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

July 15, 2014
1 p.m. – 4 p.m.
Patrick Henry Building, Richmond, VA

Workgroup Meetings Agenda

All Workgroups Have the Same Agenda except Crisis Response

1:00 p.m. – 1:10 p.m.	Welcome and Recording of Members Present
1:10 p.m. – 1:15 p.m.	Approval of Minutes
1:15 p.m. – 3:00 p.m.	Discuss items for possible recommendation and ensure previous recommendations cover responsibility for Executive Order 12.
3:00 p.m. – 4:00 p.m.	Develop and record up to 3-5 actionable recommendations to send to full Taskforce based on discussion
4:00 p.m.	Adjourn

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

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

DATA and TECHNICAL INFRASTRUCTURE WORKGROUP

May 21, 2014

10 a.m. – 2 p.m.

Monroe Building, Richmond

MEETING MINUTES

Members Present

James Agnew, Sheriff, County of Goochland.
David Coe, Colonial Behavioral Health
Christine Hall, Poplar Springs Clinical Services
Cindy Koshatka, Region II Mental Health
Betty Long, Virginia Hospital & Healthcare Association (VHHA)
Vicki Montgomery, Central State Hospital
Bill Phipps, Magellan Behavioral Health
Margaret Schultze, Department of Social Services
Anne Wilmoth, State Compensation Board
Jim Whitley, Superintendent, Northwestern Regional Adult Detention Center
Eddie Macon, Assistant Executive Secretary for the Virginia Supreme Court
Cindy Rogers, Optima Health
Lucy Rotich, Bon Secours Behavioral Health –Maryview

Staff Present

Kathy Drumwright, DBHDS
Dee Keenan, DBHDS
William O'Bier, DBHDS
Nathan Miles, DBHDS

Members Absent

Kent Alford, MD Novant Health Prince William Medical Center
Gail Burruss, Blue Ridge Behavioral Health
Richard Edelman, Henrico Area Community Services
Marissa Levine, VA Department of Health
Lance Forsythe, Superintendent, Southside Regional Jail
Jake O'Shea, VA College of Emergency Physicians
Cindy Frey, VCU Medical Center
Scott Reiner, CSA for At-Risk Youth & Families (CSA)
Mark Kilgus, VA Tech Department of Psychiatry & Behavioral Health
Michael Lundberg, VHI
Karl Hade, Virginia Supreme Court

Others Present

Edie McRee Bowles, Virginia Telehealth Network
Tyrone Jackson, 9th District Court Service Unit

Karen S. Rheuban, MD, University of Virginia, Center for Telehealth
Katharine Wibberly, PhD, University of Virginia, Center for Telehealth

MEETING MINUTES:

Prior to formal meeting business Secretary William Hazel addressed the group to thank members for their work and offer some thoughts about what we needed to consider going forward for our system. In brief, his message was to be thinking about data needs and focus on creating a system that is accountable. Commissioner Debra Ferguson also introduced herself to the group and offered her support in the work that was being done.

Approval of Minutes:
Minutes from March 19, 2014 were approved.

Kathy Drumwright initiated a round of introduction of members present and announced that there was one demonstration and three presentations scheduled that would offer information on current utilization of telehealth services and potential opportunities for its use in behavioral health.

Presentations:

Statewide Video Intake--
Tyrone Jackson, Video Intake Supervisor, Department of Juvenile Justice, 9th District Court Service Unit provided a video demonstration on using Statewide Video Intake, VIA3, which is used to complete after-hours video intakes on juveniles.

History of After Hours Video Intake:

- In the early part of 2000, the Fairfax County Court Service Unit (CSU) and the 28th District Court Service Unit were the first to utilize the concept of after hour's intake by way of video teleconferencing. Shortly thereafter, (April, 2001) Fairfax County Court Service Unit also began providing after hours intake for the 9th District Court Service Unit. The 9th District Court Service Unit was chosen as a pilot video intake site in August, 2001 and began operation March, 2002 with Fairfax Court Service Unit providing backup to the 9th
- Countless hours of travel and time have been saved as a result of this initiative and application of technology. Video Intake provides a fast efficient means to complete after hours intake cases so that probation officers who have already worked their normal work shift do not have leave their homes to respond.
- In addition, law enforcement officers do not have to wait for probation officers and it increases public safety for the community
- At the present time the 9th CSU Video Intake provides coverage to court service units for 117 localities in the Commonwealth.
- Based on the need for a more flexible and less costly system to complete video based intakes, the agency began reviewing other possible ways to complete video conferences and be able to complete petitions and detention orders without having to fax copies back and forth. With the help our MIS Director, we explored some options and finally in June, 2007 a RFP committee was formed to develop a RFP for a secure IP based Video Conference System. The VIA3 Corporation was chosen to provide their web-based encrypted multiparty video solution VIA 3. The system provides a cost effective video conferencing system over an encrypted backbone that can be operate over high speed internet using a desktop or laptop computer and the documents can be signed electronically by both parties with no additional cost for the calls. The documents can then be printed at each video site without being faxed back and forth.
- Use of VIA3 provides a better video system at a much lower cost and allowed our agency to expand locations not only to complete after hours intakes but to also make supervision contacts with juveniles in our juvenile correctional centers.

- Link to VIA3 Corporation: http://www.via3.com/
- The system is HIPAA compliant, Cost= $20 per license per month. Uses HP tablets with internal web cams. No additional cost for software.
- Data storage—can down load documents and not take up space

Some questions and discussion from the workgroup members were as follows:
- Could an Emergency Service (ES) worker use something like this and be more efficient?
- Could parts of this system be used to fax documents---i.e. prescreening forms?
- Will this system interface with an electronic health record (EHR)?
- Can we explore other options with other companies?
- Can this system be phased in?
- Can it be used to network and provide information?
  Such as—
  - Lab results
  - Emergency department documentation—medical screening data, Doc to Doc communication
  - Communications with magistrates

Telehealth—Presenation to the Mental Health Task Force Data and Technology Workgroup
Karen S. Rheuban, MD
University of Virginia
Center for Telehealth

An electronic copy this presentation will be made available to workgroup members. Some presentation highlights were as follows:

UVA Center for Telehealth:
- Integrated program across the service lines and schools within the University that facilitate our missions of:
  - Clinical Care
  - Teaching across the continuum
  - Research and innovation
  - Public service/Public policy
- Centralized coordinated program within Health System
- HRSA funded Mid Atlantic Telehealth Resource Center
- Academic partner with Specialists on Call

Benefits of telehealth:
- For Patients:
  - Timely access to locally unavailable services
  - Enhances patient choice
  - Reduces the burden and cost of transportation for care
- For Health professionals
  - Access to consultative services
  - Supports collaborative care delivery models
- For Hospital systems
  - Decreases readmissions
  - Improves triage, keeps patients local when appropriate

- For Communities
    - Broadband expansion (Rural healthcare support mechanism, FCC programs)
    - Hospital viability as economic driver of rural and urban communities
- For Public health
    - Emergency preparedness
    - Disease surveillance

Issues for consideration in any telehealth program

- Funding of telehealth
- Stark, Anti-kickback regulations
- Grants versus institutional capital
- Technologies, telecommunications venues
- Sustainability of program
- Reimbursement - Medicare, Medicaid, private pay, contractual, patient
- Evolution from FFS to capitated care and outcomes based models

Tele-mental health

- Shortage of mental health providers in rural areas
- Consultations, medication management, emergency telepsychiatry
    - Improve access, shorter wait times
    - High rates of patient satisfaction in all age groups
    - Fewer no shows
    - Controlled studies show efficacy comparable to face to face psychiatry
- NUMBER ONE request for services at UVA

Mid-Atlantic Telehealth Resource Center
Katharine Wibberly, PhD

An electronic copy this presentation will be made available to workgroup members. Some presentation highlights were as follows:

The Mid-Atlantic Resource Center (MATRC; http://www.matrc.org/) advances the adoption and utilization of telehealth within the MATRC region and works collaboratively with the other federally funded Telehealth Resource Centers (TRC) to accomplish the same nationally. MATRC offers technical assistance and other resources within the following Mid-Atlantic States: Delaware, District of Columbia, Kentucky, Maryland, North Carolina, Pennsylvania, Virginia and West Virginia.

TRCs are funded by the U.S. Department of Health and Human Service Health Resources and Services Administration (HRSA) Office for the Advancement of Telehealth, which is part of the Office of Rural Health Policy. Nationally there are 14 TRCs, 12 regional and one Telehealth Technology Assessment Center and one Telehealth Policy Resource Center. The TRCs have a mission to serve as a focal point for advancing the effective use of telehealth and support access to telehealth services in rural and underserved communities.

Building a Behavioral Telehealth Network- Bay Rivers Telehealth Alliance
Edie McRee Bowles

An electronic copy this presentation will be made available to workgroup members. Some presentation highlights were as follows

History and Service Area:

- Founded 2004 as an initiative of the Rappahannock AHEC to reduce barriers to health care by bringing telehealth to the region
- A vertical network of healthcare provider members, the Alliance received its IRS Tax-exempt status in 2007, and became independent in 2008
- The original geographic area of 10 rural counties in Middle Peninsula and Northern Neck was expanded in 2011 to include 2 Eastern Shore counties and the nearby urban-suburban areas of Tidewater Virginia and Greater Richmond

Expansion of Telehealth Services:

- From the initial 4 telehealth sites in 2007 that included 2 rural hospitals and access to specialists at 2 academic medical centers…
- By 2014, the Network has grown to 23 sites, acquired the required infrastructure telecommunication equipment to support multiple end points, with regular use of mobile applications by many providers, and recently added store-and-forward content sharing capabilities
- Enabling physicians and behavioral health specialists to improve health outcomes for rural patients throughout the Northern Neck, Middle Peninsula, Eastern Shore, Hampton Roads, and surrounding areas

Review of Workplan:
After the demonstration and presentations Kathy Drumwright facilitated a review of the group's workplan and a discussion to ensure previous recommendations cover responsibility for Executive Order 12 and the referred legislations, and to gather any additional recommendations from the workgroup.

Work Plan Items and discussed recommendations:

1. Identify and examine the availability of and improvements to mental health resources for Virginia's veterans, service members, and their families and children.
   Today's discussion included the following potential recommendations:
   - What data elements are needed related to veterans---consider wounded warrior programs and the need to incorporate this into our plan
   - Consider veteran's access to emergency services and review of availability of services to military families now.

2. Examine the mental health workforce capacity and scope of practice and recommend any improvements to ensure an adequate mental health workforce.
   Today's discussion included the following potential recommendations:
   - Who can do telehealth—what are the potential barriers—licensure and credential issues--scope of services
   - How do we involve the consumer?
   - Consider the expansion of peer delivered services
   - Add judges and encourage the use of specialty courts
   - Consider do we have enough magistrates—look at current resources

3. Examine the mental health workforce capacity and scope of practice and recommend any improvements to ensure an adequate mental health workforce.

4. Explore technological resources and capabilities, equipment, training and procedures to maximize the use of telepsychiatry.
   Today's discussion included the following potential recommendations:
   - Recommend a smaller work group
   - Should be a statewide network with single state administration, management and over site so that it works seamlessly
   - Certification—update training for pre-screeners
   - Leverage existing infrastructure
   - Consider more cohesive approach to MW/SA services in jails----there are gaps

5. Recommend refinements and clarifications of protocols and procedures for community services boards, state hospitals, law enforcement and receiving hospitals.
   Today's discussion included the following potential recommendations:
   - Standardize statewide training
   - Look at funding strategies
   - Consider the need for regular interaction of various participants in the system to come up with a process to enhance communication between public and private providers
   - Ongoing and involvement from stakeholders ---similar to the CIT model

6. Examine extensions or adjustments to the emergency custody order and the temporary detention order period.
   Today's discussion included the following potential recommendations:
   - Enable law enforcement responders to have access to TDO/ECO information
   - What would a statewide assessment site look like? –especially in rural areas—what about capacity

7. Examine the cooperation that exists among the courts, law enforcement and mental health systems in communities that have incorporated crisis intervention teams and cross systems mapping.
   Today's discussion included the following potential recommendations:
   - Include all key players to improve ongoing communication
   - TDO Task force---consistent training and application across the state

8. Assess state and private provider capacity for psychiatric inpatient care, the assessment process hospitals use to select which patients are appropriate for such care, and explore whether psychiatric bed registries and/or census management teams improve the process for locating beds.
   Today's discussion included the following potential recommendations:
   - Use data from PBR to help inform
   - Recognize that there are certain types of patients are difficult to place —ID/ DD/ Geriatric
   - Think about a specialized step-down service with the capacity to deal with difficult and complex cases
   - Consider opportunities to automate data entry

9. Review for possible expansion those services that will provide ongoing support for individuals with mental illness and reduce the frequency and intensity of mental health crises. These services may include rapid, consistent access to outpatient treatment and psychiatric services, as well as co-located primary care and behavioral health services, critical supportive services such as wrap-around

stabilizing services, peer support services, PACT services, housing, employment and case management.
Today's discussion included the following potential recommendations:

- Review the disincentive of using MOT—related to payment for special judges
- Expanded patient monitoring after discharges
- Examine telehealth—explore all applications of teleheath as a way of service delivery

10. Recommend how families and friends of a loved one facing a mental health crisis can improve the environment and safety of an individual in crisis.
    Today's discussion included the following potential recommendations:
    - Increase education on Advance Directives and encourage use of crisis plans, WRAP plans, and Mental Health First Aide
    - Explore application for MH Support services
    - Utilize NAMI and other resources to promote and provide education on prevention and wellness

ANY NEXT STEPS: Betty Long will present recommendations from the work group to the next Task Force meeting on June 16, 2014. Kathy Drumwright thanked the workgroup members for their participation and stated that we would consolidate the recommendations going forward.

The meeting adjourned at 2:00 p.m.

Governor's Taskforce on
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ONGOING TREATMENT AND SUPPORTS WORKGROUP

May 21, 2014

10 a.m. – 2 p.m.

Monroe Building, Richmond

MEETING MINUTES

Members Present

Richardean Benjamin, Old Dominion University
Mary Ann Bergeron, Executive Director, Virginia Association of Community Services Boards
Jan Brown, Acting Director, Substance Abuse and Addiction Recovery Alliance (SAARA)
Debbie Burcham, Executive Director, Chesterfield Community Services Board
Molly Cheek, LCSW, President, Dominion Youth Services
Steven Crossman, MD, Associate Professor, VCU Department of Family Medicine
William Elwood, AEGIS Associates, LLC
Nancy Fowler, Program Manager, Office of Family Violence, Virginia Dept. of Social Services
Cristy Gallagher, Research Director, George Washington University
Teshana Henderson, CAO, NDUTIME Youth & Family Services
Jean Hovey, family member
John Kuplinski, Superintendent, Virginia Peninsula Regional Jail
Anne McDonnell, Executive Director, Brain Injury Association of Virginia
Paula Mitchell, VP Behavioral Health Services, LewisGale Medical Center
Greg Peters, President and CEO, United Methodist Family Services
Beth Rafferty, Director of Mental Health Services, Richmond Behavioral Health Authority
Mira Signer, Executive Director, NAMI Virginia
Sunil Sinha, MD, Chief Medical Officer, Memorial Regional Medical Center, Bon Secours Richmond Health System
Terry Tinsley, PhD, Youth for Tomorrow
Chuck Walsh, Executive Director, Middle Peninsula-Northern Neck CSB
Tammy Whitlock, Manager, Maternal and Child Health Division (Brian Campbell representing)
Thomas Wise, MD, Dept. of Psychiatry, Inova Fairfax Hospital
The Honorable Gabriel Morgan, Sheriff, City of Newport News
The Honorable Dana Lawhorne, Sheriff, City of Alexandria
Lt. Col. Martin Kumer, Albemarle/Charlottesville Regional Jail
David Mangano, Director of Consumer and Family Affairs, Fairfax County Government
John Kuplinski, Superintendent, Virginia Peninsula Regional Jail

Staff Present

Daniel Herr, JD, Assistant Commissioner for Behavioral Health Services, DBHDS
Janet Lung, LCSW, Director, Child and Family Services, DBHDS
Laurel Marks, Manager, Juvenile and Adult Services, Department of Criminal Justice Services
Mellie Randall, Director, Office of Substance Abuse Services, DBHDS
Michael Shank, Director, Community Support, Office of Mental Health, DBHDS

"Good and Modern" Behavioral Health Service Array

- = Ongoing Tx & Supports Recommendations
  - *= Other Workgroups' Recommendations*

Physical Health
General and specialized outpatient medical services
Acute primary care
General health screens, tests and immunization
Comprehensive Care management
Care coordination and health promotion
Comprehensive transitional care
Individual and Family Support
Referral to Community Services

- Integrated primary care teams

Prevention (including Promotion)
Screening, Brief Intervention and Referral to Treatment
Brief Motivational Interviews
Screening and Brief Intervention for Tobacco Cessation
Parent Training
Facilitated Referrals
Relapse Prevention/Wellness Recovery Support
Warm line

- Mental Health First Aid (MHFA)
- Expand Suicide Prevention programs
  - *CR – Train on Advanced Planning and WRAP*

Engagement Services
Assessment
Specialized Evaluations (psychological, Neurological)
Service planning (including crisis planning)
Consumer/Family education
Outreach

Outpatient Services
Individual Evidenced Based Therapies
Group therapy
Family therapy
Multi-family therapy
Consultation to Caregivers

Medication Services
Medication management
Pharmacotherapy (including MAT)
Laboratory services
- *CR – Emergency Service's Access to Prescribers*

Community Support (Rehabilitative)
Parent/Caregiver Support
Skill building (social, daily living, cognitive)
Case Management
Behavioral management
Supported Employment
Permanent Supported Housing (PSH)
Recovery housing
Therapeutic mentoring
Traditional healing services

- PSH
- Expand Auxiliary Grant

Other Supports (Habilitative)
Personal Care
Homemaker
Respite
Supported Education
Transportation
Assisted Living Services
Recreational Services
Interactive Communication Technology Devices
Trained behavioral health interpreters
- *T&D – Tele-psychiatry/Tele-health*
- *CR – Tele-psychiatry*

Intensive Support Services
Substance abuse intensive outpatient services
Partial hospital
Assertive community treatment
Intensive home based treatment
Multi-systemic therapy
Intensive case management

- Assertive Community Treatment (PACT)
- *PS-* • CIT Programs

Out-of-Home Residential Services
Crisis residential/stabilization
Clinically Managed 24-Hour Care
Clinically Managed Medium Intensity Care
Adult Mental Health Residential
Children's Mental Health Residential Services
Youth Substance Abuse Residential Services
Therapeutic Foster Care

- Crisis Stabilization Centers
- *PS-* • CIT Assessment Centers

Acute Intensive Services
Mobile crisis services
Medically Monitored Intensive Inpatient
Peer based crisis services
Urgent care services
23 hour crisis stabilization service
24/7 Crisis Hotline Services

- Crisis Intervention Teams
- *PS - Alternative Transportation*
- *CR – Compensate Transporters*

Recovery Supports
Peer Support
Recovery Support Coaching
Recovery Support Center Services
Supports for Self Directed Care
Continuing Care for Substance Use Disorders

- Peer to Peer

Implement What Works: Existing Best Practices shown above and

- Continue to fund Discharge Assistance Programs to maximize flow-through in state hospitals

Establish a Standard and Efficient Single Point of Access

- No wrong door
  - *PS - Community Awareness; Standardized Pathway to Access Services*
- Timely access to service
  - *CR - Access to Consistent Psychiatric Services – Benchmark and Fill Gaps*
  - *CR - Regional Access to Hospital Bed Protocols*
- Coordinate services needed by the person across agencies

System Reinvention

- Needs assessment is required to determine current capacity and gaps
- Pilots
- Community collaboration
  - *PS – Share Best Practices in Communication with Law Enforcement*
  - *T&D – First Responder Access to TDO Database*
  - *CR – Coordination between Private and VA Hospitals and CSBs and VA; Expand Va. Wounded Warriors Program; Educate about Needs of Veterans*
- Integrated community system of care – public-private partnership
  - *T&D – DBHDS to Ensure Communication among Public & Private Service Providers re Best Practices and Problem Solving*
- Make the system more user-friendly for people across the lifespan
  - *T&D – Education/Support Families with Psychiatric Advance Directives, Apps for MH Support, Resource Information, MHFA*
  - *CR – Authorize Protected Health Information Sharing re TDO Candidates with Law Enforcement, Health Care Providers, and Families/Guardians*
- Address the under-funded system
- Reinvestment of savings
- Address rising costs of services over time
- Health care coverage reform.

Ideas for guiding principles:

1. There should be no wrong door. There should be effective access to care.
2. There should be a culture of responding to human needs. Communication to consumers and families should be very clear, not confusing.
3. A continuum of care from least restrictive to most restrictive that covers the lifespan should be available statewide. The continuum should include follow-up and case management.
   - *PS – Readily Available Full Service MH Services, including Prevention*
4. There should be cross-system care coordination and collaboration (e.g., across CSBS, health, social services, criminal justice, education, housing, etc.).
   - *PS – Center of Excellence on Behavioral Health/Criminal Justice*
5. There should be diversion from jail and homelessness.
   - *PS – Behavioral Health Courts with Veterans' Dockets*
6. Prevention and early intervention services must be available.
7. Services should be culturally relevant.
8. The workforce should be adequate to meet the need and properly trained.
   - *T&D – Eliminate Scope of Practice Issues Limiting Tele-health*
9. There should be adequate and sustainable funding for services and supports.

CSB/BHA Charge from Code of Virginia

§ 37.2-500. Purpose; community services board; services to be provided.

The Department, for the purposes of establishing, maintaining, and promoting the development of mental health, developmental, and substance abuse services in the Commonwealth, may provide funds to assist any city or county or any combinations of cities or counties or cities and counties in the provision of these services. Every county or city shall establish a community services board by itself or in any combination with other cities and counties, unless it establishes a behavioral health authority pursuant to Chapter 6 (§ 37.2-600 et seq.). Every county or city or any combination of cities and counties that has established a community services board, in consultation with that board, shall designate it as an operating community services board, an administrative policy community services board or a local government department with a policy-advisory community services board. The governing body of each city or county that established the community services board may change this designation at any time by ordinance. In the case of a community services board established by more than one city or county, the decision to change this designation shall be the unanimous decision of all governing bodies.

The core of services provided by community services boards within the cities and counties that they serve shall include emergency services and, subject to the availability of funds appropriated for them, case management services. The core of services may include a comprehensive system of inpatient, outpatient, day support, residential, prevention, early intervention, and other appropriate **mental health, developmental, and substance abuse services necessary to provide individualized services and supports to persons with mental illness, intellectual disability, or substance abuse.** Community services boards may establish crisis stabilization units that provide residential crisis stabilization services. (emphasis added)

In order to provide comprehensive mental health, developmental, and substance abuse services within a continuum of care, the community services board shall function as the single point of entry into publicly funded mental health, developmental, and substance abuse services.

Virginia Code-Mandated Services/Functions for CSB/BHAs under Titles 37.2 and 16.1 of the Code:

- Emergency Services for psychiatric crises, 24/7 via phone or in-person and 24/7 in person response for pre-admission screening
- Pre-admission screening for involuntary detention, pre-admission screening report available for Special Justice at commitment hearing, recommendation to magistrate for a Temporary Detention Order (TDO), and locating a psychiatric bed if the magistrate issues a TDO.

  (As of July 1, mandates will increase as a result of new legislation to include:
  -Providing all those screened with rights and description of the process-this may not be a CSB responsibility
  -Notifying state hospital of a screening as a result of an Emergency Custody Order (ECO)
  -Specifying a state hospital to receive a TDO while continuing to work on locating a more appropriate bed

- Assuring paperwork changes are accurate
-Utilizing psychiatric bed registries

- Attendance at every commitment hearing, which follows every TDO that is executed.
- Preadmission screening for all state facility admissions
- Case management for those who qualify through DBHDS criteria and provided within available resources
- Discharge planning for individuals being discharged from state facilities: state psychiatric hospitals and Training Centers
- Oversight of Mandatory Outpatient Treatment (MOT) and reporting to the Court on the MOT
- Provision of MOT services if no other provider is available or willing
- Engage with DBHDs in annual Performance Contract which stipulates requirements for receipt of General Funds, populations to be served, data reporting, and other accountability and assurances.

Mandates other than contained in Titles 37.2 and 16.1

- As designated by the Commissioner, implement conditional release plan for those adjudicated Not Guilty by Reason of Insanity (NGRI) and report to the Court on adherence (19.2-182.7)
- CSB Staff participation on every Family Assessment and Planning Team (FAPT) (2.2-5207)
- CSB Participation on every Community Policy and Management Team (CPMT) (2.2-5205)
- CSB Director to sit on every Community Criminal Justice Board (9.1-178)
- CSBs to receive referrals from local threat assessment teams (22.1-79.4)
- Participation on local interagency coordinating councils. (2.2-5305).
- MOUs for emergency services and referrals with community colleges (23-219.1)
- VICAP assessments through the Appropriations Act
- CIT partnerships through the Appropriations Act
- Other provisions of Appropriations Act

Federal Mandates:

- Each CSB/BHA is a Voter Registration site and must adhere to all federal and state regulations and training about Voter registration.

Core services from Taxonomy that CSBs <u>may</u> provide, manage or contract in addition to the Code-mandated services:

- Psychiatric Consultation
- Medication Management
- Crisis Stabilization and Crisis Intervention
- Day Treatment for behavioral health, including psycho-social rehabilitation programs
- Day Support for ID
- Housing and Residential Arrangements

- Program of Assertive Community Treatment (PACT-if a PACT site)
- Outpatient Counseling
- Vocational and Employment Services
- Part C Early Intervention Services for Infants and Toddlers (IDEA) (which must be implemented and provided according to federal law for IDEA)
- Prevention Services including substance use, suicide and violence prevention, Mental Health First Aid training
- Crisis Stabilization Units and Crisis Stabilization Response
- Crisis Receiving Centers in partnership with health systems and law enforcement organizations

Financing of the Community Services System

Funding Streams consist of: Medicaid Fees; State General Funds; Local Government Funds; Federal Block Grant Funds; other streams that can include third-party fees, grants, and other support.

Much of the General Fund dollars are specified in the Appropriations Act.

All CSB/BHA funds are reported and accounted for in the DBHDS Performance Contract with each CSB/BHA. DBHDS requires an annual audit of each CSB/BHA. As well, local governing bodies review and sign off on the CSB/BHA Performance Contracts as required by Code.

Excerpts from the Virginia Action Plan to End Veteran Homelessness

In 2010, Virginia's Homeless Outcomes Advisory Committee outlined five strategies to attain the goal of reducing overall homelessness in Virginia by 15 percent by the end of 2013. Implementation of the strategies continues to be overseen by the Homeless Outcomes Coordinating Council (HOCC) which operates within the executive branch. Veteran specific action steps are incorporated under each strategy and support the goal to end veteran homelessness by the end of 2015.

The purpose of this plan is to outline the key action steps necessary to meet the 2015 target to end veteran homelessness in Virginia. This plan was informed by research on best practices in Virginia and across the nation as well as input from state and local stakeholders. The action steps build on the tremendous efforts of state and local homeless response systems in recent years that have reduced the number of people experiencing overall homelessness in Virginia by 16% from 2010-2013.

Goal: Prevent and end homelessness among veterans by the end of 2015

Veteran Action Steps (VAS):

HOCC Strategy 4: Increase access to mental health and substance abuse treatment

VAS 4.1: Educate [Homeless Services Continuums of Care] CoCs about veteran specific resources including Federal and State benefits

VAS 4.2: Close the coverage gap to increase access to Medicaid

VAS 4.3: Ensure that mental health services and supports are readily accessible for transitioning service members and families

VAS 4.4: Collaborate with the Virginia Wounded Warrior Program (VWWP) to provide cross training of military culture, post-combat and post-military transitions, and veteran specific treatment and support resources

HOCC Strategy 5: Evaluate, develop and ensure implementation of statewide, pre-discharge policies…

VAS 5.1: Identify opportunities to provide critical time intervention among transitioning Guard/Reserves/Active Duty and recently exited veterans to engage them in services and benefits (employment, education, and supportive services) available through VA, DVS (including the Virginia Wounded Warrior Program) and other community-based agencies

VAS 5.2: Increase opportunities to include homeless veterans in current and future initiatives regarding employment, training, and workforce development

VAS 5.3: Collaborate with veteran courts and veteran specific reentry initiatives [VA, Virginia Wounded Warrior Program, Department of Corrections (DOC)

VAS 5.4: Ensure hospitals and mental health facilities are collecting veteran status and housing stability data

Richmond Times-Dispatch Richmond Times-Dispatch Monday, Jul. 7, 2014

“Kaine joins bipartisan push for improving veterans' access to health care”

Sen. Timothy M. Kaine, D-Va., has joined a bipartisan group of senators to introduce legislation aimed at improving veterans’ access to health care and address the challenges facing the Department of Veterans Affairs.

The Veterans’ Access to Care through Choice, Accountability and Transparency Act of 2014 would allow veterans to see private doctors outside the VA system if they experience long wait times or live more than 40 miles from a VA facility for a two year period.

S.2450 - Veterans' Access to Care through Choice, Accountability, and Transparency Act of 2014

Title III: Improvement of Access to Care from Non-Department of Veterans Affairs Providers – Requires hospital care and medical services to be furnished to veterans through contracts with specified non-VA facilities if the veterans: (1) have been unable to schedule an appointment at a VA medical facility within the VHA's wait-time goals for hospital care or medical services, and (2) opt for non-VA care or services. Provides for such care through contracts with any health care provider participating in the Medicare program, any federally-qualified health center, the Department of Defense (DOD), and the Indian Health Service (IHS).

Directs the Secretary to provide veterans with information about the availability of care and services at non-VA facilities when they: (1) enroll in the VA patient enrollment system, and (2) attempt to schedule an appointment for VA hospital care or medical services but are unable to do so within the VHA's wait time goals.

Terminates this Act's requirement that the Secretary's furnish care and services through contracts with non-VA facilities two years after the Secretary publishes interim final regulations implementing the program.

Requires the Secretary to transfer the authority to pay for health care through non-VA facilities from the VA's Veterans Integrated Service Networks and medical centers to the VHA's Chief Business Office.

Directs the Secretary to conduct outreach to each Indian medical facility operated by an Indian tribe or tribal organization through a contract or compact with the IHS to raise awareness of the ability of such facilities, Indian tribes, and tribal organizations to enter into agreements with the VA for reimbursement for providing veterans with health care at such facilities.

Requires the Secretary to establish performance metrics for assessing the performance of the VA and IHS under a memorandum of understanding to increase access to, and the quality and coordination of, health care services.

Directs the Secretary to enter into agreements for the reimbursement of direct care services provided to veterans with Native Hawaiian health care systems that are in receipt of funds from grants awarded, or contracts entered into, under the Native Hawaiian Health Care Improvement Act.

Expresses the sense of Congress that the Secretary must comply with the prompt payment rule or any similar regulation or ruling in paying for health care under contracts with non-VA providers.

(See: https://beta.congress.gov/bill/113th-congress/senate-bill/2450)

Number Served by CSBs in FY 2013 Statewide and Per 100,000 Population by Region								
Population	**8,260,405**	**1,535,395**	**2,367,605**	**580,542**	**1,312,651**	**1,852,389**	**333,985**	**277,838**
Mental Health Services	FY 2013 # Served	1 North-western	2 Northern	3 South-west	4 Central	5 Tidewater	6 Southside	7 Catawba
250 Acute Psychiatric Inpatient Services	2,002	14	21	34	26	94	59	60
310 Outpatient Services	93,564	1,492	743	3,125	1,022	1,294	1,938	2,124
320 Case Management Services	57,341	652	406	2,723	772	439	1,214	1,103
350 Assertive Community Treatment	1,792	46	16	95	48	36	77	38
410 Day Treatment/Partial Hospitalization	4,929	167	41	245	211	105	84	72
420 Ambulatory Crisis Stabilization Services	1,397	202	9	48	15	47	54	
425 Rehabilitation	4,453	78	37	121	79	70	117	90
430 Sheltered Employment	37		2	18			1	
460 Transitional or Supported Employment	1,169	43	42		27	6		
465 Supported Employment - Group Model	76	10	8					
501 Highly Intensive Residential Services	78	3	3		7		2	
510 Residential Crisis Stabilization Services	4,609	139	31	162	40	108	196	133
521 Intensive Residential Services	528	7	32	6	3	2	12	2
551 Supervised Residential Services	902	13	31	27	7	10	20	15
581 Supportive Residential Services	6,099	81	28	293	53	99	98	230
Substance Abuse Services	FY 2013 # Served	1 North-western	2 Northern	3 South-west	4 Central	5 Tidewater	6 Southside	7 Catawba
250 Acute SA Inpatient Services	39	29			1		24	
260 Community-Based SA Medical Detox Inpatient Services	237	3		9	6	10	55	
310 Outpatient Services	26,591	360	248	730	307	383	275	468
320 Case Management Services	10,166	88	113	431	249	131	81	28
335 Medication Assisted Treatment	2,088		57	76	88	132		13
410 Day Treatment/Partial Hospitalization	767	67	10			24	159	21
460 Transitional or Supported Employment	53		23					
501 Highly Intensive Residential Services	2,735	248	54	149	23	14		72
510 Residential Crisis Stabilization Services	338							132
521 Intensive Residential Services	3,288	59	55	186	74	7	15	43
551 Supervised Residential Services	268	41	14		1	7		
581 Supportive Residential Services	62					10		
Emergency and Ancillary Services	FY 2013 # Served	1 North-western	2 Northern	3 South-west	4 Central	5 Tidewater	6 Southside	7 Catawba
100 Emergency Services	58,300	881	626	1,337	704	618	1,303	1,348
318 Motivational Treatment Services	4,541	130	138	52	122	191	293	
390 Consumer Monitoring Services	7,685	79	155		140	47	31	21
620 Early Intervention Services	2,429	73	38	300	226	24		28
720 Assessment and Evaluation Services	57,197	432	735	1,010	1,004	580	603	1,384

Department of Behavioral Health and Developmental Services

Descriptions of mental health and substance abuse treatment services provided by CSBs:

- ***Acute Psychiatric or Substance Abuse Inpatient Services***– These services provide short-term, intensive psychiatric treatment or substance abuse treatment, except for detoxification, in local hospitals or detoxification services using medication in a general hospital setting to systemically eliminate or reduce effects of alcohol or other drugs in the body.
- ***Outpatient Services -*** These services are generally provided to an individual, group or family on an hourly basis in a clinic or similar facility. They may include diagnosis and evaluation, intake and screening, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory and medication services. Intensive substance abuse outpatient services are included in this category, are generally provided over a four to 12 week period, and include multiple group therapy sessions plus individual and family therapy, consumer monitoring and case management.
- ***Case Management -***assist individuals and their family members to access needed services that are responsive to the person's individual needs. Services include: reaching out to individuals in need of services, assessing needs and planning services, linking the individual to services and supports, coordinating services with other providers, making collateral contacts, monitoring service delivery, and advocating for people in response to their changing needs.
- ***Assertive Community Treatment -*** consists of two modalities: Intensive Community Treatment (ICT) and Programs of Assertive Community Treatment (PACT). Individuals served by either modality have severe symptoms and impairments that are not effectively remedied by available treatments. Multidisciplinary ACT teams provide an array of clinical and case management services on a 24-hour per day basis to these individuals in their natural environments to help them achieve and maintain effective levels of functioning and participation in their communities.
- ***Medication Assisted Treatment Services –*** These services combine outpatient treatment with the administering or dispensing of synthetic narcotics approved by the federal Food and Drug Administration for the purpose of replacing use of and reducing the craving for opioid substances, such as heroin or other narcotic drugs.
- ***Day Treatment or Partial Hospitalization - is*** a treatment program that includes the major diagnostic, medical, psychiatric, psychosocial, and prevocational and educational treatment modalities designed for adults including coordinated, intensive, comprehensive, and multidisciplinary treatment that is not provided in Outpatient.
- ***Ambulatory Crisis Stabilization Services - provide*** direct care and treatment to non-hospitalized individuals experiencing an acute crisis related to mental health, substance use, or co-occurring disorders that may jeopardize their current community living situation.
- ***Rehabilitation -*** Psychosocial Rehabilitation provides assessment, medication education, opportunities to learn and use independent living skills and to enhance social and interpersonal family support and education, vocational and educational opportunities, and advocacy.
- ***Sheltered Employment -*** provide work in a non-integrated setting that is compensated below market in accordance with certain sections of the Fair Labor Standards Act.
- ***Supported Employment*** - supports paid employment to an individual (or small group) in an integrated work setting in the community, which may include transportation, job-site training, counseling, advocacy, and any other supports needed to achieve and to maintain the individual in the supported placement.
- ***Highly Intensive Residential Services –*** overnight care with intensive treatment or training services such as short term intermediate care, residential alternatives to hospitalization, and substance abuse services provide up to seven days of detoxification in nonmedical settings that systematically reduces or eliminates the effects of alcohol or other drugs in the body supervised by a physician who is available 24 hours per day and onsite services are supervised by a nurse and are provided by other trained medical personnel.
- ***Residential Crisis Stabilization Services*** - provide direct care and treatment to non-hospitalized individuals experiencing an acute crisis related to mental health, substance abuse, or co-occurring disorders that may jeopardize their current community living situation. The goals are to avert hospitalization or re-hospitalization.
- ***Intensive Residential Services*** - provide overnight care with treatment or training that is less intense than highly intensive residential services with 24 hour supervision for individuals who require training and assistance in basic daily living functions such as meal preparation, personal hygiene, transportation, recreation, laundry, and budgeting. This service category also includes long-term substance abuse rehabilitation services and stabilization, daily group therapy and

psycho-education, consumer monitoring, case management, individual and family therapy, and discharge planning.

- ***Supervised Residential Services*** **-** directly-operated or contracted, licensed or unlicensed, residential programs that place and provide services to individuals in apartments or other residential settings including onsite supervision and overnight care.
- ***Supportive Residential Services*** are unstructured services that support individuals in their own housing arrangements. These services normally do not involve overnight care delivered by a program. However, due to the flexible nature of these services overnight care may be provided on an hourly basis.
- ***Emergency Services*** – unscheduled services available 24 hours per day, seven days per week, to provide crisis intervention, stabilization and referral assistance either over the telephone or face-to-face. They may include jail interventions and pre-admission screenings associated with the judicial hospital admission process.
- ***Motivational Treatment Services*** - are generally individual or group counseling structured to help individuals resolve their ambivalence about changing problematic behaviors by using a repertoire of data gathering and feedback techniques.
- ***Consumer Monitoring Services*** **–** are provided to individuals who have not yet been admitted to a CSB program area including individuals who receive outreach through Projects for Assistance in Transition from Homelessness (PATH), individuals in waiting list groups, and outreach by peers to individuals who are in need of services or have been referred for services.
- ***Early Intervention Services*** are intended to improve functioning or change behavior in those individuals identified as beginning to experience problems, symptoms, or behaviors that, without intervention, are likely to result in the need for treatment.
- ***Assessment and Evaluation Services*** **-** include court-ordered or psychological evaluations; initial assessments for screening, triage, and referral for individuals who probably will not continue in services; and initial evaluations or assessments that result in placement on waiting lists without receiving other services.

Ongoing Treatment and Support Workgroup

Proposed Recommendations for Governor's Taskforce On Improving Mental Health

1. **Improving Access to Care :**
   - Form a group of key system (public and private) stakeholders chaired by the Lieutenant Governor to conduct a statewide gap analysis of mental health services with a 3 year work-plan including funding to address these gaps to be completed by 12/1/14. (Workgroup has already recommended expansion of Crisis Intervention Teams and Mental Health First Aid.)
2. **Support for families and friends dealing with family members or friends experiencing mental health issues or crisis:**
   - Appoint a Governor's Advisor in the Governor's Office to conduct a public awareness campaign on mental health and serve as an advocate for system change.
   - Implement Mental Health First Aid in every Planning District of the Commonwealth by January 2015. Create a partnership with the Department of Education to deliver this program at the elementary and high school levels.
3. **Mental Health Workforce Capacity:**
   - Form a partnership with state community colleges and Universities to address workforce shortage. Establish education subsidies, loan forgiveness programs and other incentives for students pursuing careers in mental health.
   - Provide ongoing education for mental health service professionals and paraprofessionals.
   - Form a small workgroup to develop a work-plan with funding proposals to expand tele-health, tele-psychiatry and use of video technology.
4. **Early Intervention/Prevention:**
   - Establish a plan with funding recommendations by the Secretaries representing services to children to bring Virginia's mental health early intervention and prevention services to the national median in four years.
   - Make legal, policy and/or procedural changes to the Comprehensive Services Act in the Non-mandated category to address accessibility to children with mental health disabilities including those in the juvenile justice system.
   - Expand system of care pilots and high fidelity wraparound services.
   - Form an interdepartmental public/private task force to work with DBHDS to develop comprehensive mental health services beginning with pilot projects for transitioning adults (ages 18 – 25).

Members Absent
Frank Gallagher, Vice President of Behavioral Health Services, Sentara
Tabitha Geary, Vice President, Washington, DC Office, SapientNitro
Neal Graham, CEO, Virginia Community Healthcare Association
Keith Hare, VP Government Affairs, Virginia Health Care Association
Steve Herrick, Director, Piedmont Geriatric Hospital
Mike O'Connor, Executive Director, Henrico Area Community Services

Others Present
The Honorable Bill Hazel, MD, Secretary, Health and Human Resources
Debra Ferguson, Commissioner, DBHDS
Meghan McGuire, Communications Director, DBHDS
Allison Tysinger, Office of the Attorney General
Holly Coy, Policy Director, Lt. Governor's Office
Don Darr, Chief Financial Officer, Department of Behavioral Health and Developmental Services
Heidi Dix
Jennifer Faison, Virginia Community Services Board Association
Suzanne Gore, Deputy Secretary, Health and Human Resources

INTRODUCTIONS –members introduced themselves and their affiliation.
Secretary Hazel welcomed the group and encouraged members to move beyond the "quick fixes" previously requested and now focus on the big picture of what the mental health system should become, including priorities, accountability, and system reliability.
Meghan McGuire referenced Governor McAuliffe's Executive Order 12, continuing the Task Force and asked that members address the Order's obligations, particularly items one through five of the workgroup's work plan, and come up with actionable recommendations for the next Task Force meeting in July.
Daniel Herr as facilitator reviewed Executive Order 12 and the areas of responsibility that pertain most to this workgroup.

MEETING MINUTES
There was discussion about the minutes reflecting what was said versus reflecting the recommendations of the workgroup without necessarily capturing the precise words spoken in the meeting. There were a few additions to the minutes, which will be made prior to posting them, including adding the work group's recommendations as presented to the last Task Force meeting. Approved.

There was some discussion about the scope of discussion for this meeting:
Rather than focusing on the specifics of work plan items 1-5, consider a comprehensive system - What is it we want the system to look like versus the specific service recommendations the group would like to make.
The group agreed to spend the first hour talking about the big picture issues. Then to focus on the specific recommendations the group is going to make. These recommendations may affect the future budget.

Mary Ann Bergeron provided background on the CSB service system, the history of policy and funding for priority populations, and mandates derived from State Code and DBHDS regulations. A discussion ensued about other populations, including those with addiction disorders or brain injury, and how they may be incorporated into service priorities.

There was a discussion about the terminology: some believe behavioral health, mental health, brain health, brain injury, substance abuse, justice system need to be included. Others thought this was "getting into the weeds" and could sacrifice the attention of decision makers currently focused on this work.

Members provided the following items to serve as guiding principles to support system reinvention:

Ideas for guiding principles:

1. There should be no wrong door. There should be effective access to care.
2. There should be a culture of responding to human needs. Communication to consumers and families should be very clear, not confusing.
3. A continuum of care from least restrictive to most restrictive that covers the lifespan should be available statewide. The continuum should include follow-up and case management.
4. There should be cross-system care coordination and collaboration (e.g., across CSBS, health, social services, criminal justice, education, housing, etc.).
5. There should be diversion from jail and homelessness.
6. Prevention and early intervention services must be available.
7. Services should be culturally relevant.
8. The workforce should be adequate to meet the need and properly trained.
9. There should be adequate and sustainable funding for services and supports.

It was suggested that the work group consider consolidating some of the principles and identify the minimal responsibility every community should meet in providing services and supports reflective of local resources.

Mellie Randall provided an overview of the SAMHSA document provided to the workgroup, "Description of a Good and Modern Addictions and Mental Health Service System." The group noted the consistency with the paper's set of principles and endorsed it, with the addition of criminal justice/homelessness diversion, as the background for this work.

The following were also discussed as to whether and how they should be stated within the principles above:

- Evidence-based practices or evidence-informed practices
- public/private partnerships or public/private collaboration (including advocates and organizations)
- roles and responsibilities of the public and private system
- cultural relevance
- funding

Some thought that they should; others believed these things are more operational and do not fit with broad principles. They thought that these things should be addressed in implementation.

There was a motion made and accepted to approve the above principles.

NEXT STEPS

In the interest of the time available to the workgroup, work will be done later to consider the "wordsmithing issues" and their appropriateness for the brief list of principles.

After agreeing upon the guiding principles, the consensus was that there wasn't time, and further discussion would be necessary, to accomplish the charge of making 3 to 5 recommendations. There was a recommendation that the guiding principles be sent out for further review and comment and that another meeting of this group be scheduled. Allison Tysinger described the rules limiting communication among work group members between meetings and clarified that staff may distribute materials to members, members may respond individually to staff, but members may not communicate with each other regarding work group business (i.e., no "respond all" emails).

Agreement was made to send comments on the guiding principles and ideas for how to approach developing the 3 to 5 recommendations to Michael Shank at michael.shank@dbhds.virginia.gov.

Mary Ann Bergeron agreed to provide information to staff on the mandates that govern CSBs. Staff will also provide information of what the other workgroups have done on items one through five of the workgroup's work plan. We will establish a deadline for actions that are needed next.

The meeting adjourned at 1:45 p.m.

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

PUBLIC SAFETY WORKGROUP

May 21, 2014

10 a.m. – 2 p.m.

James Monroe Building

MEETING MINUTES

Members Present

Melanie Adkins, Emergency Services Director, New River Valley Community Services
Jim Bebeau, Executive Director, Danville-Pittsylvania CS
The Honorable R. Edwin Burnette Jr. Judge, 24th Judicial District
Kevin Fay, President, Alcalde & Fay
Mike Francisco, NAMI Central Virginia
Sue Medeiros, Chesterfield Department of Mental Health Support Services
The Honorable Charles Poston, Judge (Retired), Norfolk Circuit Court
Gary Roche, Chief, Pulaski Police Department
Bobby Russell, Western Virginia Regional Jail
Becky Sterling, Consumer Recovery Liaison, Middle Peninsula-Northern Neck CSB
John Williams, Director of Public Safety Novant Prince William Medical Center

Staff Present

Victoria Cochran, Deputy Secretary Public Safety
Drew Molloy, Deputy Chief Director Dept of Criminal Justice Services
Michael Schaefer, Director Forensic Services Dept of Behavioral Health & Developmental Services

Members Absent

Colonel Steven Flaherty, Superintendent, Virginia Department of State Police
Gary Kavit, MD, Riverside, Norfolk
Cindy Kemp, Arlington County Dept. of Human Services
The Honorable Stacey Kincaid, Sheriff, Fairfax County
William Rea, MD, Associate Professor, Department of Psychiatry, Carilion Clinic and Virginia Tech Carilion School of Medicine
Rhonda VanLowe, Counsel, Rolls Royce North America
Sandy Ward, PhD, President, VASP, Professor, College of William and Mary
Gerald Wistein, Peer Provider, Region Ten CSB
The Honorable Tommy Whitt, Sheriff, Montgomery County

Others Present

William Ellwood, AEGIS Associates, LLC

MEETING MINUTES (Specific workgroup recommendations are noted in bold italics)

1. Workgroup reviewed and unanimously approved minutes from last meeting with one minor grammatical change.
2. Reviewed Public Safety Workgroup Workplan stemming from Executive Order 12
    a. Identify & examine the availability of and improvements to mental health resources for Virginia's veterans, service members, and their families & children.
        i. Some jails use VA's justice outreach coordinator to access services
        ii. Each of the 3 VA hospitals has outreach coordinators – one of the jobs of coordinators is in-reach into jails/prisons. Because these positions are linked to the 3 hospitals there are some geographical challenges as these positions cover the entire state. Only one workgroup member had had contact, thus it appears they are not well represented across the state
        iii. In Norfolk the Coordinator comes to jail every week and helps with transition planning. Judge Poston has seen some of the outreach coordinators show up in court with clients they are working with.
        iv. ***Workgroup recommends while the VA outreach coordinators are a good service, there are an insufficient number of them to meet needs. Workgroup recommends that services be expanded and encourage more active engagement with community partners. This services needs to be more integrated into service array.***
        v. A related challenge is the VA catchment areas don't match up with existing catchment areas thus this becomes barrier to linking persons to services.
        vi. Many veterans are unaware of existence of services and how to access. ***The workgroup recommends that the VA be encouraged to do outreach (meals, meetings, etc) to let Veterans and families know about services. The VA should be encouraged to coordinate outreach in collaboration with local CSB providers***
        vii. Siloing seems to occur between Virginia's public system and the VA system. – Wonder whether Virginia's Department of Veterans Affairs could help penetrate barrier and help resolve some of the siloing.
        viii. Wounded Warrior – need to better incorporate into service array.
        ix. Virginia needs to have a better understanding of the level of needs of its veterans. Need better data on where Veteran's reside, what their needs are, etc. ***Workgroup recommends that Center of Excellence (reference in previous meeting minutes) collaborate with the VA to conduct a needs assessment and then make recommendations about deployment of services across the Commonwealth.***
        x. Some veterans experience a delay in service due to waitlists or because of lack of VA providers in their community (may not have transportation to travel to VA clinic). ***VA should be encouraged to explore contracting with private providers when VA has waitlist or is too far away – expanding service availability and access to service. Expand list of services person can access through private practitioners and other providers.***
        xi. ***Virginia needs a clearinghouse of information about what services are available in which locations and how to go about accessing services.*** Experience is that

each VA program has a different process. Having the clearinghouse would help case managers and others in linking eligible veterans to services.

xii. There needs to be a strengthening of the relationship between the VA, CSBs, criminal justice system, others - explore expansion of services and expansion of providers

xiii. ***Commonwealth should recommend and encourage the VA to explore how to expand services to those who historically have not been eligible for benefits – i.e. those dishonorably discharged, etc***.

xiv. ***Workgroup recommends that Commonwealth develop Veteran's Courts/dockets as either stand alone or as part of MH/specialty court/docket. To accomplish this we need to engage the Supreme Court as currently there are barriers to the development of such programs.***

b. Review for possible expansion the programs and services that assure prompt response to individuals in mental health crises and their families such as emergency services teams, law enforcement crisis intervention teams (CIT), secure assessment centers, mobile crisis teams, crises stabilization centers and mental health first aid.

i. Sustainability of CIT training – concern is that funding used to support training now is time-limited. What will programs do in future to keep training going once grant ends. There is no funding for CIT coordinator or other necessary infrastructure to support CIT. Finally, localities have to absorb the costs of sending officers to CIT training and often this becomes a barrier to a locality developing a fully operational CIT program. ***Workgroup recommends that the Commonwealth fund the expenses associated with operating a CIT program.***

ii. Need CIT type training for correctional officers. Currently some localities are enrolling jail deputies in CIT training but CIT was/is really designed for first responders in the community. ***Recommendation is that the Commonwealth (DBHDS/ DCJS)should develop jail staff CIT type training***

iii. Funding for sustainability of CIT assessment centers – current funding is via grants to localities and does not include any yearly increases to offset rising costs of care and/or to expand services. ***Workgroup recommends the General Assembly not only fund new programs but also build into allocations additional funding to help off-set the rising costs of care over time.***

c. Examine extensions or adjustments to the emergency custody order and the temporary detention order period. Explore options for reducing the use of law enforcement in the involuntary admission process – to include reducing time demands on law enforcement for transporting individuals during involuntary admission process.

i. DCJS & DBHDS completed study of how other states handle transport of individuals with mental illness during commitment process. A summary document was prepared and reviewed by the group. This document showed that several states use alternative transport of individuals in lieu of having law enforcement transport.

ii. It was reported that approximately 25% of ECOs statewide involve law enforcement

iii. Payment for alternative transportation through DMAS is an issue.

iv. Who should do transportation, what are the criteria for alternative transportation, and who should pay for it?

1. ***Workgroup recommends that a study be conducted surveying ES clinicians and law enforcement - which persons would they recommend could be transported via alternate transport– what percentage of ECO clients could be safely transported. Use Center of Excellence to gather data and do a study with goal of how to reduce involvement of law enforcement in transport.***
2. If recommendation is to use ambulance, then need to provide training, give authority (to detain against one's will), release of reliability, and need to identify a mechanism to pay for this service.
3. As part of study and resulting recommendations, need to determine who decides who is eligible for alternative transportation. Majority of group members suggested this decision be made by magistrate after hearing recommendations from clinician and officer.
4. In study also need to explore how to enhance recovery based, trauma informed approach to transport while still addressing individual and community safety. Need to look at entire restraint issue – hard vs. soft restraints. Workgroup agreed that safety of individual, officer, and community is paramount and cannot be jeopardized.

d. Examine the cooperation that exists among courts, law enforcement and mental health systems in communities

i. ***Workgroup recommends that Center for Criminal Justice & Behavioral Health Excellence should create and distribute best practice standards.***

ii. ***Workgroup recommends that each community should establish a position/committee/group to ensure best practices are actually implemented and analyze instances when programs do not work as intended (i.e. individual with mental illness is not intercepted by CIT but rather ends up in jail for MI related behavior). Goal is to minimize the involvement of MI in criminal justice system and cluttering up courts with mi related offenses. Also need oversight system to make sure communities are doing this and also need to tie money to compliance.***

iii. Need magistrate training to enhance their understanding of MI issues and diversion alternatives – need to strengthen diversion alternatives at all intercepts (of the Sequential Intercept Model) but especially at magistrate level.

iv. ***DBHDS & DCJS should be tasked with creating center for excellence and can collaboration with others (ILPPP, others). Center of Excellence should also be responsible for ensuring community compliance.***

3. Due to time constraints, workgroup was unable to review the remaining responsibilities (numbered 5-10) on the Public Safety Workgroup Workplan. However, members were asked to prioritize/rank the four issues discussed in this meaning in terms of prioritized recommendations to the Governor's Taskforce.
   a. 1st priority is related to CIT (unanimously agreed upon)
   b. 2nd priority is transportation (unanimously agreed upon)

    c. 3rd priority is Center of Excellence (unanimously agreed upon)
    d. 4th priority is VA Services (unanimously agreed upon)
4. DCJS will do some research of the costs/ cost savings for some of recommendations. Results will help support recommendations to general assembly by showing that while there is an associated cost with some of the recommendations we also anticipate a cost-savings in other areas.
5. Workgroup requested that members receive a briefing at or before the next meeting from the Technology workgroup about telepsychiatry as this is an item which the public safety workgroup is tasked with addressing.

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

July 15, 2014
1 p.m. – 4 p.m.
Patrick Henry Building, Richmond, VA

Crisis Response Workgroup Meeting Agenda

1:00 p.m. – 1:10 p.m.	Welcome and Recording of Members Present
1:10 p.m. – 1:15 p.m.	Approval of Minutes
1:15 p.m. – 3:00 p.m.	Discuss items for possible recommendation (see bullets below) and ensure previous recommendations cover responsibility for Executive Order 12. Items for further discussion: • Physician TDO authority (Dr. Knittel) • Regional Psychiatric Emergency Centers (Ted Stryker) • Promoting healthy competition (Ted Stryker)
3:00 p.m. – 4:00 p.m.	Develop and record up to 3-5 actionable recommendations to send to full Taskforce based on discussion
4:00 p.m.	Adjourn

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

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

CRISIS RESPONSE WORKGROUP

May 21, 2014

10 a.m. – 2 p.m.

James Monroe Building

MEETING MINUTES

Members Present

Lawrence "Buzz" Barnett, Emergency Services Director, Region Ten CSB
Varun Choudhary, MD, Medical Director, Magellan Behavioral Health
Sherry Confer, sitting in for Karen Kimsey, Deputy Director, DMAS Complex Care and Services
Kaye Fair, Emergency Services Director, Fairfax-Falls Church CSB, Fairfax
Daniel Holser, Chief Magistrate, 12th Judicial District
Douglas Knittel, MD, Psychiatric Emergency Services, Portsmouth Naval Hospital, Portsmouth
Margaret Nimmo Crowe, Executive Director, Voices for Virginia's Children
Kit Cummings, Lieutenant, Blacksburg Police Department
Jeffery Lanham, Regional Magistrate Supervisor, 6th Magisterial Region
Cynthia McClaskey, PhD, Director, Southwestern Virginia Mental Health Institute
Sandy Mottesheard, Member at Large, National Alliance on Mental Illness (NAMI) Virginia
Shirley Repta, Executive Director, Inova Behavioral Health
David Rockwell, Peer Support Provider, Henrico Area MH and Developmental Services
Ted Stryker, Vice President, Centra Mental Health Services, Lynchburg
Scott Syverud, MD, Vice Chair, Clinical Operations, UVA School of Medicine
Ben Shaw, Region 1 Coordinator, Virginia Wounded Warrior Program, Virginia Dept. of Veterans Services
Tom Spurlock, Vice President, Art Tile, Inc.
Joseph Trapani, Chief Executive Officer, Poplar Springs Hospital, Petersburg
Brian Wood, MD, Director, DO, Director, Psychiatric Education, VAMC
Jason Young, Executive Director, Community Brain Injury Services

Staff Present
Debra Ferguson, Commissioner, DBHDS
Jim Martinez
Mary Begor
Stephanie Arnold
Kate Marshall
Andrew Diefenthaler

Members Absent
William Barker, MD, Emergency Medicine, Fauquier Hospital
Kirsten Berglund Bradley
Robin Foster, MD, Virginia Commonwealth University Medical Center
Chuck Hall, Executive Director, Hampton-Newport News CSB
Bruce Lo, MD, Chief, Department of Emergency Medicine, Sentara Norfolk General Hospital
Bonnie Neighbour, Executive Director, VOCAL

John Venuti, Chief, VCU Police Department
Cindy Wood, Lieutenant, Henrico Police Department

Others Present
Allyson Tysinger, Senior Assistant Attorney General, Office of the Attorney General
Will Frank, VACSB

MEETING MINUTES

Secretary Hazel asked the group about how they envision crisis response services in Virginia? Is the current structure of services that we have in Virginia sufficient to move ahead? There is an impetus to build accountability in all levels of service around the state. One of the challenges will be ensuring the system works 100% of the time and that the resources are sufficient to support this 100% accountability achievement. The resources will include financial and personnel.

The meeting was convened and attendees introduced themselves.

Minutes from the previous meeting on March 19, 2014 were distributed and reviewed. There were two revisions to the minutes noted and the minutes will be changed to reflect the revisions. Dr. Wood corrected his credentials and Tom Spurlock indicated that a statement he had made was not included in the minutes. No further objections to the minutes voiced, and the minutes were approved by the members.

Jim Martinez provided a Task Force update from the last full Task Force meeting. The Task Force did not consider any of the recommendations provided by the four workgroups at this meeting and deferred these until their next meeting on June 16, 2014.

Jim Martinez spoke about Executive Order #12 and the need for the work group to fulfill the obligations as set forth in this order for this workgroup. Executive Order #12 was issued by Governor McAuliffe and replaces Executive Order #68 issued in December by Governor McDonnell. During this meeting, the focus will be on refining and filling in the gaps of the recommendations already made by this workgroup.

Jim Martinez shared information from an article in The Richmond Times Dispatch that was published on May 20, 2014 by guest columnist Ralph Northam about Virginia's mental health system and its coverage gap.

Jim also shared an email that Dr. Bruce Lo had sent to Mary Begor and Jim Martinez about his desire to focus on persons who are not necessarily under an ECO but whose situation may lead to a TDO or possibly a voluntary admission and their need for timely disposition just as for those in custody of law enforcement. Also, Dr. Lo expressed concern about standardizing criteria for admission to the crisis stabilization units within his region.

Meghan McGuire introduced Holly Coy who works for Lt. Governor Northam. Meghan also reminded everyone that there is only one last meeting of the workgroups that will be scheduled for July. The Taskforce will take up the recommendations made in March and from today at the next meeting in June, 2014. Meghan suggested that everyone on the workgroup help to develop the recommendations so that can be action oriented and with any budget considerations included as this type of recommendation is more likely to have action by the Taskforce.

The "Topics to Cover" handout was distributed. Jim Martinez reviewed the topics for this meeting. Members were asked to compile a list of 3-4 recommendations for the full Task Force to consider at the next meeting on June, 2014.

Overview of Mental Health Legislation-2014

Cynthia McClaskey suggested that an overview of the legislation that was passed by the General Assembly this year as it relates to crisis response services in the state of Virginia is needed. Jim Martinez summarized the legislation for the group as follows:

1. Psychiatric Bed Registry –The bed registry statute was effective immediately upon signing and requires "real time" updates from all participating facilities, both private and public. Facilities can post descriptive information such as populations served and limitations of the particular setting.
2. ECO period was changed from 4 hours with one possible 2 hour extension to straight 8 hours, with no extension.
3. Law enforcement is to notify the CSB of each ECO when it has been executed, the location of the individual and the need for an evaluation. The CSB will call the state facility to notify of potential admission when they receive notification of an ECO and again following the evaluation. CSB contacts state facility again if a private psychiatric bed or residential crisis stabilization bed has not been located toward the end of the 8 hour ECO to arrange admission to the state facility.
4. An individual cannot be released if a determination has been made that they meet the criteria for a TDO but the TDO has not been executed.
   State facilities are the facility of last resort and cannot refuse admission when an alternative facility is unable to be secured and the emergency custody period expires. State hospitals can look a bed at another facility, but they are the facility of last resort if a bed can't be located elsewhere. The state hospital as "facility of last resort" was crafted to ensure that no one falls through the cracks.
5. TDO period for adults has been extended from 48 hours to 72 hours (or next business day for weekends and holidays)
6. There is a requirement that DBHDS conduct a study of the qualifications, training and oversight of CSB emergency evaluators. Jason Young inquired about being a part of this study as a representative of individuals with brain injuries. Dr. Knittel commented that only a physician can adequately evaluate a brain-injured individual. Mr. Young was informed that he could provide input at any time for the study and contact information would be provided to him. DBHDS is to look for ways to strengthen and enhance the workforce of evaluator's screeners in Virginia.
7. The TDO facility can be changed at any time up to the time of hearing if another facility is needed to meet the medical, safety and behavioral needs of the individual. The CSB is the entity that designates the new facility. Tom Spurlock stated a state hospital was more likely to serve aggressive individuals and he thought the change of facility will more likely be used for state facility transfers from private or CSU beds more than state facilities seeking a less intensive level of care during the TDO period.

   DBHDS noted the limited state bed capacity and the need for managing not only admission but discharges in a timely manner to address utilization at state facilities. The facilities are currently operating at or near capacity at any given time.

   DBHDS will be issuing guidance this week to CSBs and state hospitals for revision of regional admission protocols based on the new legislation.

Jim Martinez continued the conversation by reporting the noted increase in TDOs to state facilities. As an example of the increases, Western State Hospital had has many TDOs in the last several months as there were in all of 2013 to the facility.

Buzz Barnett stated that the bed registry offers a blueprint of possible bed capacity at any given time and it does provide a picture for CSB ES workers most of the time but it still does not address the time that is spent locating a willing facility for any one particular individual. Buzz Barnett stressed that there is an impression CSB workers aren't working as hard now to find a bed due to state hospitals being the facility of last resort, and that private hospitals aren't accepting as many admissions for the same reason. Buzz suggested a need to incentivize private hospitals being more willing to accept more difficult or complex persons. Kaye Fair stated that placements for individuals who are minors, who have an intellectual disability and a mental illness and those with Alzheimers or Dementia, are problematic.

There is currently no approved budget and there are competing proposals which are still unresolved. McAuliffe's proposed budget builds upon the mental health initiatives proposed by former Governor McDonnell.

Data Collection

There is a fragmented data structure which impedes the ability to collect data to understand study and provide an accurate report to the General Assembly. The General Assembly was frustrated with the relatively little data that exists on which to refine of the system. There is a need to collect a significant amount t of data to evaluate the impact of the new legislation for 2014.

Cynthia McClaskey observed that the effect of the changes has been to drive partners apart and all of us need to acknowledge this and then work to overcome the barriers. This includes private and public entities. Dr. Knittel stated that the structure of the system is currently inadequate and there is a need to recommit time and resources to improvement and to shore up the infrastructure so that no more unfortunate circumstances occur.

Joseph Trapani expressed that there is an obligation of those in the room to work together to solve the issues after defining the actual problem. Is the acuity level increasing? Is there insufficient funding to support community based care? Joe related that it is difficult for private providers to open more beds due to the process involved. Suggestions were to look at the COPN process to unclog the system by overcoming the difficulty in opening new beds and units around the state, and particularly, to look at the state's needs and not just a localities need before determining to not allow additional beds to be opened.

New Commissioner

Debra Ferguson joined and was introduced to the workgroup. She thanked each member for their participation in the workgroup and expressed her appreciation for the thoughtfulness and purposefulness that she was observing in the room. Jim Martinez provided a brief orientation for Commissioner Ferguson on the work that has been done is the Crisis Response Workgroup to date.

Discussion of Crisis Response Work plan

Task for the day was to sharpen existing recommendations to make sure they are utilitarian, to develop recommendations for items that have not yet been addressed by this workgroup, and to prioritize the workgroup's recommendations for presentation to the Task Force.

Question was raised re: recommendations from other work groups and whether they overlap. A spreadsheet with the recommendations from all of the other work groups was circulated.

Discussion among members about how to improve the communication from healthcare providers to law enforcement agencies with a focus not on crisis or emergency situations but on continuum of care such as notification of discharge, hearing status, etc. A suggestion was made to have legal counsel develop language

for new legislation regarding the protection of healthcare providers to share certain elements of information with the local law enforcement agency.

Discussion about confidentiality and HIPAA continued. Kit Cummings stated that at present, protected health information can be shared by healthcare provider to law enforcement during a crisis or emergency situation but the information is not to be transferred to another officer, the information cannot be included in a police report and any written information must be securely discarded. Kit Cummings suggests that if information could be shared more freely it could maximize the cooperation of law enforcement especially for locale with CIT officers.

Buzz reminded the group that individuals under ECOs or TDOs are only a small percentage of the much larger group of individuals who seek voluntary care during a psychiatric crisis. Dr. Knittel stated that Virginia law cannot trump federal privacy laws and a question of how to work this out legally is for general counsel to decide.

If an individual is a threat to himself/others, behavioral healthcare providers may communicate with anyone appropriate to lessen the threat so law enforcement is included in current provisions. Tom Spurlock said that as parents of an adult child, they are not notified of a hearing unless they are the petitioner. This was noted as being a separate discussion and not for inclusion here.

Allyson Tysinger stated that facilitating information exchange for people not necessarily under an ECO or TDO has been attempted in the past but consumer advocacy group tend to oppose these measures due to fears of the information being too widely shared due to stigma and the potential impact on an individual in the present and future. Allyson said that language can be drafted but getting it through the General Assembly would be difficult. Allyson recommends looking at CIT nationally to see how information exchange is facilitated in other states.

Kit reminded the group that officers do not attend the commitment hearings but would like to be able to know the disposition or outcome at the hearing and maybe more is needed to assist individuals in the community and as well protection for the community. Commissioner Ferguson spoke about the limitations of HIPAA but recognized that there are times for real time communication. She also spoke about how practitioners and organizations sometimes over-interpret restrictions and there may be a need to re-visit state law. Allyson agreed that state law can allow disclosure if it is legislated. Jim noted that to expand disclosure we need to make sure that authorizations are explicit and that restrictions are identified very clearly.

Allyson mentioned that DBHDS and OAG have provided confidentiality training in the past and will look at offering this again around the state.

Recommendation:

1. Develop and enact legislation that allows/authorizes exchange of PHI between CSBs, law enforcement and develop and enact legislation that allows/authorizes exchange of PHI between CSBs, law enforcement and health care providers for individuals who meet TDO criteria (whether they are under an ECO/TDOd or not). Tom Spurlock asked that families and guardians be added.
    a. Also, create a "tool kit" for practitioners so that they understand and use authority to exchange information appropriately.
    b. Also, ensure that legislation includes a "safe harbor" clause so that practitioners following these release/exchange guidelines and acting in good faith would not be subject to penalties.

Buzz suggested getting law enforcement involved especially CIT, may be a key to getting legislation through the General Assembly.

There was a brief discussion on the use of Advanced Directives for behavioral health crises.

Veterans in the Crisis Response System

The group moved to the next responsibility to identify and examine the availability of and improvements to mental health resources for Virginia's veterans, service members, their families and children.

Ben Shaw reported that veterans have substantially more options for crisis services than most citizens because they can access the VAMC, VA outpatient office, other non-profit organizations and Wounded Warrior program. Ben admits that there are access issues for some in the state due to primarily geography. The Wounded Warrior program was discussed and identified as having one person representing the program embedded in the CSBs. Misunderstandings about who is eligible for VA services, lack of consistency in outpatient services across the state, disparity in each clinic/facility, convenient appointment times, transportation and lack of collaboration the VAMC and CSBs were all identified as potential challenges/barriers for veterans and their families seeking behavioral health services. The Wounded Warrior program serves to educate the community and CSBs about the services available to veterans and their families as well as to help facilitate/coordinate services directly between organizations.

Recommendations:

1. That every CSB have a veteran's liaison identified who will serve as a resource for veterans and their families and to also educate providers on determining eligibility for services with the VA and what specific services may be available for this individual.
    a. Better relationships need to be developed between the VAMC, CSBs, private and state facilities to facilitate transfers if needed.
    b. Make sure every CSB has an identified veterans' resource person to triage, refer, guide, and empower veterans to receive services through the Wounded Warrior program or other services.
    c. Submit a funding request for the Wounded Warrior program to be embedded in every CSB to help veterans and providers navigate the Veteran's Administration services as well as other local providers.

There was discussion of VAMC taking direct TDOs (primarily during the day) and this varies from center to center.

Family Involvement during a Crisis

There was discussion of use of peer support specialists to work with families when an individual is in crisis and to do prevention work with families. Mental Health First Aid (MHFA) initiative was discussed, with reference to training for trainers occurring in communities across the state. Family education through Family-to-Family (NAMI) was mentioned as a beneficial program for family members with a mental illness.

Ben identified that the VA system is could utilize peer supports more in their services.

Much research has been done on the efficacy of peer support in reducing the frequency of behavioral health crises for an individual. It was recognized that efforts to develop a peer support curriculum, certification of peers and the ability to bill for peer provided services are needed to make the use of peers more likely to occur.

Funding for peer support development is needed.

The group discussed encouraging broader application of psychiatric advance directives. DBHDS is working with Duke, UVA, ILPPP, CSBs and state hospitals to promote use of PADs. CSBs in Southwest VA don't feel they can take the time for this task as it is not billable time. Adopting this change in practice is complex

because it doesn't fit easily in existing staff roles (e.g., ES vs. case management). Additional funding to help support the CSBs workforce to assist people with completing an Advanced Directive may help reduce the use of crisis services for individuals. There is a registry of advanced directives that is maintained by Virginia Department of Health (VDH).

Mental Health Workforce Capacity

Jim mentioned the joint sub-committee of the legislature being formed to conduct a four year study of mental health services in the state (SJR 47).

DBHDS has been tasked by the General Assembly to survey the current qualifications, training and supervision of preadmission screener and make recommendations for change. Brief discussion of current qualifications and training for preadmission screener was held. It was identified that there is a key shortage of licensed clinical social workers (LCSW), psychiatrists and other licensed individuals (LPC, PhD, etc) in the state. Shirley Repta reported there is a shortage of all of these individuals across the country not just Virginia. Advancing the use of tele-psychiatry is going to be needed to help fill gaps in services around the state.

Dr. Knittel suggests the current system of ECO/TDO is redundant and wasteful. He feels that licensed physicians should be allowed to make decisions in emergency departments. He supports a physician or licensed psychologist being able to petition the magistrate for a TDO. It was identified that half of all TDOs originate in emergency departments. Discussion followed on this and members suggested it did not have to be an either/or situation but could be done by both physicians and CSBs.

Discussion continued about the need for possible diversion from hospitalization and whether a physician would take the time for crisis intervention and not just assessment for admission. Concerns were expressed about physicians not being as familiar with community resources and current CSB evaluators are frequently able to divert people to less-restrictive alternatives when appropriate. Dr. Knittel shared how Maryland allows a physician to arrange temporary detention. Dr. Knittel feels a magistrate is a disinterested party and could be a buffer for inappropriate admissions. Jim stated that an attending or treating physician is currently able to petition the magistrate for a TDO but Dr. Knittel reported that in practice the magistrate typically refuses to hear from the physician. Joseph Trapani stated that a physician should be able to do it but there is the conflict of dollars being attached to every detention. Dr. Knittel again stated the magistrate is a disinterested party.

Cynthia McClasky voiced two concerns about this: 1) emergency rooms are busy, the doctors in them are busy and do not have much psychiatry training and often just want to get people out of the emergency room in the quickest way possible, and 2) there would not be an emphasis on diverting admissions by using safety planning and community resources to meet the person's needs and people's medical needs are often overlooked in emergency rooms when a person appears with a psychiatric condition.

There has been a 21% increase in the number of TDOs in the past 6 months.

Dr. Knittel stated Virginia hides behind the current system under the guise of civil liberties. Discussion about how psychiatric admissions are unique as there are no tests to determine if a person is in a psychiatric crisis and people minimize, deny or exaggerate to avoid/gain access to a psychiatric bed now. Acknowledgement was made that a physician may have a low threshold for admission due to the potential for suicide (no test for that as there is for medical disorders.)

Buzz felt this would streamline part of the process but complicate other parts. The issue is inefficiency of the process, not the outcome – in most cases, CSBs and hospitals are in agreement. Since physicians are more likely to TDO, this option could lead to serious capacity issues in Virginia. Also noted that there is some benefit to not making the decision to TDO too rapidly (process of the prescreening could be therapeutic, an hour later the individual may no longer require hospitalization). Margaret Nimmo Crowe asserted the process of a prescreening can be therapeutic which may allow the crisis to resolve.

To wrap up the discussion, Jim observed that the workgroup does not have the data to facilitate further discussion at this time nor to come to consensus on a recommendation. He suggested further dialogue about this issue when the data is obtained.

Recommendations from this workgroup to the Task Force from this meeting were as follows:

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. (This recommendation is from March 19, Priority 1. Listed under Item 8, EO 12 "Work plan" document)

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. (New, addresses Item 9 on EO 12 "Work plan" document)

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. (New, addresses Item 1 on EO12 "Work plan" document)

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. (Recommendation is from March 19, Priority 2A and 2B. Listed under Item 6, EO 12 "Work plan" document)

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. (New, addresses Item 2 on EO12 "Work plan" document)

NEXT STEPS: FINAL MEETING DATE, TIME AND LOCATION WILL BE SENT IN EMAIL

The meeting was adjourned at 2:12 PM.

From: Ted Stryker [mailto:Ted.Stryker@Centrahealth.com]
Sent: Tuesday, June 17, 2014 3:51 PM
To: Martinez, Jim (DBHDS)
Cc: Long, Betty
Subject: Governor's Task Force Workgroup Agenda

Jim –

While it's fresh on my mind from yesterday's meeting of the full Governor's Task Force on Improving Mental Health Services and Crisis Response, I thought I would ask if you could put on our agenda a discussion around reforming the delivery system of care for patients in psychiatric crisis at our next (and last?) meeting of the Crisis Response Workgroup. In reviewing all of the recommendations from the various workgroups, it is striking to me there is relatively little said about reforming the delivery system of care for the purposes of strengthening the integration of services; reducing unnecessary hand-offs; and increasing accountability. Some of the workgroups have kind of mentioned it (Ongoing Treatment talks about an "integrated community system of care – public/private partnership" and Public Safety talks about creating "functional CIT Assessment Centers") – but you don't really see anything that puts forward any kind of bold delivery system changes that would accomplish the above stated goals.

More specifically, I would like to recommend we discuss the idea of establishing regional psychiatric emergency centers. We have talked about this in previous meetings, but I don't think we ever got to considering creating a specific recommendation around this idea. These centers could effectively combine four separate, fragmented levels of care: Crisis Screening Centers operated by CSB's; Crisis Stabilization Centers' ; CIT Secure Assessment Centers; & Hospital ED's. A unified system of psychiatric care under one roof would improve coordination of care (single point of access; unified and common clinical electronic record; single point of accountability; and reduced system hand-offs) to create a high reliability system of care for people seeking care when they are in psychiatric crisis.

Another delivery system of care idea would be to consider opening up the services presently monopolized by the CSB's to other private providers and hospitals, for the purposes of promoting healthy competition; encouraging innovation; and strengthening the integration of care opportunities. Many states have done just that to create more organized systems of care (crisis, inpatient, and outpatient services) in an effort to improve access, strengthen accountability, and reduce cost. There are probably other system of care reforms out there, but it did strike me that we certainly made changes to the civil commitment aspects of our mental health system, but essentially left the same fragmented unaccountable delivery system intact.

Let me know if we can discuss this at our next and final meeting. Thank you for your kind consideration of this request.

Commonwealth of Virginia
Office of Governor Terry McAuliffe

EXECUTIVE ORDER NUMBER TWELVE (2014)

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

Importance of the Taskforce

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

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

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

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

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

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

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

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

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

The Task Force's responsibilities shall include the following:

- Recommend refinements and clarifications of protocols and procedures for community services boards, state hospitals, law enforcement and receiving hospitals.

- Review for possible expansion the programs and services that assure prompt response to individuals in mental health crises and their families such as emergency services teams,

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

- Examine extensions or adjustments to the emergency custody order and the temporary detention order period.

- Explore technological resources and capabilities, equipment, training and procedures to maximize the use of telepsychiatry.

- Examine the cooperation that exists among the courts, law enforcement and mental health systems in communities that have incorporated crisis intervention teams and cross systems mapping.

- Identify and examine the availability of and improvements to mental health resources for Virginia's veterans, service members, and their families and children.

- Assess state and private provider capacity for psychiatric inpatient care, the assessment process hospitals use to select which patients are appropriate for such care, and explore whether psychiatric bed registries and/or census management teams improve the process for locating beds.

- Review for possible expansion those services that will provide ongoing support for individuals with mental illness and reduce the frequency and intensity of mental health crises. These services may include rapid, consistent access to outpatient treatment and psychiatric services, as well as co-located primary care and behavioral health services, critical supportive services such as wrap-around stabilizing services, peer support services, PACT services, housing, employment and case management.

- Recommend how families and friends of a loved one facing a mental health crisis can improve the environment and safety of an individual in crisis.

- Examine the mental health workforce capacity and scope of practice and recommend any improvements to ensure an adequate mental health workforce.

Task Force Membership

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

- The Task Force shall be co-chaired by the Secretaries of Health and Human Resources and

  Public Safety and Homeland Security;

Membership shall include the following individuals or their designees:

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

The Governor may appoint other members as he deems necessary.

Task Force Staffing and Funding

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

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

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

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

Effective Date of the Executive Order

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

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

Richmond Times-Dispatch

Fifteen years later, much work remains

Guest Columnist Dr. Debra Ferguson, DBHDS Commissioner

June 20, 2014

Fifteen years ago this month, a U.S. Supreme Court case was decided that would fundamentally change the course of treatment and services for people with disabilities, specifically those with intellectual and/or mental health disabilities. The 1999 Olmstead case upheld the civil rights of people with disabilities to live in communities instead of institutions in compliance with the Americans with Disabilities Act. It also required that states serve people with disabilities in the most integrated settings appropriate to meet their needs, consistent with their choice. This ruling applies to both individuals with intellectual disabilities, as Virginia is undergoing a careful downsizing of its institutions (called training centers), and to those with mental illnesses, who should have immediate access to the mental health services they need, when they need them.

Institutional living can no longer be the only choice. Community integration means that people live in their own communities, surrounded by friends and family, with opportunities to learn and work and be a part of life in their neighborhoods. Virginia's community services system must be designed to facilitate, support and preserve this life for people.

As I begin my tenure as Commissioner of Virginia's Department of Behavioral Health and Developmental Services, the 15th anniversary of the Olmstead decision provides a rich opportunity to examine our system of care in the commonwealth and to identify ways to strengthen and improve it.

Virginia's system for people with mental illness, substance-use disorders and developmental disabilities is undergoing significant and needed changes. It is a time of intense monitoring as Virginia implements the terms of a settlement agreement following the U.S. Department of Justice conclusion that Virginia failed to provide services to individuals with developmental disabilities in the most integrated setting appropriate to their needs. It is a time of scrutiny. The mental health system must improve its access, timeliness, and quality of services. The inevitable changes are also an opportunity to look unflinchingly and non-defensively at our system and commit to strengthening and improving it.

Our primary responsibility is to provide a safety net of services that ensures access, quality services and the appropriate clinical response, especially in times of crisis. To start, we are working in several key areas:

(1) Improving access to care. There is tremendous demand for services, but they are inconsistently available across Virginia. We must ensure that people have access to the mental health services they need, and we must continue to increase Medicaid waiver slots so people with developmental disabilities can get services in their communities. A staggering 8,500 Virginians with developmental disabilities are now on waiting lists for services.

(2) Investing more in programs that work. For example, Mental Health First Aid is a program that teaches family members, health care and school employees and others how to respond to an escalating mental-health crisis. Crisis intervention teams produce positive outcomes by diverting people in mental-health crises from jail and instead providing much needed mental-health services. Supportive employment and supported housing programs for people with behavioral health disorders and developmental disabilities facilitate stability and self-sufficiency in the community.

(3) Closing the coverage gap. Expanding Medicaid coverage to more than 400,000 uninsured Virginians would provide access to clearly needed mental health and substance abuse services.

(4) Funding and developing programs for improved substance abuse services. Opioid abuse and overdoses are increasing, often with fatal consequences.

(5) Using technology, such as telepsychiatry, to increase access to care in under-served areas. Those included, particularly, the southwestern and rural portions of the commonwealth.

(6) Strengthening partnerships with key system stakeholders. Effective collaboration among community services boards, law enforcement, the court system, primary health care providers, landlords, and advocates, as well as with the persons served and their family members, helps to ensure the best outcomes for Virginians.

(7) Developing, supporting and expanding peer support activities. The aim is to improve the care we provide and promote our values of recovery, resiliency and self-determination.

On the anniversary of this important ruling, it is important to remind ourselves that Olmstead is fundamentally about improving the lives of the people we serve. Regardless of whether there is a mental illness, substance use disorder, and/or a developmental disability, a life in the community is our enduring goal.