Final Report of the SJ 47 Statewide TDO Task Force
March, 2019

In early 2018, the Statewide TDO Task Force was formed at the direction of the leadership of the SJ 47 Joint Subcommittee, to assess and recommend solutions to the growing crisis in Virginia's state psychiatric hospitals from the dramatic increase in patients being placed in those facilities through Temporary Detention Orders (TDOs). Task Force members included public and private mental health agencies and facilities and statewide mental health advocacy organizations. At the same time, staff of the Institute of Law, Psychiatry and Public Policy (ILPPP) participated in meetings in each of the state's five Health Planning Regions (with 3 sub-region meetings being held in Region 3 due to that region's large geographic size) with local and regional public and private mental health agencies and facilities (with participation by mental health advocacy organization in some of those meetings). Those meetings were held to discuss the specific conditions and needs of each region in responding to individuals in mental health crisis, and to obtain specific recommendations from each region regarding services and programs that would improve outcomes for individuals in crisis while reducing the demand on the state's psychiatric hospitals. Specific findings and concerns gathered from those regional meetings, along with recommended services and programs, were shared with the statewide Task Force in its meetings. Also shared were findings from research by ILPPP staff regarding TDOs and the growing demand for admission to state psychiatric hospitals. The subsequent findings and recommendations of the statewide Task Force were submitted to the SJ 47 Joint Subcommittee at its December 4, 2018 meeting.

Subsequently, the 2019 General Assembly enacted SB 1488, which directed the Secretary of Health and Human Resources to form a work group to address the TDO crisis, and to specifically address a number of key issues, including those identified and discussed by the TDO Task Force in its December 2018 report. Since the mandate of the SB 1488 work group is largely the same as the mandate to the TDO Task Force, it was agreed by Secretary Carey and Senator Deeds that the TDO Task Force would be discontinued and that the research initiated by the Task Force would be continued under the auspices of the SB 1488 Work Group. In addition, it was agreed that the legislative proposals under consideration by the SJ 47 Task Force would be considered by the SB 1488 Work Group.

This final report of the SJ 47-initiated TDO Task Force summarizes and updates the key findings and recommendations from the December 2018 Task Force Report, together with "next steps" that the Task Force was expecting to address in the anticipated second year of work before the General Assembly directed the Secretary to establish the SB 1488 Work Group to address the TDO crisis.[*]

[*] This Report of the SJ 47 TDO Task Force was drafted in January, 2019 by John E. Oliver and Richard J. Bonnie on behalf of the Task Force, updated in March, 2019, and formally submitted to Secretary Carey and the SB 1488 Work Group and the SJ 47 Joint Subcommittee in June, 2019

I. Findings from the Statewide TDO Task Force

In its interim report to the SJ 47 Joint Subcommittee for its December 4, 2018 meeting, the Task Force presented the following key findings regarding Virginia's TDO crisis:

A. The Challenges

1. The number of private hospital beds available for TDO patients continues to decline, with no end to this trend in sight.

Private hospitals statewide helped to absorb an increase in total TDOs experienced between 2014 and 2016, but since 2016 the annual number of TDOs statewide has *decreased* while the number of TDOs to state hospitals has dramatically *increased* (from less than 10% of all TDOs to more than 20% in 2018), leading to the current crisis in state hospital overcrowding.

2. The greatest single contributor to this phenomenon appears to be a significant rise in the number of voluntary inpatient admissions to private psychiatric hospitals, resulting in fewer private hospital beds being available for TDOs.

Significantly, no information is currently available regarding these increasing inpatient admissions (diagnoses, length of stay, pre- and post-hospitalization engagement in outpatient treatment, etc.), so it is unknown what non-hospital services or programs might help to reduce this increasing demand for private psychiatric hospital care.

3. Other factors are also contributing to the decreasing number of available private beds.

They include: bed closures because some hospitals cannot meet new requirements from the Joint Commission on the Accreditation of Hospitals (JCOAH) to reduce "ligature" risks – that is, risks of suicidal patients hanging or strangling themselves; staffing shortages requiring the temporary closure of beds or units; months-long occupancy of acute care beds by patients for whom a community placement cannot be found.

4. More individuals in crisis are presenting significant medical and behavioral challenges that many private hospitals find to be beyond their capacity.

a. Individuals with complex medical conditions.

b. Individuals with ID/DD and related behavioral challenges.
c. Individuals who have dementia and other challenging conditions that result in community programs being unwilling to accept them for services.

B. The Responses to these Challenges

1. *Behavioral healthcare system solutions:*

The best long-term solution to psychiatric crises is strengthening the community-based system of mental health care.

a. Provide full funding for STEP-VA.

Notably, some Task Force members expressed their concern that specific recommendations from the Task Force for changes in crisis response could divert attention and resources from the system-wide goal of fully funding STEP-VA, thereby assuring the adequate services and community supports are available to prevent crises. At the time of the Task Force's last meeting on November 27, 2018, DBHDS had not indicated its priorities regarding crisis services to address the TDO crisis.

b. Provide sufficient Medicaid funding to support community-based services.

While there was limited discussion of this issue at the Statewide TDO Task Force meetings, it was a central issue in related regional meetings, with CSB leaders noting that, among other things, Medicaid Managed Care was not providing compensation for certain community services that helped to maintain the stability of individuals with serious mental illness, and that the compensation for those services that Medicaid did cover was often less than the costs of providing those services.

2. *Crisis response system solutions:*

a. Make less restrictive crisis services available, so that crises can be resolved without hospitalization.

(i) Provide alternatives to the hospital ED for the individual experiencing crisis:

- Mobile crisis teams that can come to the individual and provide assistance and support.

- Peer support recovery centers that are peer-operated and offer a home-like environment for individuals to seek assistance and support when they sense that they are entering into crisis.

- Psychiatric Emergency Centers (PECs) that operate as outpatient facilities, offering care for up to 24 hours and welcoming "walk-ins", as well as referrals from police, hospital EDs and mental health providers, with engagement from peer specialists and treatment staff and a determination made within the 24-hour stay on whether a person needs hospitalization or can be helped through a transition to less restrictive services.

- Hospital observation units that are within the hospital complex but separate from the hospital ED, so that individuals who arrive at the ED in mental health crisis have a quieter setting, staffed with professionals trained in mental health care (but with other medical care readily available) who can better assess and address these crises.

- Crisis Stabilization Units (CSUs) that are sufficiently staffed and funded to enable them to function more effectively as both an alternative to the hospital ED and psychiatric hospital and as a "step-down" for patients discharged from hospitals.

There was a wide range of views regarding which of these alternatives should receive priority, and recognition that any service needed to be shaped to match varying local and regional needs.

b. Prevent unnecessary hospitalization by providing the option for some individuals in custody to have the time needed to recover from crisis.

The overall sentiment from SJ 47 TDO Task Force discussions was that the 8-hour ECO period in Virginia law must remain as the presumptive time period for holding in custody a person who is in mental health crisis to determine whether that person needs temporary hospitalization under a TDO, but that in specific limited instances, such as the placement of such a person in a PEC (which is designed for active and supportive therapeutic engagement with the individual for a period of up to 24 hours) the 8-hour ECO period might be extended to up to 24 hours. This would require a change in the current law.

c. Improve the linkages between the private and public mental health crisis response systems so that individuals can transition more smoothly between placements and services.

Two key areas were identified as needing improved linkages for the transition of care. First, hospital EDs reported challenges in making timely transfers of patients from the ED to community facilities and programs, particularly CSUs, and expressed the need for more uniform standards and sufficient staffing of the CSUs to enable transfers to be carried out more quickly. Second, a proposal for ensuring improved communication between private psychiatric hospitals and community mental health service providers, to improve discharge planning and connection to local services,

was submitted by a regional program. This proposal prompted discussion about possible needed statutory authorization or other measures to improve communication for effective transition services while complying with the privacy standards of the Health Insurance Portability and Accountability Act (HIPAA).

The value of enabling engagement by community mental health providers with individuals who are in the hospital under a TDO is being demonstrated by the Henrico Area Mental Health and Developmental Services (HAMHDS) "Same Place Access Program." The goal of the program is "to reduce re-hospitalization through actively engaging individuals while they were in the hospital to develop a discharge plan and to link them to appropriate after-care services." HAMHDS has established a working relationship with one area hospital to enable an HAMHDS certified peer recovery specialist to visit at the hospital with TDO patients who were not connected to mental health services in the community at the time of their TDO, to offer them discharge planning services. Those patients who express an interest in discharge planning services are then visited by a mental health clinician who, working with hospital staff, conducts an assessment and works with the patient to develop a plan and arrange connections for community care following discharge. The peer specialist makes contact with each patient following discharge, to help ensure the individual follows up on the arranged community services. Early indications are that the rate of re-hospitalization is significantly lower for those individuals who are seen in the hospital and linked to community services in this way.

Because of uncertainties over the degree to which HIPAA privacy restrictions might affect the sharing of patient information and the provision of patient access that this program needed in order to function as envisioned, ILPPP staff drafted proposed changes to Virginia law to provide mandates for such sharing and access. Those are discussed later in this report. HAMHDS has been able to develop a HIPAA-compliant arrangement with the local hospital to implement the Same Place Access program. That arrangement should provide a model for others. At the same time, statutory changes might still be helpful to make this process easier to implement.

d. Ensure the education, training and retention of enough skilled mental health service providers.

While other bodies are addressing the growing workforce crisis in the mental health field, this crisis is of such urgency that it bears repeating at every opportunity. Better services cannot be provided without sufficient numbers of skilled mental health professionals and peers.

II. Recommendations of the SJ 47 TDO Task Force

Specific recommendations for services, including "pilot projects" and statutory changes to support crisis responses and follow-up, arose out of the related regional

stakeholder meetings. They were reviewed by the Statewide TDO Task Force at its November 27 meeting.

A. Proposed Statutory Changes

1. Amend VA Code Section 37.2-808(K) to ensure that needed custody of a person held under an ECO is maintained until the TDO is served.

The Task Force recommended approval of this amendment.

Update: The SJ 47 Joint Subcommittee did not take action on this recommendation. It remains the case that the 8-hour ECO period expires for a number of individuals being held under an ECO before those individuals can be served with a TDO, raising uncertainty for law enforcement officers and mental health providers as to the authority to keep these individuals in custody for their protection.

2. Amend VA Code Section 37.2-1104 to authorize magistrates to hear requests for Medical TDOs without requiring that the local courts must first be "unavailable".

The Magistrate Advisor in the Office of the Executive Secretary of the Virginia Supreme Court raised a number of objections to this proposal, which was aimed at enabling doctors to obtain a more timely response to their requests for medical TDOs to maintain the temporary care and treatment of individuals needing care but incapable of giving informed consent to that care (and in some cases actively objecting to that care). That response prompted additional inquiries and research, leading to the following discoveries: (a) the use of medical TDOs varies dramatically among jurisdictions throughout Virginia, with significant differences in regard to the frequency with which they are requested and granted and in regard to which authority - the local courts or local magistrate - normally enter such orders; and (b) the timely entry and use of medical TDOs is only part of a larger issue involving the timely provision of emergency medical care to individuals in mental health (and other health) crises, and the authority – and liability – of doctors in providing such care to individuals who lack the capacity to give informed consent to it (especially when those individuals also object to that care).

Update: Following dialogue with hospital Emergency Department (ED) doctors, ILPPP staff drafted legislation to clarify the authority of medical staff to provide emergency medical care to a patient in the absence of informed consent. That legislation is described later in this report. If enacted, the legislation would remove the need for amending Section 37.2-1104, but would also require the Virginia Supreme Court to develop uniform practices among the local courts in regard to the issuance of a "medical TDO" under Section 37.2-1104.

3. Amend VA Code Sections 37.2-813, 37.2-838 and 37.2-839 to ensure CSB access to patients and patient information for psychiatric hospital discharge planning.

Hospitals represented by the Virginia Hospital and Healthcare Association submitted concerns that the amendments as proposed were not consistent with the terms of the federal HIPAA regulation , and would put hospitals in the untenable position of having to violate one law in order to comply with the other. The VHHA noted that hospital representatives feel that it is possible to develop arrangements with community mental health care providers that will enable the needed sharing of information for effective discharge planning, without additional legislation, and expressed their willingness to work to develop such arrangements.

Update: The "Same Place Access" program developed by Henrico Area Mental Health and Developmental Services, discussed above, indicates that a hospital and community provider can develop HIPAA-compliant protocols for information sharing and patient access to enable effective discharge planning for individuals in the hospital under a TDO. The unanswered question is whether all such providers will be willing or able to develop such protocols or will need the assistance of legislation to make such cooperation and coordination a standard practice.

B. Other Recommendations

1. The need to address the crisis in state psychiatric hospitals regarding individuals with complex medical conditions

The Task Force report noted that there is medical consensus in Virginia that individuals who are in mental health crisis but who also have certain complex medical conditions (e.g., severe burns requiring acute care, unstable seizures, acute respiratory distress, intravenous fluids or IV antibiotics) are not appropriate for placement in state psychiatric hospitals, which do not have the in-house capacity to treat those medical conditions. However, because of Virginia's "placement of last resort" requirement, state psychiatric hospitals are being required to accept such individuals under a TDO if their 8-hour ECO period has run out and no private hospital bed has been found for them.

ILPPP staff drafted possible changes to Virginia Code Sections 37.2-809 and 37.2- 809.2, including a provision that would allow state psychiatric hospitals to decline the admission of such individuals and would extend the ECO period in those situations to provide additional time to find an appropriate facility. While Task force members agreed that the current burden on state hospitals is inappropriate, the proposed code changes were seen by key stakeholders as simply shifting that burden to hospital EDs, where these individuals' mental health crises likely would worsen if they could not be psychiatrically hospitalized in a timely way. The Task Force recommended that a suitable body of experts be appointed to study and make recommendations to the General Assembly by the fall of 2019

on how best to address the treatment needs of these individuals to remove the costly and unfair burden currently carried by the state hospitals.

2. Support for Specific Crisis Response Service Innovation Proposals

From the regional stakeholder meetings a number of proposals were developed for crisis response services aimed at improving local capacity to help individuals in crisis and thereby reduce the need for hospitalization. These proposals had varying levels of detail. The projects highlighted by ILPPP staff for the Statewide TDO Task Force were: (1) PEC-like facilities based on the Living Room model, from Region 4, Region 3b and New River Valley Community Services (NRVCS), with the NRVCS and Region 3b programs including proposed budgets; (2) a mobile crisis program from the Blue Ridge Community Services Board that would include services and consultation from a psychiatrist to enable more in-depth assessment and medication prescription as part of the mobile team services.

The response of most Task Force members was that, while the proposed services were consistent with the Task Force's findings regarding the need for alternative services for individuals experiencing mental health crisis, it would not be appropriate to make recommendations for specific projects. Among the reasons: (1) the state was in the critically important process of fully implementing STEP-VA (which does include crisis services as a key component part, though the specifics of those crisis services are still in development), and focus needs to be concentrated on that process; (2) recommending specific projects to the Joint Subcommittee would not be consistent with the historical practice of the General Assembly, which has been to provide funding for identified services, with the specific programs to provide those services being selected later through grant or RFP processes. That said, the Task Force noted that regionally generated and implemented innovations to enable crisis intervention services that prevent hospitalization is a key element in the Commonwealth's mental health transformation strategy. The Task Force also noted that DBHDS was facilitating regional conversations and collaborations, so that the role of the Task Force in pursuing and recommending crisis service innovations would depend upon the nature and outcome of the collaboration between DBHDS and the CSBs regarding such innovations.

Update: The SJ 47 Joint Subcommittee endorsed the NRVCS proposal, and a budget amendment was submitted to provide the $500,000 requested for it. While the amendment made it through one house of the General Assembly, it did not make it into the final budget.

It is notable that the regional meetings produced four separate proposals for a PEC-like facility, demonstrating a growing consensus at the community level about the importance of such facilities as part of the crisis response continuum of services.

III. Next Steps

Based upon the findings and recommendation of the Statewide TDO Task Force in its December 4, 2018 report, ILPPP staff identified the following "next step" issues that require addressing in order to improve crisis response and reduce the current burden on the state hospitals. Although these issues and priorities were not formally reviewed by the members of the Task Force, they arose out of the Task Force deliberations.

1. Creating better alignment and integration along two key axes of Virginia's mental health service system: (a) public-private care and (b) state hospital-local/regional public community- based care, and developing the data needed to evaluate the system.

a. *Public-private system alignment and integration:*

As noted in the 2018 report, currently there is no generally available information regarding the diagnoses and needs of the individuals who are occupying private psychiatric hospital beds through voluntary (vs. TDO) hospitalization. In addition, there is no information on their length of stay, or their pre- or post-hospital engagement with community mental health services. Fully studying data of this kind would enable better planning and decision-making about the development of less restrictive alternatives to hospitalization, so that hospital beds can be reserved for those who truly need an inpatient setting. In addition, more sharing of information on the extent of private hospital capacities to accept individuals in crisis who have particular challenging behaviors, diagnoses, or treatment histories, could also guide decision-making on whether more specialized facilities or programs are needed to meet the needs of these individuals. While there have been some initial discussions regarding data sharing, much key information regarding the private psychiatric hospital system is not available for shared analysis and planning. A key agenda item would be to pursue efforts to make that information available and to integrate public and private data to enable better assessment of mental health crisis service needs statewide and develop public and private programs and services accordingly.

b. State-local/regional alignment and integration:

Crisis services are a key element of STEP-VA, but the required components of such crisis services under STEP-VA have not yet been specified by DBHDS. At the same time, DBHDS has put forward a "fiscal realignment" plan under which local CSBs, in exchange for STEP-VA funding to expand community-based treatment services, would accept financial responsibility for individuals from their service area who end up requiring inpatient care in a state psychiatric hospital. There are huge challenges in both tasks. The community-based crisis services that work best for one locality or region may not be the best fit for another region, due to a variety of factors. In addition, unless or until Medicaid Managed Care and other medical insurers change

current compensation practices, there is no consequence for private mental health providers when their patients experience a crisis and require inpatient or other crisis care. Properly aligning financing and incentives for community-based care is critically important, and largely a task for DBHDS and the CSBs. The content and outcome of that work has a direct effect on the service options that are realistic for consideration. Against this background, ongoing communication and coordination among DBHDS, the CSBs, DMAS and the MCOs contracted by DMAS are extremely important.

2. Developing local/regional capacities to provide effective non-hospital mental health crisis services to reduce hospitalization rates and improve treatment.

In a November 13, 2018 letter to all State Medicaid Directors, Mary C. Mayhew, CMS Deputy Administrator and Director, described ways in which CMS would support state-developed "innovative service delivery systems" for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED). On page 7 of that letter Ms. Mayhew wrote that adults with SMI and children with SED "need access to a continuum of care since these conditions are often episodic and the severity of symptoms can vary over time." Noting that many regions have only outpatient care and hospital care as options, with no "intermediate level of care", with the result that many individuals with SMI are hospitalized when they could be better served in the community, Ms. Mayhew cited approvingly a strategy "to increase availability of intensive outpatient and crisis stabilization programs designed to divert Medicaid beneficiaries from unnecessary stays in emergency departments (EDs) and inpatient facilities as well as criminal justice involvement." "Core elements of crisis stabilization programs," she continued, "include regional or statewide crisis call centers coordinating access to care in real time, centrally deployed mobile crisis units available 24 hours a day and seven days a week, and short- term, subacute residential crisis stabilization programs." This finding by Ms. Mayhew is fully consistent with the findings and recommendations emerging out of each region regarding region-wide crisis services.

3. Developing placement and treatment solutions for individuals in mental health crisis who have medically complex conditions.

There is a consensus in the medical community that individuals in mental health crisis who have certain complex medical conditions are *not* appropriate for placement in state psychiatric hospitals, which are unequipped to care for their medical conditions. However, such individuals are extremely challenging in any hospital setting, including hospitals that have both medical and mental health capabilities to treat them. Moreover, those hospitals regularly report that they have no beds available when these individuals need a TDO placement. A solution to this problem has to be found. The status quo is unacceptable.

4. Clarifying and securing the authority to provide emergency medical treatment in cases of incapacity and objection

Conversations with hospital ED physicians and with CSB Emergency Services staff in different jurisdictions have identified an increasingly critical and enduring dilemma: the lack of well-defined authority for emergency medical staff to provide stabilizing treatments for individuals in medical/psychiatric crisis when those individuals appear to lack the capacity to give informed consent to that treatment, and especially when those individuals are objecting to treatment that doctors deem medically necessary to stabilize the individual and prevent serious harm. While there is a longstanding common law "emergency" exception to the requirement of informed consent, the extent of that exception is uncertain, raising concerns among doctors and their staffs over their ability to treat and stabilize individuals in crisis situations in which the patients are objecting to needed care.

While Virginia law enables doctors to obtain "medical TDOs" from the courts (or magistrates, if the courts are not available) to hold and treat individuals for up to 24 hours, most of these individuals need immediate care to stabilize their condition, so that it is not possible to seek a medical TDO before providing emergency care. Even after an individual has been stabilized, and doctors recommend a period of additional observation and treatment, obtaining a medical TDO in some jurisdictions can take many hours. Some doctors have become so frustrated with the process that they have given up on seeking medical TDOs. Other states have statutes that address emergency medical care more directly. More comprehensive legislation to address this issue should be considered for Virginia. In addition, the use of medical TDOs currently should be studied to determine whether the medical TDO process should be revised.

ILPPP staff have developed proposed legislation to address this issue by clarifying when such emergency treatment would be authorized. The legislation would also place a limitation on how long such emergency treatment can be provided without informed consent before seeking judicial authorization for the treatment. The existing "medical TDO" statute (Section 37.2-1104) would remain the same, but the Virginia Supreme Court would be directed to set standards to ensure uniform application of the statute throughout the state. (ILPPP research has found that the current use of this section varies widely across the state.)

5. Ensuring appropriate communication between hospitals and community providers to enable effective discharge planning that connects hospitalized individuals to community services.

The November 13, 2018 letter from CMS Director Mayhew, cited above, included as a key goal for Medicaid innovation "better care coordination and transition to community-based care". Citing a recent study, Ms. Mayhew noted that the "risk of suicide following

discharge from psychiatric hospitals or wards is greatest immediately following an inpatient stay, with the rate of suicide during the first three months after discharge approximately 100 times higher than the global suicide rate…", but that, despite this, "many Medicaid beneficiaries do not receive timely follow-up care within the timeframes of 7 or 30 days that are used to measure timely follow-up care in the widely used measure "Follow-up After Hospitalization for Mental Illness" (NQF #0576)." The bills proposed, but deferred, for the 2019 General Assembly session, were intended to ensure proper communication between psychiatric hospitals and community providers for follow-up communication with, and care for, individuals who are psychiatrically hospitalized. As noted earlier, while private hospitals objected to the bills because of HIPAA compliance concerns, they expressed their willingness to work with community providers to ensure the kind of care coordination and transitioning between the hospital and community setting that the CMS director identified as a key need. The success of Henrico's "Same Place Access" program, described earlier in this report, may provide the template for such coordination and transitioning throughout the state without the need for additional legislation. Active engagement with the hospitals and community providers will be needed to determine if that is the case.

6. Reducing the "Extraordinary Barriers List" (EBL) of difficult-to-place patients in state hospitals and their counterparts in private hospitals.

Research in particular by CSB staff in Region 2 confirmed that most of the individuals on the EBL of the state psychiatric hospitals serving that region were unable to obtain community placements because their treatment needs and behavioral challenges were so complex, requiring levels of care that community residential facilities and programs do not have. Region 2 has proposed the development of specialized facilities capable of caring for these individuals in the community. Collecting similar data on the needs of patients on the EBL in the state's other psychiatric hospitals would provide a comprehensive picture of the nature and extent of the needs of these individuals for community-based care, and enable the development of a statewide plan for community residential services for EBL patients. While the ideal model for permanent supportive housing for individuals with serious mental illness is one that maximizes community integration, the realities of the care needs of some individuals makes it necessary to consider congregate care facilities that can meet their needs.

7. Ensuring continuing patient engagement in community mental health services following hospitalization: mandatory outpatient treatment orders vs. other treatment engagement strategies.

A major source of conflict within the mental health treatment and advocacy communities arises out of the observation that some individuals with serious mental illness have so little insight into their illness that they resist treatment and as a result fall into repeated mental health crises, leading to repeated involuntary hospitalizations,

which result in distress and loss and even harm to them and to others and which imposes increasing costs on an overburdened mental health services system. Some argue that these individuals will engage in community-based care only if ordered to do so, and they support Mandatory Outpatient Treatment (MOT) orders as part of their hospital discharge, to better ensure that they will participate in treatment in the community and not return to the hospital. Others respond that MOT orders are inherently coercive, and will result in more resistance to treatment from these individuals, and that the best answer is enriched community-based services – which, they argue, have been the real source of the success claimed for MOT orders by states that have fully implemented them.

Because individuals who experience repeated involuntary hospitalizations due to repeated disengagement from treatment have an impact on the demand for hospital beds (and because these individuals experience instability and decline as a result of these multiple hospitalizations), it is vital to look in depth at the best ways to address this population, first by determining how many individuals regularly "cycle" through the hospital system (which will require first that we define the threshold for such "cycling") and then deciding how to assess what approaches would be most helpful and effective for these individuals. ILPPP staff are currently researching the use of MOT orders in Virginia under current law. A work group on MOT has been formed and is working with the ILPPP in developing a set of recommendations regarding the efficacy of MOT and what, if any, changes to Virginia's MOT law might be appropriate.

8. Addressing the burdens and costs of the inefficient Statewide Bed Registry and of transporting of TDO'd patients to hospitals far from home

In order to find an available psychiatric hospital bed for a person being held under an 8-hour ECO, CSB emergency services evaluators must assess that person as early in the 8-hour period as possible, so that, if the person is found to meet TDO criteria, the evaluator can spend as much of that 8-hour period as possible looking for an available private hospital bed. Because the state hospitals have the burden of accepting these individuals if no bed is found at the end of the ECO period, evaluators must show the state hospital that they have made an exhaustive statewide search.

While the Statewide Bed Registry was created to make that search easier, evaluators report that the Registry still does not provide "real time" information regarding bed openings, and that an "open" bed often is found not to be available for a particular person because of that person's condition or behaviors. So, the evaluators make phone calls, starting with nearby hospitals and then radiating outward throughout the state. They also fax, sending patient information to enable hospitals that have a bed to assess whether that bed is available for that particular person. 25 or more hospitals are often contacted in this routine, which goes on daily in every CSB throughout the state.

There are a number of results from this: evaluators are turned into " bed brokers", as so much of their time is taken up in this search; hospitals are inundated by calls from inquiring evaluators and by faxes with patient information to be reviewed; and individuals are increasingly TDO'd to hospitals far from their homes, which has a set of consequences of its own: patients still in crisis find themselves in the back of a law enforcement vehicle for hours; law enforcement officers are on the road, and away from their primary public safety functions, for hours at a time, which imposes particularly severe burdens on small sheriff departments in rural areas; and patients who are later discharged from the hospital (up to 25% of them at the 3-day commitment hearing) find themselves hundreds of miles from home, with no meaningful discharge plan or transition back to community-based care, and with no guarantee of being able to get back home. (Some private and state hospitals, and some CSBs, are funding these rides home, at an increasing cost every year, with no source of reimbursement, and without any provision in state law or regulation for how these patients are to be returned to their own community.)

This system is creating poor outcomes for individuals and providers alike, and is placing enormous stress on the staffing and resources of local law enforcement. (While the General Assembly has budgeted funds to establish non-law enforcement transport for TDO'd individuals, it remains unclear whether that funding will be sufficient for statewide implementation, and the long-distance travel will still make such transport expensive and still detrimental to the individuals experiencing crisis.)

There have been some discussions regarding how best to address this problem – the development of non-hospital services and facilities for crisis care is one way to reduce this problem – but it requires more comprehensive attention. Individuals in crisis need to receive support and care in the least restrictive setting possible and as close to home as possible. That is not happening now. Notably, while the Bed Registry is a part of the agenda of the SB 1488 work group, the current focus of the work group appears to be on making the registry more reflective of real-time bed availability. Even success on that issue, important as it would be, will not address the damage done by the long-distance hospital placements that are likely to continue even with an improved registry. Ending that damage will require other reforms.