

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

April 10, 2014

1 p.m. – 4 p.m.

Board Room 2, Virginia Department of Health Professions

Agenda

- 1:00 p.m. – 1:05 p.m. **Welcome and Approval of Minutes**
William A. Hazel Jr., MD, Secretary of Health and Human Resources
Brian Moran, Secretary of Public Safety
- 1:05 p.m. – 1:15 p.m. **Update on General Assembly legislative and budget action**
Suzanne Gore, Deputy Secretary, Health and Human Resources
- 1:15 p.m. – 1:25 p.m. **Review and Update of Revised Protocols, Online Psychiatric Bed Registry
and Other Actions**
*John Pezzoli, Acting Commissioner, Department of Behavioral Health and
Developmental Services*
- 1:25 p.m. – 2:10 p.m. **Presentation – Critical Incident Investigation, Bath County Virginia,
November 18, 2013**
Michael F.A. Morehart, State Inspector General
- 2:10 p.m. – 2:20 p.m. **Crisis Response Workgroup Recommendations**
*Cynthia McClaskey, Ph.D., Task Force Member, Southwestern Virginia Mental
Health Institute*
- 2:20 p.m. – 2:30 p.m. **Ongoing Treatment & Supports Workgroup Recommendations**
Greg Peters, Task Force Member, United Methodist Family Services
- 2:30 p.m. – 2:40 p.m. **Public Safety Workgroup Recommendations**
Victoria Cochran, Deputy Secretary, Public Safety
- 2:40 p.m. – 2:50 p.m. **Technical & Data Infrastructure Workgroup**
David Coe, Colonial Behavioral Health
- 2:50 p.m. – 3:45 p.m. **Discussion and Determination of Taskforce Recommendations**
- 3:45 p.m. – 3:55 p.m. **Public Comment**
- 3:55 p.m. – 4:00 p.m. **Next Steps**
- 4:00 p.m. **Adjourn**

Notes:

* *Members will be invited to take needed breaks as they choose during the course of the meeting.*

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

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

January 28, 2014

1 p.m. –4 p.m.

East Reading Room, Patrick Henry Building

*****DRAFT***MEETING MINUTES**

Members Present

Co-Chairs

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

The Honorable Brian Moran, Secretary of Public Safety

Members

The Honorable Cynthia Kinser (proxy), Chief Justice of Virginia Supreme Court

John Pezzoli, Acting Commissioner, Department of Behavioral Health and Developmental Services

Cindi Jones, Commissioner, Department of Medical Assistance Services

Margaret Schultze, Commissioner, Department of Social Services

Colonel Steven Flaherty, Superintendent, Virginia Department of State Police

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

John Venuti, Chief, VCU Police Department, Richmond

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

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

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

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

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

Jeffrey Lanham, Regional Magistrate Supervisor, 6th Magisterial Region

Daniel Holser, Chief Magistrate, 12th Judicial District

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

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

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

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

Anand Pandurangi, MD, VCU, Richmond

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

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

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

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

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

Teshana Henderson, CAO, NDUTIME Youth & Family Services, Richmond
Becky Sterling, Consumer Recovery Liaison, Middle Peninsula-Northern Neck CSB
Ben Shaw, Region 1 Coordinator, Virginia Wounded Warrior Program, RACSB, Virginia Dept. of Veterans Services, Fredericksburg
Rhonda VanLowe, Counsel, Rolls Royce North America, Fairfax
Tom Spurlock, Vice President, Art Tile, Inc., Roanoke

Staff Present

Jim Martinez, Director of Office of Mental Health Services, DBHDS
Janet Lung, Director of Office of Child and Family Services, DBHDS
Michael Shank, Director of Community Support, DBHDS
Meghan McGuire, Director of Communications, DBHDS
Maria Reppas, Deputy Director of Communications, DBHDS
Allyson Tysinger, Senior Assistant Attorney General

Members Absent

The Honorable Mark Herring, Attorney General of Virginia
The Honorable Emmett Hanger, Senate of Virginia
The Honorable Janet Howell, Senate of Virginia
The Honorable Rob Bell, Virginia House of Delegates
The Honorable Joseph Yost, Virginia House of Delegates
The Honorable Gabriel Morgan, Sheriff, City of Newport News

Welcome and Approval of Minutes

William A. Hazel Jr., MD, Secretary of Health and Human Resources
Brian Moran, Secretary of Public Safety

Secretary Hazel called the meeting to order. He and Secretary Moran both welcomed the task force members and the public. Lt. Governor Northam is expected to join the group later during the meeting. He asked John Pezzoli to give an overview of the agenda and handouts.

Presentation – Revised DBHDS policies and protocols for accessing state hospital beds within the ECO period

Jack Barber, M.D., DBHDS Medical Director

Dr. Barber reviewed the status of DBHDS' effort to develop Protocol Revisions to “Find a Bed” for an individual requiring a Temporary Detention Order. The protocol needs to be completely clear and helpful to the emergency services worker. The regions are all different, so the protocols need to take into consideration the circumstances of the region. He also reviewed the specific steps in the entire process from prescreening to location of a bed. The question was raised as to whether the Department has the authority to require the CSBs to develop a protocol. Acting Commissioner Pezzoli responded that it can be included in the performance contract which is revised annually.

(Handout provided)

Crisis Response Workgroup Recommendations

Cynthia McClaskey, Ph.D., Task Force Member, Southwestern Virginia Mental Health Institute

Dr. McClaskey reviewed the work of the Crisis Response Workgroup. The group emphasized that what works in urban areas doesn't necessarily work in rural areas, and noted issues of distance, funding, and other considerations. The workgroup supports with caution the electronic bed registry. The caution is that it is only as good as its latest update and doesn't replace the direct communications that will need to occur. Clinicians will still have to call and calling takes time. The group recommended separating issuance of the TDO from finding a bed. Legislation would be required to accomplish this. There is variability in practice about whether the prescriber must present in person before the magistrate, or whether this can be done by phone. Cautions were expressed about doing another study.

(Handout provided)

Ongoing Treatment & Supports Workgroup Recommendations

Michael O'Connor, Task Force Member, Henrico CSB

This workgroup was challenged by the broad charge of all ongoing treatment and supports across all populations. The workgroup supported the Governor's budget items, but also noted that even these would not be enough to truly improve the system. The group supported the extension to a 24-hour ECO because this is what is proposed in SB260. The group did not discuss the ECO time frame further because it was seen as the purview of the Crisis Response Workgroup.

(Handout provided)

Public Safety Workgroup Recommendations

Victoria Cochran, Deputy Secretary, Public Safety

Ms. Cochran summarized the discussion and recommendations of the Public Safety Workgroup. There were concerns about the time spent and associated cost of law enforcement personnel for extended ECO timeframes, especially if the person is not receiving care during that time. The group did recommend extension of the ECO period to 8 hours. Jail mental health services should not be used in lieu of state psychiatric hospitals.

(Handout provided)

Technical & Data Infrastructure Workgroup Recommendation

Betty Long, Virginia Hospital and Healthcare Association

Ms. Long reviewed the charge of the workgroup and noted that it was narrower than some of the others. They had a demonstration of the electronic bed registry. The group discussed the notion of separating the TDO from finding a bed but noted that there could be important process issues. There is very strong support for expansion of the secure assessment sites. Data could support decisions about where to place these. The group also considered the use of data in supporting people who have been discharged.

(Handout provided)

Suzanne Gore, Deputy Secretary of HHR

Ms. Gore reviewed Senator Barker's Omnibus bill Recommendations:

1. ECO 12-hour time period.
 - a. **One trip to magistrate to initiate ECO** – no trips for a time extension required.
 - b. **Clock begins:** CSB assessment and search for bed if TDO required.
 - c. **Hour 4:** If no local private bed located, the CSB calls the closest state psychiatric hospital.

- d. **Hour 8:** If no bed, the CSB calls the state Central Office – require a mandatory placement in a state psychiatric hospital.
 - e. **Hour 12:** ECO expires – hours 8-12 would be the “safety net time period” placement in a state hospital if no other bed is located.
2. TDO 72-hour maximum (currently 48-hour maximum). 24-hour minimum prior to a hearing.
 3. Expand Secure Assessment Centers (near hospital ERs), Drop-off Centers and Crisis Stabilization Units.
 4. Expand funding for CIT training for law enforcement.
 5. Expand access to telepsychiatry.
 6. Support enhanced data collection.
 7. Want to come back and review changes in 2 years.

DBHDS Acting Commissioner John Pezzoli was asked to identify major system priorities and mentioned moderate bed capacity increase, increase DAP, increase MH outpatient services, staff at CO to monitor and support and capital projects.

Discussion and Formulation of Initial Recommendations

The members discussed and commented on the proposals identified by the workgroups. Secretary Hazel asked for a motion that would reflect the consensus of the group and the group made the following recommendations:

The Taskforce recommended that the emergency custody order period should be 12 hours and include tiered levels of notification every four hours. Four hours after execution of the emergency custody order, if the CSB prescreener believes that the individual meets the commitment criteria and has not been able to locate a bed, the prescreener shall notify the state hospital serving the region. Eight hours after execution of the emergency custody order, if neither the CSB prescreener nor the state hospital serving the region has been able to locate a bed, the Department of Behavioral Health and Developmental Services Central Office shall be notified. DBHDS Central Office may assist in the search for a bed and as a safety net, the state hospital serving the region will ultimately be designated as the facility of temporary detention if a private bed cannot be located.

The Taskforce endorsed the Governor’s proposal to extend the period of temporary detention from the current 48 hours to 72 hours with a minimum period of 24 hours prior to a commitment hearing.

The Taskforce recommended that the law enforcement agency that executes the emergency custody order notify the applicable community services board upon execution.

The Taskforce endorsed the Governor's budget for new mental health funding but also agreed that the amount of funding was a step in the right direction, but not substantial enough to make a significant, positive impact on the system. More funding would need to be included in the future.

The Taskforce supported expanding secure assessment centers (drop-off centers) and crisis stabilization units for children and adults across the Commonwealth as the highest priorities for funding. These should be available across the lifespan and located on the same campus as emergency rooms. Stabilize people within a short time and move them back into the community.

The Taskforce supported expanding access to telepsychiatry and endorsed the increased use of telepsychiatry. The Taskforce noted that there may not be sufficient funding.

The Taskforce supported expanding funding for CIT training for law enforcement officers throughout the Commonwealth.

The Taskforce also recommended including a two year sunset clause on its recommendations to ensure that any new laws are meeting the needs of the Commonwealth.

Public Comment

No public comment was made at the meeting. Copies of public comments made on the webpage as of January 27 were provided in the Task Force member's packets.

Adjourn – the meeting adjourned at 3:45p.m.

Note:

** Materials provided to the task force members are available at www.dbhds.virginia.gov/MHSCRTTaskforce.htm*

Comments from the public may also be made through the same webpage.

2014 Legislative Changes to Virginia's Civil Commitment Laws

Allyson K. Tysinger

Office of the Attorney General

April 2014

Bed Registry

SB260/HB1232

- DBHDS shall develop and administer a web-based acute psychiatric bed registry to contain information about available acute beds in public and private inpatient psychiatric facilities and residential crisis stabilization units to facilitate identification and designation of facilities for temporary detention of individuals who meet the TDO criteria

Bed Registry

- Bed registry shall:
 - Include descriptive information for each inpatient psychiatric facility and residential crisis stabilization unit, including contact information
 - Provide real-time information about the number of beds available and for each bed
 - The type of patient that may be admitted
 - The level of security provided
 - Any other information to allow identification of appropriate facilities for temporary detention

Bed Registry

- Registry shall allow searches by:
 - CSBs
 - Inpatient psychiatric facilities
 - Residential crisis stabilization units
 - Health care providers working in an ER or other facility rendering emergency medical care

Bed Registry

- Who is required to participate in the bed registry?
 - State facilities
 - CSBs
 - Private inpatient providers licensed by DBHDS
- Participants must designate employees to submit information to the system and serve as a point of contact for requests for information

Emergency Custody

SB260/HB478

- ECO valid for a period not to exceed 8 hours from the time of execution
 - 8-hour period applies to paper ECOs and “paperless” ECOs
 - Old Law: 4 hours with possible 2-hour extension
 - Provision for extension has been removed
- 8 hours to execute an ECO from its issuance
 - Old law: 6 hours

Emergency Custody SB260

- If the individual is detained in a state facility at the expiration of the 8-hour period because a facility of temporary detention could not be identified, the CSB and the state facility may continue to attempt to identify an alternative facility for an additional 4 hours
 - Expires June 30, 2018
 - But see HB1172

Emergency Custody

SB260/HB478

- Law enforcement agency that executes the ECO shall notify the CSB responsible for conducting the evaluation as soon as practicable after taking the person into custody
 - Applies to paper ECOs and “paperless” ECOs

Emergency Custody SB260/HB478

- Any person taken into emergency custody shall be given a written summary of the emergency custody procedures and the statutory protections associated with those procedures

Determining the Facility of Temporary Detention SB260/HB293

- Upon receiving notification of the need for an evaluation, the CSB shall contact the state facility serving the area in which the CSB is located and notify it that the individual will be transported to it upon the issuance of a TDO if an alternative facility cannot be identified by the expiration of the 8 hour emergency custody period
- Upon completion of the evaluation, CSB shall provide information about the individual to the state facility to allow it to determine the services the individual will require on admission

Determining the Facility of Temporary Detention SB260/HB293

- Once notified, the state facility may conduct a search for an alternative facility
 - May contact another state facility if it is unable to provide temporary detention and appropriate care
- If state facility finds an alternative facility, it shall notify the CSB and the CSB shall designate the alternative facility on the preadmission screening report

Determining the Facility of Temporary Detention SB260/HB293

- A state facility shall not fail or refuse to admit an individual who meets the criteria for a TDO unless an alternative facility agrees to accept the individual
- An individual who meets the criteria for a TDO shall not be released

Determining the Facility of Temporary Detention SB260/HB293

- If a facility of temporary detention cannot be identified by the expiration of the 8-hour emergency custody period, the individual shall be detained in the state facility
- State facility shall be indicated on the TDO

Temporary Detention

HB1172-Change of facility

- CSB may change the facility of temporary detention and may designate an alternative facility at any point during the period of temporary detention
 - Must determine that the alternative facility is a more appropriate facility given the specific security, medical, or behavioral needs of the person
 - CSB must provide notice to the clerk of name and address of the alternative facility

Temporary Detention

HB1172-Change of facility

- If facility of temporary detention is changed, transportation is provided in accordance with § 37.2-810
 - If law enforcement or an alternative transportation provider has custody of the person when the change is made, individual shall be transported to alternative facility
 - If individual has been transported to initial TDO facility, CSB shall request the magistrate to enter an order specifying an alternative transportation provider or, if no alternative transportation provider, the local law enforcement agency where the person resides or is located if 50-mile rule is applicable

Temporary Detention – Transportation

HB323

- In determining the primary law enforcement agency to provide transportation, magistrate shall specify in the TDO the law enforcement agency of the jurisdiction where the person resides *or any other willing law enforcement agency that has agreed to provide transportation*

Temporary Detention

S260/HB478

- Person detained shall be given a written summary of the temporary detention procedures and the statutory protections associated with those procedures

Temporary Detention

SB260/HB574

- Commitment hearing shall be held within 72 hours of execution of the TDO
- If 72-hour period ends on a Saturday, Sunday, legal holiday, or day on which the court is lawfully closed, person may be detained until COB on the next business day when the court is open
 - Old Law: 48 hours

Commitment Hearing

SB260/SB439/HB574

- When judge informs the individual of his right to apply for voluntary admission and advises him that if he chooses to be voluntarily admitted he will be prohibited from possessing or purchasing a gun, the judge must now advise the individual that he will also be prohibited from transporting a gun.
 - Consistent with § 18.2-308.1:3

Orders – Filing with Clerk

SB576/HB743

- Judge or special justice shall file orders from a commitment hearing for involuntary admission, MOT, or voluntary admission after a TDO with the clerk as soon as practicable but no later than COB on the next business day following completion of the hearing

MOT

SB439/HB574

- CSB must acknowledge receipt of an MOT order to the clerk within 5 business days
- CSB shall acknowledge receipt of an order transferring jurisdiction of an MOT case within 5 business days

Minors

SB260/HB478

- ECO period increased to 8 hours (was 4)
 - Provision for extension removed
 - 8 hours to execute an ECO (was 6)
 - TDO period unchanged for minors (96 hours)
- Law enforcement agency that executes the ECO shall notify the CSB responsible for conducting the evaluation as soon as practicable after taking the person into custody.
 - Applies to paper and “paperless” ECOs

Minors

SB260/HB293

- Provisions for determining the facility of temporary detention are the same as for adults
 - State facility if an alternative facility is not identified before expiration of the ECO
- If the individual is detained in a state facility at the expiration of the 8 hour period because a facility of temporary detention could not be identified, the CSB and the state facility may continue to attempt to identify an alternative facility for an additional 4 hours
 - Expires June 30, 2018
 - HB1172 only applicable to adults

Annual Report

SB260/HB293

- DBHDS must submit an annual report on June 30 of each year to the Governor and Chairmen of House Appropriations and Senate Finance
 - Number of notifications of individuals in need of facility services by CSBs
 - Number of alternative facilities contacted by CSBs and state facilities
 - Number of temporary detentions provided by state facilities and alternative facilities, the lengths of stay, and the cost of the detentions

Task Force – LE Study

SB260/HB478

- Governor’s Task Force on Improving Mental Health Services and Crisis Response shall identify and examine issues related to the use of law enforcement in the involuntary admission process
 - Consider options to reduce the amount of resources needed to detain individuals during the ECO, including the amount of time spent transporting. Options shall include:
 - Developing crisis stabilization units in all regions
 - Contracting for retired officers to provide transportation
- Report of findings and recommendations to Governor and General Assembly by October 1, 2014

CSB Evaluators – Study SB261/HB1216

- DBHDS shall review the requirements related to qualifications, training, and oversight of individuals performing preadmission screening evaluations
- Make recommendations for increasing qualifications, training, and oversight
- Report findings to the Governor and General Assembly by December 1, 2014

Information Regarding Crisis Strategies HB1222

- Secretaries of Public Safety and HHR shall encourage the dissemination of information about specialized training in evidence-based strategies to prevent and minimize mental health crises. Strategies shall include:
 - CIT training
 - Mental Health First Aid
- Information disseminated to law enforcement, first responders, ER personnel, school personnel, and other interested parties

Joint Subcommittee to Study Mental Health Services (SJ47)

- 12 legislative members
- Review and coordinate with the work of the Governor's Task Force
- Review laws governing the provision of mental health services, including civil commitment laws
- Assess the systems of publicly funded mental health services (emergency, forensic, long-term, and services in jails and juvenile detention facilities)
- Identify gaps in services and types of facilities and programs needed
- Recommend statutory or regulatory changes to improve access to services, quality of services, and outcomes for individuals
- Interim report by December 1, 2015; final report by December 1, 2017

DBHDS

Virginia Department of
Behavioral Health and
Developmental Services

Department of Behavioral Health and Developmental Services Update on Protocols, Bed Registry and Other Items

Governor's Taskforce on Improving
Mental Health Services and Crisis Response
April 10, 2014

John Pezzoli
Acting Commissioner

Psychiatric Bed Registry

- Online bed registry launched March 3, 2014
- DBHDS' partners included Virginia Health Information (VHI), Virginia Hospital and Healthcare Association (VHHA) and community services boards.
- Provides pre-screeners with accurate, detailed information for bed availability in Virginia's public mental health hospitals, private hospitals and crisis stabilization units.
- Monitoring shows it is being updated at least daily by both state and private hospitals as required.

Outcome of bed search by geographic area and specific chosen facilities

VIRGINIA ACUTE PSYCHIATRIC AND CSB BED REGISTRY

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

Home

Search ▾

Searcher

Updaters ▾

Reports ▾

Help ▾

Log Out

Welcome, **Bill O'Bier**



During Phase 2 of the PBR Beta Search Testing, search results will be limited to your facility's individual bed census data unless you are a member of the beta test group.

SEARCH AVAILABLE PSYCHIATRIC BEDS

Search for Available Psychiatric Beds

Step 1: Select Region

- All Virginia
- Northwestern
- Northern
- Southwestern
- Central
- Eastern

View Map

- State Hosp
- CSU
- Hosp

Step 2: Select Facility

DBHDS
Bon Secours Richmond Community Hospital
Bon Secours St. Mary's Hospital
Central State Hospital
CJW Medical Center
John Randolph Medical Center
Piedmont Geriatric Hospital
Poplar Springs Hospital
Southern Virginia Regional Medical Center
Southside Regional Medical Center
VCU Health System

**You can select more than one facility by holding the ctrl key down*

Step 3: Bed Criteria

Select Age Category*

- Child
- Adolescent
- Adult
- Geriatric

Select Gender

- Male
- Female

Select Type

- Locked
- Open

*Age ranges vary by facility

Step 4: Hospital Criteria

- Accepts TDO

Special Payer Types Accepted

- Straight Medicaid
- FAMIS
- FAMIS PLUS
- Virginia Premier
- Healthkeepers Plus
- Southern Health/Carenet
- Optima
- Amerigroup
- LIPOS

Step 5:

Display Facilities With Available Beds

[View Search History](#)

Medical Screening and Medical Assessment

- Many medical illnesses can create or exacerbate psychiatric symptoms, and complicate clinical presentation.
- Medical screening and assessments help prevent someone from being sent to a treatment facility that cannot adequately manage an illness or condition, exposing the person and the system to the risk of an undiagnosed, undertreated or untreated condition.
- However, screenings and assessments can be difficult to accomplish in a timely, thorough manner in the emergency disposition of individuals with psychiatric disorders.
- DBHDS worked with system stakeholders to provide guidance materials for medical screenings and assessments. Protocol was adopted at all DBHDS facilities and all CSBs April 1, 2014.

The Medical Screening & Assessment Guidance Materials and Medical Capabilities Form can be found online at: [www.dbhds.virginia.gov/documents/140401MedicalScreeningGuidance%20\(2\).pdf](http://www.dbhds.virginia.gov/documents/140401MedicalScreeningGuidance%20(2).pdf)

Regional Admission Policies and Procedures

December 2013	DBHDS and CSBs reviewed regional practices
January 15, 2014	DBHDS issued guidance to all of Virginia's partnership planning regions to develop written policies and procedures for accessing the appropriate level of care during mental health emergency situations. 1) private hospitals to be contacted prior to using the state hospital and 2) assurance that state hospital will be called prior to expiration of an ECO.
March 15, 2014	Protocols were completed, reviewed by DBHDS and now being utilized.

Protocols can be viewed online at:

www.dbhds.virginia.gov/documents/2014RegionalProtocols.pdf

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

Issued by DBHDS, Jan. 15, 2014

Step 1

CSB prescreener evaluates person and determines if TDO is necessary

Step 2

CSB arranges for necessary medical screening according to clearly established regional hospital requirements

Step 3

Using bed registry and other contacts, CSB begins contacting private hospitals in the area according to regional protocols

Step 4

Before the ECO expiration if it is appearing likely that the community hospital bed search will not be successful, CSB alerts state hospital director (or designee)

Step 5

If state hospital director is satisfied protocols are complete and person's needs can be met (medical clearance) an admission is arranged at the primary hospital

Step 6

If the primary hospital does not have an appropriate bed the primary hospital director seeks a bed from sister state hospitals

Step 7

If bed can't be found in a reasonable time at another state hospital, the primary hospital director will contact the Asst Comm. for BH or designee to find a bed if available in the state hospital system

Step 8

If necessary Central Office will direct admission at a state hospital

Step 9

DBHDS staff will develop a processes to monitor and track outcomes with CSBs, private hospitals, state hospitals, the use of bed registry data, and to introduce continued quality improvement based on data and experience

Major Mental Health Efforts by DBHDS Behavioral Health Division

- Training to CSB, courts and other stakeholders on mental health law reform for the development and implementation of new laws
- Federal grants for diversion of juvenile offenders with behavioral health issues, homelessness, recovery-based services, and advance directives
- Interagency services plans for mental health, substance abuse, and children's services
- Expanding prevention programs, including Strengthening Families, Mental Health First Aid and Suicide Prevention
- Constructing a new, state of the art Western State Hospital
- Developing/implementing electronic health records
- Expanding of Virginia's Crisis Intervention Training programs
- Building children's MH crisis response and child psychiatry services
- New peer review inspections at state facilities



Commonwealth of Virginia *Office of Governor Terry McAuliffe*

EXECUTIVE ORDER NUMBER TWELVE (2014)

CONTINUING THE GOVERNOR'S TASK FORCE ON IMPROVING MENTAL HEALTH SERVICES AND CRISIS RESPONSE

Importance of the Taskforce

Virginians have experienced tremendous heartache as a result of mental health tragedies. It is incumbent upon us to reevaluate how we can better serve our fellow Virginians with mental health needs and examine ways to improve the system by filling in gaps in services and making impactful investments. Collaborative groups of experts, advocates, policy-makers and others have assessed certain aspects of the system and affected critical changes over the years. In particular, following the tragedy at Virginia Tech, Virginia's leaders drew upon work done by the Virginia Tech Review Panel and the Commission on Mental Health Law Reform to study and investigate the tragedy in order to strengthen the civil commitment process through legislation so that individuals with serious mental illness could receive needed help in a timely manner. The 2008 budget included an infusion of funds to build core community services such as emergency services, case management, and outpatient treatment. Unfortunately, many of these gains were lost as a result of the economic downturn. Last year, targeted investments were made to Virginia's mental health system upon recommendations from the Governor's Taskforce on School and Campus Safety.

While bolstering our ability to respond to mental health crises when they occur, we must continue to seek ways to intervene early and prevent crises from developing. Virginia has crisis prevention services in place, such as outpatient psychiatric consultation, suicide prevention, Program of Assertive Community Treatment (PACT) services, and rehabilitation services. These services are in high demand, and are not consistently available across the Commonwealth.

Virginia's mental health system has moved away from the days of overcrowded state mental institutions toward a community-based system for individuals to receive treatment in their homes and communities. However, the mental health system remains extremely complex and difficult to navigate for families seeking assistance and for workers within the system. Though state law helps guide the process, practices and services are locally developed. This system allows flexibility to implement the policies that work best for particular regions, though the protocols have not always been in writing and variations have existed across the Commonwealth.

The mental health system for emergency services is dependent upon cooperation and communication from a variety of partners, including community services boards, law enforcement, the judicial system and private hospitals. Effective collaboration among these many parties ensures the most favorable outcomes for people in crisis. While emergency mental health services work for most people, it is critical that the mental health safety net responds effectively to all individuals and families in crisis.

Since taking office, my administration and I have been committed to finding and supporting measures to assure the care and safety of persons suffering mental health crises along with their families, neighbors, and members of the community. Lawmakers acted quickly this session to make numerous changes to Virginia's mental health laws. Among the changes is extending the emergency custody order (ECO) period from a maximum of six to a total of eight possible hours. This change will give clinicians more time to locate an available psychiatric bed during the ECO period. Our legislators also extended the temporary detention order period from 48 to 72 hours to help ensure individuals have enough treatment time to stabilize prior to the court hearing which determines involuntary admission to a psychiatric hospital.

To help Virginia improve its mental health crisis response, the Department of Behavioral Health and Developmental Services (DBHDS) has taken steps since the beginning of 2014 to outline clear and specific statewide expectations for securing a private or a state psychiatric bed when an individual qualifies for a temporary detention order. In turn, partners across Virginia's seven DBHDS Partnership Planning Regions, including community services boards and state and private hospitals, have incorporated state guidance into tightened and clarified admission procedures for the regions' private and state psychiatric beds. In addition, in a collaborative effort among DBHDS, Virginia Health Information, the Virginia Hospital and Healthcare Association and the 40 local community services boards, Virginia launched an online psychiatric bed registry to help clinicians locate available beds in an emergency situation. While the changes that have been made in recent months have been critical, more solutions are needed to improve Virginia's complicated and chronically underfunded mental health system. Because the system is multifaceted, the solutions must be as well.

Through this Executive Order, I am calling on leaders in the mental health field, law enforcement communities, the judicial system, private hospitals, and individuals receiving mental health services, to seek and recommend solutions that will improve Virginia's mental health crisis services and help prevent crises from developing.

To accomplish this, in accordance with the authority vested in me by Article V of the Constitution of Virginia and under the laws of the Commonwealth, including but not limited to §§ 2.2-134 and 2.2-135 of the *Code of Virginia*, and subject to my continuing and ultimate authority and responsibility to act in such matters, I hereby continue the Governor's Task Force on Improving Mental Health Services and Crisis Response.

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

The Task Force's responsibilities shall include the following:

- Recommend refinements and clarifications of protocols and procedures for community services boards, state hospitals, law enforcement and receiving hospitals.
- Review for possible expansion the programs and services that assure prompt response to individuals in mental health crises and their families such as emergency services teams,

law enforcement crisis intervention teams (CIT), secure assessment centers, mobile crisis teams, crisis stabilization centers and mental health first aid.

- Examine extensions or adjustments to the emergency custody order and the temporary detention order period.
- Explore technological resources and capabilities, equipment, training and procedures to maximize the use of telepsychiatry.
- Examine the cooperation that exists among the courts, law enforcement and mental health systems in communities that have incorporated crisis intervention teams and cross systems mapping.
- Identify and examine the availability of and improvements to mental health resources for Virginia's veterans, service members, and their families and children.
- Assess state and private provider capacity for psychiatric inpatient care, the assessment process hospitals use to select which patients are appropriate for such care, and explore whether psychiatric bed registries and/or census management teams improve the process for locating beds.
- Review for possible expansion those services that will provide ongoing support for individuals with mental illness and reduce the frequency and intensity of mental health crises. These services may include rapid, consistent access to outpatient treatment and psychiatric services, as well as co-located primary care and behavioral health services, critical supportive services such as wrap-around stabilizing services, peer support services, PACT services, housing, employment and case management.
- Recommend how families and friends of a loved one facing a mental health crisis can improve the environment and safety of an individual in crisis.
- Examine the mental health workforce capacity and scope of practice and recommend any improvements to ensure an adequate mental health workforce.

Task Force Membership

- The Task Force shall be chaired by the Lieutenant Governor.

- The Task Force shall be co-chaired by the Secretaries of Health and Human Resources and
Public Safety and Homeland Security;

Membership shall include the following individuals or their designees:

- The Attorney General of Virginia;
- Secretary of Veterans and Defense Affairs;
- Chief Justice of the Supreme Court of Virginia;
- Commissioner of the Department of Behavioral Health and Developmental Services;
- Commissioner of the Department of Social Services;
- Director of the Department of Medical Assistance Services;
- Superintendent of the Virginia State Police;
- At least three community services board emergency services directors;
- At least three law enforcement officers, including at least one sheriff;
- At least two executive directors of community services boards;
- At least two magistrates;
- At least two private hospital emergency department physicians;
- At least two psychiatrists;
- At least one representative of a state mental health facility;
- At least two representatives from Virginia's private hospital systems;
- At least two individuals receiving mental health services;
- At least one member from a statewide veterans organization;
- At least two family members of individuals receiving services; and
- Two members of the House of Delegates and two members of the Senate of Virginia.

The Governor may appoint other members as he deems necessary.

Task Force Staffing and Funding

Necessary staff support for the Task Force's work during its existence shall be furnished by the Office of the Governor, and the Offices of the Secretary of Health and Human Resources and the

Secretary of Public Safety and Homeland Security, as well as other agencies and offices designated by the Governor. An estimated 750 hours of staff time will be required to support the work of the Task Force.

Necessary funding to support the Commission and its staff shall be provided from federal funds, private contributions, and state funds appropriated for the same purposes as the Task Force, as authorized by § 2.2-135 of the *Code of Virginia*, as well as any other private sources of funding that may be identified. Estimated direct costs for this Commission are \$5,000 per year.

The Task Force shall commence its work promptly and suggest legislative and budgetary proposals that will enable the implementation of identified recommendations. The Task Force shall make recommendations on an ongoing basis and shall provide a final report to the Governor no later than October 1, 2014. The Task Force shall issue such other reports and recommendations as necessary or as requested by the Governor.

Effective Date of the Executive Order

This Executive Order replaces Executive Order No. 68 (2013) issued on December 10, 2013, by Governor Robert F. McDonnell. This Executive Order shall be effective upon signing and, pursuant to §§ 2.2-134 and 2.2-135 of the *Code of Virginia*, shall remain in force and effect for one year from its signing unless amended or rescinded by further executive order.

Given under my hand and under the Seal of the Commonwealth of Virginia, this 8th day of April, 2014.

**Office of the State Inspector General's Address to the
Task Force on Improving Mental Health Services and Crisis Response**

The seal of the Office of the State Inspector General, Commonwealth of Virginia, is a circular emblem. It features a central shield with a plow and a sheaf of wheat, symbolizing industry and agriculture. The shield is set against a background of a rising sun. The outer ring of the seal contains the text "OFFICE OF THE STATE INSPECTOR GENERAL" at the top and "COMMONWEALTH OF VIRGINIA" at the bottom. The letters "OSIG" are prominently displayed in the center of the seal.

Critical Incident Investigation
Bath County, Virginia, November 18, 2013

Michael F.A. Morehart, State Inspector General

Phone: 804-625-3248 • Email: Michael.Morehart@osig.virginia.gov

Critical Incident Investigation

The Office of the State Inspector General's (OSIG) investigation of the critical incident in Bath County was made pursuant to its authority under the *Code of Virginia (Code)* [§ 2.2-309.1\(B\)\(1\)](#).

The investigation's goals and objectives included:

- Establishing a timeline of events.
- Identifying contributing factors.
- Providing the Commonwealth's psychiatric emergency response system with performance improvement recommendations.

The seal of the Office of the State Inspector General, Commonwealth of Virginia, is a circular emblem. It features a central shield with a plow and a sheaf of wheat, symbolizing agriculture. The shield is set against a background of a map of Virginia. The outer ring of the seal contains the text "OFFICE OF THE STATE INSPECTOR GENERAL" at the top and "COMMONWEALTH OF VIRGINIA" at the bottom.

Timeline Overview

Timeline Overview

11:23 a.m.

Upon the sworn testimony of the petitioner, an Alleghany County Magistrate issues an Emergency Custody Order (ECO) and faxes it to the Bath County Sheriff's Department for assignment and execution.

12:26 a.m.

A Bath County Sheriff's Deputy executes the ECO by taking the individual into custody and transporting the individual to BCH. The ECO commences when served and expires four hours later, at 4:26 p.m.

Timeline Overview

1:40 p.m.

The family member speaks with the Rockbridge Area Community Services (RACS) emergency services supervisor to report that an individual under an ECO is at BCH, and the emergency services supervisor assigns a community services board evaluator (CSB evaluator).

2:30 p.m.

An unknown individual, reportedly from BCH, calls the RACS asking when the CSB evaluator will arrive, which is the first reported contact between BCH and the RACS.

Timeline Overview

3:10 p.m.

The CSB evaluator arrives at BCH. The CSB evaluator initially meets with nursing staff, obtains medical clearance information, and discusses the individual's status with the attending emergency room physician.

4:01 p.m.

The CSB evaluator contacts the local magistrate to request a two-hour extension for the ECO, and at 4:07 p.m. the magistrate faxes authorization for a two-hour extension. The (extended) ECO will end at 6:26 p.m.

Timeline Overview

4:45 p.m.

The CSB evaluator informs the family member and the individual that further evaluation is recommended. The individual is offered the opportunity to accept treatment voluntarily, but the individual refuses. The CSB evaluator informs the individual and the family member that a TDO will be pursued.

6:26 p.m.

When the two-hour extension for the ECO expires, the Bath County Deputy Sheriff tells the individual the ECO has expired. The CSB evaluator reports requesting that the individual stay until a bed can be found, but the individual refuses.

6:35 p.m.

The individual and family member leave the BCH Emergency Department.

The seal of the Office of the State Inspector General, Commonwealth of Virginia, is a circular emblem. It features a central shield with a plow and a sheaf of wheat, symbolizing agriculture. The shield is set against a background of a landscape with a rising sun and a river. The outer ring of the seal contains the text "OFFICE OF THE STATE INSPECTOR GENERAL" at the top and "COMMONWEALTH OF VIRGINIA" at the bottom.

Issues and Recommendations

Issues and Recommendations

Issue No. 1

The DBHDS had not implemented the recommendations of Report No. 206-11, *OIG Review of Emergency Services: Individuals meeting statutory criteria for temporary detention not admitted to a psychiatric facility for further evaluation and treatment* dated February 28, 2012.

Issues and Recommendations

Recommendation No. 1a

Implementations currently in progress by DBHDS will be monitored by the OSIG.

Recommendation No. 1b

The OSIG suggests that the DBHDS revise its *Guidance for Developing Regional Admission Policy and Procedures* document to include advocacy organizations in its list of stakeholders and recommends that the DBHDS consider revising the document to include input from advocacy groups such as NAMI, VOCAL, SAARA, the Disability Law Center, MHAV, and others in the creation of policies and procedures for accessing care in the Commonwealth during psychiatric emergencies.

Issues and Recommendations

Issue No. 2

Web-Based Psychiatric Bed Registry. The OIG-BHDS noted in its 2012 Report No. 206-11 that:

...Emergency Services Directors reported that crisis clinicians are expected to contact all available private psychiatric hospital in their region, and often beyond, before contacting the state-operated facilities. This process often requires considerable time. Interviews with the ES Directors revealed that the establishment of a “real time” registry of available beds may substantially decrease the time needed to secure a bed; however, some were skeptical that the bed registry would mitigate the problems securing admission for the most challenging individuals. The Department continues to move forward with implementation of a statewide online psychiatric bed registry. This initiative theoretically promises to create a real time summary of the bed availability at private psychiatric hospitals around the state; however, the jury is still out as to whether the bed registry will actually reduce the average time required to locate an “appropriate bed” for the most challenging individuals.

The detailed timeline of events in Bath County on November 18, 2013 ... suggests that if a web-based psychiatric bed registry had been available, the CSB evaluator may have been able to use his time more effectively and connect with one of the facilities that later reported having available beds that afternoon.

Issues and Recommendations

Recommendation No. 2

Status—Complete.

The Virginia Acute Psychiatric and CSB Bed Registry was launched by DBHDS, Virginia Health Information, Virginia Hospital and Healthcare Association, and CSB representatives on March 4, 2014.

Issues and Recommendations

Issue No. 3

Coordination among CSBs, law enforcement, and assessment facilities. The travel times required in a rural area in Virginia and the absence of an established notification procedure that an ECO had been executed took up approximately two hours and 45 minutes of the ECO's time, and truncated the preadmission screening process from six hours to three hours and 15 minutes.

Issues and Recommendations

Recommendation No. 3

Guidelines or standards of practice should be established that ensure that CSB evaluators are notified immediately when an ECO is executed.

Issues and Recommendations

Issue No. 4

CSB Evaluator training, standards, and competency reviews. This review revealed that there were no specific local or statewide standards of practice governing the professional conduct of CSB evaluators, and that while there is an online module that must be completed by each CSB evaluator before they are certified by the DBHDS, there is no follow-up testing or recertification for the Commonwealth's hundreds of CSB evaluators. Additionally, there are no statewide protocols to guide the actions of preadmissions screeners or their supervisors when a person is about to be released who has been determined to meet the criteria for involuntary temporary detention.

Issues and Recommendations

Recommendation No. 4

The OSIG recommends that the DBHDS take the lead to create a workgroup to review and recommend standards of practice, training, and ongoing recertification requirements for the Commonwealth's CSB evaluators. At a minimum, the workgroup should consider:

- Periodic competency testing for re-certification.
- Options for peer review and consultation process.
- Performance indicators that would be of value in providing ongoing supervision.
- Creation of clearly defined protocols and guidance for CSB evaluators to follow when for whatever reason a person determined to meet TDO criteria is about to be released from custody.

Issues and Recommendations

Issue No. 5

Uncoupling the bed search and the clinical evaluation. ... the CSB evaluator spent little uninterrupted time with the individual of the ECO. CSB evaluators anecdotally reported that the term “bed brokers” describes too much of their current job. In large part, the focus on the search for a bed is driven by the requirement of *Code § 37.2-809* (E) that requires that the receiving facility be listed on the *Preadmission Screening Report* and the Temporary Detention Order.

Issues and Recommendations

Recommendation No. 5

Consideration be given to revising *Code* [§ 37.2-809](#) (E) to allow the *Preadmission Screening Report* to be completed and the resulting Temporary Detention Order to be executed without identifying the receiving facility. For example, the statute could be revised to indicate involuntary detention “in a location to be determined,” with provision that the venue determination would be made within 24 hours, or some period, following the execution of the TDO and the Temporary Detention Order amended accordingly.



Questions and Answers

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

Recommendations Crisis Response Workgroup

March 19, 2014

Summary of Workgroup Recommendations (3-5 total recommendations)

Priority Rank	Proposal Description
1	Set benchmarks for access to consistent psychiatric services in a timely manner (possible models used in other health care environments). Calculate the cost to accomplish across the Commonwealth. Improve access to telepsychiatry in underserved areas as a way to reduce wait times for individuals. Require access to a prescriber, if not a psychiatrist, for emergency service providers to reduce hospitalizations as a means to get medications.
2	Increase compensation for providing transportation, encourage and support increased use of alternative transportation providers such as family, friends, EMS, etc., and cover the uncompensated costs to police, This would also help ensure that individuals would not have to wait for long periods for transport. Development of an informational toolkit to help communities build collaborative relationships with law enforcement with information exchange while protecting the privacy of individuals.
3	Train providers on assisting individuals with all forms of advanced planning and how to keep the planning current. Train law enforcement and other providers to ask about any advanced planning and to utilize the advanced planning to minimize trauma during an individual's crisis.
4	Construct a reporting system for regions to provide to DBHDS regarding the use of the regional access to bed space protocols as a way to identify any challenges, barriers and successes on the actual protocols as a quality check to insure that the protocols are working. Also the reporting system should include how the dissemination of the protocols is taking place in each region with an emphasis on initial and ongoing information about the regional protocols including any updates to the protocols.
4	Total Ranked Proposals

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

Recommendations Ongoing Treatment and Supports Workgroup

March 19, 2014

Summary of Workgroup Recommendations (3-5 total recommendations)

Priority Rank	Proposal Description
1	<p><u>System Reinvention</u> Needs assessment is required to determine current capacity and gaps Pilots Community collaboration Integrated community system of care – public-private partnership Make the system more user-friendly for people across the lifespan Address the under-funded system Reinvestment of savings Address rising costs of services over time Health care coverage reform.</p>
2	<p><u>Implement What Works</u> Existing Best Practices, such as the following examples</p> <ul style="list-style-type: none"> • Crisis Intervention Teams • Peer to Peer • Mental Health First Aid • Programs of Assertive Community Treatment • Discharge Assistance Programs • Permanent supportive housing • Integrated primary care teams
3	<p><u>Establish a Standard and Efficient Single Point of Access</u> No wrong door Timely access to service Coordinate services needed by the person across agencies</p>
3	Total Ranked Proposals

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

Recommendations Public Safety Workgroup

March 19, 2014

Summary of Workgroup Recommendations (3-5 total recommendations)

Priority Rank	Proposal Description
1	Virginia needs to invest in readily available, full service mental health services to include prevention services.
2	Need to improve community awareness of behavioral health disorders and an education campaign instructing citizens how to access help. There needs to be a standardized pathway to access services.
3	Virginia needs to effect a paradigm shift away from having law enforcement be first responders for mental health issues. To achieve this goal, taskforce should commission a study on how other states address this issue to include how other states employ alternate transport (other than having law enforcement perform mental health transportation).
4	Virginia needs to invest in CIT programs (to include CIT Assessment Centers) so that every community in Virginia has a functional CIT program and Assessment Center.
5	Virginia needs to create a Center of Excellence for Behavioral Health Issues and should strive to be a model state for behavioral healthcare.
6	Each community should establish and employ best practices to enhance and improve communication between law enforcement and mental health with the goal of decreasing the amount of time individuals with mental health issues are in police custody.
6	Total Ranked Proposals

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

**Recommendations
Technical Infrastructure and Data Workgroup**

March 19, 2014

Summary of Workgroup Recommendations (3-5 total recommendations)

Priority Rank	Proposal Description
1	Look at existing data collected from CSBs and law enforcement related to TDOs, ECOs, including transportation and custody time and identify opportunities for better data sharing and integration.
2	Look at data from the Supreme Court on ECO/TDO activity. What is currently captured and how can it be used?
3	Complete an inventory of existing technology around the use of telehealth, telepsychiatry and use of video technology. Identify best practices currently in use and identify gaps.
4	Consider building data form as an addendum to the bed registry to identify basic data, focus on exceptions. Present challenges identified by the task force committee to stakeholder group being developed by DBHDS and request recommendations around use of the registry. Specifically, identify when the bed registry should be used as not every placement starts with a search. There must be uniformity in the data collection so the data is reliable.
4	Total Ranked Proposals

Note: The Workgroup identified the need to do a thorough review of existing data available and current best practices in order to minimize duplication of effort.

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

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

Received as of Thursday, April 10, 2014

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

Dear Taylor,

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

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

Here are our suggestions:

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

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

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

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

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

Sincerely,

Connie & Ray Maternick

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

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

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

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

Respectfully,

Brian

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

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

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

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

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

Missy Wernstrom
Charlottesville, Va

Sent from Windows Mail

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

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

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

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

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

Thank You
Paige Burton

Sent from my iPad

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

To: Task Force MH WorkGroup (DBHDS)

Subject: Experience Seeking Help

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

Shane Funk

From: Joy Loving

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

To: Task Force MH WorkGroup (DBHDS)

Subject: Public Comment for the MH Task Force

Ladies and Gentlemen of the Task Force,

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

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

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

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

Joy Loving
Grottoes VA

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

Committee Members,

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

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

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

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

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

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

Thank you for your time and your consideration.

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

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

Hello Task Force for Mental Health in Virginia,

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

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

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

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

Sincerely,

Mrs. Joan Lunsford

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

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

Betty Long
Vice President
Virginia Hospital & Healthcare Association

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

January 21, 2014

Background

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

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

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

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

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

VHHA Recommendations

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

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

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

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

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

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

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

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

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

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

Principles for Strengthening Virginia’s Mental Health System

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

- A high-functioning mental health system requires regular communication among the agencies and organizations involved in the system, both at the state and regional level.
 - Funding policies must be in alignment with the goals and expectations of the mental health system.
 - Private providers must be treated as partners by involving them in decisions that affect them, funding them fairly and holding them accountable for their results.
 - Achieving lasting and comprehensive improvements requires a long-term plan.
-

From: Simpkins, Melissa
Sent: Wednesday, January 22, 2014 8:14 AM
To: Task Force MH WorkGroup (DBHDS)
Subject: Public Comment for the MH Task Force

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

Melissa Simpkins

Dear Ms. Simpkins,

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

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

Warm regards,

Tracy Eppard
Legislative Aide

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

Senator R. Creigh Deeds,

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

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

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

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

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

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

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

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

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

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

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

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

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

12:01 – he is released.

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

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

Sincerely,

Melissa Simpkins

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

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

June Jenkins

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

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

To Members of the TaskForce Mental Health Group of Virginia:

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

Facts:

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

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

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

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

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

Issues:

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

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

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

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

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

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

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

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

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

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

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

Thank you.

Sincerely,

Les & Landra Skelly, RN

From: Mary Evans

Sent: Tuesday, January 28, 2014 6:12 PM

To: Task Force MH WorkGroup (DBHDS)

Cc: Walsh, Charles (DBHDS)

Subject: Doin' time for Mental Illness

To the Task Force Group:

It is imperative that we put the Jails out of business as far as mentally ill prisoners are concerned. The jail environment is not suitable to provide effective treatment for our Consumers (of mental health services).

A quiet, comfortable and safe environment is the setting required -- definitely not behind bars, to be therapeutic for recovery from an already anxiety ridden mental illness that caused their arrest in the first place. Pushing a few pills as prescribed on a daily schedule may look like treatment; however, I doubt the medication would have the desired effect in such a hostile environment,.

It is suggested that every effort be made to develop an effective JAIL DIVERSION Program to include: (1) In several localities, a well staffed Triage Center for examination and evaluation by professionally trained Staff, then depending on severity of the alleged offense, referral to a mental health Court by the Consumer's attorney - usually, I understand, a court appointed Public Defender. (2) Upon successful completion of the Program ordered by a Judge, the Trial would be waived.

I will try to learn in more detail development of jail diversion and would be glad to pass these along to the Task Force.

Sincerely,

Mary Evans
Mental Health Advocate Volunteer

From: Janie Harris
Sent: Thursday, January 30, 2014 8:39 AM
To: Task Force MH WorkGroup (DBHDS)
Subject: Seeking assistance from Governor's Task Force

Good Morning,

It has been recommended that I reach out to the governor's task force and share my story about my son and the trials and tribulations we have gone through since his diagnosis of a mental illness.

I truly thought last year we were on our way to assistance with drafting of proposed legislation regarding apprehension of a person court ordered to a psychiatric unit by the magistrate for stablization. There should be another alternative when a minor offense has been committed against a staff member besides incarceration.

From: senate district25
Sent: Thursday, January 16, 2014 8:21 PM
To: Brown-Harris, Janie B
Cc: Richard L Anderson; senate district29/Senate
Subject: Re: Legislation

Dear Ms. Brown-Harris,

Thank you for your email to Senator Deeds and all of the information you provided. We have received so many emails, letters and phone calls from families in crisis or with concerns about our mental health system. The overlap with our criminal justice system (and oftentimes for reasons that do not make sense) and the difficulties of parents with adult children have been two recurring themes. If you have not done so already, I hope you will share your son's story, and your story, with the Governor's Task Force on Mental Health Services and Crisis Response: <http://www.dbhds.virginia.gov/MHSCRTTaskforce.htm>.

I am copying your legislators on this email. Perhaps they may be able to get in touch with DBHDS on your behalf and inquire about whether there is a process for filing a complaint against the facility.

Warm regards,

Tracy Eppard
Legislative Aide

On Tue, Jan 14, 2014 at 11:42 AM, Brown-Harris, Janie B wrote:

Good Morning Senator Deeds,

So sorry to hear of the tragedy that occurred within your family. I have been reading articles in the Washington Post during the prior week regarding the mental health legislation that you have proposed. During the past year I tried to reach out to persons who might be able to assist me with drafting legislation on mental health. I have a son who has paranoid schizophrenia. He's currently in the Adult Detention Center (ADC), Manassas, VA. He was on probation but left the state without approval from the court. Now he's charged with contempt of court and no bond. (please review first attachment)

I would like to reach out to you to assist me with my request to draft proposed mental health legislation. I attempted this process July 2013 but my efforts fell short (please review second attachment). A magistrate judge in Prince William County issued an emergency custody order for my son October 2011. He was court ordered to Prince William Hospital Psychiatric and Addiction Unit for stabilization. While there he threw tea on a staff member they had him arrested and taken to the ADC. He was charged with an assault. After about two weeks he was released to me with on pre-trial and ordered for treatment with Prince William Community Service Board until his court date which was two weeks away. At the court appearance which was November 19, 2011 the court order for treatment wasn't even mentioned. Instead he was placed on probation and ordered to take classes for substance abuse. On December 7, 2011 he was charged with indecent exposure. He never received the stabilization treatment from the magistrate's court order due to the arrest from Prince William Hospital Psychiatric and Addiction Unit.

Please review first attachment written to the commonwealth who handled my son's bond hearing on December 20, 2013. The Commonwealth had Dan Manza with pre-trial to speak with my son at ADC before the New Year, but as always the efforts diminish. I spoke with Mrs. Intihar with pre-trial on January 10, 2014 but the attorney I hired said she has to provide him with more information regarding my son's case before he will be able to request another bond hearing.

Please review third attachment emailed to The American Association of People with Disabilities (AAPD), September 12, 2013. I was contacted by Mike Gray, attorney he state he was told to contact me by Jim Stewart. We spoke but only for him to informed me he couldn't discuss anything referencing my son since he wasn't a minor. I informed him he was missing he advised me when he returned to have him get in touch with him.

Trying to find someone to help me, assist me, or provide a helping hand has turn out to be a whirlwind. I have written, seen and spoken with so many people who are suppose to be there to help since 2011 when this arrest from the psychiatric unit occurred, but nothing thus far. I have truly thought a thousand times to just let it go but it not right and I can't let it go. We were seeking help through the emergency court order and what we got was an arrest. It's hard for me to live with it as the parent I regret the decision to contact the magistrate for help almost everyday, because what has it merited us - nothing but we are caught up in the judicial system.

My heartfelt sympathy to you and your family. Only individual's or family members living with people with a mental illness can identify with how the mental health system should be looked at more closely. I have come to realize that there's not even an attorney who wants to handle an arrest of an psychiatric patient from a mental institution. It's just taboo, hands off, everyone knows it's wrong but no one wants to deal with it. It probably happens often and nothing is being done to correct the situation. It's just logical that's the reason the people with mental health diagnosis is seeking stabilization or treatments and especially the individuals that are emergency court ordered by a magistrate are seeking help. Why would a staff member in a mental health facility have a patient arrested for a minor offense?

If you can provide any assistance please reach out to me.

Thank you,
Janie Harris (Mother of son diagnosed with paranoid schizophrenia)

--

Office of Senator R. Creigh Deeds

P.O. Box 396
Richmond, VA 23218

From: Annette Parker

Sent: Saturday, February 01, 2014 12:51 PM

To: Task Force MH WorkGroup (DBHDS)

Subject: Additional Funding for Mental Health Services Virginia Beach

It's imperative for individuals living with mental illness that funding for services be increased. Funding for therapeutic, medical, medication, transportation and housing services is crucial for these individuals. Mental Illness strikes many individuals down in their life path ***not because of any poor choices they've made.*** Many individuals are educated and were able to provide for themselves financially. Mental Illness has robbed them of self-sufficiency and independence. In many cases these people are fighting for mere existence. Additionally, trying to get disability benefits in many instances unsuccessfully resulting in the appeal process which can take years. How are these citizens suppose to survive? That's when they sometimes end up living on the streets. Impoverished, cold, no food, no warm home, no clean clothes, and no ability to earn an income because they've been dealt the hand of mental illness. So many want to work but can't hold jobs and have to live with the stigma. Many individuals suffering with mental illness did nothing to bring on their symptoms. Mental Health Diagnoses require constant monitoring because sometimes medications work and changes occur and different treatment modalities are required.

Please give careful consideration to this request.

Kindest Regards,

Annette Parker, Volunteer

NAMI IOOV Program Coordinator

Virginia Beach

From: B. Alexandra Kedrock

Sent: Sunday, February 02, 2014 4:06 PM

To: Task Force MH WorkGroup (DBHDS)

Cc: B. Alexandra Kedrock; Marylin Copeland; Sarah Fuller

Subject: mental health needs

Dear members of the Task force for mental health services,

I am delighted that you are focusing on improving services that will support the stabilization and life quality for those suffering with mental illness.

My 45 y.o. son was diagnosed with Schizophrenia 23 years ago. He follows his medication regimen quite diligently even as this has many times not helped him and sometimes has even been detrimental. Due to lack of support services available to him, he returns to the hospital at frequent intervals. Often after suffering greatly and putting himself in dangerous situations (walking for miles and getting lost).

I am attaching a recent letter that I sent to the Governor and Lt. Governor as well as others. This describes what I believe he (as well as others) would benefit from.

I would be happy to assist the task force in whatever way I can.

Sincerely,

Alexandra Kedrock

The Honorable Terry McAuliffe
Governor-elect of Virginia
1111 East Broad St.
Richmond, VA 23219

December 9, 2013

Dear Governor-elect McAuliffe,

This letter has a dual purpose:

1. To ask you for help and direction on where I can go to get the services that would benefit my son.
2. To delineate the inadequacy of mental health services and the inequity for patients ineligible for Medicaid assistance.

I am asking for your assistance in obtaining services that would benefit my 45 yr. old son who was diagnosed with Schizophrenia 23 years ago. With considerable diligence, he finished college with a math degree and over the past 23 years, he has attempted on numerous occasions to work. With the exacerbation of his symptoms, he is unable to sustain work. Due to his early employment, he currently receives SSDI in the amount of \$1100/month (to cover rent, child support payments, medical treatment, food, and utilities).

The amount of this payment makes him ineligible for MEDICAID. Without Medicaid, he is denied the support services he needs.

Currently, he is unable to care for his daily functioning without assistance. His ability for self-care is progressively deteriorating. At times, he doesn't eat, forgets to take his medications or takes too much. He is often disoriented and confused, is scared to leave his apartment and locks himself in, or on an impulse wanders the streets throughout the night. He gives any money he has to anyone who asks for it, which makes him a target in the neighborhood. His actions often draw negative attention to him and repeatedly put him at risk for harm or arrest.

He has frequent hospitalizations, each commitment a humiliating experience for him and expensive for Medicare. In the hospital he is given a new medication regimen, often without consulting his outpatient psychiatrist or me. When he states that he is neither suicidal nor homicidal, he is discharged to return home without support services provided. And it is not uncommon for him to be prescribed an ineffective medication, which results in a re-hospitalization.

These frequent hospitalizations and his living in fear are both unnecessary. His need is for a supervised group home or for active CSB support, including the Program of Assertive Community Treatment (PACT services). The CSB website describes PACT as follows:

“The three primary components of the PACT Program are: (1) Treatment, (2) Rehabilitation, and (3) Support Services. Services are provided seven days a week, including evenings and holidays. The individuals to be served by PACT have severe and persistent symptoms and impairments, not effectively remedied by other available treatments.”

My son is a clear candidate for PACT and he would greatly benefit from these services. ***These services, however, are only available to individuals with Medicaid which he is ineligible for due to the amount of his SSDI payment.***

It is incomprehensible that he can't receive the treatment he desperately needs because he doesn't have MEDICAID.

As a professional social worker, I have some understanding about how to seek services that many parents of adult children with Schizophrenia do not have and, all I run into are brick walls. As a mother, I implore you to help me find access to resources that would assist my son now.

I appreciate your help and guidance in finding a way to obtain the support services my son needs.

Sincerely,

B. Alexandra Kedrock, LCSW

From: Betsy Greer

Sent: Wednesday, February 05, 2014 2:02 PM

To: Task Force MH WorkGroup (DBHDS)

Subject: A comment

A comment on your deliberations as the Governor's Task Force responding to the Austin Deeds event:

The Task Force's first order of business should be to read all the previous reports on the Commonwealth's Mental Health system -- the 1968 study and report that set up the CSBs, the Hall Gartlan Commission of the mid-1990s and the Virginia Tech Task Force Study of 2008. (For good measure, also look at the President's Commission on Mental Health report of 2001 or 2002.)

If there is one theme that runs through all of them it is the state's reluctance to assume responsibility to fund community-based services, leaving local governments under-resourced to provide the care that is needed. Hall Gartlan Commission declared the level of services provided should not be a function of where the individual lives, but that is exactly what happens today in Virginia.

My suspicion -- unconfirmed -- is that the EDO for Austin Deeds expired because the CSB that covers that area had only one case manager to make the needed calls, and that one case manager got taken away from that task for another pressing one. Arlington can have two or three staff members on the telephone at one time looking for a bed.

Resources -- \$\$\$\$\$ -- is what is needed. \$38 million is nice, but even double that (\$76 million) would barely make a dent in what's required to bring community-based services up to the level needed for adequate care for those who struggle with mental illness.

Betsy Samuelson Greer
Arlington, VA

From: Jack Wall

Sent: Saturday, February 08, 2014 9:22 AM

To: Task Force MH WorkGroup (DBHDS)

Subject: Public Comment for the MH Task Force

Question: If the Commonwealth proceeds with the Marketplace solution to healthcare expansion instead of the strait Medicaid insurance expansion, will this coverage provide the full mental health coverage benefits that are a part of the Affordable Care Act provisions? One of the best things about the ACA is the expansion of covered mental health care. It is important to me that Virginia provide this level of service to all citizens. With standard ongoing mental health care coverage, we should be able to reduce some of the tragic problems that occur when a person with a long-term mh disability goes untreated because they cannot afford good preventive care.

Jack Wall, Director, Wall Residences, Inc.

PRIVACY/CONFIDENTIALITY NOTICE: This e-mail communication may contain private, confidential, or legally privileged information intended for the sole use of the designated and/or duly authorized recipient(s). If you are not the intended recipient or have received this communication in error, please notify the sender immediately by email and destroy all copies of this e-mail, including all attachments, without reading them or saving them to your computer or any attached storage device. If you are the intended recipient, you will need to secure the contents conforming to all applicable state and/or federal requirements related to the privacy and confidentiality of such information, including the HIPAA Privacy guidelines.

From: Buckley, Kathleen

Sent: Monday, February 10, 2014 4:09 PM

To: Task Force MH WorkGroup (DBHDS)
Subject: Public Comment for the MH Task Force

My name is Kathleen Buckley. I live at 14701 St. Germain Drive in Centreville, Virginia. Thank you for letting me submit my comments.

My brother has been battling schizophrenia for 30 years. In his twenties he went out of state and tried to commit suicide in North Carolina. He was in treatment for a couple of months there, then came home to Virginia to continue outpatient treatment. He has had at least two schizophrenic episodes where he, again, in my opinion should have been in an inpatient facility. Instead he just went back to the doctor and had his meds adjusted. He has not worked since 9/11/2001.

My brother lives with my widowed mom, who is 83, and I have to tell you I do not have confidence in the Virginia mental health system at all if he has another episode, especially whenever my mom passes away. I have actually been frightened for her a couple of times, although my brother insists he would never hurt her. I have been in a mental health help group for family members and I've heard every horror story from stressed parents who have been assaulted by their children, to battling with police because they are taken to jail instead of being checked into a facility, at least for 24 hours. Because I work in local government and have to respond to constituents who contact the office under every circumstance, I have also taken Mental Health First Aid instruction given by Fairfax County.

I implore you to pass this important bill. It is absolutely horrific what happened to Senator Deeds. Any help you can give families who deal with their loved ones in emergency crisis is truly a godsend. I actually work for a local official in Fairfax County, so he knows my feelings on this subject.

Thank you for whatever you can do.

Kathleen Buckley
Centreville, Virginia

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

From:
Sent: Monday, February 10, 2014 9:22 PM
To: Task Force MH WorkGroup (DBHDS)
Subject: Public Comment for the MH Task Force

I am a 60 year old female who has sought effective mental health resources for the past 8 years. I have tried 6 anti depressants , 5 psychologists , PCP , and a pyschirtrist . I have taken advantage of Employee assistance mental health counseling for 2 years and after all of the above. I am still depressed, suffer anxiety ., panic attacks & can not afford the ridiculous co pays associated with visits . I would be honored to volunteer and/or participate in sharing my frustrations in a group settingThere must be definitive answers for those suffering depression...work related stress & anxiety issues . The mental health system is "broken"..I can not give up.. I am single And must continue to

From: Amy Cannava
Sent: Tuesday, March 04, 2014 4:12 PM
To: Task Force MH WorkGroup (DBHDS)
Subject: Public Comment for the MH Task Force

I wanted to applaud you for taking the initiative to start a long-overdue discussion on mental health and public safety in the Commonwealth. I also commend you for seeking the input of Dr. Sandy Ward of William & Mary's School Psychology program.

Given the fact that schools are often the first point of contact for families, the first to recognize mental health needs in students, and the first to attempt to coordinate services through external providers, wouldn't it be prudent to have school-based mental health practitioners (school psychologists, counselors, and social workers) providing commentary for the task force as well?

Thanks so much for your consideration,

Amy

Amy R. Cannava, Ed.S, NCSP
Lead School Psychologist
Loudoun County Public Schools
Diagnostic & Prevention Services
(571) 252-1013

Confidentiality/Privacy Notice-The documents included in this transmission may contain information that is confidential and/or legally privileged. If you are not the intended recipient, or the employee or agent responsible for delivering the information to the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the content of these documents is strictly prohibited. If you have received this document in error, please notify the sender immediately to arrange for return or destruction of these documents.

From: Diana Stinson
Sent: Tuesday, March 25, 2014 3:58 PM
To: Reppas, Maria (DBHDS)
Subject: RE: Public Comment for the MH Task Force

Dear Maria Reppas:

I need to let you know that my sons name is Dwayne Hicks and if there is anything anyone could do to help him get out of the mental hospital – we would be most grateful. Bear in mind that although he misses his children desperately, he is compliant and has resorted to the fact that there is no way out - except to go through the steps. Therefore he busies himself with groups and makes objects in ceramics class. He is brilliant and very creative. It is such a waste to keep him locked up and away from his family. However, I am the one that continually request his release. I do not want him to become dependent on the system as some become so accustomed to institutionalization that they cannot function in the community. He says whenever he is released he will be fine and there is nothing anybody can do except wait.

Please note that Dwayne does not know I am making this request or writing to about his circumstances; if he did he might object to my interference.

Also, I want to include the following link to [Pete Easley's blog](#). He is a well-known author and has first-hand experience as a parent of a son also has bipolar disorder. His articles and books provide an insight into the mental health system as well as the justice system that houses many mentally ill individuals in America. He has visited the jails, correctional centers and mental hospitals. He also speaks out and advocates for the mentally ill.

I agree with Pete Earley, and know that families who have loved ones with mental illnesses are ignored by the systems put in place to help and assist when there is nowhere else to turn. My experience with the madness spans over more than one generation. My father, who served in Korea during the Korean Conflict, suffered from post-traumatic stress syndrome. He was mostly mistreated by the authorities because of his condition – and our family was given very little help his illness before he passed away in 1999. He just drifted in and out of Emergency Rooms and Veterans hospitals most of his life. Our whole family felt the devastation of a man that couldn't manage his emotions and behavior.

I didn't mean to keep writing so much. Again, thank you for your time and efforts!

Sincerely,

Diana Stinson

From: Diana Stinson
Sent: Saturday, March 22, 2014 11:12 PM
To: Task Force MH WorkGroup (DBHDS)
Subject: Public Comment for the MH Task Force

Dear Task Force on Mental Health Reform:

My son is a disabled mentally ill individual who was denied crisis intervention services while going through a nervous breakdown/bipolar manic episode. There was no help for him because he was not violent and was not a danger to himself or others. Since he did not meet criteria to receive help – he wandered around aimlessly in a psychotic state for over a week. His live in girlfriend made him leave, he walked down the road and into a basement of a strangers home. He sat there with the light on until he was discovered. The police were called and he was arrested. They documented that he was he was irrational and “was going to save the world”. He was taken to jail and the police officer did not call anyone from the local CSB/Crisis Intervention Services. Instead, the officer called the commonwealth attorney – who told them to lock him up. My son stayed in jail for 2 months without medication. He was incarcerated without bond for a total of six months and charged with “Entering a home with the intention of A&B”. His children (ages 2 and 5) went to visit him at the jail every Sunday. I called the jail continuously to ask them to contact the a mental health worker to evaluate him and provide medication. They kept telling me that someone would evaluate him and treat him, but no one did. He was suffering from malnutrition and was very thin. He stayed sick and I feared for his life before he was finally transferred to the mental hospital 2 months later. He was hallucinating and thought everyone was out to get him. He was receiving messages from the TV and the food was so bad – he became very frail and sickly. After the evaluations they sent him back to jail – he had to sleep on the floor and was kept in solitary confinement most of the time.

There are lot more details and I have wrote and contacted every mental health agency and Politian across the state of Virginia and in Washington DC. Yet he remains involuntarily committed. He has been stabilized on lithium for a very long time and is compliant at the mental hospital. It is not fair to his children, our family or him.

Sincerely,

Diana Stinson

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

DRAFT: Taskforce/Workgroup Meeting Schedule

Date	Meeting
January 7	Full Taskforce Meeting 1
January 24	Workgroup Meetings 1
January 28	Full Taskforce Meeting 2
March 19	Workgroup Meetings 2
April 10	Full Taskforce Meeting 3
May TBD	Workgroup Meetings 3
June TBD	Full Taskforce Meeting 4
July TBD	Workgroup Meetings 4
August TBD*	Full Taskforce Meeting 5
September/October 31	Write/Approve Report

**Leaves time for emergency meeting of full TF in late August if need be.*

No simple mental health system answers

OP/Ed by John Pezzoli, for the Daily Press

April 7, 2014

The debate about mental health and the challenges facing Virginia's mental health system was recently renewed when a state senator lost his beloved son to suicide. It was a terrible tragedy, and we stand with him and many others who have experienced such heartache, in calling for change. The Office of the State Inspector General's report on the tragedy shows there was no one person or procedure to blame. Multiple processes did not work as they should have. Assigning singular blame is much easier, but the facts reveal a far more complicated challenge and no quick fixes for a system serving tens of thousands of Virginians.

The Governor, Health and Human Resources Secretary William Hazel and the General Assembly responded swiftly to the tragedy. The secretary developed critical recommendations for system improvements. Though work on the state budget is still underway, there are many proposals that would increase service capacity. Lawmakers extended the emergency custody order period from six to eight hours to give more time to locate an available bed for persons in crisis. They also lengthened the temporary detention period from 48 to 72 hours so individuals have enough treatment time to stabilize.

This winter, the Department of Behavioral Health and Developmental Services (DBHDS) required Virginia's community services boards to revise existing policies and develop clear written protocols to access care during mental health emergencies, including ensuring state hospitals are available as a last resort. Also, Virginia launched an online psychiatric bed registry to help locate beds in emergencies. While these actions alone cannot prevent a tragedy, they are valuable emergency response tools.

There is much more to be done, both to reform our emergency response system and to improve mental health services as a whole. DBHDS and our partners are making improvements in many key areas, including increasing prevention programs such as Mental Health First Aid and suicide prevention, expanding child psychiatry and outpatient treatment programs, diverting individuals from the criminal justice system, and securing and implementing federal grants for homelessness services and other supports.

These are important steps to improve our system and make it more responsive to the people we serve, but there is no question that more must be done to ensure that every Virginian has the resources they need to keep themselves and others healthy and safe. Where should we go from here? Very broadly, we should:

- Expand services that support people with mental illness and prevent psychiatric crises. When we intervene earlier, fewer crises arise, which reduces pressure on the emergency response system. Preventive services include medication management, suicide prevention, housing and employment programs, case management and Programs for Assertive Community Treatment, which reach out to individuals who may need additional support with their treatment plans.
- Improve Access to Services. Virginia lacks the capacity to provide all mental health services in all communities. Upcoming General Assembly studies and the Governor's Task force on Improving Mental Health Services may examine what services should be available everywhere. How many crisis stabilization units are needed? How many secure assessment centers are needed where law enforcement officers can take an individual experiencing a mental health crisis for immediate care and the officer can get back on the road? Also, many adults forgo getting needed mental health care because they lack funding or insurance, an issue that could be addressed in closing the health care coverage gap by expanding Medicaid in Virginia.
- Focus on Individuals and Their Recovery. People tend to be more involved in their care when encouraged to make informed choices - from what medication works best to establishing mental health advance directives. Peer support groups are extremely effective in infusing these principles and practices.

Reform involves a multitude of stakeholders, such as lawmakers, mental health professionals, the criminal justice system and advocates. It will take attention for years, not months, to make enduring improvements to the system. We are committed to bringing positive changes to Virginia's public mental health system so it responds immediately to all individuals and families who need help.

Pezzoli serves as Virginia's Acting Commissioner for DBHDS.

Copyright © 2014, [Newport News, Va., Daily Press](#)