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**Note from the ILPPP Director:
Introducing New DMHL Editor**

I am pleased to announce that John E. Oliver, J.D., has agreed to become the Editor of Developments in Mental Health Law, succeeding Jane D. Hickey, J.D. I want to thank Jane for her superlative service as DMHL Editor since she ended her stellar career with the Office of the Attorney General. John and I are aware that Jane’s standard of excellence will be difficult to meet, but I am confident that John will rise to the challenge. He has decided to devote this entire double issue of DMHL to the activities of the executive and legislative branches in the wake of the tragic death of Gus Deeds in November of 2013. We will resume quarterly issues in the next volume.

Richard J. Bonnie

**Preface to Issue 3-4:
Reforming Mental Health Law and Practice: Virginia’s Response to Tragedy**

A tragic assault and death at the home of a prominent Virginia legislator in November of 2013 prompted a major reassessment of mental health law and practice in Virginia. New laws were enacted by the Virginia General Assembly in 2014, and the General Assembly established a Joint Committee to undertake a multiyear study of the mental health services system. One Governor established a task force, and his successor continued it, to make specific recommendations for changes to the mental health crisis response system and to the mental health services system as a whole. In addition, the new director of the Virginia Department of Behavioral Health and Developmental Services, shortly after assuming her position in 2014, directed a “System Transformation Initiative” to reshape the structure and

operations of that department and the delivery of mental health services in the Commonwealth. These momentous developments are the subject of this issue.

Tragedy Triggers a Call For Change

On November 19, 2013, 24-year-old Austin “Gus” Deeds, driven by delusions caused by a bipolar disorder, attacked his father, Virginia State Senator Creigh Deeds, with a knife, cutting his father multiple times in the head and upper body before suddenly stopping and walking back to the family house from the yard where the assault occurred. Senator Deeds, bleeding heavily from the attack, struggled to the nearby highway, where he was picked up and taken to the hospital. Alone in the family house, Gus took his own life, using an old hunting rifle for which family members had thought there were no available bullets.

Just a day earlier, Senator Deeds, concerned about the continuing deterioration he had seen in his son’s mental condition, had tried to obtain the psychiatric hospital care for his son that the next day’s events would show he so desperately needed. That failure was *not* because mental health specialists disagreed with this father’s concern. In Virginia, public outpatient mental health services agencies, called community services boards (CSBs), have the duty under Virginia law to assess persons reported to be in mental health crisis and in need of psychiatric hospitalization. That duty is carried out by mental health emergency evaluators. In Gus Deeds’ case, the evaluator for that region’s CSBs *agreed* that Gus needed to be placed in a psychiatric facility, even though Gus was objecting to it. The evaluator was ready to recommend that a temporary detention order (TDO) be issued by the local magistrate, requiring Gus’ temporary hospitalization until a hearing could be held on whether Gus should be ordered to remain in the hospital for treatment.

Why did that hospitalization not happen? Senator Deeds had requested, and the local magistrate had issued, an emergency custody order (ECO), which authorized local law enforcement to temporarily take Gus into custody and transport him from his home to a safe setting—in this case, the closest hospital (which did not have a psychiatric unit), for evaluation by the emergency evaluator. But Virginia law at the time allowed Gus to be held under an ECO for a maximum of 6 hours (4 hours plus one 2 hour extension that a magistrate could grant upon request), and it allowed a TDO to be entered only if the TDO identified the psychiatric facility in which Gus would be placed. The evaluator had the responsibility to find a psychiatric hospital that would accept Gus under the TDO before the ECO ran out.

A large and precious chunk of the 6-hour period for the ECO had already lapsed before the emergency evaluator was contacted about Gus and was able to drive to the hospital. After examining Gus, the evaluator began a search for a psychiatric hospital that could take Gus under the TDO. The evaluator reported to Senator Deeds and hospital staff that all hospitals he contacted reported that they did not have a bed in which Gus could be placed. (More than one of those hospitals later reported that they did in fact have an available bed and disputed the evaluator’s claim of contact.) Without an identified hospital for placement, the magistrate could not enter the TDO. The ECO expired before an available hospital could be found.

When Gus was informed that the ECO was no longer in effect, he was asked if he would remain at the hospital voluntarily while the search for a psychiatric bed continued. Gus refused to stay. He could not

be held any longer over his objection. His father drove him home. The next day Gus was dead and his father was gravely wounded. (A detailed account of these events is available in the Critical Incident Investigation of the OIG, which is summarized and linked in the [May 2014 issue](#) of Developments in Mental Health Law.)

This tragedy prompted changes in Virginia law regarding the issuance of ECOs and TDOs and impelled the completion of a web-based statewide psychiatric bed registry that was still being developed at the time of Gus' death. His death also impelled new reviews of Virginia's mental health system and the response of Virginia localities to mental health crises. One review was initiated by the Governor. A second was initiated by the General Assembly at its 2014 session through Senate Resolution 47, establishing a joint subcommittee chaired by Senator Deeds. The third review was initiated by Debra Ferguson, appointed by Governor McAuliffe early in 2014 as the new Director of DBHDS, as part of her "System Transformation Initiative" for that department.

The General Assembly's Response: 2014 Amendments to Mental Health Law

A. Overview of Mental Health Legislation-2014

Several major bills in the Senate and House were passed by the 2014 General Assembly to address key problems highlighted by the Deeds tragedy.

Those bills included:

[Senate Bill 260](#), lengthening ECO and TDO time periods and procedures, and directing establishment of an acute psychiatric bed registry by DBHDS;

[Senate Bill 439](#), also lengthening the ECO and TDO time periods, and requiring local CSBs to acknowledge receipt of mandatory outpatient treatment orders and transfer of persons subject to those orders to another CSB;

[Senate Bill 576](#) (identical to House Bill 743), requiring the prompt filing in the court and forwarding to the Virginia State Police Central Criminal Records Exchange all commitment related orders affecting persons' rights in regard to firearms;

[House Bill 293](#), providing procedures for assuring a facility placement for persons who are subject to an ECO and meet the criteria for a TDO;

[House Bill 323](#), increasing a magistrate's options for a transportation order for persons under a TDO;

[House Bill 478](#), lengthening ECO and TDO time periods, providing notice to the CSB when an ECO is executed, requiring rights notification to the person involved, and directing a study on reducing the burden on law enforcement in commitment cases; and

[House Bill 1172](#), providing a procedure for persons in a facility under a TDO to be transferred to another facility prior to their commitment hearings.

Together, these bills resulted in the following changes in Virginia law related to mental health crisis response:

1. Time period for the Emergency Custody Order (ECO)

Before: 4 hours, with magistrate having discretion to grant a 2 hour extension

Now: 8 hours, with *no* extension [see §§[16.1-340G](#), H and K(minors), [37.2-808G](#), H, and K (adults)]

2. Notification to the CSB evaluator that the ECO has been executed and the person is in custody for evaluation

Before: The Virginia Code had no specific provision for notifying the CSB evaluator

Now: Law enforcement must notify the closest CSB when an ECO has been executed and where the person needing evaluation is located. [see §§[16.1-340I](#) (minors) and [37.2-808J](#) (adults)]

3. Assurance that a person held under and ECO and found by the CSB evaluator and the magistrate to meet the criteria for a TDO will be psychiatrically hospitalized under a TDO before the ECO expires

Before: No such assurance. A TDO could not be entered until the magistrate could identify in the TDO the hospital in which the person would be detained pending the involuntary commitment hearing. The CSB evaluator had to find a private or state psychiatric facility that would accept the person's placement under a TDO. There was *no* state statutory requirement that either a private or state hospital accept the person. If the ECO period (4 hours, plus a possible 2 hour extension) expired before a willing hospital could be found, the person could no longer be held, as the ECO could not be renewed.

Now: Assurance of hospital placement is provided. It is *still* the case that a TDO cannot be entered until the hospital in which the person will be detained can be identified in the order. However, Virginia law now provides that *state* mental health facilities cannot refuse the admission of a person held under an ECO when an alternative facility cannot be found and the ECO period is expiring. There are *no* exceptions to this requirement. However, both the state facility and the CSB can continue to search for another willing facility for up to 4 hours after the expiration of the ECO. [see §[16.1-341D](#) (for minors), and [37.2-809.1](#) (adults)]. (Note: as discussed below, there is a *separate* authorization in the newly amended Section 37.2-809(E) for the transfer of a person from the initial TDO facility to an "alternative" facility at any time during the TDO period, based upon specified criteria.)

4. The process for finding a psychiatric facility to accept a person under a TDO

Before: Normally, CSB emergency evaluators had to contact psychiatric facilities by phone, usually starting with those located in their jurisdiction and region and sometimes extending statewide, in an effort to find a willing facility. State facilities were under no state statutory obligation to provide a bed. Although DBHDS was in the process of developing a real-time web-based hospital bed registry to ease the search for beds by CSB evaluators, that registry was not online by the time of the 2014 General Assembly session. As discussed in the coverage of

the Governor’s Task Force below, in a small percentage of cases, CSB evaluators were unable to find a bed for individuals within the ECO period. Some of those individuals cooperated with the CSB evaluator and remained available for hospitalization under a TDO even after the ECO had expired, and eventually *were* hospitalized under a TDO despite the lapse of the ECO. However, others, like Gus Deeds, declined to cooperate, did not remain available, and were not hospitalized.

Now:

- a. *Bed Registry:* A web-based Acute Psychiatric Bed Registry is now a requirement of state law under the new Section [37.2-308.1](#) to the Virginia Code. The law requires “real time” updates from all participating facilities, both private and public. Facilities can post descriptive information such as populations served and the limitations of the facilities’ services and capacities. Community services boards, inpatient psychiatric facilities, public and private residential crisis stabilization units, and health care providers working in an emergency room of a hospital or clinic, or other facility rendering emergency medical care can access the bed registry.

- b. *Notice to the State Facility:* Upon receiving notification of the need for an evaluation under an ECO, the CSB is required to contact the state facility serving the area to inform them that the individual will be transported to their facility upon the issuance of a TDO if an alternative facility cannot be identified by the expiration of the 8 hour ECO period. Once the evaluation is done, the CSB must give information about the individual to the state facility so it can determine the services the individual will need if admitted there. The state facility may search on its own for an alternative facility, including another state facility, for placement under a TDO. If it succeeds in finding an alternative facility, the state facility notifies the CSB, which then designates the alternative facility on the preadmission screening report. [see §§ [16.1-340.1](#).D. and [16.1-340.1:1](#) (minors), and §§ [37.2-809E](#) and [37.2-809.1](#) (adults)]. Even if the ECO period ends and the state facility must accept an individual under a TDO, the state facility and the CSB may continue to seek an alternative temporary detention facility for an additional 4 hours following admission. [see §§ [16.1-340M](#) (minors) and [37.2-808N](#) (adults), both of which are currently set to expire on June 30, 2018].

- c. *Transfer to an alternative willing facility even after initial TDO placement in a facility:* Section [37.2-809\(E\)](#) authorizes transfer of a person to an alternative willing facility at any time during the TDO period “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.” The CSB must provide notice to the court clerk of the name and address of the alternative facility and must include that information in the preadmission screening report that is submitted to the special justice at the involuntary commitment hearing.

5. The maximum TDO period pending the involuntary commitment hearing

Before: 48 hours for adults (or next business day for weekends and holidays); for juveniles, it was, and remains, 96 hours

Now: 72 hours for adults (or next business day for weekends and holidays) [see [§37.2-814](#)]

6. Notification of Rights

Before: There was no specific provision in the Virginia Code to ensure that a person subject to a detention and commitment process was informed about the nature of that process and the person's rights within it.

Now: An adult taken into emergency custody or temporary detention must be given a written explanation of the process and the statutory protections for the individual that are associated with that process [see §§[37.2-808L](#) and [37.2-809E](#)].

7. Transportation to carry out TDO

Before: A magistrate had to designate the law enforcement agency in the jurisdiction where a person under a TDO was *residing* to transport that person to a facility under a TDO. The only exception was when the "nearest boundary of the jurisdiction" in which that person was *residing* was "more than 50 miles from the nearest boundary of the jurisdiction in which the person is *located*". (emphasis added) In that case, the magistrate could designate the law enforcement agency in the jurisdiction in which the person was *located* to transport the person.

Now: The magistrate has the additional option of designating "any other willing law enforcement agency that has agreed to provide transportation." [see Section [37.2-810](#)].

8. Commitment Hearing and Gun Ownership

Before: Virginia Code Section [18.2-308.1:3](#) prohibits a person from purchasing possessing *or transporting* a firearm if that person was involuntarily committed to a psychiatric hospital *or* was subject to a TDO and then voluntarily entered a psychiatric hospital. Virginia Code Section [37.2-814B](#) required the special justice to advise a person at the beginning of a commitment hearing that he or she had the right to apply for voluntary admission *but* that to do so meant the person would be prohibited from possessing or purchasing a firearm. The code section did not mention the prohibition on *transporting* a firearm.

Now: The special justice is now required to inform the person that the person (if he or she has the capacity) has the right to apply for voluntary admission *but* that, if the person chooses to be voluntarily admitted, the person will be prohibited from possessing, purchasing *or transporting* a firearm [see [Section 37.2-814B](#)].

9. Mandatory Outpatient Treatment (MOT)

Monitoring CSB acknowledges receipt of MOT order

Before: Section [37.2-817I](#) required a local CSB responsible for monitoring a person who was under a Mandatory Outpatient Treatment (MOT) order to acknowledge that it had received a copy of the MOT order, but the code did not require that the acknowledgement occur within any specific time frame.

Now: The CSB ordered to provide monitoring under an MOT order must now acknowledge receipt of the MOT order within five business days of receiving it.

CSB transfer of monitoring responsibility when person moves

Before: Section 37.2-817J required that, when a person who was being monitored by a local CSB under a mandatory outpatient commitment order, the CSB remained responsible for such monitoring even after the person moved to a locality that was served by another CSB, *until* the CSB in the person's new locality acknowledged (1) the transfer of monitoring responsibilities to it, and (2) receipt of the order of transfer from the person's original committing court. The statute did not require that this acknowledgement occur within any specific time frame.

Now: A CSB receiving a transfer of MOT supervision from another CSB is now required to acknowledge the transfer of monitoring and receipt of the court order within 5 business days [see Section [37.2-817J](#)].

10. *Filing Commitment Orders with the Clerk of the Court*

Before: Virginia Code Section 37.2-819 required court clerks to promptly forward to the CCRE both commitment orders and certifications of voluntary hospitalization by persons who were the subjects of TDOs. However, this section did not create any obligation on the special justices or judges to get these documents to the court clerks within any period of time.

Now: A judge or special justice must now file with the clerk commitment orders for involuntary admission and mandatory outpatient treatment, and documentation of voluntary admissions after a TDO, as soon as practicable but no later than the close of business on the next business day following completion of the hearing [see Section [37.2-819](#)].

11. *Annual Report by DBHDS*

DBHDS must submit a report by June 30 of each year to the Governor and Chairmen of House Appropriations and Senate Finance "on the implementation" of [Senate Bill 260](#). The information in the annual report must include:

- Number of notifications of individuals in need of facility services by CSBs,
- Number of alternative facilities contacted by CSBs and state facilities, and
- Number of temporary detentions provided by state facilities and alternative facilities, the lengths of stay, and the cost of the detentions.

B. Ongoing Studies Mandated by the 2014 General Assembly

1. *On the role of law enforcement in the involuntary commitment process*

Both [Senate Bill 260](#) and [House Bill 478](#) direct the Governor's Task Force on Improving Mental Health Services and Crisis Response (discussed below) to do the following by October 1, 2014:

- a. “identify and examine issues related to the use of law enforcement in the involuntary admission process”, and
- b. “consider options to reduce the amount of resources needed to detain individuals during the emergency custody order period, including the amount of time spent providing transportation throughout the admission process.”
Options to include:
 - (i) developing crisis stabilization units in all regions of the Commonwealth, and
 - (ii) contracting for retired officers to provide needed transportation.

2. On CSB evaluators

Both [Senate Bill 261](#) and [House Bill 1216](#) require DBHDS to:

- a. “review the requirements related to qualifications, training, and oversight of” CSB evaluators of persons held under ECOs,
- b. “make recommendations for increasing qualifications, training, and oversight” of those evaluators, and
- c. report its findings to the Governor and General Assembly by December 1, 2014.

3. On the entire mental health services system in Virginia

[Senate Joint Resolution No. 47](#) (SJ 47) establishes a joint subcommittee “to study mental health services in Virginia in the twenty-first century.” The subcommittee, consisting of 5 members of the Senate and 7 members of the House of Delegates, was tasked to do the following:

- a. Review and coordinate with the work of the Governor’s Task Force on Improving Mental Health Services and Crisis Response (discussed below).
- b. Review the state laws governing the provision of mental health services, including civil commitment laws.
- c. Assess the systems of publicly funded mental health services, including emergency, forensic, and long-term, *and* services in jails and juvenile detention facilities.
- d. Identify gaps in services and types of facilities and programs needed for mental health care in this century.
- e. Recommend statutory or regulatory changes needed to improve access to services, quality of services, and outcomes for individuals.

Some key Senate Joint Resolution 47 findings:

Inadequate community resources: The Resolution is notable in acknowledging that, despite Virginia’s long-term commitment to community-based care and access to emergency mental health services “without delay”, the resources available to localities to realize that commitment have not kept pace with demand, while, at the same time, the number of state psychiatric hospital beds available to treat people has continued to shrink, leaving gaps in services that have not been filled by either the private or public sector.

Incarceration vs. treatment of people with mental illness: The Resolution is also notable for acknowledging that “a significant number of persons with mental illness commit various offenses, in many cases minor, nonviolent offenses, and are arrested by law-enforcement officers, brought before the

courts, and held in jails or juvenile detention facilities rather than being provided with the necessary treatment in the most appropriate setting in order to prevent their entry into the criminal justice system.” In addition, it notes that the Commonwealth has provided financial incentives to localities to build jails and juvenile detention centers, while it has provided no similar incentives for the construction of facilities to treat persons with mental illness, and that other regulatory requirements and financial incentives may have created the unintended consequence of increasing the involvement of people with mental illness in the criminal justice system.

The SJ 47 joint subcommittee’s work is intended to be comprehensive, with the committee submitting an Interim report by December 1, 2015, and a final report by December 1, 2017. The joint subcommittee has met four times, either as a body or through one of its three workgroups (Crisis Intervention, Continuum of Care, and Special Populations), with the most recent meeting being on December 16, 2014, when it reviewed and approved the recommendations of the Governor’s Task Force on Improving Mental Health Services and Crisis Response (discussed below). The agendas, materials and minutes of the joint subcommittee are being maintained by the Division of Legislative Services, which is providing support functions for the subcommittee. Those materials, which can be found on [this DLS page](#), are full of excellent information, and will be reviewed in a future issue of the DMHL.

The Governor’s Response: The Task Force on Improving Mental Health Services and Crisis Response

A. Executive Order 12: Creation of the Governor’s Task Force

The “Governor’s Task Force on Improving Mental Health Services and Crisis Response,” was established by Governor McDonnell, and renewed by Governor McAuliffe, through [Executive Order 12](#). The Task Force, chaired by Lt. Governor Northam and co-chaired by HHR Secretary Hazel and Public Safety and Homeland Security Secretary Moran, was directed by the order not only to examine the gaps in services and procedures that directly contributed to the Deeds tragedy, but also to look at what the entire mental health services system needed to help prevent similar crises.

Areas for Task Force review:

The order directed a review of 10 specific areas in mental health services:

1. System protocols and procedures
2. Crisis services
3. Emergency custody and temporary detention periods
4. Telepsychiatry
5. Cooperation among courts, law enforcement and mental health systems
6. Veterans, service members and their families
7. Public and private psychiatric bed capacity
8. Early intervention and ongoing supports
9. Families and loved ones
10. Mental health workforce development

Task Force membership and organization:

The Task Force had 43 members ([listed here](#)), with representatives from the mental health field, law enforcement, the judicial system, and private hospitals, and also included individuals receiving services, and family members. The Task Force as a body met five times from January to August 2014, and established the following subgroups that met independently and reported findings and recommendations to the Task Force:

- Workgroup on Crisis Response ([roster](#))
- Workgroup on Ongoing Treatment and Supports ([roster](#))
- Workgroup on Public Safety ([roster](#))
- Workgroup on Technical and Data Infrastructure ([roster](#))
- Subgroup on Workforce
- Subgroup on Family/Loved Ones

Task Force Report:

The [Task Force report](#) to the Governor, dated October 1, 2014, included 25 recommendations across three dimensions: to expand access to services, to strengthen administration, and to improve the quality of care.

Task Force Meetings, Minutes and Materials: Important Information and Debate

The meetings in which the Task Force recommendations were developed involved a number of presentations by speakers across different professions, which provided significant information and insights into the history of mental health care and mental health reform in Virginia. The minutes of the subgroup and Task Force meetings show that the discussions among Task Force members were substantive and challenging. They reveal not only an awareness among these members of the needs of persons with serious mental illness in achieving recovery and stability and managing mental health crises, but also an awareness of the needs of the currently inadequate behavioral healthcare system in serving these individuals.

The materials and minutes of the meetings, can be found by going to [this page](#) on the DBHDS website. Unfortunately, at this time those materials and minutes can be accessed only by clicking on the “Materials” heading for each meeting of the Task Force, and scrolling through a long PDF that holds many different documents. Sometimes articles and minutes and other documents are not stored where you might expect them. This article will attempt to make these materials more accessible by identifying and summarizing specific presentations and deliberations in the narrative below, and providing links and/or directions to the Task Force materials. They are worth seeking out and reviewing. There is important information, and there are important debates on these pages.

First Task Force Meeting: January 7, 2014

The agenda for the January 7 meeting can be found on [the DBHDS Task Force page](#), by clicking the “Meeting Materials” link on that page under January 7, 2014. The minutes of that meeting can be found by clicking the “Meeting Materials” link for the January 28 meeting.

The January 7 meeting included the following nine presentations (which can be found by clicking the “Meeting Materials” link for the January 7 meeting on the [DBHDS Task Force page](#); the pages on which each presentation appears are noted below):

1. Overview of Virginia’s Behavioral Healthcare System and History of its Reform Efforts (pp. 5-29) - Presentation by then-DBHDS Commissioner James Stewart, III

Commissioner Stewart set out an overview of key milestones in the organization and delivery of behavioral health care services in Virginia:

- **Prior to 1960s** – Long-term (lifelong) state hospital care was norm for many individuals with mental illness and for others.
- **Early 1960’s** – Census of all state hospitals exceeded 11,500 with 4,800 at Central State Hospital (1962), 2,400 at Eastern State Hospital (1964), and 3,000 at Western State Hospital (1965)
- **1963** – Federal Community Mental Health Centers Act (enabling construction and staffing of multi-service CMHCs)
- **1968** – Virginia legislation establishing the local community services board system.
- **1980** – U.S. Congress passed Civil Rights of Institutionalized Person Act (CRIPA), which provides for protection from harm, access to active treatment, discharge when ready
- **1990** – U.S. Congress passed the Americans with Disabilities Act (ADA), which prohibits discrimination, and ensures equal opportunity for persons with disabilities in employment, public services, public accommodations, etc.
- **1990** – Medicaid reimbursement for adult/child psychiatric rehabilitation services and targeted case management available for public CSBs
- **1992-98** – U.S. Department of Justice investigations of state hospitals and settlement agreements focused on quality of services in facilities
- **1995** – Medicaid managed care of outpatient and inpatient services (including mental health) – Medallion I (excluded rehabilitation services)
- **1999** – U.S. Supreme Court *Olmstead* decision ruled public entities must provide community-based services to persons with disabilities when specific criteria present
- **2000** – DBHDS establishment of Local Inpatient Purchase of Service (LIPOS) program to facilitate admissions to private hospitals for acute psychiatric treatment
- **2000** – Medicaid reimbursement for psychiatric rehabilitation services for adults and children opened to private providers
- **2003** – President’s New Freedom Commission on Mental Health envisions future in which “everyone with mental illness will recover”
- **2013** – Medicaid psychiatric rehabilitation services placed in managed care (Magellan)

Commissioner Stewart also identified the repeated studies of the state’s behavioral healthcare system since 1949, and noted that the major recommendation made in *all* of those studies was the same: “Virginia needs to expand its capacity to serve individuals in their own communities with coordinated behavioral health and developmental programs and supports”:

- **1949** – Report by Gov. Tuck’s Chief of Staff Charles Duke Jr.

- **1965** – The Virginia Mental Health Study Commission, chaired by Sen. Willey
- **1972** – The Commission on Mental Indigent and Geriatric Patients, chaired by Sen. Hirst
- **1980** – The Commission on Mental Health and Mental Retardation, chaired by Del. Bagley
- **1986** – The Commission on Deinstitutionalization, chaired by Sen. Emick
- **1996-1998** – The Joint Commission Studying the Future Delivery of MH, MR and SA Services, chaired by Sen. Gartlan and Del. Hall
- **1999** – Gov. Gilmore Commission on Community Services and Inpatient Care
- **2006 – 2011** – Supreme Court Commission on MH Law Reform
- **2007** – Gov. Kaine’s Virginia Tech Review Panel
- **2013** – Gov. McDonnell’s Taskforce on School and Campus Safety (Mental Health Workgroup)

Commissioner Stewart’s presentation also provides an explanation of the state’s community services board system and the state operated behavioral health facilities (which now have a total of fewer than 1,200 patients, in contrast to a total of almost 12,000 in the early 1960’s). It describes the budgets and funding streams for both community-based and facility services, the various community-based programs (both those “mandated” by statute and those that are “non-mandated”) provided by the local community services boards, including the “crisis intervention services continuum”, and the set of services recommended for enabling a person with serious mental illness to achieve and maintain recovery.

Two key observations from Commissioner Stewart’s presentation, as set out in the minutes for the January 7 meeting:

- a. “Due to the inadequate capacity of ongoing treatment and support services, the crisis response network has often become the default system.”
- b. “Very little new funding has been targeted to improving the ongoing treatment and support services,” with increases in funding in the early 2000’s being retrenched by budget cuts during the recessionary years starting in 2008.

2. Overview of Virginia Civil Commitment Law (pp. 30-45) - Presentation by Senior Assistant Attorney General Allyson Tysinger, OAG

Ms. Tysinger’s presentation set out the laws in Virginia that governed the commitment process prior to the amendments enacted by the 2014 General Assembly; they were the provisions in effect at the time of Gus Deeds’ crisis and death in November of 2013.

3. Clinical Issues in the Prevention of Psychiatric Crises and the Provision of Crisis Response Services - Presentation by Jack Barber, M.D., DBHDS Medical Director

There were no materials linked to Dr. Barber’s presentation, which, according to the minutes, highlighted the following:

- a. 50% of the people seen in crisis by Community Services Board (CSB) emergency evaluators had never been seen by the CSB before. In these cases, evaluators had to assess the person’s risk of harm without any information about this person’s history. Dr. Barber noted that assessing risk is difficult, and that a person’s history is one of the best predictors of future behavior.

b. Proper management of state hospital bed resources is “critical” to assuring that beds are available when needed. (See below the criticism of that management in the presentation by Mr. Bevelacqua later in the same meeting).

c. Medical screening is necessary to assure that a medical event is not obscured by a psychiatric disorder and that the receiving facility can provide the medical care needed by the individual in crisis.

4. Overview of the New Managed Care Initiative for Behavioral Health Care Coordination for Medicaid Enrollees (pp. 46-60) - Presentation by Karen Kimsey, Deputy Director of Complex Care and Services, Virginia Department of Medical Assistance Services (DMAS), and William Phipps, LCSW, General Manager, Magellan of Virginia

Some of the highlights from this presentation included the following:

In May of 2013, Magellan of Virginia was awarded a contract by DMAS, implemented on December 1, 2013, to act as the “Behavioral Health Services Administrator (BHSA)” to improve coordination of behavioral health services (which constitute 9% of the state’s Medicaid budget).

The contract is an ASO (Administrative Services Only) Model, with a contract term of three (3) years, with an option to extend for two (2) more years.

New Program Features:

- A 24/7 centralized call center to provide eligibility, benefits, referral and appeal information to members and providers;
- Member assistance: Crisis calls, referral, information, outreach and education;
- Provider recruitment, credentialing, issue resolution, network management, and training;
- Quality Assurance, Improvement and Outcomes program;
- Care Management Services: care coordination, interface with MCOs (Managed Care Organizations), appropriate care, timely access; and
- Quality Care Initiatives: psychotropic medication and peer support program.

BHSA Objectives:

- Improve timely access to quality behavioral health services – helping members in need get the right care at the right time;
- Improve health outcomes for members;
- Ensure efficient utilization of services;
- Develop quality and outcome measures; and
- Promote member engagement.

Stakeholder Engagement:

- Provider & Community Stakeholder Forums/Sessions;
- 12 sessions held across the Commonwealth in September 2013; and
- 10 Member sessions held across the Commonwealth in November 2013 in partnership with NAMI (National Alliance on Mental Illness) & VOCAL (Virginia Organization of Consumers Asserting Leadership).

Stakeholder Meetings:

- Weekly meetings with provider associations (Virginia Association of Community Services Boards [VACSB] & private provider associations);
- Twice weekly meetings with consumer advocacy groups; and
- Weekly all-provider calls to provide program updates & Q/A.

Partnership with VACSB & CSA (Comprehensive Services Act):

- Current VICAP (Virginia Independent Clinical Assessment Program) process in effect without change through 6/30/14; and
- Dedicated clinical liaisons to CSBs and CSA regions.

5. The Role of Law Enforcement in Mental Health (pp. 61-65) - Presentation (link) by John W. Jones, Executive Director of the Virginia Sheriffs' Association

Mr. Jones reported that local and regional jails were housing approximately 30,000 inmates per day. Of these, 6,000 were in need of mental health services, with over 3,000 being in *serious* need of mental health services. These individuals were a “significant drain” on Sheriff’s Office resources in all localities.

The recommendations from the Virginia Sheriffs’ Association to the Task Force included the following:

- Survey all law enforcement agencies to determine the “true impact” of responding to mental health crises (For example: how many ECO’s and TDO’s were being issued; how many officers were involved; how much time was consumed);
- Establish an automated system to readily identify available beds;
- Find additional beds to relieve the jails and provide 50% construction reimbursement cost and staff appropriately, in lieu of 50% construction reimbursement costs for regional jails; and
- Drop off centers work well and need expanding.

6. The Impact of Mental Health Crisis on Law Enforcement (pp. 66-73) - Presentation (link) by Dana Schrad, Executive Director, Virginia Association of Chiefs of Police & Virginia Association of Campus Law Enforcement Administrators

Some of the key recommendations from Ms. Schrad focused on the need to *remove* law enforcement from the duty of transporting people in mental health crisis (an activity that removes officers from their normal duties and imposes uncompensated costs on local agencies) whenever possible, with training for medical transport providers to be able to effectively provide that transportation. Ms. Schrad also noted the need for funding to improve access to training for law enforcement in responding to people in mental health crisis and to their families.

She stressed that the mental health transportation burden on local law enforcement is significant. Though safety is served, transportation by law enforcement officers adds to the stress experienced by the individual and his or her family, especially when it involves being transported in handcuffs by a uniformed officer in a marked vehicle.

7. Untitled Presentation on Failures of the Emergency Mental Health Response System in Virginia (pp. 74-80) - Presentation by Douglas Bevelacqua, former Director of the Behavioral Health and Developmental Services Division of the Office of the State Inspector General

Highlights from Mr. Bevelacqua's presentation included the following:

The "streeting" of people in mental health crisis: Mr. Bevelacqua reported that the term "streeted" "was used to describe a person who had been evaluated and found to meet criteria for temporary detention" but who, "instead of being admitted to a psychiatric hospital for further evaluation," was "released without the clinically indicated intervention."

The documentation of "streeting" in 2011: ...a three-month statewide study (link) of the state's 40 CSBs that was conducted by the OIG with DBHDS found that, between July and October of 2011,

72 individuals (1½%) meeting criteria for a TDO were denied access to the clinically indicated inpatient psychiatric treatment. In addition, the study found that 273 individuals (5½%) were granted detention orders, but only after the six-hour time limit imposed by the Code of Virginia had expired. These and other findings, along with 13 recommendations, were published in the OIG Review of Emergency Services, Report No. 206-11, dated February 28, 2012.

This means that almost 1,400 people a year could be expected to either be denied access to clinically appropriate care or granted a TDO after the six hour time limit. Not to put too fine a point on it, but based on this review, every day three to four people will experience this outcome in the Commonwealth.

A 2013 study by the University of Virginia (UVA), Institute of Law, Psychiatry and Public Policy (included in the Task Force materials for the January 28 meeting, found [here](#), at pages 18-29), "documented marginally 'worse'" results than the 2011 OIG findings. The UVA study found that a TDO was issued for 96.5% of the individuals meeting TDO criteria and that 95.2% of persons recommended for a TDO "were eventually admitted to a mental health facility."

The bed capacity issues in the state psychiatric hospitals that contribute to the "streeting" of people in crisis: While emphasizing that Virginia's community-based behavioral health programs, including permanent supported housing, are under-funded, "system inefficiencies" also make the problem worse,

As the Commonwealth's public sector system has been operating, at least 10% of the state facility beds are occupied by people who could be discharged into the community and approximately 20% of the operating capacity went unused on September 12, 2013, [with the result that state facilities were refusing to admit] people in need of acute care for temporary detention[due to lack of capacity when they should have had beds available for these individual].

Jails as a current alternative to psychiatric hospitals: Since 2008, the number of individuals identified with mental illness in jails has increased by 30%, from 4,879 to 6,322. Each year, several thousand people with mental illness move among community-based programs, state-operated behavioral health facilities, and local or regional jails.

Reimbursement issues and the burden on private psychiatric hospitals — private hospital refusals to accept some individuals for a TDO, and premature hospital discharge of others:

If the regional state facility creates barriers to admission and there is no clear path to reimbursement for services rendered, it should come as no surprise that some private providers will avoid admitting a person under a TDO who might require long-term treatment—treatment for which they [the private providers] may not be paid....

Another preventable human tragedy waiting to happen in the Commonwealth will occur when a person is released from a private psychiatric facility after a brief period of hospitalization for acute symptoms, with a discharge summary reflecting that, “this person has received maximum benefit from this hospitalization.

The unspoken part of this discharge summary will be that the state-operated facility has denied admission for the patient and the private provider has no reimbursement path for the continued hospitalization of this individual. When the transfer of patients to state-operated facilities for long-term care is not an option, private providers must choose between either not being paid for services or discharging the individual.

“The core value that should drive all responses to persons in mental health crisis”:

According to Mr. Bevelacqua, “...the solutions to streeting are straightforward but, to be effective, all solutions will require consensus around a core value. ...**That core value is that every person with mental illness, who is evaluated by a preadmission screener and determined to meet criteria for a TDO, is admitted to a psychiatric facility....**”

Changes to address the problem: Mr. Bevelacqua proposed a number of specific changes to the Virginia Code and to system practices and procedures to address the problem of streeting, including:

- require private psychiatric facilities to promptly update their bed status in the statewide Bed Registry as a condition of continued licensing;
- designate “bed brokers” at state facilities to work with local emergency evaluators in identifying available hospital beds;
- remove the requirement that the TDO specify the facility where the person will be placed under the TDO;
- allow re-issuance of an ECO after its initial expiration; and
- authorize and require the Commissioner of DBHDS to designate a state facility for placement of a person who meets the criteria for a TDO if a private facility cannot be identified.

(Note: To date, new laws and new procedures have done much of what Mr. Bevelacqua recommended. However, even under the laws and procedures enacted by the 2014 General Assembly, if a person is not under an ECO but meets the criteria for a TDO, state hospitals are under no legal obligation to accept that person, even if a private bed cannot be found, and a TDO cannot be issued for that person until a hospital for that person’s temporary placement can be identified in the TDO. Mr. Bevelacqua did not suggest any reforms to address the problems he identified with (1) the inability to discharge patients who no longer meet criteria for hospitalization, and (2) the under-utilization of hospital capacity, or (3) the reluctance of private hospitals to accept patients in crisis because of fears of being unable to find a community facility to accept them once they were stabilized.)

8. Governor’s Budget for the Behavioral Health System and Secretary of HHR Recommendations for Improved Mental Health Crisis Response (pp. 81-84) - Presentation by John Pezzoli, DBHDS Assistant Director for Behavioral Health Services

Mr. Pezzoli’s presentation described the additional funds being sought in order to improve and expand services across several dimensions, including: expanding bed capacity in state hospitals, and expanding the capacities of crisis intervention teams and assessment centers, PACT programs, outpatient mental health and substance abuse treatment programs.

9. HHR Recommendations for Changes Affecting the Civil Commitment Process (pp. 85-90) - Presentation by John Pezzoli, DBHDS Assistant Director for Behavioral Health Services.

Mr. Pezzoli noted that the Governor's budget recommendations were based upon effecting the following recommended changes related to the civil commitment process:

Virginia Code changes regarding mental health crisis response:

1. Clarify responsibility for notifying local CSB when ECO is issued, when an ECO has been executed by an officer, and where the person needing pre-screening is located,
2. Allow the ECO period to extend beyond 6 hours when person has been found to meet TDO criteria but hospital bed has not been found, and
3. Possibly remove requirement to name hospital for person's placement in TDO.

Changes regarding pre-screening procedures and resources:

1. Assess the need for secure assessment sites and establish where needed,
2. Complete and make operational the statewide psychiatric Bed Registry,
3. Enhance the quality and availability of electronic conferencing and information exchange and expand tele-medicine,
4. Complete and implement new guidelines for medical screenings for persons in mental health crisis,
5. Clarify the roles and relationships of crisis stabilization units and state hospitals in caring for a person in crisis,
6. Clarify when it is appropriate to contact the state hospital about admission, and
7. Expand the capacity to provide diversion services to prevent hospitalization of persons in crisis.

Changes regarding system-wide services:

1. Study the statewide need for services for early identification of, and services for, mental health problems in children and young adults,
2. Find appropriate and timely community placements for people in the hospital who no longer meet hospital criteria, and
3. Increase cooperation and collaboration among agencies involved in emergency response.

First Workgroup Meetings: January 24, 2014

The Task Force workgroups all gathered at the Richmond Public Library on January 24, 2014, dividing into their separate workgroups after a plenary session, with the task of developing a set of recommendations for consideration by the Task Force as a whole. Those initial recommendations were shared in plenary session before the meeting adjourned. The agenda for the meeting can be found [here](#). The minutes for all four work groups can be found [here](#), with each set of minutes located on this link as follows:

Crisis Response – pages 1-4

Ongoing Treatment & Supports – pages 5- 8

Public Safety – pages 9-12

Technical & Data Infrastructure – 13-16

What is notable from a review of the recommendations is the general consensus around the following:

1. *The ECO period*: extend the ECO period to 8 hours, and ensure that a CSB is notified immediately when ECO is executed.
2. *Pre-admission intervention and screening*: expand the use and training of Crisis Intervention Teams (CIT) statewide, including the creation of CIT “secure assessment sites”, and expand awareness and training for electronic pre-admission screenings (authorized under Section 37.2-809) to facilitate their timely completion.
3. *The TDO period*: extend the TDO period to 72 hours.
4. *Community prevention and treatment services*: expand and enhance the capacity to provide services to prevent and divert mental health crises.
5. *Ongoing services and supports following crisis and hospitalization*: adequately fund the Discharge Assistance Program (DAP) and other initiatives to enable the discharge of persons once they are stable and to help them remain stable in the community.
6. *Communication and collaboration among different agencies and institutions involved in working with persons in crisis*: address key barriers, including problems with information-sharing due to (misunderstanding of) confidentiality requirements, and different mandates governing actions of different agencies.

Second Task Force Meeting: January 28, 2014

The agenda of the January 28 Task Force meeting can be found [here](#). The minutes can be found on the [DBHDS Task Force page](#), by clicking the link for “Meeting Materials” of the April 10, 2014 Task Force meeting (pages 2-6). The bulk of the meeting involved a review and discussion of the recommendations of the four workgroups from their January 24 meetings, and adoption by the Task Force of a set of preliminary recommendations.

The following two presentations were made at the January 28 meeting (and can be accessed by going to the DBHDS page for the Task Force [here](#), and clicking the “Meeting Materials” link for the January 28 meeting):

1. Regional Protocol Revisions to “Find a Bed” for Individual Requiring TDO (pp. 8-37) - Presentation by Dr. Jack Barber, Medical Director, DBHDS

Dr. Barber noted that DBHDS recognized that in approximately .5% of emergency evaluations (conducted under an ECO) where the person *did* meet the criteria for a TDO, *no* psychiatric bed was found, so that a TDO was *not* issued for that person because the ECO period expired; and that in 3.7% of the cases in which TDOs *were* issued, the TDO actually was not issued until *after* the expiration of the 6-hour ECO period. Those individuals, like Gus Deeds, could have insisted on leaving at the end of the ECO period, but did not, and were eventually hospitalized under a TDO. [Note: These statistics leave out another group of people in crisis who were cited by Mr. Bevelacqua in his earlier presentation:

those who are in crisis and who meet the criteria for a TDO, but who are not subject to an ECO (for example, individuals who have come to the ER on their own, or were transported there by family, while in crisis).]

Each region was developing new protocols for handling ECO and TDO cases, pursuant to guidelines issued by DBHDS on January 15, 2014: “**Guidelines: Required Protocol Elements for State Hospitals, CSBs, Private Hospitals.**” (Those regional protocols can now be seen [here](#) on the DBHDS website.) Dr. Barber noted that “the regions are all different, so the protocols need to take into consideration the circumstances of each region.” Each region, however, was expected to comply with the DBHDS guidelines, which would be enforced through the annual contracts between DBHDS and the local community services boards.

The DBHDS guidelines require the following steps:

- Step 1-** CSB emergency evaluator evaluates person and determines if TDO is necessary.
- Step 2-** CSB arranges for necessary medical screening according to clearly established regional hospital requirements.
- Step 3-** Using bed registry and other contacts, CSB begins contacting private hospitals in the area according to regional protocols.
- Step 4-** If it appears likely that the community hospital bed search will not be successful before the ECO expiration, CSB alerts state hospital director (or designee).
- Step 5-** If state hospital director is satisfied protocols are complete and person’s needs can be met (medical clearance), an admission is arranged at the primary hospital.
- Step 6-** If the primary hospital does not have an appropriate bed, the primary hospital director seeks a bed from sister state hospitals.
- Step 7-** If bed cannot be found in a reasonable time at another state hospital, the primary hospital director will contact the Assistant Commissioner for Behavioral Health or designee to find a bed if available in the state hospital system.
- Step 8-** If necessary Central Office will direct admission at a state hospital.
- Step 9-** DBHDS staff will develop a process to monitor and track outcomes with CSBs, private hospitals, state hospitals, the use of bed registry data, and to introduce continued quality improvement based on data and experience.

Information was also provided on the Acute Care Psychiatric Bed Registry.

2. Suzanne Gore, Deputy Secretary of HHR (*presentation in meeting minutes only*)

Ms. Gore reviewed the provisions of Senator Barker’s Omnibus bill.

Review of Workgroup Recommendations and Adoption of *Initial Recommendations*

Following presentation of the recommendations of each of the work groups, the Task Force adopted the following initial recommendations (which can also be found [here](#) on the DBHDS Task Force page):

1. A 12-hour ECO period, with tiered levels of notification every four hours:
 - (a) at 4 hours, CSB emergency evaluator notifies the state hospital for the region if person appears to meet TDO criteria but no bed has been found;
 - (b) at 8 hours if neither the CSB evaluator nor the state hospital can locate a bed, DBHDS Central Office shall be notified, and may assist in the bed search;

(c) as a safety net, the state hospital serving the region will ultimately be designated as the facility of temporary detention if a private bed cannot be located.

2. Extend the period of temporary detention from the current 48 hours to 72 hours with a minimum period of 24 hours prior to a commitment hearing.
3. The law enforcement agency that executes the emergency custody order must notify the applicable community services board upon execution.
4. Endorse the Governor's budget for new mental health funding, with understanding that it is still not substantial enough to make a significant, positive impact on the system. More funding would need to be included in the future.
5. Expand secure assessment centers (drop-off centers) and crisis stabilization units for children and adults across the Commonwealth as the highest priorities for funding.
6. Expand access to tele-psychiatry.
7. Expand funding for CIT training for law enforcement officers throughout the Commonwealth.
8. Include a two-year sunset clause on its recommendations to ensure that any new laws are meeting the needs of the Commonwealth.

Second Workgroup Meetings: March 19, 2014

The Task Force workgroups all gathered for a second time at the Richmond Public Library on March 19, dividing into their separate workgroups after a plenary session, with the task of further developing their recommendations for consideration by the Task Force as a whole. (The day's agenda, and the tasks for each work group, can be found [here](#).)

The recommendations of each work group can be found on the [DBHDS Task Force page](#) under the "Meeting Materials" for the April 10, 2014 meeting of the Task Force, as follows:

Crisis Response – p. 66

Ongoing Treatment & Supports – p. 67

Public Safety – p. 68

Technical & Data Infrastructure – p. 69

The minutes of each work group from March 19 can be found on the [DBHDS Task Force page](#) under the "Meeting Materials" link for the May 21, 2014 meeting of the Work Groups, as follows:

Crisis Response – pp. 15-20

Ongoing Treatment & Supports – pp. 5-8

Public Safety – pp. 2-4

Technical & Data Infrastructure – pp. 9-14

Each group also established Work Plans, which can be found on pages 25-30 of the same Meeting Materials section.

What is notable from a review of the recommendations developed by each of these groups is the general consensus around the following:

1. Reduce the role of law enforcement in mental health crisis intervention: look in particular at ways to support alternatives to law enforcement transport of individuals, especially for TDO placement.
2. Enhance pre-admission intervention and screening: expand the use and training of Crisis Intervention Teams (CIT) statewide, including the creation of CIT “secure assessment sites”, and expand awareness and training for electronic pre-admission screenings (authorized under Section 37.2-809) to facilitate their timely completion.
3. Expand community prevention and treatment services: recognize the need for greater availability of outpatient mental health services and easier access to those services (“no wrong door” concept) as best way to reduce crises; improve public awareness of mental health services and available options to avoid or address crises; support statewide adoption of best practices—advance care planning (including advance directives); Peer to Peer; Mental Health First Aid; permanent supportive housing; integrated primary care teams.
4. Improve ongoing services and supports following crisis and hospitalization: adequately fund the Discharge Assistance Program (DAP) and other initiatives to enable the discharge of persons once they are stable and to help them remain stable in the community.
5. Improve communication and collaboration among different agencies and institutions involved in working with persons in crisis: address key barriers, including problems with information-sharing due to (misunderstanding of) confidentiality requirements, and different mandates governing actions of different agencies.
6. Use meaningful measures, procedures and technology for data collection to assess effectiveness: measures and data needed to determine the success of the following: the online bed registry; the extension of the emergency custody order period; crisis stabilization, hospital diversion, secure assessment sites, acute inpatient treatment, state hospital specialized care, other crisis response and ongoing services (PACT, outpatient, case management, etc.).
7. Improve services and skills for working with special populations:

Over 65: Facilities serving individuals over the age of 65 are not used to having to accept rapid admission and this will need to be addressed.

Individuals with Medical/SA issues: There is currently a concern among state facilities regarding individuals with medical conditions that may exceed the medical capability of the state facility. The question of medical stability continues to be an issue when physicians or facilities are not in agreement about the suitability of admissions based on medical needs and lab results.

Children: There are insufficient inpatient children’s services statewide. (Also see the memorandum to the Task Force from Joseph Trapani, a Task Force member and CEO of Poplar Springs Hospital, on

the shortage of acute psychiatric beds for children and adolescents and the impact of the Certificate of Public Need (COPN) process, and of various regulatory restrictions, on that shortage. That memorandum can be found on pages 13 through 15 of the June 21, 2014 “Meeting Materials” on the [DBHDS Task Force web page.](#))

Persons with Intellectual Disability (ID): A number of these individuals present serious aggressive behaviors that do not respond to traditional mental health interventions, in either the community or hospital setting, and they can seriously disrupt a hospital setting. Many facilities are simply unequipped to manage their care.

Individuals with addiction issues: Practices vary from one facility to another in working with individuals who have both a mental health diagnosis and an identified addiction problem.

8. ***Tele-psychiatry and other technology:*** Given the challenges of distance and low resource levels in rural areas of the state, technological resources and capabilities, equipment, training and procedures should be explored to maximize the use of tele-psychiatry and other technology.

Third Task Force Meeting: April 10, 2014

The agenda for the April 10 meeting is on the [DBHDS Task Force page](#), under the “Meeting Materials” link for the April 10, 2014 meeting. The minutes from the meeting can be found in the “Meeting Materials” link for the June 16 meeting of the Task Force.

Some highlights from the April 10 meeting include the following (which are also found under the “Meeting Materials” link for the April 10 meeting, with the page locations cited below):

1. Critical Incident Investigation, Bath County, Virginia, November 18, 2013 (pp. 47-65) - Presentation by Michael F.A. Morehart, State Inspector General

Mr. Morehart’s presentation provided a “timeline overview of the events of November 18 and 19 that began with the issuance of an ECO for Austin (“Gus”) Deeds, based upon the sworn testimony before a magistrate by Mr. Creigh Deeds, and ended the next day with the assault on Creigh Deeds by Gus Deeds and Gus Deeds’ subsequent death.

Issues and recommendations from the OIG:

1. Mr. Morehart noted that the OIG had issued a report and recommendations in February of 2012 ([link](#)) for improving the mental health services response system, and that the DBHDS had not implemented the OIG recommendations from that report. The OIG recommended that, as part of its process of revising its emergency psychiatric hospital admissions policy and procedure, DBHDS include in that process more advocacy groups, such as NAMI, VOCAL, SAARA, the disAbility Law Center, MHAV.
2. Mr. Morehart noted that a key prior recommendation of the OIG – that a web based registry of available psychiatric beds be established – had been carried out on March 4, 2014.

3. Guidelines or standards of practice should be established that ensure that CSB evaluators are notified immediately when an ECO is executed.
4. DBHDS take the lead to create a workgroup to review and recommend standards of practice, training, ongoing recertification requirements, and performance evaluations of CSB evaluators, and provide clear guidance on actions to be taken by CSB evaluators whenever a person determined to meet TDO criteria is about to be released from custody.
5. Because so many CSB evaluators report that much of the 4-6 hour ECO period is taken up with their efforts to find an available psychiatric hospital bed (to the point that evaluators were often referred to as “bed brokers”), consideration should be given to revising Code § 37.2-809 (E) to allow the Preadmission Screening Report to be completed and the resulting TDO to be executed without identifying the receiving facility.

2. Update by Suzanne Gore, Deputy Secretary, Health and Human Resources on General Assembly Legislative and Budget Action (*reflected in minutes*)

Suzanne Gore provided an update on the budget proposals affecting mental health care and the legislative initiatives modifying the ECO and TDO process. Delegate Bell and Senator Hanger also spoke, summarizing General Assembly actions. They noted that the “goal was to reduce the number of unexecuted TDOs, assure notification, and assure state hospital as facility of last resort.”

3. Update on Protocols, Bed Registry and Other Items (pp. 35-41) - Presentation by John Pezzoli, Acting Commissioner Department of Behavioral Health and Developmental Services

Highlights of Mr. Pezzoli’s presentation included the following:

1. *Online Bed Registry Launched March 3, 2014 (the OIG cited March 4 as the launch date):*
 - DBHDS’ partners included Virginia Health Information (VHI), Virginia Hospital and Healthcare Association (VHHA) and community services boards.
 - Provides emergency evaluators with accurate, detailed information for bed availability in Virginia’s public mental health hospitals, private hospitals and crisis stabilization units.
 - Monitoring shows it is being updated daily by both state and private hospitals as required.

2. Medical Screening and Medical Assessment:

Many medical illnesses can create or exacerbate psychiatric symptoms, and complicate clinical presentation.

- Medical screening and assessments help prevent someone from being sent to a treatment facility that cannot adequately manage an illness or condition, exposing the person and the system to the risk of an undiagnosed, undertreated or untreated condition.
- However, screenings and assessments can be difficult to accomplish in a timely, thorough manner in the emergency disposition of individuals with psychiatric disorders.
- DBHDS worked with system stakeholders to provide guidance materials for medical screenings and assessments. Protocol was adopted at all DBHDS facilities and all CSBs April 1, 2014.

The Medical Screening & Assessment Guidance Materials and Medical Capabilities Form can be found online [here](#).

3. *Major Mental Health Efforts by DBHDS Behavioral Health Division:*

Training to CSB, courts and other stakeholders on mental health law reform for the development and implementation of new laws.

- Federal grants for diversion of juvenile offenders with behavioral health issues, homelessness, recovery-based services, and advance directives.
- Interagency services plans for mental health, substance abuse, and children's services.
- Expanding prevention programs, including Strengthening Families, Mental Health First Aid and Suicide Prevention.
- Constructing a new, state of the art Western State Hospital.
- Developing/implementing electronic health records.
- Expanding of Virginia's Crisis Intervention Training programs.
- Building children's MH crisis response and child psychiatry services.
- New peer review inspections at state facilities.

The recommendations from the Task Force work groups (pp. 66 through 69) were presented to the Task Force at the April 10 meeting. No formal action was taken on those recommendations.

Third Workgroup Meetings: May 21, 2014

The Work Groups met in separate sessions in the Monroe Building on May 21, to further hone their recommendations to the Task Force. The minutes and related documents from these Work Group meetings are notable for both the depth and breadth of the discussions regarding ways in which Virginia's overall behavioral healthcare system in general, and its response to persons in mental health crisis in particular, can be improved. They also provide a window on how each Work Group moved toward a set of specific recommendations, which, as in past meetings, had certain common elements, and they reveal some of the continuing areas of tension and disagreement on how best to improve the system of care. Given this, some specific attention is given below to what these minutes reveal about the work of, and ideas in, each group.

The minutes and recommendations of each workgroup can be found on the [DBHDS Task Force page](#) under the "Meeting Materials" link for the Work Group's July 15, 2014 meeting, as follows:
Crisis Response – pp. 30-37

Jim Martinez of DBHDS provided the Work Group with a comprehensive review of the relevant statutory changes enacted by the 2014 General Assembly. The minutes also reflect the following significant discussions, which warrant attention and review:

The fate of patients who are not under an ECO: Dr. Bruce Lo, Director of Emergency Medicine at Sentara Norfolk General Hospital, was not able to attend this meeting but asked by email that the Work Group also "focus on persons who are not necessarily under an ECO but whose situation may lead to a TDO or possibly a voluntary admission and their need for timely disposition just as for those in custody of law enforcement." Significantly, even with this request, neither this nor any other Work Group chose to address this population, and the Task Force did not address them either. Dr. Lo's point, noted

elsewhere in this article, is that, even with the statutory reforms enacted by the 2014 General Assembly, persons who are in mental health crisis and may meet the criteria for a TDO but who are not subject to an ECO (and who often are in a hospital Emergency Department (ED), like the one Dr. Lo supervises, because of a self-referral or a referral by family or others), may have to wait hours before they are seen by an emergency evaluator, and may have to wait *days* before a psychiatric bed can be found for them. Other patients in the ED may be in genuine mental health crisis and be appropriate for psychiatric hospitalization – and not appropriate for return home – but are not yet displaying behaviors or conditions warranting a TDO. They, too, according to Dr. Lo, may spend many hours, and even days, in the hospital ED, where they need but are not receiving ongoing psychiatric care. (Lawrence “Buzz” Barnett, the now-retired director of Emergency Services for Region 10, later noted to the Work Group that individuals under ECOs or TDOs “are only a small percentage” of the “much larger group” of individuals who seek voluntary care during a psychiatric crisis.) The extended stays of these individuals in hospital ERs waiting for psychiatric care, often referred to as “psychiatric boarding”, was not directly addressed by the Work Group. In his communication to the group, Dr. Lo also expressed concern about standardizing criteria for admission to the crisis stabilization units (CSUs) within his region. While the Work Group later endorsed the expansion of such units throughout Virginia, the issue of admission criteria for moving individuals from the ED to a CSU was not discussed.

Private hospital refusals and increased state hospital admissions: Jim Martinez noted a significant increase in hospitalizations in state psychiatric facilities in 2014, with admissions in the “last several months” to Western State Hospital, for example, exceeding the hospital’s total admissions for 2013. Later in the meeting it was noted that statewide there had been a 21% increase in the number of TDOs in the past 6 months. Mr. Lawrence “Buzz” Barnett stressed that “there is an impression that CSB workers aren’t working as hard now to find a bed due to state hospitals being the facility of last resort, and that private hospitals aren’t accepting as many admissions for the same reason.” Mr. Barnett suggested a need to incentivize private hospitals so they will be “more willing to accept more difficult or complex persons.”

Hard-to-place individuals: Ms. Kaye Fair stated that placements for individuals who are minors, who have an intellectual disability and a mental illness, and those with Alzheimer’s or Dementia, are “problematic.”

Fragmented data: “There is a fragmented data structure which impedes the ability to collect data to understand study and provide an accurate report to the General Assembly. The General Assembly was frustrated with the relatively little data that exists on which to refine of the system. There is a need to collect a significant amount of data to evaluate the impact of the new legislation for 2014.”

Law changes driving partners apart: “Cynthia McClaskey observed that the effect of the changes has been to drive partners apart and all of us need to acknowledge this and then work to overcome the barriers.”

Impact of COPN(“Certificate of Public Need”) process on available private beds: “Joe Trapani related that it is difficult for private providers to open more beds due to the process involved. Suggestions were to look at the COPN process to unclog the system by overcoming the difficulty in opening new beds and units around the state, and particularly, to look at the state’s needs and not just a localities [sic] need before determining to not allow additional beds to be opened.”

HIPAA/confidentiality and need for information exchange: “Kit Cummings stated that at present, protected health information can be shared by a healthcare provider to law enforcement during a crisis or emergency situation but the information is not to be transferred to another officer, the information cannot be included in a police report and any written information must be securely discarded. Kit Cummings suggested that if information could be shared more freely it could maximize the cooperation of law enforcement, especially for locales with CIT officers.”

Advocates’ concerns regarding release of PHI: Allyson Tysinger (from the Attorney General’s office) stated that facilitating information exchange for people not necessarily under an ECO or TDO has been attempted in the past but consumer advocacy groups tend to oppose these measures due to fears of the information being too widely shared due to stigma and the potential impact on an individual in the present and future. Allyson said that language can be drafted but getting it through the General Assembly would be difficult. Allyson recommends looking at CIT nationally to see how information exchange is facilitated in other states.”

Veterans: One group member noted that eligible veterans “have substantially more options for crisis services than most citizens because they can access the VAMC, VA outpatient office, other non-profit organizations and Wounded Warrior program...” Nevertheless, misunderstandings about “who is eligible for VA services, lack of consistency in outpatient services across the state, disparity in each clinic/facility, convenient appointment times, transportation and lack of collaboration the VAMC and CSBs were all identified as potential challenges/barriers for veterans and their families seeking behavioral health services.”

Peer support: “Much research has been done on the efficacy of peer support in reducing the frequency of behavioral health crises for an individual. It was recognized that efforts to develop a peer support curriculum, certification of peers and the ability to bill for peer provided services are needed to make the use of peers more likely to occur. Funding for peer support development is needed.”

Advance Directives: “The group discussed encouraging broader application of psychiatric advance directives. DBHDS is working with Duke, UVA ILPPP, CSBs and state hospitals to promote use of PADs. CSBs in Southwest VA don’t feel they can take the time for this task as it is not billable time.” [Note: this has become a recurring theme in CSBs throughout the Commonwealth.] “Adopting this change in practice is complex because it doesn’t fit easily in existing staff roles (e.g., ES vs. case management). Additional funding to help support the CSBs workforce to assist people with completing an Advanced [sic] Directive may help reduce the use of crisis services for individuals. There is a registry of advanced directives that is maintained by Virginia Department of Health (VDH).”

Mental Health Workforce Capacity/Shortages of qualified MH professionals: “It was identified that there is a key shortage of licensed clinical social workers (LCSW), psychiatrists and other licensed individuals (LPC, PhD, etc.) in the state”, and that “[a]dvancing the use of tele-psychiatry is going to be needed to help fill gaps in services around the state.”

ER Physician-Emergency Evaluator relationships and roles: “Dr. Knittel suggests the current system of ECO/TDO is redundant and wasteful. He feels that licensed physicians should be allowed to make decisions in emergency departments. He supports a physician or licensed psychologist being able to

petition the magistrate for a TDO....It was identified that half of all TDOs originate in emergency departments...” On the other hand, “... Concerns were expressed about physicians not being as familiar with community resources and current CSB evaluators are frequently able to divert people to less-restrictive alternatives when appropriate.”

“...Also noted that there is some benefit to not making the decision to TDO too rapidly (process of the prescreening could be therapeutic, an hour later the individual may no longer require hospitalization).”

Recommendations:

1. *Access to Services:* “Improve access to consistent psychiatric services in a timely manner, using a benchmark standard, as exists in other health care, and make resources available to accomplish this goal.”
2. *Psychiatric Bed Shortages and COPN process:* Refine the COPN process “so that it more effectively addresses state needs, and incentivizes providers to respond to state needs, particularly specialized services for complex or challenging cases.
3. *PHI exchange during crises:* Enact legislation that “(a) authorizes sharing of PHI between CSBs, LEAs, health care entities and providers, and families and guardians about individuals who are believed to meet the criteria for temporary detention (whether or not they are in custody or ultimately detained) and (b) contains a “safe harbor” provision for practitioners and law enforcement officers who make such disclosures in good faith. Workgroup also recommends that DBHDS develop a disclosure “toolkit” for practitioners and law enforcement that can support effective, consistent understanding of disclosure and information sharing in the emergency context.”
4. *Transportation for ECO/TDO:* Increase compensation for transportation, to encourage “increased use of alternative transportation providers such as family, friends, EMS, etc., and to cover the uncompensated costs of transportation to police,” and take measures to improve communications and relationships between emergency services providers and law enforcement.
5. *Relationships with the VA system:* Improve coordination between private hospitals and VA hospitals, and support crisis response clinicians to collaborate with veterans to meet their needs by (a) establishing a “point person” at each CSB to coordinate between VA and CSB, (b) increasing financial support to the VWWP, and (c) continuing to educate the public and CSBs about the needs of veterans and military families.

Ongoing Treatment & Supports – pp. 9-22

System Reinvention: The Work Group members agreed that effective reform required “system reinvention”, and they adopted a set of “guiding principles” for such reinvention:

1. There should be no wrong door. There should be effective access to care.

2. There should be a culture of responding to human needs. Communication to consumers and families should be very clear, not confusing.
3. A continuum of care from least restrictive to most restrictive that covers the lifespan should be available statewide. The continuum should include follow-up and case management.
4. There should be cross-system care coordination and collaboration (e.g., across CSBS, health, social services, criminal justice, education, housing, etc.).
5. There should be diversion from jail and homelessness.
6. Prevention and early intervention services must be available.
7. Services should be culturally relevant.
8. The workforce should be adequate to meet the need and properly trained.
9. There should be adequate and sustainable funding for services and supports

There was a review of current mandated services for the CSBs, current and proposed “funding streams” to support various services, and a lengthy discussion of veterans’ mental health issues and the need for more coordination with the VA system. A number of explanatory materials that were reviewed by the Work Group members were attached to the minutes.

Behavioral Health Services Array: Among the materials was a chart (which, according to the minutes, was obtained from the Substance Abuse and Mental Health Services Administration (SAMHSA) entitled: “Description of a Good and Modern Behavioral Health Service Array”. The chart’s service array begins with primary health care and prevention programs, and then moves through increasingly intensive services, from outpatient and medication services, to intensive support services, to acute care and residential services and recovery supports. Significantly, the “Array” begins with *physical* health, including general and specialized outpatient medical services, tests, screenings and immunizations, care coordination and referral to community services. The Work Group added “integrated primary teams” to the listing of health care services. Also of significance is the inclusion, within the Array, of community support services, including housing, supported employment and related services, along with case management. The array also describes more intensive support services, crisis intervention services, and recovery supports following crisis. The Work Group endorsed the Array as describing the Work Group’s vision of a “reinvented” system, but added “criminal justice/homelessness diversion” as an included service.

Assessing Virginia’s System based on the Array: The Ongoing Treatment and Supports Work Group recommended to the Task Force that the SAMHSA “Array” of services model be used as the framework for conducting a “comprehensive analysis of the behavioral health service needs in Virginia, identify a core set of services that should be available across the Commonwealth, complete a gap analysis that includes public and private service sectors, and recommend a consistent, multi-year funding strategy that would ensure timely access to core services for all Virginians.” (See page 16 of the “Materials” for the August 11, 2014 Task Force meeting.)

Recommending Reinvention of Virginia’s System: Relatedly, the Work Group recommended that Virginia “reinvent the system by conducting a needs assessment to determine current capacity and gaps, develop pilots, foster community collaboration, incorporate an integrated community system of care – public-private partnership, make the system more user-friendly for people

across the lifespan, address the under-funded system, reinvest savings, address rising costs of services over time and reform health care coverage reform.” (See page 16 of the “Materials” for the August 11, 2014 Task Force meeting.) It also recommended that ways be found to “[c]apture savings” that the reinvented system produced, to help to support the system financially.

Those recommendations were not ultimately adopted by the Task Force, but they are significant and will require re-visiting, because they address the framework of services and financing on which the recommendations that *were* adopted will ultimately depend.

Public Safety – pp. 23-27

The Public Safety Work Group minutes show that the group developed a comprehensive set of recommendations, and then highlighted those that should be given priority. As in the case of ongoing treatment work group, the needs of veterans, and coordination with VA services, emerged as one of several key themes. This group also endorsed improved public access to services, and supported the development of a “Center of Excellence” that would assess service needs, highlight and implement best practices, and coordinate with the VA and other systems. The other two central themes from this group were the need for expanded and improved CIT capacity statewide, and a need to de-criminalize the state’s interventions with persons whose behavioral problems arise out of their mental illness. This included not only finding ways to transport people in crisis without using law enforcement, but also identifying and treating people in jail whose primary issue is their mental illness.

Technical & Data Infrastructure – pp. 2-8

The minutes of this Work Group’s May 21 meeting include important presentations about developing communications technologies that may enable rural jurisdictions in particular to significantly improve both the efficiency and quality of their mental health services, both in crisis situations and in general health care provision. The presentations included the following:

Statewide Video Intake used to provide the required intake process for juveniles taken into custody in the Juvenile Justice system – Presentation by Tyrone Jackson, Video Intake Supervisor, Department of Juvenile Justice, 9th District Court Service Unit

Mr. Jackson reported that in 2000 the Fairfax County Court Services Unit (CSU) was the first CSU in Virginia to implement a video intake process for juveniles taken into custody after hours. The savings in time and resources were so significant that the system has been adopted statewide. An encrypted video conferencing system enables intake officers to carry out an effective intake process with juveniles taken into custody, and also enables probation officers to “supervision contacts” with juveniles in the system’s various juvenile correctional centers.

Presentation by Karen S. Rheuban, MD University of Virginia Center for Telehealth, regarding the Telehealth system.

Dr. Rheuban noted that the system at UVA, which partners with medical specialists who are on call, provides a number of advantages to the under-served rural communities of Virginia.

- For patients: timely access to locally unavailable services, enhanced patient choice, reduced burdens and costs for transportation to access care;

- For health professionals: access to consultative services, and support for collaborative care delivery models;
- For hospital systems: decreased readmissions, improved triage, local treatment of patients when appropriate;
- For communities: broadband expansion (rural healthcare support mechanism, FCC programs) to make the system possible, increased local hospital viability as economic driver of rural and urban communities; and
- For public health: enhanced emergency preparedness and disease surveillance.

Two other presentations – one by Katherine Wibberly on the *The Mid-Atlantic Telehealth Resource Center* (<http://www.matrc.org/>) and the other by Edie McRee Bowles on the *Bay Rivers Telehealth Alliance* – supported Dr. Rheuban’s presentation on the improved health services and consultations provided to patients and providers in rural areas through telehealth networks.

This Work Group developed 10 recommendations, with specific commentary under each, with most recommendations ranging beyond the expansion of tele-psychiatry services to also include such tasks as outreach to veterans and the VA to coordinate services; expand and improve mental health workforce capabilities; standardize procedures statewide in regard to the processing of ECOs and TDOs; collect data to evaluate the efficacy of different treatment strategies; and expand preventive services and advance care planning, including the use of advance directives.

Fourth Task Force Meeting: June 16, 2014

The agenda of the June 16 Task Force meeting can be found under the “Meeting Materials” link for the June 16 meeting on the [DBHDS Task Force page](#). Three of the four Work Groups submitted recommendations, which were, in succession, adopted by the Task Force. The listing of those adopted recommendations can be found under the “Meeting Materials” link for the Task Force’s August 11 meeting, on page 12 and 13. The Ongoing Treatment and Supports Work Group did not have final recommendations for the June 16 meeting, and planned to develop those recommendations at the July 15 Work Group meeting. The minutes of the June 16 meeting are under the “Meeting Materials” link for the Task Force’s August 11, 2014 meeting, on pages 2-4.

Fourth Workgroup Meetings: July 15, 2014

The fourth session for Work Group meetings was held on July 15, 2014, at the Patrick Henry Building in Richmond. The agendas for the Work Groups can be found under the “Meeting Materials” link for the July 15 meeting on the [DBHDS Task Force page](#). Three of the four groups had the same agenda, found on page 1 of the “Meeting Materials”. They were tasked with discussing the recommendations to be made to the Task Force, ensuring that they fit with the directives of Executive Order 12, and developing and recording “up to 3-5 actionable recommendations” for the Task Force.

The agenda for the Crisis Response Work Group, on page 28, added three additional items for discussion: Physician TDO authority; Regional Psychiatric Emergency Centers; and “Promoting healthy competition.” The last two items came from Mr. Ted Stryker, Vice President of Centra Mental Health Services. His suggestions regarding both items are set out in a June 17, 2014 email that Mr. Stryker sent to Mr. Jim Martinez at DBHDS. That email can be found on page 38 of the “Meeting Materials” for July 15.

The final recommendations from the Work Groups are found under the “Meeting Materials” link for the August 11, 2014 meeting of the Task Force, on pages 14 through 17.

Fifth Task Force Meeting: August 11, 2014

The agenda for the August 11, 2014 meeting is on the [DBHDS Task Force page](#), under the “Meeting Materials” link for the August 11, 2014 meeting. The minutes from the meeting can be found [here](#) (under the link “Draft Meeting Minutes” located below the link “Meeting Materials” for the August 11 meeting).

The meeting began with a presentation by Dr. Debra Ferguson, the new DBHDS Commissioner, on both crisis response in the mental health system and a vision for “transformation” of the mental health system (on pages 5-11 of the “Meeting Materials” for August 11.):

Crisis Response: “TDO Exceptions”

Dr. Ferguson provided charts showing significant declines from January through May of 2014 in the number of “TDO exceptions” for persons taken into custody under and ECO

- Type 1 TDO exceptions – those in which a TDO was sought but not obtained because a willing facility could not be identified
- Type 2 TDO exceptions – those in which a TDO was eventually obtained, but not until after the ECO period had expired

A more detailed report regarding TDO exceptions during this period is available [here](#).

(Note: This report, like the reform measures enacted by the General Assembly, addresses only persons in crisis who are subject to an ECO. As noted in discussions throughout the deliberations of the Task Force, there are many other people who experience mental health crisis, and need hospitalization, but who (for various reasons) are not in custody under an ECO. Many are in hospital emergency rooms, and sometimes wait for many hours and even days for inpatient psychiatric care. However, in working with CSBs throughout the state, the DBHDS Medical Director, Dr. Barber, has advised CSB staffs and hospital staffs that a hospital bed must be found for all individuals in crisis who are found to meet TDO criteria, regardless of whether those individuals are under an ECO. This is a practice commitment by the Department that goes beyond the more limited mandate of the new state law, and reflects an effort by DBHDS to ensure that people in acute crisis obtain inpatient psychiatric care when they meet the criteria for a TDO.)

DBHDS Vision for Mental Health Services

Dr. Ferguson made a presentation describing the central features of a “transformed” mental health services system, and described her “Transformation Plan”, a multi-year project in which she is asking small “transformation teams” to address and make recommendations regarding key issues in the area of (1) adult behavioral health, (2) adult developmental services, (3) children’s behavioral health, and (4) justice-involved behavioral health and developmental disability services.

Final Report

The final report of the Task Force can be found [here](#). There were 25 recommendations, grouped under three major categories: (1) recommendations to expand access; (2) recommendations to strengthen administration; (3) recommendations to improve quality.

Because the mandate of the Task Force was to make recommendations about both the state's mental health services system in general *and* its mental health crisis response services in particular, it is useful to group the recommendations in these three categories: (1) recommendations to improve the response to mental health crises; (2) recommendations to improve overall mental health treatment services; (3) recommendations to improve education and prevention.

Under this grouping, the Task Force recommendations can be listed and summarized as follows (with the order of their listing in the Task Force Report shown in parentheses at the end of each recommendation):

I. Recommendations to Improve Mental Health Crisis Response

1. **Recommendations regarding ECO and TDO processes that were adopted in whole or in part by the 2014 General Assembly:**
 - a. *Notification during the ECO Period:* The law enforcement agency that executes the emergency custody order should notify the applicable community services board upon execution. (no. 17)
 - b. *Emergency Custody Order Period:* Establish a 12-hour emergency custody order period that includes tiered levels of notification every four hours. (no. 18)
 - c. *Temporary Detention Order Period:* Extend the period of temporary detention from the current 48 hours to 72 hours with a minimum period of 24 hours prior to a commitment hearing. (no. 19)
 - d. *Psychiatric Bed Registry Reporting:* Fully utilize the data reporting capacity of the psychiatric bed registry and add data fields as necessary to automate data collection to better understand where the gaps or pressure points are. (no. 25)
2. **Assessment Centers and CSUs:** Expand secure CIT (Crisis Intervention Team) assessment centers and crisis stabilization units statewide. (no. 1)
3. **CIT:** Expand funding for CIT program development statewide. (no. 2)
4. **Tele-psychiatry:** Expand access to tele-psychiatry. (no. 3)
5. **Access to Psychiatrist Services:** Establish a standard for making timely improvements in access to psychiatric services, with a priority to giving emergency service providers statewide should have access to a prescriber, if not a psychiatrist, to reduce the use of hospitalization as the means to access medication. (no. 7)
6. **Communication Among Providers:** Provide capacity to DBHDS to lead a system-wide development of an effective communication structure linking public and private mental health providers, at the local, regional and state levels, to enhance problem-solving and spread best practices in providing mental health services. (no. 9)

7. **Alternative Transportation:** Move away from having law enforcement be primary transporters for mental health issues (from ECO to TDO), with training and funding for medical transporters and the use of law enforcement only as needed for safety purposes. (no. 10)
8. **Virginia Criminal Information Network (VCIN) and TDO information:** Enable first responders (police officers) to gain access to the TDO database already in VCIN. Add training requirements for VCIN. (no. 14)
9. **Protected Health Information (PHI) Disclosures to Improve Crisis Response:** Develop legislation to clearly authorize communications and disclosures of PHI during emergency/TDO situations, and provide protection for those making disclosures in good faith, and provide “tool kit” to guide responders on such disclosures. (no. 15)

II. Recommendations to Improve Overall Mental Health Treatment Services

A. Treatment Services

1. **Center for Excellence:** Establish an intergovernmental Center for Behavioral Health and Justice to improve behavioral healthcare practices statewide and address the behavioral healthcare needs of individuals involved in the criminal justice system. (no. 8)
2. **Veterans Collaboration:** Improve coordination among private hospitals, CSBs and VA hospitals regarding the needs of veterans and their families and increase support for the Virginia Wounded Warrior Project. (no. 11)
3. **Veterans:** Improve the availability of mental health services to veterans and their families, as well as coordination of services with the VA and the use of “problem solving courts” to address improper behaviors that are the direct result of mental health conditions. (no. 6)
4. **Jail Services:** Utilize proposed Center of Excellence to develop plan to enable every Virginia jail to provide readily accessible, evidenced based, trauma-informed treatment for individuals in jail. (no. 12)
5. **Improve Certificate of Public Need (COPN) process:** Refine the COPN process to more effectively address state needs, and incentivize providers to meet those needs, especially specialized services for complex or challenging cases. (no. 16)

B. Treatment Staff

1. **MH Nurse Practitioner/Physician Assistant Training and Continuing Medical Education:** Promote increased education for these professionals, and consider expanding the Nurse Practitioner’s and Physician Assistant’s scope of practice to provide additional psychiatric services, particularly in underserved areas. (no 21)
2. **Recruitment and Retention:** Support and facilitate the creation of programs to aid in recruiting and retaining mental health professionals in specialties that are in short supply. (no. 23)
3. **Direct Support Professional:** Create a new level of direct service position, entitled Direct Support Professional, in Virginia for state facilities, CSBs and private providers. (no. 24)

C. Data, Technology and Communications

1. **Computerized Jail Notification System:** Increase post-release engagement by CSBs with incarcerated persons with behavioral health needs by advising CSBs of the release of these persons to the community. (no. 13)
2. **Data and Technology:** Develop a single consistent statewide process for data and oversight structure to maximize the use of tele-psychiatry and video-technology. (no. 4)

III. Recommendations to Improve Education and Prevention Services

1. **Mental Health First Aid:** Implement and expand the Mental Health First Aid program statewide, both in communities and in schools and universities. (no. 5)
2. **Resources for Families:** Strive for “no wrong door” or path to get information; explore various tools for helping individuals and families prepare for behavioral health crises, such as education and support on advance directives, mental health first aid, and technological innovations such as apps for mental health and other forms of electronic communication. (no. 20)
3. **Primary Care Education and Incentives:** Strengthen the capacity of primary care physicians and others in primary care to effectively serve individuals with complex behavioral health needs, encouraging collaboration across disciplines, assigning peer support specialists to serve as navigators and case managers to assist with linkages to behavioral health service providers, and making such models a condition of participation in Medicaid. (no. 22)

B. The Governor’s “Healthy Virginia” Plan: the GAP program

In September of 2014 Governor McAuliffe announced a number of initiatives to increase health care access for low income Virginians who have no health care insurance and are ineligible for Medicaid. One of those initiatives is the [Governor’s Access Plan](#) (GAP) for Medical and Behavioral Health Services. Through the GAP, which has since been approved by the federal government for matching federal Medicaid funding, up to 20,000 currently uninsured and underserved Virginia adults with serious mental illness will receive “a focused [benefit package](#) that includes primary, specialty, behavioral health, and substance abuse services”. The behavioral health services provided under GAP include most of the community-based services available under the standard Medicaid program, including crisis intervention and crisis stabilization. The program will be administered through the Virginia Department of Medical Assistance Services (DMAS) and Magellan of Virginia, the Behavioral Health Services Administrator for the Virginia Medicaid program.

The plan has been criticized by some members of the General Assembly as being inadequately conceived and planned and as being beyond the Governor’s authority to establish, with, in their view, prior General Assembly approval being necessary. Secretary of Health and Human Services Hazel, while stating that creation of the GAP program was within the Governor’s authority, has acknowledged that the General Assembly would have to appropriate funds for the program in order for it to continue beyond June 30, 2015. The plan has been approved by the federal government for matching federal Medicaid funds, and has already started enrolling individuals

The GAP program is the Governor’s effort to provide mental health services to Virginians with low income and a diagnosis of serious mental illness who are not eligible for Medicaid coverage under current Virginia standards. The Governor’s larger effort, starting as a campaign pledge and continuing through his time in office, to expand Medicaid coverage to more low income Virginians as allowed under the Affordable Care Act, has not been supported by the General Assembly. The conflict between the Governor and the General Assembly over Medicaid expansion in general and the GAP program in particular is reflected in [this recent article](#) from the *Richmond Times Dispatch*. The article points out that survival of the GAP program beyond June 30, 2015, still requires an appropriation of 77.1 million dollars by the General Assembly.

The article also notes that individuals enrolled in GAP are not covered for emergency room and inpatient behavioral health services. However, that is also true for individuals (ages 21 through 64) who are currently enrolled in Medicaid. The 1965 Medicaid Act did not provide Medicaid coverage for care provided to anyone under age 65 in any “institutions for mental disease” (the “IMD exclusion”). In the 1960’s, psychiatric hospital care was paid for almost exclusively by the states, and most psychiatric hospitals were long term care facilities. The IMD exclusion was established to ensure that federal dollars would not support those institutions. Subsequent amendment of the law allows for coverage of behavioral healthcare in IMDs for individuals under age 21 (sometimes age 22), and a later amendment changed the definition of an IMD to *exclude* residential psychiatric treatment facilities with fewer than 17 beds, thus enabling Crisis Stabilization Units (CSUs) in Virginia to charge Medicaid for behavioral health services they provide to individuals receiving Medicaid. (See pages 4-8 through 4-10 of this [Medicaid Handbook](#), published by the Substance Abuse and Mental Health Services Administration [SAMSHA], for a description and discussion of IMDs.) The GAP program also covers services provided by CSUs.

(Notably, the federal government has recognized that the nature and length of psychiatric hospitalization has changed dramatically since 1965, when the IMD exclusion was enacted, and that the lack of Medicaid coverage for psychiatric inpatient treatment is now contributing to increased “psychiatric boarding” of individuals in hospital emergency departments, resulting in higher costs of care and poorer care for Medicaid recipients. As a result, the government has initiated a three-year demonstration project, with participation by 11 states and the District of Columbia, “that allows participating states to provide payment to certain nongovernment psychiatric hospitals for inpatient emergency psychiatric care”. (See page 4-10 of the [Handbook](#) for more on this project). In addition, the federal government is allowing Medicaid reimbursement for services in an IMD under certain arrangements with Medicaid managed care programs. (See page 4-11 of the Handbook for that discussion.))

C. The Virginia Budget for Mental Health Care

Although Governor McAuliffe requested, and the 2014 General Assembly declined, to expand Medicaid coverage to more low income Virginians, the General Assembly did increase mental health services funding in 2014 by 54.9 million dollars, for additional psychiatric hospital beds and increased community services. According to a Pew Charitable Trusts [report](#), a number of other states decreased their mental health spending for 2014, though 27 states and the District of

Columbia provided for Medicaid expansion under the Affordable Care Act, which Virginia declined to provide.

For 2015, [this report](#) from the Virginia Association of Counties (VACO) notes that the Governor, despite revenue shortfalls announced in the fall of 2014, has maintained a commitment to mental health services, specifically including additional funding for the costs of involuntary commitments and inpatient mental health facilities.

The DBHDS Response

A. The Transformation Plan

The new DBHDS Commissioner, Debra Ferguson, Ph.D., has initiated what she describes as a “transformation process” that includes “a comprehensive review of the state behavioral health and developmental services system.” Although this initiative did not arise directly out of the Deeds case, and while the initiative covers all areas of DBHDS service, the effort dovetails into the work of the Governor’s Task Force and the SJ 47 joint subcommittee. In addition, on the [DBHDS page](#) in which she describes the transformation teams established under this initiative, the Commissioner notes that “the adequacy and effectiveness” of the emergency services system is under close examination.

On that same page, the Commissioner describes the transformation effort as focusing on the following four areas:

- Access
- Quality
- Stewardship of resources
- Accountability

It is grounded in the following principles, for everyone served by the system:

- Recovery
- Resiliency
- Self-determination
- Wellness

As indicated in her presentation to the Governor’s Task Force, the Commissioner has formed four “Transformation Teams”, with each team addressing one of the following areas of focus:

- Adult behavioral health services,
- Adult developmental services,
- Child and adolescent behavioral health services, and
- Services to individuals who are justice-involved.

The Commissioner has directed that the teams carry out the following plan:

- “Each of the transformation teams will analyze our behavioral health and developmental disabilities services system and develop strategic proposals for services, delivery and infrastructure.
- The “stakeholder group” (a single group formed by the Commissioner and made up of a variety of public and private providers and advocates) will serve as a review and consultation group for transformation teams. The stakeholders will provide input on team proposals and offer recommendations and refinements.
- A public comment period will consist of three statewide town-hall style meetings. DBHDS will also post the latest transformation team updates on the DBHDS website. This will afford the public the opportunity to review the proposals developed by the Teams and provide feedback in person and/or via email.
- The Commissioner will finalize recommendations and present them to legislative committees, task forces (as appropriate) and the State Board of Behavioral Health & Developmental Services.”

The entire process is currently planned to take 2 years, divided into 6 month increments. For each 6 month increment, the Commissioner provides each team with a set of questions to address.

A more complete description of the transformation process, including the members of each team and the members of the stakeholders group, is on the DBHDS website and can be accessed [here](#), and from the [DBHDS page](#) on the transformation teams.

B. Collaboration with CSBs In Regard to Mental Health Crises: Ensuring a Psychiatric Bed for Individuals Meeting TDO Criteria

As noted earlier, the new Virginia Code Section 37.2-809.1, enacted by the 2014 General Assembly, requires that DBHDS provide a psychiatric hospital bed for a person who is under an ECO and meets the criteria for a TDO *but* for whom a psychiatric bed has not been found within the 8-hour period that the ECO is in effect. The law does *not* provide any similar guarantee for a person who is *not* under an ECO but who is found to meet the criteria for a TDO. As a 2013 study (available [here](#)) of CSB emergency mental health evaluations showed, approximately 70% of the individuals in crisis who are seen by CSB evaluators are *not* under an ECO, and (for the month of April, 2013, when the data for the study was collected), a third of those non-ECO individuals were found to meet the criteria for a TDO. Those individuals (a total of 797 in April, 2013) could be “streeted” rather than hospitalized, as described to the Task Force by Mr. Bevelacqua in his January 7, 2014 presentation (cited above), without violating any provision of Virginia law.

To the credit of DBHDS, its Medical Director, Jack Barber, M.D., has advised the CSBs and DBHDS hospitals that the Department’s position is that *every* person who is found to meet the criteria for a TDO must be placed in a psychiatric bed, so that DBHDS hospitals are also the placements of last resort for those persons who meet TDO criteria and are *not* under an ECO.

Although this important effort by the DBHDS helps to ensure that people are no longer “streeted”, as Mr. Bevelacqua described, it does not ensure the quality of the outcomes that individuals in mental

health crisis experience. The added pressures on the state hospitals to accept new patients clearly impact the quality of care that those hospitals are able to provide and the related pressure to release patients as soon as possible. In addition, DBHDS understandably requires the CSBs to continue searching for an alternative hospital placement after a person has been placed in a state facility. When that alternative placement is found, the person, who in many cases has just been transported a long distance to the stated hospital and has undergone the admissions process there, must then take another long trip to a new facility for another admissions process. This disruption of the treatment process for a person in mental health crisis can undermine treatment efforts and outcomes, though the person's fundamental safety is protected.

Finally, as noted in the discussions of the Work Groups of the Governor's Task Force, there are many people in mental health crisis who need emergency treatment, and in some cases need psychiatric hospitalization, but who do not yet present sufficient danger of harm or disability to meet the criteria for a TDO. These individuals are often helped by CSB evaluators to find appropriate treatment, but many may also remain in hospital Emergency Departments for extended periods of time with little or no psychiatric care, while an appropriate placement for them is sought, a phenomenon known nationwide as "[psychiatric boarding](#)."

C. Improving Crisis Response: Qualifications and Training of CSB Emergency Evaluators

In response to the mandate of SB 261, DBHDS conducted a thorough examination of the qualifications, training, performance and supervision of CSB evaluators throughout Virginia. In her report to the General Assembly and the Governor, entitled "Assessment of Virginia's Emergency Evaluators: Qualifications, Training and Oversight" (Senate Document No. 9). DBHDS Commissioner Ferguson made 7 recommendations. The key recommendations involved upgrading the position of CSB "emergency evaluator" to that of "crisis intervention specialist" to better reflect the complexity of the CSB representative's work in responding to and resolving mental health crises. Along with that upgrade would come both an upgrade in the training and supervision involved, *and* an upgrade in the education and licensing required of all such specialists. By 2020, all crisis intervention specialists would have to have a professional license in one of the following disciplines: Licensed Professional Counselor (LPC), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Substance Abuse Treatment Practitioner (LSATP), Clinical Psychologist (LCP), Psychiatric Nurse Practitioner (PNP) with ANCC Board Certification as an Adult Psychiatric and Mental Health Nurse Practitioner, Physician's Assistant (PA), with NCCPA Certificate of Added Qualification in Psychiatry, or Psychiatrist (MD, DO).

The report provides an estimate of the costs of implementing these recommendations, but it limits those costs to the costs incurred by the Commonwealth in developing and presenting the training programs for these specialists and monitoring them. There is no discussion of the costs to the CSBs in trying to recruit, hire and continue to employ licensed individuals in the specialist position. Given the increasing demands for licensed mental health clinicians nationwide, especially for purposes of treating the complex mental health needs of returning war veterans mental health needs of veterans, the costs of finding, hiring and retaining licensed clinicians for emergency services work could be very high. For rural communities, in particular, it may prove impossible to recruit enough individuals meeting the new licensing requirements.

It is notable that, although the Governor’s Task Force did make recommendations regarding increased training among all of the professionals involved in responding to mental health crises, the Task Force did *not* identify lack of sufficient licensing among CSB emergency evaluators as a critical problem. This would indicate that the quality of the emergency services staff is less of an issue than is the lack of adequate services and placements to which these evaluators can refer people when those people are in crisis. Given the costs of the actions that *were* listed by the Task Force as being critical to system reform, and the challenges faced by CSBs in being able to find licensed individuals willing to do emergency work at the available compensation rates, DBHDS (a May 2014 [report](#) by the Kaiser Family Foundation found that Virginia currently has only 61% of needed licensed mental health professionals), the Governor and the General Assembly may want to consider how high a priority to make the licensing requirement. In any event the General Assembly will need to provide far more funds than those identified in Senate Document No. 9 to hire the people needed to meet the recommended licensing requirements.

Virginia State Senator Creigh Deeds has introduced Senate Bill [1410](#) to make the licensing and credentialing standards recommended by the Commissioner a matter of state law. As noted in an article in the *Daily Press*, found [here](#), Community Services Board directors throughout the state have responded that they do not have the funds to pay for this requirement, that they will have extreme difficulty attracting licensed individuals to this work, and that the unlicensed staff in these positions are currently doing a good job.

D. The DBHDS Commitment to Wellness and Recovery

In General

Even before the implementation of the Transformation Initiative by the new DBHDS Commissioner Ferguson, the Department has had a commitment to a recovery model of mental health services, with a person-centered focus and an encouragement of mental health wellness practices in the community setting. The Department has included the promotion of wellness planning and the use of advance directives in its annual plan and in its performance contracts with local community services boards. It maintains contracts with a number of advocacy organizations to promote wellness, and it has devoted both financial resources and staff resources to a project led by Professor Richard Bonnie at the Institute of Law, Psychiatry and Public Policy to study and recommend best practices for enabling people with serious mental illness to complete and utilize advance directives for managing mental health crises. MHAV maintains a [website](#) as part of that project that provides information, resources and advance directive forms that can be used by the public.

In Response to the 2014 General Assembly Reforms

The presentation (found [here](#)) by Mr. Jim Martinez, Jr., Director of the Office of Mental Health Services for DBHDS, to local CSBs in response to the 2014 amendments to the mental health law, reflects this orientation toward providing support and services, rather than imposing coercive interventions, for people experiencing mental health crisis. In the slides for that presentation, Mr. Martinez wrote: “Reform cannot just be about making coercive treatment laws “better”. It must be about reducing the need to use these laws.” He noted the importance of having a “person-centered”, “recovery oriented system” “that helps people get their lives back.” He emphasized the importance of implementing the

new laws right away in agency practice, collaborating with other providers in the community, and trying to “reduce and eliminate barriers to timely and appropriate care.”

Mr. Martinez emphasized the importance of trying to “minimize involuntary care”, and pursuing strategies such as WRAP (Wellness Recovery Action Plan), ADs (Advance Directives) and “similar strategies” “to reduce crises and the need for judicial intervention.” At the same time, he recognized that “Virginia has strong incentives for involuntary treatment (e.g., transport by law officers, payment for inpatient care for uninsured, etc.)”, and that the newly enacted requirements (e.g., the state providing the “facility of last resort”) “may create even stronger incentives for involuntary care”. Mr. Martinez encouraged staff to use tools and strategies (including the increased use of wellness plans and advance directives) to reduce involuntary hospitalizations, and to try to identify and address the barriers that are preventing people from obtaining timely, appropriate treatment.

The Ongoing Work: The SJ 47 Joint Subcommittee - Initial Deliberations

The Joint Subcommittee Studying Mental Health Services in the 21st Century, which has met five times between July and December of 2014, either as a body or through one of its three workgroups: Crisis Intervention, Continuum of Care, and Special Populations. Staff support is being provided by the Division of Legislative Services, and the dates, agendas and materials from each of the subcommittee’s meetings can be found [here](#) on the DLS website. Some highlights include:

A. DBHDS presentations: Overview of the Current Mental Health System and a Vision of a “Reformed” System.

At its July 14, 2014 meeting, the subcommittee received an overview of Virginia’s mental health services system from Dr. Ferguson, the DBHDS Director. That presentation can be found [here](#). At the October 23 meeting, Dr. Ferguson’s overview was supplemented by a presentation by Mr. Jim Martinez (cited above), who elaborated on the relationship between the DBHDS and both the public CSBs in the community and the private licensed mental health services providers. He described some of the Department’s key initiatives for helping people with mental illness to remain out of the hospital, including the Crisis Intervention Team (CIT) program and the Discharge Assistance Program (DAP). He also offered the key characteristics of a “Reformed System.” His presentation can be found [here](#). Dr. Barber, Medical Director of DBHDS, made a presentation (found [here](#)) at the September 9 meeting on the major mental illnesses and how they are treated, and noted the Department’s commitment to a Recovery model of mental health treatment, stating: “People do recover their lives.”

B. A Critique of Virginia’s Mental Health Commitment Laws: The Treatment Advocacy Center

Commitment standards

At the subcommittee’s July meeting, representatives of the Treatment Advocacy Center presented an overview and discussion of civil commitment statutes nationwide (the PowerPoint version is found [here](#) and a more detailed text version is [here](#)). The Center, a national nonprofit organization established in Arlington, Virginia, describes itself as being “dedicated to eliminating legal and other barriers to the timely and effective treatment of severe mental illness”. At the subcommittee meeting, it presented a major critique of Virginia’s commitment law. The central theme of the Center’s presentation was that Virginia law has a variation of both the “dangerousness” and “gravely disabled” standards found in all states for involuntary commitment of a person in mental health crisis, but that there is a third and equally important standard—“need for treatment”—that has been adopted by approximately half of the states, but *not* Virginia, that, in the view of the Center, is critically important to ensuring timely care of persons who are disabled by their mental illness but who do not yet present behaviors or conditions meeting the “dangerousness” or “gravely disabled” standards for involuntary treatment. The Center representatives argue that failure to include a “need for treatment” standard for more timely intervention and treatment results in “higher relapse rates”, “poorer course of illness”, “increased hospitalizations”, “violence”, “victimization”, “incarceration” and “homelessness.” (In contrast, there is a strong advocacy community that argues that Virginia’s current commitment standards set too *low* a threshold for state intervention into the life of a person experiencing mental illness. The complexities of this debate are captured in part in a recent *Washington Post* article that can be found [here](#). That article also highlights the continuing problems, cited by Mr. Bevelacqua in his presentation to the Governor’s Task Force, and noted by the Task Force in its deliberations, in finding appropriate community placements for individuals after they have achieved stability in the psychiatric hospital setting, with the lack of such placements resulting in individuals remaining in the hospital far longer than they should.)

Mandatory Outpatient Treatment (MOT)

The Center representatives also submitted that involuntary commitment did not necessarily mean involuntary *inpatient* treatment, and that a robust involuntary *outpatient* commitment program (which they referred to as “Assisted Outpatient Commitment”) can result in improved outcomes for persons with serious mental illness. The Center representatives noted that, while Virginia has mandatory outpatient treatment (MOT) legislation, that legislation (in the Center’s view) has inconsistencies (including a “voluntary” component that is inconsistent with the concept that the treatment is “mandatory”) and does not provide for a sufficiently *long* minimum period of MOT. The Center submitted that research has shown the best outcomes for individuals subject to MOT occur when the MOT period is at least 6 months long. (Note: unaddressed in the Center’s

presentation was the fact that there has been very little use of MOT in the vast majority of jurisdictions in Virginia. A 2011 report by Amy Askew of the University of Virginia School of Medicine (found [here](#)) stated that two of the key reasons cited by CSBs statewide for the lack of use of MOTs were: (1) the inadequacy of local CSB resources to provide the services and supervision required to carry out MOT; (2) the reluctance of special justices to enter MOT orders because of their complexity and the lack of compensation to special justices for the extra time and work involved in monitoring MOT order compliance.)

A related article by Brian Stettin, JD, et al, appearing in the February, 2014 issue of *Psychiatric Annals* and entitled “Elements of an Ideal Statutory Scheme for Mental Health Civil Commitment”, supporting both the “need for treatment standard” and the use of “Assisted Outpatient Treatment”, was also submitted at the July meeting, and can be found [here](#) on the DLS website.

C. Children’s Services

The October 28, 2014 meeting of the Subcommittee’s “Special Populations” workgroup focused on children’s mental health issues. Amy Atkinson, the Executive Director of the Commission on Youth, made a presentation, found [here](#), that described the origins, legislative mandate and current areas of focus on the Commission on Youth. Ms. Atkinson noted in particular the Commission’s work in developing, and updating biannually, “The Collection of Evidence-based Practices for Children and Adolescents with Mental Health Treatment Needs”, which is currently in its 5th edition. The Collection can be found [here](#), on the Commission’s website.

Margaret Nimmo Crowe, the Executive Director of Voices for Virginia’s Children, made a presentation, found [here](#), on the “1 in 5 Kids” mental health initiative led by her organization. (“1 in 5” refers to the finding that approximately 20% of children experience mental illness.) Ms. Crowe’s presentation reviewed the prevalence and types of mental illness appearing in childhood, and factors contributing to it, and noted that half of all cases of chronic mental illness “start” by age 14, and three-quarters by age 24). Ms. Nimmo reviewed the importance of prevention and early intervention and treatment measures, and the inadequacies in the Virginia’s services to children across prevention, treatment and crisis intervention services.

D. Review of the Governor’s Task Force Recommendations

At its December 16, 2014 meeting, the subcommittee heard a presentation from HHS Secretary Hazel, found [here](#), on the recommendations from the Governor’s Task Force on Improving Mental Health Services and Crisis Response. Secretary Hazel also updated the subcommittee on the operation of the statewide psychiatric bed registry. A report on that meeting in the *Washington Post* can be found [here](#).

Editor’s Observations on The Way Forward: Helping People “Get Their Lives Back”

A. The Recurring Finding: The Need to Expand Community Service Capacity

As the impacts of the 2014 General Assembly reforms are reviewed, the recommendations of the Governor’s Task Force are considered, and the deliberations of the SJ 47 Subcommittee continue, it may be useful to return to the observation provided by former DBHDS Commissioner Stewart in the first presentation at the first meeting of the Governor’s Task Force in January of 2014. In that presentation, Commissioner Stewart noted that, in each of the multiple studies of Virginia’s mental health system, dating back to 1949, the primary study recommendation has always been the same: “Virginia needs to expand its capacity to serve individuals in their own communities with coordinated behavioral health and developmental programs and supports.” Each of those studies has also found that the funding to make that recommendation a reality has never been available. Moreover, the recession starting in 2008 resulted in *reductions* in state funding that still have not been fully restored. The consequence, according to Commissioner Stewart: “*Due to the inadequate capacity of ongoing treatment and support services, the crisis response network has often become the default system.*”

This chronic condition of the system means that more people with mental illness will enter into crisis and will need emergency services that would not be needed if there were adequate community based services and supports available.

When those crises do occur, the challenge, as articulated by Dr. Barber and Mr. Martinez of DBHDS, is how to help these individuals in crisis “get their lives back” in a way that respects their autonomy and their right as citizens to make decisions about the care of their own minds and bodies.

The name chosen for the Governor’s Task Force reflects Virginia’s challenge: first, the Commonwealth must have a health care system that enables people to remain healthy and stable; second, when individuals do experience a mental health crisis, the Commonwealth must have intervention and support services and processes that enable those individuals to “get their lives back” as quickly, and with as little trauma, as possible.

B. The Challenge of Financing Transformation in Behavioral Health Care

While the Task Force report included a number of recommendations that addressed key components of the overall system of behavioral health care in Virginia, it did not specifically address the financing of that system, or its linkage to other, related systems. The Ongoing Treatment and Supports Work Group did address this in part in recommendations that were *not* included in the final Task Force report. Those recommendations called for “reinventing” the service system in a way that, among other things, makes mental health care a part of overall health care; that provided primary and prevention services; that incorporate housing, employment and other non-medical support services as critical components of maintaining behavioral health; and that funds these various services by *not* separating the funding streams that support them, and enabling service providers to keep and re-invest any savings realized as a result of their efforts.

The Kaiser Family Foundation reviewed the funding challenges facing behavioral health care nationally in a 2011 [report](#) entitled *Mental Health Financing in the United States: A Primer*. Two of the key findings of the Primer in regard to financing the behavioral health care system appear to affirm the recommendations of the Ongoing Services and Support Work Group for “reinvention” of the behavioral health care system in Virginia. They are:

1. *The need for “physical-behavioral health integration”* – As the primer noted, research has documented “a high rate of co-occurrence of mental and physical health problems. Adults with a serious mental illness are more likely than those without to have chronic medical conditions such as heart disease and diabetes, and children who experience behavioral health problems are more likely to develop general health problems as adults. Similarly, poor physical health has been associated with mental health problems such as depression or anxiety. System fragmentation exacerbates this problem: people with serious mental illness often receive most of their care from the specialty behavioral health sector and have poor access to physical care services (and are less likely to receive evidence-based or high-quality care when they do access services), and physical health specialists are often not attuned to the need for or reimbursed for mental health services.” To date, most efforts to integrate physical and behavioral health care services have been “stymied” by “difficulty navigating information-sharing regulations, cultural norms among providers, and competing priorities.” ([Primer](#), pp. 20-21)

2. *The need to reduce the current fragmentation of financing for services in order to make “transformation” possible* - The *Primer* notes the push nationwide for “transformation” of the behavioral health care system, with the goal of enabling persons with serious mental illness to “live, work, learn, and participate fully in their communities.” In a “transformed” system, “services are coordinated to provide the full range of evidence-based clinical and support services that an individual needs”. Unfortunately, financing for this “full range of services” is “fragmented across multiple programs,” with programs that “provide health financing” operating in isolation from programs that provide “social services”, resulting in “conflicting eligibility rules, service providers, or information systems.” One example: “...federal vocational rehabilitation funds may reimburse for vocational training in supported employment programs, while Medicaid may finance the individual counseling required to achieve success in such a program. In many cases, an individual does not meet eligibility for services under each distinct program and cannot access the breadth of benefits.” ([Primer](#), pp. 21-22)(An innovative program in Arlington County, Virginia, which has a central goal of finding stable housing for the homeless – but which often works with clients for whom mental illness and/or substance abuse is a central issue – uses an interagency team that takes a “no silos” approach in regard to the eligibility of individuals for services. That program, described in this *Washington Post* [article](#), may be one model for overcoming the fragmentation of services.)

C. Responding to Crisis

The statutory reforms of the 2014 General Assembly session revised Virginia’s involuntary commitment system to require that persons in mental health crisis and subject to an Emergency Custody Order (ECO), who are found to meet the criteria for issuance of a Temporary Detention Order (TDO) for psychiatric hospitalization, will not be subject to release to the community for lack of a psychiatric hospital bed but instead will have an emergency psychiatric hospital bed provided

somewhere in Virginia. While that statutory assurance does *not* apply to persons in mental health crisis who meet TDO criteria but are *not* subject to an ECO, DBHDS has made a sensible administrative decision to ensure that these individuals also are *not* released but instead find an emergency psychiatric bed.

These important reforms should ensure that Virginia does not experience another tragedy like the one experienced by the Deeds family in November of 2013. However, those reforms did not question, and did not substantially change, the current Virginia statutory model for intervention and treatment in the case of mental health crisis. The current Virginia model is significantly different from the model used by a number of other states.

If the goal of crisis intervention is to enable people in crisis to “get their lives back” as quickly, and with as little trauma, as possible, is it possible that another model of state intervention can more effectively accomplish that goal? The Commonwealth finds itself at a juncture where that question needs to be fully explored.

John E. Oliver, Editor

Institute Programs

Please visit the Institute’s website at
<http://cacsprd.web.virginia.edu/ILPPP/OREM/TrainingAndSymposia>
to see announcements of programs being offered in the period September 2014 through June 2015. Please re-visit the website for updates.

Of special note:

***Violence and Aggression Assessment with Veterans
March 27 2015, Charlottesville VA***

<http://cacsprd.web.virginia.edu/ILPPP/OREM/AdultPrograms/Course/69>

This one-day program will engage participants with a leading expert on forensic mental health issues with veterans, Eric Elbogen PhD, University of North Carolina-Chapel Hill. Dr Elbogen will review and discuss up-to-date scientific literatures on risk and protective factors associated with aggression post-deployment and on violence in military populations generally. Systematic risk assessment will be discussed. Participants will experience a ‘walk through’ of a violence screening (with the VIO-SCAN) and a systematic violence risk assessment.

Registration fee:

Employees of Virginia DBHDS facilities and Community Services Boards: \$60.

Others: \$135

With any questions about this or other program please contact els2e@virginia.edu

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