Progress Report of SJ 47 Expert Advisory Panel on Crisis Response and Emergency Services, November 27, 2017

The Panel has continued to meet periodically through conference calls, while pane subgroups have done more focused work on the following priorities set by the panel: tele-mental health services; non-law enforcement transportation of persons in mental health crisis; psychiatric emergency centers and other alternatives to emergency psychiatric hospitalization; and the identification of a set of "core" emergency services that should be available to persons in crisis in every jurisdiction in Virginia.

1. ***Tele-mental health services:***
We recommend a 3-year cycle of funding for the 4-part initiative to strengthen and expand the technical and organizational infrastructure for tele-mental health services in Virginia, with a focus on the under-served western region of the state, as set out in the report by Dr. Katharine Wibberly entitled "Appalachian Telemental Health Network Initiative - Virginia Pilot". Those parts are: 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. update the programming and capacity of the Southside Telehealth Training Academy and Resource Center (STAR) to provide online training for tele-mental health service providers ($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 teleheatlh network and to 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); d. sustain and expand Project ECHO, which enables primary care providers in under-served communities to consult and coordinate via tele-health with specialists in medical specialties (including mental health) and thereby extend and improve quality care available from primary care providers ($300,000 per year, extending the one-year grant that the Virginia Department of Health currently has from SAMHSA that is focused on treating addiction disorders).

2. ***Non-Law Enforcement Transportation of Individuals in Mental Health Crisis***
As set out in our report, *De-criminalizing Transportation for Children and Adults in Mental Health Crisis in Virginia: Proposed Next Steps*, we support the findings and recommendations of the Task Force on Alternative Transportation. We are aware that Task Force's report estimates that it would cost $10 million annually to implement statewide non-law enforcement transport of 50% of adults transported under a TDO. We are concerned that this price tag may result in the General Assembly passing over this vital reform. As an alternative, we recommend a phased implementation of non-law enforcement transport, beginning with two sites – the area in western Virginia served by the Mount Rogers CSB and 5 neighboring CSBs (which had been the original area envisioned for the recently completed Mount Rogers pilot project) and the area served by the Region 10 CSB (which serves a mix of urban, suburban and rural jurisdictions, and which currently is working actively to find alternatives to law enforcement transport of children in mental health crisis). As our report notes, we believe that these projects would provide a clearer picture of the actual costs of non-law enforcement transport, and

may also give us a better picture of the savings, particularly to local law enforcement and the communities they serve. We are confident that the actual costs are lower, and the numbers of TDO transports that can be managed by non-law enforcement providers are higher, than assumed in the Task Force report. In addition, it's critical that both children and adults be relieved of the trauma and stigma of being handcuffed and even shackled and then placed in police and sheriff vehicles for the purpose of going to the hospital for treatment; and further, that police and sheriff departments, particularly in rural areas of the state, be relieved of this burden and that their officers be able to return to community policing.

We also note that properly relieving law enforcement of the burdens related to this process also requires that they not be designated by statute – as they currently are – as the only ones with authority to serve on the person in crisis a copy of the ECO and TDO issued for that person. These orders are part of a civil process, and therefore can also be served by individuals other than law enforcement officers.

3. ***Psychiatric Emergency Centers and other alternatives to hospitalization, including state hospitalization, during mental health crises***
Panel members remain in agreement that efforts must continue to find ways to provide individuals who are in mental health crisis with additional time (when appropriate) in a supportive and therapeutic setting, to increase the opportunity for these individuals to resolve their crisis in a manner that does not require inpatient hospital care. The panel has looked at the model of the Psychiatric Emergency Center, which is used with considerable success (but under different statutory procedures) in some other states, but to date we do not have a financially viable model to propose to the General Assembly. We have looked at the possibility of a pilot project to "upgrade" an existing Crisis Intervention Team (CIT) Assessment Center to include, among other things, medical staff and expanded services, but to date only the crisis center operated by the Arlington CSB offers a potential approximation to a PEC. Based on panel discussions, we intend to look at whether increasing the staffing and facility capacities of existing and proposed Crisis Stabilization Units (CSUs) might provide effective alternatives to both hospital EDs and psychiatric hospitalization. There has also been discussion of the success of Peer Recovery Centers used in other states as alternative places of support for individuals experiencing mental health crisis. Studies have found that these Centers have helped to reduce the rates of involuntary psychiatric hospitalization.

In regard to the issue of providing individuals in crisis with additional time, the general view is that, until we can establish alternative facilities that have the capacity to work with individuals in crisis, providing an option for increasing the 8-hour ECO period could create more problems than it might solve. We first need to provide the right sort of place for people to be during their crisis before we provide additional time for them to be there.

In looking at the issue of the capacity of private psychiatric hospitals to accept individuals under a TDO, and the continuing increase of state psychiatric hospital TDO placements, four key issues have emerged in various discussions: (1) a trend toward higher levels of acuity, and related verbal and physical aggression, among the individuals

who are under TDO, resulting in private hospitals finding that they cannot manage these individuals; (2) an increase in the numbers of individuals with complicated medical issues in addition to their mental health issues, making it difficult for private hospitals to accept them; (3) shortages of psychiatrists and other mental health hospital staff resulting in some private psychiatric hospitals (or, more often, psychiatric wards of general hospitals) having empty beds but not having the staffing coverage required to admit patients to those beds; (4) chronically unstable and often homeless "high utilizers" of hospital services, who appear to end up on informal "do not admit" lists for some hospitals.

What is critical to understand is that, at this time, we really do not have the needed data on what conditions, circumstances or characteristics distinguish the individuals who are accepted by local private psychiatric hospitals from those who end up at the state hospitals as placements of "last resort". While the new (July 1, 2017) pre-admission screening form used by CSB evaluators provides comprehensive information regarding, among other things, each individual's presenting conditions and behaviors, medical and psychiatric diagnoses, treatment history, statements or actions regarding self-harm or harm to others, observed capacity for self-care, and the grounds cited by the evaluator for recommending a TDO, that information is not automatically recorded in any electronic database when entered by the evaluator on the form. Any review of that information has to be accomplished by a manual inspection of each completed pre-admission evaluation form. This is part of a larger challenge in data collection that limits our ability to fully assess the problems we are facing. We will be looking at how we can meet that challenge in the coming year. It will be vitally important to establish a process in which representatives of DBHDS, the involved private psychiatric hospitals, and the CSBs can meet and share the needed data about the individuals in crisis they are seeing, and how best they can work together to effectively serve those individuals. The SJ 47 Joint Subcommittee may be the authority to direct that such a process occur.

4. ***Important measures that significantly impact emergency services***

Panel members also expressed agreement on the need for the following components of the public mental health system to reduce the frequency and severity of mental health crises:

a. ***Early access to treatment***: While it remains as true as ever that a key path for reducing mental health crises is providing effective early treatment and support services, funding decisions have not yet adequately supported that truth. The implementation of STEP-VA offers the best way forward, and full funding for statewide implementation of "same day access" to Virginia's community services boards would be an important first step in enabling providers to identify and treat individuals experiencing mental health challenges that could, without such services, escalate into crisis.

b. ***Permanent supportive housing:*** While permanent supportive housing had its own expert panel, the emergency services panel views this service as key in reducing mental health crises, as stable housing with daily supports enables individuals with serious and persistent mental illness to maintain stability in their lives and live successfully in their

communities. The research supporting the efficacy of permanent supportive housing in reducing individuals' use of ambulances and emergency rooms, in reducing their encounters with emergency behavioral health services and law enforcement, and in lowering their rate of psychiatric hospitalization and incarceration, is compelling.

c. ***PACT (Program or Assertive Community Treatment) services for persons with serious and persistent mental illness***: The PACT teams, which ideally include clinicians and peer support specialists, provide ongoing contact with and support for individuals with serious and persistent mental illness. This contact and support help individuals to maintain their lives in the community, and also help to identify early on, and resolve, problems that a person may be experiencing. Each community should have the capacity to provide PACT services to those needing them.

d. ***Crisis Intervention Team (CIT) training and response:*** While CIT technically falls within the province of the Criminal Justice Diversion panel, we consider CIT training for all law enforcement officers to have high value for enabling a more effective and humane response to mental health crises and their successful de-escalation. Law enforcement officers are involved in almost all of mental health crises in which an ECO is issued by a magistrate, and officers can take individuals into custody for evaluation based upon their own observations of the mental state of those individuals. It is critically important for those officers to have a meaningful understanding of mental illness and how best to engage a person who is experiencing a mental health crisis, and how to work with mental health professionals in these crisis situations. While CIT training is spreading throughout the Commonwealth, we are sensitive to the fact that smaller law enforcement departments in particular seldom have the resources to allow them to send officers to the 40-hour/one-week training required for CIT certification. State support for enabling such training is very important, to ensure a consistent quality of engagement by law enforcement officers when working with a person in crisis. Similarly, CIT Assessment Centers – locations that serve as alternatives to both the local jail and the hospital ED for evaluation of (and potentially assistance to) individuals in crisis (and where officers can release the person to another officer serving at the Center and return to other duties) – have proven to be a positive experience for everyone involved.