Colorado Department of Human Services
Division of Behavioral Health

Senate Bill 09-239
Nurse Practice Act – Drug and Alcohol Abusers Involuntary Commitment Study Report

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Introduction/Background

The issue of changes to the involuntary commitment process for drug and alcohol abusers came about with an amendment to H.B. 08–1061 which originally concerned signatures by Advance Practice Nurses (APN) on specified documents including: handicapped parking, cancellation of health club contracts, disqualification for juror service, immunizations, applications for public assistance, and for absentee voting. The bill was further amended on second reading in the Senate, including the authority for APNs to provide examinations, certification, and testimony for a court to commit drug and alcohol abusers into the legal custody of the state against their will for up to 7 months. Prior Colorado law restricted this authority to a licensed physician. The Governor signed the bill on March 20, 2008. However, in response to concerns raised by the Department and county attorneys, an amendment was later added to H.B. 08-1167 to delay implementation of the involuntary commitment sections of the bill until July 1, 2009.

Following the session, the Department conducted numerous meetings with the Advance Practice Nurses and the Colorado Nursing Association to find a mutually agreed upon solution to the issue. Unfortunately, no agreements were reached and during the 2009 legislative session S.B. 09-239 returned the Nurse Practice Act to its original language; allowing only a physician to provide examinations, certification, and testimony for a court to commit drug and alcohol abusers into the legal custody of the state against their will for up to 7 months. The legislation also required the Department to conduct a review of the involuntary commitment process, including qualifications of health providers involved in the process and any other issue the Department deems appropriate that are related to involuntary commitments and report back to the legislature and make any legislative recommendations.

Summary of Findings and Recommendations -

The Department's review included a review of other state statutes and approaches, extensive discussions regarding what data currently exists or does not exist to inform decision-making in Colorado, and a thorough vetting of diverse opinions concerning the involuntary commitment process. Based on a lack of consensus for agreed upon changes among the involved subject matter experts, the Department does not recommend any legislative changes to the current statutes.

The Department identified areas and opportunities to improve the involuntary commitment process on a system level that would not require legislative changes. The Department will continue to work with stakeholder groups on the common agreement areas and the collection of appropriate data to help inform and continuously improve the behavioral health system to ensure the best outcomes and success for consumers to recover and live healthy productive lives.

Discussion and Study Group Process

Definitions - Central to this review is a clear understanding of the difference between *emergency commitment* and *involuntary commitment* for drug and alcohol abusers.

> **Emergency Commitment** – Emergency Commitment means taking an individual into protective custody for up to five days for detoxification. A number of individuals are authorized in sections 25-1-306, 1107 C.R.S. to make a written application for emergency commitment to an approved treatment facility, including: law enforcement officers; emergency service patrolmen; physicians; nurses; spouses, guardians, or other relatives of the person to be committed; or any other

responsible person. The approved treatment facility is authorized to assess and decide whether an emergency commitment is appropriate.

Involuntary Commitment –Involuntary commitment means committing a person into legal custody against their will for 30-day periods of time and for up to a total of 7 months. A court hearing is required to authorize an involuntary commitment and if committed, individuals are deprived of their civil liberties for the period of the commitment.

Department's Responsibility - The Colorado Department of Human Services', Division of Behavioral Health (Department) is statutorily responsible for ensuring that consumer rights are protected, least restrictive forms of treatment are employed and standards of care are optimal to the consumer's needs. (Sections 25-1-303 and 304 C.R.S.). Additionally, the Department's Involuntary Commitment Coordinator represents the Department in every involuntary commitment court proceeding. If the court determines an involuntary commitment should occur, it orders custody to the Department. The Department has the right to delegate physical custody of the person to an approved treatment facility (Sections 25-1-311 and 25-1-1107 C.R.S.).

Involuntary Commitment Study Group

The Charge and Process

Created in S.B. 09-239, the Colorado Division of Behavioral Health (Division) was asked to:

Conduct a review of the involuntary commitment process, including qualifications of health providers involved in the process and any other issues the Division deems appropriate that are related to involuntary commitments made pursuant to Sections 25-1-311 and 25-1-1107 C.R.S. The Division shall consult with interested parties in conducting the review. On or before January 15, 2010, the Division shall provide a report detailing the findings and any legislative recommendations of the review to the Health and Human Service Committees of the Senate and the House of Representatives, or any successor committees.

In August of 2009, the Department retained a neutral facilitator, Lisa Carlson from the University of Colorado of Denver's School of Public Affairs, to assist in the Involuntary Commitment Study Group (Study Group) process. A group of roughly 35 stakeholders were invited to participate. A complete list of those participating is included in Appendix A. The Study Group met five times over three months with each meeting lasting approximately three hours. The group agreed to the ground rules for the study group process. An agenda committee of diverse interests was formed to help frame the issues and guide the process for each of the meetings. A list of agenda committee members is included in Appendix B. Discussion topics for each meeting are listed below.

September 2, 2009:

- ✓ Understand the Involuntary Commitment Study Group charge and timeline
- ✓ Develop and agree on ground rules and decision making method
- ✓ Clarify and agree on key terms
- ✓ Identify outstanding issues and information needed
- ✓ Develop and agree on the next steps

September 18, 2009:

- ✓ Understand detoxification evaluation and process
- ✓ Better understand nurse and physician distribution in Colorado
- ✓ Understand what other States are doing
- ✓ Clarify legal issues and interest in the involuntary commitment process
- ✓ Develop and agree on the next agenda topics

October 1, 2009:

- ✓ Better understand involuntary commitment evaluation knowledge/skills required
- ✓ Review and refine DBH report "format" outline
- ✓ Understand Freedom of Information Act data obtained from DORA
- ✓ Develop and agree on the next agenda topics

October 14, 2009:

- ✓ Better understand involuntary commitment evaluation knowledge/skills required
- ✓ Analyze signature options and identify areas of agreement (if any)
- ✓ Investigate "Site of Practice" Criteria
- ✓ Review Jefferson County Proposal
- ✓ Develop and agree on the next steps

December 2, 2009:

- ✓ Review and refine the "Jefferson County" Proposal
- ✓ Review and refine the agreements and disagreement to date
- ✓ Understand the next steps

The meeting notes are included in Appendix C. Summaries of the main discussion items follow.

Study Group Findings

Categories of Agreement:

1. Data needs. There are a number of areas where data is incomplete or not available. Data is not currently being collected on the number, if any, of involuntary commitment processes that are not completed because a physician's certification cannot be obtained within the timeframe mandated. In addition, little is known about the education, expertise and location of the healthcare professional provider workforce in Colorado. The level of detail and form of this information (e.g. what level of education, expertise, location) is not available from DORA; where there is data, it is not specific nor compiled and therefore not very helpful. The study group recommends that data be gathered for a specific (e.g. seasonal) period of time. Data gathered should include:

- When an involuntary commitment is not completed because of the lack of a physician's signature.
- When an involuntary commitment is not completed because of lack of treatment.
- What content is being included in the certificate by physician (standardized content).
- Background of physicians certifying involuntary commitment.
- Time frame for certification.

Furthermore, regardless of what if any program changes are made, the participants agree that metrics are needed for program evaluation to better inform decision makers in the future.

2. Balance of interests needed to consider. The Study Group participants agreed to the following interests that need to be balanced in the involuntary commitment process. (The relative weight of each of these items was not agreed upon).

- Civil liberties of patients
- Statewide healthcare workforce shortage
- Consistency statewide in involuntary commitments
- Access to appropriate treatment
- Costs/additional costs: exams, certification, testimony
- Legal: May increase hearing requests for attorneys and requests for 2nd opinions
- State management of involuntary commitment program
- Efficient utilization of resources
- Need for qualified people conducting involuntary commitment certifications

3. Need for more treatment options. The Study Group agreed that there is a shortage of available treatment options for involuntary commitment patients. If no treatment is identified for an involuntary commitment, the process will not go forward.

4. Need for greater system reform. While it is beyond the direct scope of this study group, a number of overarching issues were surfaced. While there was not agreement on any specifics for these systems changes, there was some agreement that changes were needed within the broader context of substance abuse treatment. Some brainstormed concerns/ideas include:

- People languish in detoxification too long because there are no other options short of turning them on the street. This costs money and it is not providing treatment.
- There may be more opportunities for collaboration among providers to deliver more efficient, effective care.
- There may be some creative ways of utilizing technology to ensure access to medical expertise (e.g. establishing protocols to provide telemedicine in the absence of limited medical personnel).
- The lack of insurance coverage for substance abuse treatment and the large number of underinsured people creates a situation where people wait until they are addicted to alcohol/drugs before seeking treatment resulting in the most expensive care.

5. Need for more written protocols and guidelines. There is still widespread misunderstanding between Emergency Commitments and Involuntary Commitments and inconsistencies about the process in general. If there were more written guidelines about the processes, more people could be better informed.

Categories of Disagreement:

1. Problem Definition. The Study Group does not agree about the problem. Some participants do not perceive a problem exists supported by the lack of data about how many involuntary commitments are *not* being made. Others believe that their experience and/or the anecdotal stories are evidence enough to suggest that there is problem. While some participating detoxification centers hold this view, the

participating rural communities, in particular, perceive that access to or willingness of physicians limits their ability to conduct certifications.

2. Categories of professions for certification responsibility. A consensus was not reached about whether other professions should be allowed to certify an individual for involuntary commitment. The group considered over a dozen categories of social workers, counselors, psychologists and advanced practice nurses. There was not agreement about the minimum qualifications needed for the certification process. Each discipline has different education and curriculum requirements, which complicated this analysis. In a dot polling exercise, Certified Addiction Counselors (CAC) without Masters Degrees were clearly not favored and there was a slight margin for inclusion of the Advanced Practice Psychiatric Nurse –APPN (A role of either a Nurse Practitioner or Clinical Nurse Specialist which requires a Masters Degree) to perform this role. However, the dot polling is a straw poll and should not be construed as an exact vote count because it was based upon who attended that particular meeting.

It should be noted that the Advanced Practice Nurse categories of Certified Nurse Midwife (CNM) and the Certified Registered Nurse Anesthetists (CRNA) did not want to be considered for the certification process.

3. Legal Issues. There was not agreement about whether in the eye of a judge a physician is a better witness than other disciplines. Another issue raised (but not agreed to) concerned a possible constitutional challenge. If a non-physician could certify an involuntary commitment for alcohol or drugs but not for mental health and both deprive the respondent of civil liberties, would this be challenged? It should be noted that there are differences between the two processes.

4. Scope of Practice. While the intention of the group was to identify the specific skills, competencies, and qualifications required to conduct the medical certification in the involuntary commitment process, the reality of applying those attributes to the professional disciplines is complicated. Each professional group has specific and different requirements and all have subcategories of specialties with other requirements. The professional disciplines have an interest in practicing to the full extent of their regulatory ability. Others are hesitant to endorse any policy change without having the specifics of required training and education given the varying levels of education among the non-physician providers.

Legislative Recommendations:

The Study Group Process included a review of other state statutes and approaches, extensive discussions regarding what data currently exists or does not exist to inform decision-making in Colorado, and thorough vetting of diverse opinions concerning the involuntary commitment process. Based on a lack of consensus for agreed upon changes among the involved subject matter experts, the Department does not recommend any legislative changes to the current statutes.

The Department identified areas and opportunities to improve the involuntary commitment process on a systems level that would not require legislative changes. The Department will continue to work with stakeholder groups on the common agreement areas and the collection of appropriate data to help inform us to continuously improve the behavioral health system to ensure the best outcomes and success for consumers to recover and live healthy productive lives.