

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

**January 7, 2014**

*1 p.m. – 4 p.m.*

*West Reading Room, Patrick Henry Building*

## **Agenda**

- 1:00 p.m. – 1:30 p.m.    **Welcome and Charge from the Governor**  
*Governor Robert F. McDonnell*  
*William A. Hazel, Jr., MD, Secretary of Health and Human Resources*  
*Bryan M. Rhode, Secretary of Public Safety*  
**Swearing In of Members**  
Briefing on FOIA  
*Allyson K. Tysinger, Senior Assistant Attorney General/Chief, Office of the Attorney General*  
**Plan and Schedule of Meetings, Deadlines and Workgroup Activity**  
*William A. Hazel, Jr., MD, Secretary of Health and Human Resources*
- 1:30 p.m. – 1:50 p.m.    **Introductions by Members** – *Members will briefly identify their roles and the expertise/interests they bring to the Task Force*
- 1:50 p.m. – 2:20 p.m.    **Presentation – Overview of the Publically-Funded Behavioral Health Service System**  
*James W. Stewart, III, Commissioner, Department of Behavioral Health and Developmental Services*
- 2:20 p.m. – 2:30 p.m.    **Overview of Civil Commitment Statutes**  
*Allyson K. Tysinger, Senior Assistant Attorney General/Chief, Office of the Attorney General*
- 2:30 p.m. – 2:45 p.m.    **Presentation – Clinical Issues in the Prevention of Psychiatric Crises and the Provision of Crisis Response Services**  
*Jack Barber, M.D., DBHDS Medical Director*
- 2:45 p.m. – 3:00 p.m.    **Presentation – Law Enforcement Perspective**  
*Dana Schrad, Virginia Association of Chiefs of Police, and John Jones, Virginia Sheriff's Association)*
- 3:00 p.m. – 3:10 p.m.    **Presentation – Medicaid and Magellan Perspective**  
*Bill Phipps, LCSW, General Manager, Magellan of Virginia*
- 3:10 p.m. – 3:20 p.m.    **Presentation – G. Douglas Bevelacqua, Director, Behavioral Health and Developmental Services Division, Office of the State Inspector General**

- 3:20 p.m. – 3:30 p.m.     **Presentation – Governor McDonnell’s Mental Health Legislation and Budget Proposals and Recommendations from Secretary of HHR Investigation**  
*John Pezzoli, Assistant Commissioner for Behavioral Health Services, DBHDS*
- 3:30 p.m. – 3:50 p.m.     **Task Force Discussion and Recommendations of Items for Consideration**
- 3:50 p.m. – 4:00 p.m.     **Public Comment**
- 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](http://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**

***Taskforce Members***

***Co-Chairs***

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

**The Honorable Bryan Rhode**  
Secretary of Public Safety

***Members***

**The Honorable Kenneth Cuccinelli**  
Attorney General of Virginia

**The Honorable Gabriel Morgan, Sheriff**  
City of Newport News

**The Honorable Cynthia Kinser**  
Chief Justice of Virginia Supreme Court

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

**The Honorable Emmett Hanger**  
Senate of Virginia

**John Venuti, Chief**  
VCU Police Department, Richmond

**The Honorable Janet Howell**  
Senate of Virginia

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

**The Honorable Rob Bell**  
Virginia House of Delegates

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

**The Honorable Joseph Yost**  
Virginia House of Delegates

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

**James Stewart, Commissioner**  
Department of Behavioral Health  
and Developmental Services

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

**Cindi Jones, Commissioner**  
Department of Medical Assistance Services

**Melanie Adkins, Emergency Services  
Director, New River Valley Community  
Services, Roanoke**

**Margaret Schultze, Commissioner**  
Department of Social Services

**Jeffrey Lanham, Regional Magistrate  
Supervisor**  
6<sup>th</sup> Magisterial Region

**Colonel Steven Flaherty, Superintendent**  
Virginia Department of State Police

**Daniel Holser**, Chief Magistrate  
12<sup>th</sup> 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**  
Saluda

**Ben Shaw**  
Fredericksburg

**Rhonda VanLowe**  
Fairfax

**Tom Spurlock**  
Roanoke

**DBHDS**

Virginia Department of  
Behavioral Health and  
Developmental Services

# Virginia's Publicly-Funded Behavioral Health Services System

**James W. Stewart, III.**

Commissioner

Virginia Department of Behavioral  
Health and Developmental Services

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# Legislative/Gubernatorial Joint Committees/Commissions

- **1949** – Report by Gov. Tuck’s Chief of Staff Charles Duke Jr
- **1965** – The Virginia Mental Health Study Commission, chaired by Sen. Willey
- **1972** – The Commission on Mental Indigent and Geriatric Patients, chaired by Sen. Hirst
- **1980** – The Commission on Mental Health and Mental Retardation, chaired by Del. Bagley
- **1986** – The Commission on Deinstitutionalization, chaired by Sen. Emick
- **1996-1998** – The Joint Commission Studying the Future Delivery of MH, MR and SA Services, chaired by Sen. Gartlan and Del. Hall
- **1999** – Gov. Gilmore Commission on Community Services and Inpatient Care

# More Recent Commissions and Task Forces

- **2006 – 2011** – Supreme Court Commission on MH Law Reform
- **2007** – Gov. Kaine’s Virginia Tech Review Panel
- **2013** – Gov. McDonnell’s Taskforce on School and Campus Safety (Mental Health Workgroup)

# Legislative/Gubernatorial Joint Committees/Commissions

## **Major recommendation since 1949:**

Virginia needs to expand its capacity to serve individuals in their own communities with coordinated behavioral health and developmental programs and supports.

# Behavioral Health History

- **Prior to 1960s** – long-term (lifelong) state hospital care was norm for many individuals with mental illness and for others.
- **Early 1960's** – Census of all state hospitals exceeded 11,500 with 4,800 at CSH/1962, 2,400 at ESH/1964 and 3,000 at WSH/1965
- **1963** – Federal Community Mental Health Centers Act (enabling construction and staffing of multi-service CMHCs).
- **1968** – Virginia legislation establishing the local community services board system.
- **1980** - Congress passed Civil Rights of Institutionalized Person Act (CRIPA) – protection from harm, access to active treatment, discharge when ready
- **1990** – Congress passed the Americans with Disabilities Act (ADA) – prohibits discrimination, ensures equal opportunity for persons with disabilities in employment, public services, public accommodations, etc.
- **1992-98** – Dept. of Justice investigations of state hospitals and settlement agreements focused on quality of services in facilities.

# Behavioral Health History

- **1990** – Medicaid reimbursement for adult/child psychiatric rehab. services & targeted case management available for public CSBs
- **1995** – Medicaid managed care of outpatient and inpatient services (including mental health) - Medallion I (excluded rehab. Services)
- **1999** – U.S. Supreme Court Olmstead decision ruled public entities must provide community-based services to persons with disabilities when specific criteria present.
- **2000** – DBHDS establishment of Local Inpatient Purchase of Service (LIPOS) program to facilitate admissions to private hospitals for acute psychiatric treatment
- **2000** – Medicaid reimbursement for psychiatric rehabilitation services for adults and children opened to private providers.
- **2003** – President's *New Freedom Commission on Mental Health* envisions future in which "everyone with mental illness will recover".
- **2013** – Medicaid psychiatric rehabilitation services placed in managed care (Magellan)

# Virginia's Publicly-Funded Behavioral Health Services Delivery System

- System includes public and private community providers:

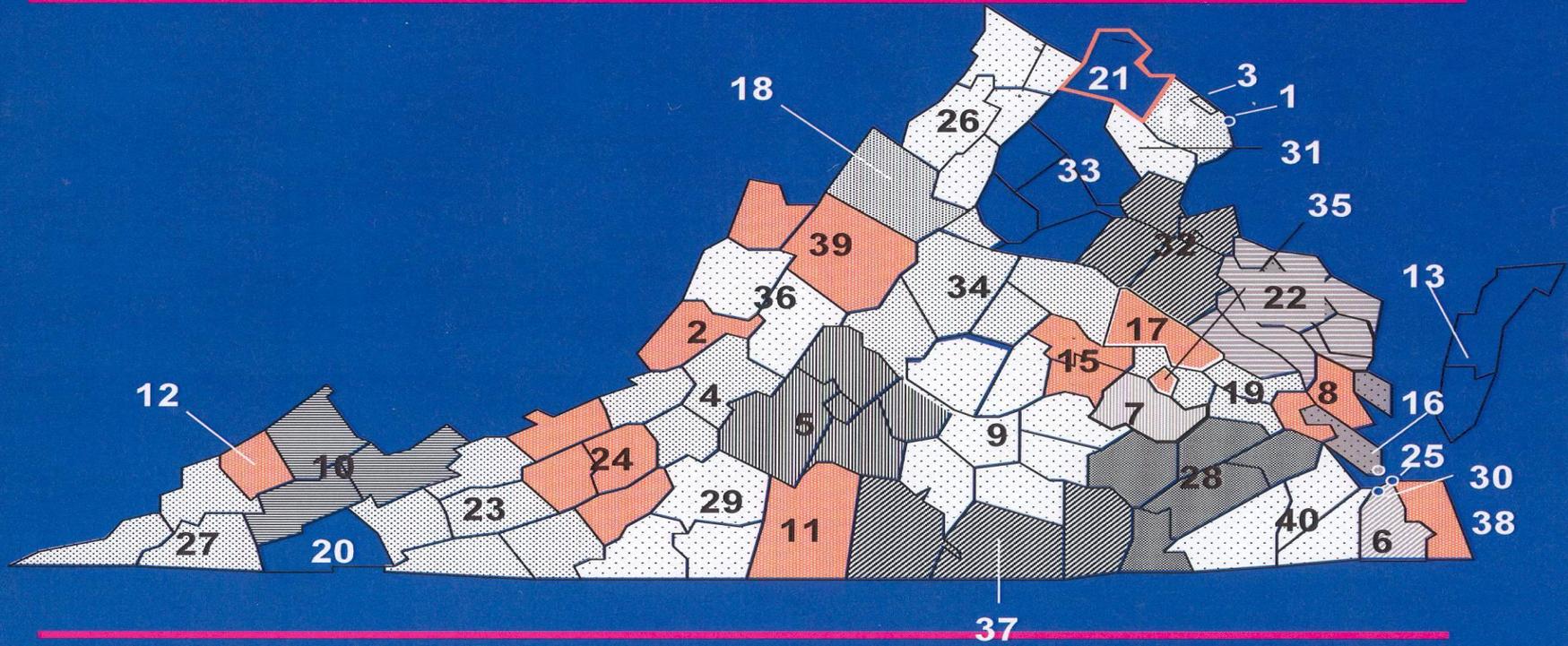
	Licensed Providers	MH/SA Providers	Locations	MH/SA Locations
CSB	40	40	2006	1,716
Private Providers	828	557	5365	2,683
<b>Total</b>	<b>868</b>	<b>597</b>	<b>7371</b>	<b>4,399</b>

- And nine state hospitals
  - 8 adult hospitals
    - 1 all geriatric
    - 3 with geriatric units
    - 1 with maximum security forensic unit
  - 1 child/adolescent hospital

# Community Services Boards

- CSBs are established in Code to be the single point of entry into publicly-funded behavioral health and developmental services system
- Receive state, local and federal funding
- Established by 133 local governments:
  - 39 CSBs and 1 BHA (Richmond)
  - 29 established by 2-10 cities or counties or combinations, and 11 established by one city or county
  - 11 administrative policy, 27 operating, and 1 advisory-advisory (Portsmouth)
- Performance contract with and licensed by DBHDS

# 40 Community Services Boards



5'

- |                         |                             |                                 |                           |
|-------------------------|-----------------------------|---------------------------------|---------------------------|
| 1. Alexandria           | 11. Danville-Pittsylvania   | 21. Loudoun County              | 31. Prince William County |
| 2. Allegheny-Highlands  | 12. Dickenson County        | 22. Mid Peninsula-Northern Neck | 32. Rappahannock Area     |
| 3. Arlington County     | 13. Eastern Shore           | 23. Mount Rogers                | 33. Rappanannock-Rapidan  |
| 4. Blue Ridge           | 14. Fairfax-Falls Church    | 24. New River Valley            | 34. Region Ten            |
| 5. Central Virginia     | 15. Goochland-Powhatan      | 25. Norfolk                     | 35. Richmond              |
| 6. Chesapeake           | 16. Hampton-Newport News    | 26. Northwestern                | 36. Rockbridge Area       |
| 7. Chesterfield         | 17. Hanover County          | 27. Planning District 1         | 37. Southside             |
| 8. Colonial             | 18. Harrisonburg-Rockingham | 28. Planning District 19        | 38. Virginia Beach        |
| 9. Crossroads           | 19. Henrico Area            | 29. Piedmont Regional           | 39. Valley                |
| 10. Cumberland Mountain | 20. Highlands               | 30. Portsmouth                  | 40. Western Tidewater     |

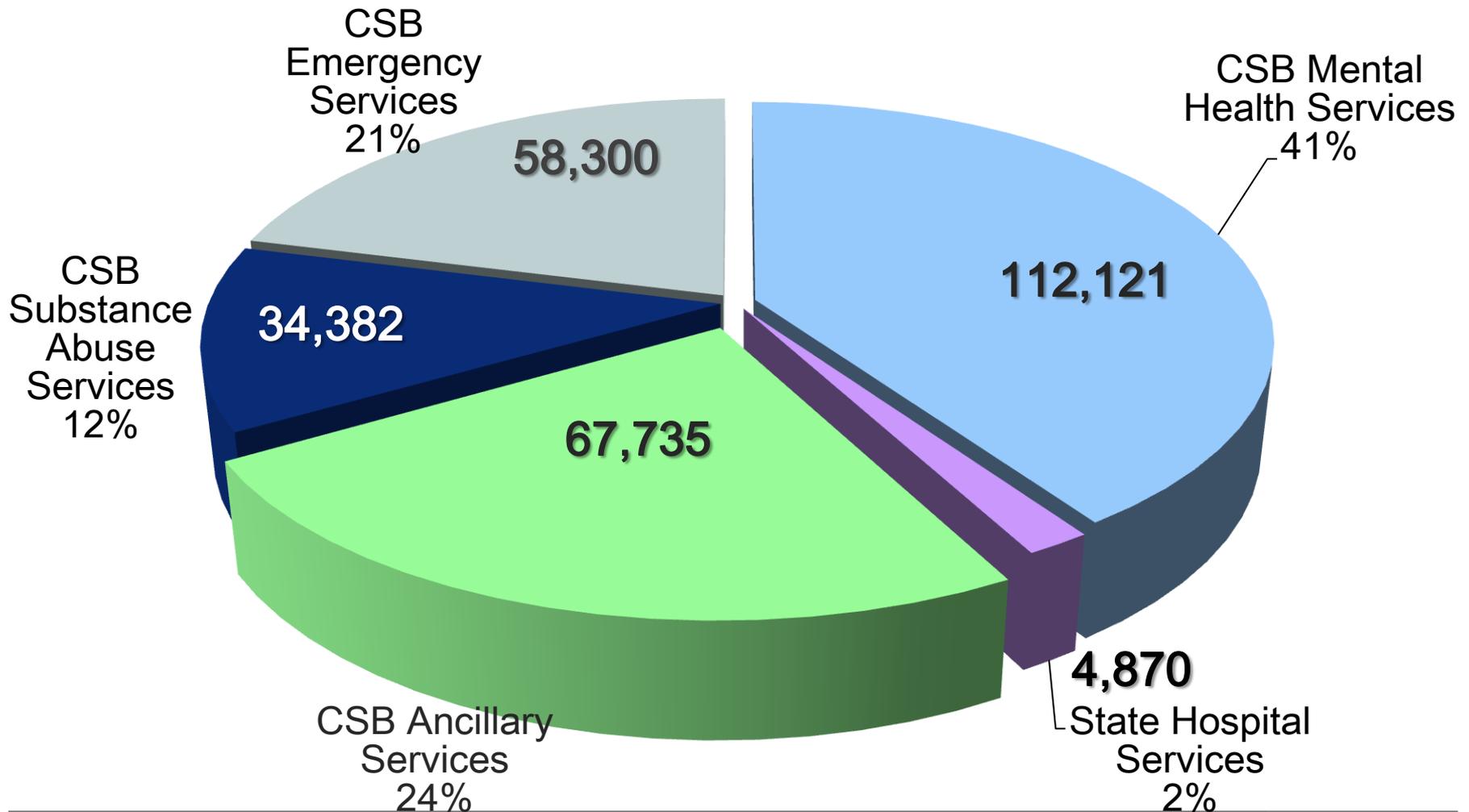
# CSB Services

- **Mandated to provide:**
  - Emergency services
  - Case management subject to the availability of funds
  - Preadmission screening and discharge planning
- **May provide a core of comprehensive services:**
  - Services can be provided directly by CSB
  - CSB may contract for services
  - Groups of CSBs may contract for services or provide them directly on a regional basis

# Array of Services Provided by CSBs

<b>Core Services</b>	<b>Mental Health Services</b>	<b>Substance Abuse Services</b>
<b>Emergency Services</b>	<b>X</b>	<b>X</b>
<b>Inpatient Services</b>	<b>X</b>	<b>X</b>
<b>Outpatient Services</b>	<b>X</b>	<b>X</b>
<b>Case Management Services</b>	<b>X</b>	<b>X</b>
<b>Day Support Services</b>	<b>X</b>	<b>X</b>
<b>Employment Services</b>	<b>X</b>	<b>X</b>
<b>Residential Services</b>	<b>X</b>	<b>X</b>
<b>Prevention Services</b>	<b>X</b>	<b>X</b>
<b>Consumer-Run Services</b>	<b>X</b>	<b>X</b>

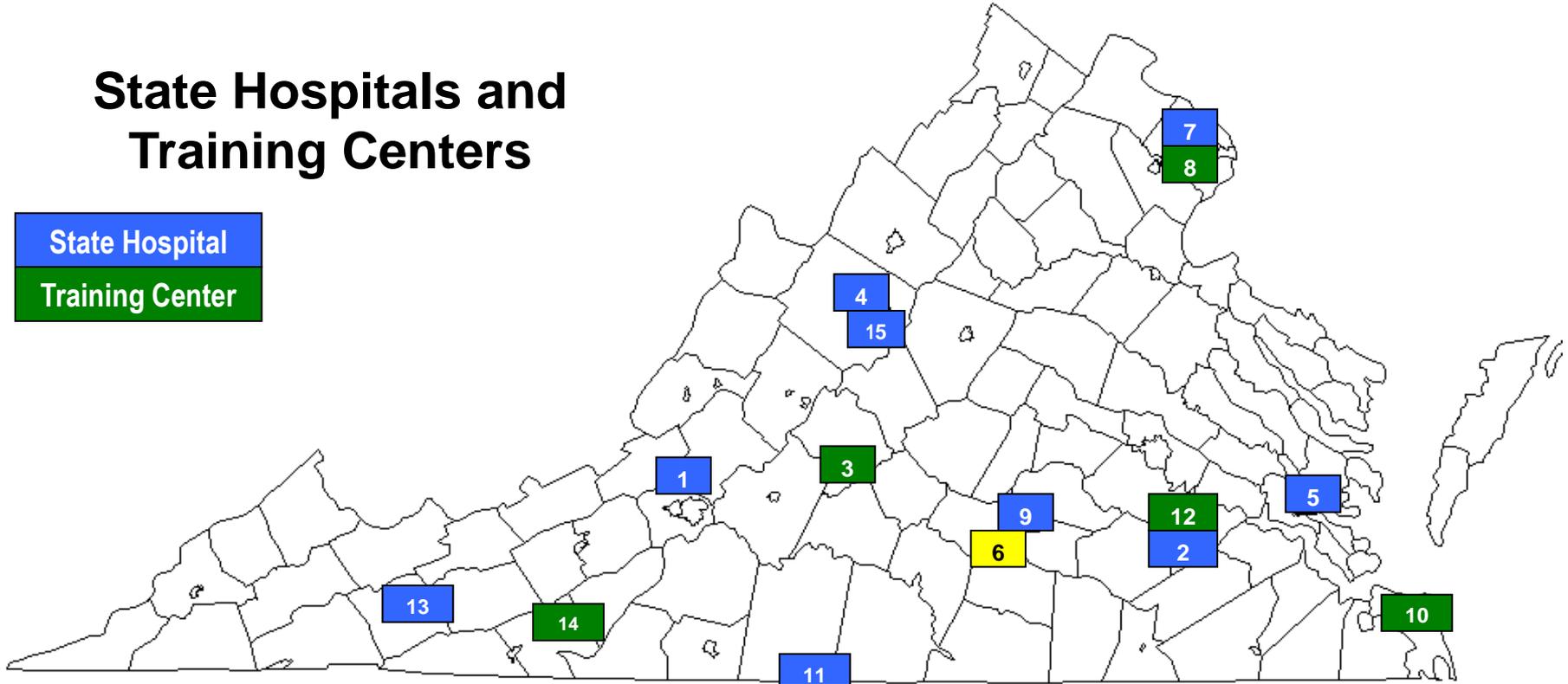
# Individuals Receiving Behavioral Health Services in FY2013



# State Facilities

## State Hospitals and Training Centers

State Hospital  
Training Center



	Facility	Location		Facility	Location
1	Catawba Hospital	Catawba	9	Piedmont Geriatric Hospital	Burkeville
2	Central State Hospital	Petersburg	10	Southeastern VA Training Center	Chesapeake
3	Central VA Training Center	Madison Heights	11	Southern VA MH Institute	Danville
4	CCCA	Staunton	12	Southside VA Training Center	Petersburg
5	Eastern State Hospital	Williamsburg	13	Southwestern VA MH Institute	Marion
6	Behavioral Rehabilitation Center	Burkeville	14	Southwestern VA Training Center	Hillsville
7	Northern VA MH Institute	Falls Church	15	Western State Hospital	Staunton
8	Northern VA Training Center	Fairfax			

# Virginia's 8 (Adult) State Behavioral Health Hospitals

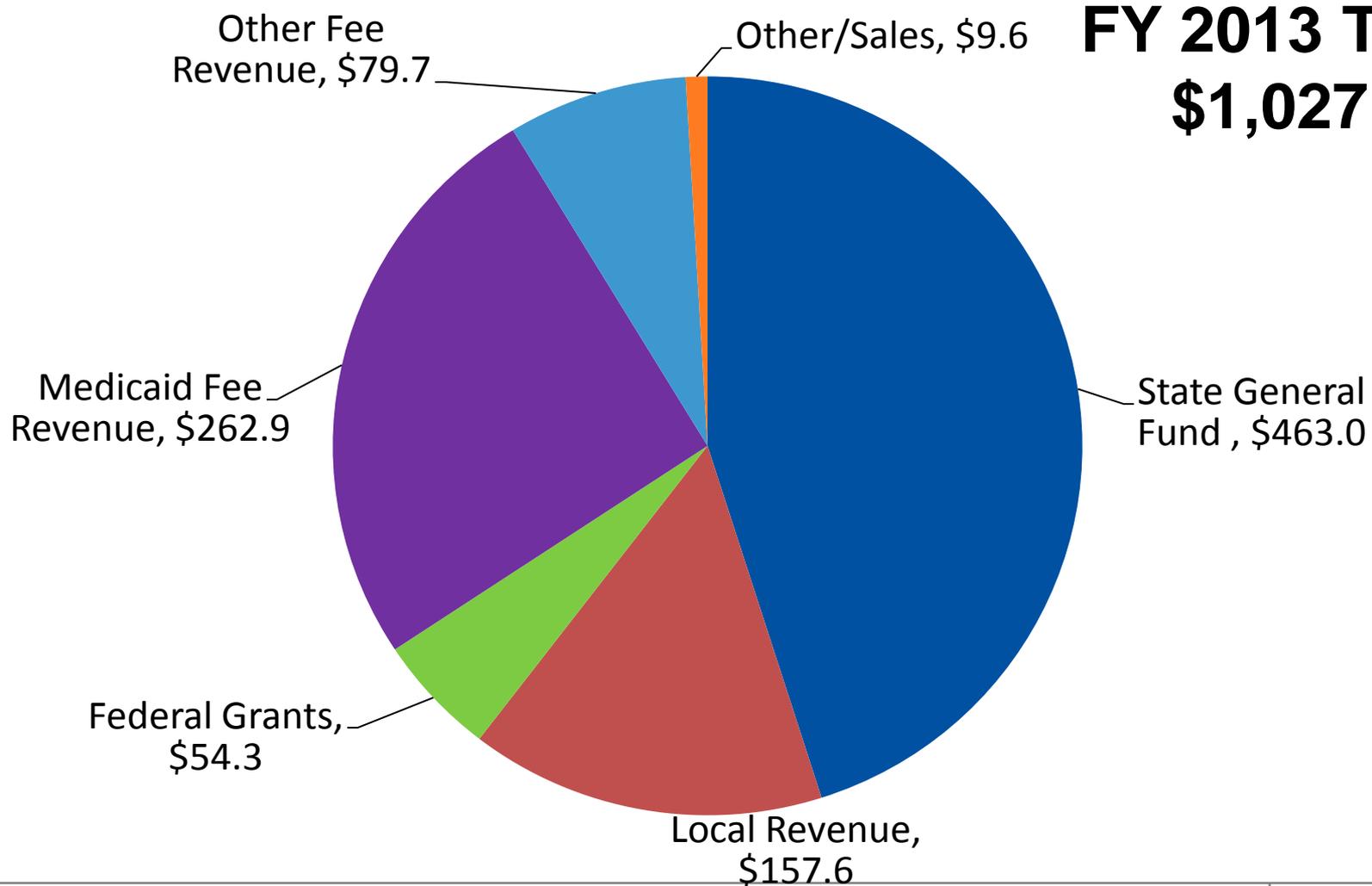
Name	2000 Census	2005 Census	2010 Census	12/26/13
<b>Catawba</b> , Catawba	88	100	100	99
<b>Central State</b> , Petersburg	303	244	211	180
<b>Eastern State</b> , Williamsburg	485	409	329	262
<b>Northern VA MHI</b> , Falls Church	121	123	120	118
<b>Piedmont</b> , Burkeville	126	118	110	107
<b>Southern VA MHI</b> , Danville	89	69	75	68
<b>SWVA MHI</b> , Marion	166	143	151	159
<b>Western State</b> , Staunton	275	243	226	204
<b>TOTAL</b>	<b>1653</b>	<b>1449</b>	<b>1322</b>	<b>1197</b>

# FY 2013 Funding for CSB MH/SA and State Hospital Operations

(in millions)

	Community Programs			MH Facilities	Total
	MH	SA	Total		
<b>State General Fund</b>	\$184.9	\$46.6	\$231.5	\$231.5	<b>\$463.0</b>
<b>Local Revenue</b>	\$117.4	\$40.2	\$157.6	\$0.0	<b>\$157.6</b>
<b>Federal Grants</b>	\$11.6	\$42.6	\$54.2	\$0.1	<b>\$54.3</b>
<b>Medicaid Fee Revenue</b>	\$208.3	\$3.1	\$211.4	\$51.5	<b>\$262.9</b>
<b>Other Fee Revenue</b>	\$42.1	\$11.3	\$53.4	\$26.3	<b>\$79.7</b>
<b>Other/Sales</b>	\$5.5	\$3.0	\$8.5	\$1.1	<b>\$9.6</b>
<b>Total Revenue</b>	<b>\$569.8</b>	<b>\$146.8</b>	<b>\$716.6</b>	<b>\$310.5</b>	<b>\$1,027.1</b>

# FY 2013 Funding for CSB MH/SA and State Hospital Operations (in millions)



# Medicaid Payments to All Providers in FY 2013

Medicaid Services	Private Providers	CSBs
Mental Health Rehabilitation Services	\$404,893,452	\$107,875,977
Mental Health Clinic Services	\$190,680	\$2,160,083
Substance Abuse Services	\$367,493	\$1,224,342
Habilitation (ID Waiver) Services	\$446,971,020	\$106,237,916
Case Management and Other Services	\$0	\$136,349,876
Total Medicaid Payments	\$852,422,645 (71%)	\$353,848,194 (29%)
<b>Total Medicaid Payments to All Providers</b>		<b>\$1,206,270,839</b>

# Behavioral Health Services

## Ongoing Treatment and Support Services

Children/  
Youth  
MH/SA

Adults  
MH/SA/  
Forensic

Older  
Adults

Serious/  
Persistent  
Mental  
Illness

Develop-  
mental  
Disabilities

## Crisis Response Services (Including Acute Psychiatric Inpatient)

# Ongoing and Support and Treatment Services

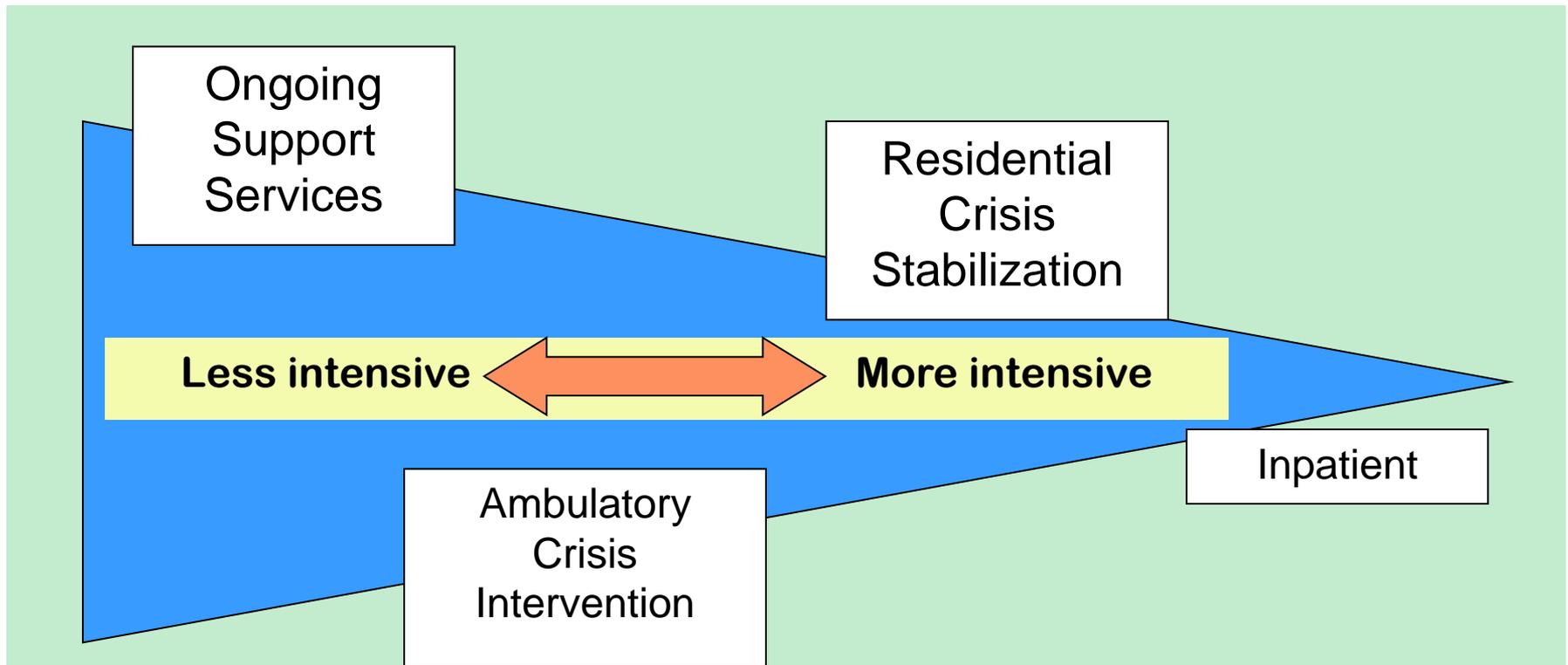
Assessment, evaluation, care planning	Medical care
Outreach and engagement	Vocational and educational support
Counseling and therapy	Basic needs (decent housing, food, safety)
Medications and management	Respite
Peer support	Drop-in centers
Case management	Financial support
In-home supports	
PACT/wraparound services	

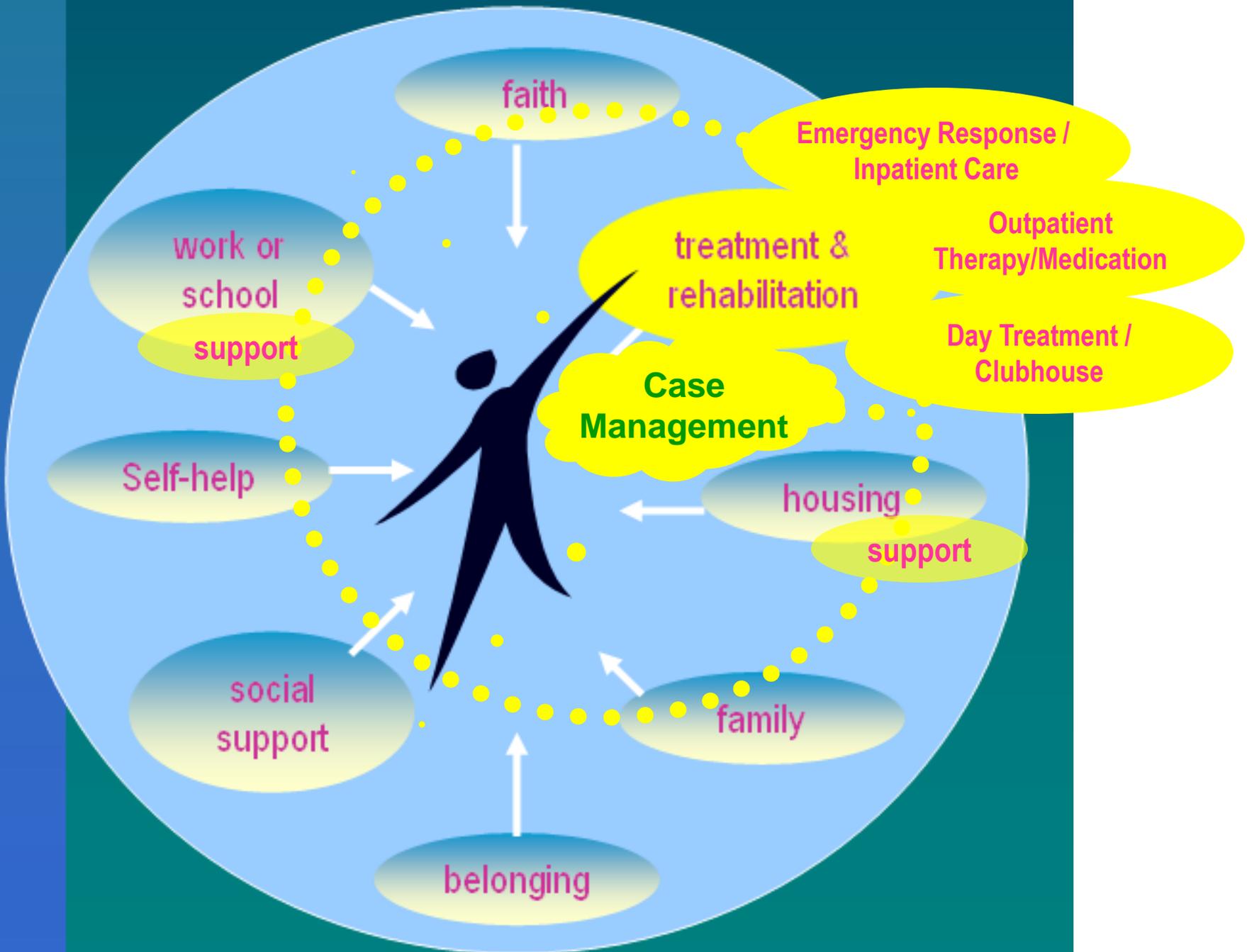
# Crisis Intervention Services Continuum

<b>Crisis Response, Resolution, and Referral</b>	<b>Crisis Stabilization</b>
Hotline	Consumer-run residential support service
Phone crisis contact – brief	Residential Crisis Stabilization – voluntary
Phone crisis counseling – extended	Residential Crisis Stabilization
Crisis consultation w/ CSB program	In-Home residential support service
Face-to-face counseling – next day	
Face-to-face counseling – immediate	
Psych crisis consultation	<b>Inpatient Hospital</b>
Psych, eval, med	Local Hospital
Mobile outreach crisis team	State Hospital

# Behavioral Health Model

Investment in ongoing treatment and support services reduces demand for intensive services and acute care interventions:





# Targeted Efforts to Address MH/SA Service Capacity FY 2005 – FY 2014

New Funding	Total (in millions)
<b>Community Total</b>	<b>\$71.40</b>
Crisis Response	\$24.12
Adults with Serious and Persistent Mental Illness	\$23.33
Mental Health Treatment for Children & Adolescents	\$12.15
Mental Health & Criminal Justice Interface	\$4.77
Substance Abuse Services	\$3.43
Outpatient Mental Health Treatment for Adults	\$3.00
Prevention	\$0.60
<b>State Hospitals Total</b>	<b>\$20.52</b>
<b>Total New Funding</b>	<b>\$91.92</b>
<b>Total Reductions</b>	<b>(\$57.50)</b>
<b>Net Total</b>	<b>\$34.42</b>

# Priority Initiatives During Current Administration

- Developmental Services and Supports Community Capacity
- Behavioral Health Emergency Response Services
- Child and Adolescent Mental Health Services
- Case Management
- Effectiveness/Efficiency of State Hospital Services
- Employment
- Housing
- Substance Abuse Treatment Services
- Peer Services and Supports
- DBHDS Electronic Health Record (EHR)
- Sexually Violent Predator (SVP) Service Capacity

# Behavioral Health Services

## Ongoing Treatment and Support Services

Children/  
Youth  
MH/SA

Adults  
MH/SA/  
Forensic

Older  
Adults

Serious/  
Persistent  
Mental  
Illness

Develop-  
mental  
Disabilities

## Crisis Response Services (Including Acute Psychiatric Inpatient)

# Virginia's Civil Commitment Process

Allyson K. Tysinger  
Office of the Attorney General  
January 2014

# ECO

## Virginia Code § 37.2-808

- Emergency Custody Order (ECO) - order issued by a magistrate that requires any person in the magistrate's judicial district who is incapable of volunteering or unwilling to volunteer for treatment to be taken into custody and transported for an evaluation in order to assess the need for hospitalization or treatment

# ECO

- ECO can be issued on the sworn petition of any responsible person or on magistrate's own motion
- Issued when magistrate finds probable cause to believe that a person meets the commitment criteria
  - Mental illness
  - Substantial likelihood that person will in near future
    - Cause serious physical harm to self or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant info, if any
    - Suffer serious harm due to lack of capacity to protect himself from harm or to provide for his basic human needs

# ECO

- Magistrate may consider
  - Recommendations of any treating or examining physician or psychologist
  - Past actions of the person
  - Past mental health treatment
  - Relevant hearsay
  - Any medical records available
  - Affidavits if the witness is unavailable and the affidavit so states
  - Any other relevant information

# ECO

- Period of custody not to exceed 4 hours
- ECO extension
  - ECO can be extended for an additional two hours if requested by a family member, CSB, treating physician or law enforcement and magistrate finds good cause exists to grant the extension
  - Good cause includes the need for additional time to allow
    - CSB to identify a facility of temporary detention
    - Medical evaluation

# TDO

## Virginia Code § 37.2-809

- Temporary Detention Order (TDO) - an order issued by a magistrate that authorizes law enforcement to take a person into custody and transport to a facility designated on the order

# TDO

- Issued on sworn petition of any responsible person or magistrate's own motion
- Only after an in-person evaluation by CSB employee or designee
  - Exception: TDO may be issued without an ECO evaluation if the person has been examined within the previous 72 hours by the CSB or there is significant physical, psychological, or medical risk to the person or others associated with conducting such evaluation.

# TDO-Criteria

- Issued when magistrate finds probable cause to believe that a person meets the commitment criteria
- Magistrate may consider
  - Recommendations of any treating or examining physician or psychologist
  - Past actions of the person
  - Past mental health treatment
  - Relevant hearsay
  - Any medical records available
  - Affidavits if the witness is unavailable and the affidavit so states
  - Any other relevant information

# TDO – Facility of Temporary Detention

- CSB must determine the facility of temporary detention
- Must be identified on the preadmission screening report
- Must be indicated on the TDO
- Person shall remain in custody of law enforcement until custody has been accepted by the facility identified in the TDO

# TDO - Duration

- Duration of temporary detention shall be sufficient to allow for completion of the preadmission screening report, the independent examination, and initiation of mental health treatment to stabilize the person
- Shall not exceed 48 hours
  - Unless the 48 hour period ends on a Saturday, Sunday, or legal holiday and then the person can be detained until close of business on the next business day

# Hearing - Timing

- Held after sufficient time to allow for completion of the preadmission screening report, the independent examination, and initiation of mental health treatment to stabilize the person but within 48 hours of execution of TDO unless Saturday, Sunday or legal holiday and then extended to the next day that is not a Saturday, Sunday or legal holiday
- At least 12 hours prior to the hearing, the court shall provide the CSB with the time and location of the hearing.

# Hearing

- Held before a district court judge or special justice
- Individual is represented by counsel, who provides a written explanation of the process and explains it prior to the hearing
- Petitioner is given notice of the place, date, and time of hearing
- Open to the public

# Hearing - Reports

- Preadmission screening report (§ 37.2-816)
  - Shall be admitted as evidence of the facts stated therein
- Independent Examination (§ 37.2-815)
  - May be accepted into evidence unless objected to, in which case the examiner must attend the hearing in person or by electronic communication

# Hearing - Attendance

- An employee of the CSB that prepared the preadmission screening report must attend the hearing
  - If physical attendance is not practicable, shall participate through electronic communication
- Independent examiner, if not physically present, and the treating physician at the facility of temporary detention must be available whenever possible for questioning through electronic communication

# Hearing - Evidence

- Judge or special justice may consider:
  - Recommendations of any treating or examining physician or psychologist
  - Past actions of the person
  - Past mental health treatment
  - Examiner's certification
  - Preadmission screening report
  - Any health records available
  - Any other relevant evidence that was admitted

# Hearing - Disposition

- Possible Dispositions
  - Voluntary Admission
  - Involuntary Admission
  - Mandatory Outpatient Treatment
    - Three types: MOT, Step-down MOT, MOT on Motion
  - Release



# Improved Behavioral Health Coordination for Medicaid Enrollees

Karen Kimsey, Deputy Director of Complex Care and Services  
Virginia Department of Medical Assistance Services

William Phipps, LCSW, General Manager  
Magellan of Virginia

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Governor's Task Force on Improving Mental Health Services and Crisis Response  
January 7, 2014

# Overview

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- Background for the new Behavioral Health Services Administrator (BHSA) to Improve Coordination of Behavioral Health Services
- New Program Features as of December 1, 2013
- Early Results



# Behavioral Health Service Utilization

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- Behavioral Health Expenditures in 2013 reached \$775,984,011 (9% of total Medicaid expenditures)
  - FY 2000 expenditures - \$3.6 million (non-traditional services opened up to private providers in this year)
  - Over 79% of behavioral health claim dollars went to private providers for non-traditional services
  - Expenditures for these services have increased by 25% between 2009 to 2013

# Key Step Toward Medicaid Reform

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- The BHSA contract was awarded to Magellan Behavioral Health Services in May 2013 and was implemented December 1, 2013.
  - ASO Model; contract for the next three (3) years with option to extend for two (2) more years
- The contract with Magellan fulfills the directive to improve several program areas including:
  - Improved coordination of care for individuals receiving behavioral health services with acute and primary services; and
  - The value of behavioral health services purchased by the Commonwealth of Virginia

# BHSA CONTRACT

Who is Covered	What is Covered	What is not Covered
<ul style="list-style-type: none"> <li>• Magellan will handle behavioral health benefits for most fee-for-service beneficiaries</li> <li>• If a beneficiary is in managed care and receives a service that is administered by the BHSA, Magellan will work with the member's managed care organization to coordinate and improve care received by the beneficiary</li> </ul>	<ul style="list-style-type: none"> <li>• Community Mental Health Rehabilitation Services (includes Intensive In Home, Therapeutic Day Treatment, and Mental Health Skill-Building)</li> <li>• Targeted Case Management</li> <li>• Treatment Foster Care Case Management</li> <li>• Residential Treatment (Levels A, B &amp; C)</li> <li>• Substance Abuse Services</li> <li>• Inpatient and Outpatient Psychiatric Services</li> <li>• EPSDT In-home Services</li> </ul>	<ul style="list-style-type: none"> <li>• Inpatient and outpatient psychiatric services for members enrolled in a Managed Care Organization are excluded</li> <li>• Behavioral health services for individuals enrolled in the Commonwealth Care Coordination Demonstration (except for Targeted Case Management)</li> </ul>

# BHSA Objectives

- Improve timely access to quality behavioral health services - helping members in need get the right care at the right time;
- Improving health outcomes for members;
- Ensure efficient utilization of services;
- Develop quality and outcome measures; and
- Promote member engagement

# BHSA Implementation

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New Program Features as of December 1, 2013



# New Program Features

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- A 24/7 centralized call center to provide eligibility, benefits, referral and appeal information to members and providers;
- Member assistance: Crisis calls, referral, information, outreach and education;
- Provider recruitment, credentialing, issue resolution, network management, and training;
- Quality Assurance, Improvement and Outcomes program;
- Care Management services: care coordination, interface with MCOs, appropriate care, timely access; and
- Quality Care Initiatives –psychotropic medication and, peer support program;

# Network Management

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- Medicaid providers grandfathered into Magellan's network through 3/31/14 to ensure no disruption in care - credentialing to be completed prior to 4/1/14
- 7,587 providers (facilities, groups, practitioners) in network
- A peer review committee to provide oversight to participation in the Magellan network
- Enhanced provider directory for ease of locating an appropriate provider
- Multiple resources available to providers to enhance their practice
  - Performance dashboards, quality reviews, open communication regarding patient care planning needs and options, training, free CEUs

# Stakeholder Engagement

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- Provider & Community Stakeholder Forums/Sessions
  - 12 sessions held across the commonwealth in September 2013
  - 10 Member sessions held across the commonwealth in November 2013 in partnership with NAMI & VOCAL.
- Post Go-Live Stakeholder Meetings
  - Daily meetings with provider associations (VACSB & private provider associations) during December; continuing with weekly frequency
  - Twice weekly meetings with consumer advocacy groups
  - Weekly all provider calls to provide program updates & Q/A
- Partnership with VACSB & CSA
  - Current VICAP process in effect without change through 6/30/14
  - Dedicated clinical liaisons to CSBs and CSA regions

# Call Center Performance

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## Month One Results -

- 6,936 calls received by the call center
- Majority of calls received from members (60%)
- 2,455 calls managed by the care management team
  - Member assistance with determining appropriate care, precertification, other situations where clinical judgment is required
- 228 crisis calls managed
  - Risk of harm (suicidal/homicidal thoughts or attempts), abuse (child, elder, domestic), emotional distress

# Crisis Call Example

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- 26yo male called Magellan reporting chronic pain and feeling like no one cared about him. He had a plan to harm his mother with whom he resided. He had a prior history of injuring his mother. The mother was contacted by another clinician and notified of his plan to harm her to ensure her safety. The member was kept on the line with the clinician until EMS arrived and transported him for evaluation.

# Performance to Date

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## Month One Results Continued –

- 7,066 authorization requests processed
- 2,201 registration requests processed
- 100 calls received on the Primary Care Physician Consultation Line
  - PCP resources available: BH consultation, toolkit, clinical monograph
- 63,550 claims received
  - 63,256 electronic submission
  - 26,225 submitted via Magellan’s free Claims Courier tool
- \$6.6M claims paid in December

# Next Steps

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- Continue to trouble shoot on any remaining implementation issues to promote smooth operations;
- Continue open communication with all stakeholders and specialized training with providers;
- Complete credentialing of all behavioral health providers;
- Assess and identify system inefficiencies and gaps;
- Initiate a Stakeholder Governance Board and continue community engagement and partnerships;
- Inclusion of recovery principles; and
- Implement quality initiatives – peer support program, integrated care and psychotropic medication utilization

# Questions

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## Resources

Magellan of Virginia Website:  
<http://magellanofvirginia.com/>

Magellan Call Center: 1-800-424-4046

# LAW ENFORCEMENT AND MENTAL HEALTH

January 7, 2014

John W. Jones, Executive Director  
Virginia Sheriffs' Association





## ***Sheriffs are Primary Law Enforcement in 86 counties***

- \* Serve Emergency Custody Orders (ECO) – *PRIMARY LAW ENFORCEMENT***
  - 4 hours/plus 2 hours
  
- \* Serve Temporary Detention Orders (TDO) – *ALL SHERIFFS***
  
- \*Provide Transportation**
  - This is a Public Safety Issue, but
  - This Service is not always a public safety issue
  - Alternative transportation should be used where possible
  
- \*Sheriffs typically use office space (Example: Library) to hold the patients**

# *Calendar Years 2010, 2011, 2012*

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*= 16,053 Transports*

*= 63,322 Transport Hours*

*Based on 3 hours for in jurisdiction transports and 4.5 hours for out of jurisdiction transports, one deputy.*

*= 72 FTE Deputy Sheriff Positions Needed*

*Based on current statutory hours – two deputies*

*\*\*Source: Compensation Board*

*= Currently the law enforcement standard for sheriffs of 1:1500 is short by 168 deputy sheriffs in 49 counties*

# Jail Issues

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*Local & Regional Jails are housing approximately  
30,000 inmates per day*

*6,000 are in need of mental health services*

*3,000 + are in **SERIOUS** need of mental health services*

# ***Significant drain on Sheriff's Office resources in all localities.***

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## **Recommendations:**

- **Survey all Law Enforcement agencies to determine true impact**  
For example: How many ECO's; TDO's; Officers involved, Time Consumed
- **Establish an automated system to readily identify available beds**
- **Find additional beds to relieve the jails, provide 50% construction reimbursement cost and staff appropriately, in lieu of 50% construction reimbursement costs for regional jails**
- **Drop off centers work well and need expanding**

# The Impact of the Mental Health Crisis on Law Enforcement

Dana Schrad, Executive Director

Virginia Association of Chiefs of Police

Virginia Association of Campus Law Enforcement Administrators

# Recommendation #1

- Address the mental health transportation burden on local law enforcement by providing dedicated funding to offset the costs incurred by our chiefs and sheriffs

# Recommendation #2

- Stress the need to identify and use alternate transportation modalities whenever feasible and safe – this may necessitate additional training for law enforcement, magistrates, CSB's and treatment providers

# Recommendation #3

- Examine the network of mental health treatment facilities in Virginia to ensure ready access in all areas of the state to minimize transportation times for law enforcement and to provide treatment services that are closer for families (family members may be more likely to provide transportation when the facility isn't more than an hour away.)

# Recommendation #4

- Ensure adequate funding for law enforcement to access appropriate training to better understand and interact with the mentally ill and their families.

# Recommendation #5

- Provide adequate and appropriate mental health treatment services in our jails and prisons, and in pre-trial and community corrections supervision programs.

# Recommendation #6

- Ensure that Virginia courts transmit information on all persons committed for mental health treatment to the Virginia State Police for the purpose of enforcing state and federal firearms purchase prohibitions.

# Recommendation #7

- Address the need for a better means of identifying persons with mental health treatment needs, and ensure that treatment is both appropriate and sustained for the long term to help the mentally ill function successfully and safely in our communities.

**The Governor's Task Force on  
Improving Mental Health Services and Crisis Response  
January 7, 2014**

I applaud Governor McDonnell and Governor-elect McAuliffe's willingness to create and support the work of this Task Force to improve mental health services in the Commonwealth.

In the summer of 2011, my former agency, the Office of the Inspector General for Behavioral Health and Developmental Services (OIG), first heard the term *streeted*. This term was used to describe a person who had been evaluated and found to meet criteria for temporary detention but, instead of being admitted to a psychiatric hospital for further evaluation, a *streeted* person was released without the clinically indicated intervention.<sup>1</sup>

In the months that followed, the OIG polled the Commonwealth's CSBs to learn if *streeting* was limited to Hampton Roads or if it occurred in other regions of the state. The anecdotal information we received in response to our informal survey supported the conclusion that approximately 200 people had been *streeted* during the preceding twelve months.

The results of our poll led to a three-month statewide study of the state's 40 CSBs that was conducted jointly with the Department of Behavioral Health and Developmental Services (DBHDS).

This joint study documented that, during the 90 days between July and October 2011, Virginia issued approximately 5,000 Temporary Detention Orders (TDO). Of the 5,000 TDOs, 72 individuals (1½%) meeting criteria for a TDO were denied access to the clinically indicated inpatient psychiatric treatment. In addition, the study found that 273 individuals (5½%) were granted detention orders, but only after the six-hour time limit imposed by the *Code of Virginia (Code)* had expired. These and other findings, along

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<sup>1</sup>The criteria for involuntary temporary detention are set forth in the *Code of Virginia* at § 37.2-809(E) "... to determine whether the person meets the criteria for temporary detention, a temporary detention order if it appears from all evidence readily available, including any recommendation from a physician or clinical psychologist treating the person, that the person (i) has a mental illness and that there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future, (a) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or (b) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs, (ii) is in need of hospitalization or treatment, and (iii) is unwilling to volunteer or incapable of volunteering for hospitalization or treatment."

with 13 recommendations, were published in the *OIG Review of Emergency Services*, Report No. 206-11, dated February 28, 2012.

This means that almost 1,400 people a year could be expected to either be denied a access to clinically appropriate care or granted a TDO after the six hour time limit. Not to put too fine a point on it, but based on this review, every day three to four people will experience this outcome in the Commonwealth.

It is worth noting that the recently completed study by the University of Virginia (UVA), Institute of Law and Public Policy in December 2013 documented marginally “worse” results than the 2011 OIG findings. This recent UVA study found that a TDO was issued to 96.5% of the individuals meeting TDO criteria and that 95.2% of persons recommended for a TDO “were eventually admitted to a mental health facility.”<sup>2/3</sup>

The UVA study also documented that, “...almost one of every five adults (18.2%, n=624) was under the influence of drugs or alcohol, and another 5.2% (n=180) were suspected to be under the influence.” This finding has important implications for determining if a person should be admitted to an acute care facility for evaluation and treatment or transferred to a facility for detox services.

Some behavioral health topics can appear byzantine; full of indecipherable acronyms only accessible to subject matter experts, and beyond the reach of people who do not work in the field; however, the solutions to *streeting* are straightforward but, to be effective, all solutions will require consensus around a core value.

**That core value is that every person with mental illness, who is evaluated by a preadmission screener and determined to meet criteria for a TDO, is admitted to a psychiatric facility.<sup>4</sup>**

As long as we are willing to accept that any person with mental illness, who has been found to be a danger to self or others – and lacking the capacity to protect him/herself from harm, can be released without hospitalization—where hospitalization is clinically indicated, the Commonwealth will continue to *street* people and experience some unknowable number of preventable tragedies.

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<sup>2</sup> *A Study of Face-to-Face Emergency Evaluations Conducted by Community Services Boards in April 2013*, Institute of Law and Public Policy, University of Virginia, 2013.

[http://www.law.virginia.edu/pdf/news/face\\_to\\_face\\_emergency\\_evaluations\\_report\\_v2.pdf](http://www.law.virginia.edu/pdf/news/face_to_face_emergency_evaluations_report_v2.pdf)

<sup>3</sup> UVA's study sample universe included all emergency evaluations; unlike the OIG's study sample that limited its focus to those people who had been evaluated and determined to meet criteria for temporary detention. Therefore, these two studies may not represent an apples-to-apples comparison.

<sup>4</sup> The *Virginia Preadmissions Screening Form* (01-22-13 Version) can be found on the DBHDS website at: <http://www.dbhds.virginia.gov/documents/forms/Preadmission%20Screening%20Form%2001-22-2013.pdf>

Again, unless and until the Commonwealth endorses a zero tolerance for *streeting*, this dangerous practice will continue; however, if we collectively agree that *streeting* will not be tolerated in Virginia, it can quickly be eliminated from the mental health landscape and lexicon.

During my travels around the state and countless discussions with emergency services managers, preadmissions screeners, emergency room physicians, and CSB executive directors, I have heard many ideas that, if implemented, would end the practice of *streeting*. Most of those ideas are contained in the 2012 OIG Report and many have been restated in Secretary Hazel's December, 2013 Report and Governor McDonnell's Recommendations.

There is no shortage of good ideas. I challenge the members of this Task Force not to be satisfied with the status quo. Instead of asking "What is?" I challenge you ask, "What could be?" and "What should be?" For example:

- The 2012 OIG Report and Secretary's Hazel's Report to the Governor both mention the electronic Bed Registry as a possible way to reduce the time required to locate an appropriate bed for someone in a psychiatric crisis;<sup>5</sup> but the naysayers quickly observe that the Bed Registry will only work if private psychiatric hospitals promptly update the Registry.

Given the stakes, there is no good reason why private providers should not promptly update a Bed Registry and post the available beds in a forum accessible to all prescreeners. If necessary to accomplish "what should be" instead of "what is," the regulations could be revised to make timely participation in the Bed Registry Program a condition of licensure for psychiatric hospitals.

- State-operated hospitals employ hundreds of staff at each facility. Could one person in each of the state's behavioral health facilities function as a psych bed clearinghouse – a "bed-broker" if you will – for the dozens of preadmission screeners serving each of the state's seven planning regions?
- *Streeting* could be ended the day after revising Code § 37.2-809 (E). Currently the Code requires the receiving facility be listed on the preadmission screening report and the temporary detention order. This could be changed to reflect that the individual "will be detained at a location to be determined"—instead of the current requirement to identify the receiving facility in order to execute the TDO.

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<sup>5</sup> OIG Review of Emergency Services, Report No. 206-11 (pg. 25).  
<http://www.oig.virginia.gov/documents/SS-EmergencySvcsReview206-11.pdf>

- *Streeting* could be greatly curtailed if Emergency Custody Orders (ECO) could be reissued following expiration. My understanding is that the reason a new ECO is not issued following the expiration of the first ECO is rooted in a 15 year-old Attorney General's *Opinion*. If true, this *Opinion* could be revisited for current relevance or revision to the *Code*.
- Authorize, and require, the Commissioner of DBHDS, or his designee, to direct placement of any person meeting criteria for temporary detention in any state-operated hospital if a private facility cannot be located for that individual.

This list of effective actions undoubtedly can be expanded and improved, if Virginia embraces the value that no person meeting TDO criteria will be released as long as they meet the statutory criteria for involuntary detention.

Obviously, revisions to the *Code* will not happen overnight, but there are actions that the Commonwealth can, and should, undertake with all possible dispatch. We cannot rewrite history and retrospectively implement the OIG's February 2012 recommendations, but we can take decisive action on some items that will make a difference. Two such items requiring immediate attention include:

1. Complete updating the *Medical Screening and Assessment Guidance Materials* as quickly as possible. This workgroup last met on **December 11, 2012**. In a December, 2013 meeting with Emergency Services Managers and conversations with Emergency Department physicians, medical clearance remains one of the most time consuming, and unpredictable, aspects of the preadmissions screening process.
2. DBHDS can provide clear operational protocols to all CSBs that include an unequivocal policy statement that every person in a psychiatric crisis will be treated at the appropriate level of in-patient care: *streeting* is an unacceptable outcome in Virginia.

As profoundly sad and shocking as the events of November 19, 2013 were, this tragedy represents a symptom of the underlying problem with the Commonwealth's behavioral health system.

**The underlying problem is that Virginia currently lacks the capacity to serve its citizens with mental illness and, unless we increase the system's capacity, this tragic outcome will be repeated.**

No one credibly disputes that Virginia needs more community-based behavioral health programs, including permanent supported housing, for individuals with mental illness.

At the same time, the Commonwealth also needs to use its existing resources more efficiently. For example, the state-operated facilities continue to serve people that have been determined to be discharge-ready. These are individuals who could be discharged and return to their communities if the community-based programming and housing existed to serve them. At least 10% of the state facility psychiatric beds continue to be occupied by people who could be served in the community.<sup>6</sup> When facility beds are occupied by discharge-ready people, some state facilities will be unable to admit people in need of acute care for temporary detention because they are at capacity.

Speaking of capacity, I recommend that the Task Force inquire into why the state operated behavioral health facilities had an operating capacity of 1,487, but a census of 1,200 as of September 12, 2013.<sup>7</sup> Further, according to the December 2013 update of the *Comprehensive State Plan*, “In FY 2013, state facilities served 5,772 individuals, down from 6,238 in July 2012 and 6,338 in July 2011.” (pg. ii)

As the Commonwealth’s public sector system has been operating, at least 10% of the state facility beds are occupied by people who could be discharged into the community and approximately 20% of the operating capacity went unused on September 12, 2013. With roughly a third of the system’s facility capacity either unused or used for people deemed discharge-ready, it is not surprising that the state facility system served about 10% fewer people in FY 2013 than it did two years earlier. Three obvious questions arise:

1. Does anyone believe that there is 10% less acuity in the Commonwealth’s mental health system today than there was two or three years ago?
2. Has the DBHDS’s cost for facilities operation gone down by 10%? and,
3. Has the budget for community mental health been increased by 10% since 2011?

As the *Barriers to Discharge Report* observed, the component parts of Virginia’s mental health system are interdependent. When state-operated facilities are at capacity, people needing acute and long-term care can be denied admission to those facilities. Likewise,

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<sup>6</sup> *Review of the Barriers to Discharge in the State-Operated Adult Behavioral Health Facilities*, OIG Report No. 207-12, April 2012. <http://www.oig.virginia.gov/documents/Syst-Rev-207-12.pdf>

<sup>7</sup> *Comprehensive State Plan 2014-2020*, Virginia Department of Behavioral Health and Developmental Services, pg. i. (December 2013). <http://www.dbhds.virginia.gov/documents/reports/opd-StatePlan2014thru2020.pdf>

when community-based programs are insufficient to allow for the timely discharge of individuals from state hospitals, and individuals must remain involuntarily committed for months, or years, after being determined ready for discharge, then the state-operated facilities may not be able to admit people in desperate need of acute or long term care.

There is cohort of individuals with mental illness who move between the community and facility systems of care. When community capacity is insufficient to absorb the individuals released from state hospitals and state facilities erect barriers to admissions, (like the requirement to call 8, 10, or 15 private facilities before seeking a TDO admission in a state hospital) the people in need of acute care will be directed to private psychiatric facilities—or will end-up in our local and regional jails.

Since 2008, the number of individuals identified with mental illness in jails has increased by 30%, from 4,879 to 6,322.<sup>8</sup> Each year, several thousand people with mental illness move among community-based programs, state-operated behavioral health facilities, and local or regional jails.

In its 2012 *Review of Emergency Services*, the OIG observed that, every time a person meeting criteria is denied temporary detention, it represented a failure of the system and placed that person, their family and their community at-risk.

Another preventable human tragedy waiting to happen in the Commonwealth will occur when a person is released from a private psychiatric facility after a brief period of hospitalization for acute symptoms, with a discharge summary reflecting that, “this person has received maximum benefit from this hospitalization.”

The unspoken part of this discharge summary will be that the state-operated facility has denied admission for the patient and the private provider has no reimbursement path for the continued hospitalization of this individual. When the transfer of patients to state operated facilities for long-term care is not an option, private providers must choose between either not being paid for services or discharging the individual.

If the regional state facility creates barriers to admission and there is no clear path to reimbursement for services rendered, it should come as no surprise that some private providers will avoid admitting a person under a TDO who might require long-term treatment—treatment for which they may not be paid.

In conclusion, during this presentation, I have chosen to use the term *streeted* (instead of failed-TDO) because it is shocking. The term offends our sensibilities, and our common sense, when a person meeting statutory criteria for hospitalization is allowed to

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<sup>8</sup> Comparison of the 2008 and 2012 Compensation Board Report on Mental Illness in Jails.

leave an emergency room following an evaluation concluding that he, or she, is in need of hospitalization.

I will never forget where I was when the media reported that Gus Deeds had attacked his father and had taken his own life after a bed could not be found to execute a temporary detention order. I sobbed at the news—and, honestly, for days after. I will always wonder what I could have done differently in the last two years to shed more light on *streeting* that may have produced a different outcome on November 19, 2013.

I recommend that the Task Force consider how it will ensure that its recommendations are actually implemented and to directly address the issue of accountability in its Report to the Governor and the General Assembly.

My hope is that the Task Force will be focused by recent events to identify and finally address the underlying capacity problems with the Commonwealth's system of care for its citizens with mental illness—so that no family ever has to experience what the Deeds family is going through.

Thank you for the opportunity to speak with the Task Force today. I remain,

Sincerely,

*G. Douglas Bevelacqua*

G. Douglas Bevelacqua

Governor's Budget for Virginia's  
Behavioral Health System  
and  
Secretary of Health and Human Resources'  
Recommendations Based on the  
Review of the Tragedy in Bath County

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**John Pezzoli**

DBHDS Assistant Commissioner  
for Behavioral Health Services

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# Mental Health Crisis Response Governor's Budget Submission

Budget Action	General Fund FY 2015	General Fund FY 2016
Provide for a 2 <sup>nd</sup> 2-hour Emergency Custody Order extension to the 4 hour ECO period	Negligible	Negligible
Increase max TDO period from 48 to 72 hours	\$1.4M	\$1.7M
Ensure operational supports for new Western State Hospital (WSH) facility	\$0.7M	\$0.7M
Maintain current adult capacity at Eastern State Hospital (ESH)/Replace lost Medicaid revenues from decreased demand for geriatric beds	\$5.0M	\$5.0M
Expand adult capacity at ESH in FY 2015 – Opens vacant 20-bed geriatric unit for non-geriatric use	\$2.2M	\$2.2M
Expand availability of secure intervention team (CIT) assessment centers	\$1.8M	\$3.6M
Expand telepsychiatry	\$1.1M	\$0.6M

# MH/SA Treatment & Support Services Governor's Budget Submission

Budget Action	General Fund FY 2015	General Fund FY 2016
Expand MH outpatient services for older teens and young adults; Hire 34 clinicians	\$3.5M	\$4.0M
Expand Program of Assertive Community Treatment (PACT)	\$1.0M	\$1.9M
Expand peer support recovery programs	\$0.6M	\$1.0M
Substance abuse community recovery program	\$0.3M	\$0.3M

# Secretary of Health and Human Resources Review

- Included reviews of pertinent medical records and interviews with clinicians, hospital personnel, and law enforcement personnel involved in the events of November 18, 2013.
- Conducted by DBHDS Licensing and Program staff.
- To comply with state confidentiality laws and to respect the privacy of the family, the full report of the review has not released.
- 15 recommendations to improve Virginia's mental health system in categories including the civil commitment process, facility of temporary detention, and creation of adequate service capacity.

# HHR Secretary Recommendations Civil Commitment Process

Amend Virginia *Code* to clarify responsibility for notifying CSBs:

1. When an emergency custody order (ECO) has been issued by the magistrate
2. When the ECO has been executed by law enforcement
3. Of the location to which the individual has been taken for the preadmission screening assessment

Clarify through education of CSBs and willing hospitals that preadmission screening can be carried out electronically and provide funding to assure all CSBs have adequate and appropriate equipment to perform electronic screenings.

# HHR Secretary Recommendations Civil Commitment Process

Amend Virginia *Code* to provide an option for further extending the ECO period beyond 6 hours when the CSB clinician has determined the individual meets criteria for a temporary detention order (TDO) and additional time is needed to locate an available bed at a willing facility.

Consider removing the requirement that the facility of temporary detention be specified on the TDO.

Conduct a study to assess the need statewide for secure assessment sites and establish these sites in communities across the state as indicated by the study.

# HHR Secretary Recommendations Facility of Temporary Detention

Complete the implementation of the electronic psychiatric bed registry that is currently under development. Develop guidelines with the involvement of the CSBs and private hospitals to help assure that the database is maintained to reflect real time accuracy of available beds.

Explore other technological capacities such as video conferencing and electronic exchanges of information that may improve the processes of finding and documenting resource availability in crises.

Complete and implement revised guidelines for medical screening for use by private and state psychiatric hospitals and emergency departments.

# HHR Secretary Recommendations Facility of Temporary Detention

Clarify and assure more consistent and widespread awareness of the procedures for when the state hospital in the region should be contacted to secure a bed for the TDO and what prerequisites the CSB must meet before contacting the state hospital.

Clarify when it is appropriate for a state hospital to be utilized for temporary detention and process for requesting and accessing such a bed.

Clarify the role and expectations of crisis stabilization programs related to accepting individuals under temporary detention.

# HHR Secretary Recommendations Creation of Adequate Service Capacity

Expand the availability and capacity of services within the full crisis services response continuum in order to provide more effective alternatives to hospitalization in crises and to provide access to inpatient services when this is the most appropriate response.

Conduct a study to determine the needs in each Virginia region for services to enable assessment and early identification of emotional and psychiatric concerns for children and adults, the provision of ongoing treatment and supports for children, adults and their families that will help maintain stability and functionality in their communities and thereby reduce the frequency and intensity of psychiatric crises.

# HHR Secretary Recommendations Creation of Adequate Service Capacity and Other Recommendations

Assure continued and increased efforts to provide assistance to enable persons who no longer require inpatient services to be discharged from hospitals, thereby freeing up hospital resources for additional persons needing inpatient level of services.

## ***Other Recommendation***

Explore all avenues to increase and improve cooperation and mutual support through the partnerships between CSBs, state hospitals, private hospitals, law enforcement and judicial officials.