COMMONWEALTH of VIRGINIA

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June 30, 2016

To: The Honorable Terry R. McAuliffe, Governor

and

Members, Virginia General Assembly

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,

Jack Barber, M.D.

Enc.

Cc: William A. Hazel, Jr., M.D.
Kathy Drumwright
Joe Flores
Susan E. Massart
Mike Tweedy
Daniel Herr

Annual Report on the Implementation of Senate Bill 260 (2014)

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

June 30, 2016

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Executive Summary

Senate Bill (SB) 260 (Chap. 691, 2014) amended and added several sections of the *Code of Virginia* 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.

SB 260 arose from concerns about Virginia's behavioral health crisis response system. In particular, there were instances across the Commonwealth where individuals, who met clinical criteria for temporary detention, were not hospitalized due to the lack of a willing facility to admit them. SB 260 was designed to eliminate these occurrences and guarantee that everyone who met clinical criteria for temporary detention was able to access this care.

A brief overview of the most salient impacts 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 subject to an Emergency Custody Order (ECO) determined to meet clinical criteria for temporary detention has been turned away for lack of a psychiatric bed.
- There has been a consistent increase in the daily number of evaluations for involuntary hospitalizations.
    - In FY 2015, Community Services Boards (CSBs) emergency services clinicians completed an average of 227 face-to-face evaluations for involuntary hospitalizations each day.
    - In the first two quarters of FY 2016, (July 1, 2015 to December 31, 2015), they completed an average of 249 daily face-to-face evaluations for involuntary hospitalizations.
- There has been a consistent increase in the daily number of temporary detention orders:
    - In FY 2015, magistrates issued an average of 67 TDOs each day for involuntary hospitalization.
    - In the first two quarters of FY 2016, magistrates issued an average of 69 TDOs each day for involuntary hospitalization.
- There has been a consistent increase in the daily number of emergency psychiatric hospital admissions:

- In FY 2014, state hospitals admitted an average of 12 persons per day.
- In FY 2015, state hospitals admitted an average of 14 persons per day.
- In the first two quarters of FY 2016, state hospitals admitted an average of 15 persons per day.

As demonstrated above, concurrent with the requirements and implementation of SB 260, the Commonwealth of Virginia continues to experience a significant increase in the demand for emergency services, including all areas related to the involuntary admission process.

Operationally, this trend is reflected in both the community services and institutional facilities aspects of the public system continuum. CSBs have seen the need for increases in emergency evaluations conducted by CSB staff, while for state hospitals, this is reflected in the increased number of TDO referrals and hospital admissions overall. The data reflects that these statewide trends tilt the system towards more restrictive and resource intensive interventions. These approaches are inconsistent with national best practices and with *Olmstead v. L.C.'s (Olmstead)*[1] interpretation of the *American's With Disabilities Act (ADA).*[2] The *ADA* requires states to provide services to individuals with disabilities in the most integrated community settings.

SB 260 has contributed to multifaceted changes in Virginia's behavioral health emergency and crisis services. DBHDS has found it critical to ensure that a strong safety net be securely in place and that inpatient care be available to all who need this service, in order to address any crisis situation. However, DBHDS also recognizes that a healthy behavioral health system requires commitment 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.

1. Introduction

SB 260 (Chap. 691, 2014) amended and added several sections of the *Code of Virginia* 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*

[1] Olmstead v. L. C., 527 U.S. 581 (1999).
[2] Americans With Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 328 (1990).

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. Overview of SB 260

SB 260 bill was signed into law as Chapter 691 by Governor Terry McAuliffe effective April 6, 2014. The salient features of this bill are described below:

Eight hour maximum period of emergency custody: The legislature doubled the maximum period of emergency custody to eight hours, in §§ 16.1-340 (minors), 19.2-182.9 (NGRI acquittees on conditional release), and 37.2-808 (adults).

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 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 emergency custody period. This provision ensures that no individual meeting clinical criteria for temporary detention is denied access to care, because the state hospital will serve as the "last resort" in the event that treatment cannot be accessed in a private psychiatric community hospital or other facility. Finally, to ensure that no individual slips through system cracks, 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.

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

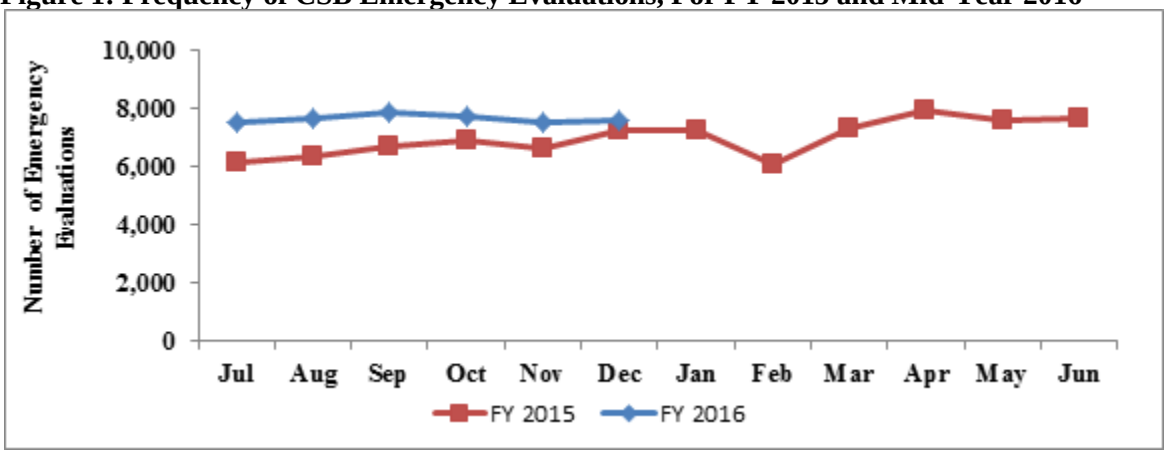
Acute Psychiatric Bed Registry: § 37.2-308.1, was added to SB 260 requiring DBHDS to operate an acute psychiatric bed registry to provide real-time information on bed availability to designated searchers so that CSBs, inpatient psychiatric facilities, public and private residential crisis stabilization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

3. Impacts of SB 260

Of central importance to the implementation of SB 260 was the development of new standards and protocols to ensure that no individual in acute psychiatric crisis, meeting clinical criteria for temporary detention, would fail to receive that care due to lack of a clinically appropriate and available bed that meets the needs of the patient. This section describes the impact of these new standards and protocols in the following key areas.

CSB Emergency Evaluations: Emergency evaluations are comprehensive in-person clinical examinations conducted by CSB emergency services staff for individuals who are in crisis. These evaluations may be conducted in person or electronically by two-way video and audio communication. The Figure 1, below, shows the number of emergency evaluations completed by CSBs during FY 2015 and the first two quarters of FY 2016. DBHDS does not have comparative data for FY 2014 but will be collecting data going forward.

Figure 1: Frequency of CSB Emergency Evaluations, For FY 2015 and Mid-Year 2016



These data show a steady increase over the course of FY 2015 and continuing through the first two quarters of FY 2016.

In addition to the data shown on Figure 1 above, the CSBs also 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 this 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 which the TDO is not executed for any reason. These reports are aggregated and analyzed monthly with the results and analyses posted on the DBHDS website.[3]

State Hospital Admissions: Overall admissions to state hospitals have increased significantly since the passage of SB 260. Figure 2, below, shows the trend in state hospital admissions for FY 2014, FY 2015 through the first two quarters of FY 2016.

Figure 2: State Hospital Admissions, FY 2014, FY 2015 and Mid-Year FY 2016

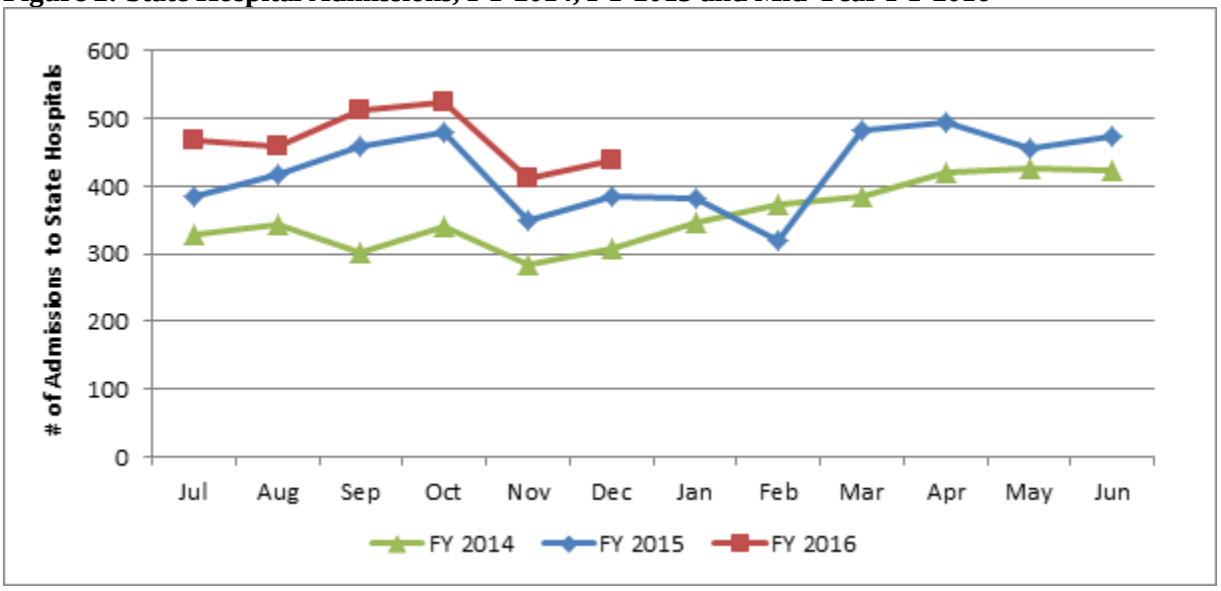
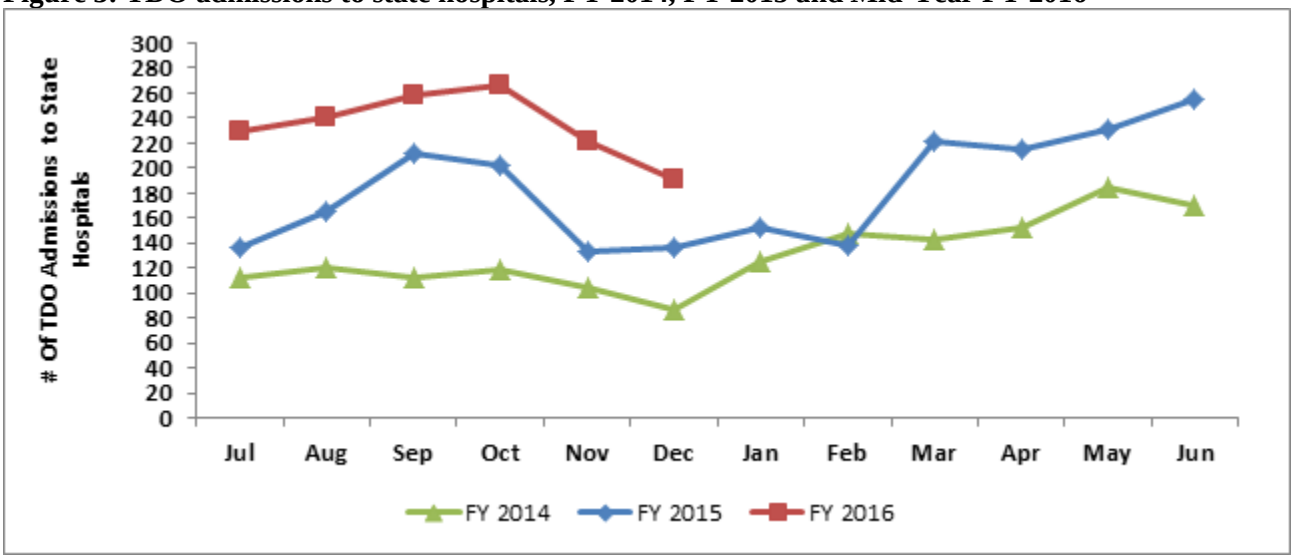


Figure 3, below, shows the TDO admissions to state hospitals for FY 2014, FY 2015, and through the first two quarters of FY 2016. TDO admissions to state hospitals have increased dramatically since 2014 and the passage of SB 260.

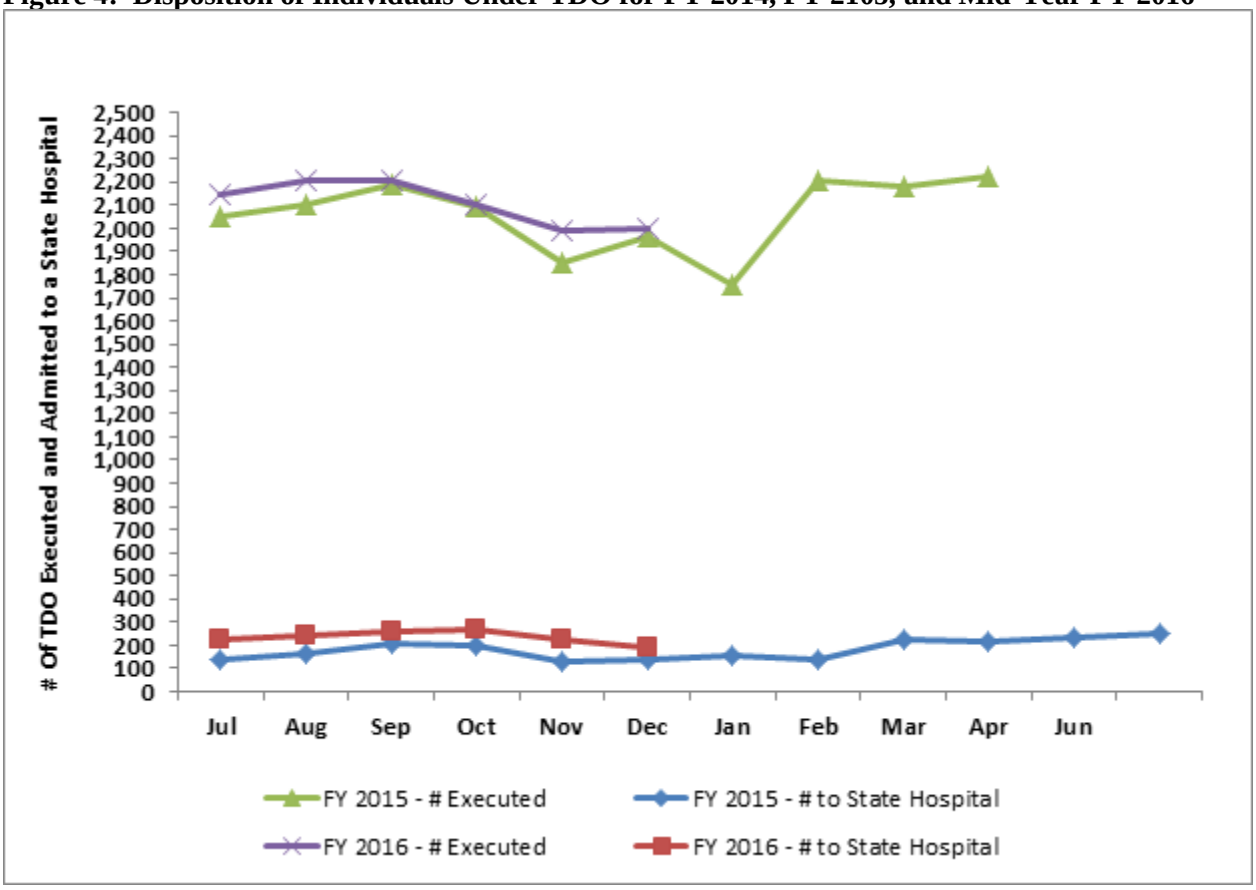
[3] 7See http://www.dbhds.virginia.gov/professionals-and-service-providers/mental-health-practices-procedures-and-law/data

Figure 3: TDO admissions to state hospitals, FY 2014, FY 2015 and Mid-Year FY 2016



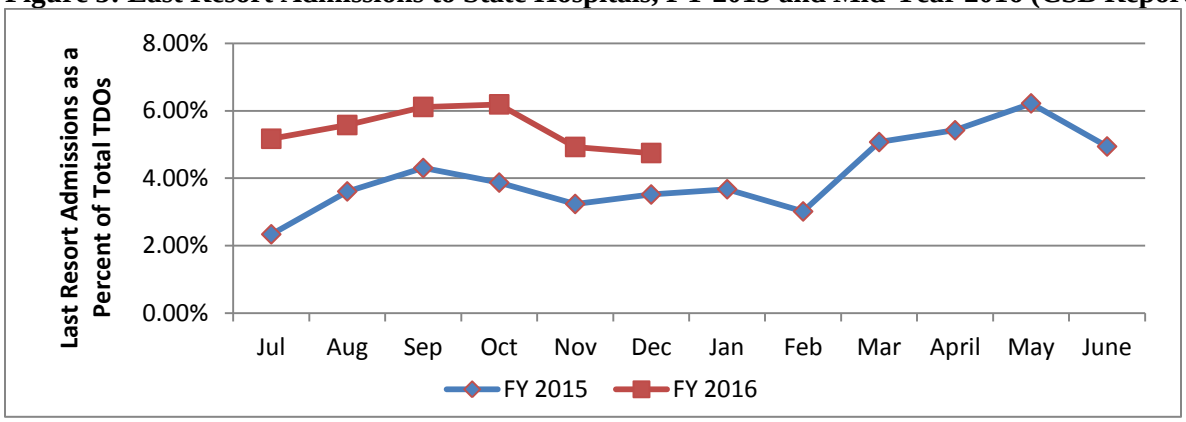
Disposition Of Individuals Under TDO: Figure 5 below, shows the total number of TDOs issued each month compared to the total number of TDO admissions to state hospitals for FY 2014, FY 2015 and through the first two quarters of FY 2016. The percentage of executed TDOs admitted to state hospitals has increased in the first two quarters of FY2016.

Figure 4: Disposition of Individuals Under TDO for FY 2014, FY 2105, and Mid-Year FY 2016



Number of "Last Resort" Admissions: Figure 6, below, shows the number of cases where an individual was admitted to a state hospital under the last resort provisions of §§37.2-809.1 and 16.1-340.1:1 because no other alternative facility could be found at the conclusion of the eight hour period of emergency custody.

Figure 5: Last Resort Admissions to State Hospitals, FY 2015 and Mid-Year 2016 (CSB Reports)



Length of Stay for Temporary Detention: SB 260 extended the maximum period of temporary detention for adults from 48 hours to 72 hours. In FY 2014, the average length of stay for adults admitted to state hospitals under a temporary detention order was 4.42 days, in FY 2015 it was 2.25 days, and from July 1, 2015 to December 31, 2015, it was 2.87. This data is not available from alternate private psychiatric hospitals.

Number of Alternative Hospitals Contacted: Prior to the passage of SB 260, each region developed Regional Admission Protocols, which established the processes for contacting the alternative hospitals prior to requesting admission to the regional state hospital. Each region identified alternative hospitals 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. These regional protocols are posted on DBHDS' website.[4]

Treatment Costs For Individuals Under Temporary Detention: DBHDS is unable to provide 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. There is no available data source for all of this information. Figure 7 below, shows the costs for temporary detention in state hospitals for FY 2014, FY2015 and through the first two quarters of FY2016.

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

Figure 6: Costs For Individuals Under TDO Admitted To State Hospitals for FY 2014, FY 2105, and Mid-Year FY 2016

Total cost for TDO Bed Days by FY at State Hospitals			
	Total Civil TDO Bed Days	Average cost for a Bed Day	**Total Cost for Civil TDO Bed Days[1]**
FY 2014	82,151	$723.83	$59,463,358.33
FY 2015	95,477	$747.14	$71,334,685.78
FY 2016 (Jul-Dec 2015)	54,869	$743.34	$40,786,322.46

[1] Civil bed days times average bed day cost

A more comprehensive measure of the cost of temporary detention is the total charges to the Involuntary Mental Commitment Fund (IMCF) administered by Department of Medical Assistance Services (DMAS). The IMCF pays the hospital and physician costs for uninsured individuals hospitalized under a TDO. The total IMCF expenditures for FY 2015 and the first two quarters of FY 2016 are displayed in Figure 8 below.

Figure 7: Reimbursements for Temporary Detention from the Involuntary Mental Commitment Fund (ICF)

Temporary Detention Order Expenditures	TDO Fund	Medicaid Fund
SFY 2015	$14,608,199.46	$1,460,856.37
7/1/15-12/13/15	$8,513,656.39	$470,906.93

Source: DMAS

The "ICMF Expenditures" in Figure 8 above represent statewide expenditures paid by DMAS to private and state psychiatric hospitals in Virginia for temporary detention services provided through the second quarter of FY2016.

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. Then, 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 hospital 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 state hospitals are required to document the initial notifications.

The total number of initial notifications received by state hospitals from CSBs in FY 2015 regarding individuals under ECOs was 19,780. The total number of initial notifications for the

first two quarters in FY2016 was 8,451. The reduction in reported initial notifications in the first two quarters of FY2016 can be attributed to changes in the method of data collection at each of the nine hospitals. During FY 2015, some of the hospital numbers included the initial notification call as well as any additional calls to the hospital for each individual subject to an ECO. Following the review of this data, DBHDS and the state hospitals have developed protocols to ensure improved consistency in data collection.

4. Enhancements To The Commonwealth's Psychiatric Crisis Response System

To further strengthen the emergency services aspects of the public behavioral health system, DBHDS will implement educational, training, certification, and quality oversight requirements for emergency services clinicians, effective July 1, 2016. The requirements have been included in the FY 2017 Performance Contract with CSBs and include the following key elements:

- All new hires for preadmission clinicians must have an educational attainment of a Master's or Doctoral Degree with an associated professional license or educational attainment that would be required for a license in Virginia.
- Supervisors of Certified Preadmission Screening Clinicians must be licensed and have a minimum of two years of experience working in emergency services or with persons with serious mental illness and be a Certified Preadmission Screening Clinician.
- All Certified Preadmission Screening Clinicians must have 24/7 access to clinical consultation by a qualified supervisor.
- Every Certified Preadmission Screening Clinician must have documentation of a minimum of 12 hours of individual or group supervision annually.
- All Certified Preadmission Screening Clinician must have completed a minimum of 16 documented hours of continuing education annually.
- Prior to certification, the individual must have completed all the required training modules and an emergency services orientation that meets the requirements of DBHDS.
- Certified Preadmission Screening Clinician must re-certify every two years.

5. System Changes

To help make this critically necessary shift, DBHDS is exploring a model of core community based services to be made available across the Commonwealth, called System Transformation Excellence and Performance in Virginia or STEP-VA. STEP-VA is based on a federal model of Certified Community Behavioral Health Clinics (CCBHCs) and includes nine required core services and evidence based practices with quality measures to improve the problems of access, quality, consistency and accountability in public behavioral health services in Virginia.

Through a focus on behavioral health wellness, early identification of treatment needs, and prompt intervention in behavioral health conditions, individuals are able to receive the necessary treatment before it reaches crisis level. Through sustained investments in community infrastructure and capacity, recovery-oriented, patient-centered and integrated with primary healthcare, and other human services supports, behavioral healthcare that is the most effective can be provided.

6. Conclusion

Since the implementation of SB 260 on July 1, 2014, no individual subject to an ECO and who was determined to have met criteria for temporary detention has been turned away from emergency psychiatric treatment for lack of a bed. This represents a significant achievement in the standard of behavioral healthcare.

DBHDS remains committed to ensuring an effective and robust safety net for Virginians experiencing a behavioral health crisis. However, in order to preserve the strength and health of our emergency services safety net, Virginia must continue its efforts to rebalance the public behavioral health system, by building capacity in the community, to treat individuals earlier in the disease cycle, where the cost of care is less, and health and life outcomes are better. This shift will better allow for our crisis system to function at its best for treating crisis situations, and for crisis situations to be a rare occurrence, instead of the norm.

Such community investments bear rich dividends not only in terms of averting avoidable crises and hospitalizations but also by preventing unnecessary contact with 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 to ensure that the expectation of recovery is actualized for all Virginians.