communities in South Dakota. Senator Solano said there is a spin-off benefit in that reducing the hospitalizations in the three psychiatric hospitals and HSC will improve the ability for people from rural areas to find an available bed.

Representative Haugaard said telehealth can help with some care needed in the rural areas of the state.

Dr. Stanage said it is not always clear what the expectations are for outpatient treatment. Impact treatment is often used because it is the highest level of outpatient care. There needs to be some set of expectations when using telehealth for outpatient care.

Senator Solano asked if there needs to be adjustments made to statutes or if outpatient commitment is an area that can be addressed through rule making authority. Representative Haugaard said the legislature needs to take action on this at least for the next few years to avoid rules being written based on an antiquated system.

SDCL 27A-10-9.2. Medical treatment for mental illness or treatment of co-occurring substance use disorder. Dr. Stanage said the option of the commitment hearing for treatment of substance use disorders subsequent to a mental illness commitment is not being used by the mental illness boards. Representative Haugaard agreed the boards have the authority but do not use this option doing a disservice to the patient and the community. The boards have procedures that have been used for years and this is different from the normal procedures. This is a statute that should be used but conversations may need to be held with providers and mental health boards across the state to determine the best process for doing so.

Senator Solano suggested the word "may" in the first line of the statute could be changed to "shall." Representative Haugaard agreed as the change would force mental health boards to take action. All witnesses may not be available for the first hearing so there needs to be a subsequent hearing.

Senator Solano said there may be a need to do some training for mental health board chairs and mental health care providers regarding the rewrite of this chapter.

SDCL 27A-10-9.3. Least restrictive treatment alternative. Mr. Cummings said the definition of "least restrictive" is found in SDCL 27A-1-1. Representative Haugaard said the QMHP provides the treatment options to the board at the hearing.

SDCL 27A-10-9.4. Failure to comply with requirements of outpatient commitment or treatment order. Senator Solano said this statute allows the program director or patient's treating physician to contact law enforcement. The language "treating physician" may need to be broadened. There needs to be some recognition that it would be the treatment provider who would contact law enforcement.

SDCL 27A-10-9.5. Transportation by law enforcement—Limit upon detention and nonconsensual medication. Senator Solano said this section continues on with the outpatient commitment. Law enforcement can transfer the patient to the provider for treatment and allows him or her to be detained for one hour at the treatment facility. Representative Haugaard said this may be the section to include the medications as ordered by the board.

Mr. Lindquist said there can be an order for outpatient commitment and an order for outpatient medication. Noncompliance with a medication program when on the outside is one of the main reasons people relapse.

Senator Solano noted the phrase "treating physician" will need to be changed as it is changed in 27A-10-9.4.

SDCL 27A-10-9.6. Supplemental Hearing or alternative disposition upon failure to comply with requirements of outpatient commitment or treatment order. Senator Solano said this continues the outpatient commitment orders. Dr. Stanage said he has never known the process described in this section to be used. Currently, when this situation occurs a new petition is filed. Representative Haugaard said this situation should be going back to the board that made the original order, not to the state's attorney. The statute references the person failing to comply with the order and that would be the order of the Board of Mental Illness. This should say "goes back to the board" rather than "back to the original petitioner." The state's attorney does not have time to follow up on these issues.

Dr. Stanage said there would need to be a petition or something similar alleging non-compliance sent to the board to make them aware of the issue. Representative Haugaard said there should be something submitted in writing.

In summary, Senator Solano said these suggestions will be included in the rewrite: the person does not comply, the treatment provider notifies the board in writing, the board then decides if there is a need to interview the treatment provider and if there is reason to conduct another hearing.

SDCL 27A-10-9.7. Detention by law enforcement officer for emergency intervention—Immunity from civil liability. Senator Solano said this is intended to protect law enforcement from civil liability when transporting mental health clients. This statute refers to transportation during the involuntary process. People are encouraged to access treatment through voluntary means but during an involuntary commitment process law enforcement transport should be used. This will be discussed further when reviewing the legislative rewrite.

SDCL 27A-10-14. Review hearing after involuntary commitment order—Notice—Rights and procedures. Senator Solano said this section is regarding the review hearing process for involuntary commitment after the initial 90 days. Representative Haugaard said this review process is seldom if ever done. The person this section refers to would be in HSC or off the involuntary commitment orders. Ms. Iversen-Pollreisz said most people would not be staying after the 90 days but if they do they would go to the psych rehab program. The average stay in acute mental health care is 15 days.

Dr. Stanage said for psych rehab there would be the 90-day review and then the commitment time frame may roll over to 6 months and then into a year. There are about 60 patients in the psych rehab wards at this time. Dr. Stanage said he has not heard of any issues with the process.

SDCL 27A-10-15. Additional review hearings. Dr. Stanage said this statute gives the Board of Mental Illness, if justified, the authority to conduct a hearing sooner than would normally occur. There have been special review

hearings when needed. Representative Haugaard said the last sentence of this section refers to not allowing the board to arbitrarily select the length of time for commitment. The board must follow the time of commitment guidelines of up to 90 days. Mr. Lindquist said the last sentence was added in 1991 regarding concern that the board would become more involved in treatment than the psychiatry staff.

SDCL 27A-10-16. Emergency apprehension—Evaluation by designated mental health professional. Dr. Stanage said the "shall" in this section is being ignored and the community mental health centers are not being notified. Mr. Lindquist said there is value in having the healthcare centers notified as they can prepare for the person's arrival. Representative Haugaard said the Sheriff's office often calls the healthcare center as the board chair doesn't always know when someone has been apprehended. It was suggested to change the language to say chair of the board "or law enforcement agency involved."

Ms. Marshall said there are counties that do not have Boards of Mental Illness and in those locations it would be best to have law enforcement to make the contact. Senator Solano said all counties are assigned to a community mental health center and law enforcement will know the appropriate center to contact.

Senator Solano said if this is kept in statute then it should be included in training of law enforcement and the county Boards of Mental Illness.

Mr. Cummings asked about the phrase "with jurisdiction." Representative Haugaard said this jurisdiction would be the county in which the person was apprehended.

SDCL 27A-10-17. Prehearing admission and commitment denied if medical condition exceeds center's capacity. Senator Solano said the center refers to the Human Services Center (HSC). Mr. Lindquist explained at the time this was put into statute there were people being admitted to HSC with severe medical conditions that could not be treated at HSC. This section was added to statute in order to protect HSC.

Ms. Iversen-Pollreisz said DSS tries not to use this statute very often but there are conditions that cannot be treated at HSC such as kidney dialysis. The patient needs to be stable enough medically to be admitted to a psychiatric hospital.

Senator Solano said this section will be kept in statute, but "center" should be changed to "Human Services Center."

SDCL 27A-10-18. Refusal of admission and commitment when medical condition exceeds center's capacity. Dr. Stanage explained 27A-10-17 is prehearing and 27A-10-18 applies after the person is committed.

SDCL 27A-10-19. Twenty-four hour hold of severely mentally ill person permitted—Notice to county board. Senator Solano said this section refers to when a person is taken to the emergency room and the doctor is considered the qualified mental health professional in this situation. The doctor can initiate a 24-hour hold. Senator Solano asked if this section should include allowing QMHPs at appropriate regional facilities to also initiate the 24-hour hold on someone who is there voluntarily but is a danger to self or others.

Dr. Stanage said creating the residential crisis stabilization level of care will divert people from the emergency departments addressing the increased commitments currently coming out of emergency departments. It would be good to allow the crisis center QMHP to do the hold if someone is there who cannot be managed.

Representative Haugaard suggested adding "or other healthcare facility" after the word "hospital." Ms. Iversen-Pollreisz said she would not want to open this to urgent care facilities and prefers to not make that change. Dr. Stanage said he would be reluctant to support this change as it is important in these situations to have 24-hour staff available. Mr. Lindquist said prior to this change in the statutes only law enforcement could detain the person.

SDCL 27A-10-20. Definition of terms related to crisis referral and placement. Senator Solano said this section was added recently and this is when the mobile crisis teams were written into statute. Mr. Tice said the use of crisis intervention team and law enforcement officer may cause some confusion and it would be good to clarify.

Mr. Cummings said he condensed all the mobile crisis team statutes into one section to make those areas more comprehensible. There are still some items in the section needing better clarification.

Mr. Lindquist said the task force may want to reconsider the use of the word mobile. Senator Solano said rather than just mobile perhaps the task force should look at this more broadly using crisis intervention as a whole and that could include telehealth as well. Dr. Stanage said he has copies of definitions of crisis intervention and will forward those to the task force members.

SDCL 27A-10-21. Referral to mobile crisis team or crisis intervention team certified law enforcement officer—Voluntary resolution or placement. Senator Solano said this should include referral to any crisis intervention. Law enforcement does have the authority to apprehend and transport through other statutes so that section may not be needed.

SDCL 27A-10-22. Discretion of law enforcement officer to arrest—Priority given to placement. Mr. Cummings suggested inserting "alleged" before the word misdemeanor. Senator Solano said this statute allows law enforcement the option of taking the person apprehended to treatment first.

SDCL 27A-10-23. Immunity from liability for crisis referral or placement—Exception. Mr. Lindquist said an emergency room physician told him this statute gives the QMHP immunity from liability but does not grant immunity from liability to the QMHP's employer which means the hospital could be at risk. The suggestion was made to include the QMHP's employing organization in this section regarding immunity from liability.

Mr. Cummings said the phrase "law enforcement officer or authority" found in this statute is the only place the word "authority" is used in this context. This is also the statute where criminal liability is mentioned in the last sentence which applies to transport to substance abuse facilities.

Dr. Stanage said the criminal liability section may be based on the fact ingestion is a felony in South Dakota and this may be written to protect law enforcement if they do not report a felony in the completion of their duties when transporting to a substance abuse facility.

Representative Haugaard said the word "authority" in this section may apply to the Board of Mental Illness.

SDCL 27A-10-24. Report to attorney general of certain names for reporting to National Instant Criminal Background Check System. Representative Haugaard said the form submitted to the Attorney General allows for a signature from the States Attorney or the Chair of the Board of Mental Illness, so there may be a place in statute that allows for either of those people to make the report to the Attorney General. Only those who fall under SDCL 27A-1-1(7)(a) and (6) are reported to the Attorney General.

Senator Solano asked if someone can be removed from the background check system. Mr. Cummings said SDCL 23-7-50 allows the person to file a petition and the court can determine the person is not a danger to self or others.

Public Testimony

Ms. Kris Graham, CEO, Southeastern Behavioral Healthcare, Sioux Falls, and Ms. Kim Hansen, Southeastern Behavioral Healthcare, Sioux Falls, were invited to address the task force. Ms. Graham said Southeastern Behavioral Healthcare is one of eleven community mental health facilities in South Dakota. The facility does accept

outpatient commitments in Sioux Falls. When patients come to the facility they have treatment orders and those orders are reviewed constantly.

Ms. Hansen explained the process used when the treatment plan is not being followed by the patient. The patient is assessed as to if the patient meets the criteria for an involuntary hospitalization and the facility petitions to have the patient rehospitalized.

Ms. Graham said the facility has never turned a patient away. When the patient comes to the facility from the hospital setting they usually qualify for Severely Mentally Ill (SMI) funding (state grant funding), so the facility does get paid to care for the patient. Some of the services provided by Southeastern are psychiatric, midmanagement counseling, case management, Impact, and a care program in which the patient is not seen as often but is monitored as to medications and doctor visits. There are a lot of wrap-around services.

Dr. Stanage asked if the facility has used law enforcement to bring the patient to the facility. Ms. Graham said Southeastern also does the med management enforcement. If the patient is not following the treatment plan the police are called in to visit with the patient. Ms. Hansen said the police have never had to remove someone from the facility, but law enforcement may assist the staff at the patient's residence to talk about the importance of following through with the treatment plan. If there is a court order the patient will typically comply with the ordered treatment. If there is a need to get someone hospitalized it is usually a very quick process; that may not be the case in the more rural areas.

Ms. Graham said the facility serves Minnehaha, Lincoln, Turner, and McCook Counties. The outpatient referrals generally come from HSC. The facility does accept patients from other areas in South Dakota if the patient requests care at Southeastern.

Senator Solano thanked Ms. Graham and Ms. Hansen for providing information about Southeastern Behavioral Healthcare.

Mr. Terrance Dosch, Executive Director, SD Council of Community Behavioral Health, Pierre, said the council members do support telehealth but it is important to keep privacy issues in mind when establishing the procedures.

The council members agree with the task force regarding optimizing outpatient commitments by using the existing statutes. Outpatient commitment is not a strategy that can be applied universally across the state and there are capacity concerns. The council members support the development of standards for appropriate regional facilities, which could make a big difference in diverting the need for inpatient care.

Mr. Dosch said he is appreciative that SDCL 27A is going through a rewrite for comprehension. The rewrite will make this statute more applicable, more understandable, and more enforceable.

In response to Senator Solano's question, Mr. Dosch said the six communities that have the Impact program available are Sioux Falls, Yankton, Huron, Aberdeen, Pierre, and Rapid City. Impact is the highest intensity outpatient service.

Mr. Lindquist said Mr. Dosch shared some concerns with liability issues and asked if there would be a benefit to committing a patient to the State of South Dakota rather than to a private non-profit organization. Mr. Dosch said this is an intriguing idea and would like to hear from DSS regarding this concept.

Dr. Stanage said there is an existing transfer of commitment process not used very often where the commitment to HSC is transferred to a community provider.

Mr. Lindquist said Minnesota does allow for a provisional discharge from the state hospital and the discharge can be revoked if the person is not compliant with the plan of care.

Committee Discussion

Senator Solano asked the task force members to review pages 32-33 of the SAMHSA Civil Commitment and the Mental Health Care Continuum ***(Document #1)***.

Senator Solano said the task force must consider the statutes regarding mental health commitments of minors found under SDCL Chapter 27A-15. Changes made to the statutes regarding adult mental health commitments will undoubtedly have some effect on the statutes regarding the commitment of minors.

Mr. Cummings said he will go through the statute regarding mental health commitments of minors section by section and note any discrepancies with the changes the task force is suggesting for the adult commitment statute. Those discrepancies can then be discussed at the next task force meeting.

Mr. Lindquist said there was not a separate section in statute for commitment of minors until 1991. This statute was written to match some of the changes made at the federal level at that time.

Representative Haugaard said the statute regarding minors is seldom used because the parents usually stipulate the type of treatment for their child.

Mr. Cummings said another topic the task force members discussed previously was allowing for treatment for patients from out-of-state. There are a number of sections in SDCL 27A-1 which provide parameters for contracts between in-state facilities and out-of-state agencies. Mr. Cummings asked the task force members to review those sections of code and contact him if there are areas needing revision.

Mr. Lindquist gave the history of the statutes regarding out-of-state patients which allow Avera to do mental health holds for people from parts of Minnesota and Iowa, but these out-of-state residents cannot be transferred to HSC.

Representative Haugaard asked if DSS has a procedural manual for the county Boards of Mental Illness. Ms. Iversen-Pollreisz said DSS does have documents available for use by family members. There is some training for board members, but more could be done and DSS will look at providing targeted training for the Boards of Mental Illness.

At the next meeting, data regarding mental health commitments should be available for the task force members' review. Senator Solano said the task force will need to determine what data will be needed to establish benchmarks in order to understand the impact of change.

Senator Solano set the next meeting date for October 21, 2019, in Pierre starting at 10 AM in room 362 of the State Capitol.

Adjourn

A motion was made by Senator Sutton, seconded by Representative Healy, that the Reduce the Overall Use of Acute Mental Health Hospitalizations Task Force be adjourned. The motion prevailed on a voice vote.

The Task Force adjourned at 4:10 pm.