

2014 Law Changes: Putting New Law into Practice

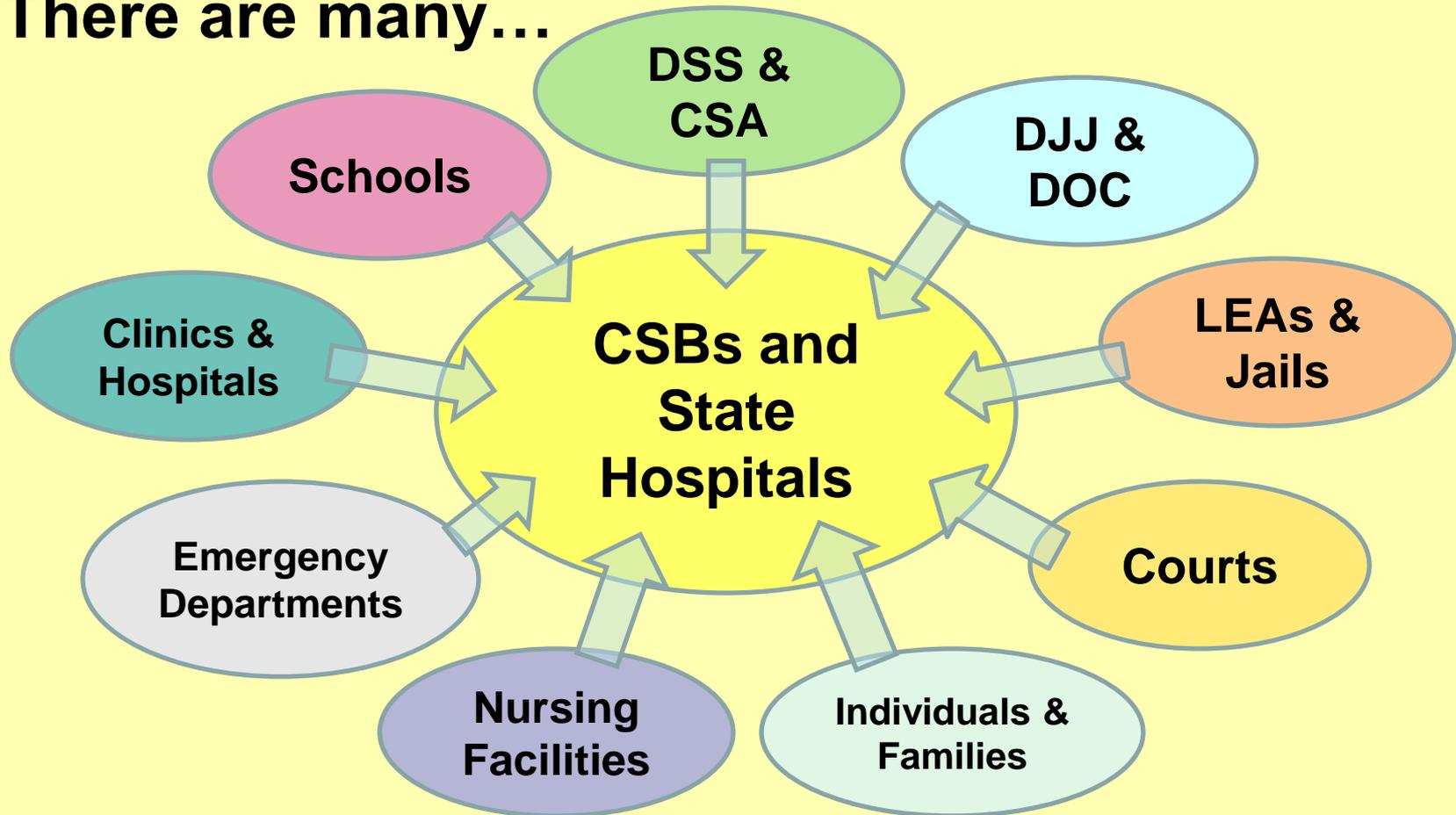
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Drivers of System Change

- High profile violence
- Family & consumer experiences (e.g., suicide)
- Limited access to too few services
- Highly variable local practices
- Criminalization of persons with MI
- Stigma

Current Sources of Demand

There are many...



Challenge of Law Reform

- There are two ways to address people who don't seek treatment:
 1. coerce people into treatment by expanding coercive treatment laws.
 2. induce more people to seek treatment voluntarily by offering better services.
- Reform cannot just be about making coercive treatment laws “better”. It must also be about reducing the need to use these laws.

Challenge of Crisis Work

- Our Vision is a **person-centered, recovery-oriented** system of services and supports that helps people get their lives back
- Crisis contact and intervention, including the involuntary admission process, is a critical point of engagement – or not
- In crisis, what are we trying to do?
- For whom?

Concurrent Developments

- Significant new laws regarding ECO and TDO process
- Regional “Safety Net” protocols
- *Medical Screening and Medical Assessment Guidance* (effective April 1)
- TDO Exception Reporting (i.e., “Failed” TDOs)
- Psychiatric Bed Registry (operational March 3)
- DAP Manual (for administrative consistency)
- Discharge Protocol (revision underway)

Guidance #1

- **Start NOW to implement and integrate these new requirements.** New laws, regional protocols, medical screening protocol, use of Psychiatric Bed Registry, documentation of TDO “exceptions”, etc. All have to be working at the front line level. Do not wait to get started.
- **Make sure all staff know what to do.**
- **DBHDS guidance will be issued** for regional protocols, and general guidance to CSBs and state facilities. **Web, FAQs** to be started. **Launch of certain procedures** before July 1, etc.

- **Regional protocols must be refined to accommodate new requirements.** The regional protocols were not developed to fit the new requirements enacted in 2014 legislation or other new developments such as *Medical Screening and Medical Assessment* protocol.
- **New guidance** on essential components of regional protocols is forthcoming from DBHDS.
- **Protocols will be reviewed** for thoroughness, on paper and in practice.

- **CSBs must take the lead with local and regional partners.** Even though CSBs are not responsible for all aspects of local emergency services or safety net operations, policy-makers and citizens expect CSBs to take the lead locally to get the job done.
- **CSB Executives must actively reach out** to law enforcement, private providers, emergency departments and others to engage in planning and to refine local practices together.
- **Utilize collaborative approaches** outlined in *Strategies for Implementing a Responsive Local Emergency System: A Short Practitioners Guide*.

Guidance #4

- **Monitor all TDO “exceptions” very closely.** DBHDS and CSBs developed a simple data gathering system to capture these cases.
- The **purpose is to** better understand the specific circumstances of these cases and to use this information locally and regionally to **reduce and eliminate barriers to timely and appropriate care.** Barriers to care may be caused by clinical issues, process problems, gaps in services, communications glitches, etc.
- **CSB Executives should know about all these cases** when these events occur, and take timely, necessary action to reduce and eliminate these events.

- **Focus aggressively on state hospital utilization management.** New law requirements may push state hospital capacity and resources to the limit.
- **Regions must manage collective resources** (i.e., state hospital beds) so that all CSBs have timely access to state hospitals when needed.
- **Utilization management** emphasis must be on all aspects of state hospital utilization, i.e., admissions, discharges, length of stay, forensic, etc. CSBs must work together, with hospitals.

- **Minimize involuntary care.** Virginia has strong incentives for involuntary treatment (e.g., transport by law officers, payment for inpatient care for uninsured, etc.). New requirements (facility of last resort) may create even stronger incentives for involuntary care.
- **Pursue strategies to reduce involuntary intervention** whenever possible.
- **Use advance planning** strategies such as WRAP, ADs, and similar strategies to reduce crises and need for judicial intervention.

- **Prepare for more demands for data and documents.** Several study requirements were enacted that will necessitate collection of additional information to assess the impact and effect of new laws and policies. Document everything you do.
- **Specific data requirements and data collection methods are under development.**
- In addition, the **Governor's EO 12 Task Force** is underway, the **SJR 47 Joint Legislative Subcommittee** will start soon, and there may be additional requirements for studies in the yet unresolved budget.

- **Don't underestimate public perceptions and expectations.** The public behavioral health safety net is widely perceived as unresponsive, bureaucratic and broken.
- **Citizens and policy-makers expect change** and will accept no excuses for the “status quo”. There is no tolerance for weak performance, nor any room for mistakes.
- For Governor McAuliffe and the General Assembly, **this is “only the beginning”**.

Public Perceptions (2008)

- “As a result of this research and committee hearings, we developed approximately 50 initiatives to solve every problem that was identified.”
- “These oversight laws will help ensure that no one slips between the cracks like Mr. Cho did.”

Thank you!

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