



COMMONWEALTH of VIRGINIA

Office of the Governor

Daniel Carey, MD
Secretary of Health and Human Resources

November 22, 2019

The Honorable Thomas K. Norment, Jr., Co-chair
The Honorable Emmett W. Hanger, Jr., Co-chair
Senate Finance Committee
The Honorable Chris S. Jones, Chair
House Appropriations Committee
900 East Main Street
Richmond, VA 23219

Dear Senator Norment, Senator Hanger, and Delegate Jones:

Senate Bill (SB) 1488 (Chapter 609, 2019 Acts of Assembly) requires the Secretary of Health and Human Resources to convene a work group to examine the causes of the high census at the Commonwealth's state hospitals for individuals with mental illness. Specifically, the language states:

§ 1. That the Secretary of Health and Human Resources shall convene a work group composed of stakeholders, including the Department of Behavioral Health and Developmental Services, the Department of Medical Assistance Services, the Virginia Association of Community Services Boards, the National Alliance on Mental Illness - Virginia, Mental Health America of Virginia, VOCAL, Inc., the Virginia Hospital and Healthcare Association, the Office of the Executive Secretary of the Supreme Court of Virginia, the Virginia Association of Chiefs of Police, the Virginia Sheriffs' Association, the Institute of Law, Psychiatry and Public Policy, the Psychiatric Society of Virginia, the Virginia College of Emergency Room Physicians, and the Medical Society of Virginia, to examine the causes of the high census at the Commonwealth's state hospitals for individuals with mental illness.

In conducting such examination, the work group shall consider the impact of the practice of conducting evaluations of individuals who are the subject of an emergency custody order in hospital emergency departments, the treatment needs of individuals with complex medical conditions, the treatment needs of individuals who are under the influence of alcohol or other controlled substances, and the need to ensure that individuals receive treatment in the most appropriate setting to meet their physical and behavioral health care needs on the census at the Commonwealth's state hospitals for individuals with mental illness. The work group shall also consider the potential impact of (i) extending the time frame during which an emergency custody order remains valid, (ii) revising security requirements to allow custody of a person who is the subject of an

emergency custody order to be transferred from law enforcement to a hospital emergency department, (iii) diverting individuals who are the subject of an emergency custody order from hospital emergency departments to other, more appropriate locations for medical and psychological evaluations, and (iv) preventing unnecessary use of hospital emergency department resources by improving the efficiency of the evaluation process on the census at the Commonwealth's state hospitals for individuals with mental illness. The work group shall include analysis of how such issues affect both adults and children. The work group shall develop recommendations, including recommendations for both long-term and short-term solutions to the high census at the Commonwealth's state hospitals for individuals with mental illness, which shall include recommendations for statutory, regulatory, and budget actions to address the high census at the Commonwealth's state hospitals for individuals with mental illness.

Staffing support for the work group shall be provided by the Department of Behavioral Health and Developmental Services. The work group shall complete its work and report its recommendations to the Chairmen of the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the Twenty-First Century, the House Committee on Appropriations, the House Committee for Courts of Justice, the Senate Committee on Finance, and the Senate Committee for Courts of Justice by November 1, 2019.


Additionally, 2019 Appropriations Act Item 310 CC.1., requires the Department of Behavioral Health and Developmental Services to establish a workgroup to examine the impact of Temporary Detention Order admissions on the state behavioral health hospitals. Specifically, the language states:

CC.1. The Department of Behavioral Health and Developmental Services shall establish a workgroup, which shall include the Virginia Hospital and Healthcare Association, other state agencies, and other stakeholders as deemed necessary by the department, to examine the impact of Temporary Detention Order admissions on the state behavioral health hospitals. The workgroup shall develop options to relieve the census pressure on state behavioral health hospitals, which shall include options for diverting more admissions to private hospitals and other opportunities to increase community services that may reduce the number of Temporary Detention Orders. The workgroup shall develop an action plan that includes actions that can be implemented immediately and other actions that may require action by the 2020 General Assembly. The action plan shall take into account the need to take short-term actions to relieve the census pressure on state behavioral health hospitals in order to develop a plan for the right sizing of the state behavioral health hospital system. The department shall report its findings to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees by October 15, 2019.

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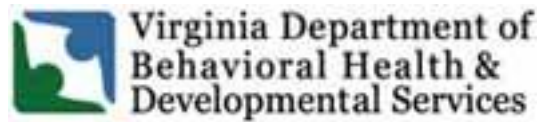
In accordance with these items, please find enclosed the combined report for SB1488 (2019) and Item 310 CC.1. of the 2019 Appropriations Act. Staff are available should you wish to discuss this request.

Sincerely,



Daniel Carey, MD

Cc:
Acting Commissioner Signer
Marvin Figueroa
Susan E. Massart
Mike Tweedy



Report on the Implementation of Senate Bill 1488 (2019) and Item 310 CC.I. Of the 2019 Appropriations Act

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

November 1, 2019

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I. Preface

This report was developed in accordance with Senate Bill (SB) 1488 (Chapter 609, 2019 Acts of Assembly), which requires the Secretary of Health and Human Resources to convene a work group to examine the causes of the high census at the Commonwealth's state hospitals for individuals with mental illness. Specifically, the language states:

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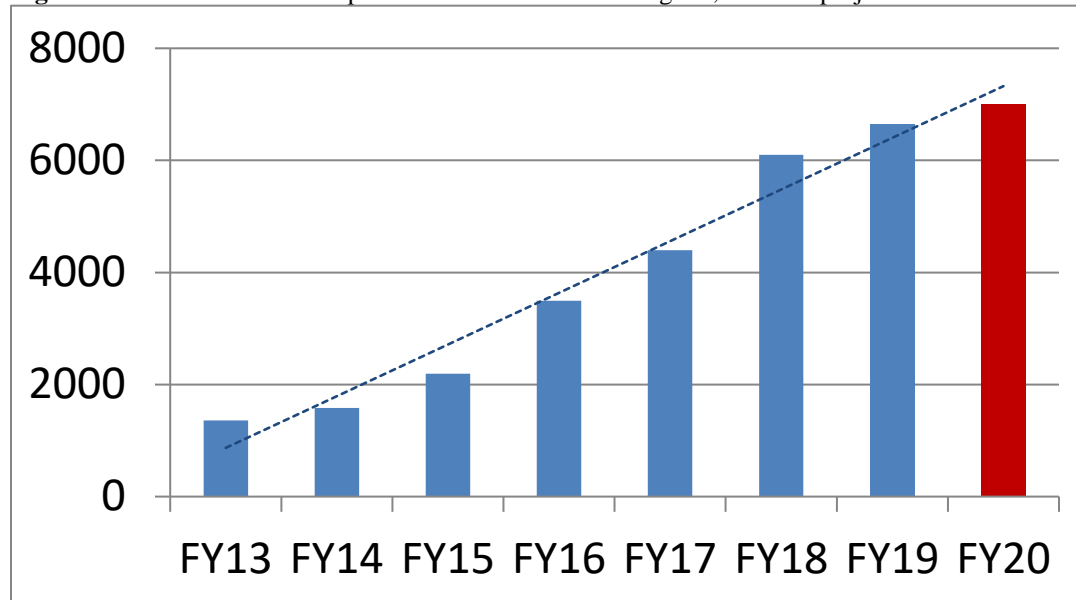
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II. Introduction and Background

Senate Bill 1488 and Item 310 CC.1. arose from concerns about the high census in Virginia's state psychiatric hospitals. The Commonwealth's nine state mental health hospitals are under tremendous strain as they are weathering a 333 percent increase in temporary detention order (TDO) admissions since "Bed of Last Resort" legislation passed in 2014 (§37.2-809) requiring state hospitals to accept admissions of individuals under a TDO if no alternate treatment location is found within the eight-hour emergency custody order (ECO) period. This has pushed many state hospitals' bed census above the industry standard operating capacity of 85 percent. State hospitals are currently operating at 96 percent with recent periods of as high as 98-100 percent. Compounding the challenge, state hospital beds have become the first resort for civil TDOs while still maintaining a primary role to serve individuals who are forensically involved or those individuals that require longer-term treatment and commitments.

Figure 1: Number of State Hospital TDO Admissions in Virginia, FY2013 projected to FY2020



Since the 2014 reforms were implemented, virtually no individuals meeting criteria for a temporary detention order (TDO) have gone without a hospital bed for crisis treatment. Although this represents a major achievement, these changes have also shifted the demands on the behavioral health system in a multitude of ways. Since the “Bed of Last Resort” law went into effect on July 1, 2014:

- Virtually no individuals subject to an Emergency Custody Order (ECO) determined to meet clinical criteria for temporary detention have 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 2019, Community Services Boards (CSBs) emergency services clinicians completed an average of 240 face-to-face evaluations for involuntary hospitalizations each day.
 - In FY2019 there were a total of 87,490 face-to-face evaluations completed for involuntary hospitalization.
- There has been a consistent increase in the daily number of state psychiatric hospital admissions:
 - In FY 2018, state hospitals admitted an average of 18 persons per day, totaling 6,101 individuals.
 - In FY 2019, state hospitals admitted an average of 19 persons per day, totaling 6,649 individuals.

The “Bed of Last Resort” statute opened the front door of state psychiatric hospitals to a much greater number of TDO admissions, as community resources and alternative treatment facilities were not in place and continue to lag behind in availability. In addition, since this statute was implemented, there has been a decline in the number of TDO admissions to private hospitals. Previously, private hospitals admitted over 90 percent of TDOs (FY14) and now admit 76

percent (FY19). At the same time, there are additional pressures at the state hospitals as they seek to discharge individuals ready to return to community life. DBHDS maintains a list of individuals residing in state hospitals who have been clinically ready for discharge for more than 14 days but are unable to leave because the necessary community housing and support services are not available to ensure a safe discharge. Each year, approximately 550 new individuals are added to this list (called the extraordinary barriers to discharge list or EBL). In FY 2019, the EBL averaged about 184.5 individuals each month, or 12.8 percent of the total state hospital census.

The effects of the “Bed of Last Resort” statute and the EBL are significant for staff and patients in state psychiatric hospitals and cost the Commonwealth additional dollars. From FY 2013 to FY 2018, the average daily census¹ of the state psychiatric hospitals on the first day of the month grew from 87 to 94 percent of capacity, with the highest daily census being five percent above the average daily census. In FY19, annual growth in census jumped again and hospitals currently operate at 98 percent of capacity or greater.

These trends have continued notwithstanding the sustained annual investment by the General Assembly to purchase private hospital beds using Local Inpatient Purchase of Service (LIPOS) funds, in discharge assistance program funds (DAP) for individuals who are clinically ready for discharge, in community-based crisis stabilization programs, and in permanent supportive housing (PSH). The table below shows these appropriated funds from FY 2014 to FY 2018.

Figure 2: LIPOS, DAP, Crisis Stabilization and Permanent Supportive Housing Funds by Fiscal Year

	FY 2014 (Actuals)	FY 2015 (Actuals)	FY 2016 (Actuals)	FY 2017 (Actuals)	FY 2018 (Actuals)	FY 2019 (Actuals)
LIPOS	\$8.4M	\$8.5M	\$10.9M	\$10.9M	\$10.9M	\$11.0M
DAP	\$20.5M	\$22M	\$27.4M	\$29.9M	\$32.4M	\$38.5M
Crisis Stabilization	\$15.6M	\$15.5M	\$15.6M	\$15.6M	\$15.6 M	\$14.9M
PSH	\$0	\$0	\$2.1M	\$4.3M	\$9.1M	\$10.5M
Total	\$44.5M	\$45.9M	\$56M	\$60.6M	\$68M	\$74.9M

In the current system, DBHDS spends an average of \$92.58 per person in state psychiatric care while community-based services can average only \$47. In the aggregate, this means DBHDS spends 50 percent of its general fund dollars on care for only three percent of those served each year. The census at state hospitals is projected to continue rising by two percent, or 28 to 30 more beds annually for the foreseeable future even with the addition of 56 temporary beds at Catawba Hospital and another 56 beds at Western State Hospital. Absent significant policy change that is clinically informed that reflects the reality of our current community behavioral health system, this growth will cause an exponential rise in state hospital capacity.

Impact on Other Stakeholders

While the 2014 reforms had a significant impact on state hospitals, other stakeholders, including individuals, private hospitals, CSBs, and law enforcement have also experienced changes.

¹ The average daily census represents the percentage of beds filled at a state hospital.

Private hospitals that provide inpatient care through psychiatric units and freestanding psychiatric hospitals for both adults and children are experiencing an increase in voluntary admissions. The Virginia Hospital & Healthcare Association (VHHA) reports that the number of voluntary admissions from FY15 to FY18 has increased by 3,725 admissions and this has affected the availability of beds for involuntary and voluntary inpatient behavioral health treatment across the Commonwealth. They also report that these changes have been exacerbated by the strains on the behavioral health workforce and increased requirements by accrediting organizations, such as the Joint Commission on Accreditation of Healthcare Organizations (The Joint Commission) to reduce ligature and other safety risks.²

CSBs have also experienced an increase in the number of emergency evaluations that must be conducted by CSB emergency services clinicians. As noted above, there has been a consistent increase in the daily number of evaluations for involuntary hospitalizations and this has increased demands for CSB emergency services clinicians, rising from an average of 227 face-to-face evaluations daily for involuntary admissions in FY15 to 240 face-to-face evaluations daily in FY19. In order to improve standards, the 2014 law also increased requirements for certification and training of CSBs staff that conduct emergency evaluations. While improving standards was an important reform, it has made it difficult for CSBs to hire and retain qualified staff for this role and the behavioral health care workforce continues to shrink.

Pursuant to Code of Virginia section 37.2-809.1 Virginia law enforcement is responsible for transporting individuals under an Emergency Custody Order and those subsequently involuntarily committed for mental health treatment for the medical clearance and then on to the mental health facility for treatment. As the number of involuntary commitments increases, so too does the obligations for law enforcement. Recent efforts to provide alternative transportation options (discussed later) will potentially help blunt some of the impact of transporting individuals once they are under a TDO. However, officers and deputies must still wait with individuals for the duration of their emergency custody period (up to 8 hours) until custody is transferred. This effort ties up officers and deputies, taking them away from other law enforcement responsibilities in their communities. Since the Bed of Last Resort statute was implemented and the emergency custody period increased, law enforcement officials have seen an increase in travel and custody of individuals.

Investments in Community-Based Services

The statewide pressures that place more individuals in voluntary or involuntary inpatient care tilt the entire behavioral health system towards more restrictive and resource intensive interventions. These approaches are inconsistent with national best practices and with *Olmstead v. L.C.*'s (*Olmstead*)³ interpretation of the *American's With Disabilities Act (ADA)*.⁴ The ADA requires states to provide services to individuals with disabilities in the most integrated community settings. DBHDS and behavioral health system stakeholders are working on many levels to advance community-based mental health services across Virginia and mitigate the growth in inpatient treatment. A comprehensive array of community-based services across the life span is

² *Relieving Census Pressures at State Psychiatric Hospitals: Private Hospital-Focused Interventions*, Virginia Hospital & Healthcare Association, November 16, 2018, amended.

³ *Olmstead v. L. C.*, 527 U.S. 581 (1999).

⁴ *Americans with Disabilities Act of 1990*, Pub. L. No. 101-336, 104 Stat. 328 (1990).

essential 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.

In 2017, the General Assembly enacted Chapter 607⁵, which expanded the core services of CSBs to include same day access, primary care screening, crisis services, outpatient services, psychiatric rehabilitation services, peer support and family services, veteran support services, care coordination, and case management. These nine services are collectively part of a multi-year initiative called System Transformation, Excellence and Performance (STEP-VA). To date, the General Assembly has funded or partially funded four steps. The statute requires STEP-VA to be implemented no later than June 30, 2021 in all CSBs. STEP-VA is foundational to creating the training and human capital necessary to offer a complete continuum of community based services that are effective in reducing behavioral health crises and diverting or preventing individuals from needing more costly levels of care.

STEP-VA is part of the larger goal to reduce over-reliance on state psychiatric hospitals and inpatient care and to advance a system that is grounded in community-based services and supports that address prevention and needs well before crisis services or inpatient services are required. Full implementation of STEP-VA will support and complement any actions to reduce state hospital census in the near term by providing access to a critical continuum of community-based services that help people manage their symptoms before reaching a point of crisis and requiring costly, restrictive hospitalization. In the long term, it serves as a key element in the platform for right sizing the state hospital system. Without the fundamental services of STEP-VA, it will be difficult to right size the current institutional system.

Complementary to STEP-VA, DBHDS, the Department of Medical Assistance Services (DMAS), CSBs, and providers across the Commonwealth are undertaking a collaborative effort to transform the current Medicaid community-based mental health services system. This effort, proposed Medicaid Behavioral Health Redesign, seeks to shift Virginia's system for adults and children from its current state to a modern, evidence-based system of community-based services. Medicaid Behavioral Health Redesign will focus on treatment that can directly divert individuals from inpatient hospital admission, either voluntary or involuntary. Services include crisis stabilization, crisis intervention and mobile crisis, 23 hour observation, as well as intensive outpatient and/or partial hospitalization (IOP/PHP), multi-systemic therapy (MST) and functional family therapy (FFT). Ensuring these are Medicaid reimbursable services will directly assist private hospitals and CSBs in diverting individuals from inpatient admissions.

Currently, the crisis system in Virginia is fragmented and the services vary by region and disability. The system is historically reactive in that it may not meet the needs of the child or adult in their current setting, and has an inconsistent focus on proactive, preventative services. Rather than meeting the crisis needs of adults and children in their current setting where there is familiarity and higher likelihood of mitigating further triggers, the adult or child is taken to the emergency department. Many compounding factors have contributed to this current situation, including the "Bed of Last Resort" legislation, which shifted the landscape from providing crisis intervention services to predominantly conducting assessment and evaluations. The vision for the

⁵ <http://lis.virginia.gov/cgi-bin/legp604.exe?171+ful+CHAP0607+pdf>

future of crisis services in Virginia is one where the same level of services are offered to all and are based on three basic pillars of a “modern crisis” system. These pillars include: a 24/7 crisis hotline and associated crisis dispatch to scene of crisis if needed, mobile crisis intervention and subsequent stabilization services in a natural setting, and the availability of a crisis receiving center which comprises safe and expedient drop off for law enforcement, 23 hour stabilization beds, and short term residential crisis placement. Elements of this best practice model are present in some regions, but are not fully connected or available for everyone.

In FY19, there were over 25,000 TDOs and law enforcement transported an estimated 99 percent of those individuals. Law enforcement transporting individuals under a TDO not only puts a strain on resources and staff for law enforcement agencies, but it also creates an environment that stigmatizes the individual’s illness and exacerbates the crisis, ultimately making treatment more difficult. Based on successful regional pilots, the 2018 General Assembly provided \$7 million for a statewide alternative transportation program. During the summer of 2019, a contract to operate the program was awarded to G4S, and DBHDS began targeted activities to support the implementation of alternative transportation statewide with initiation of alternative transportation in Southwest Virginia (Region 3) beginning October 2019. DBHDS has worked with stakeholders to finalize the protocols for adults and develop protocols for children and youth and will continue to roll out the system region by region until it is statewide. This program will reduce some of the burden on law enforcement in situations where it is safe and appropriate to do so. However, it will not completely reduce the challenges law enforcement officers’ experiences as an actor in the emergency custody and temporary detention process. Law enforcement officers still detain the majority of individuals under an ECO and then must wait with the individual while they are being evaluated and assessed, and if they must be committed, until a suitable bed is found.

Finally, the EBL compounds the high census when individuals who are clinically ready for discharge are unable to do so because there is no willing or able provider in the community. Lack of housing remains the most common barrier to state hospital discharge. Permanent Supportive Housing (PSH) is an evidence-based model of care that combines affordable rental housing with community-based services to address the treatment, rehabilitative, and recovery support needs of participants. More than three decades of research show supportive housing reduces utilization of emergency, crisis, and institutional care and improves housing stability for highly vulnerable people. The budget includes \$12.3M in funding through FY20 to support over 900 funded units of PSH for individuals in need, including 147 who have discharged directly from state hospitals to the community. Additional investments will continue to facilitate movement directly from state hospitals to community PSH, further reducing the EBL.

II. Workgroup Charge and Process

In response to SB1488 and Item 310 CC.1., the Secretary of Health and Human Resources convened a 17-member workgroup comprised of DBHDS staff and stakeholders with expertise in specific facets of Virginia’s complicated involuntary commitment process. In addition to DBHDS staff, the Secretary of Public Safety and Homeland Security, Department of Medical Assistance Services, Office of the Attorney General, and Office of the Executive Secretary

served vital roles in this workgroup. Stakeholder membership included representation from the following groups (see Appendix A for a list of members and organizations):

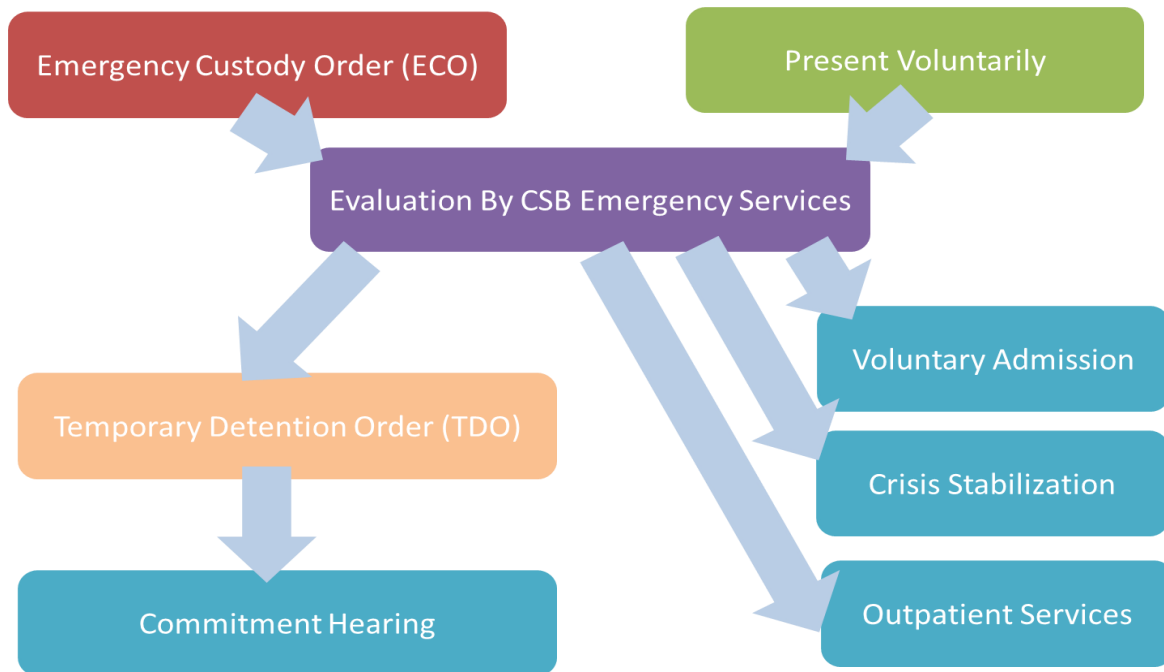
- Mental Health America of Virginia (MHA)
- The Medical Society of Virginia (MSV)
- The National Alliance on Mental Illness of Virginia (NAMI)
- The Psychiatric Society of Virginia (PSV)
- The University of Virginia Institute of Law, Psychiatry, and Public Policy (ILPPP)
- The Virginia Association of Chiefs of Police (VACP)
- The Virginia Association of Community Services Boards (VACSB)
- The Virginia College of Emergency Physicians (VCEP)
- The Virginia Hospital and Health Care Association (VHHA)
- The Virginia Organization of Consumer Asserting Leadership (VOCAL)
- The Virginia Sheriffs Association (VSA)
- Voices for Virginia's Children

The primary goal of the workgroup was to examine the causes of the high census at the Commonwealth's state hospitals for individuals with mental illness. DBHDS broke down the high census concerns to major pressure points in the system: the brevity of the ECO time period, the efficiency and location of the ECO evaluation, the comprehensive care needed for individuals who have complex medical conditions or are intoxicated, establishing a custody transfer to alleviate law enforcement, and ultimately how to divert individuals from state hospitals and increase community treatment. The workgroup included analysis of both adults and children.

III. Workgroup Discussion

From April to October of 2019, the TDO Workgroup met seven times to discuss the challenges and opportunities the system is experiencing, hearing perspectives from both the state and national context (see Appendix B for a list of meeting dates and topics discussed). To give a better understanding of this very complex process, Figure 4 demonstrates the potential routes an individual may take to experience inpatient psychiatric treatment.

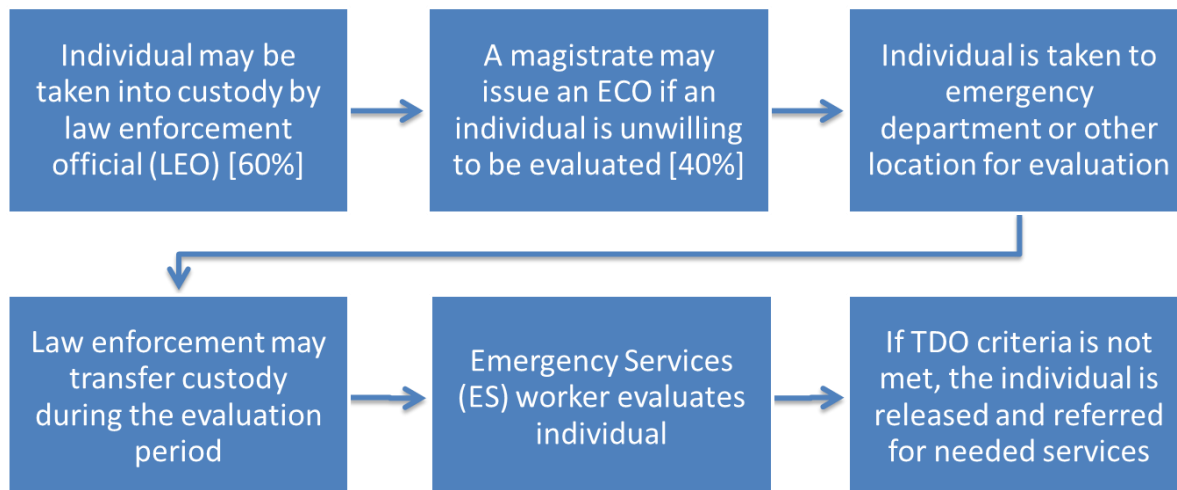
Figure 4: Routes to Inpatient Psychiatric Hospitalization



A. ECO Time Frame Analysis

Virginia’s eight hour ECO period is one of the shortest in the nation. The national average for emergency custody is 24 to 48 hours. In 2014, the ECO timeframe was increased from six to eight hours in accordance with “Bed of Last Resort” legislation. Within those eight hours, there are a multitude of steps that need to occur, demonstrated below in Figure 5.

Figure 5: ECO Period Steps



Most of the time in the eight-hour ECO period is spent searching for a hospital bed. The Virginia Bed Registry, created as a result of the 2014 reforms, was intended to assist with this process, but has not produced the intended results with significant end user dissatisfaction and

limited utility for bed finding. The workgroup members agreed that the current bed registry is not a useful tool for finding beds. In addition, the current tool, unlike other models in other states, does not collect data to capture where and when beds are available and where individuals are being admitted. The lack of data from the bed registry makes any type of systemic monitoring difficult for DBHDS and other stakeholders.

The workgroup discussed how the brevity of the eight hour ECO time period often does not allow sufficient time for clinical needs to be addressed regarding the individual's care. The individual in crisis is rushed through the ECO process and often there is not enough time to begin de-escalation and treatment prior to the issuance of a Temporary Detention Order. This results in an increased number of individuals being admitted to inpatient psychiatric care without the time necessary to properly de-escalate and evaluate an individual.

B. Location of ECO Evaluation

Currently, most ECO evaluations take place in the Emergency Room after the individual has been escorted there by a law enforcement official. In most instances, the individual remains in custody of the law enforcement official and the officer waits in the Emergency Room while the individual is being evaluated. The setting of the emergency rooms often escalate the mental health crisis the individual is experiencing due to excessive stimulation or traumatic triggers. The need for more comprehensive and appropriate emergency mental health interventions continues to rise as the number of individuals seeking behavioral health evaluations, both voluntary and involuntary, rises.

The workgroup discussed Crisis Intervention Assessment Sites (CITACs) in Virginia and how they could be leveraged as another receiving point for individuals in mental health crisis. There are 41 CITACs across the Commonwealth operating with variable hours based on local needs. The primary goal of CITACs is providing a place where individuals in crisis can safely de-escalate and receive an evaluation and assessment. Most CITACs have security on staff and are able to alleviate law enforcement from custody of the individual. The 41 CITACs vary in what services they offer from simply offering a place for law enforcement to drop off individuals into a secure environment, to providing CSB emergency service personnel to conduct TDO evaluations, to provide medical clearance capabilities or detox services. Although about 60 percent of those who come to the sites meet criteria for inpatient hospitalization, there are a significant subset of this group who may benefit from the ability to have a longer monitored de-escalation period. The time it takes to search for an appropriate inpatient bed in Virginia continues to climb, however, and much of the time during an assessment is spent on this search.

In FY 2019, approximately 9,400 evaluations of individuals under an ECO and 14,300 total assessments including individuals not under an ECO were conducted in a CITAC. While this is a significant accomplishment in alleviating law enforcement from the civil commitment process, the workgroup discussed the value of expanding the hours and services provided in CITACs. While the CITACs have been successful in the transfer of custody, the primary concern is that not all CITACs operate 24/7 or do not offer all the services needed for an individual under an ECO (e.g. detox). Furthermore, due to security constraints many CITACs

can only serve two to three individuals at a time, and the workgroup discussed the pros and cons of expanding that capability. Additionally, the workgroup discussed the addition of peers through the civil commitment process, as well as the addition of peer respite centers. While most CITACs have a peer on staff, it was concluded that this needs to be expanded to all CITACs that are in operation.

C. Efficiency of Evaluation

The emergency mental health evaluation process is a complex, multistage set of tasks that includes conducting an independent, comprehensive psychosocial evaluation of a person in crisis and referring to outpatient resources or recommending hospitalization⁶. It is a pivotal point within the larger civil commitment process because if a TDO is recommended and issued, the individual in crisis is deprived of his or her liberty for multiple days and perhaps several weeks, should he or she be civilly committed.

In order to provide a sense of the current demands at the early stages of the commitment process, it should be noted that each day in Virginia approximately 1,000 individuals seek crisis services, 240 emergency evaluations are conducted, and 70 temporary detention orders are issued. A workgroup formed in 2015 to assess the efficiency of emergency evaluations and consider expansion to allow professionals in emergency departments to conduct ECO evaluations. The workgroup conducted a survey that found that 70.8 percent of ECO evaluations took place in hospital emergency departments. The study also found that 93 percent of TDO evaluations began within two hours of the emergency custody period with respondents citing multiple concurrent evaluations as the primary reason for delay. While no recommendations were made upon conclusion of this workgroup, it opened the door for a greater discussion of the role of emergency services workers and how the evaluation process may be improved. The TDO workgroup revisited these recommendations and discussed experience with other states where clinicians, other than CSB emergency services clinicians, conduct evaluations for civil commitment. Some members believe changing Virginia's process will speed the time between arrival in the Emergency Room and treatment by allowing licensed clinicians who are appropriately trained to conduct evaluations. The VACSB representatives and other members noted that while this may be possible, modification of this process and the underlying statute is complex and touches on other processes that would have to be addressed at the same time to ensure continuity and reduce any unintended consequences. In addition, the VACSB believes strongly that a change of this sort will result in increased admissions to state hospitals.

D. Evaluations for Individuals who are Intoxicated

In addition to increasing numbers of TDO patients, the nature of this population has changed since Bed of Last Resort legislation. Today, approximately 30 percent of individuals admitted to state hospitals are intoxicated with either alcohol or other substances at the time of the prescreening evaluation. The workgroup members reported anecdotally that prior to "Bed of Last Resort" legislation the number of intoxicated individuals admitted to hospitals was much

⁶ The process for obtaining a temporary detention order (TDO) for civil commitment of adults is cited in *Virginia Codes 37.2-808, 37.2-809, 37.2-810, 37.2-813, 37.2-814, 37.2-815, 37.2-816, and 37.2-1104*. The *Codes* for minors are 16.1-338, 16.1-339.1, 16.1-340, 16.1-340.1, 16.2-341-16.2-345.

lower. However, there is no data available. Currently, the law does not align with standard clinical practice as the American College of Emergency Physicians (ACEP) and American Psychiatric Association recommends that clinicians consider using a period of observation to determine if psychiatric symptoms resolve as the episode of intoxication resolves. Once they become sober, many of these individual no longer meets civil commitment criteria and are released from the hospital at the civil commitment hearing.

State hospitals expend enormous resources on a 24-hour basis to conduct assessments and intakes of these individuals who would benefit from other types of detoxification and clinical interventions in lieu of being sent to them at the end of the 8 hour ECO period. In this regard, the workgroup discussed the need for additional detoxification and sober center resources that are either connected to CITACs or another location that will allow individuals time to become clinically sober before evaluation and treatment. However, the services these centers could offer are limited by the eight hour ECO period as an individual may not become clinically sober and be able to engage in assessment in that time period. The workgroup discussed the medical TDO process outlined in 37.2-1100 as this is an avenue to allow for additional time for individuals to become clinically sober. Currently, the use of the medical TDO process is limited due to discrepancies in interpreting the code across the Commonwealth. The workgroup discussed if the language of the medical TDO Code section included intoxicated individuals or required amendment.

E. Individuals with Complex Medical Conditions

There is an increasing number of individuals being placed under a TDO and sent to a state hospital that have co-occurring medical conditions, acute medical conditions, or medically complex conditions that would be more appropriately treated in a hospital with close access to specialty medical services that are not available in state hospitals. FY19 data shows that approximately 30 percent of all admissions have risk factors indicative of potentially unstable or complex medical conditions that are difficult to treat in psychiatric setting.⁷ Individuals who are deemed to be medically complex typically need longer time for medical and psychiatric assessment or may need re-assessment, as some serious medical conditionals may present with psychiatric symptoms. Treatment plans for these individuals may involve other medical specialists, specialized equipment, and staff competency that often psychiatric hospitals are not readily equipped to provide. The growth in numbers of individuals with complex medical conditions is reflected by the increase in costs of medical care provided to individuals in state hospitals which has increased by 90 percent since the enactment of the Bed of Last Resort statute. Additionally, state hospitals are geographically distant from tertiary medical centers where medically complex patients often receive care, creating a barrier to robust treatment.

The workgroup discussed specific funding to assist this population either for clinical resources or staff in an acute inpatient setting or within a psychiatric unit. They also discussed use of a medical TDO to allow more time before transfers when it was appropriate. There was broad consensus in among the workgroup members that this is an urgent problem and Virginia must

⁷ DBHDS calculation of HHS-HCC risk factors for FY19.

seek a solution to address the needs of adults and children who have complex medical conditions, inclusive of intoxication, and are in psychiatric crisis.

F. Transfer of Custody

There are many different entry points to the emergency behavioral health services in Virginia. Law enforcement may identify an individual experiencing a behavioral health crisis through routine patrol, interactions with the public, or through dispatch with a request for services. Generally, the law enforcement official remains in custody of the individual until they are transferred to the receiving psychiatric hospital. Since the Bed of Last Resort statute was implemented, law enforcement officials have seen an increase in travel and custody time. While alternative transportation has the potential to provide tremendous relief to law enforcement officials, officers may retain custody of the individual until a TDO is issued.

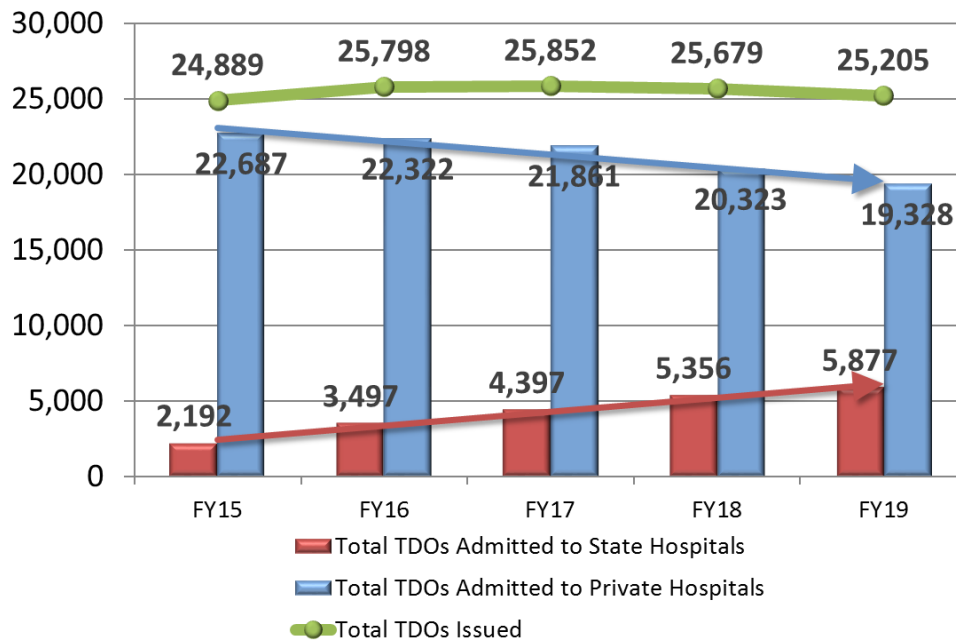
The workgroup discussed models where custody could be taken on by the hospital, but no resolution was clear. In general, the workgroup agreed that an overall examination of the role of law enforcement in the ECO/TDO process should be undertaken. National experts discussing the role of law enforcement in other states, noting for the workgroup that Virginia is atypical in this regard. National best practice shows that where crisis receiving centers are used, law enforcement involvement is reduced to the amount of time to drive to the receiving center and then less than one minute to relinquish custody to the receiving center. If hospitalization is needed, the receiving center is then responsible for transportation to the facility.

G. Diverting More Admissions from State Hospitals

While face-to-face evaluations are trending downward and overall TDO rates are currently relatively steady across Virginia, TDO admissions to state hospitals have continued to increase dramatically while TDO admissions to private hospitals have decreased nearly 14 percent since FY15. Figure six demonstrates this change.

As a result of the increase in TDO admissions to state hospitals, Virginia is using approximately 28 more state psychiatric hospital beds each year. There was not sufficient data available to distinguish between voluntary and involuntary patients admitted to private psychiatric hospitals to identify reasons individuals are civilly committed and could be diverted from involuntary commitment or hospital admission altogether. The only data that is clear is that there is a significant number of individuals who are intoxicated or medically complex that could benefit from more than 8 hours in the ECO period to receive appropriate treatment and avoid involuntary commitment. As noted earlier, options for these populations were discussed with some consensus that the problem needs to be addressed. The workgroup also discussed more broadly several options related to potential diversion of individuals from involuntary treatment in general and inpatient admission altogether. These options require continuing investment in community-based services, primarily in intensive outpatient, partial hospitalization, and continued build out of mobile crisis, 23 hour crisis stabilization, and other crisis system resources.

Figure 6: TDO Admission Trends



H. Increase Community Services

The lack of needed community based housing and support services further compounds state hospital census pressures. In FY 2018, a monthly average of 167 persons, or approximately 12 percent of all individuals in state hospitals, were clinically ready to leave but were unable to do so due to a lack of community resources. For the first two quarters in FY 2019, this number has grown to an average of 13 percent of all individuals in state hospitals.

As discussed previously, continued implementation of STEP-VA and proposed Medicaid behavioral health redesign, if approved, would continue to advance community-based services in Virginia. Within the context of these efforts, the workgroup discussed the need for the following specific services in regards to their impact on the state hospital census:

- **Mobile Crisis:** There is direct evidence that mobile crisis services disrupt the cycle of unnecessary hospitalizations for individuals with mental illness. If mobile crises services were available statewide, it would increase diversion from acute inpatient hospitalizations and over time, reduce the state hospital census.⁸
- **23 Hour Crisis Stabilization:** 23-hour crisis observation or stabilization is a direct service that provides individuals in severe distress with up to 23 consecutive hours of supervised care to assist with deescalating the severity of their crisis and/or need for

⁸ Substance Abuse and Mental Health Services Administration. 2014. "Crisis Services: Effectiveness, Cost Effectiveness, and Funding Strategies." *Substance Abuse and Mental Health Services Administration*. file:///C:/Users/kjd99769/Downloads/SAMSHA%20Publication%20on%20Effectiveness%20&%20Cost-Effectiveness%20of,%20and%20Funding%20Strategies%20for,%20Crisis%20Services%206-5-14_8.pdf.

urgent care. There is direct evidence that 23 hour crisis stabilization significantly lowers the rate of hospital admissions.⁹

- **IOP/PHP:** Partial Hospitalization and Intensive Outpatient programs are available through the Medicaid Addition Recovery Treatment Services (ARTS) Program for substance use disorder treatment and are available through most commercial plans, but are not currently represented in the Medicaid mental health benefit. These facility-based, high-intensity services hold strong potential to provide hospitals, healthcare systems and other providers with step-down care options for members served within inpatient hospitalizations. These programs allow for a progressive “weaning” of treatment intensity from inpatient stay to partial hospitalization (minimum of 20 hours per week) and then to intensive outpatient (6-19 hours per week) and finally to a traditional outpatient level of care. These programs are ideal for members whose path to recovery would benefit from time in a structured therapeutic program located a facility where risks can be more easily managed than in the community. These programs also serve as good options as alternatives for inpatient hospitalization for those who may need intensive, facility-based service structure during the day.
- **MST/FFT (for children):** Multisystemic Therapy and Functional Family Therapy are evidence-based, intensive, home- and community-based services with strong fidelity standards. Their effectiveness has been displayed for youth ages 11-17 who are frequently at risk for out of home placement and inpatient hospitalization. MST has been shown in controlled studies to have significant impacts on decreasing inpatient hospitalization utilization for children.¹⁰ MST has also displayed significantly more effective than emergency hospitalization at decreasing rates of attempted suicide.¹¹ Both MST and FFT were shown to reduce out of home placements and behavioral health costs during the system transformation in New Jersey.¹² MST and FFT both hold potential to provide high quality and high intensity alternative treatment options to inpatient hospitalization as well as strong discharge and step-down options for youth coming out of higher levels of care.
- **Program of Assertive Community Treatment (PACT):** Assertive Community Treatment provides comprehensive community-based services to adults with serious mental illness. Virginia has invested in the evidence based model, PACT, with 18 teams currently serving around the state. Recently, an investigation was conducted regarding Virginia-specific realizations of decreased inpatient admissions for individuals served in PACT. A cohort of 324 individuals, representing all FY 2016 PACT clients, had data available for 2 years prior to their enrollment and the 2 years following enrollment. This cohort accounted for 21,546 inpatient state hospital bed days in the two years prior to PACT, and 11,642 days in the two days following PACT admission. This represents a 54% reduction in bed days; which equates to \$8,061,856 cost avoidance in bed days. Full findings are presented in the PACT Outcomes report due to the General Assembly November 1, 2019.

⁹ Substance Abuse and Mental Health Services Administration. 2014. "Crisis Services: Effectiveness, Cost Effectiveness, and Funding Strategies."

¹⁰ Huey, S., Henggeler, S., Rowland, M., Halliday-Boykins, C., Cunningham, P., Pickrel, S., & Edwards, J. (2004). Multisystemic therapy effects on attempted suicide by youths presenting psychiatric emergencies. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43(2), 183-190.

¹¹ Huey, et al. 2004

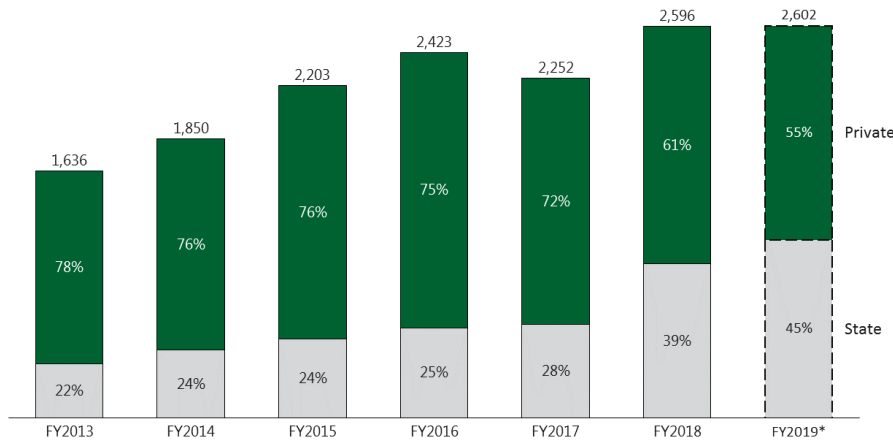
¹² Stout, B. Holleran, S. (2013). The impact of evidence-based practices on requests for out of home placements in the context of system reform. *Journal of Child and Family Studies*, 22(3), 311-321.

There was strong consensus in the workgroup that Virginia must commit to continue to build out these services in order to permanently sustain any short term actions to address the census crisis. Some workgroup members discussed prioritizing actions to develop IOP/PHP and mobile crisis as a short term action.

I. Special Populations

To gain a better understanding of how special populations experienced the involuntary commitment process, the workgroup reviewed the commitment process and the experience in the context of children and older adults, as well as for individuals with intellectual or developmental disabilities (ID/DD). There is only one state hospital in the Commonwealth that serves children: the Commonwealth Center for Children and Adolescents (CCCA), with 48 beds. While the state hospital for children and adolescents has seen a rise in TDO admissions, the private facilities have seen a decrease. Additionally, children with a primary diagnosis of a developmental disability, adjustment disorder, and conduct disorder have a higher likelihood of being sent to CCCA. The workgroup acknowledged that many psychiatric providers advocate for the elimination of seclusion and restraints. Private hospitals have approached this through pre-admission determinations of which individuals may potentially utilize seclusions and restraints as a reason for denying admission. Furthermore, children with medical complexities and children admitted to CCCA who are intoxicated were discussed and the recommendations were considered with adults and children in mind.

Figure 7: Civil TDOs in Virginia: Children



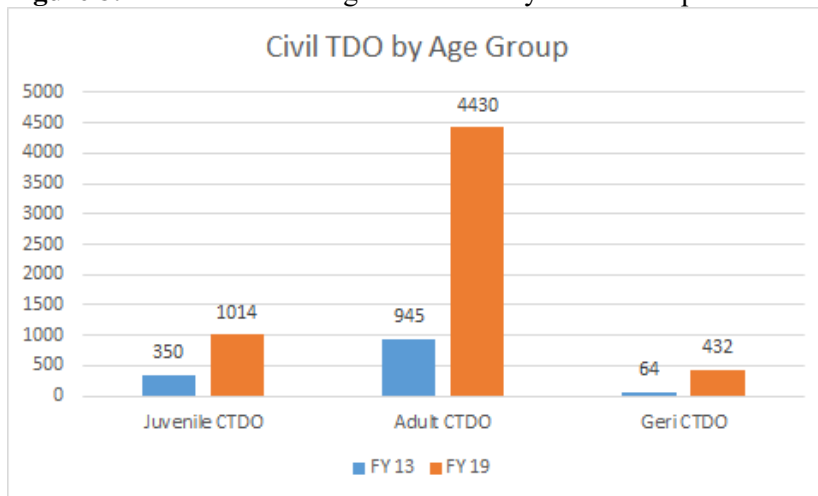
Source: Office of the Supreme Court of Virginia. All TDOs for individuals under 18 excluding forensics. Note: Hospital names are entered manually by the magistrates and do not reflect any changes in admitting or treating hospital after the entry of the initial data.

*Last two months imputed (May and June)

The workgroup spent limited time discussing the geriatric population. However, from FY2013 to FY2019 DBHDS has seen a 164.47 percent increase in geriatric admissions to state hospitals. Furthermore, the state psychiatric hospitals have seen a 575 percent increase in geriatric civil TDO admissions from FY2013 to FY2019 as displayed in Figure 7. To address this increase in admissions, the first 28 beds scheduled to open at Catawba Hospital will be reserved for geriatric patients. However, additional consideration should be given to this group who are not

homogenous in their needs. There are individuals experiencing dementia who require stabilization and treatment before returning to their home or a nursing facility. There are others who have long-term mental illness that requires support and treatment as the individual ages. The treatment needs for these two types of patients are different and consequently, any community-based supports developed to meet the needs of older adults with mental health conditions and divert inpatient admissions must reflect this variability.

Figure 8: Civil TDOs in Virginia’s State Psychiatric Hospitals



Finally, there are inadequacies in the availability and access to appropriate assessment and treatment services for individuals with developmental disabilities and co-occurring behavioral health conditions. Nationally, and in Virginia, there are several barriers that limit the availability and access to appropriate assessment and treatment services for individuals with developmental disability and co-occurring behavioral health conditions including lack of qualified behavioral health specialists, especially psychiatrist and psychologists. There is a shortage of professionals within the behavioral health field and extremely limited access to appropriate diagnostic and treatment services in rural areas. There is limited training and educational resources for pediatricians and other primary care physicians about developmental disabilities and co-occurring behavioral health conditions. Often this results in individuals with developmental disabilities being hospitalized without appropriate support or programming to ensure their treatment needs are addressed. It can also make finding appropriate placement after discharge difficult. The workgroup agreed that more resources should be made available to support individuals, both adults and children, better within inpatient environments.

V. Recommendations

After seven meetings and careful consideration, the workgroup recommendations are as follows. They are organized as consensus and non-consensus recommendations for adults and consensus and non-consensus recommendations for children. Figure 9 (below) contains information about stakeholder support for each recommendation. These recommendations should be considered as actions or steps that should be taken as a precursor to any right sizing efforts as outlined in Item 310 CC.1 – 3 of the 2019 Appropriation Act requiring DHBDS to develop and report on a plan to “right size” the state behavioral health hospital system.

Consensus Recommendations for Adults

1. Support the Continued Build Out of Community-Based Services and Supports. The workgroup emphasized that inpatient treatment is only a single aspect of a fully developed community based system of services. A comprehensive community based system will prevent and divert inpatient admissions and reduce the overall need for inpatient care in both state and private hospitals. The workgroup recommended the following:

A. *Continue Implementation of STEP-VA.* *Virginia should continue to support the public behavioral health system as the safety net of care and support the implementation of STEP-VA to ensure that all individuals, regardless of where they live in the Commonwealth, have access to assessment/care through Same Day Access and basic, essential core services such as outpatient therapy, crisis services, peer/family support, psychiatric rehabilitation, care coordination, mobile crisis, and case management. Mobile crisis, psychiatric rehabilitation services, and case management will most directly address the hospital census challenges. The provision of all nine of these services consistently at each CSB will ensure that individuals can access comprehensive care. Continuation of STEP-VA is contingent on additional funding to implement all steps.*

B. *Support Efforts toward Proposed Medicaid Behavioral Health Redesign.* *DBHDS and DMAS are working with stakeholders to develop transformative changes for community based mental health services. The goal is to shift our system to one that is trauma-informed, evidence-based, and focused on prevention and early intervention to improve outcomes for children and adults with behavioral health conditions. The current plans include the addition of six key services in FY2021. These services include partial hospital and intensive outpatient (PHP/IOP) services, program of assertive community treatment (PACT), multi-systemic therapy (MST), functional family therapy (FFT), and crisis services.*

Crisis services should include, at a minimum, mobile crisis and 23-hour crisis stabilization. Currently, Medicaid does not cover or only partially covers these high quality services, which significantly limits much needed access. Members of the workgroup agreed that action should be taken in this area because such services will enable diversion from inpatient admissions and easier step-down to less restrictive and less costly levels of care. Medicaid behavioral health redesign, if approved, would begin in FY2021. The workgroup recommends that IOP/PHP be accelerated so they are available as soon as feasible.

C. *Increase Utilization of Crisis Stabilization Units (CSUs).* *CSUs are used as a step down or diversion from hospitalization to treat individuals who may benefit from a sub-acute residential program. Currently, CSUs average a 67 percent census across the state. This underutilization may be attributed to a number of confounding factors including physical space not conducive to the level of supervision needed, the need for secure environments for individuals under a TDO, safety and risks presented by*

those in behavioral health crisis, variability in funding, and workforce challenges. It is a recommendation of the workgroup to address these factors through creating benchmarks and standards to increase the utilization of CSUs to the recommended census of 75 percent. Some specific standards that should be addressed include dropping the requirement for in-person evaluations for individuals to step down from inpatient care to a CSU, evaluations seven days per week, accepting admissions 24/7, and establishing statewide guidelines for the type of patient CSUs can admit.

D. Support Expansion of Mobile Crisis. *There is direct evidence that mobile crisis services disrupt the cycle of unnecessary hospitalizations for individuals with mental illness. If available statewide, mobile crisis can increase diversion from the emergency department and acute inpatient hospitalizations and will have an impact over time on reducing hospital census. Mobile crisis should be prioritized in discussions of additional resources related to STEP-VA crisis services.*

E. Additional Crisis Services System Resources. *The workgroup members stressed the importance of diversion from acute inpatient hospitalization as a critical step to reducing hospital census. Continuing to advance the crisis services system so that it is able to respond to all individuals experiencing a mental health crisis, regardless of their age or disability, in their home or community received strong support from the workgroup. Expansion of Crisis Intervention Team Assessment Centers (CITACs), increasing utilization of CSUs, and enhancing access to PHP/IOP and PACT are important elements related to this recommendation.*

2. Address Behavioral Health Workforce. The workgroup supports any efforts to expand and invest in the behavioral health workforce. Without additional investment in the workforce, additional services and systems changes will be hampered by limited clinicians to provide treatment. Due to the severe shortage of mental health clinicians, there was support for programs to build workforce capacity in non-traditional ways such as through telehealth and program such as Virginia Mental Health Access (VMAP). There are several cross organization and cross agency workgroups seeking to address this problem.

A. Support Existing Efforts to Address Behavioral Health Workforce. *The workgroup members support any efforts to increase the number of quality mental health professionals and licensed mental health professionals across the Commonwealth.*

3. Reduce Trauma and Improve the Civil Commitment Process. The workgroup discussed the role of law enforcement and trauma for adults and children. Members wanted to examine more closely how Virginia's processes align with other states in terms of the length of its temporary detention periods, who performs the evaluation of individuals during an emergency custody period, and the role of state hospitals in supporting citizens with mental health conditions.

A. Establish a Civil Commitment Workgroup. *The workgroup recommends the Governor or General Assembly establish a workgroup to continue to examine Virginia's civil commitment process as it relates to other states. The workgroup*

should consider how to improve the current process to reduce trauma for children and adults, reduce the role of law enforcement, and improve efficiency so individuals are evaluated as soon as feasible and can enter into treatment. Members recommend that state agencies, such as DBHDS and DMAS, participate with representatives from law enforcement, hospitals, community services boards, emergency physicians, as well as peer and family advocates. The workgroup would provide a report to the Governor and General Assembly by December 1, 2020.

4. Provide Additional Resources to Treat Individuals with Medically Complex Conditions.

Individuals who have acute medically complex conditions and are in psychiatric crisis should be medically stable before transfer to a state hospital. This may require treatment in a general acute care hospital where medical services, diagnostics, and appropriately trained clinicians are readily available to address unstable medical conditions. The workgroup noted that state hospitals are not the most appropriate treatment setting for individuals who are medically complex, which led to broad discussion for various alternatives. The workgroup discussed how individuals with complex medical conditions were treated prior to the implementation of the Bed of Last Resort statute, as well as how current Criteria for Medical Assessment (CMA) guidelines address this area of concern. The workgroup agreed additional options should be considered to improve care for those with medically complex conditions. However, there was not consensus on the best approach or one single approach to address this need. The following recommendations were consensus recommendations:

A. *Adaption of Local Inpatient Purchase of Service (LIPOS) Funds.* *These funds have been used for many years to permit CSBs to purchase private inpatient behavioral health beds from hospitals within their region. The workgroup recommended payment to hospitals, through a contract vehicle similar to, but distinct from, LIPOS, to provide for admission to medical floors, with inpatient psychiatric consultation and/or staffing, to provide rapid and effective reduction in patient being admitted to state facilities. The contract vehicle would be an additional set of resources above current LIPOS funding and established and monitored by DBHDS through a separate pool of funding. There was consensus among workgroup members to move forward with this option.*

B. *Determine the necessity for more specialized beds for geriatric and medically complex patients.* *As noted, most psychiatric hospitals/units are not equipped to provide care for individuals who have acute medical conditions or complex medical conditions. The workgroup suggested there is a lack of specialized units in private psychiatric hospitals to provide appropriate care for medically complex individuals and conversely that psychiatric care may not be reimbursed for individuals in medical units. The workgroup agreed there is a need to identify regional and statewide gaps in care for the geriatric and medically complex populations. A variety of members recommended exploring the following to help inform further discussion:*

- i.** *Revisit the recommendations from 2017 Report to the General Assembly regarding the Geropsychiatric System of Care in Virginia. This report*

highlighted an ongoing need to work towards shifting more geriatric psychiatric care to the community;

- ii. Work with academic medical centers to identify potential partnerships with state hospitals to improve care for individuals with medically complex conditions and/or older adults in need of psychiatric care; and/or*
- iii. Engage national expert consultation on how these populations are cared for in other states and/or to complete additional data collection and analysis to identify the gaps in care at a regional and local level.*

C. Provide a Specialized Inpatient Rate for Individuals with ID/DD. *Individuals with ID/DD, including children, require specialized programming to ensure they are provided treatment that meets individual needs. Workgroup members discussed how additional resources for training were needed so all levels of staff could support adults and children with developmental disabilities. These individuals may require additional care in terms of additional staffing or consultation. The workgroup agreed that a specialized inpatient rate and additional resources for training would greatly improve inpatient care. Receipt of a specialized programming rate would be contingent on using a DBHDS approved screening tool to qualify for a specialized rate. Staff would be trained in dual diagnosis and have licensed behavior analyst on staff to augment clinical treatment and stabilization.*

5. Provide Additional Resources for Individuals who are Intoxicated or Require Detoxification. Individuals who are intoxicated from alcohol or other substances may be experiencing psychiatric crisis. It is a standard of care, however, to conduct a psychiatric assessment when an individual is clinically sober to determine the level of mental health treatment they require and have the ability to engage in treatment planning. The current statute does not take this dynamic into account, which contributes to intoxicated individuals being twice as likely to be admitted to a state hospital rather than a private hospital. The workgroup discussed various ways to address the needs of this population. Better supporting individuals who are intoxicated and require detoxification to divert from involuntary commitment would reduce the number of admissions to state hospitals.

A. Assess current CITAC model: *The workgroup discussed using CITACs as an alternate option to provide relief to law enforcement and an option that could potentially divert admissions over time and provide a location for individuals become sober. It is important to note, however, that without an extension of the ECO period, it will be difficult to divert admissions because it can take more than 8 hours for individuals to be sufficiently sober for appropriate evaluation. Despite this limitation, the workgroup recommended further exploration of the CITAC model to better support individuals who are intoxicated and to provide relief for law enforcement. Part of the discussion focused on the forty-one existing CITACs and ensuring there is a common set of services and access in all CITAC models.*

DBHDS should conduct an assessment to identify the appropriate number, setting, and location of CITACs. The assessment should use data from other states and identify the core services that should be provided to reach optimal patient outcomes. The assessment

should explore how all CITACs would assume custody, offer limited medical screening, provide space for sobering up, medically supervised withdrawal, and residential crisis stabilization.

B. Amend Medical TDO Language to Include Intoxicated Individuals: *State hospitals are not equipped to treat acute medical conditions, including intoxication. In order to avoid transferring an individual who is intoxicated, amending 37.2-1104 to permit physicians to temporarily detain intoxicated individuals under a medical TDO may avoid endangering the health and safety of the individual. While under a medical TDO, detoxification and stabilization may occur, allowing the emergency services clinician to accurately assess an individual for psychiatric hospitalization. The hospital providing the observation, testing, and treatment would assume custody during this extended period.*

Non-Consensus Recommendations for Adults

- 6. Extend the Emergency Custody Order (ECO) Period.** The workgroup discussed the possibility of extending the ECO period up to 24 hours in order to divert state hospital and private hospital admissions for all individuals or, as noted above, for those who either have an acute medical condition or are intoxicated from drugs or alcohol. The additional time, moving from 8 hours to 24 hours, would allow clinicians to evaluate individuals, ensure they are receiving the most appropriate care, and potentially divert admissions through referrals to outpatient services, agreeing to voluntary admissions or other alternatives. The workgroup did not reach consensus on this option, with most members opposing (Figure 8). The following were the recommendations:

A. Extend the ECO Period for Individuals Requiring Additional Observation, Testing, and Treatment. *State hospitals are not equipped to treat acute medical conditions, including intoxication. In order to avoid transferring an individual with an unstable medical condition, extension of the ECO period to allow for additional observation, testing, and treatment may avoid endangering the health and safety of the individual. Such an extension could occur if DBHDS determines, based on CSB and ED referral information, that the individual meeting the TDO criteria has an acute medical condition, including delirium or intoxication, which cannot be safely treated in a state hospital. DBHDS may request the magistrate to grant an extension of the ECO period for up to 24 hours in order for further observation, testing, and treatment. The hospital providing the observation, testing, and treatment would assume custody during this extended period. Conditional support was given by VOCAL, NAMI, and MHA for this recommendation if there was inclusion of a sunset clause to evaluate the impact the extension of the ECO period had on the state hospital census. It was suggested that data be collected through this period including how many individuals under a TDO were diverted from admission to a hospital, the cost savings if any, and the average time peers spent with an individual through the civil commitment process. Other members of the workgroup did not support this recommendation.*

B. *Extend the ECO Period for Individuals Requiring Substance Intoxication or Withdrawal.* *State hospitals are not equipped to treat acute medical conditions, including intoxication. In order to avoid transferring an individual who is intoxicated, extension of the ECO period to allow for additional observation, testing, and treatment may avoid endangering the health and safety of the individual. Such an extension could occur if DBHDS determines, based on CSB and ED referral information, that the individual meeting the TDO criteria has an acute medical condition, including delirium or intoxication, that cannot be safely treated in a state hospital, DBHDS may request the magistrate to grant an extension of the ECO period for up to 24 hours in order for further observation, testing, and treatment. The hospital providing the observation, testing and treatment would assume custody during this extended period. Conditional support was given by VOCAL, NAMI, and MHA for this recommendation if there was inclusion of a sunset clause to evaluate the impact the extension of the ECO period had on the state hospital census. It was suggested that data be collected through this period including how many individuals under a TDO were diverted from admission to a hospital, the cost savings if any, and the average time peers spent with an individual through the civil commitment process. Other members of the workgroup did not support this recommendation.*

7. Improving the Evaluation Process. The workgroup discussed several topics related to improving or streamlining the evaluation process so individuals could be assessed and enter treatment sooner on a voluntary or involuntary basis. Currently, only CSB employees or their designees are able to conduct an evaluation under an ECO to determine if an individual meets the criteria for a temporary detention order. If the ability to conduct evaluations is expanded to clinicians in the emergency departments, the evaluators would have the ability to spend more time with each individual and begin de-escalation and clinical treatment alongside their evaluation. This recommendation could lead to relieving the sole burden for CSBs to increase diversion from state hospitals as all evaluators would have greater ability, accountability, and more time to locate services within their community. Concerns were raised that such a change could increase the number of TDOs issued and increase the state hospital census. Additional options to mitigate these concerns included a two-evaluator commitment process for TDOs, specified credentialing of evaluators, such as psychiatrists and other licensed mental health professionals, and training requirements tied to licensure. Legislation to make this change would require all evaluators to become trained and certified pre-screeners and comply with reporting and quality oversight requirements established by DBHDS. The following recommendation was considered, but consensus was not reached (Figure 8):

A. *Expand who is Able to Conduct a TDO Evaluation.* *Amend 37.2-808 to permit licensed mental health professionals and other qualified clinicians who are appropriately trained and comply with reporting and quality oversight requirements from DBHDS to conduct temporary detention evaluations. It was discussed by the workgroup to explore this recommendation further in the proposed civil commitment workgroup mentioned in recommendation 3.A.*

- 8. Enhancing Data Collection.** There were many discussions where workgroup members wanted additional data to fully understand all aspects of the current crisis in state hospital census. Because the commitment process involves the intertwining of clinical care, often provided by a myriad of providers including the CSBs, private hospitals, and state hospitals, and the judicial process, data collection is difficult. The workgroup requested several data points that were not available. Through workgroup discussions and stakeholder feedback, it became clear that the bed registry is not being utilized for its intended purpose: to locate open beds and place individuals more efficiently. Through conversations with national experts, the workgroup was informed that bed registries are only helpful with bed finding challenges if information on the registry is accurate and timely, and hospitals with empty beds are willing to accept patients. Bed registries in other states have experienced similar challenges, and reform efforts have been made to use the registry not for locating beds, but as a data collection tool. The workgroup discussed enhancing the bed registry to improve bed finding capabilities and allow for data collection to monitor reasons for admission denial, staffed capacity of psychiatric hospitals, and by needs of the individual. Based on these discussions, the following items were recommended, but no consensus was reached:
- A. **Mandate Data Reporting Requirements.** Mandate the reporting of daily bed utilization by psychiatric wards and hospitals, increase patient diagnosis information, staffed capacities, and reason for denial of admissions.*
 - B. **Utilize Bed Registry as a Data Collection Tool.** Obtain funding to revamp or create an entirely new bed registry in Virginia that permits data collection and monitoring to enable DBHDS to provide oversight and monitoring of the ECO and bed finding process.*
 - C. **Leverage Emergency Department Care Coordination (EDCC) Technology.** The EDCC technology will be moving to be inclusive of CSBs and other community-based providers. This tool could be utilized to improve care for individuals with psychiatric needs through better linkages and coordination. Support for this technology and CSB participation should continue.*
- 9. Clarify the Role of Virginia’s State Psychiatric Hospitals.** The workgroup members discussed many elements of the current structure and system that disincentivize diverting inpatient psychiatric hospital admissions and, more specifically, admissions to state psychiatric hospitals. The workgroup heard information about the role of state hospitals in other states. In many states, state-run psychiatric institutions do not accept individuals in temporary detention. Beds in public psychiatric hospitals are reserved for those adults with long-term, difficult to treat mental illness and those who are forensically involved. In Virginia, the role and function of state psychiatric hospitals is unclear. State hospitals are admitting individuals under TDOs at increasing rates, while continuing to manage individuals that require long-term treatment of their mental illness and those who are forensically involved. This lack of clarity regarding the role of state hospitals means significant reliance on these institutions to provide an expansive array of inpatient treatment types, as well as the need for additional financial resources to meet the needs of the

individuals. Based on the workgroup discussion, the following recommendation could be considered, but no consensus was reached:

- A. The workgroup recommends clarifying the role of state hospitals in Virginia’s behavioral health system. Without additional clarity, state hospitals will continue to serve multiple roles that require additional funding and resources to adapt operations. This may include build out of additional beds on a permanent basis across the system. According to national research, state psychiatric hospitals should provide treatment only to those “who cannot be safely and effectively treated in another setting”, making the role of the state hospital in Virginia two-fold: (1) to serve individuals with criminal justice involvement who require inpatient psychiatric treatment or evaluation; and (2) to provide longer term treatment services for those individuals in the care of private psychiatric hospitals who are unable to be stabilized in an acute care setting and discharged to their home communities.*

10. Address Bed of Last Resort Statute. Since Bed of Last Resort (37.2-809) legislation was enacted in 2014, TDO admissions to state hospitals have increased by 333 percent without additional creation of community services that divert individuals from inpatient care, this growth is likely to continue. The workgroup made consensus recommendations to continue investment in community services through STEP-VA, proposed Medicaid Behavioral Health Redesign, and crisis service system investments and changes. While these efforts begin to take hold, short-term actions may be necessary. Using information from other states, modifications to the current statute, along with financial incentives, could be considered. The workgroup did not reach consensus on this recommendation:

- A. Modifications to Bed of Last Resort and Incentives. Legislation could be crafted that seeks to limit state hospital admissions under specific circumstances, such as the following:*
 - i. If the certified bed capacity of the state hospitals is such that state hospitals cannot safely treat the individual until census falls; or*
 - ii. When the state facility director determines they cannot safely treat an individual due to a serious medical condition, including intoxication.*

As part of this proposal, state hospitals would be required to work on a regional basis to accept individuals for admission after 30 days or more in a private hospital. Finally, possible financial incentives to appropriately support TDO admissions should also be identified, including exploration of rate adjustments for TDOs and/or DSH payments that match resources required to care the individual.

Consensus Recommendations for Children

The workgroup noted that, for children, additional consideration should be given to address trauma and support recovery as close to their home communities as feasible. There is only one

state hospital for children, the Commonwealth Center for Children and Adolescents (CCCA), and this creates additional stressors for children and families in need of psychiatric care when no private hospital beds for children are available.

C1. Support the Continued Build Out of Community-Based Services and Supports. The workgroup emphasized inpatient treatment is only a single aspect of a fully developed community based system of services. A comprehensive community-based system will prevent and divert inpatient admissions and reduce the overall need for inpatient care in both state and private hospitals. The workgroup recommended the following:

- A. **Continue Implementation of STEP-VA.** Virginia should continue to support the public behavioral health system as the safety net of providers and support the implementation of STEP-VA to ensure that all individuals, regardless of where they live in the Commonwealth, have access to assessment/care through Same Day Access and basic and essential core services such as outpatient therapy, crisis services, peer/family support, psychiatric rehabilitation, care coordination, mobile crisis, and case management. Mobile crisis, psychiatric rehabilitation services, and case management will most directly address the hospital census challenges. Continuation of STEP-VA is contingent on additional funding to implement all steps.*
- B. **Support Efforts toward Proposed Medicaid Behavioral Health Redesign.** DBHDS and DMAS are working with stakeholders to develop transformative changes for community based mental health services. The goal is to shift our system to one that is trauma-informed, evidence-based and focused on prevention and early intervention to improve outcomes for children and adults with behavioral health conditions. The current plans include the addition of six key services in FY21 which includes partial hospitalization and intensive outpatient (PHP/IOP) services, program of assertive community treatment (PACT), multi-systemic therapy (MST), functional family therapy (FFT), and crisis services. Crisis services should include, at a minimum, mobile crisis and 23 hour crisis stabilization.*

Currently, Medicaid does not cover or only partially covers these high impact services, which significantly limits much needed access. Members of the workgroup agreed that action should be taken in this area because such services will enable diversion from inpatient admissions and easier step-down to less restrictive and less costly levels of care. Medicaid redesign, if approved, would begin in FY21. The workgroup recommends that IOP/PHP be accelerated so that they are available as soon as feasible.

- C. **Increase Utilization of Crisis Stabilization Units (CSUs).** CSUs are used as a step down or diversion from hospitalization to treat children who may benefit from a sub-acute residential program. Currently, children's CSUs vary in who and when they will admit children across the state. This variability hampers Virginia's effectiveness in providing routine, standardized access to care. The workgroup recommends funding to further standardize residential CSUs so 24/7 staffing is available, training and technical assistance are readily available, and safety enhancements can be made.*

D. Support Expansion of Mobile Crisis. *There is direct evidence that mobile crisis services disrupt the cycle of unnecessary hospitalizations for individuals with mental illness. If mobile crisis services were available statewide, it would increase diversion from acute inpatient hospitalizations and over time, reduce the state hospital census. DBHDS should prioritize additional resources for mobile crisis services as part of any STEP-VA crisis services request for resources.*

E. Additional Crisis Services System Resources. *The workgroup members stressed the importance of diversion from acute inpatient hospitalization as a critical step to reducing hospital census. Continuing to advance the crisis services system so that it is able to respond to all individuals experiencing a mental health crisis, regardless of their age or disability, in their home or community received strong support from the workgroup. Improving utilization of CSUs, and enhancing access to PHP/IOP, MST, and FFT are important elements related to this recommendation.*

C2. Address Behavioral Health Workforce. The workgroup supports any efforts to expand and invest in the behavioral health workforce. Without additional investment in the workforce, additional services and systems changes will be hampered by limited clinicians to provide treatment. Due to the severe shortage of child mental health clinicians, support for programs to build workforce capacity in non-traditional ways such as through telehealth and program such as Virginia Mental Health Access (VMAP), for which DBHDS is the state oversight agency. There are several cross organization and cross agency workgroups seeking to address challenges related to behavioral health workforce through a variety of approaches.

A. Support Existing Efforts to Address Behavioral Health Workforce. *The workgroup members support any efforts to increase the number of quality mental health professionals and licensed mental health professionals across the Commonwealth.*

C3. Reduce Trauma and Improve the Civil Commitment Process. The workgroup discussed the role of law enforcement and trauma for adults and children. In addition, members wanted to examine more closely how Virginia's processes align with other states in terms of the length of its temporary detention periods, who performs the evaluation of individuals during an emergency custody period, and the role of state hospitals in supporting citizens with mental health conditions.

A. Establish a Civil Commitment Workgroup. *The workgroup recommends the Governor or General Assembly establish a workgroup to continue to examine Virginia's civil commitment process as it relates to other states. The workgroup should consider how to improve the current process to reduce trauma for children and adults, reduce the role of law enforcement, and improve efficiency so individuals are evaluated as soon as feasible and can enter into treatment. Members recommend that state agencies, such as DBHDS and DMAS, participate with representatives from law enforcement, hospitals, community services boards, emergency physicians, as well as peer and family advocates. The workgroup would provide a report to the Governor and General Assembly by October 1, 2020.*

C4. Provide a Specialized Inpatient Rate for Children with ID/DD. Individuals with ID/DD, including children, require specialized programming to ensure they are provided treatment that meets individual needs. Workgroup members discussed how additional resources for training were needed so all levels of staff could support adults and children with developmental disabilities. In addition, these individuals may require additional care in terms of additional staffing or consultation. The workgroup agreed that a specialized inpatient rate and additional resources for training would greatly improve inpatient care. Receipt of a specialized programming rate would be contingent on using a DBHDS approved screening tool to qualify for a specialized rate. Staff would be trained in dual diagnosis and have trained behavior therapist on staff to augment clinical treatment and stabilization.

C5. Children with Medically Complex Conditions. Children who have acute medically complex conditions and are in psychiatric crisis should be medically stable before transfer to the CCCA. This may require treatment in a general acute care hospital where medical services, diagnostics, and appropriately trained clinicians are readily available to address unstable medical conditions. The workgroup noted that CCCA is not the most appropriate treatment setting for children with medically complex conditions, which led to broad discussion for various alternatives.

The workgroup discussed the ways in which children with complex medical conditions have received needed medical treatment in recent years. There was agreement that more services should be made available to support children with medically complex conditions and prevent admission to CCCA. Options to consider included:

- A. Determine the necessity for more specialized beds for children with medically complex conditions. Currently, most psychiatric hospitals/units are not equipped to provide care for children who have acute complex medical conditions. This can be due to the lack of specialized equipment available on a psychiatric unit and safety considerations related to medical equipment that may be used to cause harm to self or others. The workgroup suggested there is a lack of specialized units in private psychiatric hospitals to provide appropriate care for children with medically complex conditions and conversely that psychiatric care may not be reimbursed for children in medical units. In FY19, CCCA treated 92 children with risk factors associated with complex medical conditions. Funding to support medically complex children in general acute care inpatient settings should be identified. The funding could provide clinical as well as staffing support to permit children to receive treatment in the general inpatient units and/or within a psychiatric unit, depending on the condition.*

Non-Consensus Recommendations—Children’s

C6. Pilot Children’s Admission Team Model. Given the relatively small number of children, daily calls including DBHDS, CCCA, CSB emergency service teams, DSS, and CSA and all participating child/adolescent units could occur. The calls would provide CSB emergency service teams with real-time information about bed availability and reduce prescreener time calling each

hospital for a child admission, thereby speeding time to admission. It was noted that this recommendation could be discussed further in a separate workgroup.

C7. Legislation to Address Bed of Last Resort Statute. Since Last Resort (37.2-809) legislation was enacted in 2014, TDO admissions to state hospitals have continued to increase dramatically. The crisis is particularly acute for children because there is only one state facility for children with 48 beds. Without additional creation of community services that divert children from inpatient care, this growth is likely to continue. The workgroup supports continued investment in community services through STEP-VA, proposed Medicaid Behavioral Health Redesign, mobile crisis and other crisis service system investments and changes. While these efforts begin to take hold, short-term actions may be necessary. Using information from other states, modifications to the current statute, along with financial incentives, could be considered:

- A. Modifications to Bed of Last Resort and Incentives. Legislation could be crafted that seek to limit state hospital admissions under specific circumstances, such as the following:*
- iii. If the certified bed capacity of CCCA is such that state hospitals cannot safely treat the individual until census falls; or*
 - iv. When an individual cannot be safely treated due to a serious medical condition or intoxication that the state facility is unable to manage or treat.*

As part of this proposal, CCCA would be required to work on a regional basis to accept individuals for admission after they have stayed 30 days or more in a private hospital. Finally, possible financial incentives to appropriately support private children's psychiatric units to accept TDO admissions should be identified, including exploration of rate adjustments for TDOs and/or DSH payments that match resources required to care for these children.

VI. 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. At the same time, while the law ensures that no person under a TDO will be without a hospital bed, the law is not yet fully supported by a comprehensive system of care to meet the needs of individuals who present in a mental health crisis. As we reform the system through STEP VA and other initiatives, it becomes more obvious that a more consistent, robust and accessible community services system would reduce psychiatric crisis, emergency department visits, avoidable incarcerations, and admissions to state hospitals and other acute inpatient psychiatric facilities.

It is important to note that while the focus of the workgroup aimed toward addressing the enormous census pressures on Virginia's state psychiatric hospitals, no single recommendation can serve as the solution. The collective impact of multiple recommendations needs to take effect to produce immediate and measurable change. Modifying legislation such that the state is the last resort instead of the first resort, as was intended, can be achieved through continued

collaborative efforts among stakeholders. DBHDS remains committed to ensuring an effective and robust safety net for Virginians experiencing a behavioral health crisis. In order to preserve the strength and health of our emergency services safety net, Virginia must continue to be innovative in its efforts to rebalance the public and private behavioral health system, by building capacity in the community, to treat individuals earlier in the illness 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 enable all Virginians the opportunity to live to their fullest potential.

Figure 9: Summary of Recommendations

No.	Description	Consensus (Yes/No)	Stakeholder Position
<i>Adult Recommendations</i>			
1.A	Continue Implementation of STEP-VA	Yes	
1.B	Support Efforts toward Proposed Medicaid Behavioral Health Redesign	Yes	
1.C	Increase Utilization of CSUs	Yes	
1.D	Support Expansion of Mobile Crisis	Yes	
1.E	Additional Crisis Services System Resources	Yes	
2.A	Support Efforts to Address BH Workforce	Yes	
3.A	Continue Work Related to Civil Commitment Process	Yes	
4.A	Funding for Medically Complex Treatment (LIPOS-like)	Yes	
4.B	Determine the necessity for specialized beds for geriatric and medically complex	Yes	
4.C	Provide specialized rate and programming for ID/DD	Yes	
5.A	Assess current CITAC model	Yes	
6.A	Extend the ECO Period for Medically Complex	No	<u>Support:</u> ILPPP <u>Support Conditionally:</u> VOCAL MHA NAMI <u>Do Not Support:</u> VACSB

			VA Sheriff's Association VACEP VA Association of Police Chiefs VHHA
6.B	Extend the ECO Period for Individuals who are Intoxicated	No	<u>Support:</u> ILPPP <u>Support Conditionally:</u> VOCAL MHA NAMI <u>Do Not Support:</u> VACSB VA Sheriff's Association VACEP VA Association of Police Chiefs VHHA
7.A	Expand who is able to conduct a TDO evaluation	No	<u>Support:</u> VACEP VHHA VOCAL <u>Do Not Support:</u> VACSB ILPPP
8.A	Mandate Data Reporting Requirements	No	<u>Support:</u> MHA NAMI VOCAL ILPPP <u>Do Not Support:</u> VHHA
8.B	Utilize Bed Registry as a Data Collection Tool	No	<u>Support:</u> MHA NAMI <u>Do Not Support:</u> VACSB VHHA VOCAL
8.C	Leverage EDCC Technology	No	<u>Support</u> ILPPP
9.A	Clarify the Role of Virginia's State Hospitals	No	<u>Support</u> ILPPP MHA
10.A	Address Bed of Last Resort Statute	No	<u>Do Not Support</u> VHHA VACSB VA Sheriff's Association VACEP

			VA Association of Police Chiefs
<i>Child Recommendations</i>			
C1.A	Continue Implementation of STEP-VA	Yes	
C1.B	Support Efforts toward Proposed Medicaid Behavioral Health Redesign	Yes	
C1.C	Increase Utilization of CSUs	Yes	
C1.D	Support the Expansion of Mobile Crisis	Yes	
C1.E	Additional Crisis Services System Resources	Yes	
C2.A	Support Existing Efforts to Address Behavioral Health Workforce	Yes	
C3.A	Establish a Civil Commitment Workgroup	Yes	
C4	Provide a Specialized Inpatient Rate for Children with ID/DD	Yes	
C5.A	Determine the necessity for more specialized beds for children with medically complex conditions.	Yes	
C6	Pilot Children's Admission Team Model	No	<u>Support</u> Voices for Virginia's Children
C7	Legislation to Address Bed of Last Resort Statute	No	<u>Do Not Support</u> VHHA VACSB VA Sheriff's Association VACEP VA Association of Police Chiefs

Appendix A

Organization	Contact
DBHDS, Chief Clinical Officer	Dr. Alexis Aplasca
DMAS, Behavioral Health Clinical Director	Dr. Alyssa Ward
Office of the Attorney General	Allyson Tysinger
Mental Health America of Virginia	Bruce Cruser
Ashland Chief of Police	Chief Doug Goodman
Virginia Association of Police Chiefs	Dana Schrad
Secretary of Health and Human Resources	Dr. Daniel Carey
DBHDS, Deputy Commissioner for Facility Services	Daniel Herr
VOCAL Virginia	Deidre Johnson
DBHDS, Senior Policy Advisor	Emily Lowrie
Chief of Police Pulaski	Gary Roche
DBHDS, Deputy Commissioner for Compliance, Legislative, & Regulatory Affairs	Heidi Dix
Kempsville Center for Behavioral Health/VHHA	Jaime Fernandez
HCA Healthcare/VHHA	Dr. Jake O'Shea
Virginia Association of Community Services Boards	Jennifer Faison
Virginia Hospital and Healthcare Association	Jennifer Wicker
Danville Pittsylvania CSB/Emergency Services Worker Council	Jim Bebeau
Novant Health UVA Health System/Emergency Room Physicians	Dr. Jon D'Souza
Office of the Executive Secretary	Jonathan Green
Blue Ridge Behavioral Healthcare/Emergency Services Worker Council	Kelly Clinevell
Henrico CSB	Laura Totty
Voices for Virginia's Children	Margaret Nimmo-Holland
OSHHR	Marvin Figueroa
DBHDS, Acting Commissioner	Mira Signer
NAMI VA	Rhonda Thissen
The Institute of Law, Psychiatry and Public Policy	Richard Bonnie
Secretary of Public Safety	Ryant Washington
Sheriff of Chesterfield Virginia	Sheriff Karl Leonard
The Psychiatric Society of VA	Tony Graham, M.D.
Medical Society of Virginia	Dr. Varun Choudhary

Appendix B

Meeting Date	Discussion
April 22, 2019	Understanding the census crisis from all perspectives
May 20, 2019	Overview of the civil commitment process National Perspective
June 24, 2019	Overview of alternative sites for TDO assessment Discussion of ECO time frame extension
July 22, 2019	Overview of civil commitment process for medically complex and intoxicated individuals
August 26, 2019	Presentation and discussion of policy recommendations for children
October 11, 2019	Review workgroup recommendations and discuss policy options
October 25, 2019	Review workgroup recommendations and discuss policy options Workgroup feedback on report – Due to GA on 9/1