

Emergency Psychiatric Services Models: Finding the Best Ways to Help People Resolve Mental Health Crises

Introduction: The Limits of the 2014 Reforms – Psychiatric Boarding and the Search for Timely Emergency Mental Health Care

The 2014 statutory reforms of Virginia’s involuntary commitment process were positive and significant. The key reform was an amendment to Virginia Code Section 37.2-809 (and related sections) that ensures that every person who is brought into custody for evaluation under an Emergency Custody Order (ECO) and is found to meet the criteria for a Temporary Detention Order (TDO) for temporary psychiatric hospitalization (pending an involuntary commitment hearing) is *guaranteed* placement in a psychiatric hospital until that hearing.

Prior to the 2014 amendment, if a psychiatric bed could not be identified for such a person by the time the ECO expired (then a maximum of 6 hours), a TDO could *not* be issued for that person, and the person could not be held. The law now requires that, if a local bed is not available for such a person, a bed in a state psychiatric hospital will be provided. The Virginia Department of Behavioral Health and Developmental Services, to its credit, has informally adopted a practice of also accepting into state hospitals individuals in crisis who are *not* under an ECO, but who have been found by the local community services board (CSB) evaluator to meet TDO criteria and have no available local psychiatric bed.

These reforms have increased the safety of many individuals in mental health crisis who otherwise would have returned to their homes or the streets untreated and in danger of experiencing further crisis or harm, or causing harm to others. At the same time, however, these reforms have placed increasing strain on state hospitals and may be compromising the efficacy of the emergency care provided to these individuals. For example, admission to the state hospital may require an hours-long drive to the facility, a drive that cannot be made until a law enforcement officer is available to make that trip. The state hospital, in turn, sends the person back to the person’s place of origin as soon as a local psychiatric bed becomes available, so that the person may spend many hours, or even a period of days, without a stable placement or opportunity for further assessment or treatment. So, while there have been demonstrable gains in safety, serious questions remain about the efficacy of the care provided under the new model.

A key aspect of that model that warrants examination is the focus now placed on making a quick determination as to whether a person in crisis meets, or does not meet, the criteria for psychiatric hospitalization. While the 2014 reforms increased the time period for an ECO, during which that determination can be made, to 8 hours, there is evidence that this is simply not enough time in many cases to fully assess the nature and extent of the person’s crisis and underlying conditions *and* to determine whether the person’s crisis might be effectively resolved in a *less* restrictive setting than a psychiatric hospital. At the same time, the fact that the reform statute limits the guarantee of a hospital bed to persons who are under an ECO, and provides only 8 hours for determining whether those persons should receive a TDO, means that those who are in mental health crisis and need intervention but are *not* under an ECO are unlikely receive the same immediacy or intensity of attention. The consequence is that many people in Virginia who come to hospital Emergency Departments (EDs), or who are brought there by family members or friends, and therefore are not under an ECO, find themselves waiting for hours or even days for the mental health evaluation and treatment that EDs are unable to provide. The prolonged presence of these individuals in the ED, without receiving active evaluation and treatment services, is referred to as “psychiatric boarding”, a phenomenon that is being experienced throughout the country. The frustration of many ED directors over psychiatric boarding is at least one of the factors behind the introduction and passage of HB 2368 by the 2015 General Assembly. That bill mandates a study of how

timely evaluations of individuals in crisis in the EDs can be made to determine whether they meet the criteria for a TDO, and whether and to what extent doctors in the EDs should be able to conduct that evaluation for use by the magistrate. (Currently the magistrate must wait for an evaluation by a CSB evaluator before deciding whether to issue a TDO.)

The Alameda Model: resolving crises locally in a Psychiatric Emergency Services (PES) unit

There are some who submit that the better approach is to quickly move people who are in mental health crisis out of the ED (once it is established that they do not have an underlying medical condition that requires ED or hospital treatment) and to a psychiatric emergency services unit for evaluation and care. The Alameda model, discussed in an article in the [April 2015 issue](#) of *Developments in Mental Health Law*, utilizes a Psychiatric Emergency Services (PES) unit, staffed by mental health professionals, to which individuals in mental health crisis are directly transported (most often by ambulance rather than law enforcement) from the community, or from hospital EDs in the region if they were brought there first (on their own, by family or friends, or by ambulance if an underlying medical condition needing assessment and treatment was found.) The Alameda PES unit is designed as an outpatient unit, with an emphasis on patient engagement and consent and a time frame of 24 hours for determinations regarding the patient's need for treatment or appropriateness for discharge. According to the program's director, Scott Zeller, M.D., close to 80% of the patients seen in the Alameda PES unit achieve a level of stability within 24 hours to be discharged to their homes (with arrangements for follow-up outpatient services) or to step-down residential treatment programs in the community. The remaining 20% are found to need inpatient psychiatric care. According to Dr. Zeller, this approach has both largely eliminated psychiatric boarding in the participating Alameda County EDs and has reduced the number of individuals who have to undergo involuntary commitment to a psychiatric hospital.

Dr. Zeller's key claim is that patient engagement and consent-based treatment in a welcoming setting can help most individuals who are in mental health crisis achieve sufficient stability to remain in the community and not be psychiatrically hospitalized. He notes that key factors to making this model work include: (1) a provision in California law that authorizes law enforcement officers and certain specified mental health clinicians to keep a person in a treatment setting for up to 72 hours, without having to seek court authorization for such action, provided that they document that the person's mental health condition/behaviors pose a risk of harm to self or others, or render the person "gravely disabled", to the degree required by California statute (referred to as a "5150 hold"); (2) a billing code under California health insurance law that enables the PES unit to charge for services at a level that adequately compensates the program for its services-rich environment.

While Virginia currently has neither of these provisions, there are a number of programs developing in different parts of the state that attempt to provide evaluation, treatment and resolution for mental health crises through means that share important features with the Alameda model.

Centra Lynchburg General Hospital: adding a Psychiatric Emergency Services wing to the ED

One brand new program is a regional psychiatric emergency services center that will be opening in early October of 2015 in Lynchburg. Operated by Centra Health, this center will be a separate wing of the Emergency Department at Centra Lynchburg General Hospital. Ted Stryker, a Centra vice president for mental health services, states that, unlike the Alameda model, this center will have private rooms that, in his view, afford people experiencing mental health crisis the protection, privacy and dignity they need. (He noted that, in many hospital EDs, people brought there in mental health crisis can experience severe embarrassment and even humiliation when they are seen in their vulnerable crisis state - and sometimes in physical restraints applied to them by ED staff to prevent harm - by others in their community who are at the ED for other kinds of medical issues.)

Like Dr. Zeller, Mr. Stryker noted that properly understanding and addressing the underlying problems in a person's mental health crisis often requires a period of observation, and that time itself, especially if spent in a safe setting, can be an important factor in the resolution of a crisis. While in a certain percentage of cases a person's need for inpatient psychiatric care will be immediately apparent, for many others the 8 hours afforded under the ECO, and the focus of the ECO period on evaluating a person for involuntary hospitalization, often provide too little time and attention for effective engagement and treatment.

Patients who have come directly to Centra's PES unit or who are transferred there from the hospital ED (at Centra Lynchburg General Hospital and other area hospitals) because their primary problem is a mental health problem that the ED is not equipped to address, will be placed in private rooms for observation and treatment. The goal in having this center is to enable people in mental health crisis to move quickly out of the standard ED setting, where their mental health needs cannot be met, and into a safe facility staffed by mental health professionals who can provide evaluation and treatment services and coordinate with the local CSB and other community mental health providers to help these individuals transition successfully back to the community.

Challenges affecting the efficacy of emergency mental health services

Mr. Stryker, who noted that for 18 years he operated a regional psychiatric emergency services center in New Jersey (which has a provision in its statute similar to California's "5150 hold") before coming to Virginia, reported that the lack of such regional psychiatric emergency centers in Virginia was far from the only difference between the mental health service systems in New Jersey and Virginia. Some of his observations include the following:

1. System fragmentation in Virginia: Mr. Stryker noted that the outpatient and inpatient systems in New Jersey are well integrated. A key consequence is that, whenever a mental health patient who has been in an outpatient program in the state enters a psychiatric facility, that facility can access that person's treatment records. In Virginia, facilities often are in the dark about the background and needs of a patient in crisis, even though that patient may have an extensive record of outpatient services at a CSB (and inpatient services at other hospitals). This puts practitioners at a significant disadvantage in providing timely diagnosis and treatment and making medication decisions during a crisis. In addition, the transitions from inpatient to outpatient treatment in Virginia are also more fragmented and difficult than was the case in New Jersey.

(Note: Chuck Hall, the Executive Director of the Hampton/Newport News CSB, has noted that the lack of a uniform Electronic Health Records (EHR) system in Virginia is a serious impediment to the achieving the integrated care - and in particular, the quick (and critically needed) access by health care providers to patients' medical information during mental health crises - that the adoption of EHR was intended to promote. Mr. Hall writes: "The elements of the system have no practical way to share information in real time. In HPRV [Health Planning Region V], among the nine CSBs, there are four different EHRs that do not speak with one another (CoCentrix/Profiler, Netsmart/Avatar, Credible, Anasazi). Most of our regional hospital systems are converting to EPIC, a very powerful, and expensive, and state of the art system. The two public state facilities in HPRV (ESH and SEVTC) have no EHR at all and none is contemplated in the near future. The experience that we patients of private health care now take for granted of having our PCP [primary care physician] share our medical records with specialty physicians (with no paper exchanging hands) is impossible in the behavioral health care field" at this time. This is a problem that deserves priority attention.)

2. The involvement of law enforcement in transporting individuals in mental health crisis: Mr. Stryker noted that almost all transport of individuals in mental health crisis in New Jersey is carried out by medical transport (ambulances, etc.) and *not* by law enforcement, and that during his 18 years in New Jersey there were almost no problems with security arising out of this arrangement. Law enforcement officers did handle certain forensic cases, where the person was already involved with the criminal justice system, but otherwise became involved only if a medical transport crew requested assistance. Mr. Stryker noted that law enforcement officers in Virginia normally place individuals who are in mental health crisis in handcuffs and other physical restraints in order to transport them. This is often emotionally traumatizing for these individuals, who have committed no crime but who feel that they are being treated like criminals (and appear that way as well). The fundamental dignity of these individuals is breached by this arrangement, without a clearly demonstrated need (given the experience of New Jersey) for this level of security.

Mr. Stryker also noted that, because of Virginia's reliance on law enforcement officers to transport people in mental health, law enforcement officers in many jurisdictions, because of their other responsibilities, often are not able to respond that quickly to requests for transport, particularly when a person has to be taken to a facility in another jurisdiction. Even when an ECO or a TDO has been issued for a person, that person can languish for hours while waiting for transport.

It should be noted that the law enforcement community, while increasingly sensitive to the needs of persons in mental health crisis, has also raised ongoing questions as to whether alternative means of transport would be better for these persons. The actual costs of the current transport role to local law enforcement agencies, and to the communities they serve, both in dollars spent and in reduced law enforcement presence on the street, currently remain largely hidden in law enforcement budgets. Those costs should be made explicit, in order to demonstrate that the use of medical transport instead of law enforcement transport in these cases will actually save the Commonwealth money, as well as saving many individuals in crisis from the emotional trauma and loss of dignity they now experience when transported in handcuffs in the back of a law enforcement vehicle.

Other Models of Early Intervention and Resolution During Mental Health Crises

The Hampton/Newport News Community Services Board (H/NN CSB) has taken a different approach to reducing psychiatric boarding, by developing several complementary approaches for providing timely evaluation for persons in mental health crisis and connecting these persons to appropriate treatment, so that psychiatric boarding does not occur *and* unnecessary psychiatric hospitalizations are avoided.

Responding to the site of the crisis: First, the H/NN CSB follows a philosophy of responding to any call alleging that a person is in mental health crisis, regardless of the person's location (as long as it is within the CBS's jurisdiction) and regardless of whether the person's described condition or behavior indicate that the person currently meets the criteria for an ECO or TDO. Information is gathered to make sure that a CSB evaluator is not being sent into an unsafe setting, but in normal practice the CSB does not require that the person be brought to a hospital ED or other evaluation site. This practice is built upon the experience and philosophy of the program that meeting the person in his or her home/community often gives the evaluator important insights into factors that may be contributing to the person's crisis (and factors may be protective against future relapse) and that may need to be addressed as part of the CSB's response to and resolution of that crisis. In addition, the CSB has staff who have been trained as part of the Hampton/Newport News Crisis Intervention Team (CIT) to respond to any request by Hampton or Newport News police officers for assistance with an individual reported to be in mental health crisis. (Note: the H/NN CSB serves a relatively compact urban/suburban community, so that it does face the challenges of distance and isolation that many rural CSBs face.)

Responding to magistrate referrals: Second, H/NN CSB has an arrangement with the local magistrate's office, under which magistrates contact the CSB to evaluate any person for whom a member of the community has asked the magistrate to issue an ECO or TDO due to mental health crisis. This way, the magistrate does not have to make a determination about whether the person in crisis meets the criteria for an ECO at that time. This is a significant practice for a number of reasons. First, the person requesting the ECO/TDO may not have enough information to enable the magistrate to make the findings needed to issue an ECO, even when the person may in fact meet the criteria for an ECO. A CSB evaluator going out to see the person can gather information and make observations that the magistrate cannot, which results in more reliable and appropriate findings and decisions. If the evaluator finds that the person meets the criteria for a TDO, the practice in Hampton and Newport News is for the magistrate to then issue the TDO on the magistrate's own motion. The petition for involuntary commitment is completed and signed later, on the day of the involuntary commitment hearing. If the evaluator finds that the person does *not* meet the criteria for a TDO, the evaluator is in a position to offer and arrange services to meet the needs of the person and help the person avoid further decline that might otherwise result in the need for a TDO. Finally, even if the person is found to meet the criteria for a TDO at the time of the CSB evaluator's assessment of the person, the evaluator may also find that the person appears amenable and responsive to treatment that is less restrictive than involuntary psychiatric hospitalization, and can help to resolve the person's crisis with less restrictive treatment measures.

Partnering with area Emergency Departments: Third, two hospital systems - Sentara and Bon Secours - currently have contracts with the H/NN CSB for CSB evaluators to respond to their hospital emergency departments (EDs) in Newport News and Hampton to evaluate and assist any person who arrives in the ED in mental health crisis. (The only exception is a person who is admitted primarily for medical reasons and only then is found to also present significant mental health issues.) As in the case of a call from a magistrate or from the community, the CSB evaluator can evaluate the person in crisis and recommend treatment and services that match the person's apparent needs. Some cases may be resolved in the ED itself, with (for example) the patient being provided with a follow-up mental health outpatient appointment, or being helped into a Crisis Stabilization Unit (CSU) for care, or being assisted in gaining voluntary admission to a local psychiatric hospital. In more serious cases the evaluator may contact the magistrate and recommend a TDO for the person.

The hospital systems have a contract with the H/NN CSB under which they provide an annual payment that essentially covers the costs of one CSB evaluator per hospital, an arrangement that, on balance, appears to be a bargain for the hospitals. According to H/NN CSB staff, this arrangement has been successful in eliminating, for the most part, psychiatric boarding in the EDs of those hospitals. (The few exceptions can occur when a person who is not under an ECO is found to be in need of a TDO and a willing psychiatric hospital cannot be identified.)

Mobile crisis response teams: Fourth, H/NN CSB uses a "mobile crisis response team" (MCRT) comprised of a Psychiatric Physician Assistant, Emergency Services Workers, Peer Support Specialists, and Mental Health Support Workers (with medical supervision and direction by a H/NN CSB psychiatrist) to provide individuals in mental health crisis with intensive treatment and support services in those individuals' homes. Emergency Services staff who initially respond to a person's home make the initial assessment as to whether the person is a good candidate for MCRT services. On-site "crisis intervention services" by the MCRT include "rapid and comprehensive needs assessments, crisis counseling and on-site psychopharmacological intervention". On-site "crisis stabilization" includes "ongoing monitoring for safety, mobilizing family and community supports, monitoring compliance and linking to follow-up services". Normally, the length of "intensive engagement" is up to 24 hours. The MCRT works with the police department's Crisis Intervention Team (CIT) officers in responding to crises in the community, and also works with the Crisis Stabilization Units (CSUs) in discharge planning and follow-up services for individuals returning home from the CSU. In-home follow-up services are

also provided to individuals referred by Emergency Services staff. Currently, the MCRT operates five days a week, from 2 p.m. to 10 p.m. (the peak time period for emergency calls), but the program intends to adjust its staffing, hours and other aspects of its operation to match the demands. The program currently serves the “Greater Virginia Peninsula” - Hampton, Newport News, Poquoson, Williamsburg, James City County and York County – so it includes, urban, suburban and rural communities in its coverage.

A goal of the program is to reduce by 15% the number of people in mental health crisis who require facility-based care to resolve that crisis. The program also hopes to reduce the length of stay for those persons who do need treatment in a CSU or inpatient hospital setting, by providing more robust discharge planning and post-discharge home-based services.

Crisis Stabilization Units: Fifth, H/NN CSB and other CSBs in the Hampton Roads region (specifically, Health Planning Region [HPR] V) have developed and operate Crisis Stabilization Units (CSUs) that provide short-term residential treatment services for individuals in mental health crisis. There are three adult units in HPR-V - one in Hampton, one in Virginia Beach and one in Norfolk, with all three units accepting individuals from any of the participating jurisdictions in HPR-V. The facilities in Hampton and Virginia Beach are capable of accepting some individuals who are under a TDO, though they are not able to manage persons who are physically aggressive and threatening. They are also designed to accept individuals for a “step-down” transition from more intensive inpatient psychiatric hospital care. The average length of stay for these individuals in the CSUs is 4 to 5 days.

The H/NNCSB also helped to establish a Children’s Behavioral Health Urgent Care Center (CBHUCC) in the Behavioral Medicine wing of Maryview Hospital in Portsmouth, Virginia. This facility, which also serves all of HPR-V, is staffed by a Board-certified child psychiatrist, a program manager, an LCSW, and qualified mental health providers and mental health technicians, and provides assessment and crisis intervention, psychiatric evaluation, and comprehensive discharge planning, for children and adolescents (ages 5 through 17 years). Significantly, children and families have been referred to this unit not only from Emergency Services staff of the HPR-V CSBs, but also from staff in the ED units of some of the area’s hospitals.

A proposal - Regional Crisis Stabilization Center: The early intervention approach of Emergency Services staff in the H/NNCSB, coupled with the availability of less restrictive local treatment programs and facilities, helps more people to resolve their crises at an early stage. However, this early intervention approach, and the less restrictive local treatment programs, generally are not as available in other CSBs, either in HPR-V or elsewhere in the state. In addition, even the CSUs currently operating in HPR-V lack certain key elements that, if present, would enable them to accept and work with individuals who are presenting more difficult conditions and behaviors than can currently be managed. Some of the staff at the H/NNCSB have sought to address this by proposing (informally at this time) a “Regional Crisis Stabilization Center” that would provide, in a single setting with separate wings or buildings, differing levels of care that would match the crisis being experienced by the person brought to the facility. (This is not unlike the regional center proposed by Ted Stryker in his June 17, 2014 email to Jim Martinez at DBHDS during the deliberations of the Governor’s Task Force, which is archived [here](#) on the DBHDS website: scroll down to page 38.) The staff’s vision for the Center has the elements set out below.

For the most acute cases, there would be an “initial assessment area” where an individual would receive both a psychiatric assessment by a psychiatrist (or by another mental health clinician) and a medical assessment by a nurse practitioner or physician’s assistant (who would be available 24 hours a day). The presence of a nurse practitioner or physician’s assistant would allow for on-site management of certain medical problems, such as hypertension, diabetes, and minor infections, with patients having more acute medical problems being sent to the local hospital ED.

Less psychiatrically acute clients could be assessed for a “23 hour program”. As envisioned by staff, this 2 bed section would be utilized to monitor clients who need short term care for needs such as getting prescriptions or who need to be started on medications with minimal monitoring by a psychiatrist.

Once a person admitted to the Center was medically stable that person would be formally admitted. As envisioned by staff: “Clients would be seen daily by the psychiatrist. Clients would be medically evaluated by the NP/PA as needed. Have individual therapist, group therapist, and activity therapist. The community room would be large enough to accommodate all the clients for seating for community meetings. Clients would be able to be seated comfortably at tables for nutritious meals. We would have a large group room which would also include a TV for educational videos. There would be a separate room [equipped with] relaxation tapes, reading, working puzzles and playing games. Groups would begin in the morning and continue through the evening. Clients would also be monitored for chemical dependency issues including withdrawal from substances and those dually diagnosed. AA and NA groups will be included on the schedule.”

The envisioned staffing for this regional center, which would be capable of serving ___ clients at any one time, would run along these lines: (1) 7 a.m.-3:30 p.m.: Psychiatrist, RN-Nurse Manager, RN, LPN, PT, Administrative Assistant/ billing clerk, Therapist, Clinical Services Supervisor; (2) 3 p.m.-11:30 p.m.: RN, LP, PT, Therapist, (3) 11 p.m.-7:30 a.m.: RN, LPN, PT.

Current Virginia law and emergency mental health treatment practices

The ability of a magistrate to issue a temporary detention order (TDO) for a person in crisis to be placed (or remain in) Centra Lynchburg General Hospital’s new Psychiatric Emergency Services wing, or in a future regional Crisis Stabilization Center, is not limited by the current law, but may be limited by available resources and state licensing standards for facilities to be able to accept a person who is subject to a TDO. It’s notable that, under Virginia Code Section 37.2-809, entry of a temporary detention order (TDO) requires that the magistrate find that a person (1) has a mental illness, (2) presents a potential for harm to self or others in the foreseeable future as a result of that illness, (3) needs “hospitalization or treatment” for the illness, and (4) is unable or unwilling to consent to such “hospitalization or treatment” While Virginia Code Section 37.2-809 requires the TDO to identify the “facility” where the person is to be detained, it does not require that such a facility be an inpatient psychiatric hospital. Moreover, the 2014 reform amendments to Section 37.2-809 allow amendment of the TDO to change the facility where the person is detained, to reflect changes in the person’s condition, behavior and needs.

So, under the existing statute, a TDO could authorize continued placement of a person in crisis in the psychiatric wing of the ED at Centra Lynchburg Hospital, or in any other “facility” where the person’s condition and behaviors can be managed, if they have the requisite licensing. It is not known, however, (by this author at least) whether current facility licensing standards, or current insurance and other compensation standards for mental health treatment, allow or provide meaningful payment for the care and treatment in such settings to persons who are under a TDO. It is also not known (by this author) how the treatment modalities and discharge standards now compare (and would compare) among these different local/regional treatment facilities. It’s notable that, while Dr. Zeller reports that his PES unit in Alameda County normally discharges patients within 24 hours (with close to 80% of them stabilizing and either returning home or being discharged to a step-down facility within that period, and the remaining 20+% being admitted to a psychiatric hospital), all of the existing CSU models in Virginia have average patient lengths-of-stay of several days. These differences warrant further study to determine what treatment framework is most effective in helping people in crisis return to stability in the shortest time possible.

Even the development of a more robust system of emergency mental health care, however, fails to address the unfortunate reality identified by former DBHDS Commissioner Jim Stewart, in his January 2014 presentation at the first session of the Governor’s Task Force on Improving Mental Health Services and Crisis Response: “Due to the inadequate capacity of ongoing treatment and support services, the crisis response network has often become the default system.” If more robust resources are not committed to the other parts of the treatment system to create a truly integrated system, then people with serious mental illness will continue to experience crises that might have been avoided entirely. (One small but critically important example of how deficits in other parts of the treatment system contribute to repeated crises: Chuck Hall at H/NN CSB notes “the lack of a uniform psychiatric medication formulary among CSBs and State Facilities, and the acute care private hospitals that participate in the network of care.” The result: “patients who are fortunate enough to get into an acute care setting, will come out from the hospital stay, most likely, with a psychiatric prescription that is different from that used routinely by the OP [outpatient] setting that they are referred to. As psychotropic medication is so important to maintaining stability for the individual during this critical time in treatment, changing these prescriptions often leads to a relapse.” On a broader scale, Mr. Hall notes that critically important community-based mental health services that can help people with mental illness maintain stability are not mandated services for the CSBs, and consequently are unfunded or underfunded, and that, even for individuals with health insurance, insurance reimbursement rates for key mental health services are “inadequate to non-existent”.)

Partnership

Finally, the search for more effective responses to mental health crises would benefit from being guided by this observation by John Dool, the HPR-V Reinvestment Project Director: to the extent that a person experiences mental health treatment as something that is being done *to* that person, instead of something that is being done *with* that person, the treatment is likely to be resented and resisted and ultimately to fail. The more that we can avoid coercion and enable persons in crisis to be partners in their own care, the better our outcomes will be. Mr. Dool notes that, with that as a guide, any system for emergency mental health services, regardless of its specific shape or focus, should include the following elements: provisions for advance care planning, and in particular for advance directives, so that individuals can designate agents to make needed treatment decisions for them during incapacitating crises and can guide their agents and providers on what treatments work for them (and what treatments do not); ready access for individuals to less intensive treatments than Emergency Departments and hospitals, so that individuals who realize that they need help can get help early; and system “navigators” – most often, peer support specialists – who understand what individuals who are in mental health crisis are likely experiencing, and who are available to individuals in crisis to help them find their way through the treatment system. Any treatment, including and perhaps especially emergency treatment, needs to respect the patient as a partner.

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