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

May 21, 2014
10 a.m. – 2 p.m.
Monroe Building, Richmond, VA

Workgroup Meetings Agenda

10:00 a.m. – 10:10 a.m.	**Welcome and Members Present** *Facilitator*
10:10 a.m. – 10:15 p.m.	**Approval of Minutes** *Facilitator*
10:15 a.m. – 1:00 p.m.	Review workplan, discuss items for possible recommendation and ensure previous recommendations cover responsibility for Executive Order 12 and referred legislation. Lunch in Place
1:00 p.m. – 2:00 p.m.	Develop and record 3-5 actionable recommendations to send to full Taskforce based on discussion
2:00 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

PUBLIC SAFETY WORKGROUP
March 19, 2014
10 a.m. – 2 p.m.
Main Branch, Richmond Public Library

MEETING MINUTES

Members Present
The Honorable Stacey Kincaid, Sheriff, Fairfax County
Melanie Adkins, Emergency Services Director, New River Valley Community Services
Kevin Fay, President, Alcalde & Fay
Sue Medeiros, Chesterfield Department of Mental Health Support Services
Gary Roche, Chief, Pulaski Police Department
Bobby Russell, Western Virginia Regional Jail
Becky Sterling, Consumer Recovery Liaison, Middle Peninsula-Northern Neck CSB
Rhonda VanLowe, Counsel, Rolls Royce North America
John Williams, Director of Public Safety Novant Prince William Medical Center
Gerald Wistein, Peer Provider, Region Ten CSB
Jim Bebeau, Executive Director, Danville-Pittsylvania CS
Mike Francisco, NAMI Central Virginia
William Ellwood, AEGIS Associates, LLC

Staff Present
Victoria Cochran, Deputy Secretary Public Safety
Drew Molloy, Deputy Chief Director Dept of Criminal Justice Services
Michael Schaefer, Director Forensic Services Dept of Behavioral Health & Developmental Services

Members Absent
The Honorable R. Edwin Burnette Jr. Judge, 24th Judicial District
The Honorable Tommy Whitt, Sheriff, Montgomery County
Colonel Steven Flaherty, Superintendent, Virginia Department of State Police
Gary Kavit, MD, Riverside, Norfolk
Cindy Kemp, Arlington County Dept. of Human Services
William Rea, MD, Associate Professor, Department of Psychiatry, Carilion Clinic and Virginia Tech Carilion School of Medicine
Sandy Ward, PhD, President, Virginia Academy of School Psychologists
Professor, College of William and Mary

Others Present
Julie Truit, DBHDS
Ken Gunn, DBHDS

MEETING MINUTES

1. Workgroup reviewed and unanimously approved minutes from last meeting.
2. Workgroup reviewed HB 832 specifically focusing on issues of communication between mental health and criminal justice systems
    a. Communication happens at both a micro & macro level – there are barriers and issues at both levels
    b. Hearing about & understanding how and why law enforcement does things (i.e. through participating in CIT training) helps individuals from behavioral health system to better understand why system works the way it does.
    c. Brown bag lunch meetings/trainings across agencies is a good strategy – this was a frequent recommendation which came out during cross systems mapping exercises
    d. Need to have consumers educate LEO about their experiences
    e. Monthly/ regularly scheduled meetings across disciplines to help people understand each other's systems
    f. Statewide expectation that mental health and criminal justice systems work together
    g. Cross Systems Mapping follow up as a tool to keep behavioral health & criminal justice partners working together.

3. Workgroup agreed there is a general lack of community awareness about accessing services during a behavioral health crisis (e.g. who to call, how to get help).
    a. Default to police as calling 911 is a well-known response to crises
    b. Need to raise awareness in community of prevalence of MI and how to access help.
    c. Should create a statewide hotline to help direct person to services. Need to do prior to crisis.
    d. 211 line – it's in existence but people don't know how to use.
    e. NAMI has published resources listing service providers
    f. There is a disconnect between hospital/programs and other services – even hospital/medical staff don't know how to refer to next/ other service provider.
    g. A large contributor to problem is fact there is no statewide path for people to get into services – each community/agency has its own processes, regulations, and rules
    h. Need education campaign to help general public understand behavioral health issues and how to access services. Additionally, need to have some universal processes for accessing services
    i. Priority should be that state should do marketing plan and give localities a "tool kit" with template resources which localities can modify to address local unique policies/processes
    j. Key phone number where people call and then are referred to appropriate resources

4. Workgroup agreed community behavioral health system tends to be crisis driven which results in little emphasis on prevention. This results in limited funding for ongoing behavioral health services to support individuals in living with mental health issues.
    a. Workgroup discussed fact that current task of the workgroup is designed to investigate problems with current system and as such is not focused on creation of ideal behavioral health system but rather addressing issues with current system.
    b. Despite concerns about having police involved in mental health issues, the fact is the Code does not empower or authorize mental health workers to detain individuals against their will.
5. Workgroup agreed that while CIT Assessment Centers are beneficial, Medicaid and private insurance rules preclude payment for services provided in CIT Assessment Centers thus centers are dependent on state dollars to be sustainable.
6. Workgroup suggested that a review of the impact of ACA/ Medicaid Expansion should be undertaken to determine how it would affect access to mental health services issues for individuals involved in criminal justice system.
7. Workgroup agreed there should be statewide expectation of effective, rapid communication between law enforcement and behavioral health with goal of decreasing amount of time consumers spend in

law enforcement custody. Each community should establish protocols addressing how they will ensure effective, rapid communication.

8. Workgroup discussed issues related to transportation of individuals in behavioral health crises during ECO/TDO process
    a. Group agreed that due to infringement on personal liberties and potential for harm, law enforcement should continue to be involved in transporting during initial stages of ECO
    b. With regard to transportation of individuals under a TDO, group agreed this duty could be fulfilled by a variety of agencies/agents.
    c. Group discussed feasibility of statewide system for transport
    d. Issues such as training, funding, proper tools, and legal authority will need to be addressed
    e. Recommendation that research be done about how other states handle transportation. Look at how they did it, how they funded. DCJS will do this research.

Workgroup Summary Recommendations:

1. Virginia needs to invest in readily available, full service behavior health services to include prevention services. This will naturally result in decrease in crises and thus decrease law enforcement involvement. While we cannot fully eliminate crisis, but can do this incrementally by having available supports/resources. Virginia should set the goal that rather than being ranked 47th in terms of funding behavioral health, Virginia should rank #1 in terms of funding of behavioral health services
2. Virginia needs to improve community awareness of behavioral health disorders and embark on an education campaign instructing citizens how to access help. There needs to be a standardized pathway to access services.
3. Virginia needs to effect a paradigm shift away from having law enforcement being the first responder for mental health issues. To achieve this goal, the taskforce should commission a study on how other states address this issue to include how other states employ alternate transport for individuals in ECO/TDO status.
4. Virginia needs to provide sustained funding of CIT and CIT assessment centers – funding to a level so every community in Virginia has a functional CIT program and Assessment Center.
5. Virginia should create a Center of Excellence for behavioral health issues and should strive to be a model state for behavioral healthcare.
6. Every community in Virginia should establish and employ best practices to enhance and improve communication between law enforcement and mental health with the goal of decreasing the amount of time individuals with behavioral health issues are in police custody.

The meeting adjourned at 2:00 p.m.

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

ONGOING TREATMENT AND SUPPORTS WORKGROUP

March 19, 2014

10 a.m. – 2 p.m.

Main Branch, Richmond Public Library

MEETING MINUTES

Members Present

Mary Ann Bergeron, Executive Director, Virginia Association of Community Services Boards
Molly Cheek, LCSW, President, Dominion Youth Services
Steven Crossman, MD, Associate Professor, VCU Department of Family Medicine
William Elwood, AEGIS Associates, LLC
Nancy Fowler, Program Manager, Office of Family Violence, Virginia Dept. of Social Services
Cristy Gallagher, Research Director, George Washington University
Frank Gallagher, Vice President of Behavioral Health Services, Sentara
Tabitha Geary, Vice President, Washington, DC Office, SapientNitro
Neal Graham, CEO, Virginia Community Healthcare Association
Keith Hare, VP Government Affairs, Virginia Health Care Association
Teshana Henderson, CAO, NDUTIME Youth & Family Services
Daniel Herr, Assistant Commissioner, Department of Behavioral Health and Developmental Services
Steve Herrick, Director, Piedmont Geriatric Hospital
Anne McDonnell, Executive Director, Brain Injury Association of Virginia
Paula Mitchell, VP Behavioral Health Services, LewisGale Medical Center
Greg Peters, President and CEO, United Methodist Family Services
Mira Signer, Executive Director, NAMI Virginia
Sunil Sinha, MD, Chief Medical Officer, Memorial Regional Medical Center, Bon Secours Richmond Health System
Chuck Walsh, Executive Director, Middle Peninsula-Northern Neck CSB
Tammy Whitlock, Manager, Maternal and Child Health Division
Thomas Wise, MD, Dept. of Psychiatry, Inova Fairfax Hospital
The Honorable Gabriel Morgan, Sheriff, City of Newport News
The Honorable Dana Lawhorne, Sheriff, City of Alexandria
Lt. Col. Martin Kumer, Albemarle/Charlottesville Regional Jail
David Mangano, Director of Consumer and Family Affairs, Fairfax County Government

Staff Present

Janet Lung, LCSW, Director, Child and Family Services, DBHDS
Laurel Marks, Manager, Juvenile and Adult Services, Department of Criminal Justice Services
Mellie Randall, Director, Office of Substance Abuse Services, DBHDS
Michael Shank, Director, Community Support, Office of Mental Health, DBHDS

Members Absent

Richardean Benjamin, Old Dominion University
Jan Brown, Acting Director, Substance Abuse and Addiction Recovery Alliance (SAARA)
Debbie Burcham, Executive Director, Chesterfield Community Services Board

Mike O'Connor, Executive Director, Henrico Area Community Services
Beth Rafferty, Director of Mental Health Services, Richmond Behavioral Health Authority
Terry Tinsley, PhD, Youth for Tomorrow

Approval of Minutes
The meeting minutes from the January 24, 2014 meeting were approved as written.

MEETING MINUTES
Daniel Herr asked all members and staff to introduce themselves. He provided an overview of today's charge: to focus on the treatment and support services that would prevent people from being in crisis. Further, the group is asked to prioritize three to five recommendations to be considered by the Task Force at their April 10th meeting.

Greg Peters agreed to serve as spokesperson for this workgroup to report back to the full Task Force at its next meeting on April 10. Mike O'Connor did this last time, but was unable to attend this meeting on the workgroup.

The following key points were made in the workgroup discussion:

- There was discussion as to whether the group's recommendations should focus just on services that should be provided by CSBs, or whether all services – public and private – should be the focus.
- Mandated CSB services consist of Emergency Services, Case Management (within available resources), Discharge Planning, Mandatory Outpatient Treatment, Family Assessment and Planning (FAP) teams, and Threat Assessment teams based on MOUs with colleges. More than 50% of those who receive a prescreening by a CSB are not known to the CSB prior to this intervention.
- Some additional services are available at one CSB, but not another. Some services are available, but capacity is not sufficient. The following questions were posed.
    1. Are the mandated and core services being delivered efficiently across the state? Specifically, this group should focus on those services that are not part of the crisis continuum (Crisis Response WG will focus in those).
        a. Outpatient
        b. Psychiatry
        c. Medication management
        d. Day treatment services
    2. What are the services that need to be brought to capacity, where are the gaps in the system?
    3. What are the best practices?
- There should be standards and consistency across the state
- Integrated behavioral health and primary care
- PACT – a team of 10 staff and a specific model
- CIT
- Peer Support
- Telepsychiatry
- Supportive housing
- CSBs point out that funding is a limiting factor. Even where there is funding for a specific program, costs rise and the funding often stays level. Funding is not reliable enough to maintain programs.
- Families entering the system with children are confused. There needs to be one access point and the services need to be consistent across the state. The entry point should be the same for those with and without insurance. There should be consistent screening and referrals.
- Should we take a look at the broad issues of lack of access and fragmentation that plague the system instead of just recommending specific services. The system is broken.
    - Primary care should do a better job of being a point of entry to people, could possibly be that one access point.

  - Strategies for reducing stigma need to be created.
- Suicide prevention and mental health first aid.
- Seek ways to capture savings. When there are savings from reducing inpatient or residential care, those dollars should be redirected. The Compensation Board's funding formula for jails might be a model for a CSB funding formula. The actual CSB funding formula is historically based and largely influenced by changes made in the 1990s to cover the match required by Medicaid services.
- The mental health system suffers from the same fragmentation found in the health care system. Need to review existing studies. Why is the system so user-unfriendly?
- Early intervention, prevention, and community collaboration (system of care models) are among the broader issues that need to be addressed. Also suicide prevention and Mental Health First Aid.
- Promote the fact that treatment is effective and can lead to cost savings.

After the preceding discussion, the group began to focus on the recommendations they want to make to the Governor's Task Force. Three areas were advanced:

<u>Under-Funded System</u>
Reinvestment of savings

<u>What Works</u>
Existing Best Practices, such as
CIT
Crisis Stab
Peer to Peer
MH First Aid
PACT
DAP
Integrated primary care teams
Suicide Prevention Training

<u>System Reinvention</u>
Needs assessment
Pilots
Point of Access
Community collaboration
Integration
Make the system more user-friendly for the people we serve

- Should there be a Special Advisor on Mental Health to the Governor or Secretary, with an advisory council? Would this be a good strategy to support the task of system of reinvention? The Homeless Outcomes Coordinator position is an existing model of cross-systems work.

- The group identified the following task for its next meeting:
  - Developing a set of Guiding Principles to support system reinvention. The following, at minimum should be addressed in the guiding principles:
    - Existing service capacity is inadequate.
    - We must assure that funding is expended for what it is intended.
    - Medicaid expansion is essential.

RECOMMENDATIONS
After considerable discussion, the workgroup agreed to make three recommendations to the Governor's Task Force. These are summarized on the recommendations sheet and below.

Summary of Workgroup Recommendations (3-5 total recommendations)

Priority Rank	Proposal Description
1	System Reinvention Needs assessment is required to determine current capacity and gaps Pilots Community collaboration Integrated community system of care – public-private partnership Make the system more user-friendly for people across the lifespan Address the under-funded system Reinvestment of savings Address rising costs of services over time Health care coverage reform.
2	Implement What Works Existing Best Practices, such as the following examples • Crisis Intervention Teams • Peer to Peer • Mental Health First Aid • Programs of Assertive Community Treatment • Discharge Assistance Programs • Permanent supportive housing • Integrated primary care teams
3	Establish a Standard and Efficient Single Point of Access No wrong door Timely access to service Coordinate services needed by the person across agencies
4	
5	
	Total Ranked Proposals

NEXT STEPS

The workgroup recommendations will be presented to the full Task Force on April 10. Greg Peters agreed to be the spokesperson for the Ongoing Treatment and Supports Workgroup to the Task Force at that meeting.

The meeting adjourned at 2:00 p.m

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

DATA and TECHNICAL INFRASTRUCTURE WORKGROUP

March 19, 2014

10 a.m. – 2 p.m.

Main Branch, Richmond Public Library

MEETING MINUTES

Members Present

James Agnew, Sheriff, County of Goochland
Gail Burruss, Blue Ridge Behavioral Health
David Coe, Colonial Behavioral Health
Richard Edelman, Henrico Area Community Services
Lance Forsythe, Superintendent, Southside Regional Jail
Christine Hall, Poplar Springs Clinical Services
Debbie Condrey for Marissa Levine, VA Department of Health
Betty Long, VHHA
Deborah Waite for Michael Lundberg, VHI
Vicki Montgomery, Central State Hospital
Jake O'Shea, VA College of Emergency Physicians
Bill Phipps, Magellan Behavioral Health
Scott Reiner, CSA for At-Risk Youth & Families (CSA)
Anne Wilmoth, State Compensation Board
Lucy Rotich, Bon Secours Behavioral Health –Maryview
Lynne Trumball for Cindy Koshatka, Region II Mental Health

Staff present

Kathy Drumwright, DBHDS
Tammy Peacock, DBHDS
Carolyn Lankford, DBHDS

Members Absent

Kent Alford, MD Novant Health Prince William Medical Center
Cindy Frey, VCU Medical Center
Margaret Schultze, Department of Social Services
Karl Hade, Virginia Supreme Court
Mark Kilgus, VA Tech Department of Psychiatry & Behavioral Health

Others Present

Lynne Trumball, No. Va. Regional Project
Randy Ricker, Optima Health

MEETING MINUTES

Workgroup member introductions were made.

APPROVAL OF MINUTES
The minutes were approved.

TOPICS FOR DISCUSSION
Measures and Data needed to determine the success of the online bed registry:
Discussion focused on challenges and data that may be useful in determining success of the online bed registry.
Challenges identified include:

- When should bed registry be used
- Not every placement starts with a search
- TDO placement at state hospitals – need to see how many out of catchment area placements (zip code)
- Don't have a specific number of hospitals, saving state beds for those who need them
- Negotiate with multiple hospitals out of region
- Need everything in the registry completed
- Uniformity when used so data reliable
- Variation in processes for searching for available beds across regions; use bed registry - export function
- Stakeholder group – best practice for use
- Crisis worker not filling in all boxes
- Duplication of work in cases when required to complete paper search and bed registry search; now use paper process for bed search
- Triage and expedient access
- Communication
- CSB where admission occurs manages the admission, even if individual from other region
- When are commitment hearings held? Possibly change facility profile on bed registry to include times hearings are scheduled
- Bed registry times out quickly – should it automatically save?
- Each region should be able to identify what hospitals the registry pulls up first
- No specific number of hospitals to call
- Time – has to be done before end of ECO period
- Having to negotiate multiple hospitals
- Field in registry missed
- Available bed within specific radius
- Not complete data set
- End goal of the registry is to make sure people in crisis get a bed when they need it
- Some facilities have a Bed transfer center
- Type of bed facility appropriate
- Different sizes of facilities
- FOIA
- How to use information to review (failed/expired)
- Will go where there is quickest access
- Pros and cons of the PBR data sets

Data identified that may be useful includes:

- Utilization data
- How often registry is used
- Searches per day per region
- Total placements vs. percentage of placements that included registry search
- Number of days in month registry updated by facility
- Number of times in month registry updated by facility
- Number of updates per month
- Percentage of facilities updating search
- Expired or failed TDO
- Tally of reasons not placed with available beds
- Placements facilitated by registry
- Placements by facility
- Number of times registry shows particular facility vs. number of times placed at that facility
- Number of times called per placement
- Capacity of facility
- Percentage of time information inaccurate

Measures and Data needed to determine the success of the extension of the emergency custody order period:

The Workgroup identified issues and data for possible use in determining the success of the extension of the Emergency Custody Order period. These issues and data include:

- Data from Supreme Court on ECO/TDO activity
- Unknown what data is currently being captured, how it is being used to report consistently, and how it could be used.
- Identify baseline data to compare with post-implementation data to show whether extension of ECO has made a difference
- 100% access to beds all the time
- Success within the extended ECO period compared to the previous time period
- Reasons why
- How long it takes at each step of the process (initial, medical clearance, to admission) in order to support or revisit the time period. With respect to his, what needs to be recorded and who shall record and review data (Courts, CSBs, Sheriff)? CSBs now collect ECOs, hospitals contracted, etc. CSBs collect a lot if information about the ECO but do not know the disposition.
- Failed ECO data goes to DBHDS
- Bed placement within extended time frame
- Disposition
- Number released
- Eventually want a "Fed Ex" tracking system - time from initial to delivery
- Create a position to review ECOs?
- Since we are to measure the "success" of the extension of the ECO period, we need to define "success" before we can decide on data to measure it.
- EHR vs. training for staff to complete data

- Key number: When is ECO executed, when is TDO executed. Data should exist but unsure how to capture it.
- Prescreening shows when ECO is initiated. Training issue – what does this field mean and how complete it accurately.
- Will have a hard time getting the CSBs to collect a lot of data – maybe time in and out in the EHR?
- Bonnie study - institutionalize process
- Current laws, exceptions – consistent data set on exceptions: number, reasons for refusal, disposition
- Build data form as addendum to bed registry?
- Try to identify basic data - focus on exceptions
- Need data on time sheriff's offices spend on transportation and custody for ECOs. This data is not currently being collected. Sheriff Agnew will ask Sheriff's Association to start collecting this data. When sheriffs go out of catchment area, creates problems. Need to consider the impact of costs and time for custody and transportation on the Sheriff and local police. Did not go to 24 hours because of law enforcement.
- How to link CSB data to Law Enforcement data
- Framework for capturing aggregate vs. individual data – facility, law enforcement, CSB. Do we need to capture information on the individual or aggregate level?
- 97% of the time the previous ECO time period was successful, so perhaps focus on exceptions ("failed" cases or cases not placed)
- Don't need to "get in the weeds" for 3% since 97% of the time the process works.
- Do RCA of exceptions
- Unexecuted ECOs called Exceptions – need to standardize the process
- What are the contributing factors of the exceptions – identify where it is breaking down and collect data about that. E.g.: TBI and DD – reasons for refusals, custody. Can we combine it into the PBR? Very basic data to focus on the exceptions, not sure it needs to be in the PBR. Best option is to build it into the HER. Propriety sources can be used to pull the data elements. This is consistent with health information exchange. Interoperability is required in 2015 through HIE. Need a data warehouse that can integrate the data; DBHDS is building this now. CCS3, Avatar, and CHRIS will be integrated into data warehouse first.
- Medical clearance process – guidance for process for medical screening; length of time
- Achieve balance and identify most meaningful data
- Strike the balance of collecting data, adding requirements in proportion to the issue and take small steps. Provide existing data to the Workgroup.
- Part of the admission protocol includes retrospective review of failed TDOs
- Number of failed ECO/TDOs
- Expectation is 100% access to a bed when needed
- Focus should be on whether individual gets a bed
- How can we utilize data we already have and how can we collect data in most efficient way
- CSBs have data on number of ECOs not executed

Measures and data needed to determine effectiveness of crisis stabilization, hospital diversion, secure assessment sites, acute inpatient treatment, state hospital specialized care, other crisis response and ongoing services (PACT, outpatient, case management, etc.):

The Workgroup discussed measurement of service effectiveness and identified information the Workgroup needs to proceed and initial ideas about approaching this task. Key points from this discussion include:

- Identify existing data pertaining to the effectiveness of specified services and provide at next meeting
- Look at all regional utilization reports; standardize what is collected and ensure consistent definitions
- Define effectiveness and then determine whether data exists to measure effectiveness
- What protocols exist – standard use of terms, definitions, consistent data collection elements
- For effectiveness, focus on insuring safety net and time efficient
- Effectiveness of Crisis Stabilization – what does this mean? Look at readmissions, LOS, individuals who went to higher levels of care, etc.
- CSBs have different criteria of who they serve. GA has a problem with that – need basic service array, standard eligibility criteria
- Resist the temptation to broaden the scope beyond the effectiveness, safety net – clear about the charge
- Need to see baseline data

Recommend refinements and clarifications of protocols and procedures for community services boards, state hospitals, law enforcements and receiving hospitals:
The Workgroup questioned the fit of this task with the Workgroup's focus on technology and data, recognized that other workgroups may be addressing these issues, and questioned its ability to recommend refinements and clarifications prior to reviewing the protocols and procedures. The Workgroup recommended there be consistent terms, definitions, data collection elements, and standardized reports. It was recommended that this task be placed in the parking lot as we work through our other tasks and gain a better understanding and that hospitals conducting medical assessments be included.

Explore technological resources and capabilities, equipment, training and procedures to maximize the use of telepsychiatry and other technology:
Workgroup discussed data sharing and technology, resulting in identification of the following information and issues:

- Tom Von Hemich, software to collect data for CIT, law enforcement
- Thomas Jefferson Intervention team
- Providing telepsychiatry for the juvenile detention
- Intake with secure documents – webcam
- Recommendations – all charged with public safety – how do we in a proactive way talk among agencies to prevent hospitalization – sharing data –
- Supreme Court -need to clarify the range of practices across the state, issuing of the ECO/TDO process, ability and willingness to use technology, sharing data
- Law enforcement needs to know if individual has been TDOd when do criminal background check, not just when do a firearms check – not sure if it has to be codified or just an administrative issue, different code for query when searching for gun ownership.
- Innovation – if we could blow up the system how would we do it? Have been discussing incremental change

The Workgroup decided to have two presentations on telehealth and technology at its next meeting. It also discussed information sharing between CSBs, law enforcement, and the Supreme Court and recommended exploring use of telepsychiatry and technology.

RECOMMENDATIONS FOR FULL TASKFORCE:
Three to five recommendations for the full taskforce shall be prioritized from the discussion today and the previous meeting. Betty Long offered to report to the full Taskforce on April 10 and David Coe offered to serve as backup in the event Betty Long was unable to attend the Taskforce meeting.

Workgroup recommended presenting challenges and possible data to stakeholder group.

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

CRISIS RESPONSE WORKGROUP

March 19, 2014

10 a.m. – 2 p.m.

Main Branch, Richmond Public Library

MEETING MINUTES

Members Present

William Barker, MD, Emergency Medicine, Fauquier Hospital
Lawrence "Buzz" Barnett, Emergency Services Director, Region Ten CSB
Kirsten Berglund Bradley
Neil Bradley, sitting in for Daniel Holser, Chief Magistrate, 12th Judicial District
Varun Choudhary, MD, Medical Director, Magellan Behavioral Health
Sherry Confer, sitting in for Karen Kimsey, Deputy Director, DMAS Complex Care and Services
Margaret Nimmo Crowe, Executive Director, Voices for Virginia's Children
Kit Cummings, Lieutenant, Blacksburg Police Department
Robin Foster, MD, Virginia Commonwealth University Medical Center
Chuck Hall, Executive Director, Hampton-Newport News CSB
Jeffery Lanham, Regional Magistrate Supervisor, 6th Magisterial Region
Cynthia McClaskey, PhD, Director, Southwestern Virginia Mental Health Institute
Sandy Mottesheard Member at Large at National Alliance on Mental Illness (NAMI) Virginia
Bonnie Neighbor, Executive Director, VOCAL
Ted Stryker, Vice President, Centra Mental Health Services, Lynchburg
Scott Syverud, MD, Vice Chair, Clinical Operations, UVA School of Medicine
David Rockwell, Peer Support Provider, Henrico Area MH and Developmental Services
Ben Shaw, Region 1 Coordinator, Virginia Wounded Warrior Program, Virginia Dept. of Veterans Services
Tom Spurlock, Vice President, Art Tile, Inc.
John Venuti, Chief, VCU Police Department
Cindy Wood, Lieutenant, Henrico Police Department
Jason Young, Executive Director, Community Brain Injury Services

Staff Present

Jim Martinez
Mary Begor
Susan Pauley
Jack Barber
Stephanie Arnold

Members Absent

Douglas Knittel, MD, Psychiatric Emergency Services, Portsmouth Naval Hospital, Portsmouth
Bruce Lo, MD, Chief, Department of Emergency Medicine, Sentara Norfolk General Hospital
Shirley Repta, Executive Director, Inova Behavioral Health
Joseph Trapani, Chief Executive Officer, Poplar Springs Hospital, Petersburg

Kaye Fair, Emergency Services Director, Fairfax-Falls Church CSB, Fairfax
Brian Wood, DO, Psychiatric Education Director, Psychiatry, VAMC

Others Present
Allyson Tysinger, Senior Assistant Attorney General, Office of the Attorney General
Karen Taylor, Special Counsel, Office of the Attorney General

MEETING MINUTES

The meeting was convened and attendees introduced themselves.

Minutes from the previous meeting on January 24, 2014 were distributed and reviewed. There were no revisions or objections to the minutes, and the minutes were approved by the members.

The "Topics to Cover" handout was distributed. Jim Martinez reviewed the topics for this meeting. Members were asked to compile a list of 3-4 recommendations for the full Task Force to consider at the next meeting on April 10, 2014.

A question was raised about what was happening at the Commonwealth Center for Children and Adolescents (CCCA) based on the remarks made by Dr. Jack Barber during the opening presentations. Dr. Barber responded that there was no clear explanation for the increase in the number of admissions but this is being explored further. One explanation offered is that CCCA is the only state facility for children and adolescents and there are no other backup facilities at this time. Further study and investigation will continue.

Jim Martinez distributed the handout of legislative actions by the General Assembly that were referred or relevant to the Task Force and Workgroup. Jim provided an overview of the legislation as well as the letter from Secretary Hazel to Speaker Howell and Delegate Orrock concerning HB 832, which was referred to the Task Force.

- **DISCUSSION OF LEGISLATIVE ITEMS (1ST BULLET, TOPICS TO COVER)**

HB 832
Discussion of HB 832 began with the difficulties experienced by both CSB emergency services staff and law enforcement officers regarding sharing of information about individuals being served, especially barriers to sharing important information in non-emergency situations. Sharing of information already occurs during an ECO as authorized in statute. At other times law enforcement can share with the CSB, but not vice versa due to HIPAA. Discussion focused on the safety of sending law enforcement out with minimal information to execute an ECO, as well as the inability to communicate with law enforcement when a person is released from a facility. Also mentioned were differences in the ability to share information in the general community, versus allowable information sharing with university/college systems when there is a person posing potential risks to others. This collaboration is governed by state code to allow the communication within university and colleges and the law enforcement of the school. Several members suggested that a solution may require legislative action. The group was reminded that 42CFR also applies if there is a substance use disorder or co-occurring disorder (MH/SA), and any legislative planning should include someone that understands 42CFR.

A proposal was made to convene a group to craft legislation or guidance that would support more sharing of relevant information that would help law enforcement and healthcare providers in the context of proactive crisis prevention planning with strong protections regarding what can be shared, for what purpose and consequences.

Dialogue continued focused on using options that are already in place such as promoting the increased use of advanced directives, use of consent for disclosure forms and community planning. It was pointed out that legislation would be difficult to adequately work in all communities of the state and this may be best done on a regional or local level that could be more effective and specific to the needs and operations with the locality. There was recognition that legislation may not be needed but specific guidance would be helpful without mandating some type of state wide code. Karen Taylor and Allyson Tysinger OAG pointed out that there is no need for a law to establish regional workgroups but there would need to be statutory changes to support the sharing of protected health information between MH/SA providers and law enforcement. Members were reminded that once an individual is released they have right to make decisions that others may not agree with and we need to make sure this is not a "back door" approach to getting them back into hospital when they do things others do not agree with.

In conclusion, it was recommended that a group be convened to look into sharing of information and delineate exactly what is desired to be in place at the local level, and then determine if any statutory guidance or code change is needed to achieve the desired result and make sharing of information more extensive and effective.

HB478 and SB260

Jim Martinez distributed the enactment clauses in HB478 and SB260, which require the Governor's Task Force on Improving Mental Health Services to study options for reducing the use of law enforcement in the involuntary admission process.

Currently law enforcement officers provide the majority of such transportation, and the number of separate transports for persons under emergency custody, temporary detention or commitment orders is very large. Current laws allow for alternative transportation, but this is rarely utilized. Discussion focused on how decisions are made to use alternative transportation, and that current law allows a magistrate the discretion to authorize alternative transportation only if the individual is at risk of suffering serious harm but not causing serious harm. Magistrates must also insure that the alternative transportation provider is willing and able to safely transport the individual. The statute changed in 2013 to require the magistrate to consider alternative transportation when it is made known that alternatives may be available.

Members observed that the cost of providing transportation is often not reimbursed to the law enforcement entity. Sheriffs may seek reimbursement through the State Compensation Board but police departments cannot under current law. The burden on some jurisdictions to provide the transportation is significant, not only financially but in manpower as well Contracting alternative transportation providers is option but it remains undetermined who would administer and supervise this option.

Another issue regarding transportation is that transportation by law enforcement is not always timely, and individuals sometimes have to wait for long periods (sometimes an entire shift) to reach their ultimate treatment destination.

The group also noted that services are fragmented both within a jurisdiction, and across the system, which sometimes results in individuals being transferred to several different places before reaching their intended destinations. With each transfer, information can be overlooked and the process can increase the trauma of the experience and increase agitation of an individual in crisis. Locations of services are varied and a suggestion was made to consider consolidating services to make the crisis experience more efficient and streamlined. It was noted that the Commission of Mental Health Law Reform studied the issue of transportation extensively and their findings can be used to help improve transportation and reduce the burden on law enforcement. Another question was raised about why there is no state agency that provides and oversees transportation, no matter where the need is, rather than having local groups attempting to figure everything out all the time.

A recommendation was made to have a panel of experts create a "Toolkit" for communities to use to develop the strong collaborative structure to enable effective and efficient planning, communication, transportation,

etc. This toolkit could be adapted to each local community but would help establish guidelines for insuring a more seamless approach to helping individuals with behavioral health issues.

The summary recommendation of the Workgroup was to find ways to increase compensation for providing transportation, to encourage and support increased use of alternative transportation providers such as family, friends, EMS, etc., to cover the uncompensated costs to police, This would also help ensure that individuals would not have to wait for long periods for transport.

- **DISCUSSION OF PROTOCOLS AND PROCEDURES FOR CSBS, STATE HOSPITALS, LAW ENFORCEMENT AGENCIES AND RECEIVING HOSPITALS (2ND BULLET, TOPICS TO COVER)**

A question was raised about the proposed legislation to amend the Psychiatric Treatment of Minors Act. There was discussion about applicability of changes in ECO/TDO process and time frames to minors admission. At this point final statutory language was not yet signed into law.

There was discussion of the differences in access for children and adolescents. Private hospitals can legally refuse to admit a minor but this is especially true with an objecting minor, and the process can sometimes put the legal guardians in position of having to decide whether to seek a TDO or leave hospital without treatment for their adolescent. Concern was raised about the capacity of CCCA as a state facility for children and adolescents when private facilities can refuse admission to anyone for any reason. The question was asked whether, under the new law, if CCCA is unable to admit a minor due to capacity, will other state facilities have to take the minor under the new legislation?

New legislation extends maximum time for a TDO from 48 hours to 72 hours but the current code for minors is not changed from a minimum of 24 hours prior to hearing with a maximum of 96 hours. There is an identified larger access issue for minors.

The group felt the protocols are too new and not all members have had the opportunity to view them at the time of the meeting. A decision was made to defer further discussion and possible recommendation on this to the next workgroup meeting regarding how the protocols will be implemented in each region, The burden is on regions and state facilities with ERs, CSBs, and law enforcement to meet all of the guidelines and and requirements and to evaluate the document as well as to coordinate, communicate, receive feedback and train within the region. CSBs are ultimately responsible for the dissemination of information within their own communities. A question was raised by one member about whether DBHDS is requiring regions to provide a report on how the protocols are working? **It was recommended that the regions be asked to provide such reports and describe how the regions are making sure that everyone who needs to know the protocols has access to them and has had the opportunity to pose any questions about them to informed individuals.**

Facilities serving individuals over the age of 65 are not used to having to accept rapid admission and this will need to be addressed. It was mentioned that attention needs to be paid to this population as coverage areas are different for this population.

- **DISCUSSION OF POSSIBLE SERVICE EXPANSION THAT WILL REDUCE THE FREQUENCY AND INTENSITY OF MENTAL HEALTH CRISES (3RD BULLET, TOPICS TO COVER)**

The group emphasized encouraging individuals to develop and refine their own crisis plans as much as possible so that advance planning is recognized and supported widely and embedded into routine care. Current initiatives are underway to help and support individuals to write their own Wellness Recovery Action Plans (WRAPs) and Advanced Directives. These tools promote self determination and can help individuals avoid crises and coercive intervention, including involuntary care. **The group recommended that advance planning of all types be offered to individuals receiving behavioral healthcare services.**

The group revisited the recommendation that additional PACT or ACT teams be created to ensure that every community has a team. The group recognized that resources that are needed to support this and other possible programs and that many individuals who may benefit from these services do not have Medicaid that will pay for the services. Private insurance and self-pay options are not realistic for most seeking intensive services such PACT or ACT. A goal for Virginia should be to reduce involuntary treatment and coercive measures which will overall result in a decreased need for hospitalization. This can only be accomplished if appropriate community supports are available and funded. Other services that were discussed include the use of tele-psychiatry to make psychiatric services available in a timely fashion across the state as well as access to psychiatric consult and medications for emergency services so that clinicians to help prevent hospitalization. Child and adolescent crisis initiatives are working across the state but every region is different with resource allocation and additional funds are needed to expand programs that are working for Virginia's youth.

Members ranked expanded access to psychiatric services with reduced waiting periods for appointments as more important than expanding PACT or ACT at this time. Possible staffing expectations for psychiatrists were also suggested to be more consistent across the state (e.g., psychiatrists per 100K), and active recruitment enhancements for psychiatrists were suggested focused on underserved areas of the state, including loan repayment, etc.

Tom Spurlock suggested that laws governing mandatory outpatient treatment need to be changed.

A point was made that in primary medicine when they look at how to reduce use of emergency rooms, they find that people need better access to primary doctors and the same exists in behavioral health crisis situations. If there was better access to certain "upstream" services, there would be a reduction in the use of crisis services. There was agreement that there is quick access to primary care in communities but no quick access to psychiatric services. The requirement for primary care access is within 3 to 5 days, and this standard needs to be true for psychiatric services as well.

The recommendation of the Workgroup is to improve access to consistent psychiatric services in a timely manner, using a benchmark standard as exists in other health care, and make resources available to accomplish this goal. It is also recommended that emergency service providers should at a minimum be able to access a prescriber, if not a psychiatrist, to reduce the use of hospitalization as the means to access medication.

The use of peer-provided services in crisis care services works well to reduce trauma and the use of coercive intervention. More integrated use of peers would necessitate developing and sustaining a peer training program that can be utilized as a component of treatment.

Providing crisis intervention, and not just crisis assessment, is an important means of intervening before a situation gets worse. This can be accomplished by creating a more inviting and welcoming service environment, and reaching out to individuals who are not engaged in supportive care. Use of peer services as a bridge to care can help reduce crises.

A concern was noted about crisis workers' knowledge of substance use disorders and how to screen and respond to them.

A suggestion made that Virginia could develop a statewide registry of telemedicine resources that people could access to make timely appointments with psychiatry services. Duke University, for example, linked all their emergency services with telepsychiatry through one portal.

- **DISCUSSION OF MEDICAL ISSUES (4TH BULLET, TOPICS TO COVER)**

The Workgroup briefly discussed the recent release of the *Medical Screening and Assessment Guidance, Second Edition* by DBHDS earlier in March. The guidance is to become effective April 1, 2014. The document was distributed to all state facilities and CSBs. Planning will follow on how to disseminate the guidance most widely, and support adoption by public and private facilities, CSBs, physicians and emergency departments. Members asked that the guidelines be distributed to them.

There is currently a concern among state facilities regarding individuals with medical conditions that may exceed the medical capability of the state facility. The question of medical stability continues to be an issue in when physicians or facilities are not in agreement about the suitability of admissions based on medical needs and lab results. This continues to be a concern and will be investigated further with new statutory requirements and the *Medical Screening and Assessment Guidance*.

A suggestion was made that all crisis stabilization units and psychiatric facilities be able to provide a consistent minimum medical capability to treat the most common conditions. The use of telemedicine may be of interest to the CSUs and facilities.

Another concern was raised about individuals with addiction issues, and practices here vary from one facility to another.

HPR V (Tidewater) identified the biggest issue for obtaining a bed in that region is that facilities cite a lack of staffing as a reason for being unable to accept an admission.

In response to a question about what the Task Force will do with the Workgroup recommendations, thew Workgroup was advised that all recommendations would be presented to the Task Force. The Task Force, in turn, will determine the recommendation they will include in their final report, due October, 2014.

NEXT STEPS
Mail *Medical Screening and Assessment Guidance* to members.

The meeting was adjourned at 1:51 PM.

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

Public Safety Workgroup
WORKPLAN

EO 12: RESPONSIBILITIES	PREVIOUS RECOMMENDATIONS	MEETING PRIORITIES
1. Identify and examine the availability of and improvements to mental health **resources for** Virginia's **veterans**, service members, and their families and children.		Discuss for possible recommendation
2. Review for possible **expansion the programs and services** that assure prompt response to individuals in mental health crises and their families such as emergency services teams, law enforcement crisis intervention teams (CIT), secure assessment centers, mobile crisis teams, crisis stabilization centers and mental health first aid. *[See below; HB478)/SB260: **Such options shall include** developing crisis stabilization units in all regions of the Commonwealth and contracting for retired officers to provide needed transportation]*	• Mar. 19.Priority 4: Virginia needs to invest in CIT programs (to include CIT Assessment Centers) so that every community in Virginia has a functional CIT program and Assessment Center • Jan. 24.Priority 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.	Discuss for possible recommendation; notably, HB478/ SB260 direction to examine contracting with retired officers to provide transportation.
3. **Examine extensions or adjustments** to the emergency custody order and the temporary detention order period. *HB478)/SB260: **requires the study of** options for reducing the use of law enforcement in the involuntary admission process.* *Specifically, the task force shall **identify and examine issues** related to the use of law enforcement in the involuntary admission process and **consider options to reduce** the amount of resources needed to detain individuals during the emergency custody order period, including the amount of time spent providing transportation throughout the admission process.*	• Mar. 19.Priority 3: Virginia needs to affect a paradigm shift away from having law enforcement be first responders for mental health issues. To achieve this goal, taskforce should commission a study on how other states address this issue to include how other states employ alternate transport (other than having law enforcement perform mental health transportation). • Jan. 24.Priority 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.	Discuss for possible additional recommendations; notably, HB478/ SB260 direction to examine reducing use of law enforcement in involuntary admission process.
4. Examine the cooperation that exists among courts, law enforcement and mental health systems in communities that have incorporated crisis intervention teams and cross systems mapping. *Referred by letter (report due: HB832* ***Barriers to cooperation and communication** between law enforcement and behavioral health care providers in cases involving individuals in need of mental health evaluation and treatment;* ***Make recommendations related to improving communication and cooperation** among law*	• Mar. 19.Priority 6: Each community should establish and employ best practices to enhance and improve communication between law enforcement and mental health with the goal of decreasing the amount of time individuals with mental health issues are in police custody.	Discuss for possible additional recommendations

enforcement and behavioral health care providers, including communication and cooperation in cases in which an individual is taken into emergency custody, or held for temporary detention or involuntary admission for treatment, in order to improve the safety and well-being of the public and the individual.		
5. Recommend **how families and friends of a loved one** facing a mental health crisis can **improve the environment and safety** of an individual in crisis.	• Mar. 19.Priority 2: Need to improve community awareness of behavioral health disorders and an education campaign instructing citizens how to access help. There needs to be a standardized pathway to access services.	Discuss for possible additional recommendations
6. Recommend refinements and clarifications of **protocols and procedures** for community services boards, state hospitals, law enforcement and receiving hospitals.	• Mar. 19.Priority 5: Virginia needs to create a Center of Excellence for Criminal Justice/Behavioral Health Issues and should strive to be a model state for behavioral healthcare where individuals, agencies and entities can obtain information on best practices, where relevant data can be identified/collected/ analyzed know what works to improve outcomes; where communities can be provided technical assistance and training; and to assist government in policy development	Review to ensure responsibility is covered
7. Review for possible expansion those services that will provide ongoing support for individuals with mental illness and reduce the frequency and intensity of mental health crises. These services may include rapid, consistent access to outpatient treatment and psychiatric services, as well as co-located primary care and behavioral health services, critical supportive services such as wrap-around stabilizing services, peer support services, PACT services, housing, employment and case management.	• Mar. 19.Priority 1: Virginia needs to invest in readily available, full service mental health services to include prevention services. • Jan. 24.Priority 4: Consensus was to support the proposal for 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.	Review to ensure responsibility is covered
8. Explore technological resources and capabilities, equipment, training and procedures to maximize the use of telepsychiatry.		Review to ensure responsibility is covered
9. Assess state and private provider capacity for psychiatric inpatient care, the assessment process hospitals use to select which patients are appropriate for such care, and explore whether psychiatric bed registries and/or census management teams improve the process for locating beds.		Review to ensure responsibility is covered
10. Examine the mental health workforce capacity and scope of practice and recommend any improvements to ensure an adequate mental health workforce.		Review to ensure responsibility is covered

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

Ongoing Treatment and Supports Workgroup
WORKPLAN

EO 12: RESPONSIBILITIES	PREVIOUS RECOMMENDATIONS	MEETING PRIORITIES
1. Explore technological resources and capabilities, equipment, training and procedures to maximize the use of **telepsychiatry**.		Discuss for possible recommendation
2. Identify and examine the availability of and improvements to mental health **resources for** Virginia's **veterans**, service members, and their families and children.		Discuss for possible recommendation
3. Recommend **how families and friends of a loved one** facing a mental health crisis can **improve the environment and safety** of an individual in crisis.		Discuss for possible recommendation
4. Examine the **mental health workforce capacity and scope of practice** and recommend any improvements to ensure an adequate mental health workforce.		Discuss for possible recommendation
5. Assess **state and private provider capacity** for psychiatric inpatient care, **the assessment process hospitals use** to select which patients are appropriate for such care, and explore whether **psychiatric bed registries** and/or census management teams improve the process for locating beds.		Discuss for possible recommendation
6. Review for possible expansion the programs and services that assure prompt response to those in mental health crises and their families such as emergency services teams, law enforcement crisis intervention teams (CIT), secure assessment centers, mobile crisis teams, crisis stabilization centers and mental health first aid. *[HB478)/SB260 : **Such options shall include** developing crisis stabilization units in all regions of the Commonwealth and contracting for retired officers to provide needed transportation]*	• Mar. 19.Priority 3: Establish a Standard and Efficient Single Point of Access: No wrong door; Timely access to service; Coordinate services needed by the person across agencies • Jan. 24.Priority 3: CIT programs and CIT assessment centers should also be developed across the lifespan. • Jan. 24.Priority 4: Expand Mental Health First Aid across Virginia	Review to ensure responsibility is covered
7. **Examine extensions or adjustments** to the ECO and TDO periods. *HB478)/SB260: **requires the study of** options for reducing the use of law enforcement in the involuntary admission process. Specifically, the task force shall **identify and examine issues** related to the use of law enforcement in the involuntary admission process and consider options to reduce the amount of resources needed to detain individuals during the emergency custody order period, including the amount of time spent providing transportation throughout the admission process.*	• Jan. 24.Priority 8: Support 72 hour maximum, minimum 24-hour TDO period	Review to ensure responsibility is covered
8. Review for possible expansion those **services that will provide ongoing support** for individuals	• Mar. 19.Priority 1: System Reinvention ○ Needs assessment is required to determine	Review to ensure responsibility is

with mental illness and reduce the frequency and intensity of mental health crises. These services may include rapid, consistent access to outpatient treatment and psychiatric services, as well as co-located primary care and behavioral health services, critical supportive services such as wrap-around stabilizing services, peer support services, PACT services, housing, employment and case management.	current capacity and gaps ○ Pilots ○ Community collaboration ○ Integrated community system of care – public-private partnership ○ Make the system more user-friendly for people across the lifespan ○ Address the under-funded system ○ Reinvestment of savings ○ Address rising costs of services over time ○ Health care coverage reform. • Mar. 19.Priority 2: Implement What Works Existing Best Practices, such as the following examples: Crisis Intervention Teams; Peer to Peer; Mental Health First Aid; PACT; Discharge Assistance Programs; Permanent supportive housing; Integrated primary care teams • Jan. 24.Priority 1: Support more funding for the system. • Jan. 24.Priority 2: Programs of Assertive Community Treatment (PACT) services should be expanded across VA and services should be provided across the lifespan. 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. • Jan. 24.Priority 5: Expand Suicide Prevention programs. • Jan. 24.Priority 6: Discharge Assistance Program - Continue to fund those with extraordinary barriers and focus on the discharge process to maximize the flow-through in state hospitals. • Jan. 24.Priority 7: Capture savings - Exploration 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. • Jan. 24.Priority 9: Support the Auxiliary Grant program expansion bill	covered
9.Examine the **cooperation that exists** among the courts, law enforcement and mental health systems in communities that have incorporated crisis intervention teams and cross systems mapping. *Referred by letter: HB832* ***Barriers to cooperation and communication*** *between law enforcement and behavioral health care providers in cases involving individuals in need of mental health evaluation and treatment;* ***Make recommendations related to improving communication and cooperation*** *among law enforcement and behavioral health care providers, including communication and cooperation in cases in which an individual is taken into emergency custody, or held for temporary detention or involuntary admission for treatment, in order to improve the*		Review to ensure responsibility is covered

safety and well-being of the public and the individual.		
10. Recommend refinements and clarifications of **protocols and procedures** for community services boards, state hospitals, law enforcement and receiving hospitals.		Review to ensure responsibility is covered

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

Technical Infrastructure and Data Workgroup
WORKPLAN

EO 12: RESPONSIBILITIES	PREVIOUS RECOMMENDATIONS	MEETING PRIORITIES
1. Identify and examine the availability of and improvements to mental health resources for Virginia's veterans, service members, and their families and children.		Discuss for possible recommendation
2. Examine the mental health workforce capacity and scope of practice and recommend any improvements to ensure an adequate mental health workforce.		Discuss for possible recommendation
3. Examine the mental health workforce capacity and scope of practice and recommend any improvements to ensure an adequate mental health workforce.		Discuss for possible recommendation
4. Explore technological resources and capabilities, equipment, training and procedures to maximize the use of telepsychiatry.	• Mar. 19.Priority 3: Complete an inventory of existing technology around the use of telehealth, telepsychiatry and use of video technology. Identify best practices currently in use and identify gaps.	Discuss for possible additional recommendations
5. Recommend refinements and clarifications of protocols and procedures for community services boards, state hospitals, law enforcement and receiving hospitals.	• Mar. 19.Priority 4: Consider building data form as an addendum to the bed registry to identify basic data, focus on exceptions. Present challenges identified by the task force committee to stakeholder group being developed by DBHDS and request recommendations around use of the registry. Specifically, identify when the bed registry should be used as not every placement starts with a search. There must be uniformity in the data collection so the data is reliable. • Jan. 24.Priority 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. • Jan. 24.Priority 4.2: Develop bed registry 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.	Review to ensure responsibility is covered
6. Examine extensions or adjustments to the emergency custody order and the temporary detention order period. *HB478)/SB260: **requires the study of** options for reducing the use of law enforcement in the involuntary admission process.* *Specifically, the task force shall **identify and examine issues** related to the use of law enforcement in the involuntary admission process and **consider options to reduce** the*	• Mar. 19.Priority 1: Look at existing data collected from CSBs and law enforcement related to TDOs, ECOs, including transportation and custody time and identify opportunities for better data sharing and integration. • Mar. 19.Priority 2: Look at data from the Supreme Court on ECO/TDO activity. What is currently captured and how can it be used? • Jan. 24.Priority 2: Consider removing the requirement that the facility of temporary detention be specified	Review to ensure responsibility is covered

amount of resources needed to detain individuals during the emergency custody order period, including the amount of time spent providing transportation throughout the admission process.	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.	
7. Examine the cooperation that exists among the courts, law enforcement and mental health systems in communities that have incorporated crisis intervention teams and cross systems mapping. *Referred by letter: HB832* ***Barriers to cooperation and communication*** *between law enforcement and behavioral health care providers in cases involving individuals in need of mental health evaluation and treatment;* ***Make recommendations related to improving communication and cooperation*** *among law enforcement and behavioral health care providers, including communication and cooperation in cases in which an individual is taken into emergency custody, or held for temporary detention or involuntary admission for treatment, in order to improve the safety and well-being of the public and the individual.*	• Jan. 24.Priority 7.1: 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.	Review to ensure responsibility is covered
8. Assess state and private provider capacity for psychiatric inpatient care, the assessment process hospitals use to select which patients are appropriate for such care, and explore whether psychiatric bed registries and/or census management teams improve the process for locating beds.	• Jan. 24.Priority 4.1: Complete the implementation of the Electronic Bed Registry that is currently under development. Include recommendation for funding for staff to manage and monitor the Bed Registry. • Jan. 24.Priority 7.2: Look at integrating data across systems for purposes of operations, monitoring, and evaluation (aggregate and de-identified data).	Review to ensure responsibility is covered
9. Review for possible expansion those services that will provide ongoing support for individuals with mental illness and reduce the frequency and intensity of mental health crises. These services may include rapid, consistent access to outpatient treatment and psychiatric services, as well as co-located primary care and behavioral health services, critical supportive services such as wrap-around stabilizing services, peer support services, PACT services, housing, employment and case management.	• Jan. 24.Priority 6.1: 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 impatient level of services. • Jan. 24.Priority 6.2: Identify opportunities to use technology and innovation to assist individuals to successfully transition from hospitals back into the community. • Jan. 24.Priority 7.3: Identify opportunities to use technology to assist individuals to navigate and move through the mental health system.	Review to ensure responsibility is covered
10. Recommend how families and friends of a loved one facing a mental health crisis can improve the environment and safety of an individual in crisis.		Review to ensure responsibility is covered

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

Crisis Response Workgroup
WORKPLAN

EO 12: RESPONSIBILITIES	PREVIOUS RECOMMENDATIONS	MEETING PRIORITIES
1. Examine the **cooperation that exists** among the courts, law enforcement and mental health systems in communities that have incorporated crisis intervention teams and cross systems mapping. *Referred by letter: HB832* ***Barriers to cooperation and communication** between law enforcement and behavioral health care providers in cases involving individuals in need of mental health evaluation and treatment;* ***Make recommendations related to improving communication and cooperation** among law enforcement and behavioral health care providers, including communication and cooperation in cases in which an individual is taken into emergency custody, or held for temporary detention or involuntary admission for treatment, in order to improve the safety and well-being of the public and the individual.*		Discuss for possible recommendation
2. Identify and examine the availability of and improvements to mental health **resources for** Virginia's **veterans**, service members, and their families and children.		Discuss for possible recommendation
3. Recommend **how families and friends of a loved one** facing a mental health crisis can **improve the environment and safety** of an individual in crisis.		Discuss for possible recommendation
4. Examine the **mental health workforce capacity and scope of practice** and recommend any improvements to ensure an adequate mental health workforce.		Discuss for possible recommendation
5. Recommend refinements and clarifications of **protocols and procedures** for community services boards, state hospitals, law enforcement and receiving hospitals.	• Mar. 19.Priority 4: Construct a reporting system for regions to provide to DBHDS regarding the use of the regional access to bed space protocols as a way to identify any challenges, barriers and successes on the actual protocols as a quality check to ensure that the protocols are working. Also the reporting system should include how the dissemination of the protocols is taking place in each region with an emphasis on initial and ongoing information about the regional protocols including any updates to the protocols. • Jan. 24.Priority 4: Notify CSB, by some means,	Review to ensure responsibility is covered

	when ECO is executed. • Jan. 24.Priority 21: Support the review and improvement of these protocols.	
6. Review for possible **expansion the programs and services** that assure prompt response to individuals in mental health crises and their families such as emergency services teams, law enforcement crisis intervention teams (CIT), secure assessment centers, mobile crisis teams, crisis stabilization centers and mental health first aid. *[HB478)/SB260: **Such options shall include** developing crisis stabilization units in all regions of the Commonwealth and contracting for retired officers to provide needed transportation]*	• Mar. 19.Priority 2A: Increase compensation for providing transportation, encourage and support increased use of alternative transportation providers such as family, friends, EMS, etc., and cover the uncompensated costs to police. This would also help ensure that individuals would not have to wait for long periods for transport. • Mar. 19.Priority 2B: Development of an informational toolkit to help communities build collaborative relationships with law enforcement with information exchange while protecting the privacy of individuals. • Jan. 24.Priority 17: Intervention Centers. Strong support for within the group. Need more money than 300K per site. High priority. • Jan. 24.Priority 12: Increase CIT training to areas that have not yet received it.	Review to ensure responsibility is covered
7. **Examine extensions or adjustments** to the emergency custody order and the temporary detention order period. *HB478)/SB260: **requires the study of** options for reducing the use of law enforcement in the involuntary admission process. Specifically, the task force shall **identify and examine issues** related to the use of law enforcement in the involuntary admission process and **consider options to reduce** the amount of resources needed to detain individuals during the emergency custody order period, including the amount of time spent providing transportation throughout the admission process.*	• Jan. 24.Priority 1/13: 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. • Jan. 24.Priority 2: Consider further MD/PhD direct request to Magistrate for TDO (without requiring a CSB evaluation). • Jan. 24.Priority 3/14: 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. • Jan. 24.Priority 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. • Jan. 24.Priority 7: Make sure that extension can be obtained by phone rather than in person (if retained). • Jan. 24.Priority 15: Re-enactment and study clause for any changes in the ECO or TDO to determine what the impact was.	Review to ensure responsibility is covered
8. Explore technological resources and capabilities, equipment, training and procedures to maximize the use of **telepsychiatry**.	• Mar. 19.Priority 1: Set benchmarks for access to consistent psychiatric services in a timely manner (possible models used in other health care environments). Calculate the cost to accomplish across the Commonwealth. Improve access to telepsychiatry in underserved areas as a way to reduce wait times for individuals. Require access to a prescriber, if not a psychiatrist, for emergency service providers to reduce hospitalizations as a means to get medications.	Review to ensure responsibility is covered

9. Assess **state and private provider capacity** for psychiatric inpatient care, **the assessment process hospitals use** to select which patients are appropriate for such care, and explore whether **bed registries** and/or census management teams improve the process for locating beds.	• Jan. 24.Priority 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. • Jan. 24.Priority 7: Support the Bed Registry • Jan. 24.Priority 16: Adding beds to ESH is supported. Adding funds to WSH supported.	Review to ensure responsibility is covered
10. Review for possible expansion those **services that will provide ongoing support** for individuals with mental illness and reduce the frequency and intensity of mental health crises. These services may include rapid, consistent access to outpatient treatment and psychiatric services, as well as co-located primary care and behavioral health services, critical supportive services such as wrap-around stabilizing services, peer support services, PACT services, housing, employment and case management.	• Mar. 19.Priority 3: Train providers on assisting individuals with all forms of advanced planning and how to keep the planning current. Train law enforcement and other providers to ask about any advanced planning and to utilize the advanced planning to minimize trauma during a crisis. • Jan. 24.Priority 8: Concern re special populations: ID, TBI who may have MH issues, but be excluded based on these diagnoses. • Jan. 24.Priority 18: Additions for outpatient services are supported strongly. General consensus of lack of all 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. • Jan. 24.Priority 19: 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. • Jan. 24.Priority 20: Add DAP funding. Critical to maintaining the flow-through needed to make emergency beds available. High priority budget addition. • Jan. 24.Priority 11: Integrate existing studies and information (rather than another study). General consensus is that there is enough information as to what is needed, but longer term plan to achievement requires steady progress, funding.	Review to ensure responsibility is covered

Richmond Times-Dispatch

Northam: Virginia's mental health system and its coverage gap

Guest Columnist Ralph Northam, Richmond Times-Dispatch
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This year there have been two major health policy discussions taking place in Virginia, about how to better provide mental health services and how to provide access to health insurance for low-income, uninsured Virginias. The first was largely a result of the tragedy that took place last fall with Sen. Creigh Deeds, my friend, while the second has been a conversation that has evolved nationally over the past few years — but both came to a head in the Virginia General Assembly this year.

Though the public conversations about these issues have been largely separate, they are surprisingly similar and inherently intertwined. In both cases, Virginians in need of preventive and ongoing health care cannot afford it or cannot access it. The result is that individuals end up in health crises and make their way to our emergency rooms, where they cannot be denied care but where their care is the most expensive. Tragically, for those struggling with mental illnesses, their health crises can also lead to suicide or behavior that puts them behind bars. We know that prevention, early identification and ongoing treatment are critical components of healthy outcomes for any patient. But this type of care is also effective in minimizing health crises of any nature, and therefore minimizing the cost of indigent care in emergency rooms that is borne in part by taxpayers.

Legislators came together in a bipartisan way to address some of the gaps in our ability to respond to and care for individuals experiencing mental health crises. For example, one result of their hard work is that the state will now host an online, live-time bed registry to help those in crisis find a suitable hospital — and is now required to provide a bed of last resort at a state hospital to anyone in crisis who cannot find care elsewhere. The General Assembly also worked to provide new resources to the law enforcement community, which is often on the front lines of the mental health system. In the pending budgets there is new funding for secure assessment centers, facilities where law enforcement can take individuals for a professional mental health evaluation and treatment, rather than arresting them for behavior that may stem from their illnesses. Ultimately, this allows officers to spend more of their time keeping our communities safe from criminals, and helps ensure that those in need of it are able to receive care in a calm, appropriate setting rather than in a jail cell.

But there are also serious gaps in our ability to provide ongoing mental health treatment and services in the commonwealth. As the recently appointed chair of the Governor's Task Force on Mental Health Services and Crisis Response, it is my intention that our task force will be able to make recommendations on additional reforms and resources needed to address the ongoing needs of patients. We must do a better job of providing ongoing care and treatment if we truly want to reduce the numbers of those experiencing crises. This is a serious challenge, and will require thoughtful reform and a commitment to make smart investments over the long term.

To that end, one of the most significant improvements the commonwealth can make is closing the coverage gap for low-income uninsured Virginians. In Virginia, 6 of every 10 individuals with a mental illness went without care last year, largely because they are uninsured. It is estimated that there are 77,000 Virginians who suffer from a mental illness and do not have health care coverage — and of those, roughly 40,000 suffer from a serious illness such as bipolar disorder or schizophrenia. When those individuals have access to regular care and appropriate treatment, they can lead independent and productive lives. But without coverage and ongoing treatment they end up in crisis, which is the worst way to care for their health from a medical standpoint and is ultimately costly to taxpayers.

My colleagues in the Senate put together a bipartisan compromise to close the coverage gap, Marketplace Virginia, which is still before the General Assembly. Not only would this legislation provide health insurance for up to 400,000 low-income Virginians, it also would infuse a desperately needed $1.2 billion (between FY15 and FY22) into community mental health services. An additional $426 million would be allocated to cover psychiatric care, such as outpatient services, hospitalizations and prescriptions. It is clear that closing the coverage gap is a critical component of addressing the needs in our mental health system. The situation for uninsured Virginians, both with and without mental illnesses, is quite dire and it is absolutely imperative that Virginia policymakers come together on a solution as soon as possible. We can't afford to wait any longer.

Ralph Northam is the lieutenant governor of Virginia, a native of the Eastern Shore and a pediatric neurologist who practices in Norfolk.