Virginia Association Of Community Services Boards, Inc.

*Making a Difference Together*

*Premier Mental Health, Mental Retardation, and Substance Abuse Services in Virginia's Communities*

# RESPONDING TO MENTAL HEALTH ISSUES

Understanding CSB/BHA Roles and Practices

# Current Activity

**VACSB engaged, with DMHMRSAS, in intensive discussion and planning to define, manage, and improve what can be done NOW to enhance CSB/BHA response within existing resources, regulation, law, policy, practice.**

**We ask to return to this Committee with the results of this effort.**

# VACSB Firm Belief

**The best prevention of critical incidents is the access to and availability of stable, adequate community services that support the varying levels of mental health of adults and children, with intervention early in the life of the disease, as early as primary, middle, and high school.**

# PLEASE

- **Refuse to further stigmatize people with this disease and refuse to elevate fear of mental illness.**
- **Create an environment that supports early screening and treatment.**
- **Avoid coercion and discrimination as much as possible.**
- **View mental illness as a treatable disease.**
- **Recognize that treatment for mental illness works.**

# Recognition Needed

- **There are no "silver bullets" that will resolve the issues brought to light in recent circumstances.**
- **Mental illness, its treatment, and the law are complex issues.**
- **Multiplicity of partners, roles, and responsibilities in the process.**
- **Solutions must be targeted at all components of the process.**

# Cannot Ignore or Minimize

- Severe shortage of professionals
- Inability to recruit and retain staff
- Training needs in legal and treatment systems
- Flexible funding resources to support people and legal responsibilities, regardless of payment source
- Data for QI and accountability

# TODAY

- CSB/BHA Background/Services
- Mandated Emergency Services
- CSB Roles in Involuntary Treatment
- Factors of Varying Local Responses
- Mental illness-a national crisis
- Importance of your work

# Background

- Established in Code in 1968, after numerous legislative studies
- Address community needs of those discharged from state hospitals and training centers
- Permissive to localities, now mandated
- Citizen-directed policy boards

# Expanded Roles

- Services, populations to be served, mission, roles expanded
- Mandated services: Emergency services and case management, within resources
- Code lists services CSB/BHAs **<u>may</u>** provide

# Expanded Roles

- July, 1995, mandated that CSB staff conduct pre-screening evaluations and make recommendations to magistrates regarding need for TDOs
- Involuntary and voluntary outpatient treatment
- Discharge planning for those committed to inpatient treatment

# CSB/BHAs

- Performance Contracts with DMHMRSAS
- Services licensed by DMHMRSAS
- Provider agreements with DMAS and others
- Governed by complex Human Rights law and regulations designed to preserve rights and dignity of consumers

# CSB/BHAs defined in Code

- 10 Administrative Policy CSBs attached to, supported by local governments
- 28 Operating CSBs with ties to local governments, serving 1-10 localities
- 1 Policy Advisory CSB, a department of City of Portsmouth
- 1 Behavioral Health Authority-agreement with City of Richmond allowed by Code

# CSB/BHA Services

- In 2006, served 176,276 individuals
- Of that, 118,885 for mental health needs
- One-third needed long term, intensive and complex services, including psychiatry, medications, housing, case management, day treatment, life skills development
- Such individuals receive highest level of support from CSB/BHAs

# Economic Challenges

- Needs for intensive treatment/supports **and** the mandate for Emergency Services for total population stress funding
- Forces regular assessment of responsibilities, services and capacity to provide services
- Decisions about services and populations are based on assessment and the most critical needs within a community

# Economic Challenges

- Such business decisions impact array and intensity of services in a given locality
- CSB/BHA funding ranks in bottom ten of United States
- Public policy over the years required leveraging Medicaid, less stable now
- Virginia's stringent Medicaid eligibility is a contributing factor among the economic challenges

# Emergency Services

- Evaluating/rendering psychiatric treatment to **prevent** serious incidents
- Pre-screening evaluations for magistrate consideration
- Evaluations for voluntary admissions
- Suicide risk assessment and treatment
- Response to public safety situations and natural disasters
- Services to first-responders

# Examples

- 9/11 Pentagon-ES clinicians there 24/7
- During and after hurricanes Isabel/Gaston
- Personnel returning from Middle East
- VT Tragedy-ES clinicians there 24/7 and till commencement
- Preparing linkage to services for returning students
- Preparing for 18-24 months aftermath of VT

# Code Responsibilities

- Pre-screening evaluations for TDOs
- Locate and coordinate placement for temporary detention
- Provide pre-screening report for Independent Evaluator and Special Justice
- Participate in specific court-ordered or court voluntary outpatient treatment
- Local practices of parties involved vary

# Factors-Varied Local Responses

- Geography/Catchment areas
- Workforce constraints
- Treatment resources within communities, including private hospitals
- Magistrate and Court practices
- Public Safety Resources
- CSB/BHA state and local funding levels

# ECOs

**Emergency Custody Orders (ECOs)**

- Limited to four (4) hours.
- Can be requested by families and associates, physicians, public safety, CSB/BHAs, others
- Can be initiated by a law enforcement officer
- Can be ordered by a magistrate.
- Civil rights of the person under the ECO are suspended, although no criminal action may have occurred.

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# ECO Process Factors

- Custody
- Prescreening evaluation
- Recommendations to Magistrate
- Other evidence reviewed by magistrate
- Locating a crisis unit, an alternative, or a hospital bed and where
- Issuance of TDO (or not)
- Implementation of transportation to willing facility

# ECO Resource Factors

- Geography, miles, and multiple crises to cover
- Time Limits
- Scarce 24/7 Emergency Services Staff
- Availability of magistrates and public safety officials
- Magistrate practices: face to face, phone, etc.
- Magistrate practices regarding consideration of other evidence presented

# ECO Resource Factors

- Magistrate practices regarding medical clearance
- Available crisis stabilization units, detox, alternatives, willing facilities
- Distance to placement, when located
- Public safety officers' time
- If no TDO issued, follow-up with individual

# TDOs

**Temporary Detention Orders (TDOs)**

- Up to 48 hours in a willing facility or up to 72 hours, depending upon scheduling of hearings, holidays, weekends
- Can be requested by families and associates, physicians, public safety, and CSB/BHAs
- Medical clearance may be required by willing facility
- Evaluation, stabilization and treatment are expectations
- Can be involuntary or voluntary based on individuals' consent
- If involuntary, civil rights suspension continued

# TDO Process Factors

- Length of time of actual temporary detention, up to 48-72 hours
- Medical Clearance Requirements
- Independent Evaluation
- Report to Special Justice/Judge

# TDO Resource Factors

- Awareness/knowledge of support system/family
- Availability/timing of health assessment
- Public safety officers' time
- Availability of Independent Evaluator
- Compensation of Independent Evaluator
- Adequacy of time for stabilization, treatment, evaluation
- Commitment hearing notice practices vary

# Commitment Hearings

- Hearings  typically take place in willing facilities, but some may be conducted in a courtroom
- Hearings are open not closed, unless there is a request and the Special Justice accedes to request
- The individual under order is represented by an appointed attorney
- Special justice hears evidence
- Special justice makes a decision for court voluntary treatment, which may be inpatient or outpatient, involuntary inpatient commitment, outpatient treatment, or case is dismissed.

# Commitment Hearing Process Factors

- Hearing and location of hearing
- Attendees at hearing
- Evidence presented at hearing
- Special justice's decision
- Disposition of case

# Commitment Hearing Resource Factors

- Time for attorney representing individual to meet with person and review evidence
- Compensation of attorney
- Presence of families, others, and petitioner
- Written or oral testimony besides what is required for Special Justice to review

# Commitment Hearing Resource Factors

- Practices of Special Justice regarding evidence presentation and who may present
- Presence of Independent Evaluator and/or CSB/BHA staff
- Court decision, disposition
- Court communication

# Mental Illness-National Crisis

- **National prevalence of mental illness is now one in four (1 in 4) adults or 25% of the adult population and one in five (1 in 5) children or 20% of the youth population.**
- Statistic does not include those returning from Middle East with severe behavioral health needs but limited access to services.

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# Mental Illness-Crisis

- MI prevalence rates compete with heart disease, diabetes, and cancer
- Efficacy of medication treatment for MI is greater than for these other diseases (Sacher, 1999)
- For those with MI, primary health issues go untreated
- Those with MI die 25 years earlier than rest of population

# Mental Illness-Crisis

- Private and public insurance policies, law, federal policy place obstacles to treatment
- Public (media too) views and speaks of mental illness in the most pejorative ways
- Policy criminalizes mental illness
- Wonder why people do not seek treatment?
- Wonder why a workforce shortage?

# Mental Illness-a treatable disease

- **Children and adults with mental illness <u>do move into recovery and manage their lives and their illness</u>**

- **<u>if</u> appropriate treatment and support are provided for the amount of time needed. For many, it is lifetime.**

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# Members of HWI

- Can make the most positive statements and impacts on a critical national and state health issue.
- Can refuse to respond in ways that advance fear, discrimination, and stigma.
- Can encourage the public to view mental illness as a treatable disease, people with mental illness as fellow human beings, place a priority on treatment, and assist with recovery from mental illness.

# Members of HWI

- Can recognize and validate the need for early assessment and treatment, as early as in the primary and secondary educational systems.
- **Can make the difference in how Virginia treats people with mental illness and what priority it will become to all public policy leaders!**

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# Recommendations

- Thorough review of the legal intervention process for consistency;
- Emphasize needs of the person with the psychiatric condition;
- Consider best alternatives to coercion;
- Promote training of all parties;
- Address workforce in meaningful ways
- Promote adequate flexible funding for service gaps.

# Code Links

- Community Services Boards (establishment, mission, mandates) 37.2-500 thru 37.2-512
- Behavioral Health Authorities (establishment, mission, mandates) 37.2-600 thru 37.2-615
- Judicial Authorization of Mental Health Treatment (outpatient commitment) 37.2-1100 thru 37.2-1109
- Temporary Detention and Emergency Custody 37.2-808 thru 37.2-810
- Involuntary Commitment Hearings 37.2-814

# THANK YOU!

The VACSB hopes to be able to report on our current efforts with DMHMRSAS at a future meeting of the HWI Committee.

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