

Summary of May 17, 2016 Meeting of Advisory Panel on Mental Health Crisis Response and Emergency Services (our second meeting)

Thanks again to the panel for an excellent conference call meeting on May 17. In that second meeting of our panel, the members responded to the issues in mental health emergency services that were raised in our May 3 meeting, and identified what they considered to be the three issues that should receive priority consideration. We reversed the order of presentation from the first meeting, and invited questions and comments following each panel member's presentation. This produced some important sharing and discussion.

Below is a summary of my "take aways" from that meeting, and the priorities that appeared to emerge as a consensus of the group.

I. Key Needed Changes for an Effective Emergency Response System

The panel discussion identified needed changes in the existing system across three major categories of care: (1) prevention and community treatment; (2) crisis intervention; (3) transition from crisis. The following list (with the one noted exception) reflect what I perceived to be the consensus among the panel members:

A. Prevention and Community Treatment

1. ***The need for standardized set of "core" community services that are available equally throughout Virginia:*** No standardized set of "core" services has been agreed upon as characterizing a community that has a "complete" set of needed prevention and community-based treatment services. In addition, across Virginia jurisdictions, services that have the same name do not deliver the same services, and do not deliver them in the same way. There is hope that the development of the "model" "Certified Community Behavioral Health Centers" under the current STEP ("System Transformation Excellence and Performance") VA grant proposal might identify both the nature and level of such "core" services that are needed.

2. ***The critical need for stable housing:*** A significant number of persons with mental illness are seeking emergency services largely because of turmoil arising directly out of their unstable living situation. Even excellent outpatient treatment will not resolve the mental health crises arising out of homelessness.

B. Intervention

1. ***The need for standardized set of "core" emergency services that are available equally throughout Virginia:*** A variety of community-based intervention programs - mobile crisis teams; CIT (Crisis Intervention Team) and particularly CIT training and certification for police officers; the availability of walk-in facilities for people in crisis seeking help; and Crisis Stabilization Units (CSUs) for people needing a short-term residential setting for recovery – have established their effectiveness in improving the quality of interventions and outcomes for people in mental health crisis, but no standardized set of "core" services has been agreed upon as characterizing a community that has a "complete" set of needed emergency services. Key problems are that (a) these programs have been implemented in a highly variable fashion across different jurisdictions in Virginia, and (b) even in communities that have these services, they are not yet fully integrated.

2. *The need to properly understand and address the problem of psychiatric boarding in hospital EDs:*

Largely as a result of current law, there are different “categories” of individuals in crisis coming into the ED, each with a different response pattern and outcomes:

a. *Individuals in the ED under an ECO:* Individuals who come to the ED under an Emergency Custody Order (ECO) generally are discharged from the ED to a psychiatric hospital setting (or elsewhere) within 8 hours, as this is a result that is now required by statute. However, because of the short time frame in which a psychiatric hospital placement has to be found for such a person, the focus of the CSB evaluator from the very beginning is on the issues of: (a) whether the person meets the criteria for a Temporary Detention Order (TDO), and (b) if the person does meet those criteria, what psychiatric hospital has an available bed. There is little or no time to engage the person therapeutically, to see if some additional time might help the person resolve part or all of the crisis or reduce the person’s difficulties to the point that a less restrictive treatment setting would work. This is the case because the law requires a TDO decision within 8 hours of the issuance of the ECO (with a psychiatric hospital being the presumptive placement for a TDO).

b. *Individuals in mental health crisis in the ED but not under an ECO:* In addition to those who are in the ED under an ECO, there are three other distinct groups of people who are in the ED primarily for mental health issues, either in the ED on their own initiative or brought in by family or friends (or sometimes brought “informally” by a police officer): (a) those who are in serious crisis and may meet the criteria for a TDO but, due to their voluntary status, are not under the 8-hour time constraint imposed by statute for those under an ECO; (b) those whose mental health crisis does not require inpatient psychiatric care but who clearly need to be in a supervised residential setting such as a Crisis Stabilization Unit; and (c) those whose crisis might well be addressed through an outpatient psychiatric session but who appear too unstable to discharge from the ED without psychiatric care in the community.

Data from the Sentara Healthcare system shows that, for those individuals identified by the ED as appropriate for transfer to a CSU for treatment, the length of stay in the ED until transfer can be made to a CSU in the Tidewater area can be up to 3 *days* or more. This long wait is due to a combination of factors, including the limited number of placements available in the region’s CSUs; the lack of sufficient staff at the CSUs to handle admissions screenings from the ED; and the lack of mobile teams that might otherwise be able to respond to the EDs and provide screenings and referrals.

Referrals of individuals from the ED to outpatient treatment in the community is difficult for ED physicians because many CSBs have a waiting time of approximately 2 weeks before an intake appointment, and an additional period of time before seeing a psychiatrist. Many of these individuals need prompt treatment, including medications, and the ED does not consider itself equipped to provide that. On a number of occasions (though this is anecdotal), individuals who arrive at the ED in crisis but amenable to low level (but unavailable) mental health treatment interventions become increasingly agitated while waiting for long periods for treatment in the ED, and eventually reach a state where they need inpatient instead of outpatient care.

3. *The need for a regional Psychiatric Emergency Services Unit – providing individuals in mental health crisis with a safe place in the community where they can be engaged in active treatment and helped with their crisis for a period of time before a decision is made on whether inpatient psychiatric care – or other care – is needed.*

The current emergency services model, while preventing certain tragic outcomes by providing the assurance of a psychiatric hospital bed for persons in crisis who are under an ECO, still has a number of problems, including the following: (a) the emphasis on immediate assessment and placement within a compressed timeframe for those who are under an ECO may result in psychiatric hospitalization for individuals who, with some additional time and support, could resolve their crises at a less intense level of service and with less coercion; (b) the required transport to state hospitals of individuals under an ECO who meet TDO criteria but have no local hospital available – and their return transport to the locality when a local hospital bed becomes available - coupled with the current requirements for medical screening and clearance of individuals before they will be accepted by either a state or a local hospital, result in “multiple hand-offs” of these individuals and a delay in active treatment for the person; (c) those not under an ECO may remain in the hospital ED, without any active treatment, for many hours, and sometimes days, awaiting a CSU admission or other community-based treatment, with the conditions of some of these individuals deteriorating while in the ED and resulting in their need for inpatient psychiatric care. (Note: while DBHDS has made it a practice to accept within 8 hours of notice those individuals who are found to meet TDO criteria but are not under an ECO, this practice presents the same problem in regard to the resolution of these individuals’ crisis – a rush to hospitalization without adequate time or local resources to help the person resolve their crisis locally.)

An emergency services model that allows for more time for engagement with the individual in mental health crisis, in a therapeutic setting, where the emphasis is placed on consumer choice and recovery, would result in fewer involuntary hospitalizations and less coercion. A key component of such a model would be a regional Psychiatric Emergency Services (PES) Unit that can provide mental health assessment and treatment for up to 24/48 hours before a determination is required regarding psychiatric hospitalization. Additional time enables a more accurate assessment of each person’s underlying problems, and a more robust in-house treatment capacity enables more treatment and recovery in a less restrictive setting. While some jurisdictions currently have “drop-off centers” and similar facilities for people in crisis, these centers generally are shorter-term and are focused on assessment and referral rather than also offering active treatment. The PES unit can co-locate and integrate services – medical, psychiatric, CIT, and recovery services – that currently are spread among different agencies and locations, and thereby increase the efficiency and efficacy of services.

Models for a regional PES unit already exist in other states (e.g., New Jersey’s statewide model, and the model in Alameda County, California). Changes in Virginia’s insurance coverage and payment models would be needed to make such a facility viable, but the savings in reduced use of inpatient psychiatric beds and dramatically reduced times in the hospital ED would be significant and should be kept in mind when looking at the costs of a PES unit.

4. *The need for a medical model of transport for individuals in mental health crisis instead of the current law enforcement model:* The problems with transporting people in mental health crisis in police cars are significant and mounting: (a) this is a traumatic experience for many individuals, who feel they are being treated as criminals; (b) this imposes high costs on local law enforcement, as such transport can take long periods of time, and takes off the street officers who otherwise would be engaged in traditional public safety functions; (c) the changing availability of officers, due to their public safety duties, results in individuals having to wait many hours – without active treatment – to be transported to a hospital for admission. The use of ambulances and other medical transport has been longstanding in some other jurisdictions – New Jersey and California again are examples – without incident. A pilot program in the Mt. Rogers CSB service area, in which a vendor with trained civilian drivers (Becky Sterling of DBHDS was involved in

providing that training) transports individuals who are under a TDO to the psychiatric hospital, has been very successful to date. While these individuals must meet certain criteria, and the magistrate maintains the authority to designate whether this alternative driver is used, current reports are that this alternative transport model is being used with increasing frequency. The Mt. Rogers program is being funded by a grant, and the problem for statewide implementation of a medical and other non-law enforcement model for transport is the lack of a payment mechanism. In the meantime, local law enforcement agencies are being forced to take funds (and people) out of normal public safety functions to pay for this transport.

5. ***The need for increased use of tele-psychiatry:*** The effectiveness of tele-psychiatry in more quickly connecting people in mental health crisis to a psychiatrist and securing needed treatment has been demonstrated in other states, including South Carolina and North Carolina. There is enthusiasm for increased use of tele-psychiatry in Virginia, but currently there are significant impediments to this model being available for meaningful use. For example, current regulations prohibit physicians from prescribing psychotropic and other important medications for people in crisis unless the person has been seen by the prescribing physician in person. It was reported that UVA has received an exception to this prohibition for a tele-medicine project for which it recently received funding.

C. Transition from Crisis

1. ***The need to invigorate Mandatory Outpatient Treatment (MOT) as an option to involuntary commitment.*** There was not a specific consensus on this subject, but considerable discussion and education. Jim Martinez noted that DBHDS has provided training to a number of CSBs on the appropriate way to implement MOT under current Virginia law, and that a number of CSBs – Prince William County and Valley CSB in particular – have been implementing MOT with increasing frequency and success. Jim characterized MOT in Virginia as a kind of “contract” that results from a process of “bargaining”, where the individual sees the value of MOT as an alternative to involuntary hospitalization. The incentive for the person is to remain out of the hospital. Jim agreed that the Virginia approach is to work with those who are willing to work with the CSB, as opposed to imposing a treatment requirement on an unwilling person and then imposing an adverse consequence if the person fails to comply with that requirement. Becky Sterling confirmed Jim’s view, noting that Prince William County looked for individuals who are “good candidates for MOT”, finding that these usually were people who had additional supports in the community and who had had a good experience in outpatient treatment at one time. Becky stated that MOT will not work with someone who is opposed to treatment. Jim acknowledged that some courts refuse to use MOT because it “has no teeth” – that is, a person cannot be “punished” for failing to follow the requirements of the MOT, but instead can only be involuntarily hospitalized if the person again meets the criteria for involuntary hospitalization. Jim did not support a different model, but he acknowledged that Virginia’s model requires a lot of work and coordination, starting with the CSB pre-admission screeners, who must be actively thinking about whether the person they are evaluating is a candidate for MOT. Derek Curran noted that, in Hampton and Newport News, the person is re-evaluated on the morning of the scheduled commitment hearing, so that there is a current assessment that could better enable and allow consideration of an MOT order.

2. ***The need for prompt follow-up services in the community following discharge:*** The roots of many mental health crises may rest in the inability of individuals who have been psychiatrically hospitalized to obtain timely care in the community upon their discharge from the hospital. Even when there is pre-discharge planning for individuals from the hospital, the current waiting time before seeing a psychiatrist in the community can be weeks. In the case of persons who are

discharged because the special justice has dismissed the petition at the involuntary commitment hearing, there may not be any follow-up arrangements at all, and the person can be lost to follow-up services.

II. A Necessary Condition: Workforce Development

While this is outside the scope of this panel's work, every opportunity needs to be taken to remind everyone that no reforms can occur without an adequate and well-trained workforce. Key needed measures include: better pay for psychiatrists and other mental health professionals; "extending" the work of psychiatrists through nurse practitioners and physicians' assistants; and expansion of tele-psychiatry for more efficient use of psychiatrists' time.

III. Initial Priorities and Action

In the course of our discussion, we identified three key areas as the most important for our immediate focus and work:

- A. *The regional Psychiatric Emergency Services (PES) Unit: what it would look like, how it might function, and how it might be funded.*** I recruited four people to be on a subcommittee to work on the concept of the regional PES unit for future consideration by the whole panel: Ted Stryker, Derek Curran, Becky Sterling, and Kurt Hooks. Since I later asked Becky to serve on the medical transportation subcommittee, I am going to recruit another person for the PES unit subcommittee.
- B. *The medical model for transport in mental health crises: what it would look like, how it might function, and how it might be funded.*** Jane Hickey, Becky Sterling and Dean Barker have agreed to serve on that subcommittee.
- C. *The use of tele-psychiatry in mental health crisis response:*** Melissa Lucy at Horizon Behavioral Health (who will be substituting for Damien Cabezas) has expressed to me her interest and experience in the use of tele-psychiatry, so I have asked her to lead a subcommittee on this. (She will need a couple of additional subcommittee members, and I welcome any volunteers to contact me.)

No action was discussed in regard to the issue of *mandatory outpatient treatment*, but given the attention that we devoted to it at our last meeting, and further given its potential importance if implemented more widely (whether under the current statutory framework or with modifications), I plan to make it an agenda item for our next conference call, on May 8.

IV. Other Important Matters

Other matters that were discussed, and which are still on our agenda but waiting behind our prioritized items, are the following:

A. *Medical screening guidelines* – We had considerable discussion on the general nature of the current guidelines on what medical screening should be required by psychiatric facilities before accepting a person in mental health crisis for inpatient care. Jim Martinez noted that the guidelines are intended to provide the framework for facilities to speak with each other and work out more specific standards. Dr. Lo and others noted that getting to those specifics remains a challenge, and that hospital EDs are struggling with different requirements from different hospitals and residential programs. (An observation: the development of the regional PES unit could significantly impact this as an issue.)

B. **Financing** - We discussed financing, and the kinds of intervention and treatment that the current system of financing incentivizes, but we did not adopt a plan for addressing this in more detail at this time.

C. **Medical TDOs** – Kurt Hooks noted that the legislation on medical TDOs had been helpful in enabling hospitals to work with individuals who appeared to have significant medical issues needing evaluation and treatment but were incapable of giving informed consent to treatment. He reported that problems remain, especially in trying to gather doctors and others together from across the hospital to make a case to the special justice within 24 hours of the issuance of the initial emergency order. (Ashleigh Allen has noted that there are data available about medical TDOs, but that the data may not adequately capture the complexity of many of these cases, where there is a mix of physical and mental health emergency concerns.)

D. **Formularies:** The problems with different formularies at different key institutions – the CSBs, the jails, hospital EDs, and state and local psychiatric hospitals – were mentioned but not discussed at length at the meeting. They remain an important concern.

Professor Bonnie, in a May 19 meeting of the panel chairs, saw the need for the panel to pursue the following questions/issues to better address two key problems that we have identified:

1. **On financing:** We need to find a way to describe, and show supporting data for, the position that the emergency system’s funding creates “perverse” financial incentives to support more restrictive treatments (in particular: TDOs, involuntary commitments, and continued state hospital care for persons reported by the state to be ready for discharge back to the community). Is there research available to documents this? What data do we need to collect to document this as a phenomenon in Virginia?
2. **On formularies:** What information is currently available on the problems arising from different treatment providers having different formularies? How can we document this?

V. Plan for June 8 meeting:

1. I hope to contact the subcommittee members of each of our subcommittees and explore, before our May 8 meeting, how those subcommittees might be set up and work, and what work product they should strive to produce. We can continue those discussions at the May 8 meeting.
2. I will plan for the panel to review at its June 8 meeting the possible pursuit of the MOT issue and the other listed issues, and in particular to address the data collection challenges set out by Professor Bonnie regarding the financing and formularies problems.

I invite your feedback on what I have set out here, and on the plans for the June 8 meeting.

Thank you.