

Creating Opportunities Emergency Response Team Report

Section I - Introduction

A. Background: The Department of Behavioral Health and Developmental Services (DBHDS) *Creating Opportunities: A Plan for Advancing Community-Focused Services in Virginia* identified behavioral health and developmental services goals, strategic initiatives, and major DBHDS activities that continue the Commonwealth's progress in advancing the vision of a system of behavioral health and developmental services and supports that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of participation by individuals receiving services in all aspects of community life.

The *Creating Opportunities* strategic plan outlined goals in a number of strategic issue areas. Stakeholder teams were convened to study each issue area and make recommendations for action to improve the system. This report covers the "Emergency Response" issue area, and summarizes the work of the Emergency Response Strategic Initiative Team.

B. Emergency Response Team Goal: The goal of the Emergency Response Strategic Initiative was to *"strengthen the responsiveness of the emergency response system and maximize the consistency, availability, and accessibility of services for individuals in crisis in Virginia."* The underlying rationale for this goal was clearly articulated in three related statements, as follows:

- Persons with mental illness and substance use disorders continue to be involuntarily hospitalized and incarcerated in high numbers. Voluntary alternatives to hospital treatment and services to divert individuals from jail need to be improved.
- Virginians do not have access to a consistent basic array of emergency and crisis response services statewide, including crisis stabilization and jail diversion services.
- More consistent management of intensive services such as state hospital, local inpatient, and residential crisis programs is needed across regions to minimize use of these services and use them most efficiently and equitably.

These statements allude to several areas of inquiry that were subsequently explored by the study team, including service system capacity, development of "core" services, use of "best practices" in service delivery, criminal justice/behavioral health issues, and other important dimensions of emergency service delivery in Virginia.

C. Emergency Response Team Process: The Emergency Response Strategic Initiative Team (the ER Team) included CSB and hospital providers, service recipients, and DBHDS staff. Team member expertise spanned mental health, substance use, public and private interests. The full ER Team roster is shown below:

- John Pezzoli, Co-Convener, DBHDS
- O'Connell McKeon, Co-Convener, Middle Peninsula Northern Neck CSB
- Cynthia Koshatka, Fairfax-Falls Church CSB
- Sharon Rogers, Wellness Recovery Center, Charlottesville
- Victoria Cochran, DBHDS
- Jacque Nuzum, Rappahannock Area CSB
- Jacqueline Schaede, Norfolk CSB
- Rita Romano, Prince William CSB
- Cheryl DeHaven, Hampton Newport News CSB

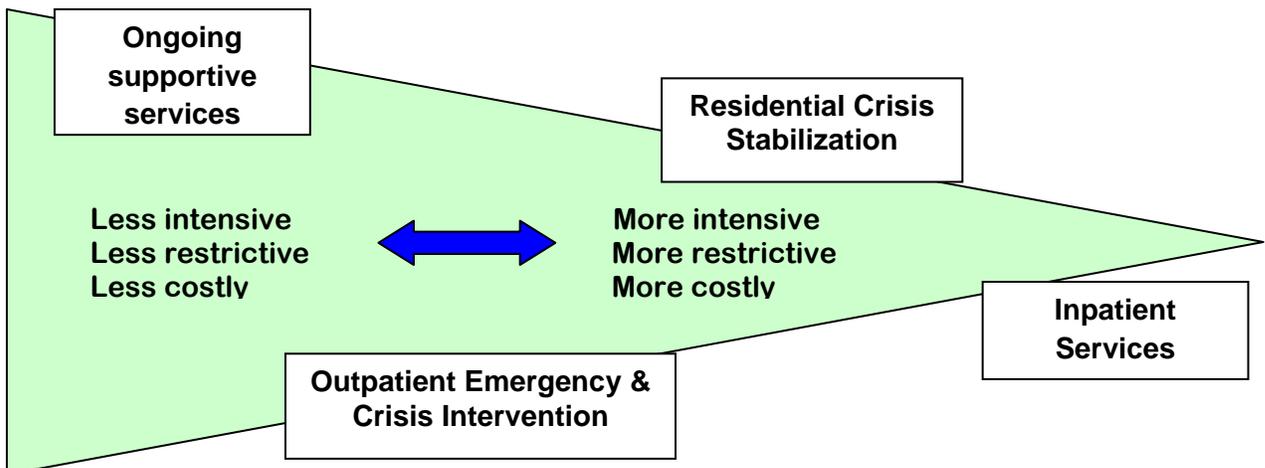
- Derek Curran, Hampton Newport News CSB
- Betty Long , Virginia Hospital & Healthcare Association
- Leslie Weisman, Arlington CSB
- Harvey Barker, New River Valley CSB
- Kristie Burke, Cumberland-Mountain CSB
- Laura Totty, Henrico Area MH and DD Services
- Jim Martinez, DBHDS
- Chad Wegkamp, Middle Peninsula-Northern Neck CSB

The team met six times¹ in full committee, and organized four subcommittees (Hospital Services, Crisis Stabilization Models, Peer Supports, and Criminal Justice Services subcommittees) which met in person or via conference call on numerous occasions to complete their work. The Subcommittee on Criminal Justice Services also met jointly with the Forensic Subcommittee of the State Hospital Efficiency and Effectiveness Team to collaborate with that group on behavioral health-criminal justice and forensic issues. The ER Peer Supports Subcommittee also convened with the Peer Services and Supports planning team (a separate behavioral health strategic planning group under the *Creating Opportunities* process). The ER team also invited input from other constituencies, and wishes to thank the following contributors:

- Anne McDonnell, Executive Director, Brain Injury Association of Virginia
- Cindy Gwinn and Dawn Traver, Office of Developmental Services, DBHDS
- Janet Lung and Katharine Hunter, Office of Child and Family Services, DBHDS
- Beverly Morgan, Office of Behavioral Health Services, DBHDS

Section II – 2011 CSB Emergency Response Service Survey

A. The Emergency Response and Crisis Service Continuum: The emergency response and crisis intervention system is a continuum of many different types of services. Toward one “end” of the continuum are outpatient and ambulatory services that are less intensive, less restrictive and less costly. At the other end of the continuum are more intensive, more restrictive and more costly services such as residential and inpatient care. These more intensive services also offer a greater degree of clinical supervision and security, which can be important considerations when an individual’s safety is concerned. This continuum is shown schematically below.



¹ September 8, October 13, and December 6, 2010; January 7, February 11, and May 17, 2011.

- B. 2005 Inventory of CSB Emergency Response and Crisis Services:** In 2005, the Office of the Inspector General completed an inventory of all CSB emergency response and crisis services for the OIG’s 2005 *Study of CSB Emergency Services*². This report was an important foundation for subsequent capacity-building and quality improvement in the CSB emergency response system. Early in its deliberations, the ER Team determined that an updated inventory of CSB emergency response and crisis intervention services was needed to fully inform its deliberations³.
- C. 2011 CSB Emergency Response Service Survey:** The 2011 ER Service Survey was intended to capture recent growth in service capacity and related improvements that were supported by the General Assembly following the 2007 Virginia Tech Review Panel report and the work-to-date of the Supreme Court’s Commission on Mental Health Law Reform. As with its predecessors, the 2011 survey was also designed to ascertain areas of needed improvement in Virginia’s behavioral health safety net, with particular attention to certain key areas. The survey was developed by the ER Team and implemented in March, 2011.

The 2011 ER Services Survey focused on the following important and related areas:

- The extent to which each CSB could access the full array of crisis response services;
- Identification of the five “most needed” emergency response services;
- The extent to which persons in crisis had access to peers or peer support services;
- Identification of the non-crisis services or supports that were most effective in preventing individuals from experiencing crises, and whether there were differences reported for persons already enrolled in CSB services than for those not previously seen by the CSB;
- Identification of resources and services that were most effective in diverting individuals from hospitalization; and
- The extent to which individuals in crisis have an advance directive or similar crisis plan.

The 2011 survey was developed by the full ER Team and designed to be completed on-line through Survey Monkey. The web link to the survey was sent by DBHDS to all forty community services boards, and completed surveys were received from all CSBs for a 100% response rate.

- D. CSB Survey Findings - Access to Services in 2011:** A primary finding of the 2005 OIG Emergency Services Report was the following:

“The majority of Virginia’s CSBs do not provide a comprehensive range of crisis intervention services for those with mental illness and substance use disorders. Almost all CSBs offer the least restrictive Crisis Response, Resolution and Referral Services and most restrictive Inpatient Hospital Services, but very few offer the critical mid-range Community Crisis Stabilization Programs that effectively stabilize difficult crisis situations in the community.”

A core objective of the 2011 ER Survey was to document the current availability and access to the full range of emergency response and crisis intervention services. To accomplish this, the ER Team articulated the specific modalities and service definitions for a continuum of crisis intervention services ranging from the most intensive and restrictive inpatient services to the least intensive interventions such as telephone crisis contact and warm lines. The continuum also included two

² Report #123-05, *Review of the Virginia Community Services Board Emergency Services Programs*, Office of the Inspector General

³ A follow-up inventory was completed by DBHDS in 2007 that confirmed important improvements, but underscored continuing needs.

practices that are not service types, but elements of the involuntary commitment process, i.e., pre-hearing assessment and commitment hearing attendance. A copy of the Crisis Intervention Continuum of Care, with service types and definitions, is attached as **Appendix A**.

The first question of the survey asked about the availability of each service in the continuum for the CSB's consumers and, if available, whether the service is offered directly by that CSB, by another CSB or by a non-CSB organization. The complete survey responses by CSB are presented in **Appendix B**, and these results are summarized below.

- 1. Most Restrictive Services** – The most restrictive services include (1) state hospital beds for voluntary, TDO, and commitment admissions; (2) local hospital beds for voluntary, TDO, and commitment admissions; and (3) Residential Crisis Stabilization Units for voluntary, TDO, and commitment admissions⁴.

Inpatient services at state or local hospitals are generally available at all community services boards, with the exception HPR V, where admissions to the state hospital Eastern State Hospital have been restricted for almost a year. [**Note:** Survey questions, instructions for recording inpatient access, and responses were inconsistent, resulting in unreliable data. These results are shaded gray in Appendix B.]

Responses indicate that the least readily accessible services are Residential Crisis Stabilization for involuntary admissions (temporary detention or commitment) which is provided in eight CSB localities by six CSBs and two non-CSB providers, and accessible through these CSBs to 10 others (18 CSBs total), along with Community Crisis Services, which was reported to be available at only 11 CSBs. Detoxification and other substance abuse services, while accessible to all 40 CSBs, showed the greatest diversity of provider organizations supplying these services to CSBs.

- 2. Mid-Range Services** – Mid-range services include community crisis stabilization; 23-hour residential crisis stabilization; mobile crisis stabilization; crisis intervention team (CIT) or similar program, psychiatric evaluation and medication administration (within 24 hours); psychiatric crisis consultation; face-to-face crisis intervention (immediate); face-to-face crisis appointment (next work day).

Survey findings reveal that the most notable gaps in service availability occur in services of mid-range intensity, as mentioned specifically in the 2005 Inspector General Report. Results of the survey indicate this is particularly true for the higher end mid-range services, available at 20-30% of the CSBs. The lower intensity mid-range services (psychiatric crisis consultation; face-to-face crisis intervention (immediate); face-to-face crisis appointment (next work day) are generally available representing a notable improvement since 2005.

- 3. Least Restrictive Services** - Least restrictive services include short-term crisis intervention; telephone crisis counseling (extended); telephone crisis contact (brief); and warm lines. As noted above in the 2005 OIG Report, these services (with the exception of warm lines) are generally available throughout the state, and tend to be provided by the local CSB.
- 4. Crisis Service Procedures** – These procedures include pre-hearing assessment, and commitment hearing attendance. Pre-hearing assessment means updating the initial preadmission screening evaluation (i.e., the face-to-face CSB assessment upon which the temporary detention order is based) immediately prior to the commitment hearing in order to present more current evidence at the hearing. Commitment hearing attendance by the CSB refers to the statutory provision

⁴ TDO and commitment refer to involuntary admissions pursuant to adult civil statutes, and do not include involuntary admissions of jail inmates and prisoners pursuant to criminal code sections.

enacted in 2008⁵ that requires CSB staff to attend the commitment hearing and actively participate in the case. Survey results show 31 of 40 CSBs (78%) provide pre-hearing assessment while all CSBs attend and participate in commitment hearings, often in conjunction with another CSB, such as when hearings take place outside of the local catchment area.

- 5. Providers of Available Emergency Response Services** - The greatest variability in provider organizations (i.e., where CSBs and providers other than the respondent CSB provide the service) appears to be residential crisis stabilization, commitment hearing attendance and detoxification and other substance abuse services. Perhaps this finding reflects the need for CSBs to seek or use partnerships and other solutions to make these critical services available. Across the continuum, CSBs in HPR IV and in HPR V seem to show a greater tendency to collaborate in this way on the provision of services. CSBs in HPR III and in HPR VI reported greater use of non-CSB organizations in the provision of inpatient services.

- E. Progress in CSB Emergency Response Service Development Since 2005:** The notable gaps in the availability of mid-range services identified in the 2005 OIG Report are still evident, but a comparison of the data from this survey and the data from 2005 indicate that significant progress has been made in expanding the availability of these services. That comparison is summarized in Table 1, below.

TABLE 1: CRISIS INTERVENTION SERVICE EXPANSION 2005 - 2011			
CRISIS INTERVENTION SERVICE	# CSBs Offering Service		
	2005	2011	
	CSBs Offering Service 24/7	CSBs Providing Service	Service Available From Other Provider
State Hospital Beds: Voluntary	40	0	27
Local Hospital Beds: Voluntary	35	0	36
Residential Crisis Stab. (TDO or Involuntary)	2	6	12
Residential Crisis Stab. (Voluntary)	9	17	22
Community Crisis Stabilization	*	10	2
Detox. and Other Subs. Abuse	*	23	30
23-Hour Crisis Stabilization	*	5	6
In-home Crisis Stabilization	6	10	1
Mobile Crisis Intervention.	9	17	2
Crisis Intervention Team (CIT)	*	20	2
Criminal Justice Drop-off Site(s)	*	10	3
Psychiatric Eval. and Med. Admin. (within 24 hours)	1	10	4
Psychiatric Crisis Consultation	12	18	4
Face-to-Face Crisis Intervention Available Immediately	27	33	5
Face-to-Face Crisis Intervention Appt. - Next Work Day	27	38	2
Short-term Crisis	*	36	2
Telephone Crisis Counseling: Extended	39	32	2
Telephone Crisis Contact: Brief	40	37	4
Warmline	*	10	9

⁵ §37.2-817.B.

Pre-Hearing Assessment	*	27	12
Commitment Hearing	*	39	15

*Note: Cells with * indicate this service was not included in 2005 survey.

Section III – 2011 Virginia Hospital and Healthcare Association Survey

A. Key Emergency Response Partnerships in Virginia: As evidenced in the CSB Emergency Response Services Survey, essential emergency and crisis services throughout Virginia are delivered through a network of CSB and non-CSB providers. Community health care providers work closely with their respective CSBs to provide these services. Today, the majority of acute inpatient care for CSB service recipients is provided through local psychiatric hospitals, and hospital emergency departments (EDs) are often the front line in the delivery of emergency response services. For local emergency response and crisis services to function effectively, well-developed working partnerships between CSBs, EDs and local psychiatric hospitals (or units) must be in place.

B. 2011 VHHA Hospital Survey: As part of the work of the ER Team, the Virginia Hospital and Healthcare Association conducted a survey of community inpatient psychiatric units and emergency departments to obtain their perspectives on Virginia’s emergency services system ER Team. The survey was conducted in March 2011. Thirty-one hospitals with psychiatric units responded to the survey. Of those, 20 provided responses to all of the questions. Those 20 hospitals account for about two-thirds of all inpatient psychiatric beds. Of the hospitals without psychiatric units, 12 provided responses to the survey questions. A list of the hospitals that submitted responses, and a summary of survey results, is provided in **Appendix C**.

C. VHHA Survey Summary of Findings: The VHHA survey asked respondents to describe CSB interactions with the EDs and psychiatric units and to rate the functioning of CSB emergency services in the hospital’s area. In addition, respondents were asked about medical screening of psychiatric patients, service delivery challenges, suggested improvements, payor impacts, and service capacity issues. Key findings from the VHHA survey include the following:

- Of the inpatient psychiatric facilities that responded, 48 percent said that CSB emergency services function well most of the time, with another 39 percent saying that it worked well for all but the most challenging individuals. Conversely, the hospitals said that emergency services did not function well about 13 percent of the time.
- The response to this question was similar for hospitals with emergency departments only (i.e. without a psychiatric unit), which said that CSB emergency services functioned well 42 percent of the time, with another 33 percent saying that it functioned well for all but the most challenging individuals. However emergency departments felt that the system did not function well 25 percent of the time.

These assessments of how well the emergency services system functions suggests that it may be important to focus on the instances where the system is not functioning well to better understand why and what can be done to improve emergency response. Other themes that emerged from the survey include:

- Respondents expressed needs for more CSB emergency services staff, better access to CSB emergency services staff outside normal working hours, and more inpatient beds.
- Despite efforts to bring more consistency to emergency services practices across the state, survey results suggest that the desired degree of uniformity has not been achieved.

Section IV – Emergency Response Services Capacity Building

A. Defining a “Core Array” of Emergency Response Services: One of the issues underlying the Emergency Response strategic initiative is that Virginians do not have access to a consistent array of emergency and crisis response services statewide. Though the *Code of Virginia*⁶ requires CSBs and BHAs to provide “emergency” services, and State Board Policy #1038 describes the desired “safety net” service continuum, each Virginia community is different and has a unique combination of emergency and crisis response services and supports. The array of available services brings together CSB services, state and community inpatient providers, outpatient behavioral health providers, law enforcement agencies, emergency rooms, the courts and others. In addition, local operational practices also differ markedly from one community to another, as each locality creates its own approach to emergency response service delivery, coordination and management within the common framework of Virginia law, policy, and other requirements. As in previous surveys, these variations were borne out by the 2011 CSB Emergency Response Survey and the VHHA Hospital Survey findings.

To help shape emergency response development and capacity-building for the future, the Crisis Stabilization Subcommittee of the ER Team recommended that a core array of services be available through each CSB. The “baseline” services include the following:

- State Hospital Beds (voluntary, TDO, and commitment admissions)
- Local Hospital Beds (voluntary, TDO, and commitment admissions)
- Residential Crisis Stabilization Unit (voluntary)⁷
- Detoxification and Other SA Services
- Psychiatric Evaluation & Medication Administration (within 24 hours)*
- Psychiatric Crisis Consultation*
- Face-to-Face Crisis Intervention (available immediately)
- Face-to-Face Crisis Intervention Appointment (guaranteed next work day with CSB ES staff)
- Short-term Crisis Intervention
- Telephone Crisis Contact (brief)
- Commitment Hearing Attendance (required by statute)

B. Current Core Service Capacity – Emergency Response Services: The results of the 2011 ER Service Survey demonstrate that almost all of the above services are available at all or most CSBs. Moreover, hospitalization and detoxification services in many CSB areas are available through multiple providers. The striking exceptions to this positive finding are Psychiatric Crisis Consultation and Psychiatric Evaluation and Medication Administration within 24 Hours (* above). Eighteen CSBs reported that they do not have access to Psychiatric Crisis Consultation. Twenty-seven CSBs reported that Psychiatric Evaluation and Medication Administration within 24 Hours are not available in their CSB area. Given the nature of psychiatric emergencies, it is not surprising that survey respondents rated Psychiatric Evaluation and Medication Administration within 24 Hours the highest priority service for additional capacity building.

The 2011 Survey results also show that despite the widespread availability of most of the above “baseline” services, insufficient access and capacity are still problematic. In addition to the general

⁶ §§ 37.2-500 and 37.2-601

⁷ DBHDS is requiring all existing CSUs to be able to accept at least some kinds of TDOs and this will be a requirement for new residential crisis stabilization programs.

lack of availability of Psychiatric Evaluation and Medication Administration within 24 Hours and Psychiatric Crisis Consultation, survey respondents also reported the highest priorities for capacity-building in the inpatient, residential crisis stabilization, and detox service categories - services that are already widely available. Comments submitted by many CSBs indicate that timely access to available services is further hampered by geography, lack of transportation, special needs of certain individuals or populations (e.g., elderly persons, persons with co-occurring medical conditions, etc.), and other complicating variables. Taken together, these findings indicate that a safety net of basic services is indeed widely available in Virginia, but just barely. Despite the availability of basic services, behavioral health providers and other emergency service partners are severely challenged every day to access services for the variety of people they serve.

C. Special Populations: Several populations of persons needing emergency services warrant special attention here, including persons with brain injuries, military veterans and families, persons with intellectual disabilities, older adults and children and youth.

1. People with Brain Injury: In two separate studies in 2007, the Joint Legislative and Audit Review Commission discussed access to services for persons with brain injury who are experiencing behavioral and psychiatric issues. In the first study, entitled *Access to State Funded Brain Injury Services in Virginia*⁸, JLARC stated:

“Given limited resources, the State may want to consider addressing the needs of those with severe behavioral issues first if additional resources are allocated to this population. This segment of the population with brain injury is most likely to be at risk of placement in a skilled nursing home, local jail, local licensed hospital, or State prison or to not receive any services at all. There is virtually no system of care in the community for people with behavioral problems who do not have the financial resources to pay for private care.”

In the second study, entitled *Availability and Cost of Psychiatric Services in Virginia*⁹, JLARC confirmed a general shortage of appropriate community based treatment options for persons with traumatic brain injury and that this population often faces difficulty accessing services. This report stated:

“Licensed hospital staff reports that State hospitals will not accept these individuals...Some persons served by State mental hospitals in previous years are now deemed inappropriate for admission, although statutorily required regulations on State hospital admission have not been issued. As a result, local departments of social services, jails, and community services boards are responsible for these persons.”

People with Brain Injury face many challenges in accessing behavioral and psychiatric treatment and services, including:

- Lack of a publicly funded in-state neurobehavioral treatment program, which contributes to out of state placement for necessary care;
- Acute care hospitals are reluctant to admit brain injury patients experiencing behavioral or psychiatric crises due to significantly limited treatment and funding and discharge options;
- Nursing homes are reluctant to admit brain injury survivors because of reimbursement rates, resident and staff safety concerns, and workforce capacity issues;
- There are too few neurobehavioral treatment beds in Virginia, and the approximately 20 beds that are available are private pay and too expensive for most brain injury survivors to access;

⁸ Senate Document #15, 2007

⁹ Senate Document #19, 2007

- Reluctance of some Community Services Boards to evaluate or treat brain injury survivors; Lack of access to appropriate treatment can allow behavior problems to escalate, resulting in the individual being arrested and incarcerated.
2. **Military Veterans and Families:** Virginia continues to develop its services and supports for veterans with stress-related disorders and traumatic brain injuries. The Virginia Wounded Warriors Program offers services and supports to veterans and their families through a network of community-based services, including emergency and crisis response services, coordinated through regional VWWP consortia made up of community providers, including community services boards, brain injury services providers, US Department of Veterans Affairs medical facilities and other public and private providers.
 3. **Persons with Intellectual Disabilities:** In the 2005 study of CSB emergency services, the OIG found that most CSBs did not have access to appropriate emergency response and crisis intervention for persons with intellectual disabilities. In addition, the roles of state psychiatric hospitals and training centers in serving these persons were not clear. As a result, persons with intellectual disability and their families, as well as staff, were often placed in dangerous situations and/or persons were referred to services that were not appropriate.

DBHDS and CSBs are beginning to address this underserved group more directly. In FY 2012, \$5,000,000 has been appropriated to establish new community crisis intervention services in each region for individuals with intellectual disabilities and co-occurring mental health and behavioral disorders. Toward that end, DBHDS is issuing a Request for Proposals to CSBs requesting that each region develop a crisis prevention and intervention system for individuals with intellectual disability (including co-occurring behavioral health needs) that are at risk of institutional placement due to challenging behavior. All regions are expected to use the nationally recognized START¹⁰ model as the basis for the program design. The START model offers a statewide framework and is flexible enough to adapt to unique regional needs. Regional proposals are due by September 1, 2011 and implementation of regional programs will begin January 16, 2012.

4. **Older Adults:** The demand for crisis intervention for older adults is rising as more and more individuals move into old age. As individuals with behavioral health disorders and intellectual disabilities age, they are more likely to develop serious, chronic physical conditions for which routine treatment is necessary, and specialized interdisciplinary care that focuses on both physical and mental health care is critical to supporting people at home and reducing inpatient hospitalization. Specialized crisis response services for older individuals with behavioral health disorders are not widely or routinely available. DBHDS continues to work closely with health and long-term care partners to strengthen the continuum of services and supports for these individuals, including emergency and crisis response services.
5. **Children and Youth:** The *Creating Opportunities* strategic planning process included a major focus on services for children and youth with behavioral health needs. As part of that process, DBHDS completed an extensive survey of CSBs services for children and youth. The CSB survey data showed widespread variability in the availability and capacity of CSB services, especially

¹⁰ Systemic Therapeutic Assessment, Respite, and Treatment, developed 1988, has been successfully implemented in many other states and localities.

among the “base” services. The Crisis Response service category had the most significant gaps and was the category in which the largest number of CSBs did not provide services at all¹¹. Also, in the 2009 CSA Service Gap Analysis¹² of 131 local Community Policy and Management Teams, crisis intervention and stabilization and emergency shelter care were in the top 10 service gaps reported. Expanding and strengthening the continuum of emergency response and crisis services for children and youth would reduce the Commonwealth’s need for higher cost, more restrictive treatments.

Virginia will continue to experience increased demand for access to emergency and crisis response services, as well as ongoing services and supports, for these groups.

- D. Building Capacity of Core Emergency Response Services:** Question 2 of the survey asked respondents to indicate which of the services in the crisis continuum they would pick as their top five priorities for additional resources, ranked from first to fifth. Respondents were instructed to pick both from services currently offered as well as from services not available in their CSB. The complete responses by CSB responses are presented in **Appendix D**.

Summarizing the total score for each service (with 5 points given for each rated as the top need, 4 points for each rated as second most needed and so forth), a total need score was calculated for each service. These total scores are presented in Table 2, below. The service rated as most needing additional resources was Psychiatric Evaluation and Medication Administration (within 24 hours) with a score of 73. Also rated highly were both state and local inpatient beds for TDO or involuntary admissions, with scores of 68 and 66, respectively. The need for detoxification and other substance abuse services was indicated by a score of 53, with the need particularly focused in HPR III and VI.

TABLE 2: SERVICE NEEDS	
Psychiatric Evaluation and Medication Administration (within 24 hours)	73
State Hospital Beds: TDO Admissions	68
Local Hospital Beds: TDO Admissions	66
Detox. and Other Substance Abuse Services	53
Local Hospital Beds: Voluntary Admissions	33
Residential Crisis Stabilization Unit (TDO or Involuntary)	33
Community Crisis	31
Crisis Intervention Team (CIT) or similar program	31
State Hospital Beds: Commitment Admissions	30
Criminal Justice Drop-off Site(s)	30
Psychiatric Crisis Consultation	29
Residential Crisis Stabilization Unit (Voluntary)	19
23-Hour Crisis Stabilization	18
Short-term Crisis Intervention	16
State Hospital Beds: Voluntary Admissions	14

¹¹ See Table 2, page 10 and Table 6, page 15 of the report, *A Plan for Community-Based Children’s Behavioral Health Services in Virginia*, DBHDS, 2011.

¹² Virginia Office of Comprehensive Services, 2009

Face-to-Face Crisis Intervention - Available immediately	13
Mobile Crisis Intervention	12
In-home Crisis Stabilization -	11
Local Hospital Beds: Commitment Admissions	6
Face-to-Face Crisis Intervention Appointment (Next Work Day)	5
Telephone Crisis Counseling: Extended	5
Telephone Crisis Contact: Brief	3
Warm line	1
Pre-Hearing Assessment	0
Commitment Hearing Attendance	0

E. Recommendations for Capacity Building – Core Emergency Response Services: Utilizing the 2011 Survey results and input from the ER Team and Subcommittees and other stakeholders, the ER Team recommends that priority consideration be given to possible future capacity-building initiatives in the following core emergency services areas:

- Local Acute Inpatient Hospital
- Substance Use Detox and Other SUD services
- Crisis Intervention Teams and similar BH/CJ Intervention
- Therapeutic Drop-Off for Law Enforcement, or similar program
- Psychiatric Evaluation and Medication Administration within 24 hours.

F. Increasing State Hospital Bed Capacity is Not Recommended: Survey respondents gave a high priority to inpatient capacity-building, including state hospital inpatient services. However, survey respondents also provided information about how to reduce the demand for inpatient services. Specifically, respondents were asked to provide their perspectives regarding services and resources that were considered to be most effective in diverting people from inpatient hospitalization. Immediate access to crisis stabilization services, and related interventions, was the most effective strategy to reduce the need for hospitalization, as shown in Table 3, below.

	Percent	Count
Crisis Stabilization	82%	33
Immediate Access to Services	15%	6
Substance Abuse Treatment	15%	6
Crisis Intervention Teams	12%	5
Integrated Services	10%	4
Supports	7%	3

The above data show that while there is a strong current demand for inpatient services, there is even stronger consensus that this demand can be reduced by expanding community-based crisis stabilization alternatives. For this reason, the ER Team does not recommend expanding state hospital inpatient capacity, and instead recommends expansion of capacity in the core services shown above.

G. Non-Emergency Services to Prevent Crises: By the time persons with mental illness or substance use disorders enter the behavioral health emergency services system, they have often experienced an accumulation of events and circumstances that have contributed to the present crisis. Notwithstanding the complex nature of psychiatric disorders, crises are very often preventable if the right services and supports are accessible at the right time.

The 2011 CSB Emergency Response Survey also asked CSB respondents to identify the kinds of services that would help prevent crises, both in people already receiving services from the CSB and in those persons who were unknown to the CSB at the time they experienced a CSB crisis contact¹³. Responses to these questions focused not on emergency and crisis response services, but on non-crisis “upstream” services and supports that help people to manage their health and wellness, maintain their living situation, interact effectively with others in their lives, thrive in their community, and experience recovery. These results are presented below. The data in Table 4 and Table 5 summarize responses regarding services most effective in preventing crises, Table 4 for individuals already receiving CSB services and Table 5 for individuals previously unknown to the CSB.

TABLE 4: Non-crisis Services or Supports Most Effective in Preventing Individuals Already Receiving Services from Your CSB/BHA from Experiencing Crises		
	Percent	Count
Case Management	62%	25
Medication Management	40%	16
MH Supports	30%	12
Psychiatric Services	30%	12
PACT	22%	9
Peer Services	20%	8
Housing	20%	8
Substance Abuse Treatment	17%	7
Wrap Around Services	5%	2

As shown in Table 4, above, the most effective preventative services for individuals already receiving services indicated most frequently by respondents were case management (62%), medication management (40%), mental health supports (30%), psychiatric services (30%), and PACT (22%). It should be noted that PACT (Programs of Assertive Community Treatment) programs are comprehensive “wrap-around” services for persons with serious mental illness who have intensive service and support needs. A PACT program combines case management, psychiatric services and medication management, and other mental health supports (peer support, employment support, etc.) through a multi-disciplinary, low-caseload team.

¹³ Anecdotally, CSBs report that about half of all crisis contacts [including interventions] are with persons not known to or enrolled in CSB services.

CSB responses about individuals who were new to the CSB are presented in Table 5, below. Respondents most frequently mentioned the importance of immediate access (57%) and education regarding community resources and outreach (34%). For both groups, respondents stressed the importance of service integration (wrap around services), housing and substance abuse treatment. Not surprisingly, housing, substance abuse services and supports were mentioned for both groups.

TABLE 5: Non-Crisis Services or Supports You Feel Are Most Effective In Preventing Those Individuals Not Previously Seen From Experiencing Crises		
	Percent	Count
Immediate Access to Services	57%	22
Education/Outreach	34%	13
Integration of Services	21%	8
Appropriate Medication	21%	8
Social Supports	18%	7
Housing	18%	7
Substance Abuse Services	13%	5

The 2011 VHHA Hospital survey also asked respondents to identify the non-crisis services that would be most effective in preventing individuals from experiencing a crisis that required inpatient admission. There was considerable overlap between CSB and private hospital responses, including increased case management, medication management and quicker access to services. Other hospital suggestions included CSB follow-up within 5 to 7 days of discharge from the inpatient setting and partial hospitalization services.

H. Recommendations for Capacity-Building for Non-Crisis Services: Utilizing the results from the 2011 CSB and Hospital Surveys, as well as perspectives of the ER Team and Subcommittees and other stakeholders, the ER Team recommends that priority consideration be given to possible future capacity-building initiatives in the following non-crisis services areas:

- Case management, especially intensive case management or Critical Time Intervention¹⁴
- Mental Health Supports¹⁵
- Psychiatric Services and Medication Management
- PACT (Program of Assertive Community Treatment)
- Peer Support
- Wrap-Around Services (see intensive case management and Critical Time Intervention, above)

Section V - Criminal Justice/ Behavioral Health Services

A. Background: An important strategic goal for Virginia has been to enhance collaboration between the criminal justice and behavioral health components of the Commonwealth’s emergency response

¹⁴ Critical Time Intervention (CTI) is an EBP providing intensive outreach and assistance to prevent adverse outcomes for people with MI facing difficult transitions (such as discharge from hospital or release from jail).

¹⁵ Mental health supports include training, coaching and support to enable individuals with significant functional limitations to achieve and maintain community integration, stability and independence in the least restrictive environment.

system. Building on a foundation of mutual interest between these entities, then-Governor Kaine issued Executive Order 98 (2009) directing the Offices of the Secretaries of Health and Human Resources and Public Safety to lead the Commonwealth Consortium for Mental Health/Criminal Justice Transformation. The dual purposes of the Consortium are to prevent unnecessary involvement of persons with mental illness in the Virginia criminal justice system and promote public safety by improving access to needed mental health treatment for persons with mental illness for whom arrest and incarceration cannot be prevented.

B. Accomplishments to Date: The Consortium and DBHDS have pursued several strategies to make progress on these goals. Among accomplishments to date are the following:

- 22 “Cross-Systems Mapping” workshops have been completed, and over 600 mental health and criminal justice stakeholders representing 43 Virginia communities participated in these 1.5 day events. Each workshop is led by a team selected from Virginia’s forty-member pool of certified facilitator trainers. Through this structured process, participants use the “Sequential Intercept Model”¹⁶ to describe in step-by-step sequence, the experience of persons with mental illness who come into contact with the criminal justice system. The resulting “map” enables behavioral health and criminal justice stakeholders to fully understand the consumer’s experience, identify gaps in services, capitalize on identified opportunities for diversion or system improvement, and create a local Action Plan. The most frequently reported priorities on the local Action Plans are:
- Comprehensive treatment in advance of release and improved discharge planning from jails and prisons.
- Additional Crisis Intervention Teams (CIT, see below), including training for officers, and development of “drop-off” centers.
- Additional community mental health and substance use disorder services, including the full range of services such as housing, mobile emergency services, crisis stabilization, detox centers, temporary shelters, medication, acquisition (or restoration) of benefits, etc.
- Over 2000 Virginia law enforcement officers have completed the 40-hour Crisis Intervention Team (CIT) training program (at over 100 week-long trainings) to improve their capacity to respond effectively and safely to persons with mental illness, to reduce the use of force and restraint, and divert persons from arrest and link them to mental health supports whenever possible.
- DBHDS recently hired a Cross-Systems Mapping Coordinator to support the expansion of this work.

C. Additional Goals: The Criminal Justice Subcommittee of the ER Team identified a number of additional goals and actions to enhance this effort.

1. **CSB Survey:** Conduct an on-line survey of CSBs, local jails, and community corrections regarding criminal justice/behavioral health activity across the state, including resources and gaps.
Action: The Criminal Justice Subcommittee developed and implemented a telephone and e-mail inventory to assess the current status of programmatic activity and resources across the 40 Community Services Boards (CSBs). As of June 23, 2011, information had been obtained from 37 of the 40 CSBs. The inventory tracks specific CSB program activity within the five stages of the Sequential Intercept Model. Additionally, the inventory includes information about the local,

¹⁶ The Sequential Intercept Model (Munetz and Griffin) describes five key points or “intercepts” (initial emergency/law enforcement contact, booking/preliminary hearings, court/jail, re-entry, and community support) at which a person may be diverted from more intensive or deeper criminal justice involvement through targeted intervention. The Sequential Intercept Model is the organizing framework for Cross-Systems Mapping.

state and federal funding streams that support these activities. Only 4 CSBs do not provide programs or activities specifically for the criminal justice involved population (Allegheny Highlands, Goochland, Hanover and Southside). A more complete summary is at **Appendix E**.

2. **CIT Development:** Support development of additional local Crisis Intervention Team (CIT) programs.
Action: Determine resource requirements to expand CIT programs across the Commonwealth, and identify potential resources for continued CIT program development, including federal SAMHSA and Bureau of Justice Assistance (BJA) Byrne grants administered directly from BJA or through the Department of Criminal Justice Services (DCJS). Objectives would include:
 - a. Utilize 40 hour CIT training model for law enforcement and first responders:
 - b. Support collaborative mental health and law enforcement faculty and practices,
 - c. Enhance train-the-trainer capability, and
 - d. Provide CIT dispatcher training for 100% of dispatchers.
 - e. Encourage emergency services workers to participate in CIT law enforcement ride-along as part of base training.

3. **Law Enforcement Drop-Off Capacity:** Support development of additional law enforcement drop-off capacity to support CIT efforts in Virginia.
Action: Determine resource requirements and implement a pilot project to establish police drop-off centers in three CSB service areas.

4. **Data Infrastructure:** Develop cross agency data and outcome measurement system to track Core Elements outcomes of CIT programs and support CIT development and quality improvement.
Action: Develop a data and CIT outcome measurement system in collaboration with CSBs and criminal justice system agencies by November 2011.

5. **Cross Systems Mapping Workshops:** Continue to utilize Cross Systems Mapping workshops to develop local criminal justice/mental health capacity and strategic plans to better meet the needs of persons with mental illness in the criminal justice system.
Action:
 - a. Develop plans to seek renewal of Executive Order 98.
 - b. Report on the current status of gaps, resources, and priorities developed through the 19 completed Cross-Systems Mapping activities by mid-April 2011.
 - c. Update report quarterly as other communities receive mapping workshops.
 - d. Implement the comprehensive outcomes reporting process for the Cross-System Mapping Initiative.
 - e. Prepare Cross Systems Mapping Initiative interim and final reports between January 2012 and January 2013.

6. **Enhance Peer Supports:** In collaboration with VOCAL, NAMI-VA, and other consumer, family, and advocacy organizations, facilitate the involvement of peer providers with lived criminal justice experience in supporting individuals with mental illness throughout the criminal justice continuum.
Action:
 - a. Provide training that specifically targets law enforcement and consumers as part of the Joint NAMI-Virginia CIT Coalition Conference on September 11-14, 2011, including

- support for up to 180 Virginia stakeholder scholarships to be made available through a contract with National Association of State Mental Health Program Directors and NAMI-VA;
- b. Examine evidence-based programs and recommend curricula and programs by the end of June 2011;
 - c. Identify costs and potential resources to provide training identified in the recommended curricula by the end of June 2012; and
 - d. Explore the feasibility of enabling peers with lived criminal justice experience to provide evidence-based programs to incarcerated individuals by the end of June 2012.
 - e. Identify curricula components by July 2012 for providing training on the following topics to court personnel (i.e., judiciary, prosecutors, defense bar and other attorneys, clerks and bailiffs), probation and parole, community corrections, jail and other corrections staff, and emergency services workers:
 - Basic mental illness,
 - Access to services,
 - Basic de-escalation,
 - Civil commitment procedures and impact on individuals,
 - Competency restoration, and
 - Insanity defense procedures and their impact.

Section VI – Use of Peers and Peer Supports

- A. Rationale for Peers and Peer Support in the Crisis Continuum** -The ER Team focused from the outset on expanding the role of peers and peer supports in the crisis continuum. Persons in psychiatric crisis are especially vulnerable to feelings of fear, loss of control, powerlessness, and isolation. These feelings may be further intensified during an involuntary intervention, when a person may be taken into emergency custody or temporary detention, and when law enforcement is often used for transportation (during which the person is likely to be in handcuffs)¹⁷. In these circumstances, the impact of peers and peer support can be enormously positive.

Access to a person who has “walked this path” – a peer – is especially important in reducing fear, fostering hope, and restoring the person’s sense of control in the midst of the crisis. The use of peer-to-peer support throughout the full continuum of emergency and crisis response services creates a person-centered, consumer-driven approach that is proven to reduce the trauma impact of crisis intervention. The presence of peers in a crisis intervention situation will reduce the number of crisis episodes experienced by an individual, ameliorate the negative aspects of the current service delivery model and allow the crisis intervention process to be managed more effectively, increasing the likelihood of positive outcomes for the person.

- B. Current Use of Peer Support in the Crisis Continuum** - At present, peers and peer supports are not widely used by CSBs in the emergency services and crisis intervention context. In the ES Survey, only 32% of CSBs reported “access to peers” was provided to persons in crisis. Many of the CSBs that

¹⁷ Several studies, including by the OIG, the Interagency Civil Admissions Advisory Council, and the Commission on MH Law Reform, have cited the use of law enforcement for transportation as a particularly traumatizing and stigmatizing experience. The Commission on MH Law Reform developed legislation enacted in 2009 to allow alternative transportation under certain conditions (e.g., family, CSB staff, etc), but these alternatives are still infrequently used.

provide access to peers also reported the positive benefits of doing so. One CSB provided a notable endorsement, quoted in part below.

“I wish I could truly explain the dramatic difference that having peers in CSU and in ES has made. It is truly incredible and both programs are now far more human. And kind. And recovery-oriented. And hopeful. And....I could go on and on.....”

CSBs providing access to peers also, however, report that access is limited, for example, to certain circumstances or certain program locations. CSBs that do not now provide access to peers in crisis reported a number of impediments to using peers. The most commonly reported barriers are presented in Table 6 below.

TABLE 6: Comments on Peer Services - Barriers		
	Percent	Count
Limited availability of peers	30%	12
Lack of funding	30%	12
Peer support in other services, limited availability in crisis	30%	12
Lack of staff resources	10%	4

C. Potential Roles of Peers in the Crisis Continuum – In order to make more use of peers in the delivery of emergency and crisis services, it is useful to understand the possible roles peers can play in this context. The ES IAT identified a number of possible roles for peers in the emergency and crisis services continuum, as shown below:

- **Early Crisis Intervention** – At this stage, the individual is still functioning in their community, but is beginning to show signs of psychiatric distress that may have led to problematic outcomes in the past. At his point, certified peer supporters could be assigned as peer partners, link with other peers, provide recovery information, sponsor Support groups, and staff peer resource centers.
- **Prescreening/Crisis Intervention** – At this point, the individual is not functioning in their community. Assessment by a qualified person is needed to assist the individual in obtaining their optimum level of treatment and intervention. Peers can assist in this process by providing a peer point of view, by being assuring during the wait periods, and by providing information on the crisis process. Peers would assist the individual to voice his or her wishes, and subsequently, provide wellness checks and follow up after the crisis has been stabilized.
- **Crisis Stabilization** - In this stage, the individual is seeking assistance to return to their pre-crisis status. Peers in this context can lead groups, educate on WRAP plans, talk about recovery, provide hope, education, and share their personal stories. Peers can also inform and link the person in crisis to peer resources in the community. If the person has been hospitalized, a peer can help the person find his or her voice, by helping to articulate what the person needs and how the person feels.
- **Diversion** – At this point in the continuum, the individual wishes to be effectively treated outside the hospital or CSU environment, and it has been deemed safe for the person and the community to utilize this least restrictive, more effective intervention option. In this context,

peers can serve as mentors, comforters, coaches and active listeners in homes, shelters, recovery sites, and other places in the community.

- **Respite** – Respite means the individual is seeking relief from a situation (or situations) that may be exacerbating their symptoms. At this time families and neighbors seek assistance in managing the outcomes of the individual’s illness. Peers can serve as a positive distraction from these circumstances, taking the person on outings, etc. Peers can offer to the person a sense of security and trust, and help provide to the family and the person a measure of relief and distraction from the impact of the person’s illness. Peers offer hope because they are they embody the proof that MHSA situations can be surmounted.
- **Wrap Around** – When the crisis has diminished, the individual wants ongoing access to resources that will assist in reducing the number, frequency and intensity of crisis episodes so that they may continue to function in their community. Peers can help link to person to peer-to-peer post crisis supports, which can provide an opportunity for peers to share their knowledge of recovery resources, wellness techniques, and other useful knowledge and information.

D. **Enhancing the Use of Peers and Peer Support in Emergency and Crisis Services** – Evidence from the literature and the ES Survey show that Virginia needs to increase the quantity and quality of peer support in the crisis continuum. Specifically, the ES IAT recommends that Virginia recruit and support additional certified peer support providers and use these staff in the delivery of emergency and crisis services. Specific action steps are:

1. **Outreach to Potential Providers** - Actively and assertively “network” through the statewide Mental Health and Substance Abuse organizations, Peer-Run service providers and organizations, Consumer Advisory Councils, and on-line peer support recovery websites to generate interest among peers and service providers.
2. **State Peer Certification Program** - Implement the Creating Opportunities Peer Support Implementation Action Team recommendations to (a) initiate, and support on an ongoing basis, a state certification program for peer support specialists as a separate discipline, and (b) change the state Medicaid Plan to add peer support as a distinct service so that peer support is Medicaid-reimbursable for Virginia providers.
3. **Ongoing Education and Support to Providers** - Utilize technical assistance from DBHDS to develop, implement and support education and consultation to crisis response systems on how to utilize peer support workers in the crisis continuum.

Section VII – Use of Best Practices in Emergency and Crisis Intervention

- A. **Current Variability of Emergency and Crisis Services Delivery.** The ES IAT members noted that despite the considerable focus on, investment in, and training about emergency and crisis services since 2005, the experiences of persons in crises continue to vary considerably statewide. In addition to inconsistencies in the array of available and accessible services, providers and partners do not always deliver services that represent “best practice” in the field. This is attributable to several legitimate factors, such as inadequate resources and the basic “press of time” that characterizes all crises. The ES IAT also acknowledged, however, a basic lack of understanding of and consensus about what constitutes “best practice” in this area of service delivery, and how to implement it in actual practice.
- B. **Consensus Best Practices** – Each of the ES IAT Subcommittees produced recommendations pertaining to “best practices” in emergency and crisis response service delivery. These recommendations often overlapped and a few, such as increasing the use of peers and peer support

services, have been described elsewhere in this report. In addition to those presented in other sections of this report, a broad consensus emerged regarding the following recommendations:

1. **Regular Communication Among all Stakeholders is Essential** - By its nature the provision of emergency services to individuals experiencing a mental health crisis presents many challenges. One theme that continually emerges is that these challenges can best be addressed when all emergency response partners, i.e., community services boards, hospitals, law enforcement officers and court officials, meet routinely to discuss problem areas and proactively collaborate to identify and implement solutions. The ES IAT recommends the following specific actions:
 - a. Using an approach similar to “Cross Systems Mapping”, emergency response partners in each locality should develop and maintain an operational “map” of the emergency response process showing how service recipients experience the local emergency response system. This should be the basis for continuous self-assessment and collaborative quality improvement in each community.
 - b. Emergency response partners should make maximum use of televideo and teleconferencing in the delivery of emergency services and crisis intervention.
2. **Values and Concepts Underlying Best Practice Should be Defined and Disseminated** – In order to cultivate and support consistent, person-centered emergency and crisis response services, providers must have an understanding of the underlying values and principles of person-centered care, as well as the ability to implement these concepts in actual practice in emergency and crisis intervention service delivery.

The ES IAT found the 2009 SAMHSA *Practice Guidelines: Core Elements for Response to Mental Health Crisis*¹⁸ to be the best synopsis of these values and service delivery principles, and recommended that this resource be disseminated widely and used as the basis for training, development and quality improvement within the emergency and crisis response system.

Specific recommended actions include:

- a. Provide training on the *Core Elements* to all emergency services and crisis stabilization service providers system wide through state, regional and local training events on emergency services and crisis stabilization;
- b. Develop web-based training resources for providers;
- c. Provide consultation and mentoring support to enable providers to use the *Practice Guidelines* to achieve proficiency in the *Core Elements*;
- d. Increase the quantity and quality of peer support services in the crisis continuum (see Section VI.D., above);
- e. Provide education and support to crisis response systems on how to utilize peer support workers and access peer networks statewide;
- f. Monitoring, oversight and mentoring of the services system, including public and private behavioral health providers, and partner entities such as law enforcement, courts, etc.; and
- g. Develop a state-level advisory group, with representation similar to the ER IAT, to meet quarterly to promote collaboration, disseminate best practices, and support quality improvement.

¹⁸ HHS Publication No. SMA-09-4427

- 3. Advance Planning Should be Used Widely and Routinely** - Research shows that advance planning can mitigate the detrimental elements of the psychiatric crises¹⁹. For example, psychiatric advance directives (PADs) are associated with more positive provider-consumer relationships, fewer crises, fewer hospitalizations, and less coercive intervention. PADs are perceived as desirable by mental health service recipients but are rarely in place. Similarly, Wellness Recovery Action Plan (WRAP) offers an opportunity for WRAP users to think about and plan for potential crises that may arise in the future²⁰.

2011 ER Services Survey asked respondents to state how often the individuals who are seen in crisis at the CSB have executed a psychiatric advance directive or similar crisis plan. Table 7 shows these results. While advance planning is “occasionally” encountered, the majority of respondents describe this as a rare occurrence.

	Percent	Count
Almost Always	0%	0
Occasionally	43%	17
Rarely	57%	23

PADs and WRAP plans empower people with psychiatric disorders to articulate their wishes in advance and thus help individuals retain more control over what happens to them in a crisis. Helping people utilize these strategies should be a routine practice in the public behavioral health system.

The ES IAT recommends the following actions for maximizing use of advance directives and wellness planning in routine service delivery:

- a. Train more Advanced WRAP Facilitators so that more WRAP Facilitators can be trained to lead WRAP classes;
- b. Pay WRAP Facilitators to attend training and to teach classes via sponsorships or scholarships;
- c. Utilize the experience of the Psychiatric Advance Directive Facilitation projects underway at four CSBs to develop training and implementation strategies for system-wide adoption and use of PADs;
- d. Utilize “Certified Psychiatric Advance Directives Coaches” using the Norfolk CSB model;
- e. Provide information (e.g., FAQs) on DBHDS website about WRAP and Advance Directives, and how providers can utilize these resources in a crisis situation and what the law requires;
- f. Provide technical assistance from DBHDS and other organizations regarding the use or PADs and WRAP in mental health care and resources for training opportunities with WRAP plans;
- g. Promote and provide support to increase the utilization of WRAP throughout the state;

¹⁹ Swanson, et. al., *Psychiatric Advance Directives and Reduction of Coercive Interventions*, Journal of Mental Health, June 2008

²⁰ A WRAP plan is not an advance directive, but a comprehensive health and wellness management tool that includes a crisis management component.

- h. Increase the number of WRAP Advanced Facilitator Trainers by providing training for two peer providers in each region;
 - i. Provide funding to CSBs, state hospitals, and peer centers for each region to provide two WRAP facilitator trainings per year, for 2 years. Result of expansion at this rate would increase the number of WRAP Facilitators to an additional 8 facilitators per CSB and state facility over a 2 year period. Slots could be distributed according to numbers served;
 - j. Increase provider awareness of support groups, warm lines, peer centers, etc.;
 - k. Increase funding for peer provided services and Medicaid reimbursement for peer provided services.
4. **Increase Providers’ Sharing of Recovery Resource Information During Crisis** – When people with mental illness or substance use disorder experience a psychiatric crisis, they are often “left out of the conversation” with emergency and crisis service providers. They may be uninformed about what is going on, what to expect, what options exist, what decisions will be made, etc. As described earlier in this report, this can be a strongly negative experience for the person, and exacerbate an already complicated situation. Small changes in practice can help reduce these traumatic effects and create a response that is more person-centered, humane and positive.

The ES IAT recommends that providers implement the following strategies in response to these concerns:

- a. Educational literature about the TDO process should be made available at the outset of a crisis event to both the consumer and his or her family;
- b. Informational literature for consumers describing “what to do if you are having a mental health crisis” should be available at all service locations;
- c. Crisis line telephone numbers should be posted widely in the community;
- d. Information about how to access peer support services should be available and disseminated proactively;
- e. Providers should educate families and link them to the family support networks and resources;
- f. Literature on the various mental illnesses and related issues should be readily available;
- g. Providers should be able to help all consumers to access resources for developing Advance Directives, Wellness Recovery Action Plans and other recovery tools.

Section VIII - DBHDS Infrastructure to Support Emergency Response System Development

- A. DBHDS has identified the need for additional staff capacity to plan, initiate, support and sustain the improvements described above. By redeploying an existing vacant position, DBHDS is strengthening this function.

Crisis Intervention Continuum of Care

State Hospital Beds: Voluntary Admissions

State Hospital Beds: TDO Admissions

State Hospital Beds: Commitment Admissions

Local Hospital Beds: Voluntary Admissions

Local Hospital Beds: TDO Admissions

Local Hospital Beds: Commitment Admissions

Residential Crisis Stabilization Unit (TDO or Involuntary) - 24 hour, site-based residential program with sufficient staffing ratios to provide intensive supports to assist in crisis resolution, licensed to accept TDOs.

Residential Crisis Stabilization Unit (Voluntary) - 24 hour, site-based residential program to provide intensive supports to assist in crisis resolution, not licensed to accept TDOs.

Community Crisis Stabilization - Lower level of care than crisis stabilization unit, no nursing staff and no doctor; a CSB-site (apt, group home, supportive apartments, etc). For example, a bed that is vacant in a group home that can be used on temporary basis for crisis stabilization.

Detox. and Other Substance Abuse Services - Emergency access to detoxification and other substance abuse services.

23-Hour Crisis Stabilization - Site-based program with sufficient staffing ratios to provide evaluation and intensive supports to assist in crisis resolution.

In-home Crisis Stabilization - On-going intensive in-home services to assist in crisis resolution.

Mobile Crisis Intervention- Off-site, face-to-face. ES clinicians go out to access and evaluate persons in crisis wherever they may be, e.g., at consumer's home, on the street, etc. ; not just to hospitals, ERs or jails.

Crisis Intervention Team (CIT) or similar program - Like Mobile Outreach Crisis Team above, but part of a collaborative initiative to provide local law enforcement intensive specialized training in crisis intervention and diverting individuals from the criminal justice system. Based on Memphis CIT Model or similar program.

Criminal Justice Drop-off Site(s) – One or more locations where law enforcement can transfer custody of an individual experiencing a behavioral health crisis for the purposes of evaluation and disposition.

Psychiatric Evaluation and Medication Administration (within 24 hours) - Face-to-face crisis medication evaluation and treatment. Physician or nurse practitioner is available to see consumer, prescribe or administer medications within 24 hours.

Psychiatric Crisis Consultation - Physician or nurse practitioner is available for telephone crisis consultation with CSB ES staff, e.g., to refill, change, call in prescription, etc. Routine process, available by policy 24 hours a day, not an occasional exception.

Face-to-Face Crisis Intervention - Available immediately, CSB ES clinician available 24 hours a day, even for voluntary individuals, regardless of ECO or prescreening requirement, for crisis counseling to resolve or reduce crisis.

Face-to-Face Crisis Intervention Appointment (Guaranteed Next Work Day with CSB ES Staff) - Crisis intervention and treatment like immediate intervention above, but scheduled for next work day after referral.

Short-term Crisis Intervention - intensive outpatient counseling that can be provided more than once a week that occurs for up to 30 days after the initial crisis intervention session.

Telephone Crisis Counseling: Extended - CSB ES clinician is available by telephone to provide therapeutic contact in an effort to diffuse the crisis. Available outside of business hours.

Telephone Crisis Contact: Brief - CSB ES clinician is available by telephone to triage call to provide information, conduct initial screening and assessment, and to make referrals and schedule CSB appointment, etc. Available 24/7.

Warmline – Service where individuals can call and talk with staff, consumers, or volunteers about their problems. Available 24/7.

Pre-Hearing Assessment – CSB staff provide an assessment prior to commitment hearing in order to update prescreening and provide first-hand, knowledgeable testimony on the least restrictive alternatives for referral and treatment.

Commitment Hearing Attendance - CSB staff or their representatives actively participate in commitment hearings in order to facilitate recommendations for continuity of care in providing the least restrictive alternatives for care and treatment.

Appendix C



Summary of VHHA Psychiatric Emergency Services Survey May 2011

Overview

- Surveys were sent in March 2011 to VHHA member hospitals with inpatient psychiatric units and to hospitals without psychiatric units so that their emergency departments could provide input to the survey as well.
- Thirty-one hospitals with psychiatric units responded to the survey. Of those, 20 provided responses to all of the questions. Those 20 hospitals account for about two-thirds of all inpatient psychiatric beds.
- Of the hospitals without psychiatric units, 12 provided responses to the survey questions.
- Most of the questions asked were open-ended. Below is an attempt to summarize the comments provided through the survey.

Summary of Responses
Question 1. Describe how your CSB's emergency services workers interact with your emergency department. Include any information that you believe is important to provide a full understanding of how emergency services are provided in your area. For example, you might describe: 1) the circumstances under which CSB workers come to the ED to pre-screen individuals for possible commitment; 2) communication between emergency department staff and CSB staff, including physicians; and 3) if applicable, variations in practice associated with different types of patients (e.g., voluntary vs. involuntary; "known to CSB" vs. "not known to CSB.")
• Scenarios under which CSB comes to ED vary. Some are involved with only involuntary patients; others are involved with both involuntary and voluntary.
• In some places, patients are transported to CSB or another central location for evaluation.
• Problems arise when ES worker doesn't communication disposition of case to hospital staff. This is particular problem if ES worker leaves without being able to find a bed.
• Some CSBs provide very accurate, complete information about patients; others do not.
• Some CSBs use the ED as their emergency services function after 5 p.m.
• It can be difficult to get copies of prescreening report.
• There is considerable variability among ES workers. Some are highly professional and responsive; others are not.
• Some hospitals report excellent relationships with their CSBs.
• It can be difficult to find a placement if CSB determines a person is voluntary.
Question 2. Describe how your CSB's emergency services program interacts with your INPATIENT PSYCHIATRIC UNIT. In your response, address any points that you believe are important to provide a full understanding of how emergency services function in your area. For example, you might describe 1) how communications occur between hospital psychiatrists and CSB psychiatrists, 2) how commitment hearings are scheduled, 3) whether you interact with other CSB staff besides emergency services staff, and 4) how discharge planning is done.
• Discharge planning works better for patients that are known to the CSBs. For example, it's difficult to get appointments upon discharge for patients not known to the CSB.
• Some hospitals report that CSBs participate in their treatment team meetings.
• There appears to be variability regarding who is responsible for the conduct of hearings. It may be the special justice, the CSB or the hospital who takes the lead.
• In some cases, hearings are not held where the patient is being detained, which leads to problems associated with patient handoff and safety as well as transportation costs.

Appendix C

Question 3.

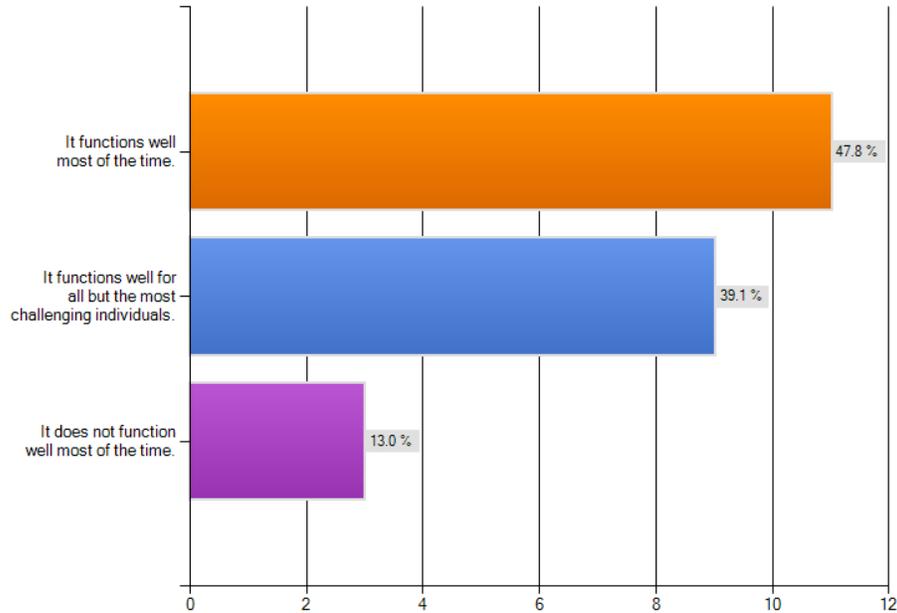
To the best of your ability, estimate the number of patients per week, on average, that involve interaction between your department or unit and your CSB.

The responses ranged from a low of 5 per week to a high of 245.

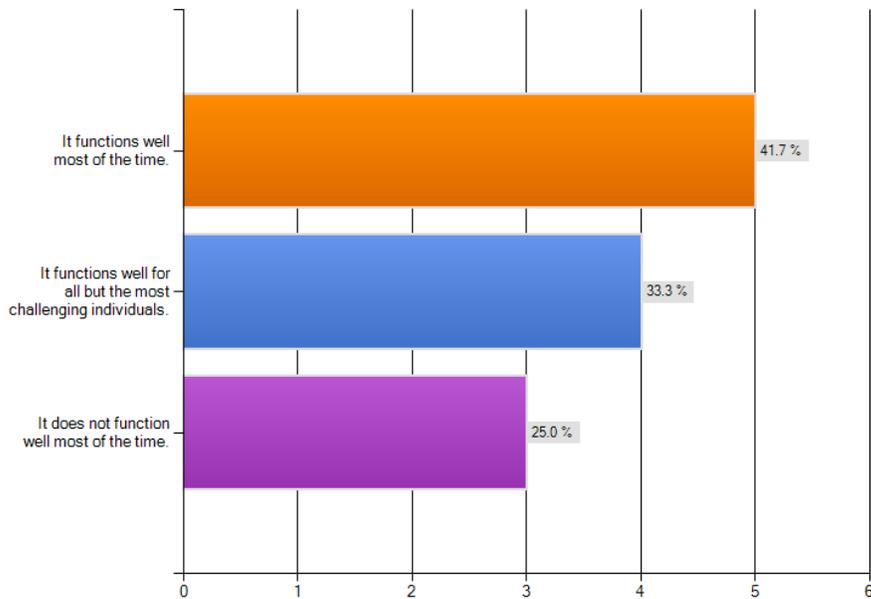
Question 4.

Which of the statements below would you say best characterizes CSB emergency services in your area?

Psychiatric Units: Which of the statements below would you say best characterizes CSB emergency services in your area?



Emergency Departments: Which of the statements below would you say best characterizes CSB emergency services in your area?

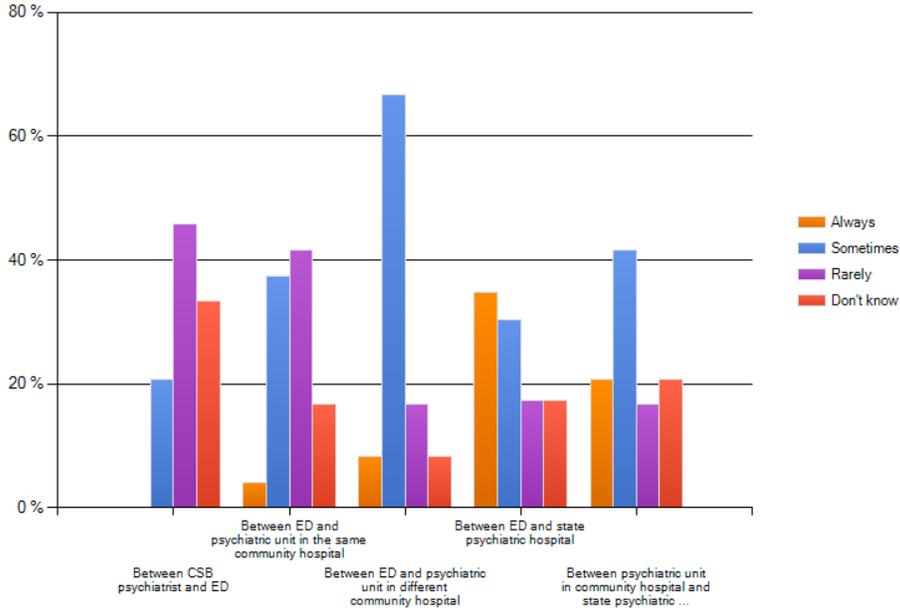


Appendix C

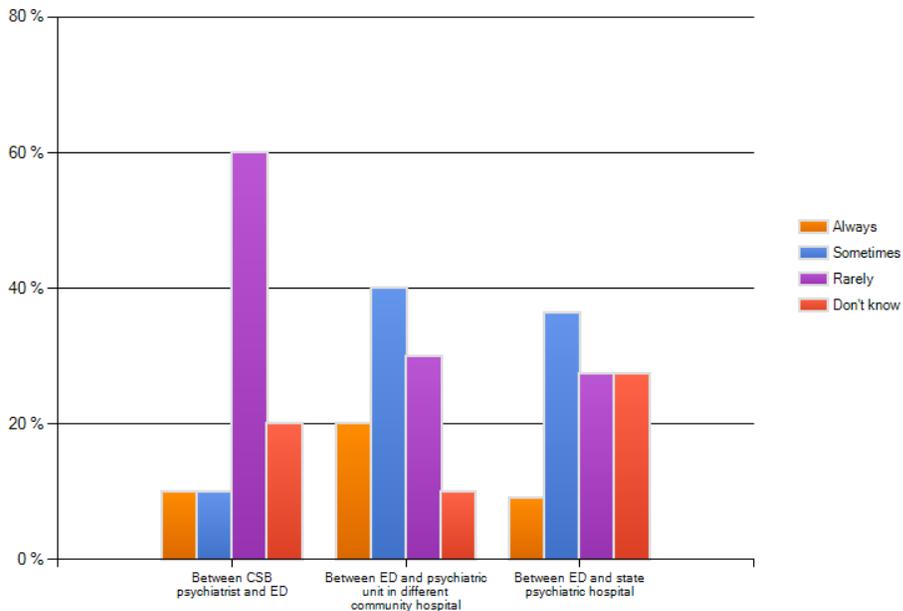
Question 5.

Indicate the extent to which problems associated with medical screening/assessment occur in each of the following settings. Check all that apply.

Psychiatric Units: Indicate the extent to which problems associated with medical screening/assessment occur in each of the following settings. Check all that apply.



Emergency Departments: Indicate the extent to which problems associated with medical screening/assessment occur in each of the following settings. Check all that apply.



Appendix C

<p>Question 6.</p> <p>What suggestions do you have for reducing the problems associated with medical screening and assessment process?</p> <ul style="list-style-type: none"> • Admitting hospitals should accept the medical assessment protocols of EDs. The amount of testing being required of EDs is getting out of hand. • Reasonable criteria need to be developed that all parties will agree to honor. • A lack of complete and accurate information from CSBs can complicate and slow down the process. • State hospitals need to be more specific about why they're not accepting a patient without further tests. • State hospitals should be required to publish their admission criteria. • State hospital physicians should be required to talk to ED physicians. • EDs are not be the best place for routine screening of psychiatric patients. • Hospitals should re-examine their own ED throughput. • There's a need for more inpatient beds. • Video-conferencing for telemedicine should be available between hospitals.
<p>Question 7.</p> <p>From your perspective, what are the three biggest challenges to maximizing the consistency, availability and accessibility of emergency services in your locality or region?</p> <ul style="list-style-type: none"> • Not enough ES staff affects response time. • Limited availability of after-hours pre-screening. • Not enough beds. • Inconsistency and lack of coordination among CSBs. • Some CSBs unwilling to come to hospital. • Limited funding for indigent patients. • Need for improved coordination with law enforcement personnel. • Need for others involved in process to understand the roles and abilities of EDs. • Need for more assistance from CSBs for non-TDO patients. • Need for more consistent definition of involuntary. • CSB reluctance to TDO patients who lack competency to consent to admission. • Need for more coordination between CSBs and admissions screeners. • Hand-off of patients from CSBs at shift change. • Limiting access to crisis stabilization units to only patients known to CSBs.
<p>Question 8.</p> <p>What specific changes or improvements would you suggest to eliminate or mitigate these challenges?</p> <ul style="list-style-type: none"> • More ES staff. • More beds. • 24/7 access to ES staff. • Commitment hearings held in hospital. • Greater consistency among CSBs. • Pre-screeners available for more than just ECOs. • Regular interaction between hospital, CSB and law enforcement personnel. • Increased funding for indigent patients. • More mobile crisis teams. • Consistent interpretation of ECO/TDO statute and education of all involved in process. • CSB staff need better understanding of admissions criteria for crisis stabilization units. • Use of telemedicine used prescreening. • Web-based access to all prescreening records (including medications prescribed and labs/tests performed) so they can be accessed by all providers attempting to provide assessment and care. • Participation of treating facility in regional meetings regarding potential transfer to state facilities. • Standard criteria for LIPOS funding and basis for authorization of number of bed days.

Appendix C

<p>Question 9. If you believe that payor source has an impact on the way emergency services are provided, describe what the impact is and any suggestions you may have for addressing the impact.</p> <ul style="list-style-type: none"> • The uninsured are the most affected. • Authorization by private payers is a major problem. • Insurers are not abiding by mental health parity requirements.
<p>Question 10. Have you or your CSB instituted any best practices that have helped to improve the way emergency services functions in your area? If yes, please describe briefly.</p> <p>Regular meetings with CSBs (some weekly, some monthly.)</p> <p>Using “patient-centered” care approach.</p> <p>Quarterly meetings with law enforcement personnel.</p> <p>“Fast-track” through ED for appropriate patients.</p> <p>Psychiatric unit helps ED assess mh/sa patients.</p> <p>Multi-disciplinary process for observation/treatment, medical assessment, crisis intervention and discharge from ED.</p> <p>MOU with CSB combined with bi-monthly operational meeting with all stakeholders.</p> <p>CSB designates hospital liaison staff to set up after-care.</p> <p>Contract with CSB that includes performance requirements.</p> <p>CSBs seeing patients in their homes when that is possible.</p> <p>Use of telemedicine.</p> <p>Have tried putting protocols in place but no two cases seem to be handled the same way.</p>
<p>Question 11. Are there best practices that you believe, if adopted, would improve the consistency, availability and accessibility of emergency services in Virginia? In thinking about this question, include all aspects of the patient encounter with the emergency services system, from the emergency custody/pre-screening phase to the discharge planning/return to the community phase.</p> <p>More consistent criteria for level of care determined by CSBs/Regional Project Administrators for discharge planning.</p> <p>Evaluation/determination of best treatment milieu for patients with intellectual disabilities.</p> <p>Hearings conducted in facility where patient is detained.</p> <p>Issues related to some CSB’s requirements for petitioner resolved.</p> <p>Needs to be more continuity so that CSBs evaluate their patients in ED and follow them through discharge from ED or inpatient setting.</p> <p>Creation of regional psychiatric emergency stabilization services.</p> <p>More mobile crisis units.</p> <p>Defer prescreening until after patient is medically cleared, especially in case of intoxication. In such cases patient is often unable to participate in evaluation process since it must occur within the four-hour window.</p> <p>Re-evaluate calculation to determine need for psychiatric beds.</p> <p>Require physician to physician interaction.</p> <p>Standardized, searchable prescreening records.</p> <p>Easier access to magistrates for TDOs.</p> <p>Not all patients require medical clearance in the ED.</p>
<p>Question 12. Which non-crisis services, if available in the community, do you believe would be most effective in preventing an individual from experiencing a crisis that requires inpatient admission to a psychiatric facility?</p> <p>Increased resources to enable follow-up within 5 to 7 days of discharge.</p> <p>Extended office hours with plan to see more people in crisis in setting other than ED.</p> <p>Group homes for the chronically ill.</p> <p>Step-down services available post-hospitalization to reduce readmissions.</p> <p>Increased outpatient services.</p> <p>More case management.</p> <p>Consistent practices within PACT and crisis stabilization.</p> <p>Increase mental health support services, including in homeless shelters.</p> <p>Partial hospitalizations services provided either through CSB or hospital.</p> <p>Crisis stabilization services, both residential and outpatient.</p>

Appendix C

Question 12. (continued) Which non-crisis services, if available in the community, do you believe would be most effective in preventing an individual from experiencing a crisis that requires inpatient admission to a psychiatric facility? Substance abuse/social detox.
Services targeted for dementia and intellectually disabled patients.
Community-supported medication management clinics.
Use community health centers to help manage patients.
More CSB walk-in centers where person can be seen.
Question 13. Is there any other input regarding the emergency services function provided through your CSB that you would you like the Team to have?
We have consistent dialogue with our CSB even under difficult scenarios.
Improved communication between all entities would improve the relationship. Sometimes it feels as if we are working against each other to get our own needs met.
It's an ongoing struggle to provide the services needed in this community. We need to work together as a team to provide them.
LIPOS funding needs to be increased and be made more workable for CSBs and hospitals, including transferability out of area.
I would like to commend our CSB for stepping up and assisting us with our effort to push for a better ED process.
We have a positive working relationship with all of the area CSBs. We call them on a monthly basis to talk about how the process is working and how we can improve our services.
We are fortunate because our local CSB is very responsive partly because we have a well-defined contract. They also assist us with staff training.
Our emergency services workers do a wonderful job.

**APPENDIX D:
PRIORITIES FOR
ADDITIONAL
RESOURCES**

	State Hospital Beds: Voluntary Admissions	State Hospital Beds: TDO Admissions	State Hospital Beds: Commitment Admissions	Local Hospital Beds: Voluntary Admissions	Local Hospital Beds: TDO Admissions	Residential Crisis Stabilization Unit (TDO) or Inpatient	Residential Crisis Stabilization Unit (Voluntary)	Community Crisis	Detox. and Other Substance Abuse Services	24-Hour Crisis Stabilization	Inpatient Crisis Stabilization	Mobile Crisis Intervention	Crisis Intervention Team (CIT) or Similar Program	Crisis Intervention Team (CIT) or Similar Program (Drop-off Sites)	Psychiatric Evaluation and Medication Administration (within 2-4 hours)	Psychiatric Crisis Consultation	Face-to-Face Crisis Intervention (within 2-4)	Face-to-Face Crisis Intervention - Available Immediately	Short-term Crisis Intervention	Telephone Crisis Intervention	Telephone Crisis Consulting - Extended	Warmline	Pre-Hearing Assessment	Hearing Attendance
PPR I																								
Central VA		3		1	2									4	5									
Harrisbrg-Rockghm						5	1		4					2	3									
Northwestern						3	1		4					2	2	5								
Rappahannock Area							4					5			1	3			2					
Rappahck Rapidan								2	1				4	5									3	
Region Ten									2						1	3	3							
Rockbridge		2		5				1	3	2					4		3	3						
Valley		3	4	2	1										5									
PPR II																								
Alexandria		2	3				4				5					1								
Arlington		1	4		2		5				3													
Fairfax-Falls Ch	4	1		3	2		5																	
Loudoun Cnty		4	5						2						1									
Prince William		1	2								4			3	3				5					
PPR III																								
Cumbrlnd Mtn						5						2	3		4		1							
Dicknson Cnty						1	2	4					3	5										
Highlands	5	1		3	2																			
Mt Rogers															3	1	5							
New River Vly					5						1	4			2								3	
Pl. Dist. 1						5			3	2		4			1									
PPR IV																								
Chesterfield					1									2	3						4			5
Crossroads			3		2		1									4	5							
Goochld-Powhtn	5						3							4	1									
Hanover		3		2	1		4			5														
Henrico															1	2		5						4
Pl. Dist. 19						2		5							4	3			1					
Richmond									3					4	5	1	2							
PPR V																								
Chesapeake	1	2	3												4									
Colonial			1	2	5				3						4									
East Shore	5	4		1	2			3																
Hampton-Newp News		5									1		3											4
Mid Peninsula		1		4	2	5					3													
Norfolk							1						5		2	3								4
Portsmouth	2	1	3	4	5																			
VA Beach			5		1	2			3	4														
West Tidewater		5	3		1										2									
PPR VI																								
Danvil-Pitts		2			1									5		4								3
Piedmnt Reg.		4				2			1	3					5									
Southside		1				3		5	2															4
PPR VII																								
Allegh-Hghlds				1				4	5					3		2								
Roanke/Blue Ridge												4	5		3	1	2							

1 Top-most Need 2 Second Greatest Need 3 Third Greatest Need 4 Fourth Greatest Need 5 Fifth greatest Need

**Behavioral Health-Criminal Justice Subcommittee Report of Survey Findings to the
Emergency Response Implementation Action Team**

A. Summary of Behavioral Health/Criminal Justice Survey Findings

In May and June, 2011, the Behavioral Health-Criminal Justice Subcommittee conducted a telephone and e-mail inventory to assess the current status of programs and resources across Virginia's 40 Community Services Boards (CSBs). As of June 23, 2011, information had been obtained for 37 of the 40 CSBs, with the remaining responses pending.

The inventory tracks program activity related to the five stages (intercepts) of the Sequential Intercept Model which identifies the five points where individuals in contact with the criminal justice system can be most effectively identified, assessed and provided or linked to appropriate services¹. Additionally, the inventory includes information regarding the funding streams that support these CSB activities, including state general funds designated for jail diversion, treatment and jail based forensic discharge planning; regionally-allocated state funds; and Federal or other grant funds. In addition, many CSBs use local funds to support staffing, training, programs and services for criminal justice involved clients. Only 4 CSBs of the 37 that responded do not provide specific programs or activities targeted to the criminal justice involved (or at-risk) population (Alleghany Highlands, Goochland, Hanover and Southside).

B. Program Activity (CSB programs or activities spanning multiple intercepts are counted at each intercept)

Intercept 1

- 23 CSBs participate in Crisis Intervention Team Programs (CIT)
 - 9 in operational status
 - 7 in developing status
 - 7 in planning status
- 1 CSB is providing modified CIT training
- 1 CSB is providing CIT training but not currently planning full CIT program development
- 1 CSB is providing linkage to housing through law enforcement referrals

Intercept 2

- 3 CSBs are providing diversion activities utilizing specially developed court processes and providing comprehensive services
- 1 CSB is identifying participants as part of a comprehensive mental health court docket
- 5 CSBs are providing linkage to services
- 2 CSBs have a designated case manager at this intercept
- 1 CSB has an initiative with their community corrections program
- 1 CSB provides linkage to housing

¹ The Sequential Intercept Model was developed by P. Griffin, M. Munetz and H. Steadman, of Policy Research Associates and provides a logic model for understanding the nexus of the criminal justice and behavioral health systems. It identifies five typical points (intercepts) where individuals with behavioral health disorders can be most readily identified and diverted from or provided services within the criminal justice system in order to reduce the amount of contact with the criminal justice system and improve access to services. The five intercepts are 1) law enforcement/emergency services (pre-booking); 2) initial detention/initial court hearings (post-booking/pre-trial); 3) jails/courts; 4) reentry (post-conviction/incarceration and release); and 5) community corrections/community support (post-conviction supervision).

Appendix E

Intercept 3

- 3 CSBs participate in a Mental Health docket or court model
- 21 CSBs provide jail based treatment and services
- 1 CSB participates in a programmatic response based in the Public Defender Office

Intercept 4

- 12 CSBs provide jail discharge planning
- 3 CSBs participate in a Reentry program
- 1 CSB provides linkage to housing

Intercept 5

- 2 CSBs participate in comprehensive programs with criminal justice supervision and services provided
- 4 CSBs provide linkage to services
- 1 CSB provides linkage to housing

C. Resource Allocation

Ongoing funding:

- \$2,127,050-- State GF through DBHDS for jail diversion allocated to 10 CSB diversion sites;
- \$270,000 – State GF through DBHDS for CIT start up grants and statewide expansion;
- \$536,250 - State GF through DBHDS for system transformation allocated and distributed regionally for jail diversion and jail treatment;
- \$ 500,000 – State GF through DBHDS for forensic discharge planning to 7 CSBs.

Limited duration grant or contract funding:

- \$248,092 – Federal Byrne Grants through DCJS for CIT program establishment;
- \$446,000 – Federal grants and other Congressional allocations;
- \$891,903 – Contracts for services and positions (Henrico County Jail contract with Henrico CSB comprises \$671,903 in this category).