

**Alternative Transportation Sub-Group  
of the  
Mental Health Crisis Response and Emergency Services Advisory Panel  
Interim Report  
October, 2016**

**Background**

Since the spring of 2016, the SJR 47 Joint Subcommittee to Study Mental Health Services in the Twenty-first Century (SJR 47) has operated with four work groups, each with an advisory panel set up and supported through the Institute of Law, Psychiatry and Public Policy. One of the Joint Subcommittee's work groups is addressing "Mental Health Crisis Response and Emergency Services". Over the course of its first two meetings (in May and June of 2016), the work group's advisory panel identified four priority issues to be considered for action by the work group and the Joint Subcommittee.

One of the priority issues identified by the panel is the transportation of people experiencing mental health crisis. Currently, under Virginia law, the presumed means for transporting a person in crisis to a hospital or other facility for evaluation or treatment is by a law enforcement officer. While Virginia statutes were modified in 2009 to allow magistrates to designate an "alternative" transport provider, this option is rarely used, and almost all transport of persons in mental health crisis has been by law enforcement officers using their marked vehicles, with the individuals in crisis almost always being placed in some form of restraint, including handcuffs. The language of the statutes involved makes it clear that the primary concern driving this presumption for law enforcement transport was safety – that individuals in mental health crisis requiring official intervention are presumed to be so behaviorally disordered that they pose a safety danger that requires law enforcement transport.

The consensus of the panel is that there is no known reliable evidence that law enforcement transport is the only safe means of transport for individuals in mental health crisis, and that law enforcement transport exacted a number of high costs, including the following: (1) law enforcement transport "criminalizes" a mental health crisis, resulting in trauma and stigma for the individual that has lasting impact and potentially compromises not only the outcome of the person's treatment but also the willingness of the person and family to seek help in the event of a subsequent crisis; (2) a percentage of mental health crises involve an underlying medical problem that law enforcement officers are not trained to identify or treat, leaving individuals in crisis without proper medical care; (3) the demands on officers to respond to their regular public safety duties can result in delays in officers being available to provide transport, resulting in delays in treatment and deterioration in the person's condition; (4) these cases can end up consuming many hours of officers' time, especially if transport to a state hospital is required, thereby reducing the number of officers "on the street" and able to respond promptly to other emergencies – a problem that can be particularly acute in rural communities served by small law enforcement staffs.

The panel set up a sub-work group composed of Ashleigh Allen, Dean Barker, Becky Sterling and Jane Hickey (with participation by Panel Chair John Oliver) to study alternative transportation models in Virginia and throughout the country.

The purpose of the sub-group is to identify safe and cost-effective alternative transportation for people in mental health crisis and to make recommendations to the SJR 47 Joint Subcommittee on models that might work in Virginia. To be considered, these models needed to be designed to reduce reliance on law enforcement agencies as the primary transportation provider, and thereby help to decriminalize the process, reduce the stigma associated with mental illness, promote the recovery of the individual, and free up law enforcement to perform their other law enforcement duties while still meeting the safety needs of the individual and the community. The work group met on August 1, September 20 and October 7, 2016 and will continue to meet throughout the coming year.

## **Current Virginia Process**

The work group identified four stages of transport in the emergency mental health services process in Virginia, the first three of which rely primarily on law-enforcement as the default transportation provider, while the fourth relies on the resources of the individual and treatment providers. These stages are 1) execution of the emergency custody order (pre-admission screening stage), 2) execution of the temporary detention order, 3) execution of the commitment order, and 4) the discharge stage, which can occur following any of the first three stages. (Individuals may also be transferred, and therefore need transport, between facilities while a person is being held under a TDO, as well as after commitment to a mental health treatment facility.) Note that not all stages of transport must occur for each person experiencing a mental health crisis. For example, individuals may voluntarily present to a facility for evaluation and ultimately be placed under a TDO, skipping stage 1 transport; additionally, the TDO facility may also serve as the commitment facility, which would negate the need for stage 3 transport.

### Transport No. 1: Bringing a person from the community to a facility for evaluation under an Emergency Custody Order (ECO) (Pre-Admission Screening)

Under Virginia Code § 37.2-808, an individual may be taken into custody when a magistrate issues an emergency custody order or a law enforcement officer on his or her own initiative, determines probable cause exists to believe the person is mentally ill and meets the criteria for commitment to a mental health facility. The person is then transported, usually by law-enforcement to a convenient location for a pre-admission screening by an employee or designee of the local community services board to determine whether the person meets the criteria for temporary detention and to assess his or her need for hospitalization or treatment. This pre-screening location is often a local hospital emergency department or more recently a "CIT assessment site". While, as noted the magistrate can designate an "alternative" transportation provider at this stage, this almost never occurs in Virginia. The emergency custody order can last up to 8 hours while a temporary detention facility is located and a medical clearance is completed, during which time a law-enforcement officer must maintain custody of the individual. (Through June 30, 2018, the emergency custody order may be extended up to four hours if the person is detained at a state psychiatric hospital.) Some local law enforcement agencies are now entering into transfer of custody agreements that permit the law-enforcement officer to transfer custody of the individual to security officers on site at the local emergency room, or to other on-site law-enforcement officers on duty at a CIT assessment site, thereby freeing the local law-enforcement officer providing transportation to return to other duties. The sub-work group recommends such arrangements wherever possible.

## Transport No. 2: Temporary Detention Order (TDO) Transports

Once a determination has been made that the individual meets the temporary detention criteria, a temporary detention facility has been identified and any needed medical clearance obtained, the magistrate will issue a temporary detention order under Virginia Code § 37.2-809. If the person is not detained at the pre-screening site, the magistrate will order law-enforcement or an alternative transportation provider to transport the person to the temporary detention facility under Virginia Code § 37.2-810, where the person may remain for up to 72 hours (or 4-5 days if a weekend and holiday intervene). The temporary detention site to which the person may be transported may include the psychiatric unit of a general hospital, a free-standing psychiatric hospital, or a state psychiatric hospital. (Some Crisis Stabilization Units (CSUs) in the state also accept persons under a TDO under certain conditions.) At times, the TDO facility may be located outside the region where the person resides or is located; such cases often require that two officers leave their jurisdiction for multiple work shifts to carry out the transport.

Since enactment of the 2009 legislation authorizing the use of alternative transportation providers described above, magistrates have issued alternative transportation orders in every region of the state with no adverse incidents reported. Providers have included family, friends, healthcare providers, medical transports and other law enforcement agencies. However, between FY2010 and FY2015, only 113 Alternative Transportation Orders (ATOs) were issued on average each year out of an average of 20,874 total Transportation Orders, or just .54% of the number of TDOs issued per year. In FY 2016, following implementation of the Mount Rogers CSB Pilot Project and the Valley CSB alternative transport program (both described below), the number of ATOs issued tripled to 487, with over 300 of those ATOs issued to certified drivers associated with the Mount Rogers and Valley CSB projects.

At times, the place of temporary detention may change based on the availability of beds or the treatment and security needs of the individual, necessitating a transfer. If a state facility is utilized for temporary detention and an alternative TDO facility is subsequently identified, the person may be transferred to that location. Transportation in these transfer situations is provided under 37.2-810 either by law-enforcement or an alternative transportation provider. The subgroup at this time does not have data that show how often such transfers occur.

## Transport No. 3: Post Commitment Hearing Transports

At any time between several hours to up to 72 hours (or 4-5 days if a weekend and holiday intervene) after execution of a temporary detention order, a special justice must hold a commitment hearing, and if the person is committed to a mental health facility other than the temporary detention facility or agrees to voluntary admission, the special justice will order the sheriff's department either where the person resides or where the hearing is held, or an alternative treatment provider, to transport the person to the mental health facility under Virginia Code § 37.2-829. While on average, 12,679 commitment orders were issued annually to adults between FY10-FY15, the subgroup does not have data at this time that show how often post commitment hearing transport occurred.

## Transport No. 4: Discharge Transports

No mechanism exists in the Virginia Code for transporting a person home if the person is released or discharged from the process at the ECO or TDO stage, or is discharged from the treatment facility following completion of treatment. The individual ordinarily must rely upon family or friends to get

home. Occasionally, treatment providers or CSBs may provide transportation or bus tickets for individuals. If the TDO facility or commitment facility is located at a distance from the person's home, transportation can present a challenge.

## **Alternative Transportation Models**

The Transportation subgroup has received differing amounts of information about a variety of transportation models. Below is a summary of the information we have collected so far:

### Transport No. 1: Bringing a person from the community to a facility for evaluation under an Emergency Custody Order (ECO) (Pre-Admission Screening)

#### ***Alameda County, CA EMS Transport:***

Scott Zeller, M.D., who helped to create and operate a Psychiatric Emergency Services (PES) unit in Alameda County, California, provided the following information about the transport of individuals in mental health crisis in a recent email:

"In Alameda County, there is no special emergency transport team for psychiatric emergencies. All field transports use the same 911 system as any other medical emergency.

This is actually consistent with federal EMTALA laws. EMTALA defines a psychiatric emergency where a patient is dangerous to self or others as a medical emergency, equivalent to a heart attack or being in a car accident. We don't have police transport heart attacks, why do they transport psychiatric emergencies?

The paramedics responding to a psychiatric emergency do not do any psychiatric assessment -- nor should they, as this is not their area of expertise. What paramedics are qualified to do is evaluate medical stability. In many cases, what appears to be a psychiatric emergency is actually a life-threatening medical emergency, something that paramedics can determine (but police definitely cannot, so their doing transport is a ticking time bomb until the day when they handcuff a person and put them in the back of the squad car without realizing the patient has an intracranial bleed -- clearly a recipe for a very bad outcome).

If a police officer starts an involuntary psych hold in Alameda County, they then contact the Emergency Medical System to get a paramedic to the site. The police then transfer custody to the paramedics, and the officer is then free to leave and go do other police duties. Our paramedics then determine if a patient is medically appropriate to come directly to the psychiatric receiving center, which has a physician on duty 24/7, so is authorized to receive ambulances.... If they deem a patient medically appropriate for the psych center, they go directly there (approximately 60% of patient transports). If the patient needs further medical evaluation as determined by the screening tool, they go to the nearest of 11 (eleven) ERs in our county for a medical clearance (about 40% of patients). After transferring the patient to that ER, the paramedics are then free to leave and handle other medical emergencies.

Once the patient at a medical ER is medically clear, the ER calls the psych receiving facility and

the patient is immediately accepted for transfer. Thus in this system:

- 1) Police are quickly freed up rather than serving as a psychiatry transfer and observation personnel;
- 2) Paramedics only determine medical stability, and also are not excessively burdened with psychiatric patients, as they can either transport in minutes to the nearest ER (regardless of insurance, etc) and transfer the patient, or they go to the centrally-located psych receiving center, where they have priority triage and are typically released less than fifteen minutes after entering the ambulance bay.
- 3) Even the eleven outside ERs are not excessively burdened, as they can transfer the medical[ly]-clear psychiatric patient to the psych center immediately -- therefore there's no such thing as 'boarding' in Alameda County."

According to Dr. Zeller, this medical transport model has not experienced safety problems related to patient behavior through the years of its operation. We currently do not have information regarding the sources of compensation for this transport. An effort is currently being made to contact the EMS coordinator for Alameda County.

Four health care systems in Portland, Oregon, are in the process of establishing a regional Psychiatric Emergency Services unit modeled on the Alameda County program. That unit is scheduled to open in January, 2017. Staff who are working on the development of this model report that it will also use Alameda County's model of EMS transport for individuals in mental health crisis.

### ***Wake County, North Carolina EMS Transport***

We learned from North Carolina state behavioral health staff that Wake County, North Carolina Emergency Medical Services received a state grant that has been paying for CIT training of Wake County EMS staff to enable them to effectively respond to and transport individuals in mental health crisis. Payment for that transport apparently has been made using the grant funds and is not yet provided through medical insurance plans. Wake County has a "Crisis Assessment Services" unit to which EMS staff can directly transport individuals in the community who are in mental health crisis and are found by EMS staff to not require medical services. The ability of the EMS staff to assess the medical treatment needs of individuals in mental health crisis in the community significantly reduces the number of individuals brought to the local hospital Emergency Department, thereby reducing "psychiatric boarding" in the hospital ED. An introductory email has been sent to the EMS coordinator for Wake County.

### **Transport No. 2: Temporary Detention Order (TDO) Transports**

#### ***Mount Rogers Community Services Board Pilot Project***

This project was initiated by the Department of Behavioral Health and Developmental Services ("DBHDS") (at the urging of former DBHDS Commissioner Ferguson), with support from the Mt. Rogers CSB, law enforcement and other stakeholders. A Request for Proposals for alternative transport was issued by DBHDS, but only one company, Steadfast Investigations and Security, LLC (which has experience transporting individuals for the Department of Juvenile Justice) expressed any interest. The challenge faced by Steadfast (and any other vendor): the infrastructure for an alternative transport system had to be built from the ground up. Steadfast provides unmarked vehicles that are equipped

with a safety panel separating the driver and passenger, has hired five drivers (who have received a version of CIT training) and has created a dispatch center operating 24 hours a day.

The benefits of the program have been clear. The magistrates, after considering the recommendations of the CSB evaluators, authorized transport by Steadfast in a third of all crisis cases in the first several months of the program, and over time transport by Steadfast has been authorized in a half of all cases, resulting in significant relief to local law enforcement. There have been *no* elopements, and *every* individual has been transported successfully. Individuals in crisis and their families have been very positive about the program, and the County Sheriff strongly supports it. The program is demonstrating that many, if not most, TDO transports can be effectively and safely carried out without having to take law enforcement officers away from their traditional public safety duties.

The problem with the Mount Rogers project, however, is cost. The Mount Rogers CSB serves a very rural region (the average distance per trip in the project's first 6 months was 138 miles), and the number of TDO transports per day has been small compared to the fixed costs of establishing and maintaining it. As a result, the current per-trip costs are extremely high, and likely unsustainable.

DBHDS, the Mt. Rogers CSB, and the County Sheriff very much want to maintain an alternative transport model because of the positive impact on individuals and families and the relief brought to local law enforcement, and they are looking for ways to identify other possible vendors and a way to reduce the costs of an alternative transport program.

### ***Valley Community Services Board***

The Valley CSB, with cooperative agreements with Augusta Health in Fishersville, Virginia, the Augusta County Sheriff's Department, the Waynesboro Police Department, the Staunton Police Department, and the Middle River Regional Jail (MRRJ), has received DBHDS grant funds to establish a CIT Assessment Center at the Augusta Health Emergency Department, where individuals in mental health crisis are brought by law enforcement officers for initial assessment under an ECO. The participating law enforcement agencies provide CIT-trained off-duty officers to staff the Center. These officers, who are paid through the grant funds, receive and maintain custody of individuals who are brought to the Center. This allows the officers who bring individuals to the Center to return to their regular duties in the community.

The grant funds also pay for an alternative transport program that utilizes off duty officers from the MRRJ to provide transport for those individuals for whom the magistrate has issued a Temporary Detention Order (TDO) and a transportation order for the person's transport to another mental health facility. The transporting MRRJ officers have received CIT certification, and drive unmarked MRRJ vehicles equipped with safety panels. Patients normally ride without being placed in restraints. All jail officers participating in this program have also received training concerning the TDO process and associated paperwork. The MRRJ assumes the costs involved in using the vehicles, while the officers are paid an hourly rate from the grant funds. The off-duty officers make themselves available on a rotating list that is used by dispatchers to call them to the Center to carry out the transport, and they are expected to respond within one hour.

The Valley CSB reports that nearly 100% of all out-of-the-area TDO transports from October 5, 2015 through June 30, 2016 have been provided by these off-duty officers, relieving local law enforcement of transport responsibilities. This represents a total savings of 1,667.12 hours during which law enforcement officers are able to attend to their normal public safety duties in the community.

#### ***G4S Secure Solutions USA (North Carolina)***

G4S Secure Solutions USA is a private company providing security services throughout the country. Since November 2013, G4S Patient Support Services has been providing secure oversight, transportation and bedside guardianship services for hospitals in North Carolina. It provides transportation from hospital emergency departments to behavioral health settings for behavioral health patients in crisis. The goal of these services is to improve patient care, improve quality of care and reduce costs. During the development stage, G4S worked closely with the North Carolina Sheriffs' Association and the North Carolina Attorney General's Office. Approximately 60% of its contracts are with hospitals and 40% are with municipalities or local law enforcement. It has freed up bed space in hospital emergency departments and lowered the costs for ambulance and law-enforcement transportation.

G4S Patient Support Services employs approximately 25 staff who have received over 100 hours of training in CPR/AED, hospital and healthcare procedures, driver and safety responsibilities and CIT certification. It utilizes a "soft approach" to security. Its staff are dressed casually and sedans can be customized to the needs of the entity requiring services. Secure panels are provided between the driver and passenger compartment with continuous GPS and radio dispatch monitoring. From November 2013 to the date of this report, it has provided secure transportation to over 8,000 individuals, provided 25,100 hours of patient care, and traveled over 500,000 miles without incident. Benefits of the program to date include improved patient care, efficient service delivery, one point of contact for paperwork transfer, uniform procedures that can be replicated statewide, transportation services after patient discharge, reduced burden on law-enforcement officers, elimination of law enforcement wait time in emergency departments, increased public safety, and 24/7 dedicated dispatching. G4S is very interested in providing similar services in Virginia.

A representative of G4S, Mr. Chris M. Roberts, confirmed recently that transport by G4S staff occurs only after a person has been brought to a hospital or other evaluation setting and authorization has been given for further transport. He reported that G4S has provided transport for individuals following discharge. Mr. Roberts noted that it was not possible to provide an estimate of the per-trip cost of providing such transportation in Virginia, as those costs depend upon a variety of factors unique to the locality involved (for example, the average number of trips per day and the distances of trips). He did note that, in the three transport programs now operated by G4S in North Carolina, the average cost "per transfer" across the three programs is \$88.00 to \$125.00. (He also noted that some hospitals are absorbing the entire cost of these transports; while he did not elaborate on this, it appears that expediting the transport of individuals in mental health crisis from the hospital ED to another facility saves the hospital money.)

#### ***Minnesota Medicaid Protected Transportation***

Minnesota recently adopted legislation that created a new category of non-emergency medical transport (NEMT) for individuals experiencing mental health crises, termed "protected transport." This type of transport resembles the secure transport model used in the Mount Rogers CSB Pilot. Protected

transport providers are certified by the Minnesota Department of Transportation and must have CIT, Mental Health First Aid, or some other form of de-escalation training; transport must be provided in a protected vehicle that is not an ambulance or police car and has safety locks, a video recorder, and a transparent thermoplastic partition between the passenger and the vehicle driver. Those eligible for protected transport include people of any age: (1) who are in crisis and need transport to a Medicaid-billable service (e.g., ED, intensive residential treatment services, etc.), and (2) who are covered by a Minnesota Health Care Program (MHCP) for which protected transport is covered, and (3) for whom protected transport is the most appropriate level of service. To qualify for protected transport, the individual must go through a level-of-service (LOS) assessment; the LOS is conducted by a member of the mental health crisis team, which is similar to a CSB pre-screener. The assessor also typically arranges the transport. Providers can be located using an MHCP (Minnesota Health Care Provider) directory. While providers may be available 24-7, they are not required to be. In addition, it should be noted that the length of involuntary holds in Minnesota is longer than in Virginia, which gives assessors a longer period of time during which to arrange transports.

Further information is required about how successful this program has been and how often the transport is used. This model is attractive in that it is non-stigmatizing and is appropriately billed as a medical service. Additionally, the transportation is cost effective; providers are reimbursed \$75 for the base rate and \$2.40 per mile traveled, with adjustments for longer trips and “super-rural” areas. One significant limitation of this model is that the individual must be transported to a Medicaid-billable service. The Institute for Mental Disease (IMD) Medicaid exclusion prohibits billing for inpatient stays in psychiatric hospitals with more than 16 beds. However, a recent CMS ruling may have mitigated this limitation somewhat in that Medicaid *managed care* may now be billed for inpatient stays in psychiatric hospitals with more than 16 beds. This may open a potential funding stream for alternative transport to these facilities.

### Transport No. 3: Post Commitment Hearing Transports

The Transportation subgroup currently has limited information regarding transport following involuntary commitment. The demonstrated efficacy of alternative transport for persons under a TDO indicates that most of those individuals who need to be transported to another mental health facility following commitment can be safely transported through means other than the use of law enforcement staff and vehicles.

### Transport No. 4: Discharge Transports

Following discharge from a facility, whether following the expiration of an ECO, or dismissal of a petition at a commitment hearing, or the determination by facility staff that discharge is medically appropriate, the person is no longer in custody. However, the person’s presence at the facility is often the result of government action, and the ability of that person to safely return home following such action should be a matter of government concern. This is not currently addressed by statute, but protocols to ensure a person’s safe return to the community following discharge, for whatever reason, should be in place statewide. If time permits, the subgroup will investigate what protocols exist for this transport, and the members will consider what actions constitute “best practices” for this important part of the experience of a person who has been in mental health crisis.



## Interim Findings

**1. The safety of alternative transport has been established in Virginia and elsewhere:** Steadfast Investigations & Security, LLC, has provided around 300 transports in the past 10 months (complete data are still being collected) through the Southwest Virginia Mount Rogers Community Services Board alternative transportation pilot project without incident and has now reduced the mental health-related transportation workload of law-enforcement agencies by one half. Similarly, the Valley CSB's alternative transport program, through the remarkable contributions from the Middle River Regional Jail and its trained staff, has provided safe transportation for nearly 100% of the TDO transports to out-of-area mental health facilities. G4S Secure Solutions in North Carolina, which is a large private security company providing an array of services, has provided alternative transportation to over 8000 individuals over a three year period with no adverse incidents.. These models demonstrate that the initial fear that public safety would be jeopardized by utilizing transportation providers other than law-enforcement has not materialized when alternative transportation is provided by well-trained staff. In addition, they have reduced the criminalization of the transport, reduced the trauma and stigma associated with law-enforcement transport for the individuals involved, and as a result they support, instead of compromise, the recovery process. Customer satisfaction for both the Mt. Rogers and G4S programs has been high. (It is not known whether the Valley CSB program has sought to measure customer satisfaction.)

**2. A medical model for at least some, and perhaps most transports from the community to the health care setting for persons in mental health crises has been successfully established in other jurisdictions.** Programs in California, North Carolina and elsewhere have determined that individuals experiencing a mental health crisis are experiencing a medical emergency, and health care agencies should respond to them as medical emergencies. Moreover, the designation of a mental health emergency as a public safety, rather than a health care emergency, hides the true cost of health care transportation and inappropriately places the burden of delivering health care on law-enforcement. Police officers are not health care providers and are not trained to provide health assessments. EMS staff are trained health care providers capable of performing this service. Ambulances transport individuals with every other medical diagnosis, and should therefore transport individuals in a mental health emergency.

## Recommendations

1. Continue the successful Southwest Virginia/Mount Rogers pilot project for another year with the goal of making the project financially sustainable. Consider, among other things, re-initiating the competitive bidding process; expanding the area served, thereby spreading overhead costs across a greater population area; identifying a more cost-effective dispatch system (perhaps utilizing the public dispatch system since these transports are carrying out the order of the magistrate); or reallocating staffing by using "on call" as opposed to "on duty" staff.
2. Develop a second pilot project in a denser population area, such as Tidewater, utilizing a combination of CIT-trained EMS as the primary transport from the community (unless specific safety concerns call for law enforcement transport) and secure alternative transportation for TDO and post-commitment hearing transports, unless a person's other medical conditions indicate a medically higher level of transport is appropriate.
3. Involve the Department of Health/Emergency Medical Services system in all studies and discussions related to alternative transportation. Ensure that emergency medical services technicians receive adequate training in responding to and screening mental health emergencies.

4. Request guidance from the Department of Medical Assistance Services on when Medicaid reimbursement will be provided for medical transport in the case of mental health crises, and review other insurance coverage standards regarding such transport and whether they comply with parity requirements for coverage of treatment of mental health conditions.