Emergency Commitment of People Residing in Assisted Living Facilities

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Abstract The objective of this study was to describe emergency commitment of people from assisted living facilities (ALFs) and to discuss relevant policy issues. This study used statewide, archival emergency commitment data from July 2000 through June 2008. During the 1 year from July 07 through June 08 there were 3,061 people with 4,163 emergency commitments from ALFs. Some individuals had more than one emergency commitment during the year, with 20% having between 2 and 9 emergency commitments from ALFs. Some of these individuals also had substantial numbers of emergency commitments in the 7 years from July 2000 through June 2007. Discussed are possible factors related to emergency commitment from ALFs and the need for additional research on these topics. This includes availability of mental health services for these populations, the role of client characteristics, and how licensing of ALFs relates to emergency commitment of ALF residents.

Keywords Assisted living facilities · Emergency commitment · Acute mental health care · Mental health care

Introduction

Assisted living facilities (ALFs) are placement options for people with behavioral health disorders. Significant mental health needs have been identified for people in ALFs (Cummings 2003; Cummings et al. 2004; Rosenblatt et al. 2004), with the number of ALFs expanding rapidly as a residential option (Cummings 2003). Mental health needs of people in ALFs are underidentified, with a lack of outreach by community mental health providers to ALF residents (Chapin et al. 2004). One study found that approximately one-third of older adults in residential care facilities or ALFs exhibited behavioral symptoms (Gruber-Baldini et al. 2004). Depression, dementia, psychosis and functional impairment are factors related to behavioral symptoms for residents of ALFs (Jackson et al. 1997).

Emergency commitment (EC) may be used to address the psychological or behavioral crisis needs of persons in ALFs. Every state has an EC statute, with laws typically requiring evidence of (a) mental illness, (b) harm to self, harm to others, and/or self-neglect, and (c) refusal of evaluation or a lack of competence to consent to evaluation. ECs are typically allowed for up to several days. In Florida, where this study was conducted, ECs may be initiated by law enforcement officials, mental health professionals, or judges and may last up to 72-hours. While there has been some focus on the mental health of ALF residents, there is a dearth of research on the use of EC for this population. The purpose of this paper is to describe the characteristics of ECs for residents in ALFs.

Methods

Statewide EC data from July 2000 through June 2008 were used. There is a check box on the Cover Sheet submitted
with each EC initiation form asking mental health center staff to indicate if the person was at an ALF immediately prior to the EC. This data element was added to the form in 2006, but implementation of this change statewide did not occur until the middle of 2007. Therefore, this variable was available and considered to be of sufficient quality to be used for ECs from July 2007 through June 2008. While the majority of the analyses used EC data for adults from July 2007 through June 2008 (n = 105,971 ECs), one analysis utilized data from July 2000 through June 2008. Additional information about these EC data is available elsewhere (Christy et al. 2006).

Results

In the 1 year from July 2007 through June 2008 there were 3,061 people with ECs who were at ALFs just prior to their EC. They had 4,163 ECs from ALFs during the year, which represents 3.93% of all ECs for adults for that year. The average age at the time of EC from an ALF was 50.37 years (Median = 49; SD = 18.15; range 18–101). The majority (n = 3,245; 77.95%) were for people under the age of 65, with 661 (15.95%) between 18 and 30, 578 (13.88%) 31–40, 969 (23.28%) 41–50, 1,034 (24.84%) 51–64, 340 (8.17%) 65–74, and 534 (12.83%) 75 and older (age was not available for 44 ECs). There were 2,317 (55.66%) ECs for men and 1,820 (43.72%) for women, with gender not reported for 26 (0.66%). ECs for women were more common with increased age, with 37.65% of ECs from ALFs for women in the 18–30 age group, 40.95% in the 31–64 age group, and 56.18% in the 65 and older age group.

Almost two-thirds (n = 2,589; 62.19%) of ECs from ALFs were initiated by mental health professionals, with 1,490 (35.79%) initiated by law enforcement and 84 (2.02%) by order of a judge. Slightly more than half (n = 2,329; 55.95%) of ECs were based on evidence of harm only, with 1,018 (24.45%) based on evidence of both harm and neglect, 639 (15.35%) based on neglect only and 177 (4.25%) with no evidence type reported. ECs were based on harm to self (n = 1,185; 28.47%), both harm to self and harm to others (n = 983; 23.61%), and harm to others (n = 678; 16.29%), with 501 (12.03%) not reporting harm type.

Repeated Emergency Commitments

The majority of people with ECs from ALFs experienced only one EC from those settings during the year (n = 2,451; 80.07%). However, some people experienced multiple ECs. Repeated ECs from ALFs included 386 (12.61%) people with two ECs, 140 (4.57%) with three, 50 (1.63%) with four, 19 (0.62%) with five, 9 (0.29%) with six, 3 (0.10%) with seven, 2 with eight, and one person with nine ECs from an ALF during the year.

Identifiers from people with ECs from ALFs during the 1 year period from July 2007 through June 2008 were used to identify ECs for these individuals for the 7 years before this time period (July 2000 through June 2007). Because the variable used to indicate whether a person was at an ALF prior to the EC was not submitted during this time period, the initiation of ECs originating from ALFs during this time period cannot be determined. Of the 3,061 people with ECs from ALFs during the recent 1 year period, 2,033 (66.42%) had one or more ECs in the prior 7 years. Of these, 1,672 (82.24%) had multiple ECs in the 7 years (range 2–170). The 10 highest numbers of ECs during the 7 years were as follows: 88, 93, 104, 112, 116, 118, 136, 142, 156, and 170.

Discussion

While ECs for people residing in ALFs represent a small percentage of the overall ECs (4.97%), the number of people who experienced ECs from ALFs (n = 3,061) in 1 year is meaningful. These residents already have identified needs requiring placement in ALFs, yet they still experienced one, and sometimes many, ECs. These findings suggest several issues to consider in future research and policy development.

As of October 2008 there were 2,275 ALFs in Florida (Florida Health Finder 2008). Florida ALFs that serve three or more “mental health residents” are required to obtain a limited mental health license, which involves additional training related to provision of services for persons with mental illness, having a copy of “each mental health resident’s community living support plan and the cooperative agreement with the mental health care provider,” and assisting residents to implement that plan (Florida Statutes 2010; Florida Administrative Code 2010). Over one-third of ALFs have a limited mental health license (n = 858; 37.71%) (Statistics were computed by the first author with information found at Florida Health Finder in October 2008).

The twenty percent of ALF residents with two or more ECs from ALFs in a 1 year period suggests that there may be issues with implementation of ALF regulations. People may be admitted to ALFs even though there is a lack of fit between the facility and the needs of the individual, which could lead to situations where EC is used as an option to address a crisis. A small group of ALF residents have a history of high numbers of ECs over a 7 year period. It is possible that ALFs admit people with the idea that their facility can meet client needs, but the needs of the client change or a situation arises that leads to a crisis that could not have been foreseen. There is also the possibility that facilities use EC as a way to “dump”
clients, using EC as a means to move a client from their facility. Therefore, in addition to studying issues of how regulations are implemented related to admission, the transition of clients to and from ALFs and receiving facilities is in need of further study.

The services that are available to residents of ALFs can be affected by what is generally available in the community in which the facility is located, since many facilities, including ALFs, rely on community providers for mental health services. This is important to consider in a resource poor state such as Florida, which ranked 48th in per capita mental health spending (National Alliance for the Mentally Ill 2006), and has been graded an F for health promotion and measurement, D for financing and core treatment recovery services, and a D for consumer and family empowerment (National Alliance on Mental Illness 2009). Further, Florida was 38th in substance abuse treatment utilization rates and like other southern states, those “who needed treatment were least likely to have treatment services available to them” (McAuliffe and Dunn 2004). This is for an estimated 2008 Florida population of 13,545,842 individuals, 3,260,235 of whom are 65 and older (Florida Department of Health, Florida Department of Health, Office of Planning, Evaluation and Data Analysis 2008). It is possible that in communities where there are few options for mental health and/or substance abuse treatment, or few ALFs that can meet the needs of people with behavioral disorders, there is an increased likelihood of admission of people to ALFs despite a known gap between service needs and available services at the time of admission to the ALF. The lack of these services may lead to crisis situations that precipitate the need for EC, or EC may be used because there are not other alternatives to address crisis needs of ALF residents. This is a scenario that may be the reality in many communities where people need to be placed somewhere, even if that somewhere is an ALF that is less than ideal but is the only option. The extent to which this occurs also needs to be determined.

The geographic distribution of services and how this relates to the use of EC for ALF residents is also not understood well. For example, nearly one-half (32 or 48%) of Florida’s 67 counties have no receiving facility, where emergency commitments take place. Some ALFs are geographically distant from a receiving facility. How do these facilities handle crises in lieu of using EC? Or is EC used, resulting in movement of clients to distant facilities? Conversely, does having a receiving facility near an ALF make it more likely that EC will be used?

An understanding of the role of various client level characteristics in the EC of people from ALFs is also in need of study. These characteristics include the history of mental health and substance abuse disorders and treatment, the nature of mental illness, social service history, and the psychosocial resources available. Unfortunately, the archival data used for this study do not include diagnosis or information about these other variables. The extent to which people with ECs from ALFs were placed in the ALFs primarily because they have had histories of homelessness or marginal housing (as opposed to other reasons for being in an ALF) is in need of further exploration.

There is considerable variability in ALFs, with variations in their size, structure, services offered, environment in which they are located, and how they are licensed. For example, the median number of residents for which ALFs were licensed was seven (mean = 27.59; SD = 39.89, max = 450) for all ALFs and six for ALFs with limited mental health licenses (mean = 14.58, SD = 21.22). There is considerable variation in size of ALF, with 187 (8.22%) ALFs licensed for 100 or more residents, but over half of ALFs statewide (n = 1,483; 65.19%) and three quarters with limited mental health licenses (n = 667; 77.74%) having 15 or fewer residents. Not yet known are the characteristics of the ALFs that account for higher numbers of ECs. Are they ALFs with limited mental health licenses? Are they ALFs with high percentages of persons with mental illness? Catering to specific populations, such as dual diagnosis or with certain demographic backgrounds? The size of ALFs has been related to the prevalence of dementia and other psychiatric disorders, with these diagnoses more prevalent in smaller ALFs than in larger ones (Leroi et al. 2007). Is the size of the ALF related to the use of EC?

Finally, there has been a focus on older adults in ALFs, sometimes to the exclusion of younger adults. In some communities the typical ALF resident is a middle aged adult with mental illness (Cadena 2006). Data from this study showing that over three quarters with ECs from ALFs were under 65 highlights the need to understand EC for younger individuals ALFs.

References


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