

Summary of May 3, 2016 Meeting of Advisory Panel on Mental Health Crisis Response and Emergency Services

My thanks to everyone for their significant contributions to our May 3 conference call meeting. The meeting was devoted largely to allowing each panel member to make a presentation of up to eight minutes to briefly describe their experience with Virginia's mental health crisis and emergency response system and discuss, based on that experience: (1) what is working in the system, (2) what is not working, (3) what changes are needed to improve outcomes for individuals in crisis, and (4) what needed changes should be given the highest priority.

In summarizing the members' contributions below, I want to take two approaches: first, a narrative, or "sequential intercept" approach, that follows the experience of a person in crisis to identify our strengths, weaknesses and needed changes to enable us to better serve the person in crisis. The second is to look at "system" issues that affect the nature and shape of our emergency service responses. While there is a "System Structure and Finance" advisory panel, many of you pointed out system issues that significantly impact the quality of services to people in crisis. These need to be noted and addressed.

First, your observations in regard to the stages in mental health crisis and response:

1. Before a concern becomes a crisis

- a. What's working
 - (i) PACT (Program of Assertive Community Treatment) teams
 - (ii) Increased peer support services
- b. What's not working
 - (i) Most CSBs are unable to see individuals seeking help on a timely basis in outpatient or home-based treatment. The waiting lists for services increase the likelihood of crises
- c. What's needed
 - (i) "Same day" access to service
 - (ii) An increase in the array, supply and availability of outpatient, case management and community-support services to help prevent the onset of crises. (This includes programs to provide stable housing and employment/income opportunities for persons with serious mental illness.)
 - (iii) Expanded and more robust PACT programs statewide
 - (iv) Expansion of the recovery model and reduction in the stigma associated with mental illness
 - (v) Integration of general health care and mental health care
 - (vi) Expanded use of peer support services

2. When a crisis occurs – responding to the person in crisis in the community

- a. What's working
 - (i) Mobile crisis teams

- (ii) CIT (Crisis Intervention Teams)
- (iii) Crisis stabilization units (CSUs)
- (iv) Improving culture of interagency collaboration and communication

b. What's not working

- (i) Many CSBs have no mobile crisis teams or too few teams, and are unable to respond in the community. For many rural jurisdictions, the challenge of distance results in people having to be brought into a facility (usually a hospital ER) for examination.
- (ii) A number of police and sheriff departments have not adopted a CIT model, while others have trained too few officers to ensure a CIT response for all crises in which law enforcement becomes involved.
- (iii) Many jurisdictions have no CSUs, while most who do have them find demand outstripping supply. While mobile crisis teams, CIT and CSUs attempt to coordinate with each other, these are not integrated services because each is often centered in different organizations. The process of admission to some CSUs remains cumbersome and confusing to some community partners.
- (iv) While community "drop-off centers" have been developed in some jurisdictions, they function primarily to provide assessment and referral (and to enable law enforcement officers to return to the street more expeditiously), and do not provide significant treatment interventions to help resolve the person's crisis.
- (v) Transportation by law enforcement officers of individuals who are in mental health crisis, even for mental health evaluation or treatment, is often an additional traumatic experience for many, and can trigger adverse emotional reactions. Virginia law's current emphasis on using such transport also takes law enforcement officers away from their public safety duties to perform what are in most instances medical functions that could be handled through medical transport.

c. What's needed

- (i) Standardized statewide use of mobile crisis teams and CIT
- (ii) Expanded development of CSUs, and establishment of Psychiatric Emergency Services Units and other alternatives that have more robust treatment interventions available for persons in mental health crisis.
- (iii) Integration of these services
- (iv) The standardized use of medical transport as the default transport for individuals who are in mental health crisis.

3. The person's experience in the hospital emergency department (ED)

a. What's working

- (i) Some EDs are providing training for ED staff on effective interventions for persons in the ED who are in mental health crisis.
- (ii) Some EDs are using tele-psychiatry to provide assistance in responding to persons in the ED who are in mental health crisis.
- (iii) Some EDs are developing their own diversion program.
- (iv) One ED reports that it has provided space within the ED for CSB and CIT staff.
- (v) Those individuals who are in the ED under an ECO and who meet the criteria for temporary psychiatric hospitalization under a TDO, have the guarantee of

receiving hospital care when the 8-hour ECO period expires, as the 2014 revisions to Virginia law require that a state psychiatric hospital be available as a “placement of last resort” for those individuals.

b. What’s not working

- (i) Because many people in mental health crisis in the ED are self-referrals or brought by family or friends, they are not in the ED under an ECO and often are in the ED for many hours, and even days, waiting for a psychiatric bed. (This amounts to psychiatric “boarding” in the ED, and is a growing concern in many EDs.) These individuals are a lower priority for CSB pre-screeners, because the pre-screeners are focused on persons under an ECO. (An observation: some of these individuals may be seeking psychiatric care voluntarily and therefore would not be candidates for a CSB pre-admission screening unless they are already CSB clients. That may need to be explored further.)
- (ii) Even where there is good coordination between ED staff and the area CSBs regarding diversion of a person in crisis from the ED to a Crisis Stabilization Unit (CSU), the process for transferring that person to a CSU can take many hours (See the statement submitted by Allison Land for the May 3 meeting regarding the experience of the Sentara system’s EDs in regard to these transfers.)
- (iii) The ED staff in many hospital EDs are not trained in mental health interventions and treatment. As a result, individuals in the ED in mental health crisis may receive little or no treatment, and a number may become increasingly agitated while waiting for assessment and services, taking more staff away from standard ED care. The care of other ED patients is compromised as a result.
- (iv) “Special populations” – persons with dementia, persons with mental illness and substance abuse problems, persons with mental illness and complex medical needs, children, and both children and adults with both mental illness and an intellectual disability (ID) or other developmental disability (DD) – are particularly challenging, and have the longest “psychiatric boarding” experiences. A related note: homelessness is an increasing issue. A number of individuals who have MI but whose primary issue is homelessness “know the right words to say” in the ER to gain admission for mental health care.
- (v) There is an inadequate supply of residential alternatives to hospitalization. Diversion, referral or discharge from the ED is not possible when there are no alternatives available.
- (vi) There is an inadequate supply of psychiatric hospital beds. It was noted that the increasing number of hospitalized forensic patients, coupled with the significant number of state psychiatric hospital patients who are ready for discharge but who remain in the hospital because a community placement cannot be found for them, is squeezing the number of beds available. The closure of some private psychiatric hospital beds was also noted.

c. What’s needed

- (i) Standard ED protocols should be adopted for providing a certain level of medical intervention and treatment for persons who arrive at the ED in mental health crisis. (An observation: Jim Martinez has since noted to me that DBHDS re-issued updated medical screening and assessment guidelines in 2014 to all practitioners. We may need to look at whether those guidelines are being used in practice.)

- (ii) The use of tele-psychiatry to assist ED staff in addressing the needs of a person in mental health crisis in the ED.
- (iii) Increased partnering with CIT teams and CSB mobile crisis teams (and an increase in the availability of those teams).
- (iv) The development of a Psychiatric Emergency Services (PES) unit for a region that can accept and treat individuals from EDs who are found to need mental health intervention and do not have an underlying medical issue requiring emergency care.
- (v) Increased availability of sub-acute residential and outpatient psychiatric services.
- (vi) Improved processes for transferring sub-acute psychiatric patients from the ED to a CSU.
- (vii) Increased capacity statewide to address the unique needs of persons in crisis who have: dementia; ID and other forms of DD; MI and SA; MI and complex medical needs.
- (viii) Increased capacity statewide to address the needs of children in mental health crisis.

4. Psychiatric hospitalization – voluntary admission in a crisis

- a. What's working (note: as you likely will recognize, this is added comment from me, to supplement the observations made in our meeting, and set out further below, regarding the incentives in the current system toward coercive intervention)
 - (i) There is an increased use of WRAP (Wellness Recovery Action Plan) programs in CSBs and advocacy organizations in the state, as well as a project funded by DBHDS on the use of advance directives by persons with serious mental illness to address mental health crises. The goal of these efforts is to empower individuals to anticipate and plan for future crises by providing instructions on what interventions work best for them and by designating agents to make decisions for them when they are incapacitated by a crisis, thereby avoiding more intensive and more coercive interventions to resolve the crisis.
 - (ii) Virginia law now authorizes a person's health care agent to consent to a person's admission to a psychiatric hospital through the power granted to the agent in an advance directive.
- b. What's not working
 - (i) There is inadequate awareness and programming in the medical and mental health treatment communities to make people aware of advance directives and help people to complete them.
 - (ii) There does not appear to be active awareness among Emergency Services staff and psychiatric hospitals of the role and value of advance directives in mental health crises.
 - (iii) All of the incentives of the current system are toward coercive intervention instead of treatment by consent or substitute consent. For example, state funding for psychiatric hospitalization of uninsured persons is available only for persons who are subject to a TDO or are involuntarily committed. Even persons who have insurance find that insurance companies have a more restrictive standard for the circumstances in which they will pay for inpatient psychiatric hospital care.

- c. What's needed
 - (i) Improved acceptance and encouragement of the use of advance directives and WRAP plans in the mental health treatment community.
 - (ii) Funding for mental health care that promotes voluntary instead of coercive care.

5. ECOs and TDOs

- a. What's working
 - (i) The 2014 statutory reforms ensure that a person who is subject to an ECO and who is found to meet TDO criteria will have the guarantee of a psychiatric hospital placement, with the regional state hospital being the hospital of last resort.
 - (ii) Recent changes in the *medical* ECO and TDO legislation have improved the ability of EDs to address and treat the medical needs of a person who comes to the ED with both a mental health crisis and a medical issue that requires evaluation and treatment.

- b. What's not working
 - (i) When a person is under an ECO, the CSB evaluator is forced to focus immediately on assessing whether the person meets TDO criteria, notifying the affected state hospital of a possible TDO placement there, and searching for an available local psychiatric bed. The CSB evaluator does not have the time or latitude to try to work directly with the individual (and with others) to reduce and resolve the crisis and find a less restrictive treatment alternative. (Taking time to resolve a crisis in an ED also creates tension with the ED, which does not consider the person an appropriate placement.) As noted above, the selectivity of local psychiatric hospitals in accepting patients can result in challenges in finding a psychiatric bed. Some state hospitals are being overwhelmed with TDO placements.
 - (ii) Retaining skilled mental health professionals as CSB evaluators is increasingly difficult, as the demands of the position (engaging, evaluating and providing appropriate referrals for people in mental health crisis; working all hours of the day and night; and, particularly in rural areas, traveling long distances to carry out this work) are not reflected in the level of compensation.
 - (iii) Individuals in crisis can find themselves being taken to multiple sites: the initial site for mental health assessment; a hospital ED for medical clearance before going to a psychiatric hospital; a state psychiatric hospital (often many miles away) for initial placement; then a return to the locality for placement in a local psychiatric facility (after a bed becomes available). These multiple placements delay effective treatment and can exacerbate the individual's crisis instead of helping to resolve it.
 - (iv) Significant issues remain in regard to the nature and extent of medical screening needed before a psychiatric hospital accepts a patient. On the one hand, hospitals sometime appear to require unnecessary and time-consuming (and money-consuming) testing, while on the other hand some psychiatric hospitals report having to immediately send a person who has been TDO'd to their facility to an ED because the person's medical needs are beyond the psychiatric hospital's capacity to manage. (As noted above, part of the current problem may be lack of implementation of existing DBHDS [guidelines](#).)

- (v) The state requirement that law enforcement transport is the default transport in these cases not only carries its own traumas for the individual (who experiences their crisis as being “criminalized”), but it also can delay treatment, as law enforcement officers (especially in rural jurisdictions) may not be available to carry out the transport for several hours.
- c. What’s needed
- (i) A way to provide more time to engage a person who is in mental health crisis and provide assessment and treatment services, to determine whether the person’s crisis can be resolved through such things as simply removing the stressors triggering the person’s crisis, allowing alcohol or drugs in the person’s system to dissipate, or allowing treatment medications to which the person consents to take effect. (As noted above, one suggestion has been the establishment of a Psychiatric Emergency Services unit where this kind of care could be provided, for a period of 24 hours or more, before a decision is made about whether the person needs psychiatric hospitalization.)
 - (ii) More work is needed on getting hospitals to follow existing guidelines for medical screening of persons in mental health crisis, with a goal of eliminating unnecessary screening tests and minimizing the number of different facilities to which a person has to be taken to effect their hospital admission.
 - (iii) Medical transport should be made the default form of transport for persons in mental health crisis, and Medicaid and other medical insurers should provide payment for such transport.

6. Psychiatric hospital treatment and discharge

- a. What’s working
- (i) We did not specifically discuss the current state of treatment in public and private psychiatric hospitals.
- b. What’s not working
- (i) When petitions for involuntary commitment are dismissed by the special justice at the commitment hearing, the persons involved (depending on the psychiatric hospital) may not receive any discharge planning, may not receive any medication or prescription for medication to continue the treatment provided while in the hospital under the TDO, and those persons must connect or re-connect to community treatment providers on their own.
 - (ii) Mandatory outpatient treatment (MOT) is not utilized in most Virginia jurisdictions because it is viewed as being too cumbersome and complex on the one hand and as creating no real incentive for the individual to comply with the ordered outpatient treatment on the other hand. (They note that the person who violates the MOT order can be ordered into psychiatric treatment only if the person again meets the criteria for involuntary treatment. So, they ask, what difference does it make?) Some CSBs appear to be concerned about possible liability issues in providing services and monitoring compliance under MOT orders.
 - (iii) Increasing numbers of individuals appear to be returning to the community from the hospital before they are fully stabilized, resulting in (what appear to be)

- increasing rates of recidivism (though this is an anecdotal observation, with no one in the group citing data).
- (iv) The medication formularies of CSBs, hospital EDs, private psychiatric hospitals, state psychiatric hospitals, and correctional facilities are all different, with the result that individuals can find that the medications and doses prescribed for them in each different facility or program can be different. The result can be poor treatment and a de-stabilizing of the individual as that person has to adjust to different medication regimens that are imposed primarily because of the differing formularies in each setting.
- c. What's needed
- (i) A process to better ensure that persons who are psychiatrically hospitalized under a TDO receive discharge planning services to enable them to continue their treatment in the community, regardless of whether the petitions for their involuntary commitment are dismissed at the commitment hearing.
 - (ii) A review of mandatory outpatient treatment (MOT) laws and practices in other states to determine whether other MOT models are considered effective in helping individuals to live successfully in the community and whether one or more features of those models can be used in Virginia. (Observation: it will also likely be important to look specifically at why CSBs and local courts are not using MOT in its current form. It's notable that the Prince William County CSB has been actively supporting the use of MOT orders. Two documents that might be reviewed are a 2011 [report](#) from the Institute of Law, Psychiatry and Public Policy on MOT implementation and a 2015 power point [presentation](#) by Rita Romano of the Prince William CSB on MOT use.
 - (iii) A review of the frequency of individuals' re-admission to psychiatric hospitalization following discharge and what practices might reduce the rate of re-admission.
 - (iv) Reform in formulary practices to better ensure consistency in medication treatment for individuals regardless of where they might be receiving treatment: in the community, in the ED, in a psychiatric hospital, or in a correctional institution.

7. Mental Health System Issues Affecting Emergency Response

While another panel has the primary task of addressing the structure and financing of the public mental health system, it was clear from the comments of our panel that there are significant “system issues” that are determining the shape and scope of emergency mental health services in Virginia. Those “system issues” included the following:

- a. **The emergency response system has become the “default” system of mental health care in Virginia.** . One result of chronically inadequate funding of community-based prevention and treatment services is that more people experience mental health crises. These crises require more coercive interventions and involuntary care, including hospitalization. The consequence is both higher costs for care and increased trauma and stigma for those who experience crisis care.
- b. **The decentralization and fragmentation of the public mental health system in Virginia.** One panel member, with years of experience in mental health care in three other states, stated that Virginia has “one of the most highly fragmented emergency

systems” he has encountered. He noted the following issues: no single point of accountability; little integration with physical healthcare; no shared clinical databases; collaboration but no integration. He suggested that Virginia’s system allows everyone to escape accountability for outcomes, and that a “single point of accountability” was needed for each defined region in the state. Another panel member noted that the current structure of the system actually created financial incentives for local CSBs to see people hospitalized in state facilities. Localities do not pay any share of the costs of caring for the individuals in their jurisdiction who are in state facilities. This contributes to the problems that all state hospitals face in being able to discharge patients who clearly no longer need hospital level care but for whom, according to the localities from which they came, a local community placement cannot be found.

- c. **The wide variability in quantity, quality and types of public mental health services provided from jurisdiction to jurisdiction.** This statement could have been listed under the “What’s not working” category for almost every step in the emergency response process. While Virginia Code Section 37.2-500 provides that the local community services board “shall function as the single point of entry into publicly funded mental health, developmental, and substance abuse services”, in order “to provide comprehensive mental health, developmental, and substance abuse services within a continuum of care”, the only services that any local CSB is *required* by law to provide are “emergency services”. The rest is up to the local CSB and the Virginia Department of Behavioral Health Services (DBHDS) as set out in the CSB’s annual performance contract with DBHDS. Each CSB receives funding from DBHDS under the performance contract, and from payments for services to consumers (paid by insurers, primarily Medicaid, or self-pay), and from appropriations from the local government(s) of the jurisdiction(s) the CSB serves. Not surprisingly, the wealthier urban and suburban jurisdictions have a far richer array of services than the CSBs in rural jurisdictions, but there is variation across all of the CSBs, reflecting the unique histories, cultures and politics of those CSBs and the jurisdictions they serve. Thus, where you live can have a significant impact on your experience, and on the outcome, if you have a mental health crisis.
- d. **The lack of data integration.** This is likely a function of the two system issues noted above. CSB’s, hospitals and other providers do not have an effective way of sharing information about shared clients, and the result is both delayed and poorer care, and care that is less integrated and coordinated.
- e. **The impact of insurance coverage and non-coverage.** The nature and extent of insurance coverage appears to have a dramatic impact on decision-making and outcomes for individuals. The state will guarantee the costs of treatment for the involuntary commitment of a person who is uninsured, but will not pay for the same person if that person (or that person’s health care agent) voluntarily accepts psychiatric hospitalization that is recommended and medically appropriate. Some insurance companies set a higher and narrower set of standards for agreeing to compensate for hospital and residential mental health care, and even with approval will pay for fewer days of care than in the past, resulting in the “recidivism” issue noted earlier. Finally, the lack of coverage for medical transport in cases of mental health crisis – coupled with the current statutory requirement that law enforcement transport be the “default” transport for such cases – prevents the widespread use of this more appropriate and humane form of transport for people in crisis. Other states have used the medical transport model without any significant problems.

- f. **The value of peer support.** There was consensus among the panel members that the involvement of trained peer specialists at each stage of the emergency response process – and as part of the continuum of mental health care – can have major positive effects on outcomes for people in need of mental health treatment, emergency or otherwise.
- g. **The medication formulary dilemma.** Medications can and do have profound impact on people who have a serious mental illness. The fact that these individuals can be subjected to numerous medication changes depending solely on the facility or program in which they find themselves – separate and apart from the issue of whether those medications are the most effective for the individual – represents a serious dilemma. Such medication changes can delay, complicate or even prevent recovery.
- h. **The need for reform of tele-medicine standards.** While there was widespread agreement about the value of tele-psychiatry at a variety of points along the emergency response system, it was noted by one of the panel members that that current standards in Virginia make implementation of tele-psychiatry for emergency mental health treatment difficult. (Two impediments noted in the meeting: not allowing schools as an “originating site”, and requiring an original face-to-face session before a remote tele-medicine session can be held. Ashleigh Allen has since spoken with the Director of Telehealth at UVA, who reports that it is possible to establish a patient-practitioner relationship via telemedicine, without a prior in-person meeting, unless “the standard of care dictates that an in-person physical examination is necessary for diagnosis”. The Director did confirm that there are “serious restrictions” on the ability to prescribe medications and treatments via telemedicine.)
- i. **The need for workforce development.** Finding, training and keeping high quality individuals for the work in emergency mental health services is challenging and currently underfunded.
- j. **The CCBHC model as a possible model for a statewide standard of services.** STEP VA (System Transformation, Excellence and Performance in Virginia) is the model developed for reforming community-based mental health services in response to a grant opportunity from the federal government. In its grant application, DBHDS is proposing to establish eight Certified Community Behavioral Health Clinics (CCBHCs) that meet standards required for the grant to “improve behavioral health quality, access, and outcomes across all regions, ages and populations in the Commonwealth”. Two of our panel members from DBHDS suggested that this model could become the basis for standardizing community-based mental health services across the Commonwealth.
- k. **The integration of mental health care with general health care and the development of a “population health” perspective.** Finally, one panel member noted that there is inadequate integration of mental health care with general health care, and that mental health care has not become part of the current trend in general medicine toward designing medical services from a “population health” perspective – that is, looking broadly at the major determinants of the health of the people in the community to determine what treatment approaches have the most effective impact on maintaining good health for all community members.