# *COMMONWEALTH of VIRGINIA*

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COMMISSIONER

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October 1, 2020

The Honorable Janet D. Howell, Chair
Senate Finance Committee
The Honorable Luke E. Torian, Chair
House Appropriations Committee
Pocahontas Building
900 East Main Street
Richmond, VA 23219

Dear Senator Howell and Delegate Torian:

Item 320.FF of the 2020 Appropriations Act directs the Department of Behavioral Health and Developmental Services (DBHDS) to develop a plan and recommendations to convert Crisis Intervention Team Assessment Centers to 24 hour, seven day operations and inclusion of regional Crisis Receiving Centers. The language states:

> *The Department of Behavioral Health and Developmental Services shall develop a plan to convert Crisis Intervention Team Assessment Centers (CITACs) to 24-hour, seven-day operations and moving toward regional CITAC sites. This plan shall include the costs and recommended areas of the Commonwealth for at least three assessment centers in fiscal year 2022. The department shall submit the plan to the Chairs of the House Appropriations and Senate Finance and Appropriations Committees by October 1, 2020.*

In accordance with this, please find enclosed the report for 320.FF of the 2020 Appropriations Act. Staff are available should you wish to discuss this request.

Sincerely,

Alison G. Land, FACHE
Commissioner
Department of Behavioral Health & Developmental Services

CC:
Daniel Carey, MD
Vanessa Walker Harris, MD
Susan Massart
Mike Tweedy

Virginia Department of Behavioral Health & Developmental Services

# Crisis Intervention Team Assessment Centers (CITAC) Expansion Plan

# (Item 320.FF. of the 2020 Appropriation Act.)

**October 1, 2020**

*DBHDS Vision: A Life of Possibilities for All Virginians*

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## Acknowledgements

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Jennifer Faison- Executive Director, Virginia Association of Community Services Boards

Sarah Gray- Henrico Area Mental Health & Developmental Services

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Cheryl St. John- Virginia Beach CSB

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# Executive Summary

Crisis services are a critical link in the public behavioral health and developmental disability continuum of care. A key function of our crisis response network is law enforcement-based jail diversion efforts that work to keep those in mental health crisis from entering the criminal justice system, including the Crisis Intervention Team Assessment Site (CITAC) program. The 2020 Appropriations Act Item 320.FF. requires a report on the feasibility of expanding the CITAC program. CITAC program staff have been working closely with grantees to find ways to expand services in a number of areas. Based on information from previous funding cycles, this report includes costs estimates and recommendations for enhancement including expansion of some CITAC locations into regionally based crisis receiving centers by FY2022.

A workgroup of subject matter experts was convened to receive input from stakeholders including six Community Services Boards (CSBs), Mental Health America of Virginia, the Virginia Association of Chiefs of Police, the Virginia Sheriffs' Association, the Virginia Association of Community Services Boards, and the Virginia Healthcare & Hospital Association. These entities either host or are stakeholders in various Crisis Intervention Team (CIT) programs in Virginia and represent interests of critical pieces in a mental health response system.

Entry into the criminal justice system or lengthy emergency department (ED) stays for someone with mental illness is not in the best interest of recovery for the individual and can create unnecessary burdens for law enforcement, jails, courts, and public mental health systems. Jail diversion programs like the CITAC program provide a resource for individuals in crisis that offer calming locations, access to timely emergency mental health evaluations, and treatment options other than inpatient hospitalization or incarceration. This report details current challenges, research on best practices, and options for how the existing Assessment Sites can be leveraged to provide more opportunities for consumers and potentially reduce additional burden on medical facilities, jails, the court system, and law enforcement agencies.

**Key Findings of the Workgroup**

- Time spent in emergency departments takes law enforcement officers away from their primary duties of community service and protection for extended periods of time.
- Arrest and incarceration are not the most appropriate options for many cases involving individuals experiencing symptoms of mental health crisis.
- Services that aid in reducing the overall number of temporary detention orders will benefit consumers, jails, and help reduce the number of TDOs to state hospitals.

**The primary recommendations** of the Workgroup include:

1. Establishment of up to five Crisis Receiving Centers, one in each behavioral health region, to provide opportunities to reduce the number of misdemeanants incarcerated with mental illness, reduce the number of psychiatric emergencies waiting in EDs, and provide access to a wider system of care for those in crisis. Crisis Receiving Centers should contain, at a minimum, basic medical evaluation,

immediate access to psychiatry, staffing by peer specialists with lived experience, extensive case management, 23 hour observation, and stabilization.

2. Retaining existing Assessment Sites that provide too great of a geographical challenge for regional participation until further data can be collected, thereby maintaining a safety net for all localities.

The total cost estimate for these recommendations is $20.3 million annually. $12.3 million of these funds can be utilized from the existing CITAC budget, and $8 million in new funds would be required. The accompanying research explains the numerous benefits these services offer the crisis system, jails, emergency departments, and state hospitals.

## Need Statement and Purpose

In Virginia, it is estimated that between 1.1 and 1.4 million people live with mental illness, some of whom may also experience substance use disorders. The National Alliance on Mental Illness (NAMI) reports in *Jailing People with Mental Illness* (2019) that 2 million people with mental illness are booked into jail each year in the United States. Jails are neither designed nor intended to successfully support recovery and housing for those with mental illness. The expense of housing and caring for someone with a mental illness in jail is costlier than treating them in lesser restrictive ways outside of the jail environment (NAMI, 2015).

The facilities housing the largest numbers of persons with mental illness are all correctional institutions or jails (Chang, 2018). Incarceration of those who commit low level or "nuisance" crimes as a result of a mental health crisis creates a ripple effect through the criminal justice system. The time spent on cases creates backlogs on misdemeanor dockets, unnecessarily extends periods of incarceration for those with mental illness, and creates substantial unnecessary cost to communities and the taxpayers who support them.

Jails in Virginia reported expenditures of $21.6 million in FY2018 on mental health treatment and medication (VCB, 2019). If diversion does not happen prior to booking following an arrest, the cost of incarceration of those with mental illness is significant. A 2018 report revealed that, while the spending is inconsistent, some Virginia jails' healthcare spending accounts for as much as 33% of their annual budget, much of it for psychiatric medication (PEW, 2018).

In addition to the myriad challenges associated with incarceration of those with mental health emergencies, the concerns for those in the healthcare system are also challenging. The Agency for Healthcare Research and Quality presented in a statistical brief in 2015 that between 2003 and 2011 the rate of mental health hospitalization increased faster than any other type of hospitalization (Hepburn, 2017). This hospitalization frequently begins with a trip to an emergency department, where the person in crisis waits for care. The Substance Abuse and Mental Health Service Administration (SAMHSA) provides a simple synopsis of the reason for this in its report, "Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies.

> "The research base on the effectiveness of crisis services is growing. There is evidence that crisis stabilization, community-based residential crisis care,

> and mobile crisis services can divert individuals from unnecessary hospitalizations and ensure the least restrictive treatment option is available to people experiencing behavioral health crises. Additionally, a continuum of crisis services can assist in reducing costs for psychiatric hospitalization, without negatively impacting clinical outcomes."

This evidence of success outlined in this document leads us to explore the ways to expand on the work that has already been done in Virginia through the CIT Assessment Sites. Enhanced capabilities for crisis services is needed. Leveraging existing resources is a straightforward way to positively affect the state hospital bed census, help reduce overcrowding in emergency departments, and positively impact the budgets of law enforcement, courts, and other public institutions that are part of the criminal justice process.

This document will provide examples of how models around the country have implemented receiving centers, the efforts currently underway in Virginia, and how the CIT Assessment Site program is a valuable platform on which to build to meet the medical and psychological needs of Virginians. The recommendations within this document are not the only initiatives that can add efficiency and service to Virginia's crisis system, but are proposed as the front door to a continuum of services to offer the appropriate level of intervention for those in crisis, and thus keep them from inappropriate arrest, costly ED visits, and unnecessary inpatient hospitalization.

# Current CIT Based Diversion in Virginia

### Overview of the CIT Assessment Site Program

The Department of Behavioral Health and Developmental Services (DBHDS) Office of Forensic Services has overseen the CIT Assessment Site Program since FY2013. This program, often called CITAC, creates opportunities for diversion from the criminal justice system for persons experiencing mental health crises, instead directing them to an assessment in a more appropriate space. The term "Assessment Site" is generally synonymous with "drop-off center", a term used during the earlier years of the program. The underlying concept that supports the Assessment Site program is the Sequential Intercept Model. The model lays out specific points along the path of entry and processing through the criminal justice system at which intervention and/or diversion can affect outcomes for those with mental illness. The CITAC program is situated at Intercept 1 which comes after contact with law enforcement but prior to an arrest or criminal charge. Virginia also has other jail- and court-based diversion programs that will not be addressed in this report.

### The Virginia CIT Assessment Site Model

Virginia is unique with its state funded, locally supported statewide diversion site network. Other examples in the U.S. are typically in metropolitan areas and use combined public and private funding. Virginia's need to reach diverse geographies however, spurred the creation of a framework that can be modified by each locality to best serve its residents. The Assessment Site

program utilizes general fund dollars to provide critical infrastructure and supports diversion through the support of a facility based process.

The success of CIT Assessment Sites depends on an invested group of knowledgeable and capable stakeholders. The entities that operate Sites are the same as those who collaborate to create and support CIT programs in communities, which facilitates a strong partnership. Also critical is a training component for law enforcement supported by the stakeholder group. An Assessment Site program is the infrastructure for diverting those in crisis and is the third core focus of a comprehensive CIT program.

The program now comprises 38 stakeholder groups oriented around CSB catchment areas in almost all communities in Virginia. Beginning with three pilot locations in fiscal year 2013, the program has grown to 42 Sites with the most recent awards for new Sites in FY2019. The average cost for each of the 38 CIT Assessment Site programs is about $323,000 annually. Site funds provide staffing for the minimum law enforcement and clinical staffing to accept transfer of custody for ECOs and to conduct code mandated pre-admission screening. Funded Peer support specialists accompany consumers at the time of crisis upon arrival to the Site and throughout the evaluation process. Various other administrative personnel staff the Sites dependent on the needs of the locality. Some localities have begun planning for expanded services at the Assessment Site including the addition of a nurse to provide medical screening. The Office of Forensic Services explores advances in crisis response and the needs for lesser restrictive care and supports these initiatives when possible.

Program CSBs and law enforcement partners try to balance the highest volume of ECOs with the available personnel to schedule hours that their local Site is open for referrals. Depending on need and availability, funded programs operate 8, 10, 12, 16 or 24 hours per day. Because of the number of localities and costs, most locations are not funded for transfer of custody 24 hours, 7 days per week and some modify hours on weekends to correspond to need.

**Program Data to Date**

The numbers reported through first six fiscal years of the Assessment Site program correlate to the increase in total Sites. The first full year of implementation in FY2014 saw 2,522 assessments reported through six programs, followed by increases in the number of programs and assessments each subsequent year. In FY2018 and FY2019 the numbers have plateaued at 14,707 and 14,322 assessments respectively. The program's consistency has allowed a pause to evaluate programmatic impact, observe data, and consider improvements.

Even though a crisis may have already resulted in contact with law enforcement, a more accurate measure of consumer acuity at a CITAC is the disposition following clinical evaluation. Since FY2015 about 60% of the total assessments reported each year result in a temporary detention order (TDO) for inpatient psychiatric hospitalization. This percentage suggests that the acuity level of the consumers diverted to the Sites could have resulted in criminal charges without the ability to divert. Frank Sirotich, in a 2009 article in the *Journal of American Psychiatry* posited that pre-booking diversion programs based on CIT showed greater likelihood of alternatives to arrest than non-CIT based initiatives. With just under 20,000 consumers in Virginia being

directed to the Sites by law enforcement field personnel in FY2018 and FY2019, the program is receiving 69% of its referrals from those who had potential to end up in the process of the criminal justice system, providing apparent support for Sirotich's stance. The CITAC program has saved thousands of hours of law enforcement time in many communities, has allowed CSBs to offer additional services to their clientele, and has helped to avoid many arrests based on symptoms of mental illness. Continued expansion of the capabilities of the program can save more hours, provide access to an extensive slate of services for residents of Virginia, and will be the supportive front end of a robust crisis system. The end result may be a lower percentage of TDOs, but the services that allow for lower acuity are shown by research to be more effective long term.

# Recommendations of the Workgroup

When considering the research and models that are available to assist in planning, the CIT Assessment Site program offers existing infrastructure to support a critical component of a well-rounded crisis system in Virginia. Based on cost and workforce needs, it is likely not feasible to try and create full-scale crisis receiving centers in all localities. Data already available to DBHDS regarding ECOs, TDOs, and the current Assessment Site program point to a number of geographical areas where CIT Assessment Sites, if expanded into full scope centers, may exhibit higher utilization while serving the greatest number of consumers. The placement of the receiving centers should be determined by a combination of two things: geographical effectiveness and workforce availability. Virginia has committed to the Crisis Now model to provide a crisis services model in the Commonwealth. Implementation of STEP-VA will address other needs in line with Crisis Now while expansion to selected CIT Assessment Sites will support the ability to provide around the clock crisis stabilization with medical and psychiatric management. Of the options discussed, two support the recommended components for a fully developed crisis system that align directly with the core components of Crisis Now to include:

- 24 hour access to 23 hour crisis stabilization
- short-term residential crisis and crisis stabilization
- crisis hotlines and warm lines
- peer services

The expansion and/or addition of a full scope receiving center should consider geography, workforce, and hours of operation as they relate to the potential constituency for each location. The options listed provide some detail on how each could leverage the existing Intercept 1 infrastructure to develop access to crisis stabilization that supports Crisis Now. It is important to note that although DBHDS is in the midst of working toward a comprehensive mobile crisis program, it is a lengthy endeavor and the existence of crisis stabilization infrastructure can provide relief for CSBs and the state hospital network with near immediate results while the mobile crisis program is still in development. The workgroup supporting this report outlines three options for expansion as listed below.

**Option 1- Expanding the existing transfer of custody to 24/7 at all CITAC locations with no additional services added.**

The current CITAC locations offer diversion over 14,000 times per year in its simplest form. One option for expansion would be to simply increase the staffing for the law enforcement and clinical personnel at all locations that are not yet operational 24/7. There are two key considerations for this "easiest" option. First, increasing availability on the front end of the crisis response without expanding the options for more substantial treatment only reduces minimal burden on the system. Most Sites are already capturing the majority of their crisis calls during existing hours. Second, expanding to include the times of least consumer utilization is not the most cost effective option. The Office of Forensic Services believes that spending more money on the CITAC program should result in more complete trauma informed care options that compliment and support STEP-VA, not simply additional transfers of custody.

Estimated total costs for expanding all existing CIT Assessment Site to 24 hour operations is shown in Figure 1. This is the lowest total funding amount, however, it is important to understand that the percentage of total assessments gained by this increase in service time is not expected to mirror the current rate of mental health cases at the Assessment Sites.

**Figure 1:** Estimated total cost for expanding all existing CIT Assessment Sites to 24 hours

| Proposal | Personnel Estimate | Facility, pharmacy, other | Total CITAC Costs for this option: | Increase in Revenue due to Option: | Total Estimated Medicaid Revenue for all CITACs: | Total Costs including Revenue Offset |
|---|---|---|---|---|---|---|
| Regional 24/7 Access | $14,082,416 | $1,993,000 | $16,075,416 | $88,409 | $3,041,795 | $13,033,621 |

**Option 2- Creating regional Crisis Receiving Centers with the ability for medical and psychiatric intervention**

This option would provide the most benefit to the various parts of the crisis system involved in responding to psychiatric emergencies, therefore receiving full support among workgroup stakeholders.

Many of the existing communities in the CITAC program have already begun to work on widening the scope of service to include medical and psychiatric capabilities as well as through additional peer services and case management. The resources needed to implement a full scale crisis receiving center will require significant local partnerships, technical assistance and enhanced funding, for these reasons the recommendation is for limited locations at the outset. It is recommended that sufficient funding be allocated to provide for basic medical clearance, immediate access to psychiatry around the clock, additional clinical staff including case management staff, additional peer specialists, and any necessary facility upgrade costs.

Locating regional receiving centers in areas that have already demonstrated significant utilization of the CIT Assessment Sites will leverage the strength of long-standing stakeholder coalitions as well as keep requests for new funds lower. Existing Assessment Site funds would be rolled into

operational costs for each regionalized location from the existing CITAC, further reducing the need for new funds.

Piloting a receiving center in each of the five behavioral health regions would allow for placement to coincide with the highest utilization as well as ensuring access to both urban and rural populations. Assessment Site programs within reasonable proximity to each of the new receiving center locations would be closed, with all emergency mental health diversions to be taken to the receiving center. In some situations this would require some additional travel distance and time for law enforcement, however a 23-hour observation period would at the minimum provide a much longer timeframe before the original agency would potentially need to return for a TDO transport. Additionally, the research in Alameda County provides compelling evidence that a return may be much less likely in any circumstance as about three-quarters of the emergency mental health cases taken to the psychiatric emergency center did not require inpatient hospitalization. The low number remaining is an opportunity to use focused response by the alternative transportation program and relieve additional burden from law enforcement agencies.

Closing surrounding Assessment Sites is expected to make some workforce available for the receiving centers, as many staff are hired specifically with Assessment Site program funds and could therefore be diverted to support the receiving center. Combining multiple localities' catchment areas into a regional receiving facility would make 24-hour referrals feasible in places where it could not currently be supported. This option allows for growth in the crisis continuum in anticipated support of mobile crisis services and as a critical front door to services. Additionally, receiving centers are expected to divert a significant number of those in crisis from state hospitals, thereby easing the strain on state hospital TDO admissions and bed availability.

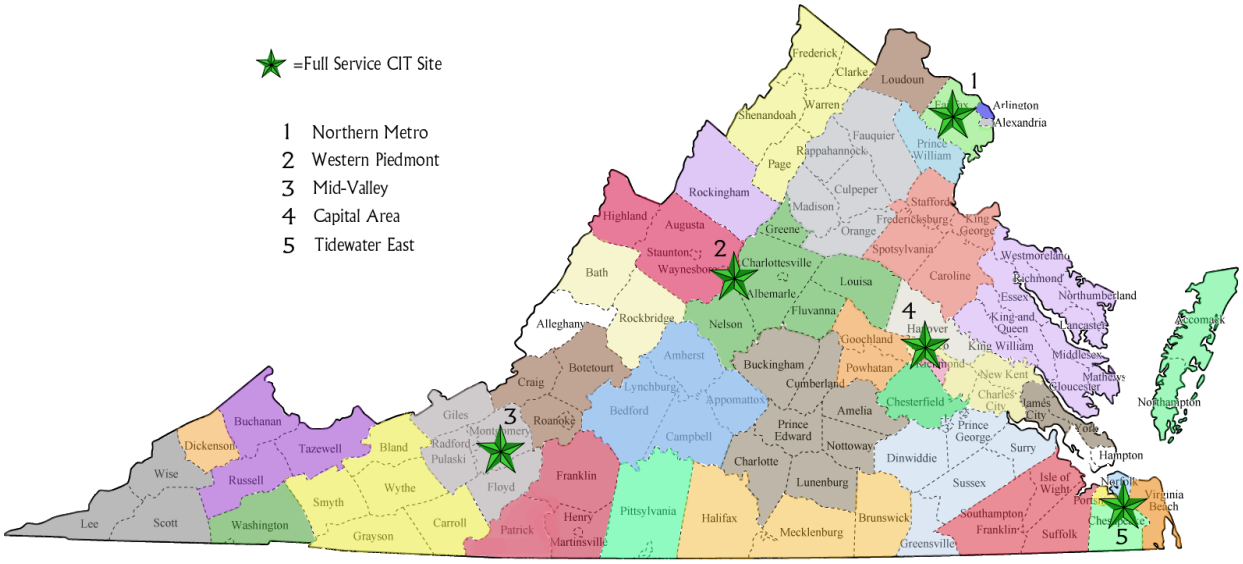
Figure 2 shows the regional breakdown of ECOs and pre-admission screenings done within identified areas for each region with percentages of the total screenings done in the Commonwealth for FY2018. The chart shows a capture rate of about 65% of the total assessments for regional based receiving center locations.

**Figure 2:** Number of ECOs Issued by Region in FY2018

| Region | ECOs | Assessments | % of total assess. |
|---|---|---|---|
| 1 | 2,051 | 12,962 | 12.0 |
| 2 | 4,638 | 19,507 | 21.3 |
| 3 | 2,614 | 11,728 | 12.8 |
| 4 | 3,609 | 9,537 | 10.4 |
| 5 | 2,817 | 9,339 | 8.6 |

Figure 3 shows potential locations for the establishment of pilot locations. Although these are only suggestions, each of the locations has at least one well-established Assessment Site program that has indicated the willingness to proceed with expansion to a receiving center model

**Figure 3:** Potential Locations for Expanded Assessment Sites




Current Assessment Site programs outside of the selected regional catchment areas would remain funded so that the highest percentage of population possible could still access diversion services. As funding becomes available and sufficient data exists to prove efficacy in Virginia, additional crisis receiving centers can be established in more remote areas of the Commonwealth.

Estimated costs for expansion under this model are shown in Figure 4.

**Figure 4:** Estimated Costs for Regional Assessment Sites

| Proposal | Current LE/ES Costs | Increase in LE/ES Costs | Total LE/ES Costs with Expansion | Total CITAC Costs with LE/ES Expansion | Increase in Revenue due to Expansion | Total Estimated Medicaid Revenue | Total Costs including Revenue Offset |
|---|---|---|---|---|---|---|---|
| All Programs to 24 hours | $9,796,767 | $8,043,947 | $17,840,714 | $20,343,947 | $443,508 | $3,396,904 | $16,947,043 |

**Option 3- Creating select Crisis Receiving Centers, with regional acceptance only during overnight hours; maintaining all remain CITAC locations during daytime hours.**

A third option for expansion of the Assessment Site program is a combination of the current program and the development of regionally placed receiving center facilities.

CIT Assessment Sites exist in almost every CSB catchment area, and because of this most localities have become accustomed to using the diversion program. Continuing to operate an Assessment Site in each current location while also creating the much-needed receiving centers is not cost effective and is redundant. A compromise would create regional receiving centers based on the same criteria as option 2, however each locality would also maintain its individual

Assessment Site for a specified duration each day. The localities with the highest utilization would still be the location for receiving centers as with option 2, however the surrounding localities would utilize the regional location for any mental health emergencies that occur after their local Assessment Site's designated daily closing time.

Estimated costs for this option are shown in Figure 5.

**Figure 5:** Total Estimated Costs for Option 3

| Proposal | Personnel Estimate for Regional Sites | Personnel Estimate for Remaining Expanded Sites | Facility, pharmacy, other | Total CITAC Costs for this option: | Increase in Revenue due to option: | Total Estimated Medicaid Revenue for all CITACs: | Total Costs including Revenue Offset |
|---|---|---|---|---|---|---|---|
| Hybrid Regional 24/7 and Expanded hours | $14,082,416 | $10,736,755 | $1,993,000 | $26,812,171 | $250,888 | $3,313,815 | $23,498,356 |

The mobile crisis program in development through DBHDS will help to create an expansive safety net that concurrently aims to keep consumers from reaching emergency status. It is important to address the needs of individuals in crisis without resorting to arrest or unnecessary trips to the emergency department when appropriate, timely, and effective evaluation and treatment can occur with a crisis receiving center. The benefits for the individuals in crisis, the reduction in strain on the behavioral health system and medical facilities, and the shifting of responsibility for those with mental illness from jails to treatment facilities makes this an effective option.

## Additional Considerations for Implementation in Virginia

Most of the current Assessment Site programs do not operate twenty four hours, seven days a week. The Office of Forensic Services works with programs to ensure they can meet staffing needs of proposed Site hours, however, even with careful consideration of the needs and examination of available funding, rural localities are frequently at or near their personnel capacity. The staffing levels for law enforcement, clinical staff, peers, and other positions that support the Site vary based on a locality's needs and ability to provide the workforce. A regional approach to crisis receiving centers that utilizes a wider geographical pool of personnel resources may reduce the pressure of staffing a larger number of program Sites.

### Medical Clearance

Obtaining a medical clearance is a requirement prior to admission into inpatient psychiatric facilities in Virginia. This ensures that a consumer with emergent or challenging medical needs is not placed in a mental health hospital that lacks the ability to provide more complex medical

intervention. In the vast majority of cases, this process takes place in busy emergency departments, leading to extended wait times for consumers who are best served in a calming space. The current process also adds costs for patients and the hospitals where the pre-admission medical clearances take place.

A number of hospital corporations operate in the Commonwealth, and most of them are in partnership with a CIT Assessment Site program. This relationship has shown to be beneficial to the locality and its public services as well as for the hospitals in most cases as well. With different partners comes different leadership, rules, and expectations. One possible challenge of bringing consumers together into a twenty-three hour regional facility is the expectation that medical clearance needs may rise in the host locality. A properly staffed and supplied receiving center should be able to provide basic medical services on-site, curtailing most additional burden anticipated by the local hospitals.

**Legal Considerations**

The current emergency custody (ECO) statute in Virginia provides for eight hours after enacting an ECO to conduct a pre-admission screening evaluation and determine a suitable course of action for the consumer. This time period is inclusive of a bed search if it is deemed necessary. During the search for a bed, it is not uncommon for the clinician to contact as many as twenty inpatient facilities to locate a suitable bed. Concurrent to this, the required medical clearance can take place, however, even with simultaneous processes, many CSBs report difficulty with the short amount of time. Research on ED boarding and psychiatric emergency facilities has shown that in many cases a time period of up to 23 hours may provide the opportunity for a consumer with medical and psychiatric support to stabilize sufficiently that involuntary inpatient treatment is not necessary (Zeller, 2016).

An extended ECO time may allow for substantial services which may further de-escalate crises and even reduce involuntary hospitalization. Because of the history of involvement of law enforcement in the emergency custody process in Virginia, any consideration of a change would likely see its maximum success from a synchronous or even preemptive addition of crisis receiving centers and all that they offer. De-escalation of a crisis and subsequent avoidance of hospitalization can lead to long-term recovery at lower cost while also returning law enforcement to traditional policing duties.

The ECO is discussed to provide understanding of the connections inherent in crisis response, however the intent of *this* report is to neither request nor suggest any alterations to existing sections of the Virginia ECO code. It would be remiss to not point out that any discussion of a 24-hour ECO should include serious consideration for the workload of law enforcement, absent additional supports being in place.

**Alternative Transportation and Assessment Sites**

Finding an inpatient bed for consumers under a temporary detention order often results in a long drive from the consumer's community to a distant hospital. Law enforcement have until recently always been required to conduct these transports which puts a significant strain on resources.

The alternative transportation program managed by DBHDS seeks to relieve that burden by conducting the transports instead of law enforcement. Any additional growth of the Assessment Site program is highly likely to also utilize the alternative transportation capabilities which will help to temper any additional burden on law enforcement.

The relationships developed through CIT collaborations are what allowed the Assessment Sites to achieve such success. Increases in the knowledge and skills through the training program have given us a view into how a successful "front door" program can be built upon to provide more comprehensive access to consumers in all stages of crisis. The relationships created in the building of CIT programs also provide a foundation for the building of additional service models to support the crisis system.

# Appendix A

**Definitions**

The following terms are common when discussing emergency mental health and used in this report.

**Emergency Custody Order (ECO):** Va Code §37.2-808 provides that for a person who appears to be suffering from a mental health crisis and may be a harm to themselves or others, or may be incapable of providing for their own safety, may require hospitalization for treatment, and is unwilling or unable to decide to go on their own will, may be taken into custody by law enforcement either on-view or on the order of a magistrate issued ECO. The time period for an ECO is 8 hours during which a pre-admission screening must occur by a qualified mental health clinician of the local community services board.

**Temporary Detention Order (TDO):** Va Code §37.2-809 authorizes a magistrate to issue an order directing a person in a mental health crisis to be involuntarily committed for psychiatric evaluation and stabilization for 72 hours.

**Crisis stabilization services**: Any of the following, alone or in combination: telephone services, walk-in services, mobile crisis, short-term residential treatment, 23-hour Crisis Stabilization Units, the Living Room Model, Crisis Stabilization Units and psychiatric hospitalization.

**Crisis Stabilization/Crisis Stabilization Unit (CSU):** The definition from *Behavioral Health Crisis Stabilization Centers: A New Normal* provides a thorough description:

> *A direct service that assists with deescalating the severity of a person's level of distress and/or need for urgent care associated with a substance use or mental health disorder. Crisis stabilization Services are designed to prevent or ameliorate a behavioral health crisis and/or reduce acute symptoms of mental illness by providing continuous 24-hour observation and supervision for persons who do not require inpatient services. Short-term crisis residential stabilization services include a range of community-based resources that can meet the needs of an individual with an acute psychiatric crisis and provide a safe environment for care and recovery.*

**The Living Room**: The Living Room Model is a walk-in respite center for individuals in crisis. These home-like environments offer a courteous and calming surrounding for immediate relief of crisis symptoms and to avert psychiatric hospitalization (Heyland, Emery, & Shattell, 2013). The goal of treatment in the Living Room Model is to provide a safe and secure environment where multidisciplinary professionals and peers with similar experiences provide treatment services. The Living Room Model highlights peers working or collaborating directly with clients to assist with symptom relief[1] (Action Alliance, 2016). The Living Room Model is distinctly different from the 23-hour crisis stabilization units. The Living Room Model provides crisis resolution and treatment for those who need more than 24 hours to resolve the issues that brought them into crisis, are short term and provide intensive treatment."

**Psychiatric Emergency Center (PEC):** This refers to a facility that typically has the capability to accept persons in crisis from many referral sources. They are also often called Crisis Receiving Centers or Psychiatric Emergency Services, and combine aspects of many parts of the existing crisis system but located together under one roof and provide ease of access and hand offs to appropriate services. Many models include a basic medical clinic or at least the ability to conduct basic medical assessments. This serves to rule out a medical need as the reason for crisis symptoms as well as ensure someone is stable enough to transition to the next step of care in the process. A PEC is typically staffed with nurses, mental health clinicians, mental health technicians, Peers (persons with lived experience to help guide those currently in crisis), a psychiatrist or immediate access to a psychiatrist, and case navigators. PECs are outpatient facilities, so even though they are accessible twenty-fours a day, each individual may remain for up to twenty-three hours, fifty-nine minutes for stabilization, treatment, and hand-off to the appropriate level of care.

**Psychiatric Boarding**: When psychiatric patients for whom inpatient treatment has been deemed necessary are kept in the emergency department after they have already been medically cleared to proceed to the receiving psychiatric bed. Boarding often occurs on gurneys, in hallways, and during this time patients are not receiving psychiatric treatment, rather just observation to ensure they remain medically stable.

# Appendix B

## Supporting Research

There has been a significant amount of research about the crisis continuum including law enforcement interventions, efficacy of crisis stabilization, and psychiatric emergency services. The overwhelming consensus in research reviewed for this report is that providing psychiatric stabilization services benefits those in crisis as well as the crisis system and related public entities including the behavioral and criminal justice systems. Research highlights challenges associated with the process and offers effective strategies to manage the responses. SAMHSA provides us with a succinct description of the strategy most supported in this report, 23-hour crisis observation:

> "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 urgent care. The primary objectives of this level of care are prompt assessments, stabilization, and/or a determination of the appropriate level of care. The main outcome of 23-hour observation beds is the avoidance of unnecessary hospitalizations for persons whose crisis may resolve with time and observation (SAMHSA, 2012)."

In 44 of the 50 states and in the District of Columbia, a jail or prison houses a larger number of persons with serious mental illness than the largest remaining psychiatric hospital (Fuller, et al., 2016). This is an alarming statistic that shines a light on the need for ever-expanding crisis and diversion services. Furthermore, almost 90% of ED physicians surveyed said they saw psychiatric patient boarding in the ED because of the lack of sufficient psychiatric beds to which to transfer patients. A major concern with this statistic is that emergency departments do not typically provide psychiatric care that is sufficient to support successful treatment and recovery (Alakeson, et al., 2010).

A 2013 study tracked all involuntary mental health patients in five community hospitals. Over 75% of those patients transferred to the psychiatric emergency service (PES), comparable to Assessment Sites, were able to be discharged to community based care, *leaving less than 25% requiring inpatient hospitalization*.

One reason a high percentage of mental health related cases arriving at the emergency department end up as inpatient admissions is that there is also a lack of mental health resources and staff for lesser restrictive services to which consumers in crisis can be referred (Zeller, Calma, & Stone, 2014). Furthermore, time spent waiting in the ED can have negative effects up to and including the decompensation of the psychological state of the consumer awaiting treatment.

## Cost Benefits of Crisis Receiving Centers

One study has found that the average cost for crisis stabilization was $1,085 in 2013 (Wilder, 2013). The reported average cost of boarding psychiatric patients in the emergency department is

estimated by the Treatment Advocacy Center at $2,264 (Hepburn, 2017). The 2013 study also calculated a $2.16 return on every dollar invested in crisis stabilization.

Determining the efficacy of a 23hour program in Virginia presents some challenges. A key concern is that the time allowed under the current ECO law creates some difficulty in producing data on potential for prevention of inpatient hospitalization. With only eight hours allowed for a pre-admission screening and evaluation, there is likely to be insufficient observation and treatment time of each guest to produce consistent data to duplicate results in other areas. The prevailing research is promising for jail diversion and recovery, but a pilot program, optimally in both urban and rural localities to evaluate, would be the most effective way to gather enough data prove efficacy in Virginia.

## Existing Crisis Receiving Center Programs

A number of models for lesser restrictive care have demonstrated success around the United States in recent years. These approaches allow for law enforcement and other acute referrals as well as family, medical provider, and walk-in clients to crisis centers.

### Illinois Living Room Model

The Living Room in Illinois aligns directly with the Crisis Now model with a recovery-oriented principle that avoids the emergency department for consumers in crisis.

In one study of the model, 93% of visits were deflections from what would have otherwise been a trip to the emergency department. Because a high percentage of guests carry no insurance, the state estimated a savings of $550,000 from 213 ED deflections.

The guests contacted for this study reported that in addition to the chaos inherent in an emergency room environment, they also did not feel that they received priority for triage. The trauma-informed principles that guide living room and all receiving center models focus on immediate triage, and because of this, the guest has the maximum amount of time available for treatment. While guests are only able to make use of the services here for up to 23 hours 59 minutes on an individual basis, the program resources are available 24 hours a day for guests in crisis. This report contains an option for 24 hours CIT Assessment Sites in their current form, but it is important to note here that 24 hours access with no other changes would likely not produce the same results as the living room because the environment is limited in available services.

One concern with the living room model is program capacity. The number of staff are limited, and the intensive services provided make it necessary to limit the total number of guests at any one time. Consideration must be given to ensuring the receiving center does not mimic the chaos of a busy emergency department.

### R.I International

R.I. International operates facilities in multiples states they refer to as “Recovery Response Centers”. These centers incorporate aspects of the Living Room model as described on the R.I. website:

*RI is known for creating the best possible recovery experience, using healing spaces with recliners, soft colors and a home-like atmosphere. The teams, comprised of doctors, nursing staff, and peers with lived experience, weave recovery, clinical, and medical services together, providing comprehensive care. RI makes every effort to eliminate seclusion and restraint and to serve all people regardless of level of acuity, without resorting to physical interventions. Peer-operated "Living Room" programs ensure that participants are paired with a team of Peer Support Specialists in recovery. Each guest is encouraged to work with the team and empowered to develop their own recovery plan.*

The Peer support model, in conjunction with calming space, is an extension of what many current CIT Assessment Site programs already provide. Addition of available services to this model including on-site nursing, access to a prescriber, and other medical capabilities would allow for consumers to receive comprehensive assessment at a single location. This reduces stress on consumers and allows for a streamlined decision making process for anyone who is involved in the referral process.

**The Center for Health Care Services**

As perhaps the most well-known example, the Crisis Care Center is often looked to as a model for communities that are interested in beginning psychiatric receiving center programs. Located in San Antonio, TX the Crisis Care Center offers a 16-bed walk-in mental health clinic with 24-hour assessment capability and warm handoffs to appropriate care. Onsite they have either a psychiatrist or psychiatric nurse practitioner, licensed clinical social workers, licensed professional counselors, and registered nurses with psychiatric specific training.

The inception of Bexar County's jail diversion was borne partly from desperation regarding overcrowding in the Bexar county jail. An early report on the Bexar county jail diversion program pointed out that the cost of treating someone with mental illness in a recovery setting was less than one fourth of the daily cost of incarceration. It drops to less than $1/20^{th}$ the cost when taking into account the extra supervision, medication, and housing needs of someone who must be placed into a jail's psychiatric pod or unit. (*ibid.*) Between 2003 and 2006, the county estimated it saved $3.8- $5 million in criminal justice spending by diverting 3,674 consumers from the jail into appropriate behavioral healthcare.

The Crisis Care Center serves as a "no wrong door" approach to consumers in need, accepting them from the street, from law enforcement, and as medical referrals, all of which have allowed for a very high number of diversions. Before the Center, law enforcement officers routinely spent 12-14 hours on average with consumers in crisis. That has been reduced to an average of just over an hour. This quick return to duty is also achieved by the CIT Assessment Sites in Virginia, but current funding availability does not allow for additional medical and psychiatric supports on location that are provided at The Center.

**Reducing Unnecessary Inpatient Hospitalization in Virginia**

Research strongly suggests that a significant number of criminal justice and emergency department diversions can take place at receiving centers in Virginia. In addition, a significant percentage of consumers who would have been detained for 72 hours under the current system may after 23 hours be released into their local community with a lower acuity level and linkage to lesser restrictive services (Zeller, Calma, & Stone, 2013). The goal of 23 hour intervention and observation is to help the consumer stabilize to the point where inpatient hospitalization is no longer required. Aside from funding, there are few roadblocks to making this type of critical service available to a great number of the residents of Virginia.

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