Mental Health Crisis Emergency Response: Improving Care for People in Crisis in Virginia

Report to SJ 47 Joint Subcommittee and the Statewide Stakeholder Task Force Summarizing Deliberations of Regional Stakeholders Meetings*

October 1, 2018

Introduction

A central goal in developing a humane and effective response to individuals who are in mental health crisis is to ensure that these individuals receive needed services as soon as possible, in the least restrictive setting possible, and as close to home as possible, so that they can recover and return to their regular lives as quickly as possible. A related goal is to ensure the safety of these individuals throughout the response process.

Unfortunately, the mechanisms currently in place in Virginia to achieve the goal of safety can unintentionally produce results that deny the individual effective treatment in the least restrictive setting closest to home. In addition, the lack of non-hospital alternatives to hospitalization in helping people in crisis is resulting in a hospital census crisis, currently centered in our state psychiatric hospitals, that is degrading the quality of care.

In response to the current crisis, the Joint Subcommittee to Study Mental Health Services in the 21st Century established a statewide Task Force to conduct a comprehensive study of the factors contributing to the crisis and to identify possible solutions. In collaboration with the SJ 47 Expert Panel on Emergency Services and Crisis Response, the Task Force convened stakeholder meetings over the course of several months in 2018 in each of the five Primary DBHDS Regions in Virginia (with separate meetings in each of the three sub-regions of the large and largely rural Region 3 in southwest Virginia; see regional map on page 18). Meetings included representatives from each region's CSBs, state hospitals, and a number of private hospitals (and, in some settings, leaders of mental health advocacy organizations). Meeting discussions focused on the challenges in the current mental health services system and identifying changes to that system that would improve the care and the crisis outcomes for individuals in Virginia with mental illness.

This preliminary report summarizes the observations, viewpoints, and recommendations that emerged out of that process. In addition, specific proposals for changes to or additional services for the crisis response system have been developing, with some of them emerging out of the regional meeting process and others having already started independently. Those service proposals, which are in various stages of conceptual development, are briefly described at the end of the report along with recommendations

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for how their development may be supported by financial or statutory actions of the General Assembly. Additional information about the proposals, including two draft amendments to the Virginia Code, are set forth in the appendices.

The observations and viewpoints that were shared in the regional meeting process are divided into three main categories: 1) building a robust community mental health care system; 2) providing a continuum of care in the crisis response system; and 3) gathering and analyzing relevant data. This preliminary report describes developments in the first two categories; a forthcoming report will address developments around data collection, availability, and use.

I. Building a Robust Community Mental Health Care System

There is consensus among all providers that the establishment of a robust community mental health care system, including effective integration with primary care to treat the "whole person," is the most important and effective way to reduce the increasing demands on the mental health crisis response system. The shape that such a system of community care takes, especially for the indigent and working poor, is critically important and a matter of much concern among all CSBs.

A. STEP-VA:

1. **Fully fund STEP-VA –** It is critical that the array of community mental health services envisioned by STEP-VA be fully funded. Implementing STEP-VA requires "up front" funding to enable CSBs to set up more robust community programs that help people with serious mental illness to remain stable in their homes (and to have homes).

2. **Use outcome measures in the Performance Contract** – The Performance Contract between DBHDS and the CSBs was not a major topic in the regional meetings. Nevertheless, a variety of CSB representatives supported the use of consumer outcome measures—specifically the measures of individuals' functioning in their communities captured by the DLA-20 (Daily Living Activities-20)—in evaluating and paying CSBs for services to uninsured individuals.

B. Medicaid Managed Care: CSBs noted a number of serious concerns about the current structure and process of Medicaid Managed Care in Virginia.

1. **The burden of having to deal with 6 different Managed Care Organizations (MCOs)** – The CSBs noted that each MCO has different staff, different standards, forms and protocols, and different responses to care issues. This places a significant administrative burden on each CSB (and other Medicaid providers) in trying to comply with these differing requirements and creates uncertainty in service delivery. This is particularly burdensome in

rural areas of the state where the CSBs' increased administrative costs are supported by fewer paying accounts.

2. **The functioning of the MCOs as gatekeepers rather than innovators** – While Managed Care in theory is supposed to encourage innovative practices that improve care while reducing costs, the MCOs to date have acted more like fiscal gatekeepers, saving money by limiting their approvals for various Medicaid reimbursed services. That negative experience has been compounded by delays in MCO approvals of services, delays in payments for services, and denials of services that the CSBs determine are important for supporting the stability of their clients.

3. **The Medicaid reimbursement rate and licensing requirements for services** – The compensation rates from Medicaid for many services are less than the costs incurred by the CSBs in providing those services. Two examples: 1) all CSBs must pay more for the services of a psychiatrist (whether in person or via telemental health) than the insurance compensation they receive for providing psychiatric services. 2) The poor payment rate for peer specialists has prevented the development of more robust peer services in CSBs that do not have the supplemental financial support from local governments that help a number of suburban and urban CSBs with their peer specialists programming. In addition, the level of credentialing and licensing required of those providing certain support services, which the CSBs report is not needed to effectively provide these services, makes it too expensive for the CSBs to continue offering these services. (For an example, see I(C) below).

4. **Denial of payment for services that provide ongoing stability for consumers with serious and persistent mental illness** – Payment for some key in-home and day treatment services for individuals with serious and persistent mental illness are now routinely denied because the patient has achieved stability and is not demonstrating further improvement in his or her condition. The CSBs point out that *maintaining* that stability once it is achieved is what enables people to avoid the decline and crisis that leads to hospitalization. By denying consumers ongoing access to the services that maintain their stability, Medicaid is "setting up" these individuals for decline into crisis.

5. **The lack of agreement between DBHDS and DMAS in establishing comparable standards of care for insured vs. non-insured individuals** – While DBHDS has been working with the CSBs to develop a meaningful outcome-measures framework for compensating the CSBs for services provided with state general funds (based on the DLA-20), that framework currently is much different from the structure of Medicaid Managed Care, where compensation is still driven primarily by the provision of defined services.

6. **The withdrawal of state general funds from CSB budgets on the grounds that those funds will be recovered through payments for client services under Medicaid Managed Care** – Under current plans, Virginia's expansion of Medicaid Managed Care is being accompanied by a reduction in the state general funds provided to the CSBs by DBHDS to provide services to individuals who currently are uninsured. The assumption behind this reduction is that the reduction will be "covered" because services to previously uninsured consumers will be compensated through Medicaid. The CSBs point out that, especially with the current work requirement for Medicaid Managed Care, coupled with the difficulties experienced by many individuals with serious mental illness in completing required paperwork and complying with insurance eligibility requirements, far fewer of the currently uninsured consumers will become Medicaid eligible than currently estimated. As a result, CSBs may experience a significant loss in revenue and will have to reduce staffing and services. They also point out that general fund dollars enable them to develop broader and more innovative programs that they find work best for clients, whereas under Medicaid Managed Care they can receive reimbursement only for providing services that are on the Medicaid approved menu of services, and only after the MCO has approved the service as being appropriate for the client. Delays in receiving that approval can result in completely missing an opportunity to help a person.

   Even if this concern is not realized, there is currently a time gap between the withdrawal of state general fund dollars and the beginning of Medicaid Managed Care reimbursement for services. The resulting revenue shortfall during that transition could be very damaging for many CSBs.

7. **The heavy reliance of many CSB operating boards on Medicaid funding –** Most operating boards, and all of the ones in rural areas, depend heavily on Medicaid as a source of revenue, and the challenges posed by Medicaid Managed Care as described above could pose a serious threat to the financial stability of one or more of those CSBs.

C. Mental health workforce crisis: Every CSB in every jurisdiction emphasized that there is a serious workforce crisis in the mental health field across specialties and positions. Hospitals had a similar report, and noted that on a number of occasions they have had to take beds "off-line" because they did not have the required professional coverage (with shortages of psychiatrists and nurses presenting the biggest problems).

In more than one regional meeting, CSBs noted that some of their best employees have been hired away by the MCOs (each of the 6 MCOs have staffing needs) at an annual compensation rate $10,000 to $20,000 above what the CSBs can pay.

CSBs also noted that new certification and licensing requirements had made it

financially unfeasible to take on undergraduate and graduate students as interns. In the past, those interns had been able to provide some meaningful services as part of their internships, and in the course of their work they often decided to continue working for the CSBs following graduation. The new requirements have largely eliminated that as a viable option.

As a result of the discussion of the workforce issue at the Region 4 meeting in the spring, Rhonda Thissen, Executive Director of NAMI Virginia, has formed and is chairing a public-private workgroup that is looking at the workforce shortage issues in the mental health field. At an initial meeting of that work group, state agency representatives noted their awareness of concerns over licensing and credentialing requirements that were impacting internships and the training of non-licensed individuals for support services. While state agency representatives made it clear that they are looking at that issue, there was agreement that the shortages of qualified mental health providers is impacting both public and private providers and is approaching crisis levels.

***D. Telemental health services*:** There is universal support for telemental health services as a vital way to "stretch" scarce mental health services and service providers in outpatient and inpatient settings, including emergency hospital care. While many CSBs use telemental health services for a variety of purposes, there are major impediments to more widespread use. A critical impediment, which must be resolved, is expense: services via telemental health cost CSBs more to provide than they receive in compensation, in part because of the fees charged by providers, in part because of the current requirement that a CSB professional be physically present with the person receiving services via telemental health. If it can be made affordable, CSBs would like to see telemental health approved for more settings. Rural CSBs in particular noted that many isolated individuals who do not want to come to a mental health clinic would readily participate by smartphone, tablet computer, or computer in sessions in their home via telemental health.

The SJ 47 Joint Subcommittee has already taken significant action on telemental health issues, resulting in the General Assembly's funding a 3 year grant for the Appalachian Telemental Health Initiative. The issue of affordability of services will be directly addressed in that project. Also as a result of the actions of the SJ 47 Joint Subcommittee, the Joint Commission on Health Care will be completing later this fall a two-year study of recommendations on expanding and strengthening telemental health services throughout Virginia. The issue of affordability has been identified by JCHC research staff and likely will be addressed in the JCHC report.

E. Permanent Supportive Housing and related in-home services (PACT, intensive case management, etc.): While no specific recommendations or proposals were made in the regional meetings regarding these services, there was agreement that expanding access to permanent

supportive housing is a key need, and particularly important for being able to discharge from the hospital individuals who remain hospitalized primarily because a community placement cannot be found.

II. Providing a Continuum of Care in Crisis Services:

A. Early Intervention - mobile crisis teams: Both Region 4 and Region 3a CSB representatives talked actively about the value of mobile crisis teams capable of going out to see people in their homes and help to resolve their crises in the least restrictive setting possible. Region 3a noted that for a number of individuals who have repeated crises, their crises are the result of stopping, losing, or otherwise not having their medication. Timely availability of a psychiatrist to prescribe needed medication can help to resolve crises early on, as a number of these individuals respond rapidly to their medications. Region 3a has developed a proposal for a mobile crisis team with psychiatric consult services, for which the Region is seeking funding (see Appendix A).

B. Providing time, support and alternatives to hospitalization for people in crisis: the Psychiatric Emergency Center (PEC) and ancillary services: The Psychiatric Emergency Center is a facility with medical and mental health services where individuals in crisis can come or be brought for a period of up to 24 hours for evaluation and treatment services. The PEC was identified early on by the Mental Health Crisis Response and Emergency Services Advisory Panel as a necessary but missing part of the continuum of crisis care in Virginia. The reported experience of such facilities in other states is that approximately 70% of the people who come to a PEC can be discharged home (with a plan and connections to community services) or "stepped down" to less restrictive settings than a psychiatric hospital setting. PECs can significantly reduce "psychiatric boarding" in hospital EDs, and can reduce the number of people psychiatrically hospitalized. CSB staff in Region 4 were already looking at possible PEC models at the time of the region-wide meeting on the TDO crisis held in April of 2018, and since that time staff have visited a "Crisis Recovery Center," which functions essentially as a PEC, operated by RI International in Newark, Delaware. (RI International operates such centers in several states.) Staff are now developing a proposal for a PEC in Region 4 (see Appendix B).

In Region 3b, the region-wide meeting on TDOs has resulted in a collaboration between the Piedmont CSB and Sovah Health to develop a PEC proposal (see Appendix C). Following a recent meeting in Marion, Virginia of regional stakeholders in the western portion of Region 3, New River Valley Community Services (NRVCS) has shared a proposal for a crisis respite center, using the "Living Room" model adopted successfully in other states (see Appendix G). That model shares characteristics with the facilities proposed by Region 4 and Region 3b. Notably, the plan is for this center to occupy space that is already available at the NRVCS Radford Center, where it will be co-located with a CIT

assessment center and two crisis assessment and intake offices, and will be only a ten-minute drive from a Crisis Stabilization Unit (CSU) with detox capability. Region 2 is also actively looking into the development of a PEC.

Although CSUs were not a major item of discussion in most regional meetings, hospital ED representatives in South Hampton Roads have noted in another forum that the limited staff coverage in some CSUs slows down the process of being able to transfer a person from the hospital ED to the CSU. More robust staffing might make the CSUs better able to process and accept new residents. The development of Peer Respite Centers (for which there are well-established models in other states) was cited as a need at the Region 4 meeting. Such Centers could function both as a less restrictive option to involuntary placements and as a "step-down" placement following time in an ED, PEC, or psychiatric hospital.

NOTE: A PEC operates on the understanding that many people in mental health crisis can be helped and referred to non-hospital supports when provided with timely care and support over a 24-hour period of time. Thus, the effectiveness of PECs in Virginia will depend upon enabling PEC providers to keep individuals in care for up to 24 hours. As a result, it would be important to amend the Virginia Code to provide that an ECO would remain in effect for 24 hours for a person who is placed in a PEC (see Appendix D).

C. Responding to individuals who present special behavioral health challenges: ID/DD, co-morbid medical conditions, dementia and aggression:

1. **The different challenges and needs of individuals in mental health crisis who have ID/DD –** There was widespread agreement among providers that individuals with Intellectual Disability/Developmental Disability (ID/DD) who experience a mental health crisis experience that crisis in a qualitatively different way than individuals without ID/DD, and therefore require a different kind of response and environment for working through that crisis. CSB staff in the western part of Region 3 noted that, in a number of instances, a behavioral crisis for a person with ID/DD is not really a mental health crisis as we normally understand it, and that "standard" mental health interventions are unlikely to work. Nonetheless, a timely response is needed, often including temporary placement of the person in another setting because these crises often involve serious physical aggression against these individuals' caretakers, who need immediate relief. Region 4 CSB staff are currently working with staff of Southside Regional Medical Center in Petersburg (operated by Community Health Systems) to open a unit specifically designed for individuals with ID/DD.

   In addition to the challenges of developing the appropriate physical infrastructure for such units and the special behavior management training for

hospital staff, there is the issue of how those beds will be reserved and filled to ensure their optimal use. The discussions between Region 4 and the hospital include the "purchase" of beds by Region 4 CSBs.

(A note: The most recent report of the Independent Reviewer for the DOJ Settlement Agreement with Virginia regarding the care of individuals with ID/DD compliments the development of community-based services under the REACH program, but faults Virginia for not having sufficient in-home response to behavioral health crises experienced by individuals with ID/DD.)

2. **The treatment needs of individuals in crisis who have other medical conditions: the unintended negative consequences of making state hospitals the placement of last resort –** Medical directors of some state psychiatric hospitals report that as a result of Virginia's "placement of last resort" law, state hospitals are receiving increasing numbers of individuals who have one or more other medical conditions that the state hospitals are not equipped or staffed to treat (e.g., individuals requiring dialysis treatment; those requiring cardiac specialty services). These placements are medically inappropriate and require disproportionate amounts of staff and facility resources to address, often because two or more staff are needed to transport these patients from the state facility to private facilities for treatment of their other conditions. Moreover, if these patients experience a medical emergency due to their non-mental health medical condition, the state hospital staff have very limited ability to respond to that emergency beyond calling for an ambulance. What is more, admission of such individuals compromises the ability of the state facilities to carry out their main mission of inpatient mental health care. In short, individuals with medical needs need to be in a setting—ideally a general hospital with a psychiatric unit—where there is capacity to address both their mental health and medical treatment needs in the same complex.

   This issue was raised most prominently by the Medical Director of NVMHI at the Region 2 stakeholders meeting, but his concerns were confirmed by the Medical Directors of Catawba and SVMHI. Their request is that state psychiatric facilities not be required to accept a person whose ECO period has expired but who has medical conditions that the state facility is not equipped or staffed to treat. An amendment to the Virginia Code has been drafted for consideration by the SJ 47 Joint Subcommittee that would end the mandatory placement of such individuals in a state psychiatric facility at the end of the ECO period (see Appendices E and F). That amendment also includes provisions for the extension of the ECO period for such patients and for relieving law enforcement from maintaining custody of the patient if the patient does not pose a danger.

3. **The capacity of private and public hospitals to respond to the crises of individuals whose crisis manifests in physically aggressive behaviors,**

including individuals with dementia – State and private hospitals have been discussing 1) what behaviors, and behavioral histories, of individuals in crisis are likely to result in private hospitals finding they are unable to treat those individuals, and 2) what supports from CSBs and DBHDS might enable the private hospitals to accept individuals who present with more aggressive behaviors. The private hospitals have noted in the regional meetings how physically aggressive patients can completely disrupt a treatment setting, posing dangers of harm to staff and other patients, and that accepting such patients can result in loss of staff and a decline in the capacity of the hospitals to meet the needs of other patients. They also have noted the increasing demands of licensure and certification programs, and the challenges in recruiting and maintaining adequate staff. The private hospitals have noted that patients with dementia respond slowly, if at all, to traditional mental health care interventions, and that nursing homes do not accept these patients back once they are stabilized in the hospital; as a result, these acute care facilities are forced to keep patients weeks or months while the search for a community placement continues. Despite the discussions, it has not yet been possible for the hospitals to clearly identify what behaviors or behavioral histories cannot be served by various private hospitals, and efforts by DBHDS to support treatment capacity-building in private facilities have not borne fruit.

4. **Responding to and supporting "frequent utilizers" and hard-to-place individuals: improved discharge planning and community services –** In Region 2 and Region 4 there was discussion of the challenges presented by "frequent utilizers" of emergency mental health services. The importance of early engagement with hospitalized individuals to discuss and make arrangements with them for community-based services to follow their discharge was emphasized in Region 4. There, Henrico County CSB is starting a collaboration with a local psychiatric hospital to arrange for such engagement with TDO'd individuals who were not involved in community-based treatment services at the time of their hospitalization. In Region 2, the Medical Director of NVMHI has noted his research on the effectiveness of Mandatory Outpatient Treatment (MOT) orders in other states, and has suggested increasing the use of physician discharge to MOT procedures to increase engagement in discharge plans and community-based care. Notably, though, there is a significant "cultural divide" in the mental health services community over MOT orders. In short, opponents argue that MOT is coercive, and that the key to increasing treatment engagement is having sufficient community services available in a system that currently is short of such services. Proponents counter that the threshold for securing an MOT order is crossed only when an individual experiences repeated involuntary hospitalizations, which indicates that the individual lacks insight into his or her condition and need for treatment. The order thus provides a "leveraging" mechanism for gaining continued engagement in treatment from a person who historically has not remained engaged and has experienced repeated crises as a result.

At the Region 2 stakeholders meeting, private hospitals noted the increasing numbers of individuals accepted by their facilities under TDOs for whom community placements were very difficult to secure. The problem poses a double danger of (i) reducing the availability of acute care beds because they are being occupied by people who no longer need those beds but cannot be placed in the community, and (ii) increasing the wariness of hospitals to accept individuals who might prove difficult to discharge. As a result of that report, the Region 2 Regional Projects Director invited the area hospitals to submit data on their experience with this problem. Data is being collected and analyzed at this time. In the meantime, the Region 2 CSBs have made a commitment to developing a regional Assisted Living Facility that will have the capacity to care for individuals with serious mental illness who are otherwise hard to place in the community. In addition, Region 2 is also committing to the development of an intensive care residential treatment facility that will focus on patients in state psychiatric hospitals who cannot be placed in other community settings because of the severity of their illness.

D. Treating individuals in crisis close to home: the current damage from long distance travel for individuals under a TDO: Because of the difficulty in finding available hospital beds in Virginia, CSB evaluators must evaluate individuals under an 8-hour ECO as soon as possible, so that the evaluator has as much of the ECO period available as possible to conduct the often several hour bed search process if the person is found to meet the criteria for a TDO. This often means that the person is seen in the height of his or her crisis. For many individuals that crisis may be fueled by alcohol or drug use, and their clinical picture—including their actual need for hospital care—could change dramatically over the course of several more hours as the effects of alcohol or drugs wear off. Such time is not available currently for persons under an 8-hour ECO. In addition, a therapeutic environment in which such time can be provided is also not available. (Hence the proposals for PECs to provide such an environment.)

The current lack of sufficient alternatives to involuntary hospitalization in Virginia has consequences that go beyond the unnecessary hospitalization of individuals who might best be treated in a less restrictive setting. It is also resulting in individuals being TDO'd to facilities that are far from their homes and families, sometimes hundreds of miles away. Using the statewide registry, CSB evaluators look for available beds anywhere and everywhere in the state. Because of the press of time, the evaluator must and will take the first bed that is available, regardless of where it is located. In far too many cases, that results in long trips, sometimes trips of hundreds of miles, to the hospital. If no private hospital bed is available, a state psychiatric hospital bed, by law, must be made available, which means that the individual often will be making a long trip to the state hospital serving that individual's region. If the regional state hospital is full, then the trip can be far longer. All of these TDO trips currently are being made with the

person in handcuffs in the back of a law enforcement vehicle.

As many as 25% of these individuals who are transported these long distances under a TDO are later found by the special justice at the "3 day hearing" *not* to meet the criteria for involuntary commitment, and are immediately released from the hospital. Virginia law and regulation make no provision for how these people get back to their homes. Several private hospitals are now paying thousands of dollars a month to provide that transportation, but there is no legal requirement that they do so. In other places, informal arrangements have been made between hospitals and CSBs to get people back home.

This experience can be traumatizing and disorienting for many individuals, and can make it more difficult for the CSBs where they live to get them to engage in services. It is also distressing to the families of these individuals, who may be unable to be a support to their loved one because of the long distance between them and the hospital where their family member is placed. Even for those individuals who remain in the hospital under an involuntary commitment order because they need hospital care, efforts to coordinate that care with community providers and provide a smooth transition back home are made more difficult by the long distances involved and by the fact that these faraway hospitals may not have an established working relationship with CSBs where the person lives.

Public and private providers alike, and most especially those in Region 4 and Region 3 (including all three sub-regions of Region 3), were very vocal in their distress over this experience of individuals in their jurisdictions being forced to make such a long journey to a hospital under a TDO. What increased their sense of distress was the fact that, prior to the use of the statewide bed registry and the mandatory state hospital placement of individuals at the expiration of their 8-hour ECO period, these regions were almost always able to find a hospital bed for a TDO patient within their region. Region 3a (Roanoke City and adjoining counties, served by Blue Ridge Regional Behavioral Healthcare) in particular noted that currently beds in their sub-region's private psychiatric hospitals average more TDO patients from other parts of the state than from their region. (Region 4 private hospitals have not yet shared data on this, but in the spring of 2018 the Region 4 CSBs noted that the total number of individuals TDO'd in Region 4 had *not* risen since 2014, while the CSBs nonetheless had been forced to send increasing numbers of their TDO patients to out-of-region hospitals during that same period.) In its proposal for a PEC (Appendix G), NRVS notes that before March of 2014, 80 percent of all adult temporary detention orders (TDOs) from the New River Valley were placed in local psychiatric facilities. The rates of local psychiatric hospital placement for TDO patients have dropped dramatically since then: 57 percent in 2015, 36 percent in 2016, and 31 percent in 2017. As a consequence, the distance of the average law enforcement transport for each TDO placement has gone from 67 miles in 2014 to 141 miles in 2017.

Compounding this distressing development is the experience of these CSBs that

different hospitals throughout the state interpret their obligation to accept TDO patients differently. Hospital administrators in Region 3 reported that they have been advised by legal counsel that, under the requirements of the federal Emergency Medical Treatment and Active Labor Act (EMTALA), they must accept transfer of a psychiatric patient to their facility if they have an available bed and if they have the capability to treat such a patient. This applies regardless of whether there are patients in the hospital's own Emergency Department who appear to need psychiatric hospitalization but who are awaiting a pre-admission screening. CSB evaluators in Region 3 note that, on the other hand, hospitals in other parts of the state decline to accept patients from Region 3 if it appears that a patient in their hospital will need a psychiatric bed, and decline other Region 3 patients for other reasons not used by the private hospitals in Region 3. This difference in hospital practice has been a source of frustration, but the clear desire of all these CSBs is to be able to treat the people in their region close to home. Moreover, both CSB and private hospital representatives expressed their view that the current system is wasting enormous amounts of resources, including CSB, hospital and law enforcement time, staff and vehicles. Because hospital beds across the state become available at unpredictable times, law enforcement vehicles carrying TDO patients increasingly end up crisscrossing the state and passing each other on the highway, as they travel to the remote hospital that was available when a TDO had to be entered. This is a waste of public resources that also diminishes good care.

EMTALA was enacted by Congress in 1985 to prevent "patient dumping" by requiring that every hospital that accepts Medicare funding admit and treat equally any person coming to its Emergency Department, regardless of the person's ability to pay for that care, and the other parts of every hospital (including psychiatric units of general hospitals and all free-standing psychiatric hospitals) must accept the transfer of a patient from the ED of another hospital if it has the capacity and the special capabilities to treat the patient, regardless of the patient's ability to pay for care. Under EMTALA regulations, the transferring ED doctor must find that the transfer is "appropriate"—specifically, that the medical benefits of transfer outweigh the medical risks. Because Virginia's TDO process applies to a patient in an ED who is under an ECO, it is not clear whether the TDO process is, in practice, currently displacing the EMTALA transfer process, with some ED doctors perhaps deferring to the TDO placements found by the CSB pre-screeners and ordered by the magistrate. In any event, the federal government has made it clear that the requirements of EMTALA still apply to any such transfer, and that the transfer must be "medically appropriate" and certified as being so by the attending ED doctor. One does have to ask how transporting a psychiatric patient who is in mental health crisis by putting that patient in handcuffs in the back of a law enforcement vehicle and driving the person 100 or 200 miles from home to a psychiatric hospital is medically appropriate. (A similar question arises in the case of a person in mental health crisis who has other medical conditions needing treatment who is transferred to a state psychiatric hospital that does not have the capacity to treat the patient's other

medical conditions.) Further careful discussion about the application of EMTALA to these cases, and the interaction between state and federal law, is needed.

(Two notes: First, because of reform action by the General Assembly, in response to the recommendations of the SJ 47 Joint Subcommittee, Virginia is now moving toward transport by non-law enforcement entities. This alternative transport will not be medical transport, but it will involve private contractors whose drivers will have received a version of Crisis Intervention Team (CIT) training and other related skills for working with individuals in crisis. They will not be placing individuals in handcuffs as a routine practice as law enforcements officers currently do. However, because of the significant distances of transport currently being experienced, the serious questions about the appropriateness of these long distance transports remain.

Second, a key way to address this problem is to build community capacity to help individuals in crisis without resort to hospitalization. The proposed Psychiatric Emergency Centers and mobile crisis teams would help to provide such community capacity. Enabling the attached proposals to function as pilot projects would allow a meaningful assessment of the efficacy of these alternative services.)

Summary of Service Proposals

While there is still active discussion in most of the regions regarding possible projects that could help to address the current TDO hospitalization crisis, the following projects are the most specific to emerge from discussions about improving the crisis response system:

1. Early Intervention - mobile crisis teams:

Establish mobile crisis teams with access to psychiatric consulting services: The fully developed proposal completed by Blue Ridge Behavioral Healthcare is attached (Appendix A). The proposed program, especially with its feature of including psychiatric consultation and medication prescription, could become a model for other regions.

2. Providing time, support and alternatives to hospitalization for people in crisis: the Psychiatric Emergency Center (PEC) and ancillary services:

a. **Psychiatric Emergency Centers (PECs)**: The PEC project proposals in Region 3b and Region 4 are in development, and the proposal from New River Valley Community Services includes a full proposed budget. Attached are summaries provided by Greg Preston, Executive Director of the Piedmont CSB for Region 3b (Appendix C); by Daniel Rigsby, Director of Henrico County Mental Health for

Region 4 (Appendix B); and by Jill Anderson, Emergency and Acute Services Manager at NRVCS, for southwestern Region 3 (Appendix G).

b. Code amendments to support the PEC model: Attached is a rough draft of a proposed amendment to Virginia Code Section 37.2-808, which would provide for a 24-hour ECO period for individuals who are placed in PECs (Appendix D).

3. Responding to individuals who present special behavioral health challenges: ID/DD, co-morbid medical conditions, dementia and aggression:

a. For individuals in mental health crisis who have ID/DD: Develop through public-private partnership psychiatric hospital units dedicated to the treatment of individuals with ID/DD: As of the writing of this report, negotiations are continuing between Region 4 staff and Southside Regional Medical Center on the establishment of a dedicated unit (4 to 5 beds) for the care of individuals with ID/DD for whom involuntary psychiatric hospitalization is needed.

b. For individuals in mental health crisis who have other medical conditions needing treatment: amend the Virginia Code so that such patients who are under an ECO are *not* placed in a state psychiatric hospital as a mandated "placement of last resort" if the medical director of the state hospital confirms that the hospital is not equipped or not staffed to treat the patients' other medical conditions: Attached is a proposed amendment to Virginia Code Section 37.2-809 and the addition of Virginia Code Section 37.2-809.2 that would "carve out" from the "placement of last resort" requirement those individuals under an ECO who have medical conditions that state psychiatric hospitals are not equipped or staffed to treat (Appendices E and F). The amendment would extend the ECO period for such individuals, including an ECO extension allowing providers to petition the local court for authorization to treat these individuals.

Other Possible Proposals:

A number of other possible proposals are in discussion stages right now, including several in Region 2: the use of DAP or similar funds for expedited discharge of hard-to-place individuals who have been TDO'd to private psychiatric facilities; the construction of residential facilities for hard-to-place hospital patients with serious and persistent mental illness; and a possible PEC.

These proposals, and the statutory changes and appropriations that may be needed to bring them into fruition, should come into sharper focus in the coming weeks.

Mental Health Crisis Emergency Response
SJ 47 Regional Stakeholders Meetings (October 1, 2018)

Summary of Requests for Legislative Action

Regional stakeholder meetings and related discussions among key stakeholders identified several key budget and statutory recommendations: They are set forth in general terms in the expectation that further refinement and specificity will be required.

Appropriations

1. **Fully fund STEP-VA (Report item I.A.1)** – Regional meetings to discuss the hospital census crisis made clear the importance of continued support for improving the community services system so that individuals may avoid reaching mental health crisis. For that, the continued fiscal support of the General Assembly for STEP-VA is critical. Expected Medicaid reimbursement under the expanded Medicaid program should not offset STEP-VA funding until adequate CSB capacity has been established to carry out the STEP-VA services.

2. **Fund mobile crisis team proposed by Region 3a (Item II.A; Appendix A)** – Early intervention that meets individuals where they are in the community, particularly in their homes, can result in the resolution of many crises without resort to hospitalization. Funding the mobile crisis team proposed by Region 3a would enable that region to demonstrate the efficacy of this service and provide a model for other jurisdictions.

3. **Establish three proposed Psychiatric Emergency Centers and ancillary services (Item II.B; Appendices B, C and G)** – PECs have the potential to fill a vast and critical gap in the continuum of crisis services (though PEC success will also depend upon the development of sufficient community services to provide ongoing support to individuals following their discharge from the PEC). Funding for the three proposed PECs—one located in an urban/suburban region of Virginia and the other two located in rural western Virginia—would provide the models needed in contrasting regions of the state to demonstrate the efficacy of this service in Virginia.

4. **Increase funding for "community integration" of hard-to-place individuals, whether in state hospitals or private hospitals (Item II.C.4)** – The Joint Subcommittee is well aware of the "extraordinary barriers list" in the state hospitals and the need for transition placements for "hard-to-place" patients in state hospitals. Several regional meetings highlighted that private hospitals are in many instances unable to take on more TDO and/or involuntarily committed individuals because beds are occupied by individuals who no longer need hospital care but are difficult to find placement for in the community. Thus, proposals for local or regional Assisted Living Facilities and/or intensive care residential treatment centers should be supported with state funds.

Statutory Amendments

1. **Extend ECO period for individuals placed in a PEC (Item II.B; Appendix D)** – The success of the PEC model turns on its provision of up to 24 hours of care during a crisis, which allows for the crisis (and the effect of alcohol and/or drugs in many cases) to subside, thereby enabling staff to better assess the person's clinical needs and, where appropriate, provide initial care in the PEC and then connect the person with "step-down" or community services, avoiding unnecessary hospitalization. This approach would significantly reduce the number of TDOs now necessitated by Virginia's current ECO timeframe of 8 hours. A proposed revision to the Virginia Code, providing for a 24-hour ECO period for persons who are in a PEC, is set out in Appendix D.

2. **Assure medically appropriate hospitalization of individuals under ECO who also have other medical conditions needing treatment (Item II.C.2; Appendices D, E and F)** – The current "placement of last resort" requirement is having the unintended consequence of requiring state psychiatric hospitals to accept individuals under a TDO who have medical conditions that the hospitals are not equipped or staffed to treat. State facilities must be able to decline patients who have these additional medical treatment needs. Proposed amendments to the Virginia Code that would allow a "carve out" from the "bed of last resort" requirement are set out in Appendices D, E and F.

   (NOTE: this recommendation is a response to deep concerns raised by state psychiatric facility medical directors. While there was robust discussion about this problem in the stakeholder meetings in both Regions 3a and 4, no consensus was reached between private and public hospitals regarding the best ways to address these challenging patients, except to agree that they are challenging. As long as state facilities are required by state law to accept these patients if no private facility will accept them within the 8 hour ECO period, it is unlikely that private and public hospitals will get beyond the discussion stage in the search for better outcomes for these patients.)

Legislative Study

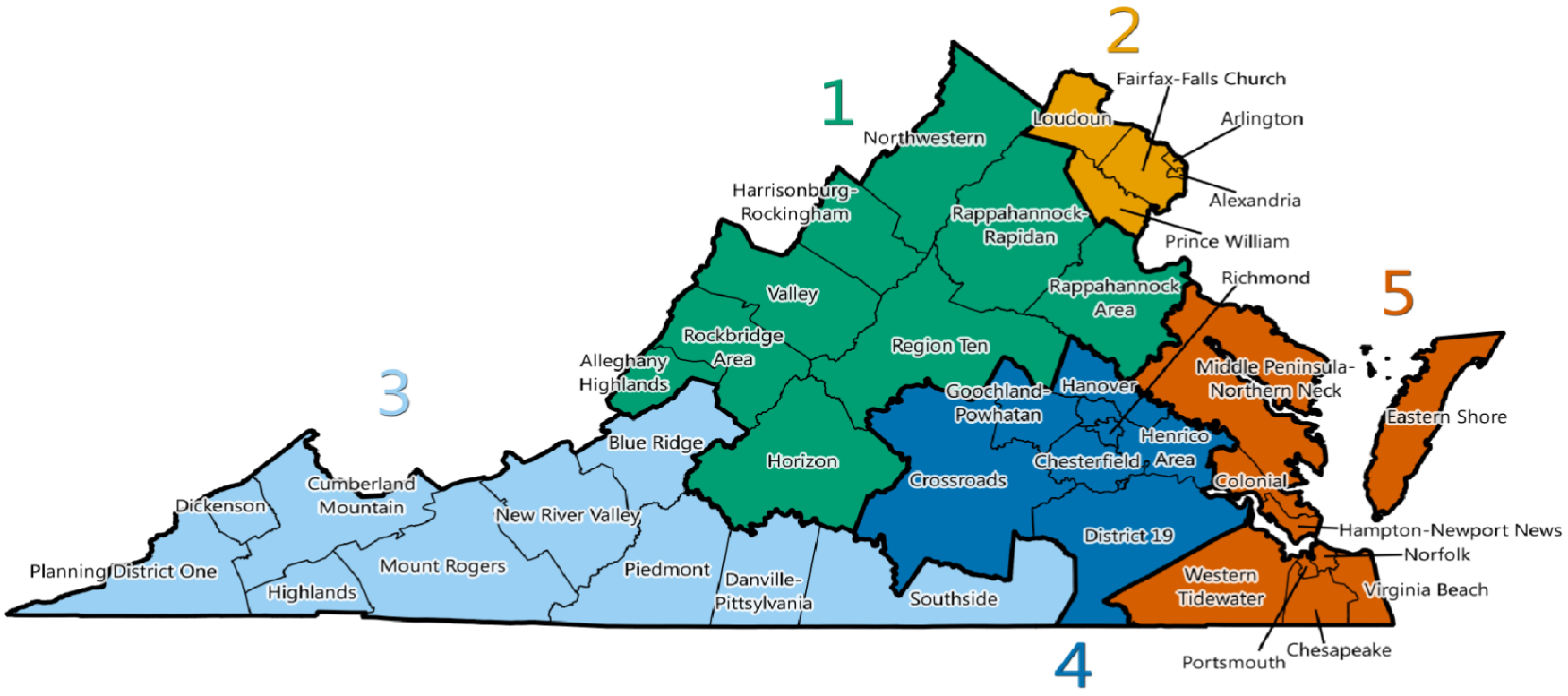
Review the intersection of Virginia emergency custody law and federal EMTALA (Item II.D) – Discussions at regional meetings highlighted variation across private hospitals in how they interpret EMTALA's requirements and their practices for prioritizing pending and requested psychiatric admissions from their local EDs over requested psychiatric admissions from other regions. The Joint Subcommittee should direct the Statewide TDO Task Force to study the various state and federal legal requirements governing emergency care admissions to facilitate consistent interpretation and application.

Summary of Possible Actions by DBHDS and/or DMAS

1. **Outcome measurement in Performance Contract (Item I.A.1)** – Regional meetings made clear the wide support among CSBs for the integration of outcomes measurement into evaluation and payment protocols and databases.

2. **Review of Medicaid Managed Care practices (Item I.B, particularly sub-items 1, 3, 5, 6)** – Discussions during regional meetings illuminated several complications in the current Medicaid Managed Care scheme that burden CSBs' (and other providers') administration and compensation, and in the worst cases, have the potential to negatively impact care. The upcoming expansion of Medicaid will likely exacerbate such problems. Thus, it is recommended that the current structure of Medicaid Managed Care be closely examined for potential areas of improvement.

3. **Mental health care workforce (Item I.C)** – Regional meetings and the public-private workgroup initiated by NAMI-Virginia underscored the growing workforce shortage, which will likely worsen as planned improvements to the mental health care system further stretch resources. To the extent that DBHDS and DMAS can revise licensing and credentialing requirements to support workforce recruitment and retention without sacrificing care quality, it is recommended that such efforts be expedited. In addition, the Secretariat of Health and Human Resources should consider a major initiative to develop an action plan for addressing these workforce challenges



Primary DBHDS Regions for Community Services Boards

Region 3a Mobile Crisis Team Proposal, Blue Ridge Behavioral Healthcare

Purpose and Background

Traditional "Mobile Crisis" teams provide timely assessment and intervention in cases of police involvement with individuals in the community. The purpose of such intervention is to provide law enforcement access to mental health experts on the scene, in real time, when they are involved with citizens who are experiencing crises such as suicidal ideation. Mobile crisis teams have existed for several decades around the country and Blue Ridge Behavioral Healthcare (BRBH) is making a proposal for funding to create a team in our area. The success of Mobile Crisis programs may be dependent on which components are provided. We believe a team that provides 1) "crisis intervention" on scene with police, 2) extended "crisis stabilization" after the initial law enforcement contact, and 3) the availability of an emergency psychiatrist to address immediate medication needs, will result in the most hospital and jail diversions.

One benefit of having a Mobile Crisis team is that mental health therapists can respond with law enforcement when they are dispatched on mental health related calls. This allows the therapists, rather than the officer alone, to assess the situation and potentially divert individuals from having to go to Emergency Departments, jails, or ultimately be hospitalized when an alternative safety plan can be put into place. More specifically, the Mobile Crisis therapist would assess the need for ECO (Emergency Custody Order), assist in de-escalation of the mental health related crisis, and potentially offer immediate therapeutic "crisis intervention." As in most traditional mobile crisis programs, staff would work in pairs when responding to scenes as requested by police, which helps with consultation and sound decision making for potentially high risk and complex cases.

After initial crisis intervention, for those that are appropriate, extended "crisis stabilization" services would be put into place. These services would begin immediately, last up to two weeks, and be in addition to other traditional services they may be receiving. Staff would be available to provide this additional support to the person, daily if needed, during that time frame. The benefit of the crisis stabilization component is that it helps the person stabilize over a longer period of time, potentially decreasing repeat law enforcement contact and provide better continuity of care.

An additional component proposed is the addition of an emergency psychiatrist to provide immediate evaluation and medication management until those in crisis could be seen for longer term psychiatric needs. The inclusion of a psychiatrist in traditional mobile crisis teams varies depending on funding levels and staffing availability, though their inclusion is deemed as ideal. The addition of a psychiatrist to our proposed team would also support hospital and jail diversion efforts for clients already open to BRBH, by making the doctor available to see same day walk-ins for those who may be unexpectedly in crisis or experiencing and escalation in symptoms.

It is expected that implementation of a Mobile Crisis team in our area would result in a decrease in ECOs and psychiatric hospital admissions. It would also help serve individuals experiencing mental health emergencies in a timelier manner and potentially decreasing the time law enforcement spends in the hospital and transporting clients. The team would also be available as requested to provide cross education to law enforcement agencies about mental health and substance abuse related topics.

Partnership

Four local law enforcement jurisdictions have expressed the desire to collaborate on this project—the police departments of Roanoke City, Roanoke County, City of Salem and town of Vinton. Two large hospital systems in the area are supportive of implementation of a Mobile Crisis team through BRBH. These efforts are also supported by our area's Mental Health and Criminal Justice Task Force and Catawba Regional Partnership. Mobile Crisis and CIT teams were recently noted as a priority area in a regional Criminal Justice and Opioid mini-cross systems mapping led by members of the Department of Behavioral Health and Human Services. This level of consensus among law enforcement, hospitals, and the Community Services Board (CSB) is expected to lend support to the success of the project. Mobile Crisis Teams are currently a part of the STEP-VA plan to be implemented in the future. Due to the experience of several in our catchment area with Mobile Crisis teams, BRBH would like to implement the project early and potentially be an example to others CSBS as needed.

Strategies

Key strategies include the availability of a mental health therapist to respond with police to a mental health related call. Additional psychiatric coverage to provide consultation and medication orders as needed is also an important component for the success of a mobile crisis team. Roanoke, Roanoke County, and Salem police departments have collected data on mental health related incidents from 2015-2017 which identified 4pm to 10pm as the peak hours of these calls and Thursdays typically having the highest volume. Many of the mental health related calls that police respond to are the result of an individual experiencing a significant external stressor, family conflict, or exacerbation of an already present mental illness. The therapist responding along with the police officer in these types of situations would provide an additional array of interventions, potential referral for immediate psychiatric services, and potential future outpatient services along with the sole police officer's ability to de-escalate, initiate an ECO, or arrest.

Activities

Mental Health related calls would be identified by the participating police jurisdictions and the mobile crisis team therapist working or on-call would be notified to meet the officer at the location of the individual in crisis. Police would assess the situation for safety, and when deemed appropriate, would invite the mobile crisis therapist to assist. The therapist would conduct a basic mental health screening, including assessment of risk, mental status, history

of mental illness, and current and previous services. The therapist would provide crisis intervention with motivational interviewing skills to de-escalate the crisis, make a safety plan if needed, and a plan for follow-up services. The individual might be referred to the Same Day Access Center the follow day for intake or, if needed, plans could be made to provide crisis stabilization services for up to the next 15 days. If there was a need for psychiatric services, the psychiatrist could meet the individual at their home or somewhere else in the community to provide assessment and intervention. In the event that the individual was a danger to themselves or others, the police officer could initiate an ECO and the individual would be taken to the hospital emergency room for assessment.

Supporting Data

There is data to support mobile crisis teams reducing psychiatric hospitalizations. A paper by Roger Scott in 2000 provided data on the success of a mobile crisis team working with police in Dekalb County, Georgia. Fifty-five percent of the emergencies handled by the mobile crisis team were managed without psychiatric hospitalization of the person in crisis, compared with 28 percent of the emergencies handled by regular police intervention. A study in 2010 by Kisely, Campbell, and Peddle found that time spent on the scene by police officers was significantly lower with the use of mobile crisis. A 2001 study by Guo, Biegel, Johnson, and Dyches found that an individual receiving hospital based crisis services was 51 percent more likely to be hospitalized within 30 days of the crisis compared to an individual receiving interventions from a mobile crisis team. In 2013, Las Vegas, Nevada began a pilot of utilizing a mobile crisis outreach team with their paramedics to divert low medical acuity psychiatric patients from unnecessary transport to the emergency room and was able to increase the percentage of diversions by 11%.

Evaluation of a Mobile Crisis Program: Effectiveness, Efficiency, and Consumer Satisfaction. Roger L. Scott, L.C.S.W., Psychiatric Services, Volume 1, Issue 9, September, 2000.

A Controlled Before-and-after Evaluation of a Mobile Crisis Partnership between Mental Health and Police Services in Nova Scotia. Stephen Kisely, MD, PhD, Leslie Anne Campbell, MSc, Sarah Peddle, MSc, Psychiatric Services, Volume 52, Issue 2, February, 2001.

Guo, S., Biegel, D.E., Johnsen, J.A, & Dyches, H. Assessing the Impact of Community-Based Mobile Crisis Services on Preventing Hospitalization. Psychiatric Services, Volume 52, Issue 2, February 2001

Diverting Psychiatric Patients to Least Restrictive Environment of Care. Presented at: The National Council for Behavioral Health Conference, March 7-9, 2016, Las Vegas.

Costs

There are a variety of potential service availability plans providing differing levels of mental health staff availability. A plan to assist mental health police calls with additional on-call coverage for all other times appears to be the most cost and recruiting effective strategy.

Day Time and on-call Coverage, Therapists

A plan for day time coverage provides at least 3 staff on shifts of 9am to 7pm at all times Monday through Friday, and the remaining time will be covered by on-call personnel available for response within 1 hour. Costs for the 4 therapist positions and 1 supervisor to cover the proposed program, including salary, fringe, management and overhead, equipment and supplies is approximately $360,000. This staffing level also provides for good coverage for when staff may be on leave or in the event a position is vacant for a short period of time. On-call expenses for the remaining 118 hours per week would cost approximately $38,350 annually. On-call staff working in the community after-hours and on weekends would be paid the typical time and a half of their hourly rate. For an average of 4 after-hours calls daily, at an estimated 3 hours for each call, costs would be approximately $120,450.

Total personnel costs for Therapist = approximately $518,800.

Psychiatrist Coverage

Psychiatric services is a key component of a successful mobile crisis team. The psychiatrist would respond to police involved mental health crisis calls with assessment and needed medication orders to accomplish de-escalation and stabilization in the community. Additionally, when not called out to the community on a mental health call, the psychiatrist could see individuals on an emergency walk in basis with a goal of preventing a potential crisis from escalating to the level of police involvement.

The cost for a full time emergency psychiatrist (including salary, fringe, management and overhead, equipment and supplies) is approximately $375,000. This position would provide coverage for 40 hours a week, with schedule and availability optimally based on the hours of peak mental health calls. Considering the increased need during daytime hours for both Mobile Crisis in the community, and walk-in emergency appointments, and the cost of additional staff to sit with the client during telepsychiatry appointments as required by regulations, the most cost effective means for coverage is a hiring a full time psychiatrist.

Blue Ridge Behavioral Healthcare (BRBH) currently has a contract with Insight Telepsychiatry to provide psychiatric consultation and medication orders after-hours by phone with the capability of video assessments if needed. This contract could be used to provide either psychiatric coverage during the remaining hours of the week when the full time psychiatrist is not scheduled, or, less optimally, as a replacement of the full time psychiatrist position. The cost of this contract is currently a $3900 monthly fixed availability fee with $50 for each phone consult up to 50 consults per month. (An additional availability fee of $3545 is charged for calls exceeding 50 per month.) Video assessments are an additional $250 each. Currently BRBH is averaging 25-30 consults per month. The Insight representative has confirmed that we could utilize the remaining monthly call availability on the current contract for mobile crisis. There would be an additional one time set up fee of approximately $1500 to set up the doctor availability. Insight is currently providing this

service to a mobile crisis unit in another state and estimates that 20 percent of calls request video assessment. The potential number of cases needing phone review is estimated at 20 monthly with a projection of about 5 monthly needing video assessment.

Total costs for a full time emergency psychiatrist and after-hours telepsychiatry services= approximately $402,000. And additional one time $1500 set up fee for telepsychiatry.

Revenue

Police data indicate approximately 10-12 mental health related calls daily between the five participating police jurisdictions. Of those, about 40% are ECOs which the CSB Emergency Services staff are already responding to in the local hospital emergency rooms. The remainder would be the calls directed to the mobile crisis team.

Crisis Intervention services could be billed for individuals with Medicaid for time spent on the initial crisis call. Crisis Stabilization services could be billed for individuals with Medicaid for daily follow-up services of up to 15 days. Considering a projected Medicaid rate of 30% of all individuals seen through mobile crisis, the following amounts are projected revenue sources:

Average of 3 hours per call billed to Crisis Intervention at $125/hour and estimated 6 calls daily=$2250 daily or $821,250. Average of 30% Medicaid clients=$246,375 in yearly Medicaid billing for Crisis Intervention.
Projection of 5 hours daily in additional Crisis Stabilization billing at $89/hour =$445 daily or $162,425 yearly. Average of 30% Medicaid clients=$48,727 in yearly Medicaid billing for Crisis Stabilization.

There would be a total projected yearly Medicaid billing to offset therapist's expenses of $295,102.

A full time psychiatrist could also bill Medicaid for evaluations and consultations with medication orders. **The potential Medicaid billing for psychiatric services is estimated at $87,000**. **Telephone consultations through Insight Telepsychiatry would not be billable.**

TOTAL ONGOING COSTS FOR MOBILE CRISIS TEAM PER YEAR

4 Therapists and 1 supervisor	$360,000
Therapist On-call and Paid Worked Time	$158,800.00
Full Time Emergency Psychiatrist	$375,000.00
Insight Telepsychiatry after hours coverage	$27,000.00
Total Staffing Cost	$920,800
ESTIMATED POTENTIAL TOTAL MEDICAID REVENUE	$382,102.00
TOTAL PROJECTED ONGOING FUNDING NEEDED	**$538,698.00**
Plus one time telepsychiatry set up fee	**$1500.00**

Outcomes

Based on empirical data, a regional mobile crisis team should result in a decreased number of psychiatric hospital admissions across the participating jurisdictions. This could in turn have a positive impact on the current high census in state hospitals. With a corresponding decrease in the number of ECOs, time spent by police officers maintaining custody during the ECO/TDO process should be significantly reduced. Local hospital emergency rooms would benefit with a decrease in number of ECOs and individuals arriving by police transport after a police call deemed mental health related. Additionally, individuals in the community would be receiving the least restrictive level of service at a time when escalation into ECO, hospitalization, and even possible arrest could exacerbate previous trauma, increase acuity, and reinforce negative perceptions of police and mental health staff. Providing services and support in the community during a time of crisis is best for the individual, their involved family, and the community.

Data planned to be collected during the project include:

Mobile Crisis calls from law enforcement and their jurisdiction
Mobile Crisis contacts
resulting in diversion/safety plan
going to Emergency Department after contact
hospitalized after contact
going to jail after contact
referred to extended ambulatory crisis stabilization
engaging in extended ambulatory crisis stabilization
entering residential crisis stabilization
with co-occurring mental health and substance use
Continue track regional hospitalization numbers

Impact

Both police and mental health staff attempt to provide solutions and support to individuals in a mental health crisis, but in traditionally very different ways. A program of mobile crisis would expand and solidify the relationships between the two types of agencies, forge better understanding of how crisis situations are perceived by the other, and provide a much more comprehensive and supportive response in these cases. As a regional program, police relationships across jurisdictions would be strengthened. State hospital bed utilization is expected to decrease, and most importantly, the community and its citizens would benefit from a program that could better meet the emergent needs of those with mental health and co-occurring disorders and help connect them to the right treatment at the right time.

Summary: Region 4 Concept Proposal for a Regional Psychiatric Emergency Center (PEC)

and Related Services for Crisis Mental Health Care

Region 4 Community Services Boards (CSB's) formed a workgroup in January, 2018 to explore the possibility of creating a Psychiatric Emergency Center. The rising number of individuals admitted to state hospitals served as a catalyst to convene this group. Membership in the workgroup includes representatives from Region 4 CSB's and NAMI Virginia. The Region 4 Executive Director Forum charged the group to develop a formal concept paper exploring the implementation of a PEC in our region.

Workgroup Activities

Interviews were conducted by phone and in person with a number of existing Psychiatric Emergency Centers:

- Recovery International, Newark, DE. (August 2018) Site Visit
- Bellevue Hospital—Pediatric Comprehensive Psychiatric Emergency Program (CPEP), New York, NY (April 2018) Phone Interview
- New York Department of Mental Health Phone Interview
- Review of slide deck of WakeBrook Campus, Wake County, North Carolina
- Coordination with the Institute of Law, Psychiatry and Public Policy

Need

The rise in Temporary Detention Orders (TDO's) to state hospitals has been well documented on both the state and regional level. In December 2017, the Joint Subcommittee to Study Mental Health Services in the 21st Century noted, "there has been a dramatic increasing in TDOs statewide since FY2015 and this has been accompanied by a disproportionately large rise in TDO admissions to state hospitals. Generally speaking, monthly TDO admissions to state hospitals have more than doubled."

Region 4 experienced a significant rise in TDO admissions to state hospitals over the last several years. Between FY12 and FY16, while the total number of TDO's remained constant, there was a 192% increase in Region 4 TDO admissions to Central State Hospital. This increase in admissions to Central State was driven primarily by the local private hospitals' lack of willingness to accept or ability to manage some of the individuals being TDO'd.

Our current continuum of mental health services lacks a means for immediate access to **treatment** for people experiencing a mental health crisis. Hospital Emergency Departments are ill equipped and typically unwilling to treat psychiatric illness in the Emergency Department environment. This reluctance extends to the administration of already prescribed psychiatric medications while individuals are waiting to be hospitalized. There are far too may examples of individuals seeking voluntary hospitalization who spend more than 24 hours in an Emergency Department while an inpatient bed is being identified, and during this time the individuals receive no psychiatric medication or treatment. The picture is equally bleak for individuals who

are being evaluated under an Emergency Custody Order (ECO). Though an individual may be in an Emergency Department while they are being prescreened for a TDO, typically the hospital offers no treatment to assist the individual in managing their psychiatric symptoms.

Attempts to Address the Need to Date:

Region 4 instituted a number of initiatives designed to ameliorate the increased level of demand that state hospitals and Central State Hospital in particular faced. The following is not an exhaustive list of these efforts, but includes some of the large initiatives:

- The region has reached out to acute care hospitals seeking assistance and providing resources for them to change the pattern of non-admission of CSB involuntary admissions to no avail;
- Four Community Service Boards throughout our region operate Crisis Receiving Centers (CRC's, also known as Crisis Intervention Team Assessment Centers, or CITACs).Due to the lack of responsiveness of the private acute care hospitals, the flow of individuals out of the CRC's has slowed down significantly;
- Poplar Springs bed purchase: The contract with Poplar to purchase beds for Region 4 clients proved not to be successful. We did not realize the extent to which individuals needing hospitalization would be refused admission, even for beds that had been purchased for use by Region 4 clients. Many Region 4 clients were turned away;
- National Counseling Group mobile crisis project: This project utilized one time state money to purchase mobile crisis services for individuals being assessed for hospitalization who could be safely managed in the community with appropriate intensive services. This program proved to be successful, but has been discontinued due to limited funding;
- Gateway Homes' transitional beds to permanent supportive housing initiative: This program allows for individuals at Central State who are discharge ready and determined to be capable of independent living if they acquire additional independent living skills, to be discharged to transitional beds at Gateway to work on skill acquisition while they are being linked to Permanent Supportive Housing. This program is relatively new and has a finite capacity. Early results are encouraging.
- Region 4 hired a Housing Specialist who tracks availability of beds in ALF's and nursing home throughout the state. A weekly list of providers and their availability is circulated to the State Facilities in the region as well as to the Community Services Boards. The Housing Specialist also visits many of the providers to gain first hand knowledge of the services provided. This has proven to be a valuable tool in assisting the CSB hospital liaisons in finding appropriate community placements.

While some of these initiatives have experienced success, they have not stemmed the flow of new patients into Central State Hospital.

Appendix B

Proposal for Psychiatric Emergency Center:

Based on our review of existing PEC's in other states, there were several key components that are important for successful implementation. These elements include:

- A non-refusal admission policy. Each of the centers we interviewed accepted all individuals who sought services with them.
- Inclusion of Certified Peer Specialists. Though not all of the programs included the use of Peer Specialists, it was noteworthy that the program which did not use seclusion or restraint relied heavily on Peer interventions to help de-escalate volatile situations.
- Close partnerships with psychiatric, substance use, and medical providers in the community. Easy procedures for admission and discharge are vital to support the 23 hour nature of these programs.
- Quick and easy access to psychiatric services. All of the programs interviewed had processes in place for individuals admitted into services to be seen by a psychiatrist, nurse practitioner, or physician's assistance within 2 hours of admission.

Recovery International (RI) has set up PEC's in 5 states. In addition to on-site operation of these programs, RI offers consultation services to facilitate states developing their own programming. Consultation includes needs assessment, cost projections, and technical assistance. Consultation services such as these may be beneficial in the development of this programming.

Phase 1:

Region 4 proposes to develop a 23 hour Psychiatric Emergency Center (PEC) to serve up to 16 adult individuals at any given time. The PEC would operate with a non-refusal process. Any individual regardless of legal status (voluntary or ECO) or diagnosis would be accepted. If the individual is assessed and determined to be in need of more intensive medical or psychiatric services than the PEC can provide, PEC staff would ensure that the individual is linked with that service. The PEC would be located in a secure physical environment to accommodate the needs of involuntary individuals.

Staffing at the PEC would include:

Position	**Staff Pattern**	**Number of Practitioners**
Psychiatrist and/or Nurse Practitioner	One 12 hour shift. Service available through tele-health in the remaining hours.	1 per shift
Nursing Staff	Three 8-hour shifts	1 per shift
Licensed Clinical Staff/Certified pre-screener	Three 8-hour shifts	1 per shift
Qualified Mental Health Professional	Three 8 hour shifts	1 per shift
Certified Peer Recovery Specialists	One 12 hour shift	2 per 12 hour shift
Off duty Police Officer	Three 8 hour shifts	1 per shift

In addition to the PEC, Region 4 proposes the creation of a mobile crisis center. Mobile crisis services would be available 24 hours a day, 7 days a week to assist in preventing hospitalization and serving as a step down services from the PEC. This service could be created or secured through contract with an organization already providing mobile crisis services.

It will be imperative to establish formal and/or information relationships with Residential Crisis Stabilization Units, PACT teams, Residential Detox Centers, and Respite Programs to ensure timely discharge of individuals from the PEC.

Phase 2:
Phase 2 of this project would focus on the creation of a 16 bed residential Crisis Stabilization Unit that would be either physically connected or in very close proximity to the PEC. This would be a 16 bed facility that could serve as a step down service for those individuals need more than 23 hours of stabilization.

Potential Barriers

Funding: Any project of this size requires significant financial investment. In addition to the physical space requirements, the staffing needs of a Psychiatric Emergency Center are extensive and require staff with a wide degree of knowledge, training, and skills. These include psychiatrists, nurses, and law enforcement officers. It is unclear how DMAS would view such a facility and what revenue streams might be available.

Licensure: It is unclear how a Psychiatric Emergency Center would be licensed. Other states have developed a distinct level of care for this type of service, while other states have used existing licensure standards to operate their programs.

Multi-jurisdictional: The level of coordination among law enforcement that a regional PEC would require is unprecedented.

Role of current Crisis Receiving Centers: There are currently 4 Crisis Receiving Centers (CRCs, also known as CITACS) being operated in the Region, and the role of these centers becomes less clear if a PEC is developed.

Changes to existing commitment laws: There would need to be legislative changes enacted to support the treatment of individuals who are not voluntarily seeking treatment. Legislation would need to be enacted allowing up to 23 hours of emergency custody only for individuals housed in a Psychiatric Emergency Center.

Region 3b: 23-hour Crisis Stabilization Program

Psychiatric Emergency Center

Overview

Piedmont, Danville, and Southside Community Service Boards (Region 3b) and Sovah Health propose opening a 23-hour Crisis Stabilization and Psychiatric Emergency Center to provide extended assessment and oversight for individuals under the order of an ECO. This facility will provide a local option for acute crisis stabilization services within our rural communities. The goals of this service are to prevent unnecessary inpatient hospitalizations, provide a thorough assessment/observational period, stabilize and improve psychological symptoms of distress in the least restrictive environment, and provide an opportunity to deescalate the crisis in a therapeutic setting. Through partnerships with local law enforcement, healthcare, and the Community Services Board (CSB) this recovery model works to stabilize individuals and return them to active participation in the community. Other positive outcomes may include:

- Decrease of unnecessary Emergency Room utilization
- Decrease state hospital utilization as a first-line treatment option
- Resource for local law enforcement
- Expand local community capacity for Region 3b
- Decrease state hospital census for the region (SVMHI)

Background

23-Hour Crisis Stabilization is an intensive level of care provided in a therapeutic and secure environment with available medical treatment. The services provided are designed for persons who, either pose an imminent danger to themselves or others, or are experiencing an acute psychiatric crisis. The facility must have 24-hour nursing care, psychiatric supervision, and a mixture of professional and paraprofessional services. In general, this service is for the individual who presents in crisis and, with assessment and intervention, may be stabilized and discharged with outpatient referral services or transferred to a higher level of care. Client disposition will be based upon an individualized assessment and treatment plan.

Conceptual Model

The proposed 23-hour Crisis Stabilization Unit may be accessed through three potential referral sources: Community Services Board, Emergency Room, and the Crisis Intervention Team. Regardless of the referral source, a peer support specialist will greet the client and begin to develop rapport. The individual is admitted into a therapeutic environment designed to promote a sense of safety and privacy, where a team of medical and crisis staff will perform intake and medical assessments. Upon completion of assessments, the treatment team will consult with the on-call psychiatrist to begin risk assessment, treatment planning, and discharge goals. Available clinical and environmental services within the Crisis Stabilization Unit may include: peer supportive

counseling, group sessions, therapy, supervision, psycho-social rehab, community integration, calm environment, nutrition, and shelter.

At the completion of the stabilization period, the treatment team and the psychiatrist will formulate a disposition. Clients who have deescalated and may be appropriate for a referral with outpatient services will be discharged with a continuing treatment plan. Similarly, individuals that may require further treatment will receive a pre-screening assessment from the CSB Emergency Services staff, where hospitalization may be needed. Leveraging the partnership with Sovah Health heightens the CSB staff's ability to provide inpatient services and treatment of the individual in their local community.

Partnerships

Along with treatment and stabilization services, this model serves to build a partnership bridge that would effectively connect the local private hospital, Region 3b CSBs, law enforcement professionals, and other community resources, thereby increasing the efficiency and effectiveness of emergency services and the continuum of care.

Staffing

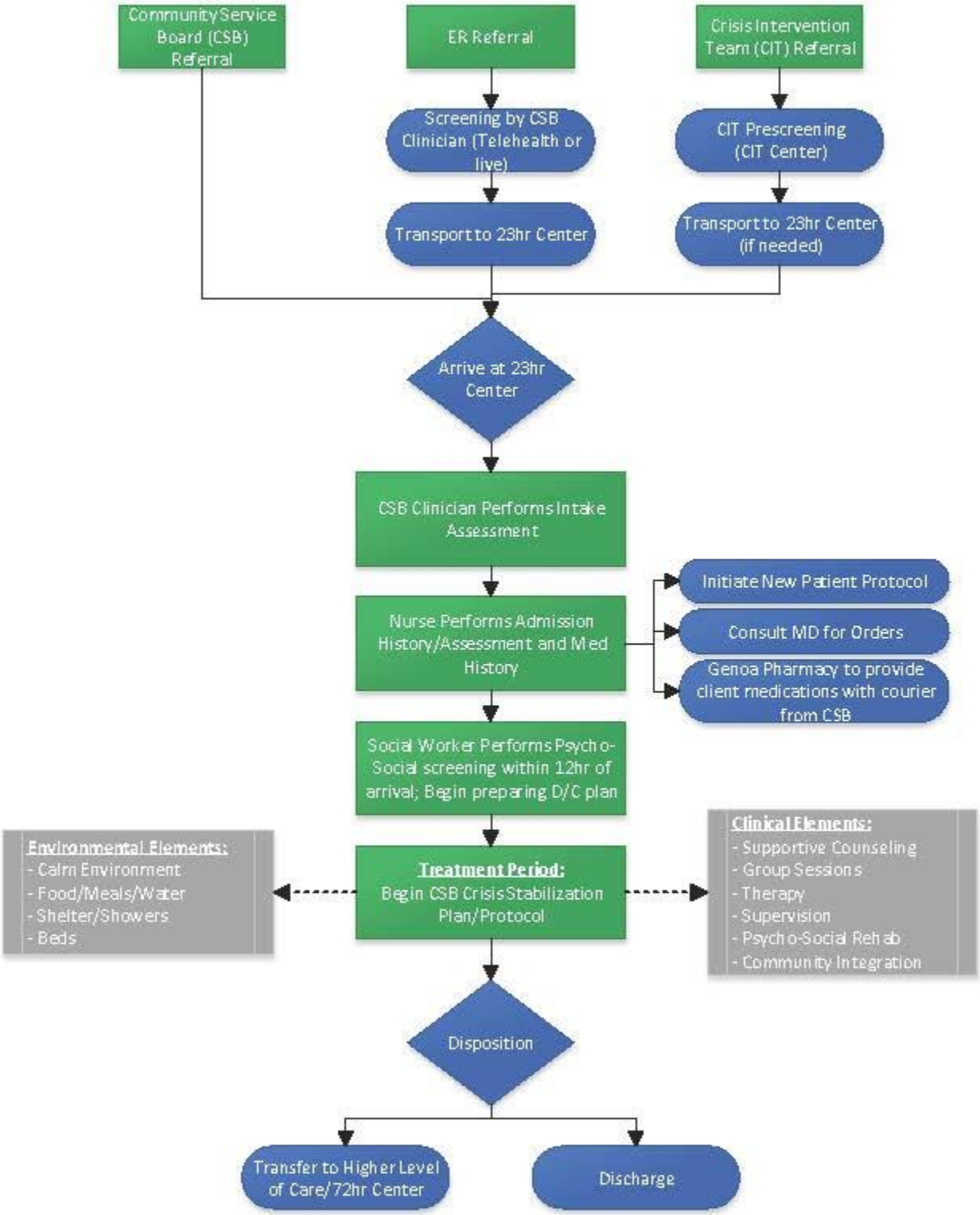
Full-Time Equivalents Needed:

- Registered Nurses- 4
- Technicians- 4
- Emergency Services Counselors- 6
- Peer Support Specialist- 8
- Clinical Site Manager- 1
- CIT Security Staff (contracted with local law enforcement)

23 Hour Crisis Stabilization Model

Piedmont Community Service Board

Sovah Health-Martinsville



Plan Details:

- 10 client maximum (Initiation to 6 months), then re-evaluate and potential expansion
- CSB to provide Clinicians and peer support specialists; Sovah to provide medical staffing.
- Onsite security needed 24/7
- FTE Needs: RN=4, Tech=4, Clinician=6, Clinical Site Manager=1.

§ 37.2-808. Emergency custody; issuance and execution of order.

A. Any magistrate shall issue, upon the sworn petition of any responsible person, treating physician, or upon his own motion, an emergency custody order when he has probable cause to believe that any person (i) has a mental illness and that there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future, (a) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or (b) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs, (ii) is in need of hospitalization or treatment, and (iii) is unwilling to volunteer or incapable of volunteering for hospitalization or treatment. Any emergency custody order entered pursuant to this section shall provide for the disclosure of medical records pursuant to § 37.2-804.2. This subsection shall not preclude any other disclosures as required or permitted by law.

When considering whether there is probable cause to issue an emergency custody order, the magistrate may, in addition to the petition, consider (1) the recommendations of any treating or examining physician or psychologist licensed in Virginia, if available, (2) any past actions of the person, (3) any past mental health treatment of the person, (4) any relevant hearsay evidence, (5) any medical records available, (6) any affidavits submitted, if the witness is unavailable and it so states in the affidavit, and (7) any other information available that the magistrate considers relevant to the determination of whether probable cause exists to issue an emergency custody order.

B. Any person for whom an emergency custody order is issued shall be taken into custody and transported to a convenient location to be evaluated to determine whether the person meets the criteria for temporary detention pursuant to § 37.2-809 and to assess the need for hospitalization or treatment. The evaluation shall be made by a person designated by the community services board who is skilled in the diagnosis and treatment of mental illness and who has completed a certification program approved by the Department.

C. The magistrate issuing an emergency custody order shall specify the primary law-enforcement agency and jurisdiction to execute the emergency custody order and provide transportation. However, the magistrate shall consider any request to authorize transportation by an alternative transportation provider in accordance with this section, whenever an alternative transportation provider is identified to the magistrate, which may be a person, facility, or agency, including a family member or friend of the person who is the subject of the order, a representative of the community services board, or other transportation provider with personnel trained to provide transportation in a safe manner, upon determining, following consideration of information provided by the petitioner; the community services board or its designee; the local law-enforcement agency, if any; the person's treating physician, if any; or other persons who are available and have knowledge of the person, and, when the magistrate deems appropriate, the proposed alternative transportation provider, either in person or via two-way electronic video and audio or telephone communication system, that the proposed alternative transportation

provider is available to provide transportation, willing to provide transportation, and able to provide transportation in a safe manner. When transportation is ordered to be provided by an alternative transportation provider, the magistrate shall order the specified primary law-enforcement agency to execute the order, to take the person into custody, and to transfer custody of the person to the alternative transportation provider identified in the order. In such cases, a copy of the emergency custody order shall accompany the person being transported pursuant to this section at all times and shall be delivered by the alternative transportation provider to the community services board or its designee responsible for conducting the evaluation. The community services board or its designee conducting the evaluation shall return a copy of the emergency custody order to the court designated by the magistrate as soon as is practicable. Delivery of an order to a law-enforcement officer or alternative transportation provider and return of an order to the court may be accomplished electronically or by facsimile.

Transportation under this section shall include transportation to a medical facility as may be necessary to obtain emergency medical evaluation or treatment that shall be conducted immediately in accordance with state and federal law. Transportation under this section shall include transportation to a medical facility for a medical evaluation if a physician at the hospital in which the person subject to the emergency custody order may be detained requires a medical evaluation prior to admission.

D. In specifying the primary law-enforcement agency and jurisdiction for purposes of this section, the magistrate shall order the primary law-enforcement agency from the jurisdiction served by the community services board that designated the person to perform the evaluation required in subsection B to execute the order and, in cases in which transportation is ordered to be provided by the primary law-enforcement agency, provide transportation. If the community services board serves more than one jurisdiction, the magistrate shall designate the primary law-enforcement agency from the particular jurisdiction within the community services board's service area where the person who is the subject of the emergency custody order was taken into custody or, if the person has not yet been taken into custody, the primary law-enforcement agency from the jurisdiction where the person is presently located to execute the order and provide transportation.

E. The law-enforcement agency or alternative transportation provider providing transportation pursuant to this section may transfer custody of the person to the facility or location to which the person is transported for the evaluation required in subsection B, G, or H if the facility or location (i) is licensed to provide the level of security necessary to protect both the person and others from harm, (ii) is actually capable of providing the level of security necessary to protect the person and others from harm, and (iii) in cases in which transportation is provided by a law-enforcement agency, has entered into an agreement or memorandum of understanding with the law-enforcement agency setting forth the terms and conditions under which it will accept a transfer of custody, provided, however, that the facility or location may not require the law-enforcement agency to pay any fees or costs for the transfer of custody.

F. A law-enforcement officer may lawfully go or be sent beyond the territorial limits of the county, city, or town in which he serves to any point in the Commonwealth for the purpose of executing an emergency custody order pursuant to this section.

G. A law-enforcement officer who, based upon his observation or the reliable reports of others, has probable cause to believe that a person meets the criteria for emergency custody as stated in this section may take that person into custody and transport that person to an appropriate location to assess the need for hospitalization or treatment without prior authorization. A law-enforcement officer who takes a person into custody pursuant to this subsection or subsection H may lawfully go or be sent beyond the territorial limits of the county, city, or town in which he serves to any point in the Commonwealth for the purpose of obtaining the assessment. Such evaluation shall be conducted immediately. The period of custody shall not exceed eight hours from the time the law-enforcement officer takes the person into custody, ***except as provided for in subsection K below.***

H. A law-enforcement officer who is transporting a person who has voluntarily consented to be transported to a facility for the purpose of assessment or evaluation and who is beyond the territorial limits of the county, city, or town in which he serves may take such person into custody and transport him to an appropriate location to assess the need for hospitalization or treatment without prior authorization when the law-enforcement officer determines (i) that the person has revoked consent to be transported to a facility for the purpose of assessment or evaluation, and (ii) based upon his observations, that probable cause exists to believe that the person meets the criteria for emergency custody as stated in this section. The period of custody shall not exceed eight hours from the time the law-enforcement officer takes the person into custody ***except as provided for in subsection K below***.

I. Nothing herein shall preclude a law-enforcement officer or alternative transportation provider from obtaining emergency medical treatment or further medical evaluation at any time for a person in his custody as provided in this section.

J. A representative of the primary law-enforcement agency specified to execute an emergency custody order or a representative of the law-enforcement agency employing a law-enforcement officer who takes a person into custody pursuant to subsection G or H shall notify the community services board responsible for conducting the evaluation required in subsection B, G, or H as soon as practicable after execution of the emergency custody order or after the person has been taken into custody pursuant to subsection G or H.

K. The person shall remain in custody until a temporary detention order is issued, until the person is released, or until the emergency custody order expires. An emergency custody order shall be valid for a period not to exceed eight hours from the time of execution***, with the following exceptions: (i) if the person is placed in a Psychiatric Emergency Center, the order shall be valid for a period of 24 hours, unless a temporary detention order is entered or the person is released prior to that time; (ii) if***

the person is determined to have one or more medical conditions in addition to his mental illness that requires treatment, and no available facility for temporary detention has been identified within the eight hour period of the emergency custody order, the period of the emergency custody order shall be extended as provided for in § 37.2-809.2 .

L. Nothing in this section shall preclude the issuance of an order for temporary detention for testing, observation, or treatment pursuant to § 37.2-1104 for a person who is also the subject of an emergency custody order issued pursuant to this section. In any case in which an order for temporary detention for testing, observation, or treatment is issued for a person who is also the subject of an emergency custody order, the person may be detained by a hospital emergency room or other appropriate facility for testing, observation, and treatment for a period not to exceed 24 hours, unless extended by the court as part of an order pursuant to § 37.2-1101, in accordance with subsection A of § 37.2-1104. Upon completion of testing, observation, or treatment pursuant to § 37.2-1104, the hospital emergency room or other appropriate facility in which the person is detained shall notify the nearest community services board, and the designee of the community services board shall, as soon as is practicable and prior to the expiration of the order for temporary detention issued pursuant to § 37.2-1104, conduct an evaluation of the person to determine if he meets the criteria for temporary detention pursuant to § 37.2-809.

M. Any person taken into emergency custody pursuant to this section shall be given a written summary of the emergency custody procedures and the statutory protections associated with those procedures.

N. If an emergency custody order is not executed within eight hours of its issuance, the order shall be void and shall be returned unexecuted to the office of the clerk of the issuing court or, if such office is not open, to any magistrate serving the jurisdiction of the issuing court.

O. In addition to the eight-hour period of emergency custody set forth in subsection G, H, or K, if the individual is detained in a state facility pursuant to subsection E of § 37.2-809, the state facility and an employee or designee of the community services board as defined in § 37.2-809 may, for an additional four hours, continue to attempt to identify an alternative facility that is able and willing to provide temporary detention and appropriate care to the individual.

P. Payments shall be made pursuant to § 37.2-804 to licensed health care providers for medical screening and assessment services provided to persons with mental illnesses while in emergency custody.

Q. No person who provides alternative transportation pursuant to this section shall be liable to the person being transported for any civil damages for ordinary negligence in acts or omissions that result from providing such alternative transportation.

§ 37.2-809.2 Individuals in care under an emergency custody order who have medical conditions requiring treatment;

A. In the case of an individual who is in care under an emergency custody order and who has been found by the local community services board employee or designee to meet the criteria for entry of a temporary detention order, but for whom a medically appropriate facility placement has not been found by the end of the 8 hour emergency custody order period, a state facility shall not be required to accept the individual under a temporary detention order if the facility's medical director certifies that the person has one or more medical conditions requiring treatment that the facility is either not equipped or not staffed to provide.

B. When a placement under a temporary detention order cannot be found in either a private or state facility for a person in care under an emergency custody order who has a medical condition requiring treatment, and the emergency custody order's initial 8-hour period is about to expire, the employee or designee of the local community services board shall request, and the magistrate shall authorize, extension of the emergency custody order period for up to an additional 16 hours. If a law enforcement officer has been maintaining custody of such a person, the officer shall be released from maintaining custody for the extended emergency custody order period, unless the magistrate extends law enforcement custody based on a specific finding that the facility responsible for the person's care lacks the capacity to protect the person's safety.

C. If a petition is filed seeking judicial authorization for treatment of a medical condition of a person who is in care under an emergency custody order, the employee or designee of the local community services board shall request, and the magistrate shall authorize extension of the emergency custody order period until the completion of the hearing and entry of an order on such petition. If a law enforcement officer has been maintaining the custody of such a person, the officer shall be released from maintaining custody when such a petition is filed.

§ 37.2-809. Involuntary temporary detention; issuance and execution of order.

A. For the purposes of this section:
"Designee of the local community services board" means an examiner designated by the local community services board who (i) is skilled in the assessment and treatment of mental illness, (ii) has completed a certification program approved by the Department, (iii) is able to provide an independent examination of the person, (iv) is not related by blood or marriage to the person being evaluated, (v) has no financial interest in the admission or treatment of the person being evaluated, (vi) has no investment interest in the facility detaining or admitting the person under this article, and (vii) except for employees of state hospitals and of the U.S. Department of Veterans Affairs, is not employed by the facility.
"Employee" means an employee of the local community services board who is skilled in the assessment and treatment of mental illness and has completed a certification program approved by the Department.
"Investment interest" means the ownership or holding of an equity or debt security, including shares of stock in a corporation, interests or units of a partnership, bonds, debentures, notes, or other equity or debt instruments.

B. A magistrate shall issue, upon the sworn petition of any responsible person, treating physician, or upon his own motion and only after an evaluation conducted in-person or by means of a two-way electronic video and audio communication system as authorized in § 37.2-804.1 by an employee or a designee of the local community services board to determine whether the person meets the criteria for temporary detention, a temporary detention order if it appears from all evidence readily available, including any recommendation from a physician or clinical psychologist treating the person, that the person (i) has a mental illness and that there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future, (a) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or (b) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs; (ii) is in need of hospitalization or treatment; and (iii) is unwilling to volunteer or incapable of volunteering for hospitalization or treatment. The magistrate shall also consider, if available, (a) information provided by the person who initiated emergency custody and (b) the recommendations of any treating or examining physician licensed in Virginia either verbally or in writing prior to rendering a decision. Any temporary detention order entered pursuant to this section shall provide for the disclosure of medical records pursuant to § 37.2-804.2. This subsection shall not preclude any other disclosures as required or permitted by law.

C. When considering whether there is probable cause to issue a temporary detention order, the magistrate may, in addition to the petition, consider (i) the recommendations of any treating or examining physician or psychologist licensed in Virginia, if available, (ii) any past actions of the person, (iii) any past mental health treatment of the person, (iv) any relevant hearsay evidence, (v) any medical records available, (vi) any affidavits

submitted, if the witness is unavailable and it so states in the affidavit, and (vii) any other information available that the magistrate considers relevant to the determination of whether probable cause exists to issue a temporary detention order.

D. A magistrate may issue a temporary detention order without an emergency custody order proceeding. A magistrate may issue a temporary detention order without a prior evaluation pursuant to subsection B if (i) the person has been personally examined within the previous 72 hours by an employee or a designee of the local community services board or (ii) there is a significant physical, psychological, or medical risk to the person or to others associated with conducting such evaluation.

E. An employee or a designee of the local community services board shall determine the facility of temporary detention in accordance with the provisions of § 37.2-809.1 for all individuals detained pursuant to this section. An employee or designee of the local community services board may change the facility of temporary detention and may designate an alternative facility for temporary detention at any point during the period of temporary detention if it is determined that the alternative facility is a more appropriate facility for temporary detention of the individual given the specific security, medical, or behavioral health needs of the person. In cases in which the facility of temporary detention is changed following transfer of custody to an initial facility of temporary custody, transportation of the individual to the alternative facility of temporary detention shall be provided in accordance with the provisions of § 37.2-810. The initial facility of temporary detention shall be identified on the preadmission screening report and indicated on the temporary detention order; however, if an employee or designee of the local community services board designates an alternative facility, that employee or designee shall provide written notice forthwith, on a form developed by the Executive Secretary of the Supreme Court of Virginia, to the clerk of the issuing court of the name and address of the alternative facility. Subject to the provisions of §§ 37.2-809.1 ***and 37.2-809.2,*** if a facility of temporary detention cannot be identified by the time of the expiration of the period of emergency custody pursuant to § 37.2-808, the individual shall be detained in a state facility for the treatment of individuals with mental illness and such facility shall be indicated on the temporary detention order. Except as provided in § 37.2-811 for inmates requiring hospitalization in accordance with subdivision A 2 of § 19.2-169.6, the person shall not be detained in a jail or other place of confinement for persons charged with criminal offenses and shall remain in the custody of law enforcement until the person is either detained within a secure facility or custody has been accepted by the appropriate personnel designated by either the initial facility of temporary detention identified in the temporary detention order or by the alternative facility of temporary detention designated by the employee or designee of the local community services board pursuant to this subsection. The person detained or in custody pursuant to this section shall be given a written summary of the temporary detention procedures and the statutory protections associated with those procedures.

F. Any facility caring for a person placed with it pursuant to a temporary detention order is authorized to provide emergency medical and psychiatric services within its capabilities when the facility determines that the services are in the best interests of the

person within its care. The costs incurred as a result of the hearings and by the facility in providing services during the period of temporary detention shall be paid and recovered pursuant to § 37.2-804. The maximum costs reimbursable by the Commonwealth pursuant to this section shall be established by the State Board of Medical Assistance Services based on reasonable criteria. The State Board of Medical Assistance Services shall, by regulation, establish a reasonable rate per day of inpatient care for temporary detention.

G. The employee or the designee of the local community services board who is conducting the evaluation pursuant to this section shall determine, prior to the issuance of the temporary detention order, the insurance status of the person. Where coverage by a third party payor exists, the facility seeking reimbursement under this section shall first seek reimbursement from the third party payor. The Commonwealth shall reimburse the facility only for the balance of costs remaining after the allowances covered by the third party payor have been received.

H. The duration of temporary detention shall be sufficient to allow for completion of the examination required by § 37.2-815, preparation of the preadmission screening report required by § 37.2-816, and initiation of mental health treatment to stabilize the person's psychiatric condition to avoid involuntary commitment where possible, but shall not exceed 72 hours prior to a hearing. If the 72-hour period herein specified terminates on a Saturday, Sunday, legal holiday, or day on which the court is lawfully closed, the person may be detained, as herein provided, until the close of business on the next day that is not a Saturday, Sunday, legal holiday, or day on which the court is lawfully closed. The person may be released, pursuant to § 37.2-813, before the 72-hour period herein specified has run.

I. If a temporary detention order is not executed within 24 hours of its issuance, or within a shorter period as is specified in the order, the order shall be void and shall be returned unexecuted to the office of the clerk of the issuing court or, if the office is not open, to any magistrate serving the jurisdiction of the issuing court. Subsequent orders may be issued upon the original petition within 96 hours after the petition is filed. However, a magistrate must again obtain the advice of an employee or a designee of the local community services board prior to issuing a subsequent order upon the original petition. Any petition for which no temporary detention order or other process in connection therewith is served on the subject of the petition within 96 hours after the petition is filed shall be void and shall be returned to the office of the clerk of the issuing court.

J. The Executive Secretary of the Supreme Court of Virginia shall establish and require that a magistrate, as provided by this section, be available seven days a week, 24 hours a day, for the purpose of performing the duties established by this section. Each community services board shall provide to each general district court and magistrate's office within its service area a list of its employees and designees who are available to perform the evaluations required herein.

K. For purposes of this section, a health care provider or designee of a local community services board or behavioral health authority shall not be required to encrypt any email containing information or medical records provided to a magistrate unless there is reason to believe that a third party will attempt to intercept the email.

L. If the employee or designee of the community services board who is conducting the evaluation pursuant to this section recommends that the person should not be subject to a temporary detention order, such employee or designee shall (i) inform the petitioner, the person who initiated emergency custody if such person is present, and an onsite treating physician of his recommendation; (ii) promptly inform such person who initiated emergency custody that the community services board will facilitate communication between the person and the magistrate if the person disagrees with recommendations of the employee or designee of the community services board who conducted the evaluation and the person who initiated emergency custody so requests; and (iii) upon prompt request made by the person who initiated emergency custody, arrange for such person who initiated emergency custody to communicate with the magistrate as soon as is practicable and prior to the expiration of the period of emergency custody. The magistrate shall consider any information provided by the person who initiated emergency custody and any recommendations of the treating or examining physician and the employee or designee of the community services board who conducted the evaluation and consider such information and recommendations in accordance with subsection B in making his determination to issue a temporary detention order. The individual who is the subject of emergency custody shall remain in the custody of law enforcement or a designee of law enforcement and shall not be released from emergency custody until communication with the magistrate pursuant to this subsection has concluded and the magistrate has made a determination regarding issuance of a temporary detention order.

M. For purposes of this section, "person who initiated emergency custody" means any person who initiated the issuance of an emergency custody order pursuant to § 37.2-808 or a law-enforcement officer who takes a person into custody pursuant to subsection G of § 37.2-808.

Appendix G

The New River Valley (NRV) is a rural community in southwest Virginia that is comprised of the counties of Floyd, Montgomery, Pulaski, Giles, and the City of Radford. The area encompasses two universities, Virginia Tech and Radford University, with student populations of 30,000 and 9,500, respectively. The population of the NRV is diverse in socioeconomic status, education, race, and culture. Law enforcement in the 1,500 square mile area is provided by fourteen criminal justice agencies. Four hospitals serve the region in addition to a psychiatric inpatient facility, and residential crisis stabilization program for adults.

The NRV has a long history of collaborative relationship among its community stakeholders, law enforcement, community mental health providers, and consumers. Our community created the nation's first rural multijurisdictional Crisis Intervention Team (CIT) in 2001, a program to provide training to law enforcement to improve interactions with individuals with mental illness. In 2013, New River Valley Community Services (NRVCS) partnered with local law enforcement and Lewis Gale Montgomery Hospital to create a crisis intervention team assessment center (CITAC), funded through DBHDS. The center provides a therapeutic environment to transfer custody of individuals under an emergency custody order, and allows law enforcement to return to their community policing duties. In 2016, NRVCS, with funding from DBHDS, created a second freestanding CITAC site located in Radford, Virginia to increase transfer capability to outlying jurisdictions and to create a space for individuals to be assessed outside of a medical facility. In fiscal year (FY) 18, the NRV had 776 emergency custody orders and of those, 52 percent were successfully transferred to one of the CITAC sites. Most transfers of custody to the sites reduce law enforcement involvement in the process to an hour or less and provide immediate access to a mental health professional. In continued commitment to the NRV community and its citizens, NRVCS proposes to develop of living room model for crisis respite to reduce psychiatric hospitalization rates to the benefit of individuals, local stakeholders and law enforcement, and the Commonwealth.

When individuals in psychiatric crisis seek assistance in an ED setting, they often wait hours before meeting with a trained mental health professional. During this long wait, the ED may be loud, uncomfortable, and stressful. The ED personnel are often not trained to assess or treat the acute psychiatric symptoms of individuals and individuals may leave the ED prior to receiving appropriate care or escalate due to lack of timely access to care and treatment. In the local EDs of the NRV, if an individual enters seeking voluntary assistance, they must be assessed by the hospital employed mental health service. These assessments are typically provided over the phone or by a two way video and can be impersonal and not perceived as therapeutic by someone experiencing a crisis. Lewis Gale Montgomery ED recent statistics indicate that from June 2018 to August 2018, approximately 50 to 75 percent of individuals in crisis seen in the ED were hospitalized. The response time for the employed mental health assessors to intervene when contacted by the ED was approximately an hour and a half. After individuals had spent significant time in the waiting room and an hour or more undergoing lab work and testing, the wait time was still almost two hours for a mental health professional to respond. While Virginia's Code mandates resolution of the emergency custody order (ECO) process within eight hours, it is not unusual for voluntary patients in EDs to wait for many hours or days before appropriate hospital placement is found.

Review of literature on the living room model in Skokie, IL, demonstrates that in the first year of operation the program successfully deflected individuals in crisis from emergency rooms 93 percent of the time, saving the State of Illinois $550,000. Of the individuals who visited the respite center, 84

percent were able to de-escalate and leave, avoiding the need for inpatient psychiatric treatment. Similarly, the living room model respite center in Ellendale, Delaware reduced local emergency room use by 50 percent and psychiatric hospitalizations by 38 percent. Another example from Fife, Washington supports the model with a single year psychiatric hospitalization reduction of 79 percent. This data strongly supports the use of the living room model to reduce financial costs to individuals and the Commonwealth through the reduction of psychiatric hospitalizations and to engage individuals in meaningful supports and treatment in their home community.

Another substantial advantage to implementation would be the benefit to our law enforcement partners. Since the changes in Virginia Code in 2014 and bed registry implementation, local citizens are often placed far from their homes in hospitals across the Commonwealth. While the certainty of an available bed is a critical component of the safety net, the long distances creates workforce challenges for law enforcement, particularly in more rural areas where there may be only one or two deputies working on a given shift. Prior to March 2014, 80 percent of all adult temporary detention orders (TDOs) from the NRV were placed in local psychiatric facilities, with average transport mileage of 67 miles for law enforcement. In calendar year 2015 this dropped to 57 percent local placements, 36 percent in 2016, and 31 percent in 2017. Law enforcement traveled an average of 141 miles per transport in 2017, a significant rise from just three years prior. Given the living room model's success in other communities, reduction in hospitalizations would result in a tremendous benefit to of law enforcement agencies who so often find themselves undertaking such long transports as to require to officers. Distant hospitalizations compromise the quality of care individuals in the community receive by separating them from their families and natural support systems. The improvement in the quality of care that could be accomplished by diverting the need for hospitalizations and engaging these supports locally cannot be overstated.

This project proposes utilizing existing undeveloped space located at NRVCS Radford Center, in Radford, Virginia. As proposed, the undertaking will represent a collaborative effort among local law enforcement, medical, private behavioral health, and public behavioral health entities with the following common goals: 1) To reduce the utilization of local EDs by individuals in psychiatric crisis; 2) To provide an alternative to ED located services that offers a calm, safe setting with rapid access to services utilizing the Recovery Model; 3) To minimize the negative impact of law enforcement custody on consumers with mental illness or co-occurring disorders; 4) To reduce the impact of the civil commitment process on local law enforcement; and 5) To provide a crisis continuum of care in a least restrictive setting.

Centrally located, the Radford Center is easily accessible by public transportation and within walking distance of Radford University. Likewise, the site is central to the jurisdictions served with convenient access for law enforcement agencies who may be transporting individuals to care or seeking to transfer custody of an ECO.

The proposed CIT crisis center will have three main components including a living room crisis respite center, CIT assessment center, and two crisis assessment and intake offices, all located less than ten minutes from the NRVCS residential crisis stabilization unit with detox capability. The living room crisis respite center, in keeping with the demonstrated model, would be staffed by two to three peer recovery specialists, one psychiatric registered nurse, and one triage clinician. The peer recovery specialists will be either certified peer recovery specialists or trainees, to provide consistency in the delivery of recovery based services. All respite center personal will receive specialized training in verbal

de-escalation, crisis management and response. They will be supervised by the NRVCS Office of Peer Supports in coordination with the living room crisis respite supervisor. Triage clinicians will be trained as certified preadmission screener and supervised by the living room crisis respite supervisor. The hours of operation will be based on call volume and initially include night and weekend hours to accommodate the known needs of the community, with current trends in emergency services indicate the living room would best serve the community from 1:00pm to 9:00pm Tuesday through Saturday. The living room crisis respite would be available for individuals 18 and older experiencing a crisis that would place them at risk of an ED visit, regardless of insurance status or county of residence.

The living room crisis respite center will be designed as a relaxing, safe space for individuals to enter and receive rapid access to services. A common area with comfortable seating and soothing décor will support de-escalation of the crisis. Three semi-private rooms will be equipped with recliners where individuals can rest during their stay. Snacks and beverages will be available for individuals that visit the living room. All rooms and common areas will have security cameras for consumer, family and staff safety. Upon entry to the common area, individuals will be welcomed by the triage clinician that will assess their needs and current risk, including risk of harm to self and others and any current intoxication or drug effect that may be too significant for the center to manage. If the individual reports any current intoxication or discloses recent substance use or withdrawal symptoms, they will be seen by the psychiatric registered nurse to determine if medical attention in a more acute setting is needed and emergency medical personnel would be contacted as appropriate. All individuals will be seen by the psychiatric registered nurse after following the initial assessment of risk and need for evaluation of basic vital signs. Medication education will be provided as needed and if any emergent medical issues are apparent, transport for emergency medical treatment will be arranged by center staff.

After this initial assessment of need and medical status, the individual will have the opportunity to remain in the common area or move to one of the three semi-private rooms located off the common area of the living room to meet with a peer recovery specialist to begin working on coping skills and a safety plan and/or wellness recovery action plan. The peer recovery specialist will continually assess the individual's level of distress and contact the triage clinician if the individual becomes at risk to a level that needs more acute intervention. After meeting with the peer recovery specialist, working on skills and reduction of distress, the individual may choose to leave the living room crisis respite center. The triage clinician will reassess the established plan, the individual's risk, and level of distress and have vital signs re-checked by the nurse prior to departure. Individuals needing services beyond those of the living room crisis respite center can receive care through a referral to same day access, other community resources, or by linking them with NRVCS mobile crisis or residential crisis stabilization resources.

The living room crisis respite center will have a "no wrong door" approach to care. Individuals may self-refer (walk in), come in with a provider from the community, or be transported by local law enforcement. They may be referred to the respite center following pre-screening on an emergency custody order (ECO) to provide support and more extensive safety planning to avoid psychiatric hospitalization. Individuals are voluntary at the living room and may come and go at any time unless determined to be at risk for harm to self or others or lack the ability to care for self by the triage clinician. If an individual is determined to be significantly at risk at the time of arrival to the living room, the triage clinician may contact emergency services to assist in conducting a preadmission screening if the individual is willing and able to consent to the assessment. At that time they will move to one of the assessment and intake offices to complete the preadmission screening. Possible outcomes of this

assessment could include a warm hand off to a mobile crisis clinician to initiate immediate services and begin a crisis plan, admission to the residential crisis stabilization unit for further assessment and stabilization on a voluntary or involuntary basis.

If the individual is unwilling for assessment and determined to be at significant risk, the triage clinician may petition for an ECO. Local law enforcement will be contacted to serve the order and if the individual is appropriate, the custody will be transferred to our CIT assessment site to be relocated at the CIT crisis center. This CITAC is one of only a few in Virginia staffed 24 hours per day by an Emergency Services Clinician and a sworn sheriff's deputy. The center has previously been located at in Radford, Virginia as freestanding site to providing transfer of custody and immediate prescreening. Approximately 32 percent of all ECOs initiated in the NRV resulted in transfers of custody to this site in FY 18. By locating this site beside the living room crisis respite, it allows for a continuum of care in which individuals that may escalate and need a higher level of care or require law enforcement custody would not need to be transported to another site and could have to option of transfer to a less restrictive, safe, and relaxing environment rather than having to be seen in an ED or police station. Colocation also lessens the burden on law enforcement with ready access to transfer capability.

As aforementioned, the proposed CIT crisis center would be located in close proximity to the agency's eight bed residential crisis stabilization unit (CSU). The CSU is currently TDO capable with an approved plan for implementation of medical detoxification services. This capability would allow for voluntary or involuntary (TDO) admissions from the CIT Crisis Center and provide ready access to detoxification services within the CSU scope of care. If an individual's needs escalated while in the living room, the CSU is a less restrictive alternative to inpatient hospitalization to and its near proximity provides ready access to more intensive supports. As the Commonwealth moves towards financial realignment and the state facilities continue to operate at or over capacity, utilization of CSUs as an alternative to inpatient treatment becomes imperative to treating and stabilizing individuals in acute crisis.

Funding Need

The funding that would be required to implement the proposed model is detailed on the following pages. Funds needed in year one would support the necessary renovation of the space and relocation of the CITAC in Radford. Peer Recovery Specialists (3 FTE) will be required to staff the Living Room crisis respite center during the hours of 1pm-9pm, Tuesday through Saturday, or as needed based on the demand of crisis calls. Intensive Services Clinician positions are required to triage and assess risk at the living room (1 FTE) as well as to compensate for additional community need for preadmission screening due to individuals seeking care at the crisis center (1 FTE). A psychiatric registered nurse (1 FTE) will be required to staff the living room to provide immediate medical triage and assessment. A clinical program supervisor will be required to provide clinical and administrative supervision to peer, nursing, and triage clinical staff. The undeveloped space in the Radford Center will need to be constructed to create the living room respite center, two clinical assessment offices, and the CIT Assessment Center. The funding requested for the project is detailed in the following pages.

PROPOSED PROJECT BUDGET

PERSONNEL

Position	Number of FTEs	Salary per FTE	Benefits/ Overhead per FTE	Total Cost per FTE	TOTAL FUNDING REQUEST
Certified Peer Recovery Specialists	3.0	$32,866.00	$10,846.00	$43,712.00	$131,136.00
Licensed Intensive Services Clinicians	2.0	$48,557.00	$16,031.00	$64,588.00	$129,124.00
Clinical Program Supervisor	1.0	$50,985.00	$16,825.00	$67,810.00	$67,810.00
Registered Nurse	1.0	$44,043.00	$14,534.00	$58,577.00	$58,577.00
				TOTAL PERSONNEL PER YEAR	$386,647.00

START UP/ ONE TIME COSTS

Building modification	Cost to modify undeveloped Radford Center space	$65,000.00
Furnishings	Furnishings for living room, three semi private rooms, nurse office, two assessment offices, including TV, couch, table, chairs, nursing equipment, recliners, office desks and chairs, refrigerator, microwave, dishwasher, IPads for consumers and docking stations, weighted blankets, and artwork	$15,000.00
8 camera video security system	Necessary for surveillance of the living room respite and assessment offices	$8,000.00
Computers (8)	Peer staff, nurse, supervisor, and Intensive Services Clinicians	$10,000.00
Network Switching Equipment	One time infrastructure expenditure	$10,000.00
	TOTAL START UP / ONE TIME COSTS	$108,000.00

OTHER ONGOING EXPENDITURES

Office supplies/snacks for consumers	Snacks, water and drinks for consumers annually. Includes other general office supplies.	$1,500.00

FUNDING REQUEST SUMMARY

TOTAL YEAR 1 FUNDING REQUEST	**$496,147.00**
TOTAL YEAR 2 and ONGOING FUNDING REQUEST	**$388,147.00**

Note: Added after report presented to SJ 47 Joint Subcommittee on October 1, 2018

DBHDS REGION 2

PROPOSAL TO DECREASE STATE HOSPITAL USE THROUGH INCREASING COMMUNITY CAPACITY

FY 2019

October 2018

Contact: Jean Post, Director of Regional Projects

Virginia.post@fairfaxcounty.gov

Appendix H

Note: Added after report presented to SJ 47 Joint Subcommittee on October 1, 2018

Introduction and Background

DBHDS Region 2 includes the Community Services Boards of Alexandria, Arlington, Fairfax-Falls Church, Loudoun, and Prince William, and represents 28% of the state's population. The Commonwealth is in a crisis regarding an increase in TDO admissions to state facilities, resulting in these facilities often exceeding what is considered a safe occupancy level. At our local state hospital, NVMHI, regional TDO admissions have increased 58% from FY17 to FY18. Concurrently, many of our local private hospitals have had a decrease in regional TDO admissions for a variety of reasons. The result is unsafe conditions due to overcrowding at our local state hospital, and more individuals receiving acute inpatient services out of area, often far from their natural and professional support system.

Region 2 instituted a number of initiatives designed to ameliorate this increased demand for state hospital admissions. These efforts include regular meetings with our hospital partners seeking collaboration in strategic problem-solving; CSB and Hospital Executive Roundtable Discussions to further address and implement strategic changes; and, currently, we are restructuring our contractual relationship with private hospitals for inpatient services to better address the public/private partnership in meeting our regional needs.

As a result of these efforts, we have learned that legal status and funding source are not significant factors in private hospital acceptance decisions; rather, private hospitals identified individuals' challenging behavioral presentations and a lack of discharge placement at the time of referral as often driving their decisions to decline admissions. Our private hospital partners expressed concerns about individuals becoming "stuck" in their hospital for longer than clinically indicated or appropriate due to lack of appropriate discharge placement. Similarly, many of the individuals on our state hospital's Extraordinary Barriers List (EBL) are those who have no identified discharge placement/no willing community facility to accept them.

Our region therefore is requesting support and funding for additional community-based services to decrease the risk of individuals becoming "stuck" in both the private and state hospitals, with the intent of ultimately decreasing state hospital bed use, and having individuals supported locally in the community.

The Proposal Concept:

We are proposing three regional community capacity enhancement programs to decrease state hospital bed use: 1) Intensive Community Residential Treatment Plus; 2) Assisted Living Facilities; and 3) a Psychiatric Emergency Crisis Center. Based on data our region has collected, and identified service needs, these programs represent critical steps toward creating a solution for the psychiatric bed crisis. They each have significant variability in projected implementation time frame and associated costs.

The Intensive Community Residential Treatment Plus:

DBHDS Region 2 currently has two eight-bed Intensive Community Residential Treatment (ICRT) programs which are a community alternative to hospitalization and include around-the-clock care with intensive treatment and training. The ICRT programs include residential services with 1:4 staff-to-client supervision, 24/7. In addition, they provide individuals with all of their mental health services to include: treatment/training services to increase self-sufficiency, psychoeducational groups and psychosocial rehabilitation activities, opportunities to learn and use independent living skills; ongoing comprehensive assessment of needs and recovery progress; medication education; opportunities to enhance social and interpersonal skills; supportive counseling; community integration, and substance abuse treatment services. These programs also provide psychiatric medication management through a board certified psychiatrist and licensed registered nurse; case coordination; coordination and support of medical and dental needs; and other services as needed. Individuals referred for admission to these programs have been hospitalized at a Virginia State Inpatient Psychiatric Facility and require highly intensive, individualized and structured residential treatment services for an indefinite period of time (based on their individual recovery process) to remain stable in the community upon discharge from the hospital. Currently, these programs are the most highly intensive residential services available in DBHDS Region 2.

Despite the high success rate that we've had with these programs as indicated by reduced hospitalization and retention in community service, there are many individuals at NVMHI who require a higher level of care than the traditional ICRT program provides due to very challenging behaviors and a need for more highly trained staff and a higher staff to client supervision ratio. We are proposing an Intensive Community Residential Treatment Plus (ICRT+) program. This program would increase both the number and the level/credentialing of staff hired to support the program, and decrease the number of individuals served in the home. This would be for those individuals who require at least a 1:2 staff to client ratio of supervision and support. The staff in this home would be able to provide therapy (both individual and group), and the program would offer the full array of necessary psychiatric treatment and supports, including a Behavioral Analyst to develop and implement appropriate Behavioral Plans to help assist in managing challenging behaviors. Each individual in the program would have their own room, which would help reduce peer-to-peer conflicts. When needed, the program would have the potential to increase staffing to 1:1, depending on the clinical needs of the individuals in the program.

Currently, we have 23 individuals at NVMHI whose needs have not been met at the traditional ICRT level of care or who have been assessed as needing a higher level of care than our ICRTs currently provide. Adding this level of care to our continuum of services would also allow people to step down to ICRT level of care when appropriate, and continue in their recovery within the community.

Because we have an existing vendor contracted to provide a full continuum of mental health residential services, and our contract addresses the expectation that service capacity needs will increase during the term of the contract, this community capacity enhancement could be implemented within 6 months of a funding award.

Assisted Living Facility:

DBHDS Region 2 has no regionally-managed/operated Assisted Living Facilities (ALF), and local private providers are often reluctant to accept individuals with serious mental illness. At the end of FY18, we had 15 individuals on the Extraordinary Barriers List (EBL) in need of ALF placement: 8 on the Northern Virginia Mental Health Institute EBL and 7 on the Piedmont Geriatric Hospital EBL. We have no way to fund these individuals in the community as our Discharge Assistance Program (DAP) is deeply over obligated, we have few auxiliary grant providers in our region and few private providers willing to serve individuals with significant behavioral health needs.

Discharge Assistance Program (DAP) funds many ALF placements in DBHDS Region 2, and of those, 61% are placed out of area, because services were not available locally.

We are proposing two 8-bed ALFs to meet the needs of Region 2 individuals in an appropriate community setting. One would be a secured memory care program and the other would be a more traditional ALF, both specializing in behavioral health needs. These programs would be staffed to meet the Psychiatric and Adult Daily Living Skill needs of residents in care.

Because this would be a new service in Region 2, we project a 12-month startup timeframe.

Psychiatric Emergency Crisis Center:

DBHDS Region 2 has experienced a significant rise in TDO admissions to state hospitals over the last several years. In FY 2016, we admitted 480 individuals under TDO to NVMHI. In FY 2017, the number of TDO admissions rose at NVMHI to 711 and in FY 2018 it rose again to 1,123. Between FY 2016 and FY 2018, TDO admissions to NVMHI rose by 134%. Between FY 2017 and FY 2018, TDO admissions at our private hospitals declined by 10%.

Too often, individuals suffering from a mental health crisis end up spending many hours in a hospital emergency room, where staffing resources are already stretched to meet medical emergencies, and where expertise in behavioral health crisis management is limited. Psychiatric Emergency Centers are emerging throughout the U.S. to better meet both the needs of those in crisis, and the community. Region 4 has consulted with 4 providers of Psychiatric Emergency Centers and is also exploring this service option. These types of programs exist in Arizona, California, New York, Delaware, North Carolina, and Washington State.

Typically, these programs include a team of physicians, nurses, social workers, peer recovery specialists, other support personnel and security (who can take individuals into custody if needed) to provide services 24 hours a day, seven days a week for both voluntary and

involuntary individuals suffering from a behavioral health crisis. These centers provide triage, mobile crisis, medical clearance and laboratory testing, evaluation, and admission services (day services, 23-hour calming rooms, sobering unit and medical detox and subacute care). The center would also be able to provide seclusion and restraint, if needed.

In FY 2018, DBHDS Region 2 funded 783 uninsured adult inpatient private hospital stays for 5473 bed days through LIPOS. Region 2 admitted 1341 individuals to NVMHI and utilized 41,061 adult bed days in state hospitals in FY18 (forensic and civil). During this same period, we also secured temporary detentions on behalf of 3,621 Adults; of these, 23.9% (856 cases) were dismissed by the special justice at the involuntary commitment hearing. If we were able to divert 23.9% of our DBHDS LIPOS-funded adult inpatient private hospital admissions and bed days to a Psychiatric Emergency Crisis Center, we would capture a savings of $1M (based on an average bed day rate of $850 and 23.9% reduction in bed days used). If we are able to divert this same percent of our civil adult state facility bed days used (approximately 60% of total adult state facility bed days used), region 2 would capture an additional savings of approximately $5M.

In addition to a cost savings, a Psychiatric Emergency Crisis Center would provide quicker access to treatment, reduce individual wait times in our hospital emergency rooms, decrease the amount of time our law enforcement officers are waiting with individuals in the hospital emergency departments for these individuals to be medically cleared (which pulls from their patrol duties in the community) and strengthen the continuum of crisis services.

We are proposing the development of a Psychiatric Emergency Center in DBHDS Region 2. Because this is a new program concept in the state of Virginia, we are projecting a multiyear startup phase.

Next steps:

Following feedback from ILPPP and GA determine interest in supporting these 3 regional community capacity enhancement programs to decrease state hospital bed use, our immediate next steps are defined by project below.

1. ICRT +: Meet with vendor to initiate program and establish startup time line.
2. ALF: Develop RFP.
3. Psychiatric Emergency Crisis Center: Partner with region 4 and hire consultant.