

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

## ***CRISIS RESPONSE WORKGROUP***

***January 24, 2014***

***10 a.m. – 2 p.m.***

***Main Branch, Richmond Public Library***

### ***MEETING MINUTES***

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#### **Members Present**

William Barker, MD, Emergency Medicine, Fauquier Hospital  
Lawrence "Buzz" Barnett, Emergency Services Director, Region Ten CSB, Charlottesville  
Kirsten Berglund Bradley  
Varun Choudhary, MD, Medical Director, Magellan Behavioral Health  
Margaret Nimmo Crowe, Executive Director, Voices for Virginia's Children  
Kit Cummings, Lieutenant, Blacksburg Police Department  
Robin Foster, MD, Virginia Commonwealth University Medical Center  
Chuck Hall, Executive Director, Hampton-Newport News Community Services Board  
Daniel Holser, Chief Magistrate, 12<sup>th</sup> Judicial District  
Karen Kimsey, Deputy Director, DMAS Complex Care and Services  
Douglas Knittel, MD, Psychiatric Emergency Services, Portsmouth Naval Hospital, Portsmouth  
Jeffrey Lanham, Regional Magistrate Supervisor, 6<sup>th</sup> Magisterial Region  
Bruce Lo, MD, Chief, Department of Emergency Medicine, Sentara Norfolk General Hospital  
Cynthia McClaskey, PhD, Director, Southwestern Virginia Mental Health Institute  
Sandy Mottesheard, Member at Large at National Alliance on Mental Illness (NAMI) Virginia  
Bonnie Neighbor, Executive Director, VOCAL  
Ted Stryker, Vice President, Centra Mental Health Services, Lynchburg  
Scott Syverud, MD, Vice Chair, Clinical Operations, UVA School of Medicine  
Shirley Repta, Executive Director, Inova Behavioral Health  
David Rockwell, Peer Support Provider Henrico Area Community Services  
Ben Shaw, Region 1 Coordinator, Virginia Wounded Warrior Program, RACSB, Virginia Dept. of Veterans Services, Fredericksburg  
Tom Spurlock, Vice President, Art Tile, Inc.  
Joseph Trapani, Chief Executive Officer, Poplar Springs Hospital, Petersburg  
John Venuti, Chief, VCU Police Department, Richmond  
Cindy Wood, Lieutenant, Henrico Police Department  
Jason Young, Executive Director, Community Brain Injury Services

#### **Staff Present**

Dr. Jack Barber, DBHDS  
James Martinez, DBHDS  
Stephanie Arnold, DCJS  
Karen Taylor, Office of the Attorney General  
Mary Begor, DBHDS  
Andrew Diefenthaler, DBHDS

## **Members Absent**

Kaye Fair, Emergency Services Director, Fairfax-Falls Church CSB, Fairfax  
Brian Wood, MD, Director, ER Psychiatry, VAMC

Jim Martinez conducted a roll call of the participants and observers in the room

Brief discussion on how best to structure the meeting.

Identified a format of:

- a. Discuss the Governor's proposed budget items and recommendations
- b. Identify issues that may be explored in other workgroups,
- c. Identify what is missing in crisis response services now
- d. Outline the recommendations of the workgroup for the Taskforce

Discussion began with a presentation and handouts on the system of temporary detention in Maryland with a focus on having either 2 physicians or 1 physician and 1 psychologist complete the application of admission for individuals experiencing a mental health crisis. This eliminates the need for involvement of magistrates and CSB Emergency Services clinicians. In this system if a person is determined to be dangerous they can be held with arbitrary time limits. This system removes the magistrates involvement in a civil process and applies to children and adolescents as well.

Question was raised on how a person gets to the crisis system in Virginia as it is now. A flow chart was drawn on the white board outlining the current system.

An advocate for individuals with traumatic brain injury's spoke about the difficulty in accessing services for these individuals due to the current legislation and admits that it is very inconsistent across the state.

Discussion on the dichotomy between medical crises and behavioral health crises.

Advocates of individuals with behavioral health crises feel that these individuals do not belong sitting in emergency rooms.

The lack of routine psychiatric services in most parts of the state and none for crisis situations was recognized and acknowledged as an area of concern.

## **ECO Discussion**

Mapping of the crisis process occurred with identifying an event, statement or concern being raised about an individual and how the professional or family needs to petition for an ECO unless the CSB is community based mobile or the person is accepting of the assessment in a neutral location (i.e., jail, clinician's office, nursing home, CSB programs, emergency rooms, CIT assessment centers). Also, the police may take a person into custody under a paperless ECO for up to four hours.

Discussion on reducing the variability of response across the Commonwealth.

Recognition that under an ECO some parts of the state just do not have enough time as the person may be taken into custody by the police then transferred to an off-duty sheriff deputy and then driven to Charlottesville before the person is ever assessed for possible TDO. **Recommend having the language amended for ECOs as to when an ECO actually begins.** Get state facilities involved before time runs out on ECO to help plug the gaps with a 100% response for 100% of the people.

Discussion on the length of time for ECO. Some reported that in other states it is up to 72 hours for an ECO which means a person can be held for up to 72 hours before a determination that a TDO may be needed or the

step of TDO is eliminated and at the conclusion of the ECO period the individual is determined to either need longer care or released. Some states allow up to 30 days for a person under TDO.

**Recommend clearly identifying who is supposed to notify the CSB when a person is taken into custody and when in the process is this supposed to occur.** (the magistrate, the law enforcement agency taking the person into custody, etc...)

Extension of the ECO discussed. Several different scenarios presented:

- a. Initial 4 hours with 2 hours extensions for up to 24 hours
- b. ECO valid for 48 hours
- c. Initial 4 hours with 2 hours extensions for up to 8 hours
- d. Initial 8 hours with special provisions after the 8 hours for medical treatment or continued bed search.

General agreement that the ECO period that is currently in the code of Virginia needs to be extended and that having to obtain extensions can be problematic as some localities require ES to make the request in person which detracts from the ES worker from working on locating a suitable placement.

Some reservations were verbalized over fear that ES would not act quickly to locate a suitable bed for an individual if the time for an ECO is extended.

Support the use of electronic means for evaluations by Emergency Services clinicians especially in rural areas. The need for cooperation and collaboration with emergency room staff would be needed to assist with facilitating and coordinating the electronic interface between the individual, the family, the ER physician and ES clinicians as well as the technology available in the most rural areas.

### **TDO Discussion**

Further exploration on detaining an individual without specifying a bed. Several areas of concern verbalized about this as to keeping the person in a possible environment that is not capable or willing to provide treatment for the time of the TDO and a legal implication of holding a person in "limbo". How would law enforcement be able to stay with an individual in some of the locations for the possible length of the TDO with the already burdened systems across the commonwealth? Having possible disruptive individuals in an ER? Overcrowding of the ER? Would the ER staff become the custodian of the individual until a TDO facility is secured? Who would then transport? Advocacy for individual spoke up and did not like the concept of no bed specified.

Discussion that the ECO facility could be the place that initiates treatment and it was expressed that many of the ECO locations are not adequately staffed to initiate treatment.

When does the medical system get involved with a person? This varies across the state as some CSB's only assess individuals in ERs and some persons with a crisis are never seen in an ER.

**Recommendation of the workgroup is to increase tele-psychiatry across the Commonwealth so that psychiatric services can be available in crisis situations, doctors in ERs can consult with a psychiatrist more easily, and to promote increased collaboration between the medical and psychiatric fields. This was identified as being needed by all 40 CSBs especially after business hours.**

Private hospitals may not be the right place for certain individuals or certain populations due to level of violence, past history of aggression, persons with intellectual or developmental disability. Question raised as to why state facilities cannot directly admits these special populations.

Identification that increased flexibility in both the private and public system of care is needed which includes the ability to transfer an individual from a private facility to a public facility if the private facility cannot

provide the level of care needed for an individual. A more collaborative approach to the continuum of care is needed.

Transportation and custody of individuals discussed such as having officers or deputies that have been trained in CIT (Crisis Intervention Training) and recognizing that anytime an officer or deputy transports the person is put into handcuffs which can be very traumatic for individuals.

**Supports a minimum 24 hours for TDO with maximum of 72 hours (except where specified as different for time periods ending on a weekend, a holiday or any day that the court is closed) with a re-enactment clause in 1-2 years.** Discussed making the TDO period 5 days to be similar to other states.

**Supports expanding capacity at state facilities to be able to adequately handle the needs of the community.**

Workgroup does not support another study of mental health system but does support taking all of the recent studies that have been done and combining them to determine the state of the mental health crisis services and outpatient services in Virginia.

### **Suggestions for areas for discussion for future meetings**

- Supports increasing the number of CIT assessment centers to add 6 in FY2015 and 6 more in FY2016. The support is also given to increase the amount of funding for CIT assessment centers as the current \$300,000 is insufficient for increased staffing to make the center accessible 24 hours a day and staffed continuously with security and clinicians.
- Support the expansion of crisis services for children and adolescents as well as outpatient services for this population in areas that are significantly underserved in the public and private sectors.
- **Recommend the expansion of PACT to having at least one PACT team in every CSB.** Discussion about a PACT type model for children and adolescents being needed in each region or CSB.
- Endorse in the future that every licensed psychiatric bed in Virginia is accessible to all and that the CSB prescreening be removed as necessary for TDO. Increased agreements and collaboration at the local level to support the individuals in their community instead of state facilities.
- Request that clearer training be provided to the special justices and magistrates with expectations of consistency around the states. Also, the training be required more frequently for refreshing to promote consistency.
- Have CSUs develop clear protocols on decision making for admission so that ES is aware of the criteria and can utilize the residential CSUs for persons under a TDO or with a higher acuity level.
- Increased opportunities for small law enforcement jurisdictions to be able to attend CIT training in their area by partnering with larger localities for the training. Provision of sustainability funds for maintaining and training CIT within established areas and increase participation from all localities. Expand CIT training to EMS providers and fund sufficiently for this to occur with little or no cost to their locality.
- Support expanding peer support recovery programs within the crisis continuum.
- Overall, responsiveness of crisis services within localities varies and the expressed need of crisis support and not just prescreening services for individuals experiencing a behavioral health crisis.
- Allowing DAP funding for persons being released from long term incarceration.
- Adding public school mental health services in more schools.
- Additional resources (people and funding) to southwest Virginia.
- Providing psychiatric and/or psychological assessment of children and adolescents in the juvenile justice system.

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

## **ONGOING TREATMENT AND SUPPORTS WORKGROUP**

**January 24, 2014**

*10 a.m. – 2 p.m.*

*Main Branch, Richmond Public Library*

### **MEETING MINUTES**

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#### **Members Present**

Richardean Benjamin, Old Dominion University

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

Jan Brown, Acting Director, Substance Abuse and Addiction Recovery Alliance (SAARA)

Debbie Burcham, Executive Director, Chesterfield Community Services Board

Molly Cheek, LCSW, President, Dominion Youth Services

Steven Crossman, MD, Associate Professor, VCU Department of Family Medicine

William Elwood, AEGIS Associates, LLC

Nancy Fowler, Program Manager, Office of Family Violence, Virginia Dept. of Social Services

Cristy Gallagher, Research Director, George Washington University

Frank Gallagher, Vice President of Behavioral Health Services, Sentara

Tabitha Geary, Vice President, Washington, DC Office, SapientNitro

Neal Graham, CEO, Virginia Community Healthcare Association

Keith Hare, VP Government Affairs, Virginia Health Care Association

Teshana Henderson, CAO, NDUTIME Youth & Family Services

Daniel Herr, Director, Southern Virginia Mental Health Institute

Steve Herrick, Director, Piedmont Geriatric Hospital

Anne McDonnell, Executive Director, Brain Injury Association of Virginia

Paula Mitchell, VP Behavioral Health Services, LewisGale Medical Center

Greg Peters, President and CEO, United Methodist Family Services

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

Beth Rafferty, Director of Mental Health Services, Richmond Behavioral Health Authority

Mira Signer, Executive Director, NAMI Virginia

Sunil Sinha, MD, Chief Medical Officer, Memorial Regional Medical Center, Bon Secours Richmond Health System

Terry Tinsley, PhD, Youth for Tomorrow

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

Tammy Whitlock, Manager, Maternal and Child Health Division

#### **Staff Present**

Kathy Drumwright, DBHDS Assistant Commissioner for Quality Improvement

Michael Shank, DBHDS Director of Community Support, Office of Mental Health

Janet Lung, DBHDS, Director of Child and Family Services

Laurel Marks, Department of Criminal Justices Services

Don Darr, DBHDS, Assistant Commissioner for Finance and Administration

#### **Members Absent**

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

The Honorable Gabriel Morgan, Sheriff, City of Newport News  
The Honorable Dana Lawhorne, Sheriff, City of Alexandria  
Lt. Col. Martin Kumer, Albemarle/Charlottesville Regional Jail  
David Mangano, Director of Consumer and Family Affairs, Fairfax County Government

### **Others in Attendance**

Lt. Governor Northam

### **Introductions – each member introduced themselves and their affiliation.**

Kathy Drumwright and Michael Shank described that the task of this workgroup is to make recommendations to the full task force. They asked for review of the material provided and discussion of what proposals should be endorsed, modified, or added.

It was acknowledged that there is overlap between this workgroup and the workgroup on Crisis Response. It is impossible to completely separate the two.

All populations, including services for younger children, individuals with brain injuries, older adults need to be considered by the workgroups. There was extensive discussion in the following areas.

### **Governor’s Budget**

*MH Outpatient services for young adults* – clinicians and psychiatry/telepsychiatry services – communities would apply for the funds.

- More will be needed than the 34 positions. Some commented that services were needed in addition to clinicians. There are some things already started transitional youth – Great Expectations, DSS Project Life, DRS services for children with dual diagnosis.
- The ongoing treatment and support system “front door” for all populations has atrophied over time. Continuum of care from prevention/early identification to step-down from crisis services. There needs to be a multi-year effort to improve this capacity.
- Workforce development issues – principally peer support

*PACT* is needed. It’s not set up for those under 18, but could help young adults 18 to 25 in transition. Two additional teams are funded in the Governor’s budget in the next biennium.

Permanent supportive housing is essential in addition to ongoing services.

Transition age services – families voice concerns that, once a young person turns 18 and leaves school, there needs to be more support, coordination, case management and assistance with treatment, work and higher education transition. Clinicians would work with identified older teens and transition them to adult services, assuring age-appropriate interventions.

Recommendation: study of Medicaid coverage for peer support. The need for non-clinic based services is based on the fact that many young adults do not come to outpatient services.

Not limit CIT to adults, across the lifespan.

Concerns about the non-mandated category of the Comprehensive Services Act and redirecting the savings from reduced numbers of youth in residential care. \$110 million was saved in CSA, but this funding did not come back to the communities. The State Executive Council is reviewing these issues.

There was general support for the Governor’s budget items, but also many concerns as listed above that it is not enough to fix the “broken” system. There was also reluctance to say that these budget proposals would fix the system.

All of the budget items are based on the long-term plan “Creating Opportunities” developed through a full stakeholder expert input process. As such, they are a down payment on the larger funding allocations that are

needed. There was consensus on supporting the governor’s budget submission, but with additional funding, and a recommendation to identify top priority items (starred below) now followed by a multi-year plan.

**Legislation**

Comments on 2014 proposed legislation:

- Support 72 hour maximum, minimum 24-hour TDO period
- Support the Auxiliary grant program expansion bill
- 2<sup>nd</sup> 2-hour Emergency Custody Order extension to be added to the 4-hour Emergency Custody Order period
- HB 206 involving CSBs to provide information to schools on available behavioral health services. Input given to make info available without requiring students to be identified to attend a presentation

**Prioritized List of Services that can be Enhanced Versus Areas for Future Development**

Enhance/Add	Other/Future
Clinic Services (mobile services mentoring)	Communication – getting information out about services and resources
PACT should be expanded across the Commonwealth and services should be provided across the life span- not just to adults.	Link public/private
CIT/Training and 24/7 Assessment centers–across the lifespan (Crisis Response workgroup)	Best practices SA/ Co-occurring services, Domestic violence
Permanent supportive housing	COLAs and need reliable funding for housing opportunities
Integrated Primary care teams	Training
Peer support	Medicaid Peer Support Service (Adult and Family)
Expand Mental Health First Aid across Virginia	
Expand Suicide prevention programs	Prevention and Early Intervention Ex. CSA non-mandated
Pilots to develop children’s comprehensive service array	Managed Care/Care transitions
DAP - There is a need to continue to fund those with extraordinary barriers and focus on the discharge process to maximize the flow-through in state hospitals	Brain injury
	Across life span
	Impact on hospital census
	Redirect savings into community services
	Partial hospitalization/day hospitalization/step-down services
Capture savings- There should be exploration of ways to keep savings in the system. Hold on the rate reduction for mental health skill building until there can be a determination as to the impact the changes in regulations will have.	
Legislative items: Support 72-hour maximum, minimum 24-	Workforce development needs

hour TDO period Support the Auxiliary Grant program expansion bill	
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**Highlights = Top Priorities**

**Interface with other workgroups**

- This workgroup is very interested in and will coordinate their work with the crisis response workgroup regarding the continuum of services.

**Agenda Items for Future Meetings**

Focus on the “Other/Future” column above. Also look at existing planning and development efforts, strategic plans, etc. that have identified needed services. Future meetings dates and logistics will be forthcoming. The full task force will have its second meeting on January 28, 2014.

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

## ***PUBLIC SAFETY WORKGROUP***

***January 24, 2014***

***10 a.m. – 2 p.m.***

***Main Branch, Richmond Public Library***

### ***MEETING MINUTES***

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#### **Members Present**

Colonel Steven Flaherty, Superintendent, Virginia Department of State Police  
The Honorable Stacey Kincaid, Sheriff, Fairfax County  
The Honorable Tommy Whitt, Sheriff, Montgomery County  
Melanie Adkins, Emergency Services Director, New River Valley Community Services  
Kevin Fay, President, Alcalde & Fay  
Sue Medeiros, Chesterfield Department of Mental Health Support Services  
Gary Roche, Chief, Pulaski Police Department  
Bobby Russell, Western Virginia Regional Jail  
Becky Sterling, Consumer Recovery Liaison, Middle Peninsula-Northern Neck CSB  
Rhonda VanLowe, Counsel, Rolls Royce North America  
John Williams, Director of Public Safety Novant Prince William Medical Center  
Gerald Wistein, Peer Provider, Region Ten CSB

#### **Staff Present**

Victoria Cochran, Deputy Secretary Public Safety  
Drew Malloy, Chief Deputy Director DCJC  
Michael Schaefer, Director Forensic Services, DBHDS  
Ken Gunn, Director Budget & Financial Reporting, DBHDS

#### **Members Absent**

The Honorable R. Edwin Burnette Jr. Judge, 24<sup>th</sup> Judicial District  
Jim Bebeau, Executive Director, Danville-Pittsylvania CS  
Mike Francisco, NAMI Central Virginia  
Gary Kavit, MD, Riverside, Norfolk  
Cindy Kemp, Arlington County Dept. of Human Services  
William Rea, MD, Associate Professor, Department of Psychiatry, Carilion Clinic and Virginia Tech Carilion School of Medicine  
Sandy Ward, PhD, President, Virginia Academy of School Psychologists  
Professor, College of William and Mary

Workgroup discussed tasks charged to this group and members shared their personal/ professional experiences with the mental health system. Topics for the group were divided into four general categories: Emergency Custody Order Process; Transportation Issues; Crisis Intervention Team (CIT); and Jail Mental Health Services.

### Emergency Custody Order Process

- Group shared their experiences with the Emergency Custody Order (ECO) process. Group discussed that although this becomes a legal/criminal justice/ law enforcement issue it really stems from a health care issue. With that frame of reference, there was some discussion about who should be the first responder and what role law enforcement should play in the process. Law enforcement shared their perspectives and educated the group about rules/regulations related to their duties in this process.
- Group discussed the challenges between infringing on individuals' rights versus keeping individuals/ the community safe. Discussed how this balance varies depending on locality.
- Group was provided with overview of the ECO process and historical changes made to the Code of Virginia. Group also reviewed, in general terms, the current proposals before the legislature regarding extending the period of ECO. Also were provided some data about how Virginia compares to some other states in terms of length of ECO/TDO and procedural issues in executing ECO/TDO. Members shared their experiences with the ECO process and described longstanding issues with getting "medical clearance" to obtain a TDO. Also discussed logistical challenges to ECO process such as the fact the clock starts the minute law enforcement detains the individual rather than from when they actually begin the evaluation process for the ECO. Travel time, coordination with CSB, and coordination with emergency rooms were all cited as factors which consume time during the process. CSB staff described for the group the clinical process involved in the ECO and the steps they must take to get a 2 hour extension to the ECO. Group discussed the pros and cons of each of the current proposals before the general assembly (i.e. ability to extend ECO + 2 hours, ECO = 8 hrs, ECO = up to 24 hours).
- *Ultimately, after much discussion, the group reached consensus that Emergency Custody Order period of detention should be extended to 8 hours. The group also agreed that whatever option is ultimately selected and whatever changes are made to Code, they should be enacted with a sunset clause with the need to re-enact the change in a couple years. In the interim, data needs to be collected on the outcomes and impact of the changes.*

### Transportation Issues

- Group discussed issues related to transportation including transportation during ECO process, during TDO process, and during civil commitment process. Group was provided an overview of historically how transportation has been handled along with recent changes to the Code of Virginia which allow for non-law enforcement transport. Questions regarding the qualifications of alternate transporters were discussed. The issue of having to be transported in handcuffs was also briefly discussed.
- *Ultimately the group agreed that the issue of transportation requires further study/discussion and will be taken on during a later workgroup meeting.*

### Crisis Intervention Teams (CIT)

- Group was provided with overview of CIT and was provided data about the current status of CIT in the Commonwealth. Information was shared about the data outcomes for CIT. Some members noted this was first time they had heard about CIT being in Virginia and encouraged better communication to the broader community about the existence and positive outcomes of this resource.
- It was noted that there are other groups in need of CIT like training including Emergency Room nurses/personnel who likely have limited training in dealing with individuals with mental illness. Other first responders also likely are in need of such training. Also discussed the type of training offered with an encouragement to ensure training includes topics related to trauma and its impact on individuals' behavior.
- ***Ultimately, after much discussion, the group agreed that expansion of CIT across the Commonwealth is needed. An analysis of the funding needs to accomplish this (expanding CIT) is needed. Additionally, an evaluation of currently funded programs should be undertaken to ensure current funding is sufficient for them to operate at full capacity. A caution was issued, however, that communities must be ready for CIT (i.e. have collaborative relationships between mental health & criminal justice, have CIT leadership, etc) and that you just can't drop a CIT Assessment Center into a community if they are not fully prepared.***

### **Jail Mental Health Treatment**

- Group members shared their experiences with regard to mental health treatment in jails. Discussed the challenges faced by having individuals with mental illness in jail and fact that some are there solely due to behaviors related to their illnesses. Discussed the fact that this group (persons with mental illness in jail) is not homogeneous but rather there are different sub-groups – thus complicating the discussion of mental health treatment as the needs for each group are somewhat different. Group also discussed the challenges faced in trying to get these individuals treatment either through community providers or through state hospitals. Finally, the group also discussed the challenges faced in linking these individuals to services upon release from jail due to lack of insurance, limited resources, etc.
- Group also had discussion about the limited options available to the judiciary with regard to alternate sentencing/ diversion. Group was provided some information about Mental Health Courts and their role in creating sentencing/ diversion alternatives. There was general consensus that exploring expanding the prevalence of mental health courts should be discussed at future meetings.
- Group discussed current proposal before the legislature to provide funding to jails to create mental health beds. There was some concern that this might supplant the need for inpatient psychiatric beds in state hospitals. There was also concern that building such beds might inadvertently lead to more individuals with mental illness ending up in jail as a means to get them treatment. There was some discussion about rather than having each jail having some capacity to provide treatment to individuals with mental illness, that there be larger, specialized facilities to address the needs of this group. ***Ultimately after much discussion, there was consensus to support the proposal for increased funding for jail mental health services as long as it was clearly defined what these services were, who the target population was, and the caveat that these beds not be viewed/used in lieu of inpatient psychiatric beds in state hospitals.***

The group concluded the meeting with the following topics needing further discussion (to include those topics identified above in need of further discussion):

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

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

***DATA and TECHNICAL INFRASTRUCTURE WORKGROUP***

***January 24, 2014***

*10 a.m. – 2 p.m.*

*Main Branch, Richmond Public Library*

***MEETING MINUTES***

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**Members Present**

James Agnew, Sheriff, County of Goochland.

Gail Burruss, Blue Ridge Behavioral Health

David Coe, Colonial Behavioral Health

Richard Edelman, Henrico Area Community Services

Lance Forsythe, Superintendent, Southside Regional Jail

Christine Hall, Poplar Springs Clinical Services

Cindy Koshatka, Region II Mental Health

Marissa Levine, VA Department of Health

Betty Long, VHHA

Michael Lundberg, VHI

Vicki Montgomery, Central State Hospital

Jake O'Shea, MD, VA College of Emergency Physicians

Bill Phipps, Magellan Behavioral Health

Scott Reiner, CSA for At-Risk Youth & Families (CSA)

Margaret Schultze, Department of Social Services

Anne Wilmoth, State Compensation Board

Eddie Macon, Asst. Exec. Secretary & Counsel, Supreme Court of Virginia, designee for Karl Hade, Virginia

Supreme Court, designee Edward Macon, Asst. Exec. Secretary & Counsel, Supreme Court of Virginia

**Staff Present**

Tammy Peacock, DBHDS

Bill O'Bier, DBHDS

Dee Keenan, DBHDS

Marc Dawkins, Virginia Department of Criminal Justice Services

Albert Stokes, Virginia Department of Criminal Justice Services

**Members Absent**

Kent Alford, MD Novant Health Prince William Medical Center

Cindy Frey, VCU Medical Center

Mark Kilgus, VA Tech Department of Psychiatry & Behavioral Health

Lucy Rotich, Bon Secours Behavioral Health – Maryview

**Others Present**

Secretary Bill Hazel, Health & Human Resources

Eddie Makins, VA Supreme Court

Workgroup member introductions were made.

As there was a planned demonstration of the Virginia Acute Psychiatric and CSB Bed Registry--- Secretary Hazel gave a background history of the project that highlighted some of the following facts:

- The Department of Behavioral Health and Developmental Services (DBHDS) has been working with the Virginia Hospital and Healthcare Association (VHHA), community services board representatives and Virginia Health Information (VHI) to develop a web-based psychiatric bed registry (PBR) to collect, aggregate, and display data on the availability of acute beds in public and private inpatient psychiatric facilities and residential crisis stabilization units (CSUs) of community services boards (CSBs). Hosted by VHI, the Virginia Acute Psychiatric and CSB Bed Registry project is on track for a planned state wide implementation
- The web-based bed registry is intended to provide descriptive information about each public and private inpatient psychiatric facility and residential crisis stabilization units to CSB emergency services providers and psychiatric hospitals that need immediate access to inpatient or residential crisis services for individuals.
- The data base will include information about the potential availability of beds at each facility.

The demonstration of the test psychiatric bed registry website included:

- Review of access and login process
- How facilities will update bed Census
- Searching for specific types of psychiatric beds
- Display of information on inpatient psychiatric facilities
- Saving search queries and capturing call and placement information

Workgroup members provided suggested ideas for improvements to the website to include

- building in short cuts to the system,
- a feature that pre-populates the field and remember user preferences,
- a field noting if and when hearings are held at the facility,
- possibly a comment field for the physician to make a note,
- a dashboard component that would display regions with all available beds.
- A review of other state registry models i.e. Kentucky, Pennsylvania

Questions about the website included---how the list of beds is sorting when it is displayed, whether queries should be attached to a specific patient, and enforcement of daily updates. DBHDS staff and Betty Long with VHHA will continue to monitor the regularity of updates. There was a discussion of the need for additional staff to provide oversight and data analysis to ensure optimal benefit of the website project.

One member noted that this tool will still not deal with the “magic black list” of individuals who have burned their bridges and individuals who are assaultive. Members acknowledged that legislation will not solve all the problems.

The charge of the committee as outlined by Acting Commissioner John Pezzoli was discussed and the specific items identified for the committee was reviewed.

The workgroup broadly discussed the ECO / TDO process with respect to technology and data to include the following issues and questions:

- Concerns about the current lengthy time for ECO/TDO----the question of on average how long does it currently take for individuals to “access and gain service from the current system”---do we have data to describe this now--what is the most efficient process----how standardized is the process statewide?
- emergency services data, what is the most efficient process
- Use of tele-psychiatry / tele-health---what are the current capabilities and needs for the future—is the amount appropriated enough?

- The utilization of tele-psychiatry for the ECO process and medical clearance---do all magistrates have access to video conferencing---can CSB access video conferencing in the prescreening process?
- There will be a need for a secure document management system----example current VICAP shared secure electronic documents.
- Can law enforcement have access to health data when dealing with individuals that may need some type of intervention----issues regarding individual civil rights were briefly discussed

The workgroup recommended the use of tele-psychiatry for crisis workers when law enforcement cannot take the individual to the hospital; the challenge of not being able to obtain medical clearance until the TDO is issued. The group widely discussed the implications and concerns about expanding the ECO process.

The workgroup discussed the challenges created due to the inability to share information between mental health and law enforcement. Recommendation was that there needed to be separate group to look at HIPAA and 42 CFR.

The group decided that while tele-psychiatry is important, it should not be looked at in isolation. It was decided that the group needed more information about how tele-health is being used throughout the Commonwealth. The group recognized that there are challenges to consider such as secure document management.

The Workgroup endorsed funding for expanding the capacity for utilization of tele-psychiatry. Sec. Hazel suggested the group view the \$1.1 million for expanding tele-psychiatry capacity as Phase one and report back on the benefits and utilization in one year.

The workgroup looked at the recommendations of Secretary Hazel and endorsed the following recommendations.

1. Clarify through education of CSBs and willing hospitals that preadmission screening can be carried out electronically pursuant to 37.2-809(B) and provide funding to assure that all CSBs have adequate and appropriate equipment to perform electronic screenings.
2. Consider removing the requirement that the facility of temporary detention be specified on the Temporary Detention Order (TDO)
  - *If so, need to look at the unintended consequences such as what would the legal status of the individual be.*
  - *The facility of temporary detention still needs to be communicated to the Magistrates.*
3. Conduct a study to assess the need statewide for secure assessment sites and establish these sites in communities across the state as indicated by the study.
  - *Study must include data and all decisions about how resources are used should be data driven decisions.*
4. Complete the implementation of the Electronic Bed Registry that is currently under development. Develop guidelines with the involvement of the CSBs and private hospitals to assure that the data base is maintained to reflect real time accuracy of available beds.
  - *Include recommendation for funding for staff to manage and monitor the Bed Registry.*

5. Clarify and assure more consistent and widespread awareness of the procedures for when the state hospital in the region should be contracted to secure a bed for the TDO and what prerequisites the CSB must meet before contacting the state hospital.
6. Assure continued and increased efforts to provide assistance to enable persons who no longer require inpatient services to be discharged from hospitals, thereby freeing up hospital resources for additional persons needing inpatient level of services.
  - *Identify opportunities to use technology and innovation to assist individuals to successfully transition from hospitals back into the community.*
7. Explore all avenues to increase and improve cooperation and mutual support through the partnership between CSBs, state hospitals, private hospitals, law enforcement and judicial officials.
  - *Formalize interagency relationships at the state and local level.*
  - *Look at integrating data across systems for purposes of operations, monitoring, and evaluation (aggregate and de-identified data).*
  - *Identify opportunities to use technology to assist individuals to navigate and move through the mental health system.*

The group discussed future meetings and decided that the following topics would each require a full meeting:

1. Initial meeting to get organized
2. Telehealth --Telepsychiatry---and use of Video technology
3. Utilization of data – exploring avenue for data sharing and/or integration across systems; look at the data that is currently available and where there are gaps
4. Best Practices – what are other states doing?
5. Innovation