COMMONWEALTH of VIRGINIA

DEBRA FERGUSON, Ph.D.
COMMISSIONER

DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
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June 30, 2015

The Honorable Walter A. Stosch, Co-Chair
The Honorable Charles Colgan, Co-Chair
Senate Finance Committee
10th Floor, General Assembly Building
910 Capitol Street
Richmond, VA 23219

Dear Senator Stosch and Senator Colgan:

Senate Bill 260 of the 2014 Legislative Session required the Department of Behavioral Health and Developmental Services (DBHDS) "*submit an annual report on or before June 30 of each year on the implementation of this act to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees. The report shall include the number of notifications of individuals in need of facility services by the community services boards, the number of alternative facilities contacted by community services boards and state facilities, the number of temporary detentions provided by state facilities and alternative facilities, the length of stay in state facilities and alternative facilities, and the cost of the detentions in state facilities and alternative facilities.*"

Please find enclosed the report in accordance SB260. Staff at the department are available should you wish to discuss this request.

Sincerely,

Debra Ferguson, Ph.D.

Enc.

Cc: William A. Hazel, Jr., M.D.
Kathleen Drumwright
Joe Flores
Susan E. Massart
Daniel Herr
Donald Darr

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June 30, 2015

The Honorable S. Chris Jones, Chair
House Appropriations Committee
General Assembly Building
P.O. Box 406
Richmond, VA 23218

Dear Delegate Jones:

Senate Bill 260 of the 2014 Legislative Session required the Department of Behavioral Health and Developmental Services (DBHDS) "*submit an annual report on or before June 30 of each year on the implementation of this act to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees. The report shall include the number of notifications of individuals in need of facility services by the community services boards, the number of alternative facilities contacted by community services boards and state facilities, the number of temporary detentions provided by state facilities and alternative facilities, the length of stay in state facilities and alternative facilities, and the cost of the detentions in state facilities and alternative facilities.*"

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June 30, 2015

The Honorable Terry McAuliffe, Governor
Commonwealth of Virginia
Patrick Henry Building
P.O. Box 1475
Richmond, VA 23218

Dear Governor McAuliffe:

Senate Bill 260 of the 2014 Legislative Session required the Department of Behavioral Health and Developmental Services (DBHDS) "*submit an annual report on or before June 30 of each year on the implementation of this act to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees. The report shall include the number of notifications of individuals in need of facility services by the community services boards, the number of alternative facilities contacted by community services boards and state facilities, the number of temporary detentions provided by state facilities and alternative facilities, the length of stay in state facilities and alternative facilities, and the cost of the detentions in state facilities and alternative facilities.*"

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Report on the Implementation of Senate Bill 260

to the Governor and the Chairs of the Senate Finance and House Appropriations Committees

June 30, 2015

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Executive Summary

SB 260 (Chap. 691, 2014) amended several existing sections of the *Code of Virginia* and added new sections related to emergency custody and temporary detention of adults and minors. The fourth enactment clause of this legislation reads as follows:

> *4. That the Department of Behavioral Health and Developmental Services shall submit an annual report on or before June 30 of each year on the implementation of this act to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees. The report shall include the number of notifications of individuals in need of facility services by the community services boards, the number of alternative facilities contacted by community services boards and state facilities, the number of temporary detentions provided by state facilities and alternative facilities, the length of stay in state facilities and alternative facilities, and the cost of the detentions in state facilities and alternative facilities.*

This report was prepared pursuant to the above language.

Senate Bill 260 arose from concerns about Virginia's behavioral health crisis response system. In particular, there were instances across the Commonwealth where individuals who needed temporary detention were not hospitalized because of the lack of a willing facility that would admit them. SB 260 was designed to eliminate these occurrences, guaranteeing that everyone who needed temporary detention was able to access this care.

A brief overview of the most salient effects of SB 260 on Virginia's emergency response system is provided below.

- Since the new law went into effect on July 1, 2014, no individual who needed such care has been turned away for lack of a bed.
- There are more than 1,000 emergency contacts with CSB emergency services each day.
- CSB emergency services clinicians complete an average of 200 face-to-face evaluations for involuntary hospitalizations each day.
- Magistrates issue an average of 70 TDOs each day for involuntary hospitalization.
- Loss of custody and medical instability requiring stabilization in the emergency department, or admission to a medical unit, are the two most common reasons for a delay in executing a temporary detention order (TDO).
- Since July 1, 2014, admissions to state hospitals have on average increased by 22 percent over the preceding year with wide variations and fluctuations in the percentage of increase by age, region, and season.

The Department of Behavioral Health and Developmental Services (DBHDS), community services boards (CSBs) and private inpatient hospitals implemented several initiatives prior to July 1, 2014 to respond to the needs of individuals needing access to inpatient temporary detention and to prepare for full implementation of SB 260. These actions included:

- Initiated full operation of the Virginia Psychiatric Bed Registry on March 3, 2014;
- Implemented a statewide Medical Screening and Medical Assessment protocol on April 1, 2014;
- Conducted extensive training on the new law for providers, law enforcement officers, and others throughout May and June, 2014;
- Revised and disseminated regional acute care access protocols to ensure consistent crisis response and access to inpatient care in June 2014; and
- Conducted a "Soft Launch" of SB 260 procedures on June 16, 2014, in advance of the July 1 effective date of the new laws, to ensure effective implementation statewide on July 1.

In addition, DBHDS designed and implemented new statewide reporting requirements to identify and monitor trends in:

- Emergency contacts to CSBs;
- Emergency evaluations conducted by CSBs;
- Temporary detention orders (TDOs) issued and executed; and
- Timeliness of access to care, and other variables associated with the new TDO procedures.

DBHDS also implemented a new reporting system for high risk events that involve individuals who are evaluated and need temporary detention, but who, regardless of the reason, do not receive that intervention. Each of these events is reported by the involved CSB on a case-by-case basis as the events occur, through submission of an incident report. Each report results in an immediate review by a DBHDS Quality Oversight Team[1] to assess the incident and the follow up actions of the CSB for comprehensiveness and appropriateness. Each incident is monitored actively by DBHDS and the CSB until the situation is resolved and all post-incident follow up is completed.

Concurrent with the development and implementation of SB 260 and its requirements, the Commonwealth of Virginia experienced a significant increase in the demand for emergency services, including all areas related to the involuntary admission process. Beginning in January 2014, referrals for involuntary admission under TDOs, including TDO admissions to state hospitals, markedly increased. From January through June 2014 the number of admissions increased to 923 from 638 the year before. The increase has continued through FY 2015 with 1,482 admissions fiscal year to date (FYTD) (March 2015), versus 1,071 for FY 2014 and 1,045 for FY 2013 for the same period of time.

Operationally, this trend is also reflected in increases in emergency contacts to CSBs and emergency evaluations conducted by CSB staff. For state hospitals, this increase is reflected in increased TDO referrals and admissions overall. These statewide trends toward more restrictive and resource intensive interventions are at odds with national best practices and with *Olmstead v. L.C.'s*[2] *(Olmstead)* interpretation of the *American's With Disabilities Act*[3] *(ADA).* The *ADA*

[1] The Quality Oversight Team includes the DBHDS Medical Director, Assistant Commissioner for Behavioral Health, Director of Mental Health, and MH Crisis Specialist.

[2] Olmstead v. L. C. , 527 U.S. 581 (1999).

requires states to provide services to individuals with disabilities in integrated community settings.

Lastly, SB 260 contributed to multifaceted changes in Virginia's behavioral health emergency and crisis services. In addition to ensuring a safety net of inpatient care for all who need this service, DBHDS also remains committed to increasing prevention, early intervention and ongoing supportive services. A comprehensive array of community-based services across the life span is essential in order to avert crises, enable individuals with behavioral health needs to be served in their home community, and, whenever possible, avoid intensive hospital-based care and inappropriate contact with the criminal justice system.

[3] Americans With Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 328 (1990).

1. Introduction

SB 260 (Chap. 691, 2014) amended several sections of the *Code of Virginia* and added new sections related to emergency custody and temporary detention of adults and minors experiencing psychiatric crises. The fourth enactment clause of this legislation reads as follows:

> *4. That the Department of Behavioral Health and Developmental Services shall submit an annual report on or before June 30 of each year on the implementation of this act to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees. The report shall include the number of notifications of individuals in need of facility services by the community services boards, the number of alternative facilities contacted by community services boards and state facilities, the number of temporary detentions provided by state facilities and alternative facilities, the length of stay in state facilities and alternative facilities, and the cost of the detentions in state facilities and alternative facilities.*

This report was prepared pursuant to the above language.

2. Behavioral Health System Description

Overview[4]: The publicly funded behavioral health and developmental services system provides services to individuals with behavioral health, intellectual disability, or co-occurring disorders through 15 state hospitals and training centers operated by DBHDS, and 39 community services boards and one behavioral health authority (hereafter referred to as CSBs).

In addition, services are provided in the public sector by a variety of private providers, including community psychiatric hospitals, emergency departments of community hospitals, and specialized outpatient and ambulatory service entities, who may provide these services through contracts with DBHDS and CSBs, or independently.

In FY 2014, 228,236 individuals received services in the publicly operated behavioral health and developmental services system: 222,419 of these individuals received services from CSBs and 5,817 individuals received services from state facilities[5]. Of the individuals who received CSB services, 2,631 received acute psychiatric inpatient services through local inpatient purchase of services (LIPOS) contracts in their communities. If these services had not been available, most of these individuals would have required inpatient treatment from state hospitals. This would have more than doubled the number of individuals (2,443) who received services in state hospital acute admission units in FY 2014.

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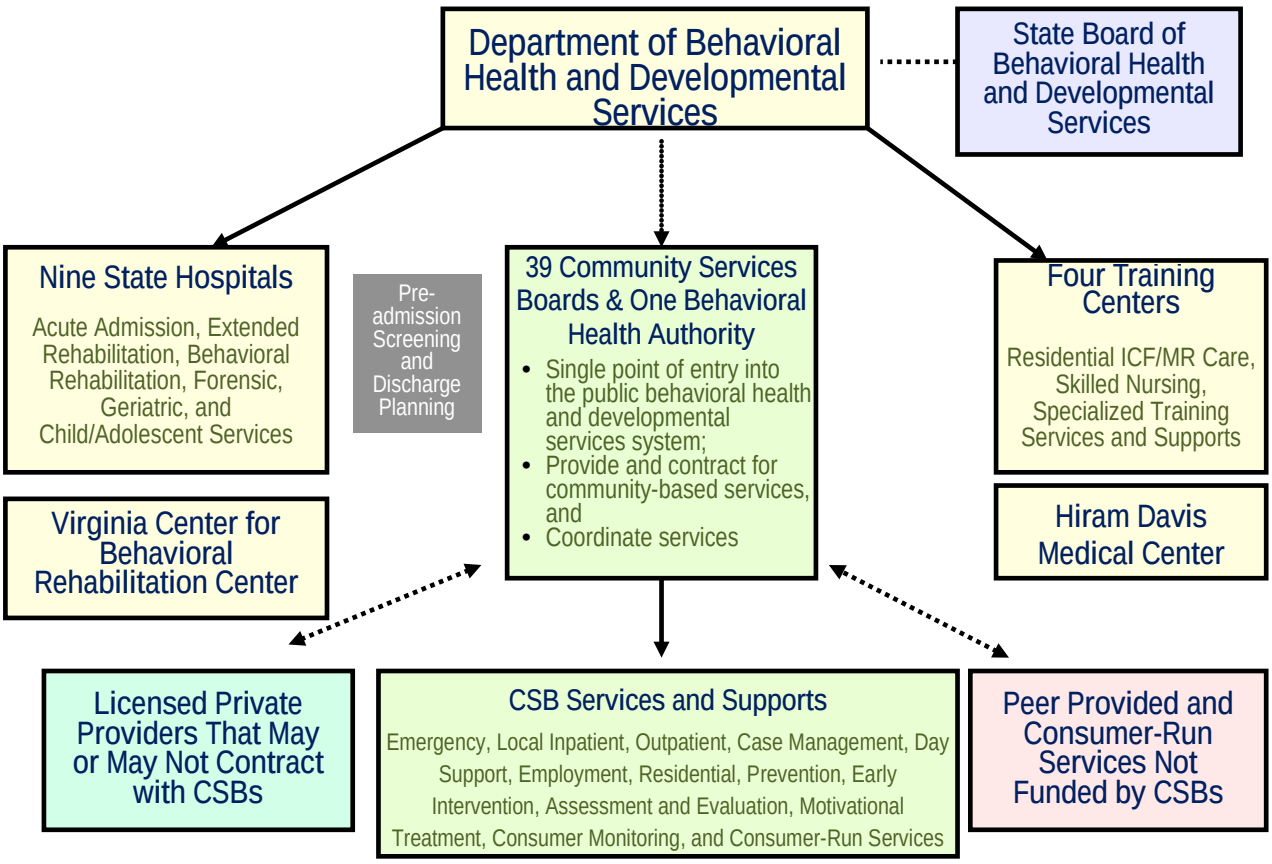
[4] The information in this overview is a brief summary of the public behavioral health and developmental services system. A comprehensive service system description and other data can be found in the *Department of Behavioral Health and Developmental Services Fiscal Year 2014 Annual Report* at http://leg2.state.va.us/DLS/h&sdocs.nsf/5c7ff392dd0ce64d85256ec400674ecb/f4586e7ac0fbb6af85257d0e005b1666?OpenDocument&Highlight=0,dbhds.

[5] However if one individual received services from more than one CSB or state hospital, each hospital or CSB will include that individual in its unduplicated count.

The figure below shows the basic structure of this system.



CSB Behavioral Health (BH) Services: CSBs were established by Virginia's 133 cities or counties pursuant to Chapters 5 or 6 of Title 37.2 of the *Code of Virginia*. CSBs provide services directly and through contracts with private providers. CSBs function as the single point of entry into publicly funded behavioral health services, and coordinate an array of services including access to state hospital services. Specific CSB behavioral health services include:

- Emergency, crisis and inpatient;
- Assessment , evaluation, counseling, psychiatry and medication services
- Medication assisted treatment (for addiction);
- Case management;
- Psychiatric rehabilitation, Assertive Community Treatment, employment supports;
- Residential services, substance abuse detoxification;
- Peer and family support and education; and
- Wellness and prevention services.

State Psychiatric Hospitals: DBHDS operates nine psychiatric hospitals with an operational capacity of 1,491 beds. Eight of these facilities provide inpatient services for adults (including older adults and justice-involved individuals), and one facility, the Commonwealth Center for

Children and Adolescents (Staunton), serves children and youth with serious emotional disturbances. DBHDS hospitals provide a variety of intensive inpatient services, including psychiatric, psychological, psychosocial rehabilitation, nursing, support, ancillary services, and other specialized programs. The DBHDS psychiatric hospitals and their current total operational bed capacities are:

State Hospital Name	Bed Capacity
Catawba Hospital, Salem	110
Central State Hospital, Petersburg	277
Eastern State Hospital, Williamsburg	302
Piedmont Geriatric Hospital, Burkeville	123
Northern Virginia Mental Health Institute, Falls Church	134
Southern Virginia Mental Health Institute, Danville	72
Southwestern Virginia Mental Health Institute, Marion	179
Western State Hospital, Staunton	246
Commonwealth Center for Children and Adolescents, Staunton	48
TOTAL	**1,491**

Other Behavioral Health Crisis Response Services: In Virginia, the safety net of behavioral health crisis response services includes not only CSBs and state psychiatric hospitals, but other providers and organizations, including community private psychiatric hospitals, emergency departments (EDs) in community hospitals, crisis stabilization programs, police, sheriffs, and other law enforcement agencies, magistrates, judges, special justices and other court officials, and other entities depending on the community. As of May 2015, there were 40 licensed community private psychiatric hospitals with 1,202 staffed adult beds, and 175 staffed beds for minors[6].

3. Overview of SB 260

Legislative History: Senate Bill 260 was prefiled on January 3, 2014, by Senators Deeds, Barker, Black, Favola, Howell and Ebbin, and Delegates Plum and Torian. The introduced bill was proposed to change the period of emergency custody from four hours with one possible two-hour extension, to a maximum of 24 hours with no extension. As SB 260 went through the Senate and House committees and chambers, several substitute bills emerged as other legislation was rolled into SB 260[7], additional amendments were made and new sections were added to the bill. The final bill was negotiated in conference and adopted by the House and Senate on March 8, 2014. Several additional enactment clauses were added and the bill was signed into law as Chapter 691 by Governor McAuliffe effective April 6, 2014.

Key Features of SB 260: The salient features of SB 260 are described below:

- **Eight hour maximum period of emergency custody:** After considering various options embodied in several bills, the legislature doubled the maximum period of emergency

[6] Source: DBHDS Office of Licensing.
[7] SB 260 incorporates SB 200, SB 263, SB 370, and SB 458.

custody, from four to eight hours, in §§ 16.1-340 (minors), 19.2-182.9 (NGRI acquittees on conditional release), and 37.2-808 (adults). The two-hour emergency custody order (ECO) extension was eliminated.

- **Law officer notification:** SB 260 specified that a law officer who executes an ECO under §§ 16.1-340 (minors) and 37.2-808 (adults) must notify the appropriate community services board (CSB) of the execution of the emergency custody order "as soon as practicable" after execution.

- **Written explanation of ECO and TDO process:** An adult taken into emergency custody or temporary detention must be given a written explanation of the process and the statutory protections associated with these procedures (§§ 37.2-808. and 37.2-809).

- **Eight hour mandatory outpatient treatment (MOT) examination period:** The period of custody to perform an examination required for court review of a MOT plan was changed from four hours to eight hours in §§ 16.1-345.4 (minors) and 37.2-817.2 (adults).

- **State hospitals are "last resort" for temporary detention:** Under §§ 16.1-340.1 and 16.1-340.1:1 (minors), and §§ 37.2-809 and 37.2-809.1 (adults), state hospitals are now required to admit any individual for temporary detention who is not admitted to an alternative treatment facility, such as a community private psychiatric hospital, prior to the expiration of the new eight hour emergency custody period. This provision ensures that no individual who needs temporary detention is denied access to care, because the state hospital will serve as the "last resort" for anyone who cannot access needed treatment in any other facility. The state hospital may not refuse such an admission. Other provisions in these sections require the CSB to notify the state hospital when an ECO is executed, and to contact the state hospital again following their examination of the individual. In addition, an individual who is deemed to need temporary detention may not be released from custody except for the purposes of transportation to the temporary detention facility.

- **State hospitals may seek alternative facilities:** Under §§ 16.1-340 (minors) and 37.2-808 (adults), state hospitals and CSBs may continue to search for an alternative temporary detention facility for an additional four hours following admission of anyone who is admitted because a suitable alternative facility could not be found by the time the eight hour emergency custody period expired. Any such alternative facility must be willing and able to provide appropriate care. A second enactment clause was added to SB 260 specifying that these provisions expire on June 30, 2018[8].

- **72-hour maximum period of temporary detention:** The maximum period of temporary detention prior to a hearing was extended from 48 hours to 72 hours in §§ 19.2-169.6.A.2

[8] A separate bill that was passed in the 2014 Session, HB 1172 (Chap. 675), allows transfer of a TDO to an alternative facility at any time during the period of temporary detention to more appropriately meet the security, medical or behavioral health needs of the individual. Language from both SB 260 and HB 1172 is in the current *Code*.

(jail inmates), 19.2-182.9 (NGRI acquittees on conditional release), and 37.2-809 and 37.2-814 (adults).

- **Acute Psychiatric Bed Registry:** Another new section, § 37.2-308.1, was added to SB 260 requiring DBHDS to operate an acute psychiatric bed registry to provide real-time information on bed availability to designated searchers so that CSBs, inpatient psychiatric facilities, public and private residential crisis stabilization units, and health care providers working in an emergency room of a hospital or clinic or other facility rendering emergency medical care could access the bed registry and this information. This provision became effective immediately upon passage, on April 6, 2014.

- **Technical amendments:** There were a few technical, clarifying amendments in this bill (see for example, lines 274-276, 493-494, 818, etc.).

- **Enactment clauses:** A second enactment clause made the bed registry provision effective upon passage. A third enactment clause established a June 30, 2018 expiration date for the four hour extension provision of §§ 16.1-340.M. (minors) and 37.2-808.N. (adults). A fourth enactment clause required this annual report, and a fifth enactment clause required the Governor's Task Force on Improving Mental Health Services and Crisis Response[9] to study options for reducing the use of law enforcement in the involuntary admission process.

4. Implementation of SB 260

Background: SB 260 was signed into law following a period of intensive review of Virginia's behavioral health emergency services operations by the Secretary of Health and Human Resources (SHHR), DBHDS, and the Office of the State Inspector General (OSIG). SB 260 explicitly codified a new set of standards and procedures that had been widely discussed among policy-makers, service providers, and other stakeholders. SB 260 was intended to ensure that the safety net of emergency behavioral health services responded appropriately in every case, that a safe intervention was provided for individuals in extreme and acute crisis, and that the system's response to individuals and their families would be consistent regardless of where they reside in Virginia. These standards and procedures represented a significant departure from existing protocols and practices. Therefore, an immediate, sustained, multi-pronged training, education and services expansion was necessary to implement and support these new requirements. The following describes these specific implementation initiatives.

1) **Acute Psychiatric Bed Registry:** Development of the psychiatric bed registry had been underway at DBHDS through a contract with Virginia Health Information (VHI) and in collaboration with the Virginia Hospital and Healthcare Association (VHHA). Following a test period, the *Virginia Psychiatric and CSB Bed Registry* became fully operational on March 3, 2014. Subsequently, DBHDS hired a full time staff specialist to manage the bed

[9] The Governor's Task Force concluded its work on March 23, 2015. The final Task Force report can be found at http://www.dbhds.virginia.gov/library/document-library/omh-mhtaskforce-final-report-oct2014.pdf.

registry. More detail on the utilization and impact of the bed registry can be found in Section 6, below.

2) **Medical Screening and Medical Assessment Protocol:** DBHDS mental health and state hospital medical staff had been working since 2012 with VHHA, the Virginia Association of Community Services Boards (VACSB), the Virginia College of Emergency Physicians (VACEP), the Medical Society of Virginia (MSV), the Psychiatric Society of Virginia (PSV), and the Department of Medical Assistance Services (DMAS) to revise and re-issue the DBHDS medical screening and medical assessment protocol to be followed by Virginia CSBs, state and private hospitals, and emergency departments.[10] The protocol was intended to support a common understanding of medical screening and medical assessment, clearly articulate the responsibilities and expectations of practitioners in the medical screening and assessment process, and support consistent application of medical screening and assessment procedures across organizations that respond to persons with psychiatric disorders in emergency situations. DBHDS reissued the revised *Second Edition* of the medical screening and assessment protocol on April 1, 2014[11], to be effective immediately.

3) **Regional Admission Protocols:** DBHDS recognized that significant improvements were needed to enhance the clarity, consistency, and understanding of the policies and procedures that CSB emergency staff and regions were to follow to access inpatient psychiatric care in Virginia. On January 15, 2014, DBHDS requested that CSBs and state hospitals in each behavioral health planning region[12] review and update their regional admission protocols to:

> *(1) clarify and ensure more consistent and widespread awareness of the procedures for when the state hospital in the region should be contacted to secure a bed for the TDO and what prerequisites the CSB must meet before contacting the state hospital, and (2) clarify when it is appropriate for a state hospital to be utilized for temporary detention and process for requesting and accessing such a bed."*[13]

The revised Regional Protocols were to be completed, reviewed by DBHDS, and implemented by each region by March 15, 2014[14]. Subsequent revisions became necessary when SB 260 passed with additional procedural requirements. The regional protocols were completed and in operation by the June 16, 2014 "Soft Launch," described in further detail on page 13.

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[10] The current April 1, 2014 *Second Edition* replaced the 2007 original edition.

[11] The medical screening and medical assessment protocol document is posted on the DBHDS website at http://www.dbhds.virginia.gov/library/document-library/140401medicalscreeningguidance%20(2).pdf.

[12] There are seven behavioral health planning regions.

[13] Memorandum from former DBHDS Acting Commissioner John Pezzoli, *Guidance for Developing Regional Admission Policy & Procedures*, January 15, 2014, DBHDS.

[14] These protocols are posted on the DBHDS website at http://www.dbhds.virginia.gov/professionals-and-service-providers/mental-health-practices-procedures-and-law/protocols-and-procedures.

4) **Regional and Stakeholder Training:** DBHDS, in collaboration with the Office of the Attorney General (OAG) and the VACSB, organized three regional training events, and participated in several others, to train practitioners and other stakeholders in the new laws and how to implement them effectively. These training events are described further below.
   - *DBHDS/OAG Regional Training* – DBHDS and the OAG presented three large regional training events on May 19, 2014 (Roanoke), June 19, 2014 (Fairfax), and June 23, 2014 (Hampton). These were open events targeted to practitioners with roles in the emergency custody, temporary detention and involuntary commitment process. Attendees were primarily CSB staff, but also included state and community hospital staff, emergency department personnel, law enforcement officers, members of the judiciary, and interested stakeholders and advocates. Approximately 345 individuals in total attended the three events. The primary focus areas of these workshops was fourfold: (1) providing a complete and detailed overview of the new laws, (2) understanding medical screening, medical assessment and medical treatment issues in the context of psychiatric emergencies, (3) integrating sound medical practice into the new statutory scheme, and (4) providing guidance on implementation strategies and accountability requirements related to the new laws.
   - *VACSB Training* – On May 1, 2014, a special session was scheduled at the VACSB Development and Training Conference in Norfolk to bring together CSB board members, executive directors and staff for a workshop on the new laws. The VACSB Emergency Services Conference, co-sponsored by DBHDS, took place on June 17-18, 2014, and also included a plenary workshop on implementing the new laws.
   - *Other events* – DBHDS and OAG staff provided training to other stakeholders upon request. For example, the OAG trained sheriffs at the Virginia Sheriffs Association annual meeting. DBHDS staff presented a workshop on the new laws at the National Alliance on Mental Illness of Virginia Annual Conference, and reviewed the statutes at the Virginia Hospital and Healthcare Association Behavioral Health Forum. In addition, The Office of the Executive Secretary of the Supreme Court of Virginia included a review of the new laws in its training and guidance materials for magistrates, special justices, circuit and district court judges, and district court clerks.

- **Web Resources:** DBHDS created several webpages on the DBHDS website to consolidate training and related guidance materials, practitioner resources and other information that would support implementation of the new laws. For example, posted on these pages are training presentations, the Medical Screening and Medical Assessment guidance materials (including federal Emergency Medical Treatment & Labor Act (EMTALA)-related guidance), an extensive list of frequently asked questions developed from dialogue with stakeholders, data and reports collected and issued by DBHDS, the regional admission protocols, and selected forms used in the involuntary admission process. These resources can be accessed at the following link: www.dbhds.virginia.gov/professionals-and-service-providers/mental-health-practices-procedures-and-law.

- **Soft Launch of New Statutes and Protocols:** On June 16, 2014, DBHDS, along with state facilities, CSBs and other service delivery partners, initiated a "Soft Launch" to test and refine local and regional protocols under the new statues. As a result, CSBs and emergency service delivery partners were able to identify and refine communication and service delivery procedures in advance of the effective date of the new laws, and to minimize service disruptions on July 1 and thereafter.

- **New Forms:** The Supreme Court of Virginia developed and implemented new forms to fulfill the notification requirements for individuals under emergency custody and temporary detention orders. Local partners (e.g., law enforcement officers) integrated these forms into their intervention practice.

- **Brown Bag Lunches**: Following passage of the new laws in 2014, DBHDS initiated a series of "Brown Bag Lunches" with stakeholders including the Virginia Association of CSBs (VACSB), the Virginia Hospital and Healthcare Association (VHHA), the National Alliance on Mental Illness of Virginia (NAMI-VA), the Medical Society of Virginia (MSV), the Psychiatric Society of Virginia (PSV), the Virginia College of Emergency Physicians (VACEP), the Supreme Court of Virginia, the Virginia Sheriffs Association, the Virginia Association of Chiefs of Police, and key DBHDS staff. These meetings were hosted by DBHDS Commissioner Ferguson and afforded an opportunity for all involved stakeholders to identify and address implementation and policy issues associated with the new laws and to address these issues immediately and collaboratively. There have been seven meetings to date[15].

- **Community Services Performance Contract Improvements:** DBHDS and CSBs implemented amendments to the FY 2015-16 Community Services Performance Contract to clarify emergency service requirements, including staff qualifications, service delivery, emergency telephone system operations and related issues to strengthen responsiveness and consistency across CSB emergency services statewide.

- **Ongoing Data Collection and Reporting:** DBHDS designed and implemented a monthly reporting system effective July 1, 2014, to track CSB emergency service contacts, emergency evaluations, and temporary detention orders, as well as "exceptional" events involving the operation of the new laws (e.g., use of state hospitals for temporary detention). In addition, DBHDS implemented a case-specific reporting process to track any instance involving an individual who was evaluated by a CSB and deemed to need temporary detention, but who was not detained for any reason. DBHDS has been publishing these data monthly on its website[16], and year to date data is included in this report below. DBHDS and CSBs use these data to identify areas where clinical practice or operations of the emergency service system can be improved. These critical quality management efforts have resulted in significant improvements in emergency services as well as adherence to regional protocols.

[15] Meetings occurred on June 10, July 9, August 18, October 14, November 24, 2014, and January 5 and February 6, 2015.

[16] See http://www.dbhds.virginia.gov/professionals-and-service-providers/mental-health-practices-procedures-and-law/data.

- **Service Capacity Improvements:** DBHDS, the Governor and General Assembly have worked together to expand the capacity of treatment services and ongoing supports that reduce and prevent mental health emergencies from occurring. Critical improvements in the mental health emergency response system have included increasing acute beds in state hospitals, maximizing funds for purchase of private hospital beds, adding secure assessment centers in several communities, improving crisis response services for children, and expanding suicide prevention. The Governor's Taskforce on Improving Mental Health Services and Crisis Response made recommendations for continued improvements in its October 1, 2014, final report and completed its work in March 2015.

- **Stakeholder Support:** Since July 1, 2014, DBHDS has provided ongoing local technical assistance and support to CSBs, the Secretary of Health and Human Resources, legislators, and others about these reforms and provided intervention and support to individuals and families who communicated with the Governor, the Secretary, legislators, and DBHDS regarding their experiences with Virginia's mental health services system.

5. Impacts of SB 260

SB 260 was intended to address specific concerns with the behavioral health crisis response system. Of critical and central importance was the implementation of new standards and protocols to ensure that no individual in acute psychiatric crisis, who was in need of temporary detention, would fail to receive that care due to lack of an available bed. As previously described, this required substantial changes in policy, practice and operations to ensure that this critical, safety net service was available whenever necessary. This section describes the impact of these changes in several key areas.

a. Statewide Trends in Involuntary Treatment: DBHDS has contracted with the University of Virginia Institute of Law, Psychiatry and Public Policy since FY 2007 to analyze data from the Supreme Court of Virginia on the operations of the involuntary civil commitment process in Virginia. These data offer the best available long-term picture of trends in emergency custody, temporary detention, and involuntary commitment[17]. Events related to civil commitment (i.e. ECOs, TDOs, and involuntary commitment orders) vary seasonally, with the least activity regularly occurring in the second fiscal quarter of each year. Due to this seasonal variation, it is important to compare current data with data from the same time of year.

These data reflect a significant increase in emergency custody, temporary detention and involuntary commitment activity throughout Virginia, beginning in April 2014. This corresponds with the time that SB 260 was finalized and enacted but precedes the actual effective date of the new law, indicating systemwide reaction to policy makers' concerns about Virginia's crisis response system in advance of the SB 260 effective date of July 1, 2014. These statewide trends are depicted in the graphs below:

[17] These data are civil cases only, not criminal justice–involved (forensic) cases.

Figure 1. Frequency of Adult ECOs, FY 2010-FY 2015 (eMagistrate)

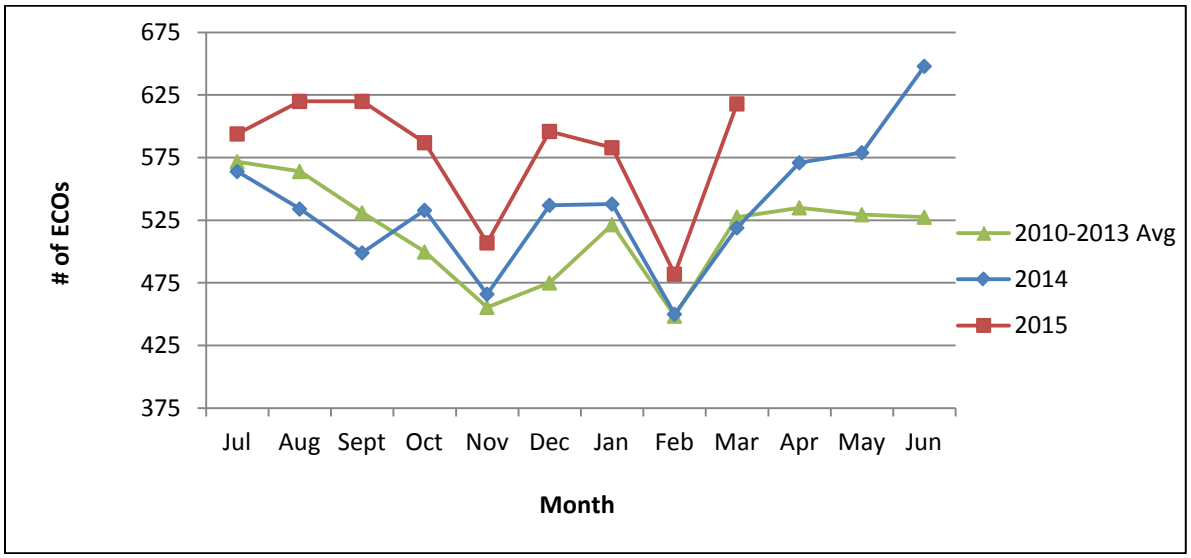
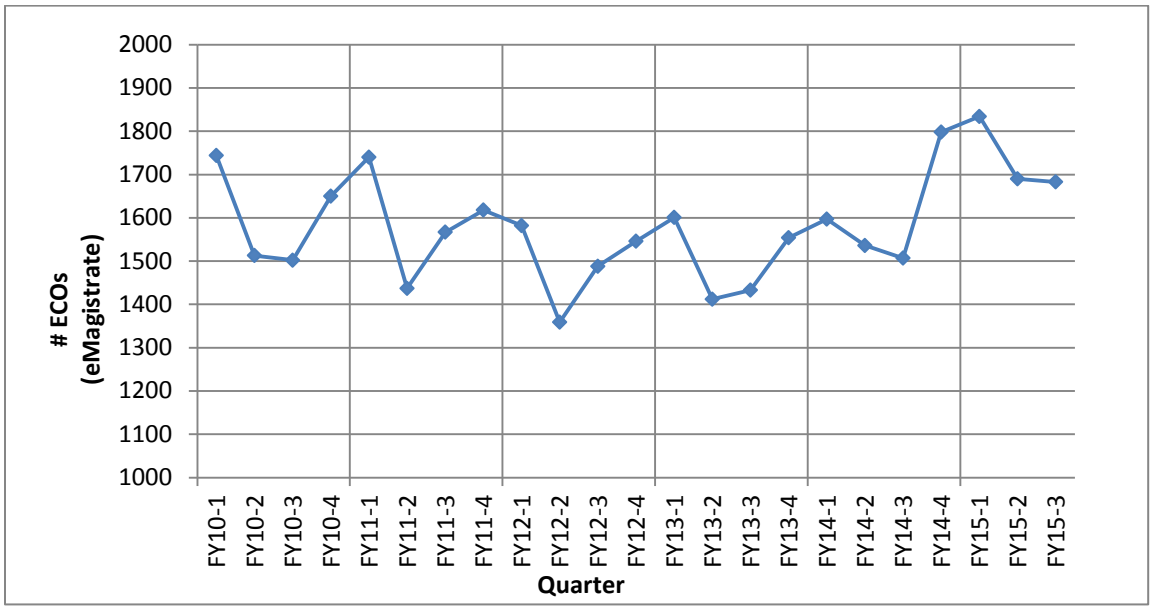


Figure 2. Adult ECO Trends, FY 2010-FY 2015 (eMagistrate)



- **Emergency Custody Orders (ECOs):** The best available source of data regarding ECOs issued by magistrates is the Supreme Court of Virginia's *eMagistrate* data system[18]. According to *eMagistrate* data, the number of ECOs issued from FY 2010-FY 2011 was stable. From FY 2012-FY 2013, the number of annual ECOs issued dropped slightly. Starting in April of FY 2014, the number of ECOs issued started to increase

[18] These are ECOs issued by magistrates, not ECOs initiated by law enforcement officers without an order. The majority of adult ECOs, about 60%, are officer initiated.

substantially when compared with similar months from past years (see Figure 1, above). The number of ECOs issued for April-June FY 2014 and July-March FY 2015 was substantially higher than the average number of ECOs for the same months in FY 2010-FY 2013 (see Figure 1 and Figure 2, above). For FY 2014, fourth quarter ECO counts were 12.9percent higher than the average fourth quarter counts for FY 2010-2013; first quarter FY 2015 counts were 10 percent higher; second quarter FY 2015 counts were 18.2 percent higher; and third quarter FY 2015 counts were 12.4 percent higher.

Figure 3: Frequency of Adult TDOs, FY 2010-FY 2015 (eMagistrate)

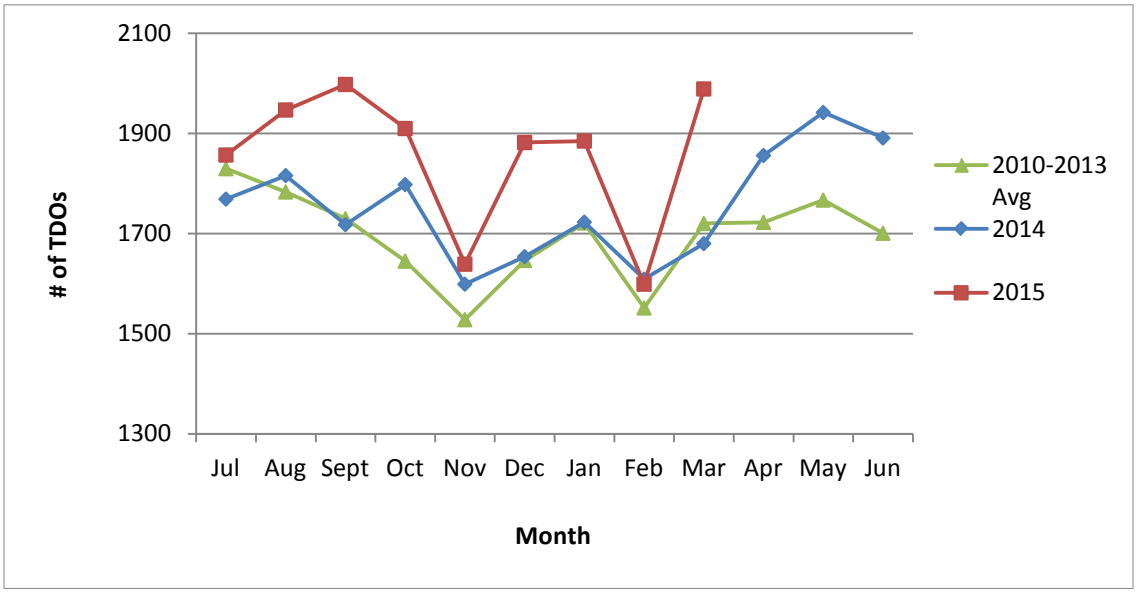
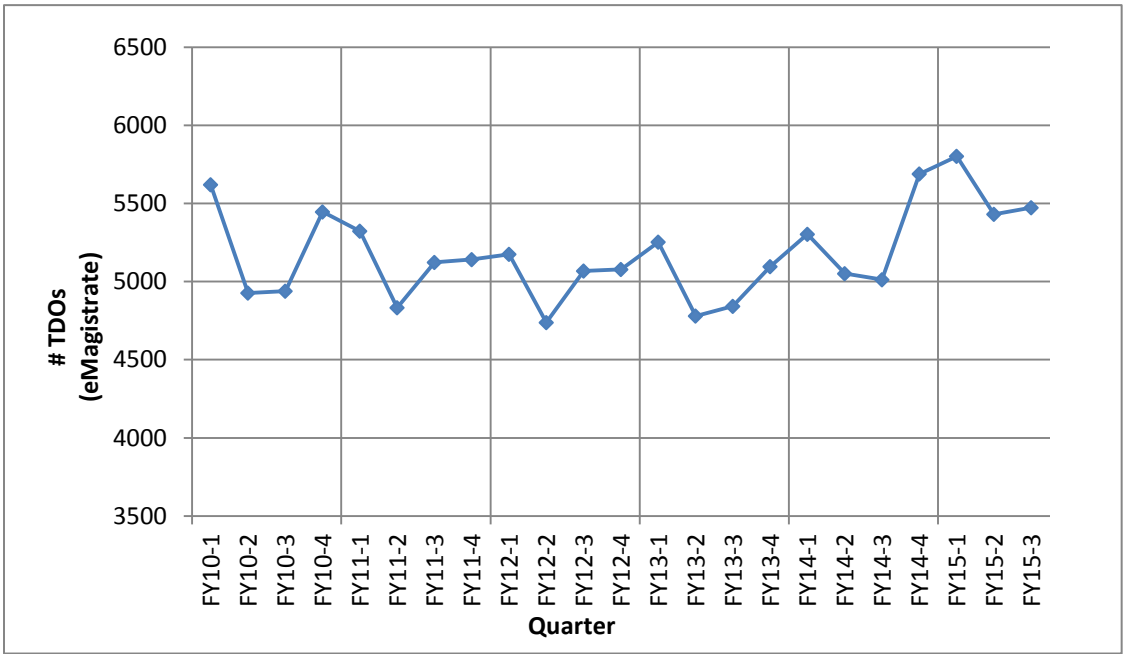


Figure 4: Adult TDO Trends, FY 2010-FY 2015 (eMagistrate)



- **Temporary Detention Orders (TDOs):** The *eMagistrate* data system from the Supreme Court of Virginia is also the best source of information on the number of TDOs issued statewide. Data extracted from *eMagistrate* showed that TDO counts in FY 2014 were higher than the average FY 2010-FY 2013 TDO counts in all but three months of FY 2014 (see Figure 3, above). Also, the number of TDOs issued declined slightly from FY 2011 to FY 2013 and began to rise in FY 2014 (see Figure 4, above). The TDO counts for April-June FY 2014 and July-March FY 2015 were all substantially higher than the average number of TDOs for the same months in FY 2010-FY 2013. The fourth quarter FY 2014 TDO totals were 9.6percent higher than the average fourth quarter totals for FY 2010-FY 2013. For the first three quarters of FY 2015 the totals were 8.6percent, 12.7percent and 9.6percent higher respectively.

Figure 5: Frequency of Adult Involuntary Commitment Orders (Inpatient Only), FY 2010-FY 2015 (CMS) (Initial Only)

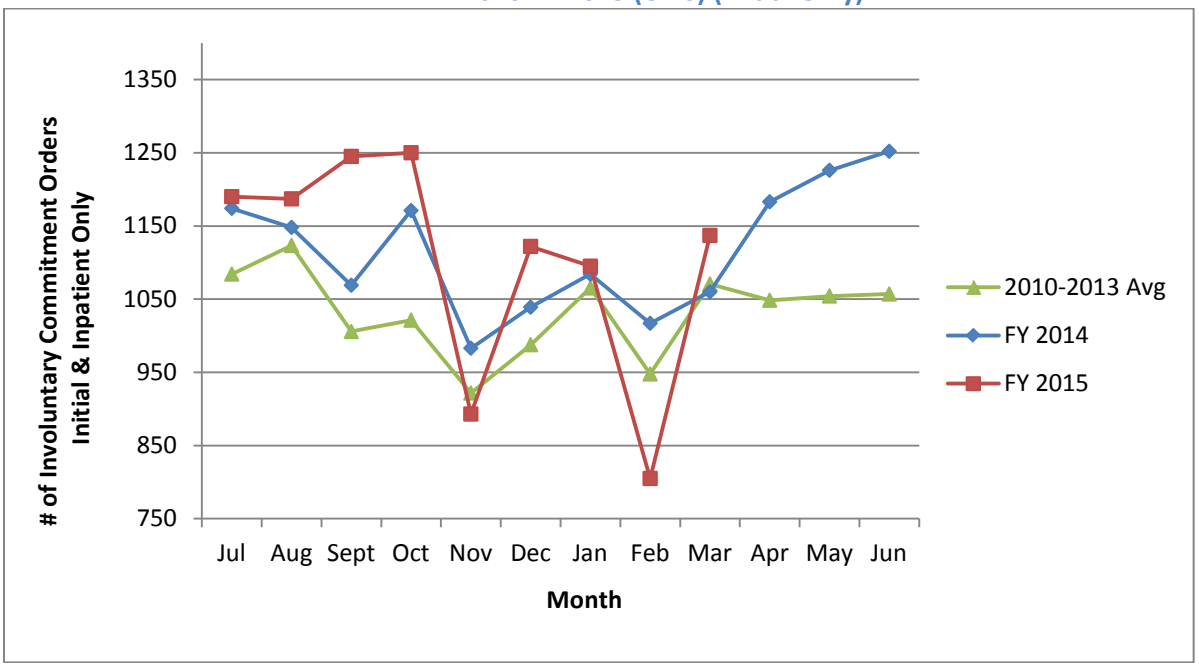
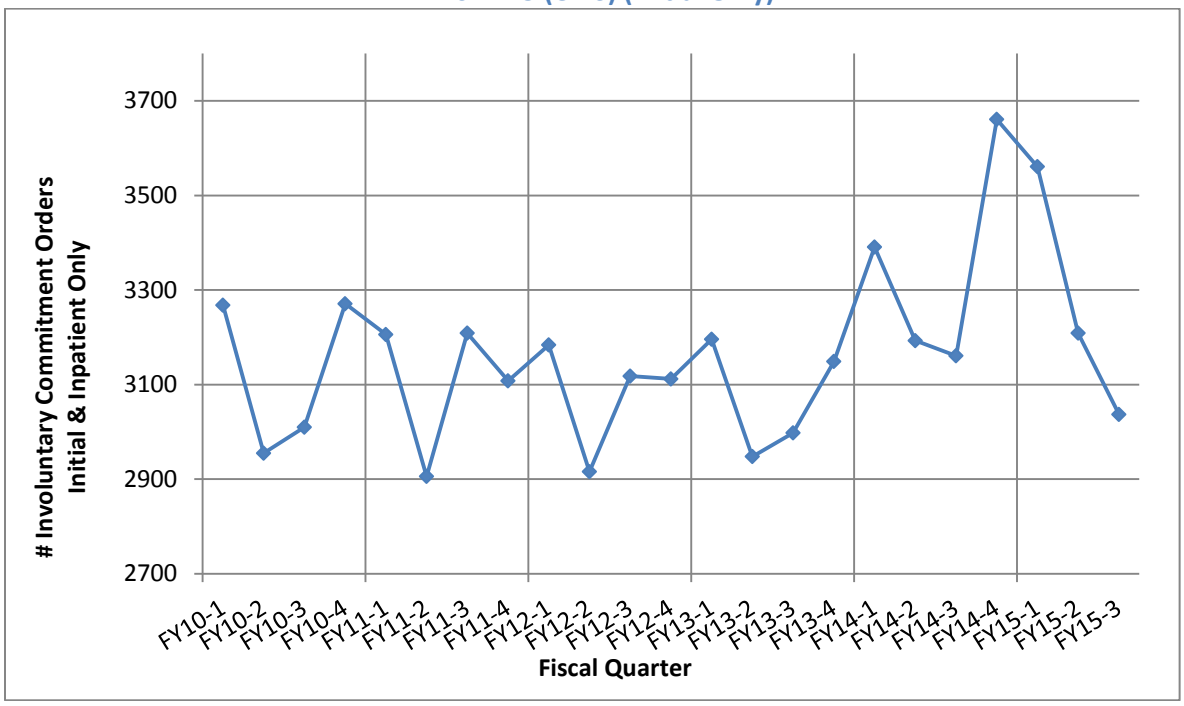


Figure 6: Adult Involuntary Commitment Order Trends (Inpatient Only) FY10-FY15 (CMS) (Initial Only)



- **Involuntary Commitment Orders:** The Supreme Court of Virginia's *Case Management System* (CMS) includes information about the dispositions resulting from commitment hearings. Data from the CMS system show that the numbers of involuntary commitment orders at initial hearings increased considerably in April through June of FY 2014, and continued to increase into FY 2015 (see Figure 5 and Figure 6, above). Fourth quarter FY 2014 commitment order totals were 15.9 percent higher than the average fourth quarter totals for FY 2010-FY 2013; first quarter FY 2015 totals were 5.5 percent higher; and second quarter FY 2015 totals were 9.5 percent higher. This is consistent with the increase in ECOs and TDOs during this same time period.

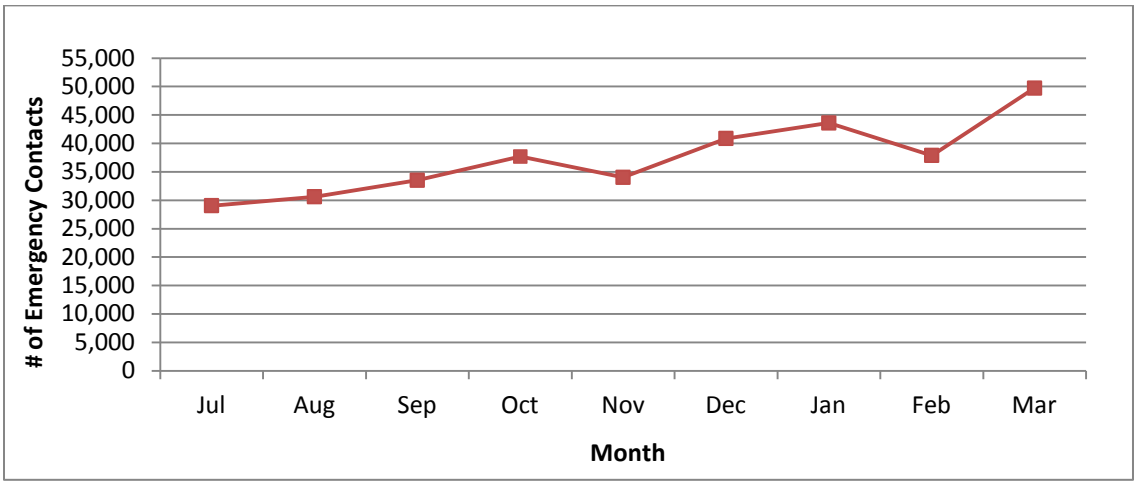
  The preliminary data for the third quarter show totals that were 1.5 percent lower than average totals for FY 2010 – FY 2013.

b. FY 2015 Year to Date (YTD) CSB Emergency Contacts and Evaluations: CSBs collect and report data to DBHDS on critical events associated with CSB emergency services utilization, TDOs, and the factors contributing to these events. DBHDS requires these data be submitted monthly by each CSB and geographic region. DBHDS also requires case-specific reports from individual CSBs within 24-hours of any event involving an individual who has been determined to require temporary detention for whom the TDO is not executed for any reason.[19] These reports are aggregated and analyzed monthly with the results and analyses posted on the DBHDS

[19] While the law applies only to individuals under an ECO who qualify for a TDO, DBHDS requires case-specific reporting by CSBs for any individual under an ECO or not who received a TDO.

website[20]. The following are data from CSB reports showing key dimensions of the involuntary commitment process under the new statutes that became effective July 1, 2014. Data are presented for the first three quarters of FY 2015. For comparison, where possible, FY 2014 data are also included.

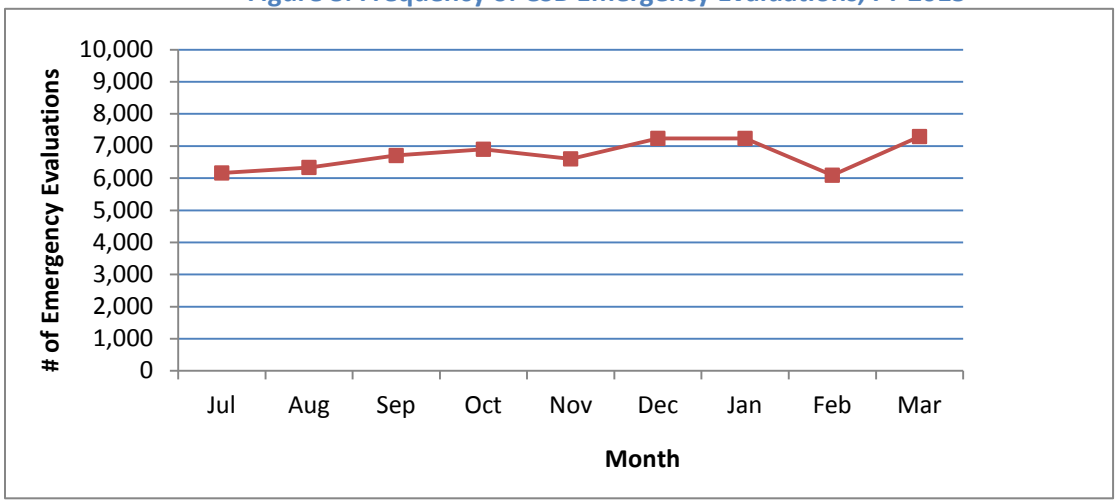
Figure 7: Frequency of CSB Emergency Contacts, FY 2015



- **Number of Emergency Contacts to CSBs:** Emergency contacts include all events that require any type of CSB emergency service involvement or intervention, such as incoming calls, referrals, requests, orders, etc., whether or not the contact is in reference to a crisis and regardless of the ultimate disposition. DBHDS and CSBs began tracking these contacts in FY 2015 in order to understand the context of demand on the CSB crisis response system. These data (See Figure 7, above) reflect a steady increase throughout FY 2015. Note that the data reflect an average of more than 35,000 emergency contacts each month. DBHDS believes that some of the monthly changes in these data reflect clarification and refinements in data gathering procedures at the local level that provided by DBHDS in November 2014.

[20] See www.dbhds.virginia.gov/professionals-and-service-providers/mental-health-practices-procedures-and-law/data.

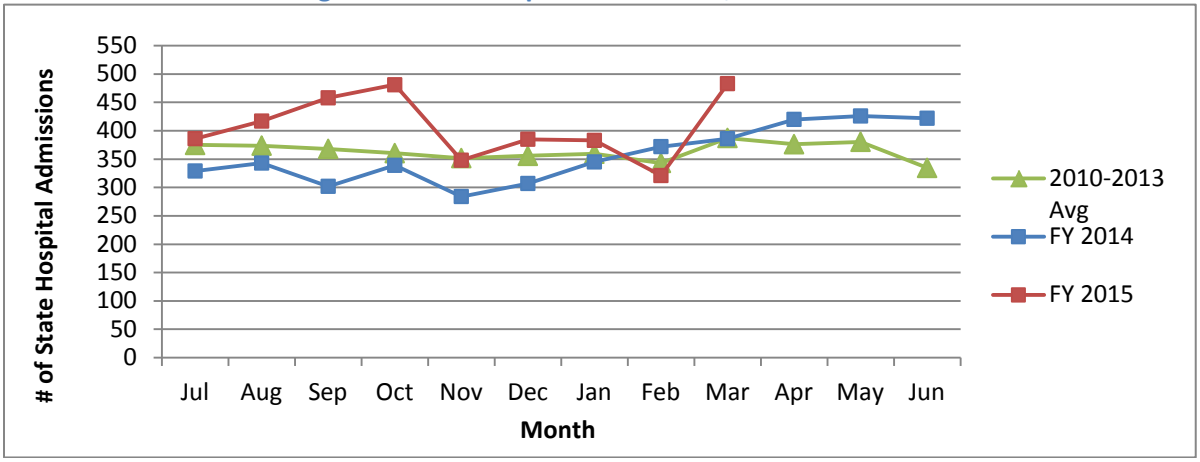
Figure 8: Frequency of CSB Emergency Evaluations, FY 2015



- **Number of Emergency Evaluations by CSBs:** The Figure 8 above shows the number of emergency evaluations completed by CSBs during the first three quarters of FY 2015. Emergency evaluations are comprehensive in-person clinical examinations conducted by CSB emergency services staff for individuals who are in crisis (these exams may be conducted electronically by two-way video and audio communication). These data show a steady increase over the course of the first two quarters, with subsequent leveling off through the third quarter. Note that the data reflect an average of more than 6,500 emergency evaluations each month.

c. Admissions to State Hospitals: As indicated in sections 6.a. and b., above, beginning in April 2014, there has been a significant increase in emergency services activity throughout Virginia, including emergency custody, temporary detention and involuntary commitment orders, emergency contacts and emergency evaluations. Admissions to state hospitals, as well as TDO admissions to state hospitals, have been consistent with these trends, as shown below. As noted previously, these events typically vary seasonally, with the least activity regularly occurring in the second quarter of each fiscal year. Therefore, it is necessary to compare current totals with past totals from the same time of year. These state hospital admission trends are summarized below.

Figure 9: State Hospital Admissions, FY 2010-2015



- **Admissions to State Hospitals:** Figure 9, above, shows the trend in state hospital admissions from FY 2010. Following a relatively stable rate of admissions for FY 2010-2013, state hospital admissions began to increase markedly in January 2014, and continued to increase through October 2014. During the last two years, admissions to state hospitals have decreased during the months of November through February and returned to past levels in March. This overall increased level of state hospital utilization has been managed through increased capacity-building described elsewhere in this report (see Section 6.e., below) and by aggressive utilization management by state hospitals, DBHDS and CSBs. Each of the state hospitals experienced different rates of increase in overall admissions by age group and these rates have fluctuated overtime.

Figures 10, 11 and 12, below, show the percentage changes in state hospital admissions by age and facility for the first three quarters of FY 2015, compared to the same quarter in FY 2014. Numbers in black, without parentheses (e.g., 36 percent), represent increases in admissions. Numbers in red, in parentheses (e.g. (22 percent)), represent decreases in admissions.

Figure 10: Percentage increase and (decrease) in admissions, by age, all DBHDS hospitals

Age	1st Quarter FY 2015 over FY 2014	2nd Quarter FY 2015 over FY 2014	3rd Quarter FY 2015 over FY 2014
Child/Adolescent	36%	11%	(22%)
Adult	25%	32%	12%
Geriatric	82%	100%	70%

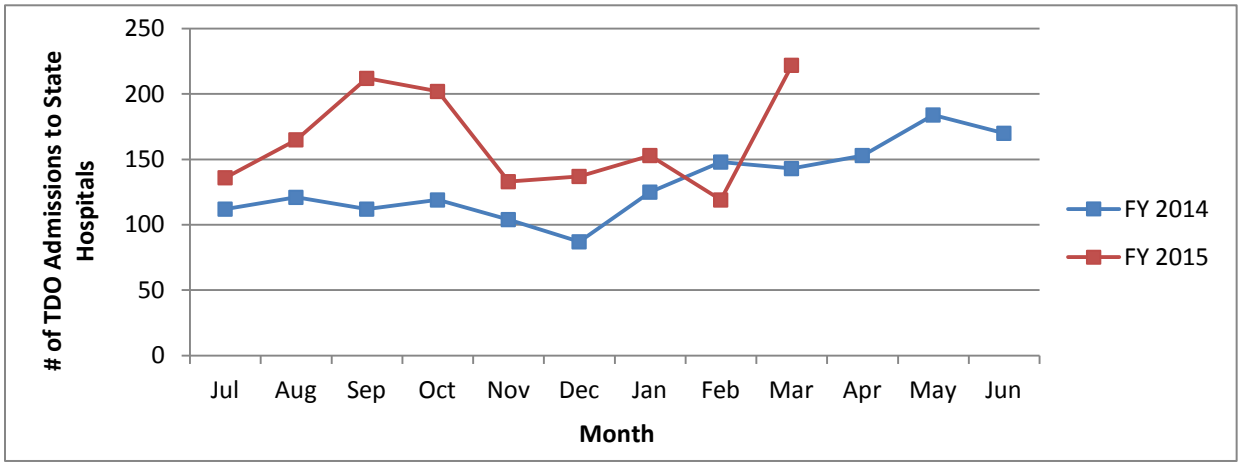
Figure 11: Percentage increase and (decrease) in admissions, by age and hospital

Facility	1st Quarter FY 2015 over FY 2014			2nd Quarter FY 2015 over FY 2014			3rd Quarter FY 2015 over FY 2014		
	C & A	Adult	Geriatric	C & A	Adult	Geriatric	C & A	Adult	Geriatric
CCCA	36%			11%			(22%)		
SWVMHI		(7%)	(9%)		(5%)	167%		(23%)	36%
CSH		29%			14%			0%	
WSH		36%			27%			8%	
CAT		56%	57%		26%	107%		10%	53%
NVMHI		43%			78%			59%	
SVMHI		(1%)			(9%)			(20%)	
ESH		66%	325%		124%	280%		83%	533%
Piedmont			84%			33%			72%

Figure 12: Percentage increase and (decrease) in TDO admissions to all DBHDS hospitals

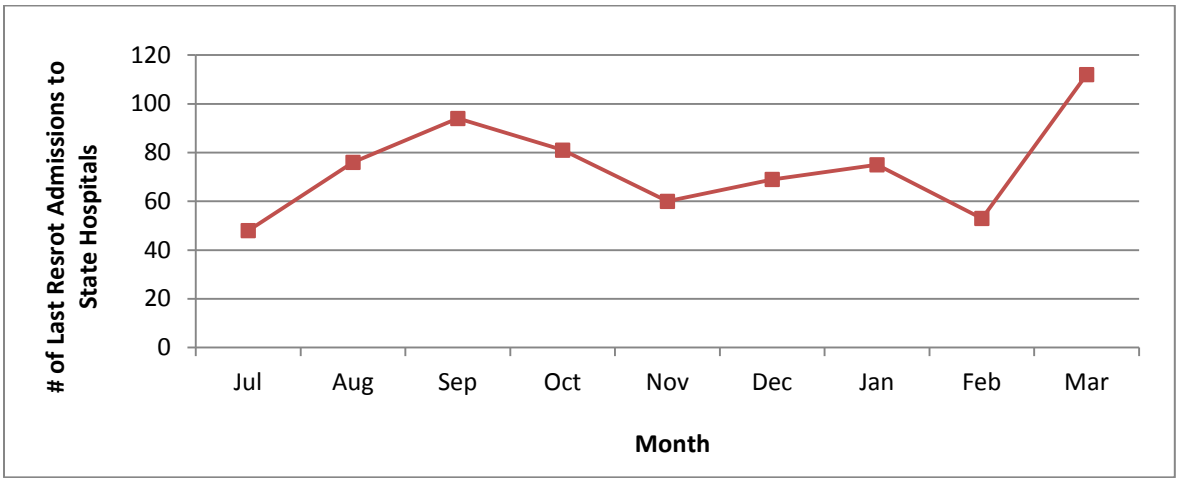
	Jan 2014 – Jun 2014 (FY 14) over Jan 2013 – Jun 2013 (FY 13)	Jul 2013 – Mar 2014 (FY 14) over Jul 2012 – Mar 2013 (FY 13)	Jul 2014 – Mar 2015 (FY 15) over Jul 2013 – Mar 2014 (FY 14)
TDO Admissions	45% increase 923 admissions (FY 14) compared to 683 admissions (FY 13)	2% increase 1,071 admissions (FY14) compared to 1,045 admissions (FY13)	38% increase 1,482 admissions (FY 15) compared to 1,071 admissions (FY 14)

Figure 13: Frequency TDO admissions to state hospitals (AVATAR)



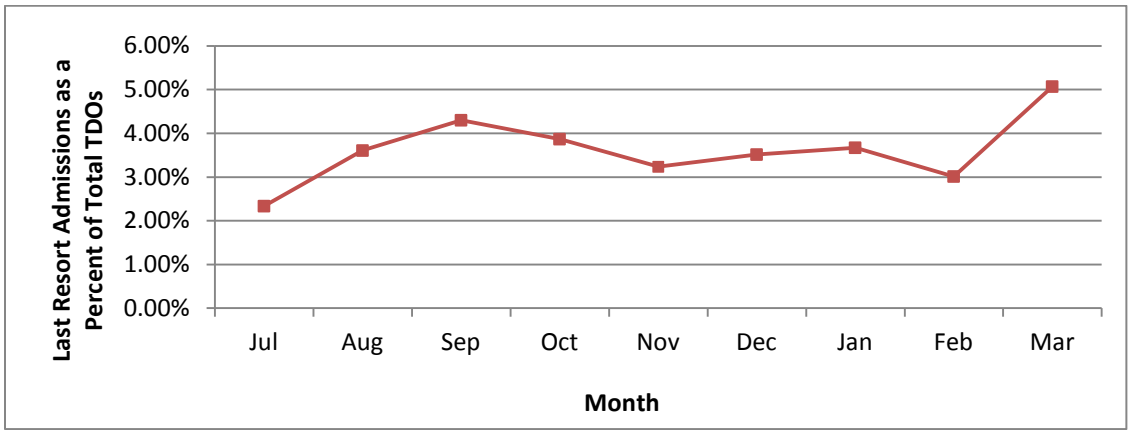
- **TDOs to State Hospitals and Community Hospitals in FY 2014 and FY 2015 (July 2014 – March 2015):** Figure 13, above, shows the significant, overall increase in TDOs to state hospitals beginning in January 2014. This reflects the broader trend in ECOs, TDOs and involuntary admissions statewide. The increase in TDOs to state hospitals does not, by itself, account for the total increase in all TDOs statewide. Community hospitals and CSB crisis stabilization units (CSUs) are absorbing the remaining increase in the number of TDOs.

Figure 14: Last Resort Admissions to State Hospitals, FY 2015 (CSB Reports)



- **Number of "Last Resort" Admissions FY 2015 (July 2014 – March 2015):** Figure 14, above, shows the number of cases where the "last resort" provisions of §§37.2-809.1 and 16.1-340.1:1 were necessitated, in that a state hospital admitted an individual for temporary detention because no other alternative facility could be found at the conclusion of the eight hour period of emergency custody[21]. These numbers increased early in the fiscal year and then stabilized until March, as shown below.

Figure 15: Last Resort Admissions as Percent of Total TDOs, FY 2015 (CSB Reports)



- **Percent of Total TDOs that were "Last Resort" Admissions (July 2014 – March 2015):** Figure 15, above, shows year-to-date (YTD) FY 2015 monthly "last resort" admissions to state hospitals as a percent of total TDOs executed for the month.

d. Operations of the Acute Psychiatric Bed Registry: The web-based Acute Psychiatric Bed Registry became fully operational on March 3, 2014. The bed registry collects, aggregates, and

[21] Note: DBHDS requires state hospitals to admit an individual under these circumstances even when an ECO is not in effect.

displays data on the availability of acute beds in every public and private inpatient psychiatric facility and CSB-operated residential crisis stabilization unit (CSUs) across the Commonwealth. The bed registry offers detailed descriptive and contact information for all facilities in a single, centralized location. This enables CSBs, emergency services clinicians and hospital users to more efficiently determine the availability of appropriate beds in Virginia hospitals and crisis stabilization units using a variety of search parameters within the registry database. Queries may be tailored to specific needs (e.g., region, patient type, level of security, etc). The bed registry does not eliminate the need to communicate directly with a hospital or crisis stabilization unit regarding a potential admission, but is a useful tool to identify potential availability of beds for an appropriate placement.

As of May 2015, there were 69 facilities listed in the bed registry and over 1,800 Virginia mental health professionals who regularly use the bed registry. Since it began operations, the registry has been used more than 27,000 times for bed searches or for general information. The registry is used over 2,500 times each month for bed searches and for general information gathering. Hospitals and crisis stabilization units update the registry on average three times a day. In response to concerns about the requirement for "real time" information to be available in the registry, H.B. 2118[22] was passed by the 2015 General Assembly, effective July 1, 2015, to require that:

> "*Every state facility, community services board, behavioral health authority, and private inpatient provider licensed by the Department shall update information included in the acute psychiatric bed registry whenever there is a change in bed availability for the facility, board, authority, or provider or, if no change in bed availability has occurred, at least daily."*

Prior to implementation, DBHDS, VHHA, and VHI formed a user stakeholder group which continues to meet to monitor and improve the effectiveness, efficiency, and utilization of the bed registry. In September 2014, the quarterly newsletter, *Connections*, was released to keep users informed about the enhancements, important topics, and changes to the bed registry.

In December 2014, DBHDS conducted a survey to solicit feedback from bed registry users. Of 381 respondents, the majority (91 percent) indicated that the website was extremely or moderately easy to navigate. Respondent use of the bed registry varied from less than once a month to several times a day. The bed registry is used several times each week or daily by 35 percent of its users. Of the respondents updating the bed registry, 87 percent indicated that the site was convenient to update.

The Acute Psychiatric Bed Registry is supported by staff in the DBHDS Central Office and a $25,000 contract between DBHDS and Virginia Health Information, which hosts the Bed Registry.

e. Number of Alternative Hospitals Contacted: As noted above, each region developed Regional Admission Protocols which included the alternative hospitals to be contacted prior to requesting admission to the regional state hospital. Each region established alternative hospitals

[22] See HB 2118 (Chap. 116) and SB 1265 (Chap. 34).

to be contacted based on variations in resources within the region including: the number residential crisis stabilization beds, the number of private hospitals, and the capacity of those hospitals to serve individuals with specialized and intensive needs.

f. Impact of SB 260 on the Involuntary Mental Commitment Fund: It is not possible to obtain a complete and comprehensive estimate of the full cost of temporary detention in the Commonwealth, because these costs are paid from various sources, including private insurance, Medicare, Medicaid, and other funds and there is no available data source for all of this information. However, one measure of the cost of temporary detention is the total charges to the Involuntary Mental Commitment Fund (ICF) administered by Department of Medical Assistance Services (DMAS). The ICF pays the hospital and physician costs for uninsured individuals hospitalized under a TDO. The total ICF expenditures for the last three fiscal years are reflected in Figure 16, above. FY 2015 figures are through March 31, 2015.

Figure 16: Reimbursements for Temporary Detention from the Involuntary Mental Commitment Fund (ICF)

	SFY 2013	SFY 2014	SFY 2015 through Mar 31, 2015
ICF Expenditures	$10,351,434	$12,600,313	$11,017,140

Source: DMAS

The "ICF Expenditures" in Figure 16 above represent statewide expenditures paid by DMAS to Virginia psychiatric hospitals for temporary detention services provided through March 31, 2015(the third quarter of FY 2015). These data illustrate a potentially significant increase in claims over FY 2013 to FY 2014. As of March 31, 2015, the ICF had expended $11,017,140, but with one quarter remaining in the fiscal year, ICF spending will likely exceed $13 million by the end of FY 2015, a marked increase over the two prior fiscal years.

Figure 17: Lengths of Stay of TDOs, January 2014 through October 2014 (DMAS)

Month	Year	Same Day	Next Day	Spans 3 Days	Spans 4 Days	Spans 5 Days	Longer Span
January	2014	8.1%	14.2%	44.5%	18.4%	11.5%	3.3%
February	2014	8.2%	14.3%	50.2%	14.6%	10.8%	2.0%
March	2014	7.3%	14.9%	55.1%	14.0%	8.7%	0.1%
April	2014	7.1%	16.3%	51.5%	15.8%	9.4%	0.0%
May	2014	7.9%	13.6%	48.7%	17.1%	10.2%	2.4%
June	2014	8.2%	18.3%	53.5%	12.7%	7.2%	0.1%
July	2014	8.0%	15.7%	25.9%	33.3%	10.4%	6.7%
August	2014	7.8%	13.4%	29.8%	35.8%	8.1%	5.0%
September	2014	7.4%	14.5%	32.1%	31.6%	10.5%	3.9%
October	2014	8.2%	14.7%	27.6%	30.0%	11.5%	8.0%

Source: DMAS

g. Impact of SB 260 on Length of Stay for Temporary Detention: SB 260 extended the maximum period of temporary detention for adults from 48 hours to 72 hours. Beginning in January 2014, the Department of Medical Assistance Services (DMAS) began to track the length

of temporary detention of patients whose temporary detention costs were reimbursed through the ICF. These data are reflected in Figure 17, above. It appears that as a result of SB 260, there has been a marked increase in the percentage of statewide temporary detention orders (TDOs) spanning four or more days. DMAS has not collected these data for TDOs after October 2014, and it is not known at this time whether this increase in longer TDOs has continued during the second and third quarters of FY 2015. The percentage of individuals under a TDO who are committed versus the percentage who are released by the expiration of the TDO period is pending further analysis.

h. State Hospital Capacity Building: State hospitals routinely operate at high occupancy, frequently between 95-100% of their operational bed capacity. In order to accommodate the increased demand for state hospital inpatient services that would result from the "last resort" provisions of § 37.2-809.1, DBHDS increased inpatient bed capacity at several facilities. The total allocations for state hospital capacity building were $8,438,601 for FY 2015. These individual hospital capacity-building initiatives are described below.

- **Eastern State Hospital (ESH):** A total of 20 new beds for forensic referrals became operational at ESH in March 2014. These beds were targeted to jail inmates in need of emergency treatment or restoration to competency, not guilty by reason of insanity acquittees, and other criminal justice-involved individuals. By accommodating these referrals, capacity for acute care could be maximized. ESH used existing staff from other areas of the hospital to cover the new unit until new staff positions were funded and filled in FY 2015. These beds are currently supported with $2,205,008 in general funds, for 36 positions and operational expenses.

- **Northern Virginia Mental Health Institute (NVMHI):** A total of 11 new beds were added at NVMHI, and became operational September 1, 2014. The NVMHI general fund appropriation was increased by $1,228,531 for 21 positions and necessary supplies and services.

- **Southwestern Virginia Mental Health Institute:** Seventeen additional beds were added at SWVMHI and were made operational July 1, 2014. An additional $2,206,523 in general funds was allocated to SWVMHI for 35 positions and necessary operational costs.

i. Impact on Local Purchase of Inpatient Services (LIPOS) from Community Hospitals: DBHDS also entered into agreements with Poplar Springs Hospital, the Virginia Beach Psychiatric Center and Russell County Medical Center to access additional community hospital beds if needed in FY 2015 to manage increased demand for state hospital services. No funds have been spent to date in FY 2015 for these adult inpatient services. Regarding child and adolescent inpatient services, DBHDS entered into service agreements with Poplar Springs Hospital and Virginia Baptist Hospital for child and adolescent care if needed. To date, $212,025 had been spent for these services.

As stated earlier, however, there are seasonal variations in admission rates. These variations have been reflected in demand for these beds. In particular, there has been a significant seasonal

impact from the change in law for child and adolescent inpatient services. At many points throughout the Fall of 2014 and early Spring of 2015, the Acute Psychiatric Bed Registry showed few if any available beds in the entire public and private inpatient system for children and adolescents. In order to fulfill its last resort responsibilities, DBHDS created the equivalent of 14 additional public sector beds on an ongoing basis through its purchase of service agreements, increasing overall available capacity by 29 percent.

j. Notifications to State Hospitals: SB 260 added several requirements for notifications. First, a law enforcement officer must notify the appropriate CSB of an ECO "as soon as practicable" after the officer takes the individual into emergency custody[23]. After receiving this notification, the CSB is, in turn, required to notify the appropriate state hospital of the pending ECO evaluation, and to communicate that the individual will be referred to the state hospital for temporary detention if needed and no other alternative facility is found. The CSB is required to make another notification to the state hospital to convey the results of the evaluation, and may continue to communicate with the state hospitals until the case is resolved. DBHDS requires state hospitals to document the initial notifications.

Figure 18: Initial ECO Notifications to State Facilities, by Facility, FY 2015 (Facility Reports)

	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Catawba	384	463	386	297	238	276	286	287	356	**2,973**
Central	192	209	207	156	152	185	195	158	196	**1,650**
CCCA	88	111	140	166	165	130	138	130	186	**1,254**
Eastern	410	420	404	451	424	459	490	446	606	**4,110**
NVMHI	80	161	165	140	122	146	119	180	134	**1,247**
Piedmont	28	23	47	27	27	32	46	45	33	**308**
SVMHI	69	80	104	81	70	65	72	76	82	**699**
SWVMHI	*	*		160	120	116	95	97	122	**710**
Western	278	272	278	268	212	274	250	235	261	**2,328**
Total			**1,731**	**1,746**	**1,530**	**1,683**	**1,691**	**1,654**	**1,976**	**15,279**

* Data was not available for the months of July and August from SWVMHI.

The figure above, Figure 18, shows the total number of initial notifications that were received by state hospitals from CSBs regarding individuals who were to be evaluated by the CSBs while under ECOs. Each of these contacts will necessitate one or more additional communications to state hospitals. Each DBHDS hospital has established new protocols to manage these communications.

k. Impact on CSB Emergency Services: As shown above, the crisis response system experienced a significant increase in emergency contacts and emergency evaluations since January 2014.

- CSBs that had experienced difficulty in managing the increased demand for emergency services reported that management staff had been reassigned to fill in where needed, and other clinical staff had been reassigned from other roles and responsibilities.

[23] Either under an ECO issued by a magistrate or an ECO initiated by the officer (i.e., a "paperless", or "officer-initiated" ECO).

l. Exceptional Cases, FY 2015: As described earlier, beginning on July 1, 2014, DBHDS designed and implemented a new reporting system to identify any case where an individual was evaluated by a CSB and deemed to need temporary detention, but the TDO was not executed for any reason. In each such case, within 24 hours of the event, the CSB executive director submits an initial report to the DBHDS Quality Oversight Team[24] . The DBHDS Team reviews the report immediately and works with the CSB to complete any necessary follow up actions, identify and implement improvements in policy or practice, and when necessary, direct the CSB and other community partners on how to strengthen the crisis response system in their community.

There have been 46 such cases reported to DBHDS from July 1, 2014 through March 31, 2015. Under federal Emergency Medical Treatment & Labor Act (EMTALA), a patient receiving treatment in a medical hospital must not be transferred to a state hospital or another facility that cannot meet the individual's acute medical needs. While no individual who needed temporary detention was unable to be detained for lack of a bed, these exceptional cases reflect other circumstances that pose potential risks to individuals, families, communities and providers. These events are summarized below:

- Of the 46 reported cases, 11 involved individuals whose immediate medical needs were critical, and who needed immediate medical evaluation and treatment before receiving psychiatric care. These individuals received treatment for their most urgent medical need first, in keeping with standards of practice. In these cases, CSBs maintained frequent contact with the treating medical facilities during the course of these individual's medical treatment. After receiving this medical treatment, some of these individuals no longer needed involuntary treatment and were admitted voluntarily to a psychiatric facility.[25] Others no longer needed psychiatric hospitalization. Still others were reassessed at the conclusion of their medical treatment and hospitalized under a TDO[26].

- Of the 46 reported events, 28 involved a loss of custody of the individual. In these cases, the individual eloped from the evaluation site before the temporary detention order could be executed.
    - Of these 28 individuals, 21 were not under an ECO and were not in the custody of law enforcement officers and no law enforcement officers were present. These cases involved individuals who initially presented voluntarily for treatment but eloped prior to a TDO being issued or executed.
    - The remaining seven of these individuals escaped from law enforcement custody. The root causes of each of these cases were examined (e.g., misunderstanding of

[24] The Quality Oversight Team includes the DBHDS Medical Director, Assistant Commissioner for Behavioral Health, Director of Mental Health, and MH Crisis Specialist.

[25] One individual went voluntarily inpatient after medical care concluded, one was determined to no longer meet criteria for TDO or to be in need of inpatient psychiatric treatment, and nine were subsequently detained following the medical treatment.

[26] The interplay between sound medical practice and involuntary temporary detention is complex. In response to these events, DBHDS proposed SB 1114, which was passed in the 2015 General Assembly session effective July 1, 2015 (Chap. 659). This bill establishes a clearer link between the emergency custody and temporary detention process under §§37.2 808 and 37.2-809 and the medical temporary detention process under §37.2-1104. This will result in more effective management of individuals with complicated co-occurring medical conditions who need temporary detention.

statutory requirements, distraction of the officer, etc.) and weaknesses were immediately corrected.

- Of the 46 reported cases:
  - Thirty-one individuals were temporarily detained at the conclusion of the episode.
  - Three individuals were hospitalized on a voluntary basis instead of a TDO.
  - Three individuals were engaged in outpatient services in lieu of involuntary hospitalization.
  - Nine individuals were not admitted or engaged in outpatient services. These included individuals who were not residents of the Commonwealth and who left the state, as well as others who were unable to be contacted or engaged despite exhaustive efforts of CSBs, law enforcement, and others. Many of these individuals had others who shielded them from contact with the service system.

- 19 CSBs (of 40) reported instances of individuals who were deemed to need temporary detention but who did not receive that intervention.

Each of these events results in the rigorous re-examination of the current practices. Significant, positive changes in policy and practice have been implemented which continue to strengthen the crisis response system[27].

6. Conclusions: The impact of SB 260 has been significant and multifaceted, as described above.

A brief overview of the most salient effects of SB 260 on Virginia's emergency response system is provided below.

- No individual under a TDO who needed inpatient psychiatric services was denied care due to the lack of an available bed.
- There are more than 1,000 emergency contacts with CSB emergency services each day.
- CSB emergency services clinicians complete an average of 200 face-to-face evaluations for involuntary hospitalizations each day.
- Magistrates issue an average of 70 TDOs each day for involuntary hospitalization.
- Loss of custody and medical instability requiring stabilization in the emergency department, or admission to a medical unit, are the two most common reasons for a delay in executing a TDO.
- Since July 1, 2014, admissions to state hospitals have on average increased by 22 percent over the preceding year with wide variations and fluctuations in the percentage of increase by age, region, and season.

[27] For example, following an elopement of an individual from a hospital emergency department, the hospital changed its policy and now posts a "sitter" with every individual who needed temporary detention, regardless of their risk profile.

Overall, statewide demand for crisis response services and acute inpatient care has increased. This demand has largely been met through the development of increased acute inpatient capacity, increased community services capacity and refinement of regional access and utilization management practices to be more consistent, effective and efficient. Costs to the Involuntary Mental Commitment Fund for temporary detention have increased in FY 2015.

From the perspective of individuals receiving care and their families, no person who has needed temporary detention has been denied access to that service for lack of an available bed. DBHDS and CSBs have closely tracked all cases where TDOs are indicated but not executed for any reason. There have been 46 such cases through March 31, 2015. Most of these were individuals who escaped from custody or eloped from emergency services, or were unable to be temporarily detained because of an urgent immediate medical need or other reason. These cases have been followed up intensively, until each individual has been engaged in involuntary treatment or otherwise determined to be safely enrolled in voluntary services. A small number of individuals declined all CSB efforts to engage in treatment, ceased communications with local safety net providers, or left the Commonwealth altogether.

In response to these events, SB 1114 was passed in the 2015 General Assembly session and becomes effective July 1, 2015. It is an important provision to address individuals who may need a psychiatric temporary detention order but are too medically ill to be transferred to a state hospital which is not equipped to treat medical needs. This bill establishes a clearer link between the ECO and TDO process and the medical temporary detention process under §37.2-1104. It allows temporary detention for medical stabilization and treatment to "prevent harm" so that individuals who are too medically ill to be transferred to a psychiatric unit or state hospital at the end of the eight hour ECO period can be treated to achieve necessary medical stability. The bill also requires that CSB staff assess the person once they have achieved medical stability to determine the need for a psychiatric temporary detention order. This new language will improve management of individuals with complicated co-occurring medical conditions who need temporary detention.

Lastly, SB 260 has contributed to multi-faced changes that strengthened Virginia's crisis response system and ensured that everyone who needed a TDO bed had access to such a bed. Nevertheless, while a necessary feature of the behavioral health safety net, involuntary hospitalization can be a painful experience for individuals and families, and imposes significant operational challenges to the Commonwealth's behavioral health providers, law enforcement agencies and courts. These structural changes to the behavioral health system have resulted in a significant increase in the number of individuals receiving the most restrictive interventions, including involuntary admission to state hospitals. This trend is at odds with national best practices and with *Olmstead's* interpretation of the *ADA*. *Olmstead* requires states to provide services to individuals with disabilities in integrated community settings. In addition, Virginia continues to balance its obligations under the new last resort legislation and federal requirements such as the Civil Rights of Institutionalized Persons Act (CRIPA), ADA and *Olmstead*.

DBHDS remains committed to ensuring an effective and robust safety net for Virginians experiencing a mental health crisis while also increasing prevention, early intervention and ongoing supportive services. Through the prevention, early identification and early intervention

in behavioral health concerns, individuals are able to receive the necessary treatment before it reaches crisis level. Through sustained investments in community infrastructure and capacity, behavioral healthcare can be provided that is the most recovery-oriented, patient-centered and integrated with primary healthcare and other human services supports. These community investments bear rich dividends not only in terms of averting avoidable crises and hospitalizations but also by preventing unnecessary contact/penetration into inappropriate service systems (e.g. criminal justice, juvenile justice, child welfare or public health). A comprehensive array of community-based services across the life span of the individual is critical to the Commonwealth providing a high value, high performing behavioral healthcare system. As we work to improve the safety net of behavioral healthcare services, we must concurrently make the necessary investments in our community capacity, in order that the expectation of recovery is actualized for all Virginia's citizens.