

**Joint Subcommittee to Study Mental Health Services
in the Commonwealth in the 21st Century**

Tuesday, April 19, 2016

General Assembly Building
Richmond, Virginia

The Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century (the Joint Subcommittee) met on Tuesday, April 19, 2016, at the General Assembly Building in Richmond, Virginia. Members present included Senator Deeds (chair), Delegate Bell (vice-chair), Senator Barker, Senator Hanger, Senator Howell, Delegate Farrell, Delegate Garrett, Delegate Ransone, Delegate Torian, Delegate Watts, and Delegate Yost.

Update on Certified Community Behavioral Health Centers

Dr. Jack Barber, Acting Commissioner of the Department for Behavioral Health and Developmental Services (DBHDS), provided an overview of the DBHDS Certified Community Behavioral Health Center initiative. Dr. Barber first described the landscape of behavioral health services, noting national and state trends in spending on behavioral health services and some of the positive results and negative consequences of those trends. Dr. Barber also pointed out some issues affecting the Commonwealth's system of publicly funded behavioral health services, noting that the Commonwealth's behavioral health service system is heavily oriented toward emergency services, that the system of services is still biased toward institutional rather than community-based care, that access to and quality of services varies considerably through the Commonwealth, and that many uninsured Virginians are unable to access or pay for services. To address these issues, DBHDS is adopting the Certified Community Behavioral Health Center model of service delivery.

The Certified Community Behavioral Health Center model is a new mode of behavioral health service delivery described in the federal Excellence in Mental Health Act (the Act). This model of service delivery provides a comprehensive range of mental health and substance use disorder services, prioritizes underserved and special populations, includes quality and performance measures to enhance quality of services, utilizes a prospective payment system, and requires ongoing oversight over service delivery to ensure uniform access to a full range of behavioral health services. The Act establishes a grant program to facilitate adoption of the model by participating states. Currently, Virginia is receiving a planning grant. As part of the grant process, DBHDS is working with eight community services boards to determine what changes may be necessary in the community services boards' existing array of services and operational procedures to comply with the requirements of the Act and to develop plans that comply with those requirements. The next step for the eight community services boards participating in the planning grant process is to apply for the federal demonstration grant. If selected, community services boards receiving the federal demonstration grant would receive an increased Medicaid match of 65 percent federal funds for behavioral health services provided.

Dr. Barber noted that even if the Commonwealth does not receive the demonstration grant, DBHDS will continue to move toward adoption of the Certified Community Behavioral Health Center model of behavioral health services delivery. Further, once the model has been implemented at the eight community services boards currently participating in the program, DBHDS will work with the remaining 32 community services boards to implement the model in

those areas as well. Dr. Barber stated that the DBHDS focus on this model will shape final budget requests, operational priorities, alignment of clinical and fiscal incentives, data collection and analysis, and capital expenditures in the coming years.

At the end of the presentation, members of the Joint Subcommittee expressed support for the model, noting the need to focus on community-based services, address differences in local financial contributions to behavioral health services spending, and facilitate coordination of behavioral health and other health care services, including services delivered by and through public schools.

Report on the Investigation of the Death of Jamycheal Mitchell

June W. Jennings, State Inspector General, and Ms. Priscilla Smith reported on the Office of the Inspector General's investigation into the death of Jamycheal Mitchell while in the custody of the Hampton Roads Regional Jail. Mr. Mitchell was found dead in his cell at the jail on August 19, 2015. On August 24, 2015, the Office of the Inspector General received a complaint regarding Mr. Mitchell's death and launched an investigation. Ms. Jennings stated that the objectives of the investigation were (i) to examine the sequence of events surrounding the death of Mr. Mitchell, the processes in place related to referral and admission of Hampton Roads Regional Jail inmates to Eastern State Hospital, and preparation of the DBHDS Office of Internal Audit Investigation Report, (ii) to identify potential risk points, and (iii) to provide recommendations for systemic improvements to prevent similar events in the future. In conducting the investigation, staff of the Office of the Inspector General reviewed multiple agencies and facilities, including the Hampton Roads Regional Jail; Portsmouth Department of Behavioral Health Services; Eastern State Hospital; Department of Behavioral Health and Developmental Services; Portsmouth General District Court; NaphCare, Inc.; and Bon Secours Maryview Medical Center.

According to findings set out in the report prepared by the Office of the Inspector General, Mr. Mitchell, who had been arrested and charged with petit larceny and trespassing, had been incarcerated in the Hampton Roads Regional Jail since April 22, 2015, and at the time of his death was awaiting transfer to Eastern State Hospital in Williamsburg for services for restoration of competency. Records obtained by the Office of the Inspector General showed that an initial Competency Restoration Order (CRO) requiring that Mr. Mitchell be transferred from the jail to Eastern State Hospital for mental health services was entered by the Portsmouth General District Court on May 21, 2015, after receipt of the results of a court-ordered psychological evaluation of Mr. Mitchell. While documents obtained from the Portsmouth General District Court indicate that copies of the order were faxed and mailed to Eastern State Hospital, no records exist to show that the order was ever received by Eastern State Hospital. Records show that a subsequent order was faxed to and received by Eastern State Hospital on July 31, 2016. However, Mr. Mitchell's name did not appear on any of the weekly Forensic Logs prepared by Eastern State Hospital to track individuals awaiting admission to the hospital between the faxing of the second Competency Restoration Order on July 31 and his death on August 19.

At the conclusion of the investigation, the Office of the Inspector General made five observations:

1. The process for transfers from the Hampton Roads Regional Jail to Eastern State Hospital had multiple decision points, risk points, and opportunities for variation, all of which had

the potential to create risks through which unanticipated and egregious outcomes could occur. No evidence existed of any standards, protocols, decision trees, required time frames, or monitoring. In the absence of written and agreed-upon protocols with responsible parties, timelines, and monitoring systems, the root causes of the death of Mr. Mitchell remained at risk of reoccurrence.

2. While Eastern State Hospital is the state facility most significantly affected by the 2014 civil commitment law changes requiring state hospitals to provide a bed of last resort in cases involving emergency custody orders, during the period in which Mr. Mitchell was under a CRO, bed availability was not an issue and a bed was available. While Eastern State Hospital did undertake a revision of policies governing admissions to streamline the process and improve efficiency in August 2015, following Mr. Mitchell's death, the revised plan did not address the completion or updating of the Jail Transfer Waiting List or the development of a monitoring system to ensure that the list remains up-to-date.
3. DBHDS has convened or participated in numerous work groups, committees, and subcommittees in the past several years centering on improving services for individuals with mental illness who are involved with the criminal justice system. All of these bodies, including the DBHDS Transformation Team for the Justice Involved, have made recommendations for additional funding, ongoing committee work, oversight, training, and system redesign, many of which have not been implemented.
4. While DBHDS did undertake an investigation into Mr. Mitchell's death, its report omitted some information and failed to identify the possible root causes of the event. Failure to identify the root cause results in recommendations that have little chance of achieving the goal of preventing similar events in the future.
5. Records provided by NaphCare, Inc., the organization contracted to provide medical care at the Hampton Roads Regional Jail at the time of Mr. Mitchell's death, to the Office of the Inspector General were incomplete and inconsistent, but did show that little action was taken to address Mr. Mitchell's medical and psychiatric symptoms. This failure to provide care is in conflict with the Hampton Roads Regional Jail's direct responsibility to provide quality medical and mental health care for those in its custody. While the contract with NaphCare has not been renewed, the change in provider offers limited promise of improvement in care or documentation in the absence of a change in oversight practices.

The Office of the Inspector General also provided five recommendations related to these observations:

1. DBHDS should take the lead on development of a regional protocol relevant to the management of individuals in the Hampton Roads Regional Jail with mental illness, working together with the Hampton Roads Regional Jail, local police departments, Eastern State Hospital, the Portsmouth Department of Behavioral Health Services, and the Health Planning Region V Reinvestment Project Office, which should focus on cross systems mapping sequential intercepts, crisis intervention teams, jail diversion, court orders, Eastern State Hospital admissions and discharges, and mental health contact in the Hampton Roads Regional Jail by the Portsmouth Department of Behavioral Health Services and other Health Planning Region V community services boards and Eastern State Hospital staff. The protocol should identify responsible parties, timelines, and

process flows and should address gaps and opportunities for improvement. DBHDS should consider the applicability of this protocol to other regions across the state.

2. Eastern State Hospital should revise the process for the development, management, and oversight of the Jail Transfer Waiting List. A system for consistently reviewing the individuals on the list should be created and should include staff from the local court system, community services boards, the Health Planning Region V Reinvestment Project Office through the Facilities Management Committee, and the Hampton Roads Regional Jail.
3. The recommendations of the DBHDS Transformation Team for the Justice Involved were substantive and, had they been implemented prior to August 2016, would have had a significant impact on the handling of cases involving justice-involved individuals with mental illness. This situation should be considered urgent, and implementation plans should be developed immediately.
4. DBHDS's investigation of critical events should be conducted independently by professionals trained and experienced in conducting health care root cause analyses and who have experience working in the behavioral health service systems in question. Reports should include all relevant risk points and analysis of root causes with specific recommendations targeting those root causes.
5. The Hampton Roads Regional Jail should revise the process for overseeing the quality and outcomes of any contract agency that provides medical and mental health care in the jail. This process should ensure regular monitoring, direct oversight, and direct feedback and correction for areas of concern.

Following Ms. Jennings' report, members of the Joint Subcommittee asked several questions about the findings and recommendations. Delegate Farrell inquired about changes to the admissions process at Eastern State Hospital. Ms. Smith confirmed that despite the fact that the safety net law had been in place for some time, and there had been prior warning of the need to prepare for increased demand for beds, Eastern State officials had not made any changes to admissions practices and did not make changes to the jail admission process even in the wake of Mr. Mitchell's death. Senator Deeds inquired about other cases of individuals not included on the Jail Transfer Waiting List. Ms. Smith stated that there were others who had not been included on the list, but that the Office of the Inspector General had been limited to investigation of the case for which it had received a complaint. Delegate Yost inquired why recommendations described in observation 3 had not been implemented. Ms. Smith noted that some of the delay was the result of failure of the General Assembly to act, but that other changes could have been undertaken without General Assembly action and were not. Delegate Ransone asked about inspections, investigations, and oversight of the Hampton Roads Regional Jail and other jails. Ms. Jennings noted that jails are subject to some inspection and oversight requirements. She also pointed out that due to statutory language, the Office of the Inspector General does not have authority to investigate the jails and that the Office was not able to access the Hampton Roads Regional Jail's internal investigation of Mr. Mitchell's death.

Discussion of Work Plan

Following presentations, Senator Deeds announced the creation of four work groups and the purpose and membership of each work group:

- **Work Group 1: Service System Structure and Financing:** To evaluate the existing public mental health service system (the system), including the types of services provided, the organization and structure of the system by which such services are provided, and the oversight and control of the system, and to make recommendations for reform of the existing system to ensure consistent delivery of a full array of high-quality mental health prevention, treatment, and recovery support services across the age range in a timely and effective manner throughout the Commonwealth.

Members: Senator Hanger (Chair), Senator Deeds, Delegate Farrell

- **Work Group 2: Criminal Justice Diversion:** To evaluate any existing mechanisms in the Commonwealth for diverting individuals with mental illness who have committed criminal offenses into available mental health services rather than into the criminal justice system and to make recommendations for reform of any existing mechanisms or for the adoption of additional mechanisms for the diversion of such individuals into mental health services that are consistent with the need to address both the mental health needs of such individuals and the safety of the community.

Members: Delegate Bell (Chair), Senator Cosgrove, Delegate Watts

- **Work Group 3: Mental Health Crisis and Emergency Services:** To evaluate the existing crisis response and emergency services system and provide recommendations for reform of such system to provide high-quality services to individuals experiencing an acute mental health crisis while ensuring the safety of such persons and the community.

Members: Delegate Garrett (Chair), Senator Barker, Delegate Yost

- **Work Group 4: Housing:** To evaluate the existing system for providing access to housing and surrounding services to individuals with serious mental illness who have housing needs and to make recommendations for reform of the existing system to ensure that such individuals receive such access and services and are able to maintain housing stability.

Members: Senator Howell (Chair), Delegate Ransone, Delegate Torrian

Senator Deeds also announced the creation of expert advisory panels to advise and assist the work groups.

Public Comment

Following the work groups discussion, the Joint Subcommittee received public comment from several family members of individuals with mental illness as well as advocates for individuals in need of mental health services.

Materials

Presentations and materials from the meeting can be found on the website of the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century at: http://dls.virginia.gov/interim_studies_MHS.html.