A Feature on the Wyoming State Hospital

Psychiatrist Profile:

A View from Inside the Safety Net

BY DAVID W. CARRINGTON, M.D.
Medical Director, Wyoming State Hospital

Human societies have always had to cope with the numerous challenging issues related to serious mental illness (SMI). I can imagine a tribe of early hunter gatherers having to insist, perhaps at the tip of a spear, that a member whose behavior had become too disruptive to tolerate leave the safety of the community after the usual rituals had proved ineffective. After a variety of not so successful treatment modalities – including exorcism, imprisonment and exile –what is thought to be the world's first psychiatric hospital was established in London in 1247. Bethlam Royal Hospital (commonly referred to as Bedlam) was an early example of government's acknowledgement of SMI as an important issue requiring its attention and resources. In the United States, the early 1800s saw the rise of the asylum system of care for persons affected by SMI. This movement was spearheaded by Dorthea Dix and Dr. Thomas Story Kirkbride and was centered on providing a relatively pleasant and humane environment for persons affected by SMI to reside and recover.

Despite having a population of only around 30,000, in 1886 the Wyoming Territorial Legislature recognized the need for a publicly supported system of care for SMI persons and appropriated $30,000 for the construction of what was originally named the Wyoming Insane Asylum (later named the Wyoming

Statue from the gates of Bethlem Royal Hospital c. 1676.

State Hospital (WSH)). Like most asylum systems at the time, the Wyoming Insane Asylum followed the Kirkbride Model of Care in which SMI was believed to be curable as long as "moral principles" were followed. These principals included the provision of pleasant surroundings, fresh air, and decent food as well as physical and intellectual engagement. This model also emphasized a professional staff trained to provide care with gentleness and compassion. Despite the progressive and hopeful mission of the hospital, many patients spent the remainder of their lives there as the numerous graves at the hospital cemetery will attest.

Throughout the early 1900s various psychiatric treatments came and went including such now discredited and distasteful practices as hydrotherapy, insulin shock and lobotomy. Though the goal of care at WSH was "cure" or at least stabilization to the point that discharge was appropriate, the increase in the hospital census over the years attest to the challenges of treating persons with SMI. When the hospital was established in 1887 the census was twenty. In 1955 it grew to 655, reaching its peak of 750 in 1968. With the advent of psychotropic medications in the 1950s and the implementation of Medicaid and Medicare in the 1960s, the process of deinstitutionalization of State Hospitals began. The idea was that a small number of hospital beds should be available for the acute stabilization of SMI persons in crisis but that the vast majority of care should be provided by outpatient clinics. This continues to be the model we aspire to today but the reality is not quite that simple.

The Present State of Affairs

The Substance Abuse and Mental Health Services Administration (SAMSA) defines SMI as "someone over 18 having (within the past year) a diagnosable mental, behavioral or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities". The Center for Behavioral Health Statistics and Quality (CBHSQ) estimates that in 2018 there were 23,758 such individuals in the State of Wyoming. Virtually everyone is in agreement that persons with SMI are ideally served by outpatient services in the community where they reside. Psychiatric hospitals should only be used in cases where less restrictive alternatives do not exist. Just this month a federal judge found the State of Mississippi has violated the Americans with Disabilities Act by failing to provide adequate levels of community based care for their mentally ill citizens, thereby unnecessarily confining them in state mental institutions.

In Wyoming the civil commitment of mentally ill persons is governed by Title 25 of the civil code. This statute sets forth the procedures as to when and how someone is to be involuntarily hospitalized. Involuntary hospitalization is an issue largely unique to psychiatric medicine. People are not involuntarily hospitalized for other medical conditions with the rare exception of communicable diseases posing a risk to the public. The practice of involuntary hospitalization remains a necessary but reluctantly utilized option of last resort in psychiatric medicine. On occasion, the very nature of some psychiatric illnesses impairs or precludes SMI individuals from having insight into their illness and their need for treatment. Other factors such as the societal stigma of mental illness and an understandable aversion to the loss of liberty and autotomy make people reluctant to seek or accept psychiatric hospitalization. To be sure, the majority of persons with SMI either alone or with the assistance of their support systems, seek treatment voluntarily when their symptoms increase to a level of discomfort or disability. These individuals are more readily treated by means of outpatient care or short stay voluntarily hospitalization in their communities and they are typically more willing and able to adhere to the course of treatment recommended by their providers. It is for the minority of SMI persons who lack the insight or ability to seek help when needed that the civil commitment laws are intended.

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In order to be involuntary hospitalized in Wyoming, a person must be found by a court to be both mentally ill and a danger to themselves or others as a result of that mental illness. In Wyoming the statutory definition of mental illness includes the presence of dangerousness:

> **Title 25-10-101:** "Mental Illness" and "Mentally Ill" means a physically, emotional, mental or behavioral disorder to cause a person to be dangerous to self or others in which requires treatment, but do not include addiction to drugs or alcohol, drug or alcohol intoxication or

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developmental disabilities except when one or more of those condition co-occurs as a secondary diagnosis with mental illness.

The Wyoming statutory definition of mental illness differs from a more clinical definition which does not require a finding of dangerousness. If an examiner (defined as a licensed psychiatrist, physician, advanced practice registered nurse, physician assistant, psychologist, professional counselor, addictions therapist, clinical social worker or marriage and family therapist) finds a person to be mentally ill under the statute (if the examiner is not a physician or psychologist the court must appoint one to review the findings) and the court finds by clear and convincing evidence that the individual is mentally ill, the court is obliged to consider the least restrictive and most therapeutic alternative available. This may include directed outpatient commitment or more typically, involuntary hospitalization at the WSH. If the committed person is found to be incompetent to make medical decisions, the Court can authorize the involuntary administration of medication subject to the medical judgement of licensed practitioner.

Directed outpatient commitment is a relatively new and underutilized alternative available to the Courts. This option essentially orders an individual to comply with the terms and conditions of a treatment plan as established by an examiner in consultation with any gatekeeper designated by the Department of Health and approved by the court. If the person does not comply with the treatment plan, i.e. take medicine, show up to appointments and refrain from using drugs and alcohol; the court may revoke the outpatient commitment order and schedule an involuntary commitment hearing which could result in the person's being ordered to the WSH. The reason why directed outpatient commitment is used so infrequently likely stems from unfamiliarity with this option (it was enacted in 2016) on the part of the Courts and county attorneys as well as a lack of community resources and expertise available to treat difficult and brittle SMI individuals on an outpatient basis.

Once a court has found by clear and convincing evidence that an individual is mentally ill (and thereby a danger to themselves and others under the statutory definition) and has been ordered to the State Hospital as the least restrictive and most therapeutic option, the committed individual typically doesn't go there right away. There is usually a waiting list to get into the WSH due to the volume of civil commitments that occur throughout the state. As of late the wait list has been in the teens but a few years ago it reached as high as forty or more. The WSH currently has 103 beds available for occupancy. The census of the hospital is typically in the low to mid 70s for a few reasons. The patient rooms in the civil part of the hospital are double occupancy and particularly ill patients with violent or disruptive behaviors may require their own rooms – a challenge we hope to resolve with the construction of the new facility which I will touch upon later. Also of late, patient rooms and treatment areas have had to be closed in order to effect required physical plant renovations including ligature point abatement and the installation of door top alarms to reduce the risk of suicide by hanging.

Natrona Hall currently serves as the administration building of the Wyoming State Hospital.

Due to the waiting list, people who have been ordered to the State Hospital for treatment are usually first diverted to a designated hospital until they are admitted to the WSH or have recovered to the point that admission is no longer required and the Tile-25 order can be dismissed. Most people waiting for admission are diverted to Wyoming Behavioral Institute in Casper, but Cheyenne Regional Medical Center, Ivinson Memorial Hospital and a few others also admit those waiting to get into the State Hospital. The State pays these designated hospitals a per diem while the patient awaits admission. In some cases a committed individual with violent or difficult behaviors will be denied admission by a designated hospital. In such instances, committed persons are sometimes held in local emergency rooms or detention centers while they wait for admission. These individuals are given priority on the State Hospital waiting list and are brought in as soon as possible.

Once admitted to the WSH, an individual treatment plan is developed and a variety of treatment modalities including psychotropic medication, medical care, and individual and group therapy are employed in order to reduce the person's symptoms of illness to the point that they are no longer a danger to themselves or others. When this point is reached, the court is notified by the treating provider that conditions necessitating hospitalization no longer exist and three days later (a statutory requirement) the individual is released to the community for outpatient follow up. The rate limiting step in this process is frequently obtaining housing and funding. People that are committed to the State Hospital frequently do not have others who are willing to help provide shelter and care. Group homes, assisted living centers and nursing home beds are in short supply. These limitations make it difficult and time consuming to place hospitalized patients with SMI back into the community. Other challenges that significantly delay discharge include the lack of available guardians to authorize care and placement for patients who are not competent to direct their care; skilled nursing home beds willing and able to cope with challenging behaviors and supported living facilities able to accept persons with intellectual disabilities and the challenging behaviors that sometimes co-occur.

In addition to treating civilly committed persons, the WSH provides forensic services to the state criminal courts under the jurisdiction of the Title 7 Criminal Code. Forensic services are provided to the entire State on both an inpatient and outpatient basis. A criminal court may order an assessment of a defendant's competency to stand trial or criminal responsibility on either an in or outpatient basis. In FY 2018, 177 outpatient evaluations and 51 inpatient evaluations were ordered. These evaluations are typically conducted by a psychologist with forensic specialization, usually in county detention centers on an outpatient basis or at the WSH when defendants are ordered to be evaluated as inpatients. The inpatient evaluations are conducted on the Criminal Justice Services unit at the WSH. This is a 28-bed unit that is designed to provide greater security than the civil unit. This unit also serves as the treatment unit for the several civil patients with aggressive behaviors that require a greater level of structure and security than can be provided on the civil adult psychiatric services unit of the hospital. If a defendant is found incompetent to stand trial, they are generally ordered to the State Hospital for the purpose of competency restoration. This involves treatment of the symptoms of mental illness that pose a barrier to the defendant's competency to stand trial but also includes group and individual education regarding the legal system and its processes. If a criminal defendant is found not criminally responsible for their actions (not guilty by reasons of mental illness or NGMI) they may be ordered to the State Hospital for an indeterminate period of time. Individuals adjudicated NGMI, particularly those who have committed violent or notorious acts, may remain at the hospital for a long time. When NGMI aquittees are deemed to be treated to a point that they no longer pose a substantial risk of danger to society, the hospital may petition the court for conditional release to the community.

The entry way to the Criminal Justice services unit of the Wyoming State Hospital

The Future

The goal of the WSH is to provide acute stabilization of acutely ill persons with SMI and to transition them back to the communities in as short period of time as possible. A major challenge to the State Hospital's ability to accomplish this goal is its role as the safety net provider for persons with a variety of psychiatric, intellectual, cognitive, neurological or medical

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Construction of the new State Hospital is ongoing and slated for completion sometime in the Summer of 2020.

Architect's rendering of the new State Hospital.

conditions for whom no alternative treatment facility can be found. The hospital is frequently placed in the position of providing custodial care for patients with dementia, intellectual disabilities and personality disorders who exhibit challenging behaviors that other treatment facilities are unable or unwilling to address.

Recognizing these challenges, in 2014 the Wyoming State Legislature established a Joint Executive and Legislative Task Force on Wyoming Department of Health Facilities. This task force presented options for the Legislature to consider governing populations served and the services offered by facilities operated by the Department of Health – primarily at the WSH in Evanston and the Wyoming Life Resource Center (WLRC) in Lander. The Task Force Report advised that the proper role of the State is that of a safety net provider, i.e. the State should not compete with services provided by the private sector. The safety net concept refers to the State's obligation to ensure access as a provider of last resort of facility level services for those individuals that would otherwise be critically endangered or a threat to public health and safety. With this role in mind, a strategic plan defining the roles of the WSH and the WLRC was adopted. Under the plan that has been adopted, the WSH's role is to provide acute short term psychiatric services to Title 25 involuntary hospitalization for civil patients and to continue to provide a variety of forensic services to the criminal courts throughout the State under Title 7. The role of the WLRC is envisioned to expand beyond providing care to the intellectually disabled and traumatic / acquired brain injured persons that they currently serve. The new role of the WLRC will also include providing intermediate level care for SMI persons; long term care for individuals that are hard to place in the private sector, have high medical needs, or require geriatric psychiatric care and manifest challenging behaviors.

To support this strategic vision, the Wyoming Legislature has appropriated $182 million for the construction of new facilities at the WSH and the WLRC. Construction at the WSH is expected to be completed by the summer of 2020 with the facilities at the WLRC anticipated to be completed the following year. A primary benefit of the clearly articulated roles for these "sister facilities" is expected to be shorter wait times for civilly committed patients awaiting admission to the State Hospital and thus a reduced civil commitment waiting list, thereby reducing costs to the State as longer term patients are transferred to the WLRC. The total number of beds at the new State Hospital facility will remain essentially the same (104 vs. 103) but with the shorter length of stay resulting from a focus on acute stabilization, more people will be able to be served.

Wyoming, like all other societal or governmental entities in the history of civilization grapples with difficult decisions related to the care of those of their citizens who struggle with severe mental illness. The care of the mentally ill involves a complex interplay of clinical, legal, financial and moral issues. I am optimistic and encouraged by the attention and concern demonstrated by the Wyoming State Legislature and the Wyoming Department of Health to these universal challenges. No society has ever developed a perfect system to address the difficult issues posed by the effects of severe mental illness. The pendulum of society's willingness to allocate thought, time and treasure to the effects of serious mental illness on both people and institutions has always swung back and forth. From where I'm standing, at least in Wyoming, it appears to me that the pendulum is swinging forward.