

**Governor's Taskforce on
Improving Mental Health Services
and Crisis Response**

Meeting Materials

January 28, 2014

- Agenda
- Minutes from January 7, 2014 meeting
- Presentation – Revised DBHDS policies and protocols for accessing state hospital beds within the ECO period, Jack Barber, MD, DBHDS Medical Director
- Details from “A Study of Face-to-Face Emergency Evaluations Conducted by Community Services Boards in April 2013” By the Institute of Law, Psychiatry, & Public Policy, University of Virginia -- Funded by the Virginia Department of Behavioral Health and Developmental Services, and in collaboration with the Virginia Association of Community Services Boards
- The Virginia Acute Psychiatric and CSB Bed Registry Initiative Update
- Recommendations from Workgroup Meetings of January 24, 2014
 - Crisis Response Workgroup Recommendations
 - Ongoing Treatment & Supports Workgroup Recommendations
 - Public Safety Workgroup Recommendations
 - Technical & Data Infrastructure Workgroup Recommendations
- Public Comment

Governor's Taskforce on Improving Mental Health Services and Crisis Response

January 28, 2014

1 p.m. – 4 p.m.

East Reading Room, Patrick Henry Building

Agenda

- 1:00 p.m. – 1:10 p.m. **Welcome and Approval of Minutes**
William A. Hazel Jr., MD, Secretary of Health and Human Resources
Brian Moran, Secretary of Public Safety
- 1:10 p.m. – 1:35 p.m. **Presentation – Revised DBHDS policies and protocols for
accessing state hospital beds within the ECO period**
Jack Barber, M.D., DBHDS Medical Director
- 1:35 p.m. – 2:05 p.m. **Crisis Response Workgroup Recommendations**
*Cynthia McClaskey, Ph.D., Task Force Member, Southwestern
Virginia Mental Health Institute*
- 2:05 p.m. – 2:35 p.m. **Ongoing Treatment & Supports Workgroup Recommendations**
Michael O'Connor, Task Force Member, Henrico CSB
- 2:35 p.m. – 2:40 p.m. **Break**
- 2:40 p.m. – 3:10 p.m. **Public Safety Workgroup Recommendations**
Victoria Cochran, Deputy Secretary, Public Safety
- 3:10 p.m. – 3:40 p.m. **Technical & Data Infrastructure Workgroup**
Betty Long, Virginia Hospital and Healthcare Association
- 3:40 p.m. – 3:50 p.m. **Public Comment**
- 3:50 p.m. – 4:00 p.m. **Next Steps**
- 4:00 p.m. **Adjourn**

Note:

* Materials provided to the task force members are available at www.dbhds.virginia.gov/MHSCRTTaskforce.htm
Comments from the public may also be made through the same webpage.

Governor's Taskforce on Improving Mental Health Services and Crisis Response

January 7, 2014

1 p.m. – 4 p.m.

West Reading Room, Patrick Henry Building

MEETING MINUTES

Members Present

Co-Chairs

The Honorable Bill Hazel, MD, Secretary of Health and Human Resources

The Honorable Bryan Rhode, Secretary of Public Safety

Members

The Honorable Kenneth Cuccinelli, Attorney General of Virginia

The Honorable Cynthia Kinser, Chief Justice of Virginia Supreme Court

(Edward Macon substituting)

The Honorable Emmett Hanger, Senate of Virginia

The Honorable Janet Howell, Senate of Virginia

The Honorable Rob Bell, Virginia House of Delegates

The Honorable Joseph Yost, Virginia House of Delegates

James Stewart, Commissioner, Department of Behavioral Health and Developmental Services

Cindi Jones, Commissioner, Department of Medical Assistance Services

Margaret Schultze, Commissioner, Department of Social Services

Colonel Steven Flaherty, Superintendent, Virginia Department of State Police

The Honorable Gabriel Morgan, Sheriff, City of Newport News

The Honorable James Agnew, Sheriff, County of Goochland, Goochland

John Venuti, Chief, VCU Police Department, Richmond

Mike O'Connor, Executive Director, Henrico Area Community Services, Henrico

Chuck Walsh, Executive Director, Middle Peninsula-Northern Neck CSB, Saluda

Lawrence "Buzz" Barnett, Emergency Services Director, Region Ten CSB, Charlottesville

Kaye Fair, Emergency Services Director, Fairfax-Falls Church CSB, Fairfax

Melanie Adkins, Emergency Services Director, New River Valley Community Services, Blacksburg

Jeffrey Lanham, Regional Magistrate Supervisor, 6th Magisterial Region

Daniel Holser, Chief Magistrate, 12th Judicial District

Bruce Lo, MD, Chief, Department of Emergency Medicine, Sentara Norfolk General Hospital, Norfolk

William Barker, MD, Emergency Medicine, Fauquier Hospital, Warrenton

Douglas Knittel, MD, Psychiatric Emergency Services, Portsmouth Naval Hospital, Portsmouth

Thomas Wise, MD, Dept. of Psychiatry, Inova Fairfax Hospital, Falls Church

Anand Pandurangi, MD, VCU, Richmond

Cynthia McClaskey, PhD, Director, Southwestern Virginia Mental Health Institute, Marion

Joseph Trapani, Chief Executive Officer, Poplar Springs Hospital, Petersburg

Ted Stryker, Vice President, Centra Mental Health Services, Lynchburg

Greg Peters, President and CEO, United Methodist Family Services, Richmond

Teshana Henderson, CAO, NDUTIME Youth & Family Services, Richmond

Becky Sterling, Saluda

Ben Shaw, Fredericksburg
Rhonda VanLowe, Fairfax
Tom Spurlock, Roanoke

Staff Present

John Pezzoli, Assistant Commissioner of Behavioral Health Services, DBHDS
Jim Martinez, Director of Office of Mental Health Services, DBHDS
Janet Lung, Director of Office of Child and Family Services, DBHDS
Michael Shank, Director of Community Support, DBHDS
Meghan McGuire, Director of Communications, DBHDS
Maria Reppas, Deputy Director of Communications, DBHDS

Members Absent

Scott Syverud, MD, Vice Chair, Clinical Operations, UVA School of Medicine, Charlottesville

Others Present

Brian Moran – Appointed Secretary of Public Safety for Governor-elect McAuliffe was also in attendance

Welcome and Charge from the Governor

Governor Robert F. McDonnell

William A. Hazel, Jr., MD, Secretary of Health and Human Resources

Bryan M. Rhode, Secretary of Public Safety

Governor McDonnell welcomed the task force members, emphasizing the extreme importance of the task force. He noted that so many of us know a family or individual who struggles with the challenges of mental health problems, and therefore is engaged in the significance of the work of the task force. There are so many people who depend upon the best ideas this task force may advance. And we can really make a difference in the daily lives of many Virginians. Much progress has been made in serving people in the community and in making improved pharmaceuticals available that support recovery. The Governor set high standards for the group, challenging members to look at every aspect of the system, especially focusing on the crisis response part of the continuum and extended temporary detention order time periods.

Secretary Hazel reviewed Executive Order 68 and the agenda for today's meeting, noting that the group has a packed agenda for today and an enormous amount of work to do. He also recognized Senator Hanger and Howell and Delegates Bell and Yost and Attorney General Cuccinelli.

Secretary Rhode expressed special appreciation for members of law enforcement. He introduced his successor, Brian Moran, who has a wealth of experience in public safety. Secretary-elect Moran noted that the challenges are great, but not insurmountable.

Swearing In of Members

Secretary Janet Kelly swore in the members of the task force and asked that they sign their official forms.

Briefing on FOIA

Allyson K. Tysinger, Senior Assistant Attorney General/Chief, Office of the Attorney General

FOIA assures ready access to public records and public meetings. This workgroup is a public body and all of its records are public. Members were cautioned that a meeting constitutes three or more members of the group and, therefore, they should avoid such small group discussions and should not "reply-all" to informal discussions of work group matters.

Plan and Schedule of Meetings, Deadlines and Workgroup Activity

William A. Hazel, Jr., MD, Secretary of Health and Human Resources

Secretary Hazel named the four workgroups that are planned:

1. Crisis Response
2. Ongoing Treatment and Supports
3. Technical and Data Infrastructure
4. Public Safety

Introductions by Members –

Members introduced themselves, briefly identifying their roles and the expertise and interests they bring to the Task Force

Presentation – Overview of the Publicly-Funded Behavioral Health Service System

James W. Stewart, III, Commissioner, Department of Behavioral Health and Developmental Services

Commissioner Stewart gave a historical overview and timeline of several commissions and task forces that have shaped and contributed to the development of the current system. The consistent message through all of these was to expand capacity to serve individuals in their own communities with coordinated behavioral health and developmental programs and supports. He described the current system, including Community Services Boards (CSBs), private providers and state hospitals. Due to the inadequate capacity of ongoing treatment and support services, the crisis response network has often become the default system. Very little new funding has been targeted to improving the ongoing treatment and support services. Since 2003, almost \$92 million has been allocated to state hospitals and community mental health programs, but over \$57 million in budget reductions resulted in a net gain of only \$34 million. Virginia ranks 10th in the nation for investment in hospitals and 37th in funding community services. Finally, he described the areas where DBHDS has implemented priority initiatives during the current administration.

(Handout provided)

Overview of Civil Commitment Statutes

Allyson K. Tysinger, Senior Assistant Attorney General/Chief, Office of the Attorney General

Ms. Tysinger discussed Virginia's commitment statutes as detailed in the handout. The statutes are complex, and today's presentation is just a general overview. She noted the multiple roles of CSBs: conducting the prescreening, including determining whether the person meets the commitment criteria, finding a facility of temporary detention during the four to six hours of the Emergency Custody Order, attending the commitment hearing (approximately 22,000 in FY 12), and also providing community services and supports.

(Handout provided)

Presentation – Clinical Issues in the Prevention of Psychiatric Crises and the Provision of Crisis Response Services

Jack Barber, M.D., DBHDS Medical Director

Dr. Barber described a study by Richard Bonnie during the month of April 2013. In 50% of the cases studied, the person evaluated had never been seen by the CSB before, thereby requiring the emergency service person to do a risk assessment often on a person for whom there is no history. It is difficult to predict risk, and history is one of the best predictors. For some individuals the crisis can be diffused through various strategies, but some will need inpatient treatment. Managing the state hospital bed resources is critical to assuring that capacity is available when needed. 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.

Presentation – Law Enforcement Perspective

Dana Schrad, Virginia Association of Chiefs of Police, and John Jones, Virginia Sheriff's Association)

On behalf of the Association of Chiefs of Police and the Association of Campus Law Enforcement Administrators, Ms. Schrad provided seven recommendations to address the challenges of the law enforcement role in dealing with mental illness, which are detailed in the handout. She stressed that the mental health transportation burden on local law enforcement is significant. Though safety is served, the traditional transportation 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.

(Handout provided)

Mr. Jones spoke on behalf of the Sheriff's Association. Transportation is viewed as a public safety issue. He urged the committee to look at alternative means of transportation. In addition, there need to be methods to divert people with mental health problem from jails, including creating other beds outside of law enforcement settings. He provided four recommendations detailed in the handout.

(Handout provided)

Presentation – Medicaid and Magellan Perspective

Karen Kimsey, Deputy Director of Complex Care and Services, Virginia Department of Medical Assistance Services

As detailed in the handout, Ms. Kimsey summarized behavioral health service utilization, comprising 9% of the Medicaid budget.

(Handout provided)

Bill Phipps, LCSW, General Manager, Magellan of Virginia

Mr. Phipps gave an overview of the Behavioral Health Service Organization contract that took effect on December 1, 2013. The purpose is to improve quality and care coordination.

(Handout provided)

Presentation – G. Douglas Bevelacqua, Director, Behavioral Health and Developmental Services Division, Office of the State Inspector General

Mr. Bevelacqua discussed findings from the OIG Review of Emergency Services 2012. About 1400 people per year may be denied clinically appropriate care (every day, that equates to 3 to 4 people in the Commonwealth). He emphasized adopting a core value for the system, that every person who is evaluated and meets criteria is admitted to a facility – every person, every time, in order to have a system that makes no mistakes. He reiterated Governor McDonnell's opening words that the system needs to be 100% right 100% of the time. It may be best to uncouple finding a bed from assessing a person's need for inpatient care. He challenged the task force not to accept the status quo – that some people who need hospitalization will not get it. He mentioned the electronic bed registry and asked if private hospitals should be required to participate in the registry in order to be licensed. Mr. Bevelacqua asked the task force members: how would you want your family to be treated?

Presentation – Governor McDonnell's Mental Health Legislation and Budget Proposals and Recommendations from Secretary of HHR Investigation

John Pezzoli, Assistant Commissioner for Behavioral Health Services, DBHDS

Assistant Commissioner Pezzoli reviewed Governor McDonnell's proposals for behavioral health focusing on legislative change and budget proposals for outpatient services, Programs of Assertive Community Treatment Teams (PACT) teams, peer support recovery programs and telepsychiatry. He also reviewed the recommendations from HHR Secretary Hazel's Review.

The electronic psychiatric bed registry is implemented in partnership with VHHA and VHI. It is being implemented now. Notices are going out to request that the data fields in the registry be populated and it will be fully operational in early March. Critical variables will be the frequency with which it is updated and the DBHDS staffing ability to monitor and analyze the data provided by the registry. Staffing in the Office of Mental Health has declined by 50% since 2008.

(Handout provided)

Governor-Elect Terry McAuliffe joined the meeting briefly. He thanked all of the task force members for their commitment to serve and emphasized the significance of the work that lies ahead. The Governor-elect pledged his commitment to support improvements in mental health services.

Public Comment

Mary Ann Bergeron, Executive Director, Virginia Association of Community Services Boards

Ms. Bergeron urged the task force to pay attention to the need for a balanced effort between law enforcement, mental health and all partners. The crisis system should fill in the gaps. The community should have the capacity to provide the ongoing treatment and support services with the crisis services filling in the gaps. Right now the opposite is true.

Mira Signer, Executive Director, National Alliance on Mental Illness, Virginia

Ms. Signer said that it is sad that we are here, but we have an opportunity that we are thankful for. Take a broad view of things, not just the specific incident, or looking for a quick fix, but a comprehensive view. Wouldn't it be wonderful if we could have crisis stabilization across the state, people out of jails, and sufficient availability of beds.

Margaret Nimmo Crowe, Executive Director, Voices for Virginia's Children

Ms. Nimmo-Crowe said that we tend to look at policies after incidents. But, even before the recent incident, there were many children who needed mental health services. On behalf of VOICES, she urged the task force to consider this. There may need to be more family members on the task force.

Ann Edgerton, Executive Director, Mental Health America, Virginia

Ms. Edgerton said that MHAV urges the task force to focus on recovery and reduction of stigma. Prevention and recovery go hand in hand.

Bonnie Neighbour, Executive Director, Virginia Organization of Consumers Asserting Leadership

Ms. Neighbour said that VOCAL's 1700 members are representative of the 1 in 4 who have mental illness or have a family member with mental illness. Looking around this room, there may not be enough consumers. They are the experts on what's working. Need to provide the community based services so that consumers can be independent, be taxpayers and stay in recovery.

Trudy Harsh, The Brain Foundation

Ms. Harsh voiced concerns about the use of language, including the terms "behavioral health," "consumer," and even "mental health." She prefers stating that a person is physically ill and has a brain disease. Should it be called a brain hospital instead of a psychiatric hospital?

Task Force Discussion and Recommendations of Items for Consideration

Secretary Hazel asked for input about four planned workgroups – one on crisis response, another on workforce and services capacity, a third on terminology and data analysis, and a fourth on law enforcement. There was limited time for discussion due to the lengthy agenda for this first meeting. Communication about next steps will be sent to members.

Next meeting: January 28th in the afternoon. Workgroups will meet on January 16th from 10 am to 2 pm. Members will receive more detailed information in the very near future.

Adjourn – the meeting adjourned at 4:15 p.m.

Notes:

* *Materials provided to the task force members are available at www.dbhds.virginia.gov/MHSCRTTaskforce.htm. Comments from the public may also be made through the same webpage.*

Governor's Task Force on Improving Mental Health Services and Crisis Response

Tuesday, January 28, 2014

Dr. Jack Barber
Medical Director,
DBHDS

Regional Protocol Revisions to “Find a Bed” for Individual Requiring TDO

- In the study conducted by UVA of the April, 2013 emergency evaluations there were four cases among the 1300 plus TDOs where “no bed” was found.
- While in many endeavors a 99.5% success rate would be considered very good **this is an area in which we have to be 100%** (Governor McDonnell, Secretary Hazel).
- Further, while the large majority of TDOs were executed within 6 hours the 3.7% that were not reflect problems which we need to address so that individuals do not wait any longer than is necessary and we do not extend our ES workers, LE Officers, and ED personnel for such extended periods whenever it is possible to do otherwise.
- While we do this we also have to recognize that **the safety net of state hospital beds is finite** and so while our efforts related to admission need to be addressed, we also have to be very active to make sure that there is a bed at the end of the line for those efforts.
- **And what we develop must work within its region as we understand there are different circumstances, demands, geography, beds, local community resources, etc.**

Regional Protocol Revisions to “Find a Bed” for Individual Requiring TDO

- **Identify the minimum specific private hospitals that are to be contacted to find a bed prior to accessing the state facility.** You all will decide if there is a particular order, whether it is or is not the same for each CSB, how to contact the hospital in terms of numbers and/or individuals, whether or for how long you wait for an answer before calling the next one, and so forth.
- You may also have additional hospitals that are optional depending on insurance status, patient preference, etc. that may be used when there is an indication and time permits. This may also become useful if your primary state hospital is full depending on time/distance to the back-up. (Out of catchment will be a challenge for Liaison staff doing DC planning, state facilities, families, LE, etc.)
- **At what point you contact the primary state hospital (adult and geriatric) PRIOR to the expiration of the ECO.** Contact information (may need to be provided by state facility, but they should be part of the development anyway). Who will make the contact if not the ES evaluator?

Regional Protocol Revisions to “Find a Bed” for Individual Requiring TDO

- Indications for the Emergency Services (ES) evaluator to contact ES Manager, CSB Clinical Director, CSB Executive Director, etc. if there are problems, i.e. going **“up the chain of command”** within the CSB by whatever steps are determined.
- Contact information for state facility 24/7/365
- Procedure to request ECO extension (if law maintains provision to do so, there are bills to simply have a straight 8 hours, 12 hours, 24 hours, etc. pending).
- Plan for record keeping regarding hospital contacts, times, and “answer”. Checksheet/log?
- Communication plan to assure all ES workers have current information
- Use of LIPOS (Local Inpatient Purchase of Service). This could affect the required list above. Calls for LIPOS only folks may be different or more limited than calls for people with Medicare or Medicaid or private insurance as this affects patient/family choices and preferences. If LIPOS runs out how does procedure change? How does the change get communicated?
- If the person is ID is there a provision to contact ID Services, START? At what point in process? Contact information?
- Provisions for Traumatic Brain Injury, Dementia, and other special populations

Regional Protocol Revisions to “Find a Bed” for Individual Requiring TDO

Medical “clearance/screening” process

- Develop information sheets for private psychiatric units and state facilities to communicate medical capacity to Emergency Department staff
- Processes necessary at interface between medical screening and TDO: accept for TDO pending clearance, accept for TDO only after clearance, both, however it is to work.
- State facility process to reach decision regarding acceptance of individual’s medical needs

Regional Protocol Revisions to “Find a Bed” for Individual Requiring TDO

Utilization Review Processes to assure state bed is available when needed beyond using alternatives whenever possible within relevant time frames.

Examples may include:

- Use of RAC (Regional Access Committee) group to review requests for transfers from private to state facilities (non-TDO).
- Monthly review of individuals ready for discharge and/or on Extraordinary Barriers list by CSB and state hospital staff
- Review of utilization related data by regional Utilization Management Team and/or CSB Executive Directors: admissions, discharges, census, number of TDOs, length of stay, LIPOS days and dollars, etc. for relevant state facilities and region’s CSBs.
- State hospital internal UM processes to assure expeditious treatment
- Forensic individuals included in UM activities

Guidelines: Required protocol elements for state hospitals, CSBs, private hospitals

Issued by DBHDS, Jan. 15, 2014

Step 1

CSB prescreener 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

Before the ECO expiration if it is appearing likely that the community hospital bed search will not be successful, 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 can't be found in a reasonable time at another state hospital, the primary hospital director will contact the Asst Comm. for BH 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 processes 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

Regional Protocol Revisions to “Find a Bed” for Individual Requiring TDO

Facility: Catawba Hospital	
CAPABILITIES	
Physician	
Primary Care Physician in house 24/7	*N
Psychiatrist in house 24/7	*N
Physician on call by phone only after hours/weekends	Y
*Note: Catawba does have 24-7 on-site physician coverage. However, coverage may be either a psychiatrist or a primary care physician.	
Nursing	
RN on unit 24/7	Y note: LPN in charge in collaboration with nursing supervisor on one unit, 6-8 times per month
RN on site 24/7, but not on each unit	Y
Nursing Services	
Frequent vital signs, q 2 hours or less	Y note: not for long periods of time
Intake and output monitoring	Y
Weights (b.i.d. or less)	Y
Accuchecks for blood glucose monitoring	Y
O2 Saturation	Y

Regional Protocol Revisions to “Find a Bed” for Individual Requiring TDO

<u>Diagnostic Testing</u>	
STAT labs on site regular working hours	N
STAT labs on site 24/7	N
Routine X Rays on site regular working hours	portable x-ray machine for simple radiologic studies
STAT X Rays on site 24/7	N
EKG/STAT EKG regular working hours	Y
STAT EKG 24/7	Y however, only preliminary read 24- 7
Arterial blood gas	N
Venous Doppler	N
Bladder Ultrasound	N
Swallow Studies on site regular work hours	N O.T. swallowing evaluations during regular work hours
Percutaneous procedures (drain fluids, biopsy, etc.)	N

Regional Protocol Revisions to “Find a Bed” for Individual Requiring TDO

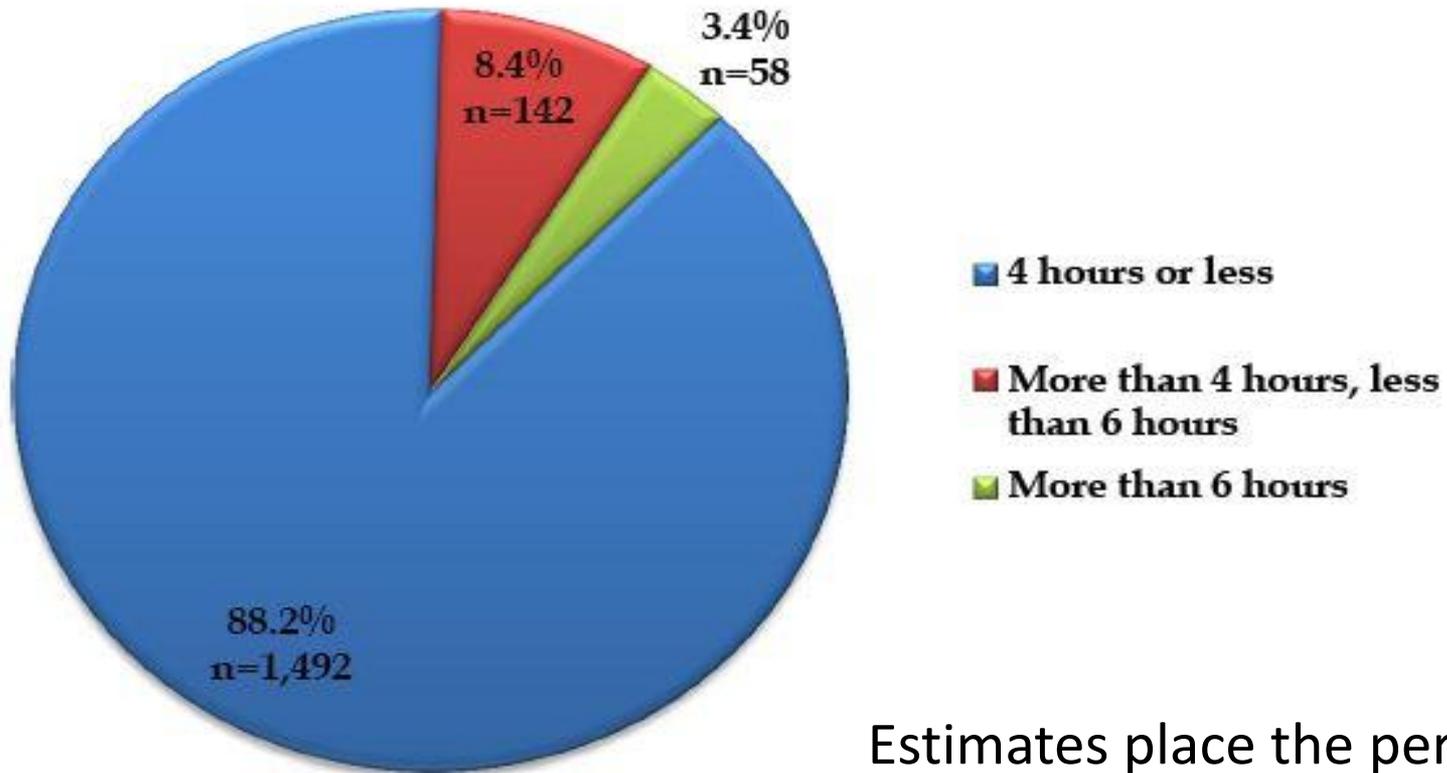
<u>Interventions</u>	
Continuous electronic monitoring (VSs, O2, etc.)	N
IV Fluids	N
IV Antibiotics or other medications	N
Indwelling urinary catheter management	only for short term, limited use; not ongoing management
PICC Management	N
Total Parenteral Nutrition (TPN)	N
Feeding through G or J tube Isolation	N G-Tube only
Decubitus management Stage 1 – 2	Y
Decubitus Management Stage 3 – 4	N
Surgical Drain Management	Y uncomplicated, short term
Tracheostomy Management	N
In and Out Urinary Catheterization	Y
Analgesic Pumps	N
Methadone Maintenance for SA	N
Chemotherapy	N
Basic CPR plus AED	Y
Advanced CPR (ACLS)	N
<u>Emergency Treatment</u>	
Immediate: In house	N
Call 911 only	Y
Time from 911 call to ER	average range is 45 – 60 min (less often 60-90”; rarely <30”)

Details from “A Study of Face-to-Face
Emergency Evaluations Conducted by
Community Services Boards in April 2013”
By the Institute of Law, Psychiatry, & Public Policy,
University of Virginia

*Funded by the Virginia Department of Behavioral Health and
Developmental Services, and in collaboration with the Virginia
Association of Community Services Boards*

Time Spent Locating an Admitting Hospital With an Available Psychiatric Bed*

Figure 25

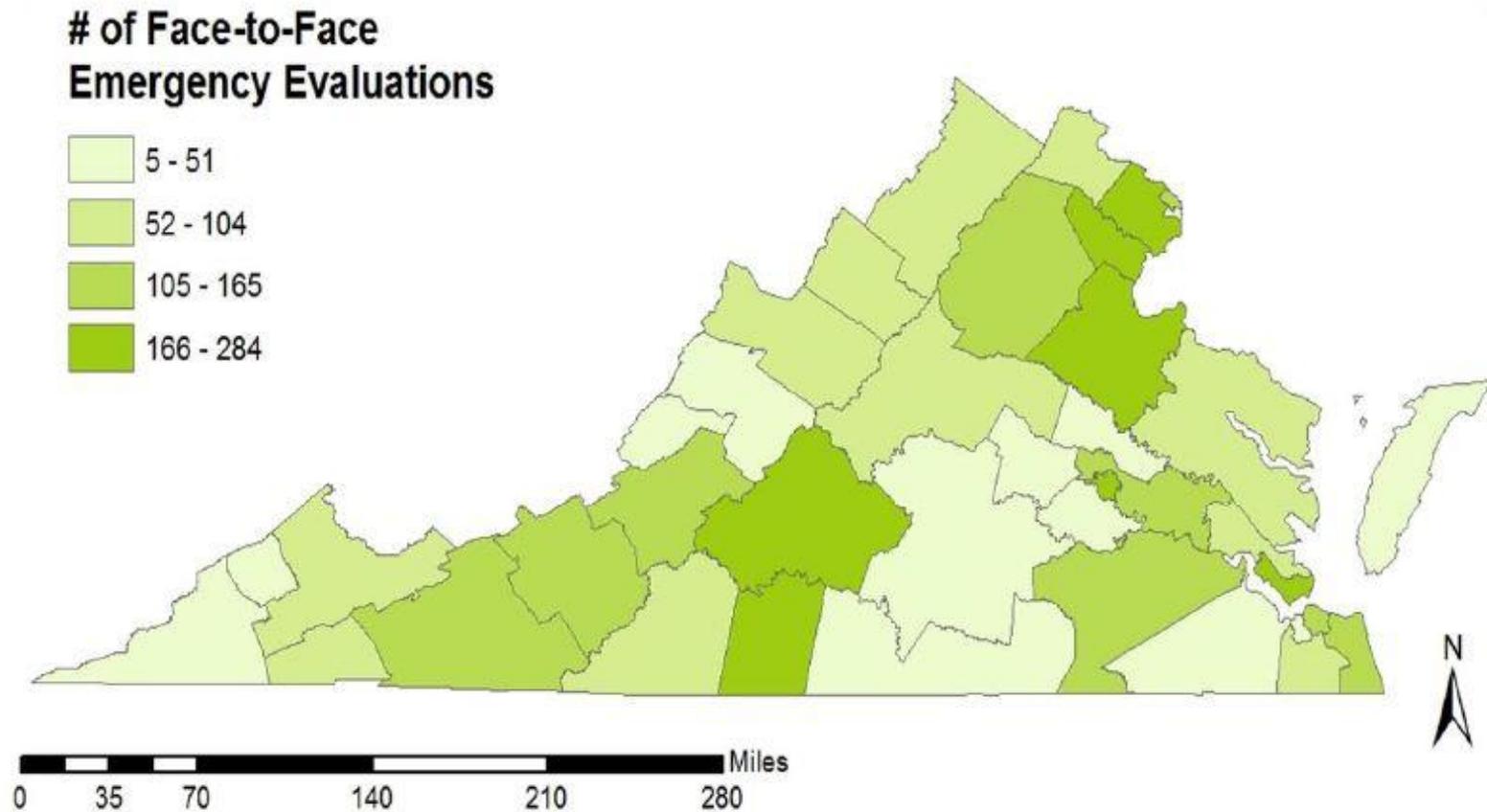


* All figures are from a UVA/DBHDS/VACSB Study: *A Study of Face-to-Face Emergency Evaluations Conducted by Community Services Boards in April 2013*

Estimates place the percentage of those who insisted on leaving when the ECO period expired at 0.71%

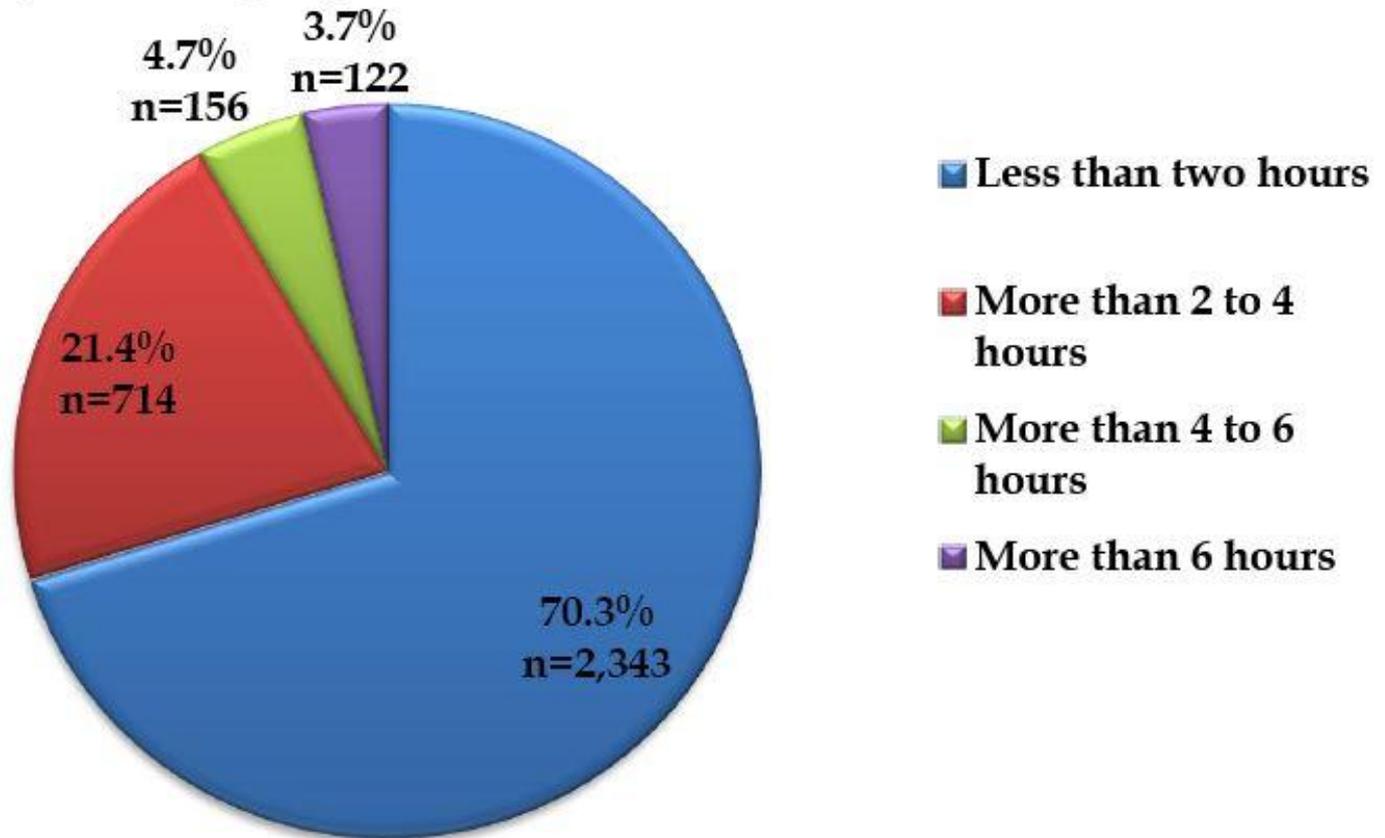
Number of Emergency Evaluations Conducted During the Survey Month, by CSB Location

Figure 1. Number of emergency evaluations conducted during the survey month, by CSB location.



Length of Emergency Evaluation

Figure 14. Length of emergency evaluation



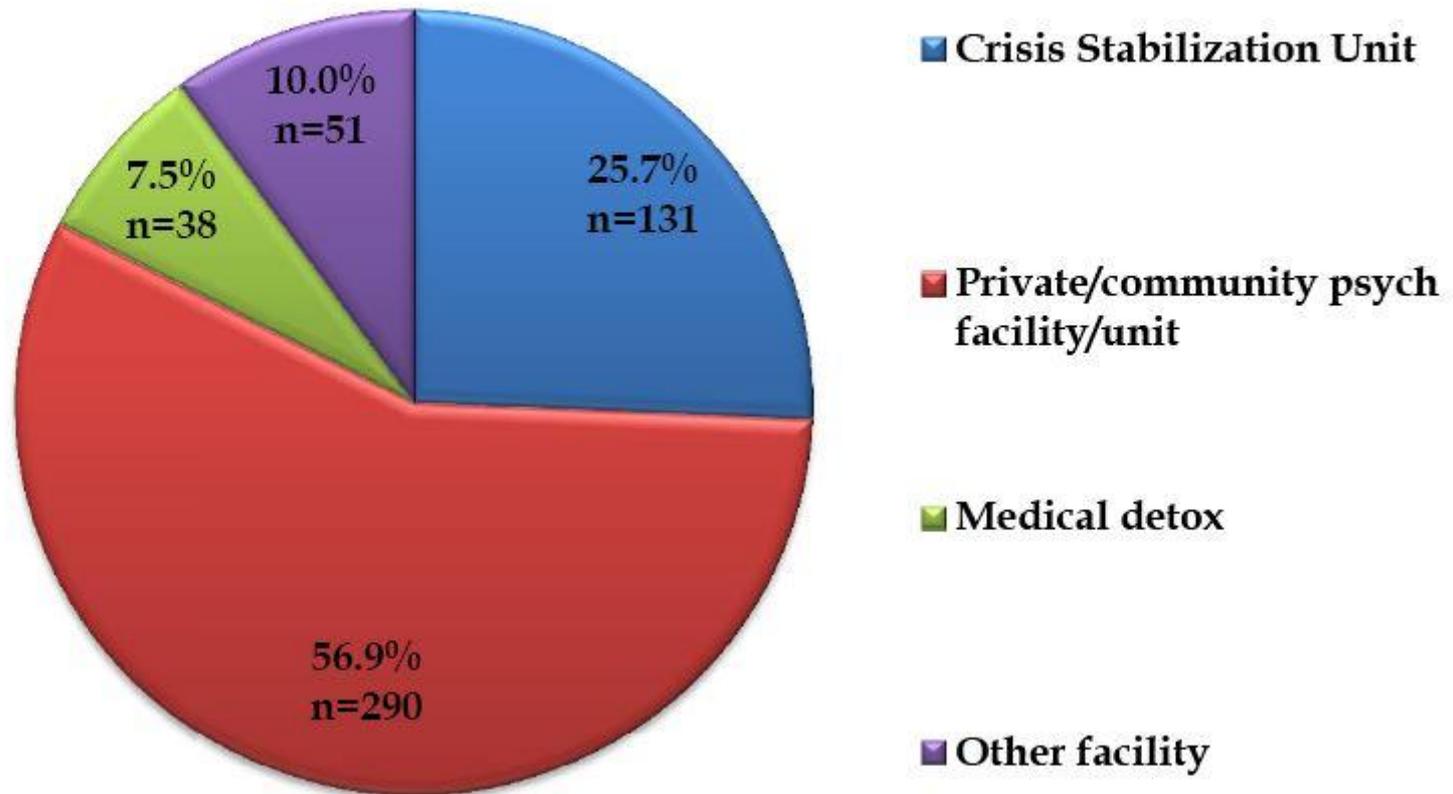
Adults Presenting Psychotic Symptoms

Table 18. Adults presenting psychotic symptoms

	Frequency	Percent
Psychotic symptoms	1,063	30.9
No psychotic symptoms	2,373	69.1
Total	3,436	100.0

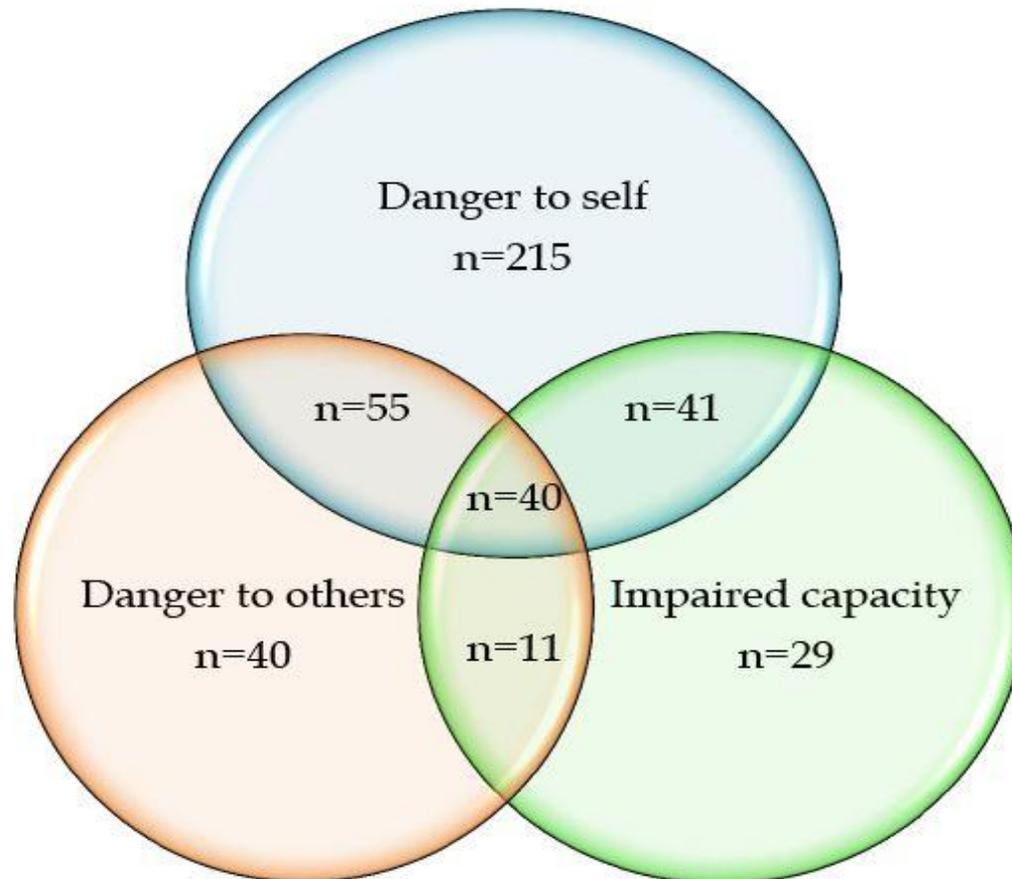
Facilities Where Adults Were Admitted After a Voluntary Admission

Figure 24. Facilities where adults were admitted after a voluntary admission



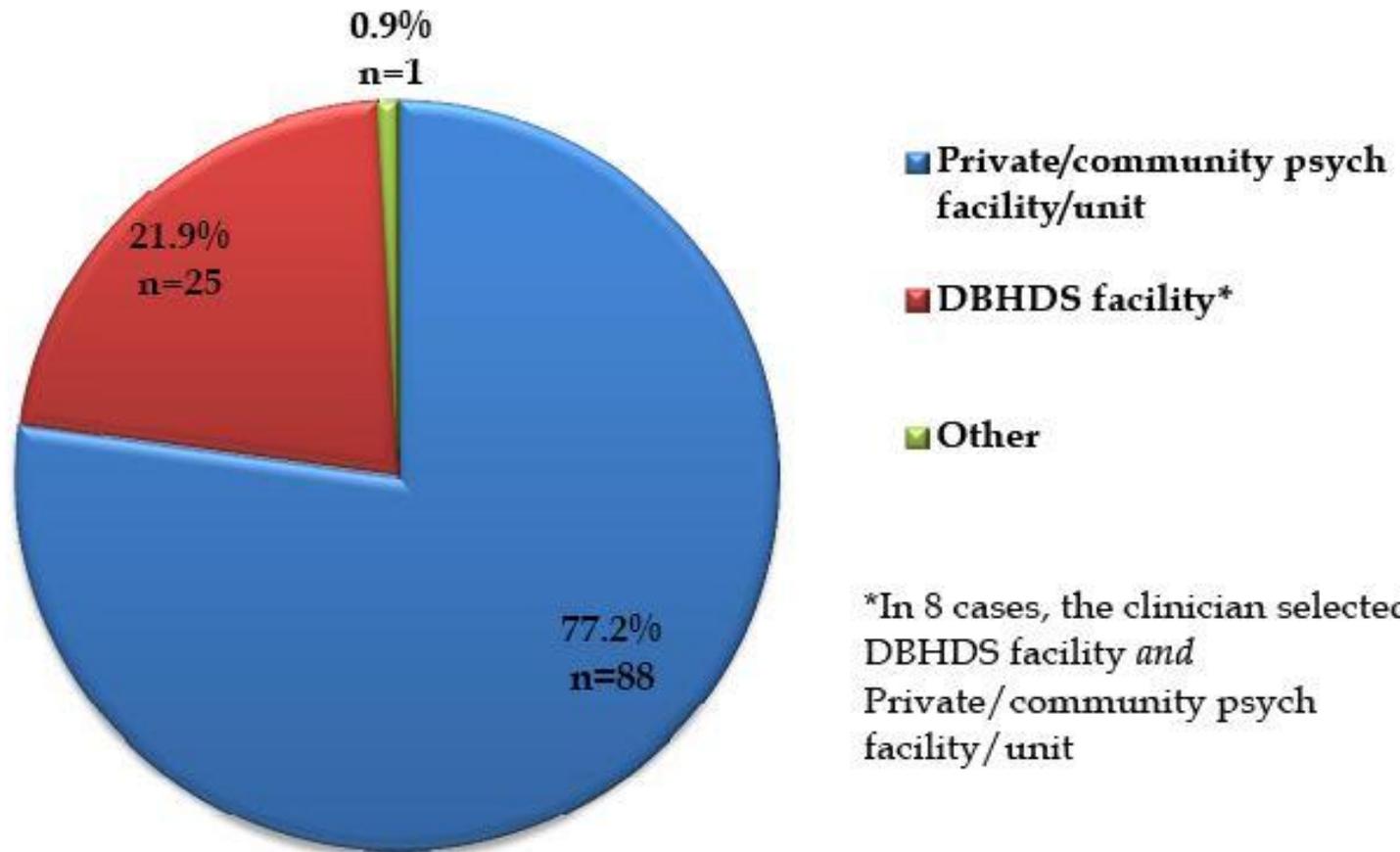
Displays by Evaluated Juveniles of Behaviors Bearing on Involuntary Commitment Criteria, Combinations

Figure 45. Displays by evaluated juveniles of behaviors bearing on involuntary commitment criteria, combinations



Facilities Where Juveniles Were Admitted After a TDO was Granted

Figure 50. Facilities where juveniles were admitted after a TDO was granted (n=114)



Length of Emergency Evaluations

Table 14. Length of emergency evaluations

	Frequency	Percent
One hour or less	1,188	35.6
Between 1 and 2 hours	1,155	34.6
More than 2 to 3 hours	467	14.0
More than 3 to 4 hours	247	7.4
More than 4 to 5 hours	111	3.3
More than 5 to 6 hours	45	1.3
More than 6 to 9 hours	41	1.2
More than 9 to 12 hours	11	0.3
More than 12 to 15 hours	47	1.4
More than 15 to 18 hours	15	0.4
More than 18 to 21 hours	3	0.1
More than 21 hours	5	0.1
Total	3,335	100.0

Clinician Recommended Dispositions

Table 24. Clinician recommended dispositions

	Frequency	Percent
Referred for involuntary admission (TDO)	1,370	40.2
Referred for voluntary admission	603	17.7
Referred for crisis intervention	130	3.8
Referred for crisis intervention and psychiatric/medication evaluation	114	3.3
Referred for other outpatient services	642	18.8
No further evaluation or treatment required	150	4.4
Client declined referral and no involuntary action taken	119	3.5
Other:		
Medical admission	48	1.4
Client stayed in hospital	7	0.2
Released with safety plan	18	0.5
Released to family	8	0.2
No bed	4	0.1
Substance abuse treatment or Detox	37	1.1
Arrested jailed	23	0.7
Left before treatment against medical advice	5	0.1
In ER	9	0.3
Help but not medical or psych	14	0.4
Crisis stabilization of some kind	92	2.7
Other (e.g., insurance issues)	15	0.4
Total	3,408	100.0

Number of Private Facilities Contacted for TDO and Voluntary Admission

Table 27. Number of private facilities contacted for TDO and voluntary admissions

Number of private facilities contacted	Referred for involuntary admission (TDO)		Referred for voluntary admission	
	Frequency	Percent	Frequency	Percent
1	751	64.3	299	81.0
2	171	14.6	31	8.4
3	84	7.2	18	4.9
4	50	4.3	3	0.8
5	27	2.3	6	1.6
Between 6 and 10	56	4.8	9	2.4
Between 11 and 20	26	2.2	3	0.8
More than 20	3	0.3	0	0.0
Total	1,168	100.0	369	100.0

Length of Juvenile Emergency Evaluation

Table 48. Length of juvenile emergency evaluation

	Frequency	Percent
One hour or less	163	28.3
Between 1 and 2 hours	229	39.8
More than 2 to 3 hours	89	15.5
More than 3 to 4 hours	54	9.4
More than 4 to 5 hours	14	2.4
More than 5 to 6 hours	11	1.9
More than 6 to 9 hours	6	1.0
More than 9 to 12 hours	1	0.2
More than 12 to 15 hours	6	1.0
More than 15 to 18 hours	2	0.3
Total	575	100.0

The Virginia Acute Psychiatric and CSB Bed Registry Initiative Update:

Background:

- The Department of Behavioral Health and Developmental Services (DBHDS) has been working with the Virginia Hospital and Healthcare Association (VHHA), community services board representatives and Virginia Health Information (VHI) to develop a web-based psychiatric bed registry (PBR) to collect, aggregate, and display data on the availability of acute beds in public and private inpatient psychiatric facilities and residential crisis stabilization units (CSUs) of community services boards (CSBs).
- Hosted by VHI, the Virginia Acute Psychiatric and CSB Bed Registry will be implemented state wide.

Purpose:

- The web-based bed registry is intended to provide descriptive information about each public and private inpatient psychiatric facility and each CSB and private residential crisis stabilization unit to CSB emergency services providers and psychiatric hospitals that need immediate access to inpatient or residential crisis services for individuals.
- The data base will include information about the potential availability of beds at each facility.
- Hospitals and Residential CSUs will maintain current program profiles. The bed census is envisioned to be updated at least daily by hospital and CSU staff.

Benefits

- The registry is a web based program which enables CSBs and psychiatric hospitals to search for acute psychiatric bed availability at all psychiatric hospitals (including state facilities) and crisis stabilization units 24/7.
- It will provide information for emergency services staff about potential bed availability and facilities to contact first, but would not eliminate need to call facilities for updated information and to discuss case specifics
- It is designed to enable CSB and hospital users to more efficiently determine the availability of appropriate beds in Virginia facilities using various search parameters within the registry data base.
- Queries can be tailored to specific needs (e.g., region, patient type, level of security, etc).
- CSBs, CSUs and state hospitals will be required by DBHDS to participate. Although participation by private hospitals is voluntary, these providers have been partners in this initiative.
- The registry will enable DBHDS administrators to monitor and evaluate usage and bed availability through various report features. This ongoing analysis of data will be used to provide feedback to all partners with the goal of increasing the efficiency of emergency services workers' ability to access a bed in an appropriate facility.

Limitations:

- The accuracy, credibility and reliability of the bed registry system will depend on the frequency of its updates (bed availability changes constantly during a 24-hour period) and the completeness and currency of facility profiles.
- Having an “available bed” is a necessary, but not sufficient, requirement to actually access a bed for needed care. Multiple factors may affect the actual availability and/or appropriateness of that bed for a specific proposed client. The provision of clinical information and medical clearance must be completed before an admission decision can be made.
- The registry will not replace the need to communicate clinical information regarding a potential admission, but it will be a useful tool in facilitation of triage to an appropriate placement.

Implementation:

- Development of the application (the bed registry) and user tutorials was completed as of November 2013.
- In December 2013, DBHDS and VHHA identified a single administrative point of contact for each CSB, state psychiatric hospitals, residential crisis stabilization units and private psychiatric hospital providers.
- Written communication about the Website launch went out from DBHDS January 6, 2014.
- A webinar training for administrative contacts and bed registry users was developed and is available through the DBHDS website.
- Daily bed census data entry began January 15, 2014. Providers are developing routines for daily data maintenance and fine-tuning operating procedures so that the bed registry will be of optimal benefit.
- Opportunities to enhance the PBR program are being identified and modifications to the program are ongoing.
- Beta testing with limited CSB emergency service workers utilizing the bed search function begins in February.
- We anticipate full operational use of the PBR in early March.
- A representative group of stakeholders will be convened to monitor the implementation process and use of the bed registry. DBHDS, VHHA and VHI will monitor implementation and bed registry utilization and provide feedback for continuous quality improvement.

If you have technical questions about the website (e.g., managing your facility data, using your login, etc.), please contact:

Deborah Waite
VHI Operations Manager
deborah@vhi.org

For non-technical or general questions regarding the Psychiatric Bed Registry, please contact:

William O’Bier
Department of Behavioral Health & Developmental Services
804-225-4242

william.obier@dbhds.virginia.gov

The Virginia Acute Psychiatric and CSB Bed Registry Initiative Screenshots:

Psychiatric Bed Registry Home Page Bed Searcher---

The screenshot shows a Windows Internet Explorer browser window displaying the website <https://www.vhi.org/pbr/>. The page has a blue header with navigation links: Home | How To Use This Website | FAQ | Update Bed Census Here. The main content area is white with a blue border. It features a welcome message: "Welcome to the Virginia Acute Psychiatric and CSB Bed Registry". Below this is a disclaimer: "Notwithstanding the information provided on this Psychiatric Bed Registry, bed availability is subject to verification of a facility's current status and the particular clinical needs of the consumer for whom a bed is being sought." To the right is a photograph of a woman lying in a hospital bed. A yellow warning box states: "During Phase 1 of the PBR Update Testing, search results will be limited to your facility's individual bed census data." Below this is a login section with a photograph of a family and the text: "This website is provided as a cooperative effort among the Virginia Department of Behavioral Health and Developmental Services, Virginia hospitals and Virginia's Community Service Boards." The login form includes fields for "Facility Number" and "Password", and a "Login" button. Below the login form, it says: "If you have forgotten your password and need it reset, please send an email to PBR@vhi.org". At the bottom, it states: "This website is available for use by registered users only." and "© 2008-2014 VIRGINIA HEALTH INFORMATION, All Rights Reserved." The browser's status bar at the bottom shows "Done" and "Internet | Protected Mode: On".

Updating the Availability of Beds (Completed daily):

Virginia Health Information - Windows Internet Explorer
 https://www.vhi.org/login/psych_bed_availability.asp

Virginia Health Information

FROM NUMBERS TO KNOWLEDGE
VHI
 VIRGINIA HEALTH INFORMATION

Virginia Acute Psychiatric and CSB Bed Registry

Welcome back, *Bill O'Bier*

Psych Bed Census
 Search Psych Bed Registry
 Psych Bed User Admin
 Update Your Contact Info
 Log Out

Test Psychiatric Hospital
 Psychiatric Bed Census
[Click here to update TDO and Payer Types](#)
 Step 1 - Update current available bed status

Beds	Gender	Age	Security	Comment - Provide any relevant information to assist the user to place a potential patient.
5	Male	Child/Adolescent	Open	flex use for substance abuse
5	Female	Child/Adolescent	Open	
2	Female	Adult	Open	
	Any	Child	Any	
	Any	Child	Any	
	Any	Child	Any	
	Any	Child	Any	
	Any	Child	Any	
	Any	Child	Any	
	Any	Child	Any	

Step 2:

Information Last updated by: [O'Bier](#) on 1/25/2014 7:24:52 PM
[View Psychiatric Bed Census update history](#)

Done Internet | Protected Mode: On 100%

Outcome of bed search by geographic area (Central Virginia) and specific chosen facilities:

https://www.vhi.org/pbr/search_results.asp - Windows Internet Explorer

https://www.vhi.org/pbr/search_results.asp

File Edit View Favorites Tools Help

Home | How To Use This Website | FAQ
Available Beds | Facility Info | Log Out

Welcome to the
**Virginia Acute Psychiatric
and CSB Bed Registry**

Notwithstanding the information provided on this Psychiatric Bed Registry, bed availability is subject to verification of a facility's current status and the particular clinical needs of the consumer for whom a bed is being sought.

Welcome, **Bill O'Bier**

During Phase 1 of the PBR Update Testing, search results will be limited to your facility's individual bed census data.

Facility	Available Beds	Bed Type	Other Info	Contact Info	Last Update	Patient Zip	Facility Called?	Bed Available?	Patient Placed?	Reason Not Placed?
Bon Secours St. Mary's Hospital	1	Gender: Female Age: Adult Security: Locked		Theresa Picone Ph# 8042871791	1/27/2014 10:37:04 AM		<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	Medical Acuity
Poplar Springs Hospital	3	Gender: Male Age: Adolescent Security: Locked		Angel Piper Ph# 8047487490	1/24/2014 10:59:20 AM		<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	Medical Acuity
Poplar Springs Hospital	3	Gender: Female Age: Adolescent Security: Locked		Angel Piper Ph# 8047487490	1/24/2014 10:59:20 AM		<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	Medical Acuity
Poplar Springs Hospital	6	Gender: Female Age: Adult Security: Locked		Angel Piper Ph# 8047487490	1/24/2014 10:59:20 AM		<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	Medical Acuity
Poplar Springs Hospital	5	Gender: Male Age: Adult Security: Locked		Angel Piper Ph# 8047487490	1/24/2014 10:59:20 AM		<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	Medical Acuity
Central State Hospital	22	Gender: Any Age: Adult Security: Locked	Only on long term care units	Ruth Ann Bates Ph# 8045247311	1/27/2014 7:53:03 AM		<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	Medical Acuity
Piedmont Geriatric Hospital	1	Gender: Any Age: Geriatric Security: Locked	Referral via CSB-ES for	Ted Susac, LCSW Ph#	1/27/2014 6:35:26 AM		<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	Medical Acuity

Internet | Protected Mode: On

Users can search widely for available beds or narrow their search based on the specific type of bed needed for the individual (child & adolescent, geriatric, etc.), a geographical location, or type of facility (state hospital, private hospital, crisis stabilization unit).

The screenshot shows a web browser window with the URL <https://www.vhi.org/pbr/search.asp>. The page content includes a navigation bar with links like Home, How To Use This Website, FAQ, Available Beds, Facility Info, and Log Out. A search bar and 'Query Lookup' button are also present. The main heading is 'Welcome to the Virginia Acute Psychiatric and CSB Bed Registry'. A disclaimer states that bed availability is subject to verification. A personalized welcome message for 'Bill O'Bier' is shown. A yellow warning box indicates that during Phase 1 of the PBR Update, search results will be limited to a facility's individual bed census data.

The search interface is titled 'Search for Available Psychiatric Beds' and is divided into five steps:

- Step 1: Select Region**
 - All Virginia
 - Northwestern
 - Northern
 - Southwestern
 - Central
 - Eastern
 - [View Map](#)
 - State Hosp
 - CSU
 - Hosp
- Step 2: Select Facility**
 - CSU - Arlington CSB dba Access
 - CSU - Regional - CARE (Community Residences In
 - CSU - Danville-Pittsylvania
 - LewisGale Hospital - Alleghany
 - Wellmont Ridgeview (Bristol Region)
 - Bon Secours Richmond Community Hospital
 - Bon Secours St. Mary's Hospital
 - Central State Hospital
 - CJW Medical Center
 - CSU - Richmond dba RBHA
 - John Randolph Medical Center
 - Piedmont Geriatric Hospital

**You can select more than one facility by holding the ctrl key down*
- Step 3: Bed Criteria**
 - Select Age Category***
 - Child
 - Adolescent
 - Adult
 - Geriatric
 - Select Gender**
 - Male
 - Female
 - Select Type**
 - Locked
 - Open

**Age ranges vary by facility*
- Step 4: Hospital Criteria**
 - Accepts TDO
 - Special Payer Types Accepted**
 - Straight Medicaid
 - FAMIS
 - FAMIS PLUS
 - Virginia Premier
 - Healthkeepers Plus
 - Southern Health/Carenet
 - Optima
 - Amerigroup
 - LIPOS
- Step 5:**

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Stored documentation of a search:

Home | How To Use This Website | FAQ
 Available Beds | Facility Info | Log Out

Welcome to the
**Virginia Acute Psychiatric
 and CSB Bed Registry**

Notwithstanding the information provided on this Psychiatric Bed Registry,
 bed availability is subject to verification of a facility's current status
 and the particular clinical needs of the consumer for whom a bed is being sought.

Welcome, **Bill O'Bier**

Warning: During Phase 1 of the PBR Update
 Testing, search results will be limited to
 your facility's individual bed census data.

Success: Comment(s) Saved Successfully

Facility	Available Beds	Bed Type	Other Info	Contact Info	Last Update	Patient Zip	Facility Called?	Bed Available?	Patient Placed?	Reason Not Placed?
Southern Virginia Regional Medical Center	2	Gender: Any Age: Adult Security: Any		Debra Hewitt Ph# 4343484590	1/21/2014 12:37:06 PM	<input type="text"/>	<input checked="" type="radio"/> Yes <input type="radio"/> No	<input checked="" type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input checked="" type="radio"/> No	Unit Acuity
Central State Hospital	22	Gender: Any Age: Adult Security: Locked	Only on long term care units	Ruth Ann Bates Ph# 8045247311	1/27/2014 7:53:03 AM	<input type="text"/>	<input checked="" type="radio"/> Yes <input type="radio"/> No	<input checked="" type="radio"/> Yes <input type="radio"/> No	<input checked="" type="radio"/> Yes <input type="radio"/> No	Medical Acuity

Save Comment Data

Query ID: 2454

[Click here for printer friendly version](#)

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Emergency services staff can document their contact with the facilities, if the bed was available, disposition, and reason not placed--- this information can be saved and tracked for reporting.

Facility information example:

VCU Health System

The screenshot shows a web browser window with the URL https://www.vhi.org/pbr/facility_detail.asp?fac_numb=1009. The page is divided into two main sections: 'Beds Reported' and 'Information Reported'.

Beds Reported

Gender: Male

	Open	Locked	Any
Child	-	-	-
Adolescent	-	-	-
Adult	-	1	-
Geriatric	-	-	-

Gender: Female

	Open	Locked	Any
Child	-	-	-
Adolescent	-	-	-
Adult	-	2	-
Geriatric	-	-	-

Gender: Any

	Open	Locked	Any
Child	-	1	-
Adolescent	-	-	-
Adult	-	0	-
Geriatric	-	-	-

Information Reported

Total Licensed Psychiatric Beds¹: 92
Total Staffed Psychiatric Beds: 58
Accepts: Accepts TDO
Special Payer Types Accepted: Straight Medicaid

¹ The number of private licensed and staffed bed counts at each facility were obtained via VHI's Annual Licensure Survey Data; the state and CSB bed counts were provided by DBHDS.

Contact Information

VCU Health System
1250 East Marshall Street
Richmond, VA 23298

For business related issues please contact:

VCU Psych Intake VCU Psych Intake
(804) 828-2000
mhunt@mcvh-vcu.edu
[Get Map](#)

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Governor's Taskforce on Improving Mental Health Services and Crisis Response

Recommendations Crisis Response Workgroup

January 24, 2014

Civil Commitment

1. Straight 8 hours for the ECO. Eliminates the time needed to request extensions. There were a few voices for a much longer ECO, e.g. 24 hours or more.
2. Consider further MD/PhD direct request to Magistrate for TDO (without requiring a CSB evaluation).
3. Extend TDO to 24 – 72 hours. A caution that this could decrease available beds. Some felt the time period should be a minimum of five days.
4. Notify CSB, by some means, when ECO is executed.

Facility of Temporary Detention

5. Support, but caution Bed Registry. If the information is not current, value is decreased. Still going to have to call hospitals to inquire about beds.
6. Idea of separating the TDO from finding a bed was endorsed by the private hospital folks present, though cautioned by OAG as custody issues are important.
7. Make sure that extension can be obtained by phone rather than in person (if retained).
8. Concern re special populations: ID, TBI who may have MH issues, but be excluded based on these diagnoses.
9. Endorse that lack of ongoing services/supports pushes people toward crisis/crisis system.

Adequate Service Capacity

10. Add DAP funds to proposals. Consider allowing use of DAP funds for individuals leaving jail.
11. Integrate existing studies and information (rather than another study). The general consensus is that there is enough information as to what is needed, but longer term plan to achievement requires steady progress, funding.
12. Increase CIT training to areas that have not yet received it.

From Budget Proposals:

13. Straight 8 hours for ECO (see above)
14. TDO 24 - 72 hours, caution that it may decrease bed availability and longer period (minimum five days) preferred by some.

15. Re-enactment and study clause for any changes in the ECO or TDO to determine what the impact was.
16. Adding beds to ESH is supported. Adding funds to WSH supported.
17. Intervention Centers. Strong support for within the group. Need more money than 300K per site. Chuck Hall said 1 million for 9 bed center, Buzz said the 300K per was not enough to pay for anything more than the Security. High priority.
18. Additions for Outpatient Services are supported strongly. General consensus that lack of all manner of ongoing services: case management, psychiatric, outpatient, PACT, residential, day programming, etc. funnel individuals and the system toward crisis services and it should be the other way around.
19. All CSBs need at least one PACT Team. Support current budget request, but more is needed. Similar provisions for children and adolescents needed. High priority.
20. Add DAP funding. Critical to maintaining the flow-through needed to make emergency beds available. High priority budget addition.

Protocol revisions:

21. Support the review and improvement of these protocols.

**Governor's Taskforce on
Improving Mental Health Services
and Crisis Response**

**Recommendations
Ongoing Treatment & Supports Workgroup**

January 24, 2014

Recommendations for the Governor's Budget Proposal

1. The workgroup supported the budget items, but was concerned it is not enough to fix a "broken" system.
2. Programs of Assertive Community Treatment (PACT) services should be expanded across the Commonwealth and services should be provided across the lifespan- not just to adults. PACT is not set up for those under 18, but could help young adults 18 to 25 in transition. Two teams could be funded during the biennium.
3. CIT programs and CIT assessment centers should also be developed across the lifespan
4. Expand Mental Health First Aid across Virginia
5. Expand Suicide Prevention programs
6. Discharge Assistance Program - There is a need to continue to fund those with extraordinary barriers and focus on the discharge process to maximize the flow-through in state hospitals
7. Capture savings - There should be exploration of ways to keep savings in the system. Hold on the rate reduction for mental health skill building until there can be a determination as to the impact the changes in regulations will have.

Legislative Recommendations

8. Support 72 hour maximum, minimum 24-hour TDO period
9. Support the Auxiliary Grant program expansion bill

Topics for future discussion:

- | | |
|-------------------------------------|--------------------------------|
| 1. Workforce needs | 2. Step-down services |
| 3. Communication/awareness of svcs. | 4. Public/private partnerships |
| 5. Best Practices | 6. SA/Co-occurring services |
| 6. Medicaid covered peer support | 8. CSA non-mandated services |
| 7. Managed care transitions | 10. Brain injury services |

Governor's Taskforce on Improving Mental Health Services and Crisis Response

Recommendations Public Safety Workgroup

January 24, 2014

Emergency Custody Order Process

1. Extend the Emergency Custody Order period of detention to 8 hours. The change should be enacted with a study and reenactment. In the interim, data needs to be collected on the outcomes and impact of the changes.

Crisis Intervention Teams (CIT)

2. Expansion of CIT programs, including CIT secure assessment sites, across the Commonwealth is needed. Additionally, an evaluation of currently funded programs and assessment site capacity should be undertaken to ensure current funding is sufficient for them to operate at full capacity. A caution was issued, however, that communities must be ready for CIT (i.e. have collaborative relationships between mental health & criminal justice, have CIT leadership, etc) in order to successfully implement and efficiently utilize CIT Assessment Centers.

Jail Mental Health Treatment

3. Support concept of increased funding for jail mental health services as long as it was clearly defined what these services were, who the target population was, and the caveat that these beds not be viewed/used in lieu of inpatient psychiatric beds in state hospitals. Recommend the study of this area be supported.

Topics for Future Discussion

- Transportation – The issue of transportation requires further study and discussion and should be undertaken at a future meeting
- Insurance – Currently insurance does not cover those services needed by individuals with serious mental illness. It is unclear how the Affordable Care Act will impact on coverage for mental health services. It is the impression that expanding Medicaid will be a benefit for individuals with serious mental illness.
- Housing – access to safe, stable, affordable housing is needed for this group. Involvement with the criminal justice system often becomes a barrier to housing
- Employment – Employment opportunities are essential for this group which also must overcome significant barriers
- Mandatory Outpatient Treatment (MOT) – While available in the Code, the perception is it is not being used enough. Need to study the barriers to more extensive use of MOT
 - Cross Systems Mapping – Recommendation to do a mapping of the entire state to identify common barriers & resources at each intercept of the Sequential Intercept Model. Use the results of this exercise to identify statewide gaps and priorities and create a statewide action plan.

**Governor's Taskforce on
Improving Mental Health Services
and Crisis Response**

Recommendations

Technical & Data Infrastructure Workgroup

January 24, 2014

1. Clarify through education of CSBs and willing hospitals that preadmission screening can be carried out electronically pursuant to 37.2-809(B) and provide funding to assure that all CSBs have adequate and appropriate equipment to perform electronic screenings.
2. Consider removing the requirement that the facility of temporary detention be specified on the Temporary Detention Order (TDO)
 - *If so, need to look at the unintended consequences such as what would the legal status of the individual be.*
 - *The facility of temporary detention still needs to be communicated to the Magistrates.*
3. Conduct a study to assess the need statewide for secure assessment sites and establish these sites in communities across the state as indicated by the study.
 - *Study must include data and all decisions about how resources are used should be data driven decisions.*
4. Complete the implementation of the Electronic Bed Registry that is currently under development. Develop guidelines with the involvement of the CSBs and private hospitals to assure that the data base is maintained to reflect real time accuracy of available beds.
 - *Include recommendation for funding for staff to manage and monitor the Bed Registry.*
5. Clarify and assure more consistent and widespread awareness of the procedures for when the state hospital in the region should be contracted to secure a bed for the TDO and what prerequisites the CSB must meet before contacting the state hospital.
6. Assure continued and increased efforts to provide assistance to enable persons who no longer require inpatient services to be discharged from hospitals, thereby freeing up hospital resources for addition persons needing inpatient level of services.
 - *Identify opportunities to use technology and innovation to assist individuals to successfully transition from hospitals back into the community.*
7. Explore all avenues to increase and improve cooperation and mutual support through the partnership between CSBs, state hospitals, private hospitals, law enforcement and judicial officials.
 - *Formalize interagency relationships at the state and local level.*
 - *Look at integrating data across systems for purposes of operations, monitoring, and evaluation (aggregate and de-identified data).*
 - *Identify opportunities to use technology to assist individuals to navigate and move through the mental health system.*

Future Topics:

1. Develop a better understanding of the emergency process, including approaches used in other states and the unique needs such as those in rural areas.
2. Identify data that already exists, data that would be useful to have and better ways to share data with organizations involved in crisis response or mental health service delivery.
3. Explore all relevant aspects of technology
4. Consider innovations that might enhance our ability to provide mental health services during crisis situations or in the community on an ongoing basis.

Governor's Taskforce on Improving Mental Health Services and Crisis Response

Public Comment to the Governor's Task Force on Improving Mental Health Services and Crisis Response

Received as of Monday, January 27, 2014

From: Ray Maternick
Sent: Friday, January 03, 2014 10:17 AM
To: Keeney, Taylor (GOV)
Subject: Governor's Task Force on Improving Mental Health Services and Crisis Response-Suggestions

Dear Taylor,

We are writing with some suggestions for the mental health task force, based on personal experience with our son, Andrew Maternick. He has had several psychotic episodes, resulting in criminal charges and is currently in Central Virginia Regional Jail (CVRJ).

We request that the task force look at the intersection of crisis response and law enforcement/judicial actions which treat mental illness as a crime.

Here are our suggestions:

1. Hospitals that evaluate someone with mental illness must provide adequate prescription and refills to cover the individual until an appointment can be made with a psychiatrist (at least 4-6 weeks). When our son was taken to Rockingham Memorial Hospital after an episode, he was released with insufficient meds and no refills so he ran out before we could get an appointment. Rockingham refused to provide a refill since he was discharged and no longer under their care. This led to a relapse.
2. Coordinate between mental hospitals and jail. When Andrew was detained after an incident in July 2013, he was sent to Poplar Springs mental hospital in Petersburg. Once stabilized, he was arrested and taken directly to CVRJ. The problem: Poplar Springs only provides the scripts, not the actual medicine, while the jail expected the individual to arrive with medicine. Staff at the jail would not allow us to refill and bring the medicine in. Result: Our son went several days without anti-psychotic medication, due to the jail schedule for delivering medicine. The deputies were concerned, since he was not sleeping and was in danger of a relapse.
3. The formulary at the jail needs to correspond with treatment established by the state mental hospital. Andrew was ordered by the judge to go to Western State for 30 days. There he was finally treated by a psychiatrist, placed on several effective medications, and started to receive some group therapy sessions. However, the medication prescribed by the doctor was not on the jail formulary, so when Andrew was taken back to CVRJ, they would not provide it, substituting another that the doctor at the jail (not a psychiatrist) said was an adequate substitute. Note that the medication prescribed by the Western State psychiatrist is not a new or experimental medication, it is well regarded as an anti-seizure and anti-psychotic. Finally, when I mentioned that the jail would be liable if anything happened to Andrew due to their disregard for the clear discharge instructions from the Western State psychiatrist, which included the statement that substitution was not allowed, they agreed that I could bring this specific medication to the jail, which I do on a monthly basis.
4. Commonwealth attorneys need training in how to handle the mentally ill and psychotic episodes that may lead to criminal charges. They treat these individuals as criminals needing punishment instead of a person with an illness that needs treatment. The criteria established at Andrew's bond hearings have been so extreme that they cannot be met, bond is not approved, and Andrew continues to sit in jail, under a 23-hour per day lockdown, with no treatment, only medication. The judge will only consider bond if we can find a secure facility and there are none available in Virginia except for juveniles. Since, with proper medication, Andrew is stabilized he cannot be sent to the state mental hospital. However, the judge and prosecutors treat him as too dangerous to be out pending trial, so Andrew remains in jail with no therapy. The medication is important, a crucial foundation. But, like a house, a foundation is not adequate to live in, medication is only one element of a treatment plan, which Andrew cannot receive due to his continuing

imprisonment. We have an attorney and continue to move through the legal process but the current system is not able to adequately identify and cope with individuals who are not criminals but are mentally ill.

5.. Virginia needs mental health courts. At the federal level, Health and Human Services (HHS) Substance Abuse & Mental Health Services (SAMHSA) has a GAINS Center for Behavioral Health and Justice Transformation. (www.samsha.gov) It is tragic that our son, Andrew, is sitting in jail rather than getting the help he needs, either in a state mental hospital or the community service centers (Region 10 in this area). He cannot be released into these programs because he is in jail. He is being treated like a criminal, rather than someone suffering from a mental illness. This is wrong. The National Institutes of Health state that mental illness is a brain chemistry disorder. Is the Commonwealth of Virginia going to continue to punish individuals for their brain disorder rather than getting them help?

We appreciate the governor's response to recent events with creation of this task force.

Please pass along our suggestions to the panel and let us know if we can speak to the members.

Sincerely,

Connie & Ray Maternick

From: Brian Clemmons
Sent: Saturday, January 11, 2014 4:23 AM
To: Task Force MH WorkGroup (DBHDS)
Subject: Public Comment for the MH Task Force

Congratulations on your appointment. I know or have heard of many of you and I am confident that the right team has been assembled for this important task!

1. Please consider increasing/encouraging the use of Crisis stabilization as a step down from inpatient. This will free up beds sooner for more acute patients and give Physicians the confidence they need to discharge sooner since this is a supervised level of care.
2. Some financial or other assistance to Law Enforcement for transports would go a long way in depressurizing the often tense relationship and delays in transport, especially of committed patients who need to be moved at hearing.
3. LIPOS truly needs some standardization across the State. I respect and honor Regional and Local desires for autonomy, and I still recognize that these are STATE dollars. It is difficult for Hospitals and even CSB folks to keep up with all the variation. For example, require the following:
 - A. Any person prescreened by a CSB is LIPOS eligible whether they are voluntary or TDO, even if they are not a current CSB client or they are from out of area.
 - B. The LIPOS dollars can be used to fund transportation home at discharge- this will greatly increase the option of using a distant hospital bed when it is the only one available.
 - C. Remove arbitrary requirements from Regional Policy that the person must be kept under TDO for a minimum of 2 midnights for example before LIPOS will pay for a bed day. This conflicts with Hospital hearing schedules and confronts due process rights of detainee.
4. Increase reimbursement for Commitment hearing personnel. With the added work for Independent Evaluators and pressure felt by SJ/Judges and Attorneys, 75-86 dollars per case is not enough; especially in rural areas where there may only be 1-2 hearings per court date.
 - A. How long has it been since these rates were increased?
5. Examine and adjust laws and policies that discourage Hospitals from hosting evaluation Centers. Offer funding to provide security at these centers. Request a variance on the IMD exclusion so these centers can be located proximal to an ER.
6. Incentivize Private Hospitals use of Bed registry; eg: recognition of individual hospital's participation- "Hospital XYZ updates their bed status daily 98% of time this year/quarter, etc". Consider financial incentive for participation in this project. Realize # of beds and type is felt by some to be sensitive info and not widely shared in favor of approving/disapproving referrals individually.
7. Please recommend that ECO's be able to be held for up to 24 hours when the decision has been made to TDO and finding a bed is the barrier. If no bed at 24 hours, the CSB Executive Director and either the Sheriff (if evaluation done at LE facility) or Hospital (if evaluation done at ER) CEO notified.

8. Please recommend that if a CSB referred patient needs discharge appointments, the Home CSB must provide. Currently, some CSB's will not offer if patient has any insurance- especially a barrier when trying to make discharge arrangements at a distance or in NoVa where few private providers want to take on SMI or recently hospitalized patients.

Respectfully,

Brian

Brian M. Clemmons, M.Ed., LPC
Director of Behavioral Health
Rappahannock General Hospital

From: mwernstrom
Sent: Wednesday, January 15, 2014 8:49 PM
To: Task Force MH WorkGroup (DBHDS)
Subject: Public Comment for the MH Task Force

I have recently heard that Region 10 CSBs do not have one strict protocol for intake of consumers. I think this is an oversight that needs to be addressed as soon as possible. One protocol would help with keeping care standards up, ease confusion on how to address incoming patients needs, and help keep malpractice lawsuits down.

I also think the emergency hold time must, must, MUST be longer than the 4-6 hours by law that is in place at the present time. As we have recently seen, six hours max is not necessarily long enough.

Thank you for your time and good luck with the Task Force.

Missy Wernstrom
Charlottesville, Va

Sent from Windows Mail

-----Original Message-----

From: TFAC2
Sent: Thursday, January 16, 2014 9:57 PM
To: Task Force MH WorkGroup (DBHDS)
Subject: Public Comment for the MH Task Force

I would love to share my story. I was encouraged to do so by Senator Deeds office.

We live in fairfax county and my 17 yr old daughter is suffering through mental illness and what we have been put through begging for help is deplorable we have been going through this for 4 years. I also contacted the department of human rights to file a complaint 3 weeks ago and they have done nothing. They never filed and now won't return my calls, I dint even know how that's legal.

When a group of professionals said my daughter was not safe to come home Alan Berenson (the head of mental health here in fairfax) said "hey look if she hurts someone in your family call 911" I'd love to talk to someone and share the entire story, especially in reference to the ICC (intensive care coordinators) this joke of a group they put together and what they did to my daughter and the rest of my family. I can be reached at 571-528-1973.

Thank You
Paige Burton

Sent from my iPad

From: Shane Funk
Sent: Friday, January 17, 2014 10:08 AM

To: Task Force MH WorkGroup (DBHDS)

Subject: Experience Seeking Help

Hello, my name is Shane Funk. I have a story to share with you that I will try to keep very short and to the point. Sometimes our lives are not the way they could be or should be and mine was different from the time I was a child. So much so that it really changed the way that I think and act. The same is true with adult life and it can throw you many curve balls. I have been diagnosed with an inherited mental illness as well. I have paid very hard for the help that I have received. My doctor told me that I would need some counseling as part of my wellness goals. I live in Wytheville, Virginia so I made an appointment with the only place that we have and went. I was locked in a room with people in orange jump suits and filled out paper work. I was told that I was no longer allowed to see my doctor in Radford as part of my recovery plan and was told that I would sign this plan or to leave now. I was also told that I would attend these same meeting every three months for a year or so and that if they thought I needed to see a doctor then and only then would they make me an appointment with one of their doctors. I had worked hard at making myself better and had also paid through the nose. I needed the therapy as part of my treatment and my doctor sent me their thinking I would have been in good hands. Had these people had their way they would have turned my progress around ten years. I know that I left feeling very unsure of what was going on and like I had done something bad. I never went back. I would like to mention that I'm doing O.K. now but still travel and pay large amounts of money, so much so that my work is staying well. I hope this might help give someone an idea of how some things are done in acute situations. Thank you very much for your time and have a blessed day.

Shane Funk

From: Joy Loving

Sent: Monday, January 20, 2014 10:00 AM

To: Task Force MH WorkGroup (DBHDS)

Subject: Public Comment for the MH Task Force

Ladies and Gentlemen of the Task Force,

I am attaching for your consideration a copy of testimony I gave on Jan 3, 2014, before members of the General Assembly's House Appropriations and Senate Finance Committees during their public hearing in Harrisonburg.

You have a most challenging opportunity before you. As a member of a family which for well over 30 years has experienced first-hand the hardships and heartbreak that mental illness brings, I encourage and urge you to work diligently to identify and mitigate the many aspects of mental health care that Virginia has the obligation to address. There are organizations, such as NAMI Virginia, that can speak more knowledgeably and eloquently than I. Please pay attention to the facts and potential solutions they present. It is unimaginable to me that Virginia would not do what it takes to give those suffering with debilitating mental illness, that robs them of hope and any meaningful quality of life, whatever chance medicine, case management, housing, and rehabilitation can offer.

So far, my family member's illness has not resulted in the tragedy that befell Senator Deeds and his family. But it could have and still might. And so could many other families' loved ones act as Gus Deeds did, out of despair and forces in their heads driving them to violence. Virginia has seen first hand, and quite publicly, what that sort of violence can do. Even after the horrible Virginia Tech event years ago, Virginia wasn't even able to establish the state-wise available beds data base that Senator Deeds needed desperately a few weeks ago. This is inexcusable in a state as economically well-off as we are.

I am sure you will take this matter very seriously. I, like many thousands of Virginians who live daily with mental illness or watch their loved ones do so, am anxiously awaiting your recommendations and will be watching your activities with high interest. Thank you for participating in this vital undertaking.

Joy Loving
Grottoes VA

Testimony before House Appropriations/Senate Finance Committees' Hearing, James Madison University, Harrisonburg, Jan 3, 2014

Committee Members,

I am Joy Loving from Rockingham County and the sister of a 55 year old man who has suffered with paranoid schizophrenia since at least his teens. He has been a client of Henrico County Mental Health for over 25 years. My family has benefited from, and greatly appreciates, that staff's efforts and the services our brother has received.

I am here to urge you to make mental health a priority during the 2014 VA General Assembly session.

My family's story is about the limits of VA's MH system to assist such a person in a consistent, pro-active way. Our family has asked for case and medication management, without the benefit of Medicaid coverage. What we need is frequent monitoring of a client who lives alone (2 hours from his closest relatives), is consistently non compliant with medications, has been hospitalized at least 15 times because of psychosis resulting from that non compliance, and has virtually no insight into his symptoms.

The funding is simply not there for the county MH staff to adequately maintain a frequently-delusional, marginally functional client. My brother's history has demonstrated that daily medication is a must and that ensuring that medication through in person daily visits, however brief, is essential to prevent extreme psychotic breaks. As a member of Henrico's PACT program, he received daily visits and medication oversight for a number of years. However, despite at least 3 hospitalizations in the past 2 years, during mid-2012, daily visits from the County PACT staff ended. It appears that Henrico MH had to triage my brother out of the PACT program, not because his non-compliant behavior with medications had changed, but because the money to keep him in that program was and is not available. Thus, now there are no visits on weekends or holidays. My brother is "on his own" to take his medication 2 days of every 7 (up to 4 days of 7 during holiday periods).

My family wants our brother to avoid more temporary detention orders, police enforced green warrants, and hospitalizations. We want the system to provide him enough medication to minimize, if not control, his worst symptoms, so his slide into psychosis and possibly into violence isn't inevitable.

These services need funding, especially for those who are not on Medicaid but nonetheless have limited resources. There are many MH funding priorities for 2014. I will mention two. First, I ask you to support Medicaid reform and expansion so additional thousands of VA's mentally ill adults can receive needed mental health services. Second, I ask you to increase the availability of, and funding for, PACT programs. The evidence shows that these programs reduce hospitalizations and incarcerations and support housing stability. Increasing PACT programs in VA is a recommendation from the Governor's School and Campus Safety Task Force.

Thank you for your time and your consideration.

-----Original Message-----

From: Joan Lunsford
Sent: Monday, January 20, 2014 2:58 PM
To: Task Force MH WorkGroup (DBHDS)
Cc: Richard Lunsford
Subject: Public Comment for the MH Task Force

Hello Task Force for Mental Health in Virginia,

I am so glad that mental health is a top issue on the agenda this year.

My son, Thomas J. Lunsford (age 28) is currently living in a group home called Cardinal House in Waynesboro, Va. He's been there a few weeks shy of two years. After being released from Northern Virginia Mental Health Institute on February 1st, 2012, Cardinal House was the only place available for him. There have been no places available for him in northern Virginia. He's on several waiting lists-- Pathway Homes, Willow Oaks of Birmingham Green-- to mention two.

Meanwhile, my husband and I have been visiting him every weekend. It's a two and a quarter hour drive each way. But the worst thing of all is the cost of keeping him at Cardinal House. Since he must have a single room, it's costing us \$5,000 a month!

Please find a solution to this horrid problem of housing for the mentally ill. I'm sure our situation is far from unique.

Sincerely,

Mrs. Joan Lunsford

From: Long, Betty
Sent: Tuesday, January 21, 2014 2:35 PM
To: Task Force MH WorkGroup (DBHDS)
Subject: Public Comment for the MH Task Force

Attached are comments from the Virginia Hospital & Healthcare Association. If you have questions or require additional information, please contact me.

Betty Long
Vice President
Virginia Hospital & Healthcare Association

Virginia Hospital & Healthcare Association Comments Submitted to the Governor's Task Force on Mental Health Services and Crisis Response

January 21, 2014

Background

The Commonwealth of Virginia has been working for several decades to remake its behavioral health system from one that provides services predominantly in state hospitals to one that delivers care in the community. While progress has been made, there are still important systemic issues that need to be addressed in order for the state to achieve its desired goal of providing people with mental illness with the appropriate services in the least restrictive setting. Members of the Virginia Hospital & Healthcare Association strongly support this goal and are committed to working with state policy makers and other stakeholders to achieve it.

Given that hospital emergency departments and psychiatric units serve a high percentage of individuals who are subject to emergency custody orders, temporary detention orders and civil commitments, we can offer a unique perspective on certain changes that would strengthen our current system.

For example, a key aspect of our current system, which may not be well understood, is that in 2003 the state began implementing policies designed to reduce inpatient admissions to state facilities and shift responsibility for managing the state admissions process to regional partnerships composed of community services boards. While the goal was to manage resources more effectively and build community capacity, the emphasis on regional decision making has had some unintended consequences that result in inconsistencies in key elements of the system.

This reliance on regional approaches might not be a problem if it wasn't necessary to cross regional boundaries in order to locate a bed for someone in need of inpatient care. Such cross-regional transactions occur regularly and, when they do, the lack of uniformity can cause problems for individuals and their families as well as the facilities providing the care.

We offer the following recommendations along with some general principles for the Task Force to consider as it develops its recommendations.

VHHA Recommendations

Develop a plan to implement crisis assessment centers and PACT teams in all areas of the state. These two approaches have proven to be highly effective in meeting the needs of persons with mental illness.

- The crisis assessment centers provide a way to address several important objectives, including the desire to lengthen the ECO period without imposing significant new burdens on law enforcement personnel or increasing the length of time that a person in mental health crisis will spend in the emergency department.

- The expansion of PACT teams may help to reduce the number of persons requiring civil commitment and may also help achieve better hand-offs when someone with a serious mental illness is discharged from the hospital.

Develop best practices for the provision of emergency services (e.g. hours of availability, interactions with hospital emergency departments, staffing levels, etc.), incorporate best practices in the Performance Contract, provide sufficient funding for CSBs to implement best practices and develop ways to evaluate performance.

Require CSBs to engage in discharge planning for all persons being released after being civilly committed, including all out-of-region placements, and for all CSB referrals to acute care facilities. Lack of CSB involvement in discharge planning can result in poor patient outcomes, longer than needed lengths of stay, and concern on the part of hospitals about admitting a person from outside their region who is likely to pose significant discharge challenges. Better discharge planning can result in improved hand-offs between hospitals and the community and higher quality of care.

Evaluate the various sources of state funding that support mental health services to ensure that they align with the goal of achieving a high-quality, recovery-based system of care. These are examples of issues that should be included in such an evaluation:

- *Reexamining current restriction on use of certain funds (e.g. Local Inpatient Purchase of Services) to pay only for persons who are involuntarily committed.* This is inconsistent with the state's commitment to a consumer-focused, recovery-based model.
- *Developing a more uniform approach to administering Local Inpatient Purchase of Services (LIPOS) funds* so that the types of patients covered and the utilization policies are based on clinical needs instead of the availability of funds.
- *Exploring ways that the state can overcome the current federal IMD restriction which prevents freestanding psychiatric facilities from accepting Medicaid patients between the ages of 18 and 64.* Although there are only six free-standing facilities in Virginia, they represent about 30 percent of all private inpatient beds, many of which are located in Hampton Roads, an area which has struggled with bed availability.
- *Evaluating current Medicaid-covered services,* who may provide them and the rates paid for those services in order to ensure that the state's policies support a cost-effective continuum of care.

Acknowledge that there is a small percentage of the total number of people who receive services that present special placement challenges and develop strategies for delivering care to them safely and effectively. These may include patients who, among other things: 1) do not respond to treatment in the normal acute-care timeframe; 2) have a history of violent behavior; 3) have an intellectual or development disability diagnosis; 4) suffer from dementia; 5) have medically complex conditions in addition to psychiatric diagnosis; or 6) require long-term care.

Establish a process and a structure that ensures regular communication among the public and private agencies and organizations involved in the mental health delivery system at both the state and regional level. The purpose would be to enhance communications, identify and share best practices and provide a regular venue for problem-solving. The Department of Behavioral Health and Developmental Services (DBHDS) would be the lead agency for this effort.

Create an expectation that private hospitals and other private providers will be consulted by the DBHDS and CSBs when major policy changes affecting them are under consideration.

Principles for Strengthening Virginia's Mental Health System

- Mental health services should be delivered in a consistent manner. There should be more emphasis on a uniform statewide approach and less reliance on regional approaches.
- The state must take a strong leadership role if services are to be delivered in a more consistent manner.
- The state's role as the ultimate safety net for individuals in need of service must be maintained, even as the state continues to right-size its facilities and rely more on community services boards (CSBs), private hospitals and other community providers.
- Gaps in the continuum of care must be identified and addressed, including the need for appropriate sub-acute settings.

- A high-functioning mental health system requires regular communication among the agencies and organizations involved in the system, both at the state and regional level.
 - Funding policies must be in alignment with the goals and expectations of the mental health system.
 - Private providers must be treated as partners by involving them in decisions that affect them, funding them fairly and holding them accountable for their results.
 - Achieving lasting and comprehensive improvements requires a long-term plan.
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From: Simpkins, Melissa
Sent: Wednesday, January 22, 2014 8:14 AM
To: Task Force MH WorkGroup (DBHDS)
Subject: Public Comment for the MH Task Force

Greetings – in lieu of the email below, please find my original letter to Senator Deeds outlining the recent experience that my son and I had with the current mental health support regulations.

Melissa Simpkins

Dear Ms. Simpkins,

Thank you for your thoughtful email to Senator Deeds last week. I am so sorry to hear of the ordeal you and your son endured. I passed along your message to him and know he appreciates your sharing your story. This legislative session, he is focused on the ECO process in particular and creating a Joint Subcommittee on Mental Health to take an in depth and broader look at our mental health system. We have heard from so many families who have run into road blocks in the mental health system, which is unconscionable. If you have not done so already, I hope you will share your insight with the Governor's Task Force on Mental Health Services and Crisis Response as well (<http://www.dbhds.virginia.gov/MHSCRTTaskforce.htm>).

Please keep in touch in the coming months. Senator Deeds will continue to work on these issues and will need people to remain engaged to bring about changes.

Warm regards,

Tracy Eppard
Legislative Aide

On Wed, Jan 15, 2014 at 10:50 AM, Simpkins, Melissa wrote:

Senator R. Creigh Deeds,

In light of the recent Mental Health Reform Bills, I'd like to take the opportunity to express my deepest sympathy for what you have endured and also share with you our experiences with the current system. Our son, currently 19, has struggled with a mental disability his entire life. We have worked with the school system, New River Valley Community Services, the Department of Rehabilitative Services (DRS), and Access Services (Access) for many years. With that being said, I'd like to provide you with a sample of our latest endeavors from last night:

Our son had communicated with his case worker at New River Valley Community Services about several descriptive issues (feeling paranoid and other possible bi-polar symptoms) that he had been experiencing and also about how these feelings were affecting his work (he currently works 12 hours a week, thanks to the assistance of DRS)

5:00 – received a call from the caseworker that she had been advised by her supervisor to staff our son's situation with Access. After this discussion, Access stated that they wanted to meet our son at the New River Valley Medical Center (NRVMC). At this time, the

caseworker explained that she could have him there around 5:45 – Access Services confirmed that they would meet her there (Access meets their clients at the NRVMC and uses their facility to assist in the evaluation process – during this period, individuals are admitted to the Emergency Department (ED), where they wait for Access to arrive).

5:30 – Caseworker picks up our son and takes him to the NRVMS.

6:15 – our son calls to tell us that he is waiting on Access and that he has not yet been admitted to the hospital, but is not allowed to leave or else the police will be contacted. (There were some negotiations in order to get our son to the hospital so when the caseworker picked him up, he was unaware that Access had been contacted)

8:00 – our son calls again, livid that he is still waiting, but was admitted to the ED at 6:30 and still has not seen a doctor or a counselor from Access.

8:15 – another call, this time the caseworker has told our son that she needs to leave to go home and that he will need to stay there until he meets with the clinician from Access. Remember, he's only 19 so you can understand my concern when the person that took my son to the hospital now tells me that they plan to leave him there, alone - I explained that I would be there as soon as I could. I then called Access Services to inquire about the delay in getting a clinician to the hospital – they had known that the caseworkers was bringing him, she staffed his situation with them at 5:00, and still no one has shown up (we are going on over 2 hours now). Nothing! The individual who answered the phone had no idea why no one had arrived, understood my concerns, and said someone would call me back. So, with that, the ED nurses finally took our sons blood around 8:10, the caseworker, once again, contacted Access to let them know this action had been done. Apparently, Access is unable to actually speak/meet with him until his labs have been completed and the results have been returned (or this is what the caseworker told me).

8:50 – I arrived at the hospital. The ED doctor comes in, for the first time, to see our son. He explains how Access isn't actually a portion of Carilion but they base their operation from their facility and that he has no control over how they operate. The caseworker also explains to me that the counselor from Access has arrived, they have a TDO which must be seen first (due to time restraints), and that our son will receive services before 10:00; she then leaves.

10:15 – our son has now been at the hospital for over 4 hours and still not seen a counselor from Access Services. The ED doctor comes into our room, because I once again requested that they release my son so that I could take him home – the extended stay in their facility was defiantly not assisting him with his mental disabilities. At this time, he explains that the counselor that was there when I arrived at 8:50, got off work at 10:00 and had left – we now needed to wait for the 10:00 person to arrive! WHAT???

With that, I went outside and made another call to the central Access Services number, being that I had still not received a call back from my 8:15 call, the individuals who answered the phone had no idea what was taking so long, they understood my concerns, and would have someone call me back (this was around 10:30).

10:40 – Access Services counselor finally comes by my sons room to let him know that she has arrived and will be with him shortly. A little later, she came in and got me – discussed the situation and then meet with our son.

11:30 – the counselor has decided that our son is fine to be released from the hospital.

12:01 – he is released.

So, in summary – his ordeal with the current mental health system in Montgomery County lasted from 5:30, when he was picked by his caseworker and taken to the NRVMC, until 12:00 when he was finally released – for a total of 6.5 hours! Do we as a society honestly think that this is an efficient way to handle individuals who suffer from a mental disability, more or less, any illness? This is the common trend for how these programs operate; our son has been hospitalized 3 times, most recently in 2013, and each time, the trip to the ED, has taken at least 6 hours. On one occasion, he was suicidal when we brought him to the ED, after 5 hours of waiting for a clinician to arrive, he had calmed down enough that they sent him back home.

In closing, we know that our story is not the only one and that many others suffer through these same battles on a daily basis. I only hope that you are successful in your journey to reform the bills that currently litigate this sad process. You have my full support in your mission and I hope that our experiences will provide you with additional documentation to make the necessary changes!

Sincerely,

Melissa Simpkins

From: June Jenkins
Sent: Thursday, January 23, 2014 9:33 AM
To: Task Force MH WorkGroup (DBHDS)
Subject: Public Comment for the MH Task Force

I was very disappointed to see that no K-12 educators are on the Task Force.

June Jenkins

June Jenkins, Director
Safe Schools/Healthy Students
Charlottesville, VA 22902

From: Leslie Skelly
Sent: Thursday, January 23, 2014 4:27 PM
To: Task Force MH WorkGroup (DBHDS)
Subject: RE: Public Comment for the MH Task Force
Importance: High

To Members of the TaskForce Mental Health Group of Virginia:

We as residents of Virginia are very impressed with Governor McDonnell's EO 68 to establish a Taskforce (and supported by Governor McAuliffe) of 37, which includes representatives from mental health, law enforcement, and private hospitals along with individuals receiving Mental Health services. Unfortunately, we have a neighbor that has impacted our safety, our community, & herself. Because of the situation we are enduring, we would like to instill some input in regard to our law enforcement, HIPPA Privacy Rules, & our concerns for future mental health (MH) crisis.

Facts:

* Virginia is one of the 41 states that authorize or require reporting of MH Records to NICS.

* HIPPA: "The U.S. Congress recognized the importance of privacy of medical records when the Health Insurance Portability and Accountability Act of 1996 (HIPAA) was enacted. Amended April 14, 2003 PHI (Protected Health Info) & Security Rules, April 21, 2005; In addition to federal laws, the Code of Va. added provisions in sections 32.1-127.1:03 & 32.7-121.1:04. HIPPA Privacy Rules are enforced by the OCR (Office of Civil Rights)." "The privacy regulations establish that personal health information must be kept confidential. The regulations are designed to safeguard the privacy and confidentiality of a consumer's health information..•
"Psychotherapy notes are accorded special privacy protections under this regulation. Ordinarily, a written client consent is required before psychotherapy notes can be disclosed to anyone."

* Psychotherapy notes are defined in the regulation as "notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and **that are separated from the rest of the individual's medical record** ." (emphasis added).

* Excluded from the definition of psychotherapy notes are medication prescription and monitoring, counseling session start and stop times, modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date.

* Statistics: Local & Regional Jails are housing approximately 30,000 inmates/day; 6,000 in need of MH services; 3,000+ are in need of Serious MH services.

Issues:

1) The police department has expressed their concerns to us:

Diagnosis in relation to MH are tied to HIPPA laws, which means they do not know the circumstances they may be encountering in regard to safety for themselves & the community.

No acknowledgment from the MH facility if the patient is still under evaluation/observation, and/or discharged.

In addressing TDO's & ECO's, law enforcement has to deal with the shortcomings of legal detention periods & bureaucratic hurdles.

"The system is broken." Not only is there difficulty in securing treatment for people who desperately need it, exploring the avenue for increased cooperation through CSBS, state hospitals, private hospitals, law enforcement, judicial officials, & funding, but because we are caught up in the attached **stigma** for those that are dealing with mental illness, innocent members of society are left with serious **safety issues**.

2) The health care industry for the mentally ill is a revolving door. Once the patient becomes compliant with their medication, they are discharged to return to the public. The costs to law enforcement for continued monitoring & detainment is expensive to all concerned. "Our officers are not social workers or counselors." They must always put their law enforcement responsibilities first, which is **SAFETY!**

3) Psychotherapy & MH needs to be readdressed in the healthcare industry. To protect society in general, maybe the HIPPA Privacy Rules should allow disclosure of some medical records without consent or authorization to our law enforcement when needed to avert a serious & imminent threat to health or safety!

Documentation of statements & actions from our neighbor of threat to herself or us: "I've got a gun." Statement from police department that she wanted to kill herself. Once discharged, we are in fear of retaliation & more threats.

"The state's system for providing mental health services to Virginians who pose a risk to themselves or others has long been inadequate." The police department has been extremely supportive. They have done the best they can to protect & inform us of our rights to a 'protective order', etc. However, none of us has the right to know once our neighbor has been discharged. Where are the rights to the citizens of Virginia, who also need an advocate? How can we divert people in a psychiatric crisis from our jails?

Our neighbor lives alone, has most recently not been compliant with her medication, is not monitored for compliance, and shares a wall between us. What are our options? As a Registered Nurse, I do understand the need for privacy regulations for personal health information, but not when our law enforcement & citizens protection is of concern.

Please review & consider the criteria referenced above. Awaiting your response.

Thank you.

Sincerely,

Les & Landra Skelly, RN
