

Mental Health Crisis Response and Emergency Services Expert Advisory Panel: 2018 Agenda

1. The TDO/state psychiatric hospital census crisis: Increasing numbers of individuals continue to be sent to state psychiatric hospitals under Temporary Detention Orders (TDOs), resulting in most of the state hospitals being at or near capacity. In addition, many individuals are being TDO'd to private facilities hundreds of miles from these individuals' homes, an experience that is inconsistent with good care. While the best long term solution to this hospitalization crisis remains the development of more robust community-based mental health services that enable more individuals to receive timely care and avoid crises, expansion of and improvements in the capacity of the community-based emergency services system can improve outcomes for individuals and reduce the need for TDOs to state facilities and to private facilities far from home.

Statewide and regional task forces: The SJ 47 Joint Subcommittee directed the establishment of a statewide task force to address the current TDO crisis. While members have been recruited for that task force, it was determined that the most effective first step was to form regional task forces, as the state's Community Services Boards have functioning regional partnerships with each other and with private mental health facilities in each of the five Health Planning Regions (HPRs). Region 4 in fact took the initiative in setting up a regional stakeholders group meeting that was hosted by the VHHA in late March, followed by a regional leadership team conference call at the end of April. Those meetings identified a number of key issues and prompted or highlighted key studies and initiatives that are now underway. Three separate sub-region stakeholder meetings are currently being planned in Region 3 for late June, and discussions are underway with CSB leadership in both Regions 2 and 5 regarding regional stakeholders meetings. The goal is to have a report from each region to the SJ 47 Joint Subcommittee (and to the statewide task force) by late September, identifying the challenges in each region to developing the needed local capacity to respond to and resolve mental health crises, and describing both the initiatives being taken to address those challenges and what funding, statutory or other changes are needed to be successful in reducing the TDO crisis.

Common challenges: CSB representatives in regions 1, 2, 3, and 5 have been provided with a copy of the agenda used for the Region 4 stakeholders meeting and the summary of that meeting and the subsequent preliminary action plan that was developed. CSB representatives in those regions have indicated that the challenges identified by Region 4 are similar to those they face. They include:

1. Collecting key data.

- a. *Private hospital data:* Currently there is no information available on how many people are in private psychiatric hospitals as voluntary patients and how long they are in the hospital. There is also a lack of information on how many people are coming into the private hospitals from outside the region. These figures dramatically impact the capacity of private psychiatric hospitals to accept TDO patients, but these figures currently are not shared. The ILPPP is in discussions with hospital representatives about the sharing of that information. The VHHA is facilitating that process.

- b. More complete data on the individuals in crisis who receive CSB pre-admission screenings for a TDO: Region 4 stakeholders agreed it would be helpful to take a one-month “snapshot” of key data regarding individuals screened for a TDO, to better determine what local services might best help these individuals avoid the need for hospitalization. The pre-admission screening forms used by CSB evaluators in assessing individuals who may need a TDO contain a great deal of information about the individuals evaluated and their presenting problems and needs, but that information currently can be extracted only through a manual review of each form. The ILPPP has offered to collect that information from the forms to assist the Region 4 CSBs. A list of the data proposed to be extracted is attached. Also attached is a service agreement that the ILPPP would have with each CSB regarding the protection of patient data.

2. Developing non-hospital treatment options for individuals experiencing mental health crisis.

Different CSBs and advocacy organizations are looking at the viability of:

- a. *Psychiatric Emergency Centers (PECs:* 23 hour facilities that could be particularly helpful for individuals whose crisis is fueled in part by alcohol or drug use).
- b. *Crisis Triage Centers,* with a particular focus on developing capacity to help individuals exhibiting aggressive and challenging behaviors.
- c. *Peer-operated Respite Centers,* where individuals can seek out help early on and avoid having their situation escalate into a crisis.
- d. Expanding or modifying the capacity of existing community facilities, such as CSUs.

3. Reviewing the current statutory requirements regarding ECOs and the 8-hour ECO decision-making period for issuing a TDO

In conjunction with the development of non-hospital emergency treatment options, there may be a need to review the current laws on ECOs and TDOs to see if changes can be crafted to allow for a longer ECO period (perhaps up to 24 hours) for individuals who meet certain criteria, as additional time may change the clinical needs of some individuals, particularly those whose crisis is fueled in part by alcohol or drug use. (The viability of such an option would depend upon developing an appropriate therapeutic space for the person in crisis to be during that extended ECO period, and assurance that the individual law enforcement officers serving or initiating the person’s ECO would not be required to maintain custody of the individual for that extended period.)

4. Developing local capacity to serve “special populations” whose treatment needs are outside “standard” mental health treatment interventions.

Several groups were identified who present behavioral challenges during crisis, and placement challenges when hospitalization is no longer needed. They include:

- a. *Individuals who are also experiencing ID/DD.*
- b. *Individuals with a history of aggressive acting out behaviors.*
- c. *Individuals with complex medical needs.*
- d. *Individuals who are homeless or have unstable housing.*

e. *Individuals with dementia.*

A key need is to develop local capacities to provide both community-based care and short-term local inpatient care for individuals with these conditions.

5. Ensuring continuity of services following hospital discharge to lessen dangers of re-hospitalization

One of the Region 4 CSBs is leading an effort, based on an existing program in New York, to identify “high utilizers” early on in their hospitalization and ensure improved collaboration and discharge planning between the hospital and the CSB so that these individuals will continue to receive contact and services following discharge from the hospital.

6. Identifying the non-emergency care that produces the greatest benefit in preventing mental health crises, and get DBHDS and Medicaid Managed Care support for that care.

A fundamental premise of establishing the array of services set out in the STEP-VA program is that access to community care, and particular types and quality of community care, will better enable people with mental illness to avoid crises altogether and, in the event of crisis, enable them to resolve those crises without the need for hospitalization. Medicaid Managed Care is, at least in theory, based on a similar premise. However, discussions with various stakeholders have indicated that the current service payment structure of Medicaid Managed Care is too restrictive, does not allow for needed innovation in community care, and does not cover the costs of care, and that the current arrangement of having 6 Managed Care Organizations (MCOs) imposes ever-higher administrative costs on CSBs and private providers alike, limiting the effectiveness and timeliness of care. Ensuring that Medicaid Managed Care properly supports services that enable people to live in the community and avoid hospitalization will be extremely important.

Public-private collaboration: The improvement of services depends upon a robust and open public-private collaboration, which includes a clear understanding of the current challenges that the public and private sector partners face, and the “business model” upon which each is acting. For example, both the state hospitals and the private hospitals face the same challenges of infrastructure maintenance and modernization, qualified staffing levels, increased regulatory requirements, and increasingly complex patients that impact operational costs and the viability of operating at certain bed capacities. The clearly stated goal of DBHDS is to reduce its hospital bed capacity in order to move to localities the funds for community-based care that would have gone to operating (and upgrading) the state hospitals. The Region 4 stakeholders discussion indicated that there are pressures on private hospitals to reduce their psychiatric bed capacities, for different reasons. There needs to be a shared “business plan” on psychiatric bed capacity in the region (and statewide), with the goal being to maximize the system’s capacity to effectively respond to and resolve individuals’ mental health crises in the least restrictive way possible, and as close to those individuals’ homes as possible. It is hoped that this would include enhancing the capacity of local private hospitals to manage the special behavioral and medical challenges presented by some individuals in crisis. In any event, there will need to be openness and candor in discussing and resolving what each partner can contribute.

2. Tele-mental health services: The 2018 General Assembly, as a result of budget requests by SJ 47 Joint Subcommittee members, approved the requested appropriations to fund the Appalachian Telemental Health Network Initiative - Virginia Pilot". That initiative has four components: (a) develop and maintain the Virginia Telehealth Network, an online directory showing providers who are able to provide telemental health services. (\$50,000 per year); (b) provide online training for telemental health service providers through the Southside Telehealth Training Academy and Resource Center (STAR) \$100,000 per year); (c) enable the Healthy Appalachia Institute at UVA-Wise to hire staff and procure and launch the needed technology platforms and support services for the telehealth network and establish working relationships with providers to use the network as part of the Allegheny Health Network Initiative. (\$650,000 per year, with the potential to obtain a dollar match from the Appalachian Regional Commission and Virginia Tobacco Revitalization Commission); and (d) sustain and expand Project ECHO (currently operated by VDH under a SAMHSA grant), which extends the capacity of primary care providers in under-served communities to consult and coordinate via tele health with specialists in mental health and other services and thereby extend and expand quality care. (\$300,000 per year, extending the one-year grant that VDH currently has from SAMHSA that is focused on treating addiction disorders). DBHDS and VDH staff are in the process of meeting to discuss the plans for implementation of this Initiative.

In the meantime, the study by JCHC of the 2016 report and recommendations of Dr. Wibberly regarding statewide implementation of telemental health services continues, with Dr. Paula Margolis being the lead researcher and writer on that study. Dr. Wibberly's report was the result of a project initiated through the SJ 47 Joint Subcommittee, as is the current JCHC study of Dr. Wibberly's report. A work group from the Emergency Services Advisory Panel continues to consult with Dr. Wibberly and with Dr. Margolis, and will be meeting with them within the next two weeks to discuss the next areas of focus for that study.

3. Alternative transportation services for individuals in mental health crisis: The 2018 General Assembly, as a result of budget requests by SJ 47 Joint Subcommittee members, approved appropriations for the phased development of alternative (non-law enforcement) transportation of children and adults in mental health crisis who are under a Temporary Detention Order (TDO). The alternative transportation work group of the Advisory Panel will continue to have input on the development of the alternative transportation plan, including the development of standards, procedures and training on the transportation of children. The ILPPP plans to conduct research on at least the first year of implementation, which is likely to be limited to one or two regions of the state before statewide implementation.

3. Possible additional advisory work groups: Mandatory Outpatient Treatment (MOT) and Study of Commitment Criteria Relating to First Episode Psychosis- The ILPP is exploring studies into both MOT and developing more nuanced responses to first episode psychosis. Depending upon how these studies move forward, the Advisory Panel may request to have a work group from the panel provide input and consultation into this work, with the goal of providing recommendations to the Joint Subcommittee at a later time.