Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century
Meeting #1
July 21, 2014

Members Present: Senator Emmett W. Hanger, Jr. (Chair), Delegate Robert B. Bell, III (Vice Chair), Senator George L. Barker, Senator Janet D. Howell, Senator Linda T. Puller, Delegate T. Scott Garrett, Delegate Margaret B. Ransone, Delegate Luke E. Torian, Delegate Vivian E. Watts, Delegate Joseph R. Yost

Members Absent: Delegate Peter F. Farrell

The Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century (the Joint Subcommittee) met for the first time on Monday, July 21, 2014, at the General Assembly Building in Richmond.

Election of Chairman and Vice-Chairman

Following introductions, the Joint Subcommittee elected Senator R. Creigh Deeds to serve as chairman of the joint subcommittee and Delegate Robert B. Bell, III, to serve as vice-chairman of the joint subcommittee.

Overview of the Scope and Purpose of the Joint Subcommittee

Sarah Stanton, Senior Staff Attorney, Division of Legislative Services, provided a brief overview of the scope and purpose of the Joint Subcommittee. Senate Joint Resolution 47 (Deeds, 2014) established the Joint Subcommittee for a period of four years and directed the Joint Subcommittee to:

(i) Review the work of and coordinate with the Governor's Task Force on Improving Mental Health Services and Crisis Response;

(ii) Review the laws of the Commonwealth governing the provision of mental health services, including involuntary commitment of persons in need of mental health care;

(iii) Assess the systems of publicly funded mental health services, including emergency, forensic, and long-term mental health care and the services provided by local and regional jails and juvenile detention facilities;

(iv) Identify gaps in services and the types of facilities and services that will be needed to serve the needs of the Commonwealth in the 21st century;

(v) Examine and incorporate the objectives of House Joint Resolution 240 (1996) and House Joint Resolution 225 (1998) into its study;

(vi) Review and consider the report *The Behavioral Health Services Study Commission: A Study of Virginia's Publicly Funded Behavioral Health Services in the 21st Century*; and

(vii) Recommend statutory or regulatory changes needed to improve access to services, the quality of services, and outcomes for individuals in need of services.

In reviewing the need for facility beds at the community level, the Joint Subcommittee is directed to consider whether the current fiscal incentives for expanding regional jail capacity should be eliminated and replaced with a new incentive for construction, renovation, or enlargement of community mental health facilities or programs, which may or may not be co-located with selected jails on a regional basis.

The Joint Subcommittee is also directed to consider the appropriate location of such facilities; cooperative arrangements with community services boards, behavioral health authorities, and public and private hospitals; licensing, staffing, and funding requirements; and the statutory and administrative arrangements for the governance of such facilities. The Joint Subcommittee shall give consideration to the development of such facilities or programs on a pilot basis.

The Office of the Executive Secretary of the Supreme Court of Virginia, the Office of the Attorney General, the Offices of the Secretaries of Health and Human Resources and Public Safety, and the staffs of the Senate Finance and House Appropriations Committees are directed to provide technical assistance to the Joint Subcommittee. All other agencies of the Commonwealth shall provide assistance to the Joint Subcommittee upon request.

The Joint Subcommittee is required to submit an interim report to the Governor and the General Assembly by December 1, 2015, and a final report to the Governor and the General Assembly by December 1, 2017. The interim and final reports shall be submitted to the Division of Legislative Automated Services for processing and shall be posted on the General Assembly's website.

PRESENTATION: Recent Changes in Laws Governing Involuntary Commitment and the Delivery of Mental Health Services

Allyson Tysinger, Senior Assistant Attorney General, Office of the Attorney General, provided an overview of the current emergency custody, temporary detention, and involuntary commitment processes in the Commonwealth and recent changes in the laws governing those processes enacted during the 2014 Session of the General Assembly, which included:

- Increasing the period of time during which an emergency custody order must be executed from six hours after issuance to eight hours after issuance and extending the duration of an emergency custody order from four hours with an optional two-hour extension to a period of up to eight hours with no provision for an extension. (SB 260 (Deeds)/HB 478 (Villanueva))
- Requiring the law-enforcement agency executing an emergency custody order to notify the community services board responsible for conducting the evaluation as soon as is practicable after taking the person into custody. (SB 260 (Deeds)/HB 478 (Villanueva))
- Requiring that every person who is subject to emergency custody or temporary detention be given a written summary of the emergency custody or temporary detention process and the statutory protections associated with those processes. (SB 260 (Deeds)/HB 478 (Villanueva))
- Establishing a web-based acute psychiatric bed registry to contain information about available acute beds in public and private inpatient psychiatric facilities and residential crisis stabilization units to facilitate identification and designation of facilities for

temporary detention of individuals who meet the temporary detention criteria. All state facilities, community services boards, and private inpatient providers licensed by the Department of Behavioral Health and Developmental Services must report data to the bed registry, and the registry must provide access to information about available beds for individuals who meet the criteria for temporary detention to community services boards, inpatient psychiatric facilities, residential crisis stabilization units, and health care providers working in emergency rooms or other facilities rendering emergency medical care. (SB 260 (Deeds)/HB 1232 (Cline))

- Requiring a community services board, upon receiving notification of the need for an evaluation, to contact the state facility serving the area in which the community services board is located and notify the state facility that the individual will be transported to the facility upon issuance of a temporary detention order if an alternative facility cannot be identified within the eight-hour emergency custody period. Upon completion of the evaluation, the community services board must provide information about the individual to the state facility to allow the state facility to determine the services the individual will require upon admission. During the eight-hour emergency custody period, both the state facility and the community services board shall seek an alternative facility for temporary detention. If an alternative facility is identified, the community services board shall designate the alternative facility in the preadmission screening report. A state facility may not fail or refuse to admit an individual who meets the criteria for temporary detention order unless an alternative facility agrees to accept the individual. No person for whom a temporary detention order has been issued shall be released prior to transfer to a state facility or other alternative facility. (SB 260 (Deeds)/HB 293 (Bell, R.B.))
- Requiring that the Department of Behavioral Health and Developmental Services submit an annual report on June 30 of each year to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees setting forth the number of notifications of individuals in need of facility services by community services boards, the number of alternative facilities contacted by community services boards and state facilities, and the number of temporary detentions provided by state facilities and alternative facilities, the lengths of stay for such detentions, and the cost of such detentions. (SB 260 (Deeds)/HB 293 (Bell, R.B.))
- Allowing a community services board to change the designated facility of temporary detention at any point during the period of temporary detention, provided that the community services board has determined that the alternative facility is a more appropriate facility given the specific security, medical, or behavioral needs of the person. Transportation to the newly designated facility shall be provided by the law-enforcement officer or alternative transportation provider who has custody of the person when the change is made. If the person has already been transported to an initial facility of temporary detention before the change is made, the community services board must require the magistrate to enter an order specifying an alternative transportation provider or local law-enforcement agency to transfer the individual to the new facility. (HB 1172 (Bell, R.B.))

- Allowing any willing law-enforcement agency, not just the primary law-enforcement agency of the jurisdiction where the person resides, to provide transportation for a person subject to an emergency custody order. (HB 323 (O'Bannon))
- Increasing the period of temporary detention from 48 to 72 hours (SB 260 (Deeds)/HB 574 (Yost))

During the 2014 Session, the General Assembly also:

- Directed the Governor's Task Force on Improving Mental Health Services and Crisis Response to identify and examine issues related to the use of law enforcement in the involuntary admission process and to consider options to reduce the resources needed to detain individuals during the emergency custody period, including the amount of time spent transporting individuals. Options should include developing crisis stabilization units in all regions and contracting for retired officers to provide transportation. The task force is directed to report its findings to the Governor and the General Assembly by October 1, 2014. (SB 260 (Deeds)/HB 478 (Villanueva))
- Required the Department of Behavioral Health and Developmental Services to review the requirements related to qualifications, training, and oversight of individuals performing preadmission screening evaluations and to make recommendations for increasing the qualifications, training, and oversight of evaluators. The department shall report its findings to the Governor and the General Assembly by December 1, 2014. (SB 261 (Deeds)/HB 1216 (Bell, R.B.))
- Directed the Secretaries of Public Safety and Health and Human Resources to encourage the dissemination of information about specialized training in evidence-based strategies to prevent and minimize mental health crises. Such strategies shall include CIT training and Mental Health First Aid. Information shall be made available to law enforcement, first responders, emergency room personnel, school personnel, and other interested parties. (HB 1222 (Watts))

PRESENTATION: Overview of the Commonwealth's Publicly Funded Mental Health System

Debra Ferguson, Ph.D., Commissioner, Department of Behavioral Health and Developmental Services (the Department), provided an overview of the Commonwealth's publicly funded mental health system, including a statement of core principles and information on the number of public and private service providers, the distribution of service providers, and the services continuum. She stated that community services boards, which compose the public service system, are required by statute to provide emergency services and preadmission screening and discharge planning services. When funds are available, community services boards must provide case management services. Community services boards may also provide a range of mental health and substance abuse services either directly or through contracts with private providers. Commissioner Ferguson noted that there is a lot of variation in the type of services provided by community services boards in the Commonwealth and that performance contracts between the Department and community services boards are the main tool by which the Department oversees the work of the community services boards.

Noting that the Department's emphasis is on prevention and early identification of and intervention for individuals in need of mental health services as a method of reducing the need for emergency services, Commissioner Ferguson described recent changes to that effect at the Department, including tightening of regional protocols for admissions, revising medical screening and assessment guidance, extending the timelines for emergency custody and temporary detention, improving communication during the civil commitment process, launching the online psychiatric bed registry, and establishing regular mental health law "brown bag lunches" to discuss issues with stakeholders. The Department has also developed a process for reporting temporary detention order exceptions, requiring community services boards to submit data monthly. Commissioner Ferguson reported that between January 1 and April 30, 2014, there were 37 cases in which a temporary detention order was sought but not obtained because a willing facility could not be identified. Of these 37 individuals, approximately half were admitted for medical treatment instead of being taken into emergency custody, two were subjected to a second temporary detention order, two received an individual crisis plan rather than being taken into custody, and three were voluntarily admitted for services. Only six of the 37 left custody without any sort of follow-up or plan, with four of those six leaving before a plan could be implemented and two leaving custody against medical advice. Commissioner Ferguson noted that with recent changes in the law, which became effective on July 1, these six individuals would not have been released from custody. Instead, they would have been transferred to the state facility. Commissioner Ferguson also reported that during the same period there were a substantial number of cases in which a temporary detention order was obtained and executed but only after more than six hours had elapsed. In many of these cases, she noted, the delay was due to the need for medical treatment before the order could be executed. The Department will continue to monitor these situations.

In closing, Commissioner Ferguson described a number of challenges facing the Department and the publicly funded mental health services system, including an underdeveloped system of prevention and early intervention services; lengthy community waiting lists; inconsistency in the availability of intensive supports such as PACT, housing, and employment services in the Commonwealth; an underdeveloped peer support services delivery system; limited availability of mid-level crisis supports such as crisis stabilization services and CIT secure assessment centers; the low income threshold for Medicaid, which presents challenges for providing services for uninsured and underinsured persons; and limited funding for community mental health services.

PRESENTATION: Civil Commitment Laws: A Survey of the States

John Snook, Deputy Director, and Katheryn Cohen, Legislative and Policy Council, Treatment Advocacy Center, provided an overview of commitment laws in other states, including background on the commitment process in the United States, trends and developments in treatment laws nationally, how Virginia compares to other states, and opportunities for Virginia to improve its commitment process. Mr. Snook and Ms. Cohen noted that though Virginia has a "gravely disabled" standard for involuntary commitment, anecdotal evidence indicates that, like in most other states, involuntary commitment is not available in the Commonwealth until an individual is actually in crisis. They reported that many states are beginning to address this type of problem by incorporating a "need-for-treatment" standard that can prevent crises from occurring and help stabilize individuals with mental health treatment needs. Mr. Snook and Ms. Cohen also spoke about mandatory outpatient treatment requirements. Virginia, like many of the

45 states that have mandatory outpatient treatment statutes, uses a single standard for both involuntary inpatient and mandatory outpatient treatment. Mr. Snook and Ms. Cohen noted that in states with this type of standard, mandatory outpatient treatment is less likely to be utilized. Some states have addressed this problem by implementing different standards for inpatient and outpatient treatment. As a result, the number of orders for mandatory outpatient treatment has increased while the number of involuntary commitments has decreased. States that have implemented this approach, including New York, Ohio, Tennessee, and Massachusetts, report that the change has freed up voluntary services by making the system more efficient and reduced the cost of mental health services.

Mr. Snook and Ms. Cohen ended their presentation with a few recommendations for the Commonwealth, including recommendations that the Commonwealth clarify and consolidate its commitment standards, train service providers on and update treatment standards to promote consistent implementation, consider revising the mandatory outpatient treatment standards and procedures to increase use of mandatory outpatient treatment, and monitor the outcomes of recent changes to the emergency custody and temporary detention time frames to determine whether longer time periods reduce the number of involuntary commitments.

DISCUSSION: Work Plan for the 2014 Interim

Finally, the Joint Subcommittee discussed its work plan for the remainder of the 2014 interim. The Joint Subcommittee will establish a number of work groups to focus on a range of topics and issues. Additional information about the work groups will be made available in advance of the next meeting.