

# **Report to the June 12, 2017 Meeting of the System Structure and Finance Work Group of the SJ 47 Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21<sup>st</sup> Century**

## ***Advisory Panel on Mental Health Crisis Response and Emergency Services***

### **2016 Panel Priorities**

In 2016, the Panel reached consensus on four needs having the highest priority for the emergency response system: (1) the need for a Psychiatric Emergency Center (PEC) to provide a temporary (up to 24 hours) safe placement, assessment and care for people in mental health crisis; (2) the need for increased use of tele-psychiatry to facilitate more timely psychiatric assessments (including pre-admission screening by CSB evaluators) and treatment in both rural and urban settings; (3) the need for an alternative to law enforcement transport for people in mental health crisis to reduce trauma for individuals and enable law enforcement to return to public safety functions; (4) the need for a standardized model of “core” emergency services that should be available to a person in crisis regardless of where in the Commonwealth that person is located.

### **2017 Review of Priorities**

The whole panel met once in conference call on April 12, 2017. Subgroups of the panel have met and been active since that time. In the April panel meeting, the members confirmed their commitment to the listed needs as our highest priorities. That meeting also included discussion of individuals with histories of repeated psychiatric hospitalization, and whether a more robust program of mandatory outpatient treatment (which is being used with increasing frequency in a few Northern Virginia jurisdictions but almost nowhere else) should be considered. There was little enthusiasm expressed by the Panel members for the MOT option at the meeting, but it remains on the agenda, in no small part because of the demands on emergency services, police and jails that are posed by these hard-to-serve individuals.

### **Status of Work on Prioritized Needs**

#### **1. *Psychiatric Emergency Centers:***

The concept: The panel members agreed that a psychiatric emergency center, which can provide a safe, therapeutic environment with active treatment offered for persons in mental health crisis, is a critical missing piece in the range of available emergency services. PECs in other states, operating on an outpatient model in which individuals stay for no more than 24 hours, have demonstrated that they can resolve up to 70+% of crises, allowing individuals to either return home (with arrangements for follow-up care in the community) or move to a community-based step-down facility instead of going into a psychiatric hospital. With a locally-based PEC to which people in crisis can be sent or can self-refer, the “psychiatric boarding” of patients in hospital EDs can be reduced, as well as the number of individuals ordered into psychiatric facilities under Temporary Detention Orders (TDOs).

The barriers to implementation: The most immediate and daunting barrier confronted by the Panel's PEC work group was the cost of the physical plant for a PEC. Regional PECs in Wake County, NC and in Portland, OR cost millions of dollars to build and equip. (Notably, these PECs serve large regions, and also house other services in the same building, thereby raising the costs of the facility.) There did not appear to be a model for cost-effective implementation of the PEC concept in Virginia. Even with the issue of infrastructure addressed, the next issue would be finding a source of sustainable funding for the services in the PEC, including reimbursement by insurance companies for services in this setting.

The proposals – building from existing CIT Assessment Centers: In the fall of 2016 Panel members turned more attention to Virginia's CIT Assessment Centers, which have operated successfully as safe and secure places to which law enforcement officers can bring people in mental health crisis – usually under an Emergency Custody Order – for assessment to determine whether the person meets the criteria for a TDO. The experience with these centers has been almost uniformly positive. Because the Centers maintain a law enforcement officer at the site, officers bringing an individual for evaluation can release the individual to the officer at the site and return to duties in the field. In addition, the on-site officer provides security for the site as a whole. Since these centers have an existing infrastructure, Panel members suggested that some of them might be “upgraded” through modest infrastructure improvements and the addition of medical and mental health providers, to make the Centers functional PECs.

As it turns out, leaders of the CIT Assessment Centers, which are funded through a grant administered by DBHDS and are supervised by DBHDS staff (Stephen Craver), have actively discussed the possible “upgrade” of one or more of the CIT Assessment Centers to a “pilot” PEC. Currently, the Centers operated by Arlington County CSB and Henrico County CSB are developing budget proposals for possible grant funding as pilot sites. The Arlington County Center, which also receives individuals in crisis who are not brought in by officers under an ECO, clearly has the physical layout, security arrangements and related features to enable it to upgrade to a PEC. It already has some medical and psychiatric staff coverage to enable timely assessment and treatment, but will need more staff and services in place to operate as a PEC.

In Hampton Roads, a proposal (attached) was submitted in May to Dr. Romero at the Brock Institute of Eastern Virginia Medical School (EVMS), which hosts an ongoing Mental Health Summit to improve integrated mental health services in Hampton Roads, calling for a public-private partnership to upgrade an existing CIT Assessment Center in Hampton Roads to a PEC. There has not yet been a response to that overture.

Dr. Michael Schaefer, the Assistant DBHDS Commissioner for Forensic Services, is well versed in PECs nationally, and in conversations he has noted the improved outcomes provided through the availability of PECs. However, Dr. Schaefer has also noted that, in order for a PEC to succeed, sufficient step-down community-based services need to be in place to make it possible for individuals to effectively flow through the PEC facility. Since the needed community-based programs do not yet exist in many Virginia localities,

he sees the 2020-2022 biennium – after the first two years of implementing the STEP VA program approved by the General Assembly - as the most appropriate time to introduce PECs in conjunction with other “core” mental health services that are part of the STEP VA model. However, Dr. Schaefer sees no problem with having one or more pilot PEC sites established before then, in localities that have more of the community-based services to which PEC patients can be transitioned or referred.

The Panel has formed a PEC work group, which has met once as a body. Several members of the work group also attended the May 2017 Mental Health Summit at EVMS, where the PEC proposal was raised. Our consensus remains that the PEC is a vital, and still missing, part of the emergency response system in Virginia.

Relationship with other studies and recommendations: The HB 2368 task force, which was established by the General Assembly to look at the issue of the timeliness of TDO evaluations of individuals in hospital EDs under an ECO, issued a second report and a set of recommendations in April of 2017. That report established that CSB evaluators have been providing timely TDO assessments of individuals in the hospital EDs under an ECO, as required by statute. However, after those TDO assessments, these individuals can remain in the ED for hours while the CSB evaluator attempts to find a psychiatric hospital bed. This impacts the functioning of the hospital ED. ED doctors also report frustration over psychiatric hospitals requiring tests for “medical clearance” of these individuals that the ED doctors consider unnecessary and time consuming. The report further notes that many individuals come to the hospital ED in mental health crisis on their own, or are brought in by others, and are not under an ECO. Because there is no 8-hour time limit for assessment of these individuals, as there is for those under an ECO, these persons can spend many hours (even days) in the hospital ED, where (in most instances) they are not receiving mental health care.

The HB 2368 task force submitted five recommendations. Interestingly, one of them included this: “*Expand the Use of CIT Assessment Sites to Relieve Burden on EDs*”. The CIT Assessment Centers might indeed be able to assume this role, but should first receive the necessary upgrades to enable them to function effectively in receiving individuals from hospital EDs (in addition to expanding to additional locations). The ideal arrangement would be for the PEC to have the capacity to accept from the hospital EDs all individuals whose primary issue is mental health crisis. The extent to which this can be done will be a function of the physical and staffing upgrades that can be carried out at the involved Centers.

The HB 2368 task force also made the following recommendation: “*Develop and Implement Standardized Medical Screening Protocols.*” A standard medical screening protocol would be important to the operation of the PECs as well, to ensure that the facility is able to meet the medical needs of individuals being sent from the hospital EDs. The Panel will want to follow and provide input on developments in regard to that recommendation.

Notably, a recommendation that did *not* make it onto the list submitted by the HB 2368 task force, and which warrants consideration, is that hospital EDs statewide adopt a standard protocol for evaluation and treatment that can be provided by ED physicians and staff for persons in psychiatric distress. While hospital EDs are not mental health treatment centers, they, like other EDs in other states (and in some Virginia localities), can establish medical practices and procedures that can alleviate some of the distress experienced by individuals in crisis while those individuals await more focused mental health assessment and care. I should note that representatives of the Chas Foundation, a mental health advocacy organization in Hampton Roads, have reported to me that a major complaint of families with loved ones who go to the hospital ED in mental health crisis is that their family members often spend hours in the hospital ED and receive no meaningful care for their condition, only to receive a large bill from the hospital weeks later for having endured that time in the ED. While, as noted some hospital EDs in Virginia do have protocols for these cases, and have psychiatric consultations in the ED, there is no standard practice.

Possible legislative proposals for the 2018 General Assembly session: Beyond funding for pilot PEC sites, it's not certain what legislative action may be needed to move forward on the creation of PECs in Virginia. There may be licensing issues affecting who may be treated in a PEC. For example, a person in a PEC under an ECO must be evaluated and, if found to meet TDO criteria, ordered into a mental health facility. While the PEC might be an appropriate place for that person to remain for some additional time (to see if their condition improves and their care needs change over that time), the person cannot remain there if the PEC does not meet current licensing requirements for TDO-level facilities. Legislation relating to that issue might be suggested. In addition, requiring medical insurance plans to compensate providers for care provided in a PEC at an appropriate level (recognizing the additional costs required for security and for an extended period of care) might enable the PECs to become self-sustaining.

## ***2. Increased Use of Tele-Psychiatry to Facilitate More Timely Psychiatric Assessments and Treatment:***

The concept: The potential value of tele-conferencing technologies for both mental health evaluations and treatment has become increasingly clear as the mental health provider community has had to do more with less. As noted in the 2016 presentation made by doctors from UVA to the former SJ 47 work group on emergency mental health services, a number of studies have confirmed that both evaluation and treatment of most individuals with mental health challenges can be performed via tele-conferencing as effectively as in-person evaluation and treatment and, for the most part, with consumers being fully engaged in the process and satisfied with the experience.

The barriers to implementation: In a project with Dr. Wibberly of the UVA Center for Telehealth, a work group of the Panel helped to identify the major barriers to implementation of an effective statewide tele-mental health program, and to propose a set of recommendations for overcoming those barriers. Dr. Wibberly's October 2016 report identified 6 types of barriers: (1) provider barriers, involving in part the hesitancy of mental health care providers to use this technology; (2) workforce barriers, involving the

shortage and mal-distribution of mental health providers in general and of those with training in telemental health in particular; (3) financial barriers, including the lack of reimbursement by insurance companies for telemental health treatment services and the lack of funding for services to uninsured and under-insured; (4) patient/client barriers, involving the unwillingness or inability of patients and clients to use these services; (5) policy barriers, involving laws and regulations that do not accommodate technology-based models of care (a prime example being language in the Virginia Code (since solved by the 2017 General Assembly session) that dramatically limited the ability of medical providers to write prescriptions for medications to treat individuals those providers were seeing via tele-conferencing); and (6) preventive care barriers, involving the lack of support for ways in which telemental health services can be used in preventive care. A total of 12 prioritized recommendations were included in the report for addressing these barriers. As a result of action by the SJ 47 Joint Subcommittee, the Joint Commission on Health Care is now studying the findings and recommendations of Dr. Wibberly's work group. The members of that group have been meeting through teleconferencing with JCHC staff to help staff in developing a report for the JCHC's review. An initial draft report has been completed by JCHC staff which, like Dr. Wibberly's 2016 report, covers the full range of telemental health services, from prevention and outpatient treatment to emergency services to in-hospital treatment consultation. The Panel will follow the work of the JCHC on this.

In addition to that report, A.A. Allen and K.M. Faris, researchers at the Institute of Law, Psychiatry and Public Policy, have been studying the development of telemental health services among the CSBs. They confirmed that most of Virginia's CSBs, in response to the pressures of time, distance and limited staff and resources in conducting evaluations for TDOs and providing needed treatment services, have purchased some kind of teleconferencing equipment. However, not all CSBs have put that equipment to use, in part due to the now-resolved statutory problem limiting the prescribing of medications via telehealth, but also in part due to the technical challenges involved in setting up and maintaining a functioning system, along with the challenges of staff training and "buy-in" to this different setting for evaluation and treatment.

The proposals: In the report resulting from their research, entitled "Telemental Health in Emergency Settings: 'Smart Practices' for Community Services Boards Learned from the Field," Ms. Allen and Ms. Faris describe four major models currently used for telemental health services by CSBs:

1. A "Triage" model, used primarily by rural CSBs where both CSB staff and law enforcement officers transporting individuals in crisis often face long drives on sometimes challenging roads just to meet the individual at an evaluation site. The CSB evaluator can determine from the tele-mental health session whether it's likely or unlikely that the person will meet TDO criteria. If unlikely, the evaluator may be able to help the person with a link to local services. If a TDO appears likely, then the person is then transported to a medical facility near the prescriber to complete the evaluation and receive medical clearance.

2. A “Routine Prescreening” model, used in both rural areas (because of the delays caused by the long distances that often have to be traveled for in-person evaluation) and urban areas (because of the challenges caused by the high number of evaluations often required of individuals who are at different hospital EDs and other settings, with these challenges compounded by the delays from urban traffic congestion). CSB evaluators are able to remain in one location and can be linked from there to multiple other participating sites: hospital EDs, CIT Assessment Centers, police departments, jails, etc.
3. A “Contingency Prescreening” model, in which CSB evaluators usually perform in-person evaluations, but can use telemental health in “contingency” situations, such as: the individuals are in certain locations, such as jails, where security requirements would delay an in-person evaluation; the individuals are far away and weather conditions create a travel hazard or the travel would be after-hours.
4. A “TDO and Commitment Hearing Management” model, in which CSBs use teleconferencing to request TDOs and to attend commitment hearings to provide petitioner testimony.

The report provides information on the benefits of these models, and the challenges in establishing them, and it offers information on how existing programs have successfully addressed those challenges. Notably, the report also provides a narrative on how the use of tele-conferencing for prescreening services in Northern Virginia was prompted by outreach to the involved CSB by the Inova Healthcare system. Inova first employed tele-mental health technology to enable its own psychiatric consultants to respond more quickly to patient psychiatric crises occurring at different Inova hospitals. After the success of that innovation, Inova approached the Fairfax-Falls Church CSB about the use of this technology to improve the timeliness of response by CSB evaluators, first for prescreening evaluations of individuals, and later for evaluating persons who appeared appropriate for placement in a Crisis Stabilization Unit (CSU) (a development that has significantly shortened the time needed to evaluate and then transfer a person from the hospital ED to a CSU). Fairfax-Falls Church CSB later approached Dominion Hospital, a free-standing mental health care facility, about utilizing tele-conferencing. As with Inova, Dominion and Fairfax-Falls Church have not only experienced improved response times and resolutions of prescreenings to determine whether a TDO should be issued for a person, they have also utilized this technology for evaluation of individuals for admission to CSUs.

Significant issues remain, ranging from technological challenges to resistance from, and the need for training of, staff from the participating agencies and institutions. In addition, the needed sharing, through virtual means, of relevant health care information about a person who is being evaluated remains challenging, as CSBs and hospitals do not have compatible electronic medical records systems. Even with these challenges, the significant value of using telemental health services is evident in the report from Ms. Allen and Ms. Faris, and the full potential for such services is clear in the report from Dr. Wibberly. The Panel will be monitoring the work of the JCHC in regard to Dr.

Wibberly's report and will be exploring ways to build on the findings made by Ms. Allen and Ms. Faris.

Possible legislative proposals for the 2018 General Assembly session: It's not certain at this time what legislative changes may be needed to implement recommendations for the increased availability and use of telemental health services. Funding may be requested for establishing needed infrastructure and to provide training and education for practitioners. In addition, legislation to require medical insurers to cover and compensate for telemental health services would be beneficial.

### ***3. Alternative Transportation for Persons in Mental Health Crisis***

The concept: The Virginia Code currently directs that transportation of individuals who are taken into custody due to a mental health crisis are to be transported by law enforcement officers, unless the magistrate finds that an alternative transportation provider is appropriate and specifically authorizes that alternative provider. However, there has been a growing consensus in Virginia (supported by the experience of other states and by the recent DBHDS-funded pilot project with the Mt. Rogers CSB) that such alternative transport can be provided safely and routinely by appropriately trained and equipped non-law enforcement drivers, providing significant benefits, including: (i) reducing the trauma and stigma experienced by individuals from being placed in the back of a law enforcement vehicle in restraints; (ii) enabling law enforcement officers to continue with their primary public safety duties; and (iii) reducing the "wait times" for many individuals, particularly in rural communities with small sheriff's departments, before an officer is available to transport that individual to a facility.

The barriers to implementation: While the Mt. Rogers CSB pilot was successful in regard to outcomes for both the individuals involved and local law enforcement (hundreds of individuals were successfully transported for hospitalization under a TDO in non-law enforcement vehicles, without the use of restraints, with no negative incidents and with positive responses and support from the individuals involved and their families), the cost of each transport was very high, in part due to the fact that a 24/7 dispatch office had to be created from scratch by the transport provider (a private security firm) as part of the operation.

The proposal: Through the work of the SJ 47 Joint Subcommittee, HB 1426 and SB 1221 were passed by the 2017 General Assembly, directing that DBHDS and DCJS jointly develop – with the input of specific stakeholders – a model for alternative transport. Both John Oliver and Ashleigh Allen from the Advisory Panel have attended the first two meetings of the task force of stakeholders formed and co-chaired by DBHDS and DCJS. Presentations have been made by representatives of the Mt. Rogers CSB pilot project and by representatives of G4S, a large private security company that has been providing transport for individuals in mental health crisis in North Carolina for several years (also without incident, and under a model that does not subject the individual to handcuffs or similar physical restraints). Based on its years of experience in North Carolina, G4S was able to offer "ballpark" estimates of costs for this service if awarded to G4S.

The current consensus of the task force is that a statewide Request for Proposals (RFP) would be the best mechanism for obtaining viable proposals for an alternative transportation system. The RFP would establish minimum standards for any transport service. Given the experience with the Mt. Rogers CSB pilot, and the presentation by G4S, there appears to be consensus that transport without the use of restraints, in a vehicle that is not a law enforcement vehicle (but is equipped with key safety features, including a clear barrier separating driver and passenger, driver control over door locks, and GPS positioning capacity), and with drivers who are not dressed or identified as law enforcement officers and who have received CIT training (or similar training), should be key features of the standard mode of transport. Task force discussions recognized that different regions of the state face different demands in regard to the establishment and operation of a transport system, with the rural vs. urban differences being the most obvious. The task force will be meeting in July to identify and discuss the barriers to implementing an alternative system.

It should be noted that input from law enforcement representatives during the discussions by task force members made it clear that, especially in rural areas of the state where sheriff's departments are small and the distances they have to cover are large, the burden placed on these departments to conduct this transport is very significant. Large areas of rural communities can go uncovered for hours at a time because a deputy (or sometimes two deputies) must attend to this transport instead of being present and available in the community. This has real consequences that affect the communities as well as these departments but do not show up on budget spreadsheets. It's important to note that when a cost estimate is submitted by the task force for implementing an alternative transportation system, it will not include a reduction in the budgets of local law enforcement agencies. The officers who will no longer have to perform these transports will instead be patrolling their communities, carrying out standard law enforcement work. Communities will be safer as a result. (Christine Mihelcic, a researcher at the ILPPP, recently completed a study in which she created a proposed cost-benefit matrix for comparing different forms of transport, including transportation by law enforcement. Her work is currently being reviewed and finalized to present to the task force as a possible tool for analyzing different transportation options.)

Possible legislative proposals for the 2018 General Assembly session: Beyond funding needs, the SJ 47 Joint Subcommittee and the General Assembly likely will need to address whether law enforcement transport should be the presumed/default transport mode for these cases in Virginia's statutes. While all task force members agree that the magistrate will need to retain the discretion and authority to direct local law enforcement to carry out a transport based on safety considerations, the concern of law enforcement is that, unless there is a clearly stated shift in the statute to using law enforcement *only* upon a specific determination by the magistrate that safety considerations require law enforcement transport, then local law enforcement agencies will have to make their staffing plans based on the demands being placed on them by the current system. This would compromise their ability to use their officers in the most efficient and effective way.



In addition, law enforcement representatives pointed out that, unless Virginia statutes explicitly authorize persons other than law enforcement to execute (serve on the person) an ECO and TDO, then officers will still be subject to traveling long distances just to carry out this function. It would appear appropriate to authorize others, including CSB evaluators, to serve these individuals.

#### **4. *Core Emergency Services***

The concept: One of the concerns of the SJ 47 Joint Subcommittee has been the variability of services available to people with mental illness, depending upon where in the Commonwealth they find themselves. This is a function of many factors, not the least of which is the wide variability in local funding for local CSB services. The concern is that, when a person experiences a crisis, there should be assurance that the types and timeliness of response by emergency service providers should meet certain standards regardless of where in Virginia the person's crisis occurs.

The barriers to implementation: The funding problem is paramount, especially for rural jurisdictions, but emergency services also vary across jurisdictions because most of these services have developed locally, and have a local history, so that there is not a uniform set of crisis intervention services across jurisdictions (though there are often many similarities). Developing a "core" set of emergency services to be implemented across the Commonwealth will require a shared way to define and describe these services, so that there can be an agreed framework for evaluating what each jurisdiction does in fact provide.

The proposal: This issue was "put on hold" in 2016, while the Panel awaited the reception of the Virginia STEP model proposed by DBHDS. Since that model has now been adopted by the General Assembly, a work group of the Panel is being formed to look at how best to develop a set of "core" emergency services that should be in every jurisdiction, and how these "core services" should be defined and described.

Possible legislative proposals for the 2018 General Assembly session: It is not certain that any legislative proposals will be recommended by the Panel for the 2018 session in regard to this issue. Under the current STEP VA plan, funding for improving these services is to be considered by a later General Assembly session.

#### **5. *A possible new agenda item for 2017: serving people who are repeatedly involved with emergency mental health services and the criminal justice system due to their serious and persistent mental illness***

The need for, and nature of, services to individuals who are repeatedly psychiatrically hospitalized and/or repeatedly arrested for conduct related to their mental illness, was raised as part of the Panel's April 2017 meeting. The primary consideration at that time was the possible value of mandatory outpatient treatment (MOT) orders for individuals who repeatedly require involuntary commitment. Panel members noted that MOT was almost never utilized outside of Northern Virginia (where it is gaining increasing use),

and they cited two key perceptions: (1) that local CSBs do not feel that they have the resources to provide the outpatient treatment plan and supervision required by statute for MOT orders; and (2) the consequences set out in statute for a person failing to comply with the terms of an MOT order appear to be “toothless”, giving the person little incentive to comply.

There has not yet been follow-up on this issue, but there are plans to invite to a future Panel meeting representatives from a CSB in Northern Virginia that is regularly utilizing the MOT process.

Another related reform development that has a direct impact on persons who are repeatedly involved with emergency mental health services and/or the criminal justice system is the development of mental health courts. While there are concerns about the enforcement “teeth” of the MOT order, a mental health court in a case in which the defendant has committed a crime can create “incentives” – usually in the form of sentencing consequences – prompting the defendant to participate in needed services and stabilize that person’s life. This authority of the court, however, is meaningless if the local CSB does not have the funding to provide meaningful services that can enable the defendant to achieve stability if followed.

As mental health courts are approved by the Virginia Supreme Court under the Court’s new Rule for Specialty Dockets, funding to enable local CSBs to provide needed services to enable defendants to achieve stability may be needed, and would be important in serving this hard-to-serve group. Success in serving these individuals could have a significant impact on the demand for emergency mental health services.

Respectfully submitted,

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