

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

June 16, 2014

12 p.m. – 3 p.m.

Board Room 2, Perimeter Center

Agenda

12:00 p.m. – 12:10 p.m.	Welcome and Approval of Minutes <i>Ralph Northam, Lieutenant Governor</i>
12:10 p.m. – 12:25 p.m.	Crisis Response Workgroup Recommendations
12:25 p.m. – 12:40 p.m.	Ongoing Treatment & Supports Workgroup Recommendations
12:40 p.m. – 12:55 p.m.	Public Safety Workgroup Recommendations
2:55 p.m. – 1:10 p.m.	Technical & Data Infrastructure Workgroup
1:10 p.m. – 1:25 p.m.	Break
1:25 p.m. – 2:40 p.m.	Discussion and Determination of Taskforce Recommendations
2:40 p.m. – 2:50 p.m.	Public Comment
2:50 p.m. – 3:00 p.m.	Next Steps
3:00 p.m.	Adjourn

Notes:

* *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

April 10, 2014

1 p.m. – 4 p.m.

Board Room 2, Virginia Department of Health Professions

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

Members Present

Chair

The Honorable Ralph Northam, Lieutenant Governor of Virginia

Co-Chairs

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

The Honorable Brian Moran, Secretary of Public Safety

Members

The Honorable Mark Herring, Attorney General of Virginia

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

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
The Honorable Emmett Hanger, 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

Staff Present

Suzanne Gore, Deputy Secretary, Health and Human Resources
Victoria Cochran, Deputy Secretary, Public Safety
Drew Molloy, Chief Deputy Director, Department of Criminal Justice Services
Jim Martinez, Director of Office of Mental Health Services, DBHDS
Janet Lung, Director of Office of Child and Family Services, DBHDS
Mellie Randall, Director of Office Substance Abuse Services, DBHDS
Michael Shank, Director of Community Support, Office of Mental Health Services, DBHDS
Maria Reppas, Deputy Director of Communications, DBHDS

Members Absent

The Honorable Cynthia Kinser, Chief Justice of Virginia Supreme Court
The Honorable Janet Howell, Senate of Virginia

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. He introduced Lt. Governor Northam who stressed the critical importance of the Task Force's work. He also introduced Attorney General Mark Herring.

Secretary Moran thanked everyone for attending the meeting in spite of all of the ongoing work they are doing every day. He noted that the issues are not short-term and will require long-term attention. Executive Order 12 has been signed and has continued the work of the Task Force.

The minutes were accepted and approved without objection.

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

Michael F.A. Morehart, State Inspector General

Mr. Morehart introduced members of his staff in attendance. His presentation followed the handout provided.

Key points:

He noted that a number of issues covered in his report have to do with a specific critical incident; others have to do with broader systemic issues. Regarding Recommendation 3, about CSB evaluators being notified immediately when an ECO is issued, it was noted that legislation has been passed to address this.

Discussion following the presentation:

There was discussion about who contacts the CSB, and that this happens differently in different localities. It was recommended that this practice be standardized on a statewide basis. In their interviews with the OIG, CSB staff used the term "bed brokers" to describe their role. Mr. Morehart stated that there was no interference with their investigation. Regarding why it took until March to get the report out, Mr. Morehart stated there were many interviews, a review of telephone

records, complicated micro/macro issues, and the need to verify facts. Complying with standards, subject to review by peers takes a couple of weeks. All together this takes time. There was a technical amendment to the report, hardcopies of which were handed out. (Handout provided)

Update on General Assembly Legislative and Budget Action

Suzanne Gore, Deputy Secretary, Health and Human Resources

Suzanne Gore provided an update on the following legislative initiatives:

- Budget – no agreement yet.
- SB260 – signed by Governor
- Psychiatric Bed Registry – in operation
- ECOs – law enforcement must notify the CSBs soon as practicable after execution of an ECO. ECO period changed from 4 hours to 8 hours total. Individual must receive written information about the ECO process.
- TDOs – If temporary detention is needed, state psychiatric hospitals are the facility of last resort and are required to take a person for whom no other bed can be found. CSB can change the TDO facility during the TDO period. Individual must receive written information about the TDO process. TDO period is increased from 48 to 72 hours maximum.
- Minors – most changes also affect minors, except the extension of the TDO period. The TDO period for minors was already 96 hours.

Delegate Bell and Senator Hanger also summarized General Assembly actions. The goal was to reduce the number of unexecuted TDOs, assure notification, and assure state hospital as facility of last resort.

Review and Update of Revised Protocols, Online Psychiatric Bed Registry and Other Actions

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

Mr. Pezzoli stated that the changes recommended in the OIG report can be implemented.

The bed registry is implemented and has received 4,185 queries since March 3. It is helpful to emergency services workers, but phone calls are still required.

Protocols were available, but needed improvement. Many felt that search for a bed should be decoupled from the prescreening assessment of need for hospitalization. Further discussion and legislation may be needed to address this.

There has been a recent surge of admissions since the incident. It is yet to be seen whether this is a temporary surge, or a long term challenge. The full implementation of the protocols was March 15.

Questions/discussion:

For medically challenged and geriatric patients, and primary substance use disorder patients who are in withdrawal and needing detox, it was strongly recommended that the state enter into formal partnerships with private hospitals.

(Handout provided)

Crisis Response Workgroup Recommendations

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

Legislative issues -

Service expansion to keep individuals out of crisis is also needed. Telepsychiatry should be further developed to expand the reach of and access to psychiatrists. This relates to the question of whether there are enough psychiatrists to staff all of these services. Medical issues – especially of geriatric patients – need to be addressed. Legislation was recommended to streamline the process by allowing ER physicians to perform preadmission screenings for TDOs. It was noted that CSB emergency services workers have the ability and knowledge to divert individuals to community services that ER physicians may not have. The workgroup was asked to continue to discuss this issue.

(Handout provided)

Ongoing Treatment & Supports Workgroup Recommendations

Greg Peters, Task Force Member, United Methodist Family Services

Mr. Peters acknowledged that this workgroup's area is very broad. He reviewed the three recommendations detailed on the handout. Further, he noted a fourth area that was discussed - the possibility of a Special Advisor. In addition, the group plans to discuss and develop guiding principles for system reinvention at its next meeting. It was recommended that there may be regulatory barriers to integrated health care that the group should consider.

(Handout provided)

Public Safety Workgroup Recommendations

Victoria Cochran, Deputy Secretary, Public Safety

This group's discussions echoed many of the same topics of interest as the other workgroups. Mrs. Cochran reviewed the recommendations detailed in the handout. A correction was noted in the handout. Recommendation #5 should read: "Virginia needs to create a Center of Excellence for Criminal Justice and Behavioral Health."

(Handout provided)

Technical & Data Infrastructure Workgroup Recommendations

David Coe, Colonial Behavioral Health

Mr. Coe reviewed the workgroup's four recommendations with a focus on using and integrating existing data in a more comprehensive way.

(Handout provided)

Public Comment – Lt. Governor Northam invited public comment at this time, but there was none.

Adjourn

The meeting adjourned at 3:15 pm

Note:

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

Recommendations Crisis Response Workgroup

May 21, 2014

Priority Rank	Proposal Description
1	Improve access to consistent psychiatric services in a timely manner, using a benchmark standard, as exists in other health care, and make resources available to accomplish this goal. At a minimum, emergency service providers statewide should have access to a prescriber, if not a psychiatrist, to reduce the use of hospitalization as the means to access medication. <i>(This recommendation is from March 19, Priority 1. Listed under Item 8, EO 12 "Workplan" document)</i>
2	Currently, there appears to be a need for more psychiatric beds in some areas, but the COPN process can prevent providers from opening more beds in these areas. The Workgroup recommends that the COPN process be refined so that it more effectively addresses state needs, and incentivizes providers to respond to state needs, particularly specialized services for complex or challenging cases. <i>(New, addresses Item 9 on EO 12 "Workplan" document)</i>
3	The Workgroup recommends that legislation be developed and enacted that (a) authorizes sharing of PHI between CSBs, LEAs, health care entities and providers, and families and guardians about individuals who are believed to meet the criteria for temporary detention (whether or not they are in custody or ultimately detained) and (b) contains a "safe harbor" provision for practitioners and law enforcement officers who make such disclosures act in good faith. Workgroup also recommends that DBHDS develop a disclosure "toolkit" for practitioners and law enforcement that can support effective, consistent understanding of disclosure and information sharing in the emergency context. <i>(New, addresses Item 1 on EO12 "Workplan" document.)</i>
4	The Workgroup recommends increasing compensation for transportation, to encourage and support increased use of alternative transportation providers such as family, friends, EMS, etc., and to cover the uncompensated costs of transportation to police. Also, DBHDS should develop an informational toolkit to help communities build collaborative relationships between behavioral health emergency services providers and law enforcement, including information exchange while protecting privacy of individuals. <i>(Recommendation is from March 19, Priority 2A and 2B. Listed under Item 6, EO 12 "Workplan" document)</i>
5	Improve coordination between private hospitals and VA hospitals, and support crisis response clinicians to collaborate with veterans to meet their needs by (a) establishing a "point person" at each CSB to coordinate between VA and CSB, (b) increasing financial support to the VWWP, and (c) continuing to educate the public and CSBs about the needs of veterans and military families. <i>(New, addresses Item 2 on EO12 "Workplan" document.)</i>
5	Total Ranked Proposals

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

May 21, 2014

Priority Rank	Proposal Description
1	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. Investment needs to include ongoing funding for CIT training, CIT coordinator(s), and related expenses associated with operating a CIT program. In addition, DBHDS/DCJS (and others) should work to develop a CIT like training curriculum for jail personnel to enhance mental health services in jails.
2	Virginia needs to effect a paradigm shift away from having law enforcement be primary transporters for mental health issues (from ECO to TDO). Virginia should develop a mechanism whereby alternative transportation (via ambulance, EMS, etc) is available in all communities. Recommendation is that both law enforcement and CSB ES clinician make recommendations and that Magistrate would determine whether individual should be transported by law enforcement or could safely be transported via alternative transportation. While the Code does currently allow for alternative transportation, it is restricted to occasions when individual is incapacitated and additionally there is no funding mechanism to support alternative transportation. Virginia would need to invest in funding this service but would also need to ensure transportation providers are trained/ qualified. Code would also need to give transportation providers the authority to detain individuals and the Commonwealth would need to address liability issues.
3	Virginia needs to create a Center of Excellence for Behavioral Health/ Criminal Justice Issues and should strive to be a model state for forensic behavioral healthcare. Each community should be required to establish a position/committee/group to ensure best practices are actually implemented and analyze instances when programs do not work as intended. Virginia also needs a statewide oversight system to make sure communities are engaged in oversight review and the state should tie funding to a community demonstrating they are in fact performing oversight review.
4	Virginia needs to identify & examine the availability of and improvements to mental health resources for Virginia's veterans, service members, and their family & children. There needs to be greater cooperation between Virginia service providers and the VA system and a streamlining of the referral process. Enhancement of services should include better linkages for Veteran's who are incarcerated to resources in the community. Virginia should investigate the feasibility/ utility of developing Veteran's Courts/ dockets.
4	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 and Data Infrastructure Workgroup

May 21, 2014

Priority Rank	Proposal Description
1	Explore technological resources: Develop a single consistent statewide process for data and oversight structure to maximize the use of tele-psychiatry/video-technology. Bring together a smaller workgroup to work with existing expertise in Virginia to develop an emergency tele-psychiatry/tele-health model that will connect law enforcement, behavioral health, magistrates, veterans services and develop practice guidelines. After viewing several presentations the group identified models in Virginia and Texas to look into in more depth.
2	Mental Health Workforce Capacity- Look at limitations to scope of practice issues that could impact use of tele-health, including licensing and credentialing requirements. Look at use of specialty courts for behavioral health and veterans as a means to look at how recipients get involved in and agree to services to minimize entry at crisis levels of care.
3	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 would be the lead agency for this effort.
4	Examine adjustments to ECO/TDO- Enable first responders access to the TDO database already in VCIN. Fully utilize the data reporting capacity of the bed registry and add data fields as necessary to automate data collection to better understand where the gaps or pressure points are.
5	Resources for families- Look at mechanisms of support for families and individuals in crisis through support of psychiatric advanced directives, complete with education on what should be included. Educate as to other forms of support through technology like aps for mental health support, electronic brochures, resource information, mental health first aid, healthy lifestyles information and other electronic forms of communication.
5	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

Statement of Joseph Trapani, Taskforce Member

I believe it is important for the Taskforce to consider how the Commonwealth should address the need for acute psychiatric hospital services for children and adolescents in Virginia. To understand the need for acute psychiatric beds for children and adolescents in Virginia, I further believe the following key factors must be appreciated:

1. Virginia has 22 planning districts for COPN purposes, but only eight of these planning districts have licensed private acute psychiatric hospital beds for children and adolescents and one other planning district has the only state hospital operated for this population, Commonwealth Center for Children and Adolescents; thus, 13 planning districts have no acute psychiatric services for children and adolescents who must, therefore, out-migrate for acute psychiatric services to other planning districts. A chart and map showing current acute beds for children and adolescents is attached hereto.
2. All of Virginia's child and adolescent acute psychiatric beds are located in urban areas with the exception of the Commonwealth Center for Children and Adolescents, which is located in Staunton, Virginia and is affiliated with the University of Virginia-Department of Psychiatric Medicine;
3. Many child and adolescent acute hospitals have large geographic service areas because they must meet the needs of planning districts that do not have acute child and adolescent psychiatric beds;

4. General psychiatric beds in planning districts without child and adolescent beds cannot be used to treat children and adolescents because Virginia requires that children and adolescents be treated in units that are physically separated from adults (12VAC35-105-580(G));
5. Children and adolescents must also be separated based on age, gender and pre-admission behavior, which requires small units to deny admission to children whose ages, genders or pre-admission behaviors make them inappropriate for admission given the patients already admitted to the unit; thus, larger facilities with multiple sleeping areas provide greater flexibility and avoid admission denials;
6. The State Medical Facilities Plan (“SMFP”) determines acute psychiatric bed need without differentiating between adult beds and child beds and also includes acute substance abuse treatment beds in its need calculations despite the fact that children and adolescents must be treated in physically separate units; and
7. The SMFP bases its need analysis on a planning district basis effectively excluding from consideration of the special needs of children and adolescents living in the 13 planning districts without child and adolescent psychiatric beds who must access a hospital in another planning district.
8. The largest private psychiatric hospital unit for children and adolescents, Dominion Hospital’s 52-bed unit, cannot admit the most challenging child and adolescent patients, those patients with violent behaviors, due limitations placed upon it by its special use permit from its local zoning agency.

The Commissioner of Health considered these factors in two recent COPN decisions, the decision in Newport News Behavioral Health Center, COPN No. VA-04418, made on October 16, 2013 (the “Newport News Decision”), copy attached, and the decision in North Spring Behavioral Healthcare, COPN Request No. VA-8062, dated March 21, 2014 (the “North Spring Decision”), copy attached. In the Newport News Decision, the Commissioner found that a service area larger than the applicable planning district was appropriate to consider and awarded a COPN based on the need of that larger service area. In the North Spring Decision, the Commissioner declined to consider a service area larger than the applicable planning district finding it was premature to do so in large part because of this Taskforce’s appointment and charge. Thus, I believe the Taskforce should consider the need for acute psychiatric beds in Virginia or note that it did not do so and suggest that the Commissioner reconsider the SMFP rules for acute psychiatric bed need for children and adolescents on an emergency basis.

Respectfully submitted,

Joseph Trapani
Chief Executive Officer
Poplar Springs Hospital

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

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 21	Workgroup Meetings 3
June 16	Full Taskforce Meeting 4
July 15 <i>1-4 p.m.</i> <i>Location TBD</i>	Workgroup Meetings 4
August 11 <i>1-4 p.m.</i> <i>DHP</i>	Full Taskforce Meeting 5
October 1	Final Report Due

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

Guest Columnist Ralph Northam, Richmond Times-Dispatch

May 20, 2014

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

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

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

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

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

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

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

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

Taskforce Members

The Honorable Ralph Northam, Chair

Lieutenant Governor

The Honorable Bill Hazel, MD, Co-Chair

Secretary of Health and Human Resources

The Honorable Brian Moran, Co-Chair

Secretary of Public Safety

The Honorable Mark Herring

Attorney General of Virginia

The Honorable Cynthia Kinser

Chief Justice of Virginia Supreme Court

The Honorable John C. Harvey, Jr.,

Secretary of Veterans and Defense Affairs

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

Debra Ferguson, Commissioner

Department of Behavioral Health
and Developmental Services

Cindi Jones, Director

Department of Medical Assistance Services

Margaret Schultze, Commissioner

Department of Social Services

Colonel Steven Flaherty, Superintendent

Virginia Department of State Police

The Honorable Gabriel Morgan, Sheriff

City of Newport News

The Honorable James Agnew, Sheriff

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Melanie Adkins, Emergency Services

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Thomas Wise, MD
Dept. of Psychiatry
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Anand Pandurangi, MD
VCU, Richmond

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

Joseph Trapani, Chief Executive Officer
Poplar Springs Hospital, Petersburg

Jean Hovey

The Honorable Charles Poston,
Judge (Retired), Norfolk Circuit Court

John Kuplinski, Superintendent,
Virginia Peninsula Regional Jail

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,
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