COMMONWEALTH of VIRGINIA

NELSON SMITH
COMMISSIONER

DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 786-3921
Fax (804) 371-6638
www.dbhds.virginia.gov

November 1, 2022

To: The Honorable Janet D. Howell, Chair, Senate Finance & Appropriations Committee
The Honorable Barry D. Knight, Chair, House Appropriations Committee

From: Nelson Smith, Commissioner, DBHDS

CC: John Littel, Secretary, Health & Human Resources
Susan E. Massart, Fiscal Analyst, House Appropriations Committee
Mike Tweedy, Fiscal Analyst, Senate Finance and Appropriations Committee

RE: § 37.2-817.2.D.4 Implementation of 2014 ECO/TDO Law Changes

Pursuant to § 37.2-817.2.D.4, enclosed is the annual report on the implementation of changes made in 2014 to Virginia's emergency custody order (ECO) and temporary detention order (TDO) laws. Specifically, the General Assembly language states:

4. That the Department of Behavioral Health and Developmental Services shall submit an annual report on or before June 30 of each year on the implementation of this act (SB260) to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees. The report shall include the number of notifications of individuals in need of facility services by the community services boards, the number of alternative facilities contacted by community services boards and state facilities, the number of temporary detentions provided by state facilities and alternative facilities, the length of stay in state facilities and alternative facilities, and the cost of the detentions in state facilities and alternative facilities.

Staff at the department are available should you wish to discuss this request.

Virginia Department of Behavioral Health & Developmental Services

Annual Report on the Implementation of 2014 ECO and TDO Law Changes

June 30, 2022

DBHDS Vision: A Life of Possibilities for All Virginians

Annual Report on the Implementation of 2014 ECO and TDO Law Changes

Preface

This report is submitted in response to Senate Bill 260 (Chapter 691, 2014), which amended and added several sections of the *Code of Virginia* § 37.2-817.2.D.4 related to emergency custody and temporary detention of adults and minors. The fourth enactment clause of this legislation reads as follows:

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

Table of Contents

Introduction

In response to concerns regarding Virginia's behavioral health crisis response system, the General Assembly enacted SB 260 in 2014 to ensure that every individual who met the criteria for temporary detention was provided access to inpatient psychiatric care. The new laws made sweeping changes in Virginia's emergency custody order (ECO) and temporary detention order (TDO) laws. The new laws included changing the ECO timeframe to eight hours, creating the "Bed of Last Resort" requiring a state hospital to admit individuals under TDOs for whom no private bed was found during the ECO period, and updating other communication and notification requirements. Since the enactment of the new ECO and TDO laws, the Department of Behavioral Health and Developmental Services (DBHDS) partnered with stakeholders, including the community services boards (CSBs), state hospitals, private hospitals, magistrates, law enforcement, and others to monitor the requirements set forth in the ECO and TDO laws passed in 2014. An overview of the legislation can be found in Appendix A. The most salient impacts of the laws for Virginia's behavioral health crisis response system are described below.

- **Rising State Hospital Admissions** – Since the law changes in 2014, there has been a continual increase in the daily number of state hospital admissions of individuals under a TDO between FY 2013 and FY 2019, growing by 389 percent between during that time. This was specifically related to the Bed of Last Resort change. There was a slight decrease in state hospital TDO admissions in FY 2020 and FY 2021, with a more significant increase in FY 2022 as some state hospital beds were not operational due to COVID-19 and a state hospital staffing crisis.
- **State Hospital Bed Closures** – In FY 2022, state hospitals experienced increased census and critical staffing shortages. The staffing shortages reached critical levels at the beginning of FY 2022, prompting a temporary admissions closure of five state hospitals while expediting appropriate discharges to move staff/patient ratios to safer levels. While all of these hospitals re-opened to limited admissions within about six weeks, currently 232 state hospital beds still remain offline due to a lack of sufficient direct care staff to operate them. There are 126 beds that have been safely reopened since the closure. At full capacity, the state hospitals have 1,380 adult and children's beds.
- **TDO Admissions Delays** – When no state bed is open for a Bed of Last Resort admission, the state hospitals do not deny the admission but the admission is delayed until a bed can be freed. In FY 2022, there were at least 7,242 patients who experienced this delay in admission. These patients waited an average of 43.2 hours for a bed. In 55 percent of these cases, a private bed was found for the patient before a state bed was made available.
- **Alternative Custody** – Virginia law requires law enforcement to maintain custody during the ECO and TDO period except in cases when a Magistrate allows alternative transportation. When patients were waiting for a bed during times of delayed admission, so were law enforcement. During the 2022 General Assembly Session, DBHDS and the Administration worked with law enforcement to allow an alternative custody provider to relieve law enforcement and take custody of a person under a TDO. DBHDS also developed a new pilot opportunity to allow off-duty officers to accept custody of patients waiting for a state hospital TDO bed. In addition, the General Assembly required a workgroup to recommend more impactful and longer-term solutions to the custody problem. The workgroup started at the end of FY 2022.

- **Decreased Temporary Detention Orders** – The number of temporary detention orders (TDOs) issued daily remained relatively stable over several years but decreased during the pandemic. The number of TDOs issued statewide also decreased during FY 2022. The reason for this change is currently unknown but is being monitored.
- **Decreased Evaluations** – Following an initial increase in the second year, the average daily number of face-to-face evaluations completed by CSB emergency services clinicians for involuntary hospitalizations since FY 2016 has decreased steadily.

Changes to ECOs, Evaluations and TDOs

This section describes the standards and protocols developed in response to the new laws and summarizes the impact of the legislation in key areas.

The number of face-to-face evaluations and TDOs were relatively steady from FY 2015 – FY 2020. However, TDO admissions to state hospital increased dramatically between FY 2013 and FY 2019, growing from 1,359 TDO admissions in FY 2013 to 6,649 admissions in FY 2019, for a growth rate of 389 percent. TDO rates to state hospitals decreased slightly in FY 2020 and FY 2021. This was likely related to the impact of the COVID-19 pandemic. Thus far in FY 2022, evaluation and TDO rates have decreased slightly, while the rate of TDO admissions to state hospitals decreased significantly. This can be attributed to the state hospitals being forced to delay admissions due to limited bed capacity because of critically low staffing levels. While private hospitals have increased the number of TDO admissions they have accepted thus far in FY 2022, historically the percentage of total TDO admissions accepted by private hospitals had declined, from 91 percent of all TDO admissions in FY 2015, to 76 percent in 2019. This is one of the reasons for the increase in TDO admissions to state hospitals since the enactment of Bed of Last Resort legislation. Figure 1, below, details these changes since FY 2013.

Figure 1. Evaluations, TDOs, and TDO Admissions, FY2013 – FY2022

	Average Daily Evaluations	Average Daily Issues TDOs	Average Daily TDO admissions	Total Evaluations	Total TDOs Issued	Total TDO Admissions	% Evaluations resulting in TDOs	% Estimated TDO admits to private/community hospitals**	% TDO Admits to State Hospitals
FY2013	-	-	3.7	-	-	1,359	-	-	-
FY2014	-	-	4.3	-	-	1,579	-	-	-
FY2015	229	68	6	83,701	24,889	2,192	29.7%	91.2%	8.8%
FY2016	262	71	9.6	96,041	25,798	3,497	26.9%	86.5%	13.5%
FY2017	256	71	10.5	93,482	25,852	3,827	27.7%	84.6%	15.4%
FY2018	251	70	14.7	91,718	25,679	5,357	28.0%	80.6%	19.4%
FY2019	239	69	18.2	87,490	25,205	6,649	28.8%	76.1%	23.9%
FY2020	208	64	14.8	75,805	23,512	5,412	31.0%	77.0%	23.0%
FY2021	187	63	14.4	68,421	22,864	5,240	33.4%	77.1%	22.9%
FY2022	178	58	6.3	48,837	15,828	1,734	32.4%	89.0%	10.96%

**** Note:** DBHDS receives data on the total number of TDOs statewide and the number of TDOs admitted to state hospitals, however the number of TDOs admitted to the private/community hospitals are an estimate based on the aforementioned data. DBHDS is aware that during the COVID-19 pandemic, a number of patients have been released from TDOs, eloped from emergency rooms, or other disposition without an in-patient admission to private/community hospital setting in FY 2022. DBHDS will work with stakeholders to develop an efficient way to capture this data moving forward.

Emergency evaluations are comprehensive in-person clinical examinations conducted by CSB emergency services staff for individuals who are in crisis. These evaluations may be conducted in person or electronically by two-way video and audio communication. An ECO is issued by a magistrate authorizing a person to be taken into custody for up to eight hours and transported for an evaluation. This evaluation determines if the individual meets the criteria for temporary detention and assesses the need for hospitalization and treatment. Figures 2 and 3, below, show the frequency of ECOs and CSB emergency evaluations since FY 2017.

Figure 2: Number of Emergency Custody Orders, FY 2017-2022 (first three quarters)

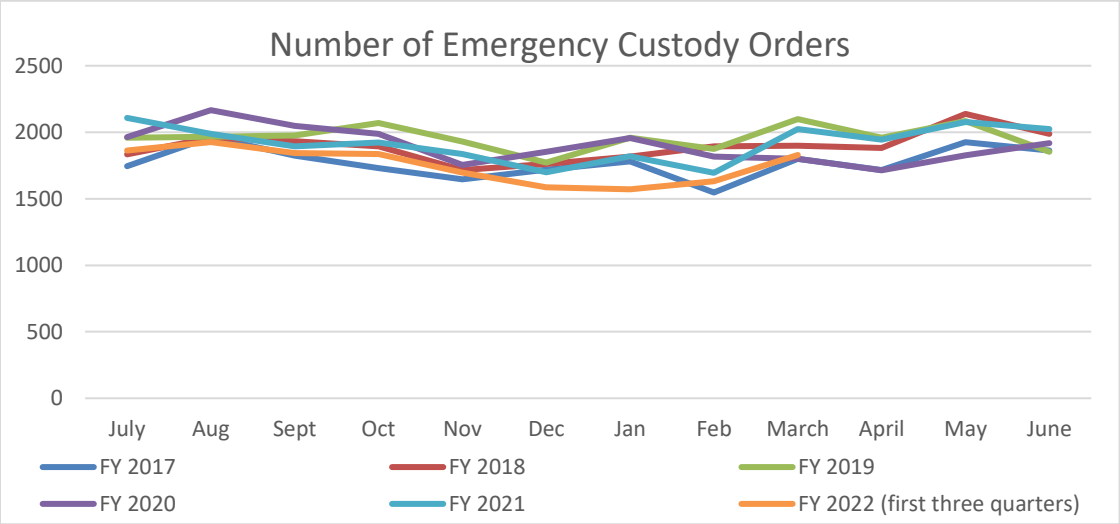
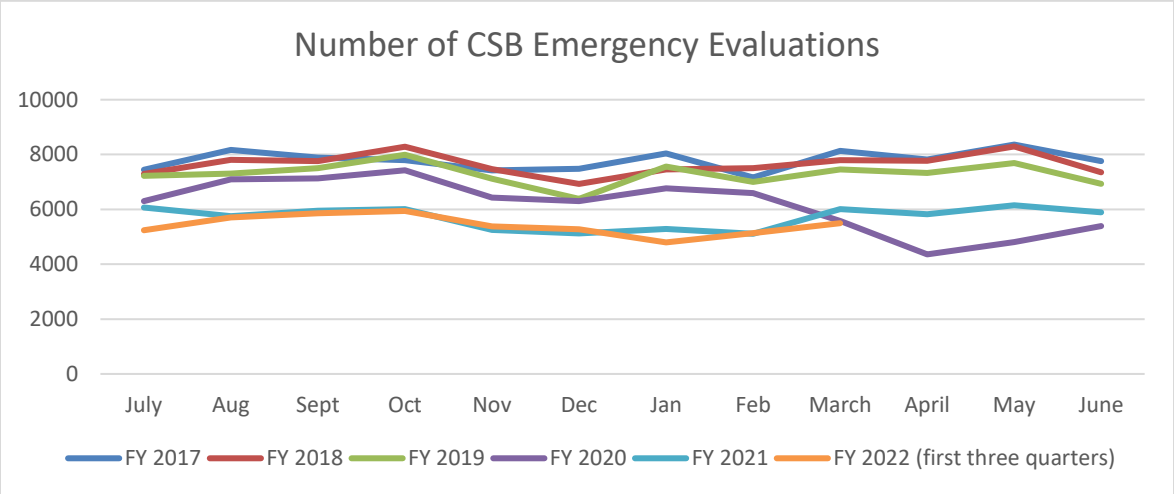


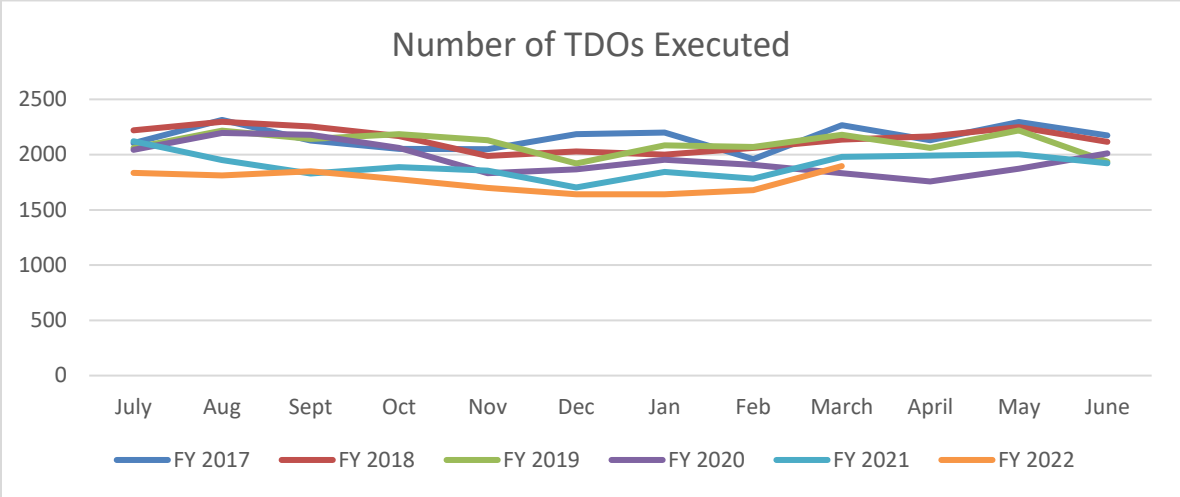
Figure 3: Number of CSB Emergency Evaluations, FY 2017 – 2022 (first three quarters)



During the ECO period, if an individual is determined to meet temporary detention criteria, a TDO is issued by a magistrate authorizing a person to be taken into custody and transported to a psychiatric facility. A TDO is considered executed at the time when the individual is served with the TDO and taken into custody for the purpose of being transported to the hospital for admission. Most CSB emergency evaluations do **not** result in a recommendation for a TDO.

Figure 4, below, shows the number of executed TDOs for FY 2015 through the first three quarters of FY 2022.

Figure 4: Number of TDOs, FY 2017 – FY 2022 (first three quarters)



The daily number of TDOs executed has remained relatively consistent after an initial increase in the number of TDOs issued in the second year of the implementation of the new laws; however, FY 2022 is on track to show a slight decrease in executed TDOs.

In addition to data shown above, the CSBs also collect data on critical events associated with CSB emergency services utilization, TDOs, and factors contributing to these events. DBHDS requires this data to be submitted monthly by each CSB and geographic region. DBHDS also requires case-specific reports from individual CSBs within 24-hours of any event involving an individual who has been determined to require temporary detention for which the TDO is not executed for any reason. These reports are aggregated and analyzed on a monthly basis.

ECO and TDO Law Changes and Bed of Last Resort Impact on State Hospitals

State Hospital Admissions – Overall, admissions to state hospitals continued to increase significantly after the passage of the new laws in 2014 and prior to the COVID-19 pandemic. FY 2022 data reflects an overall decrease in available in-patient psychiatric beds across seven state hospitals due to critical direct care staffing levels. However, state hospitals have continued to admit forensic patients throughout the pandemic.

In addition, state hospitals have experienced a dramatic increase in patient drop-offs by law enforcement without proper medical clearance, state hospital acceptance, or an available staffed bed. This has resulted in 460 patients being dropped off across five state facilities in southwest Virginia from June 1, 2021 to June 10, 2022. Of the 460, 401 were dropped off at two state hospitals. DBHDS is actively working with stakeholders to reduce the impact of delayed admissions for law enforcement with alternative custody options. Continued drop-offs further

delay admissions for patients who have been waiting in emergency rooms for inpatient beds for longer periods, deferring treatment. Figure 5, below, shows the trend in state hospital admissions for FY 2017 through May of FY 2022.

Figure 5: Number of State Hospital (SH) Admissions, FY 2017 - FY 2022 (End of May)

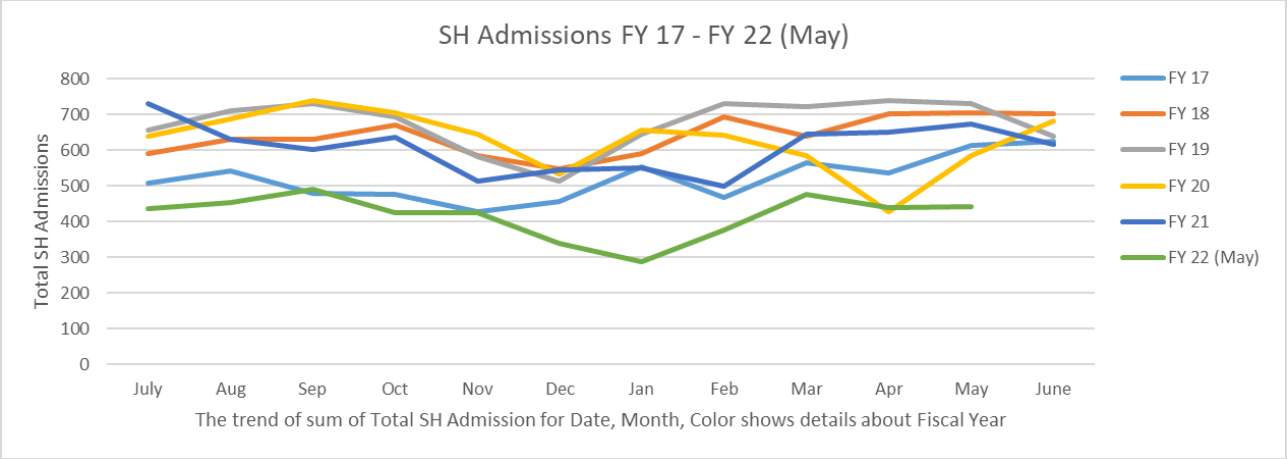
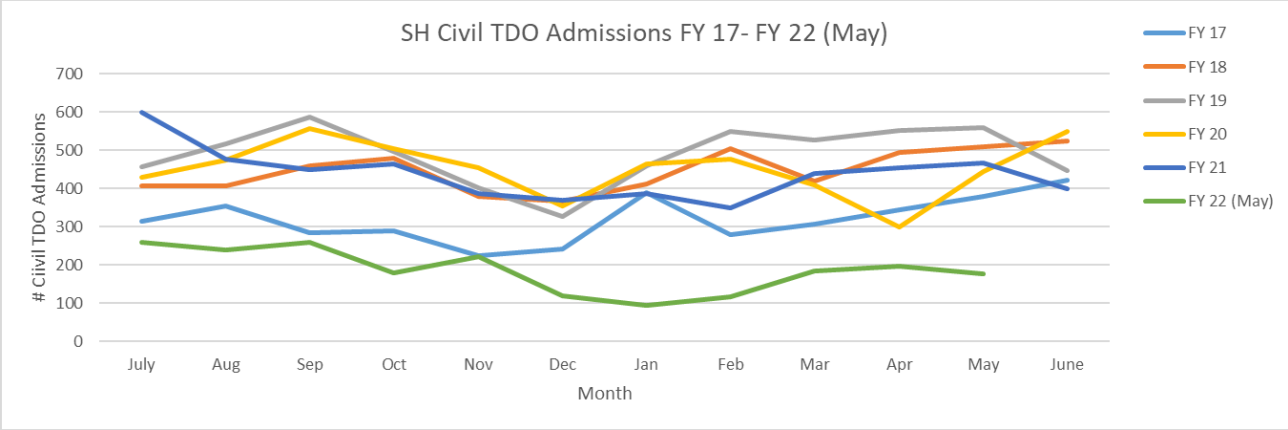


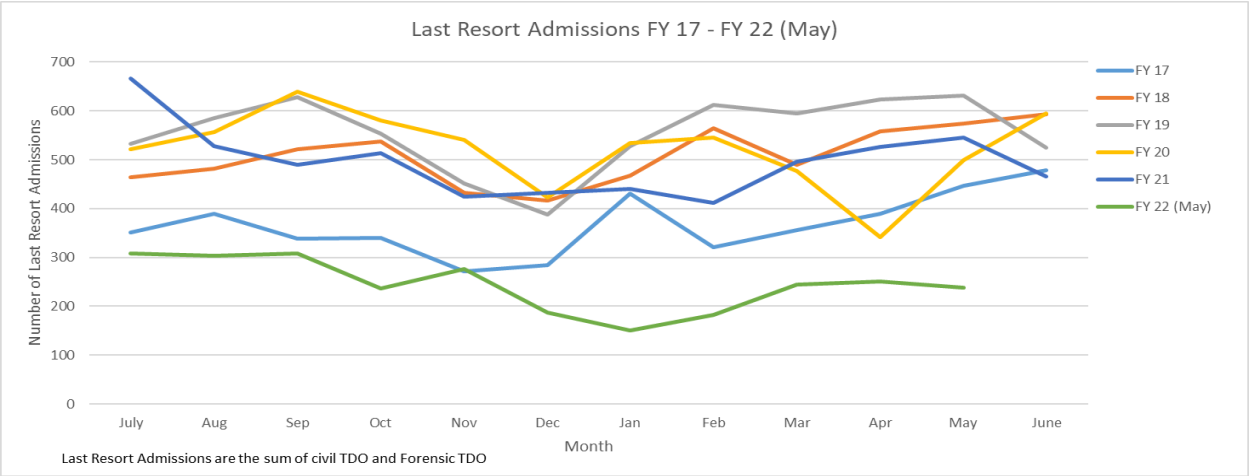
Figure 6, below, shows only civil TDO admissions. TDO admissions to state hospitals have increased dramatically since 2014. FY 2022 data reflects an overall decrease in available in-patient psychiatric beds across seven state hospitals due to critical direct care staffing levels. State hospitals also continued to admit forensic TDOs throughout the pandemic.

Figure 6: Number of SH TDO Admissions, FY 2017 – FY 2022 (End of May)



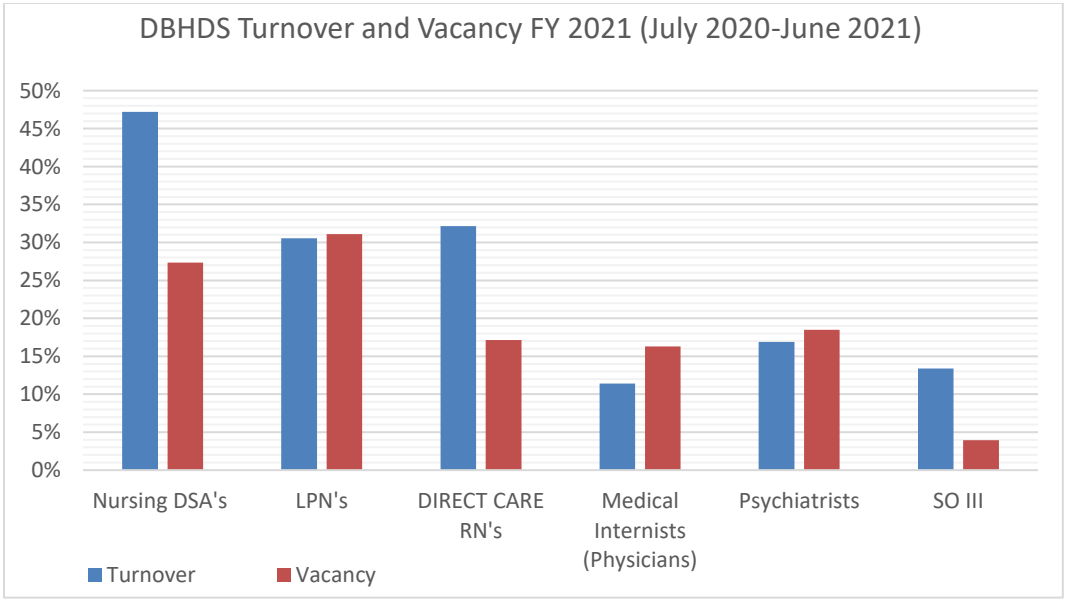
Number of "Last Resort" Admissions – From FY 2015 to FY 2019, there was an unprecedented increase in the number of last resort admissions to the state hospitals. This trend decreased slightly in FY 2020 and FY 2021, which may be attributed to the COVID-19 pandemic. In regards to private hospital TDO admissions, there was a significant decrease in the percentage of TDO admissions accepted by private hospitals between FY 2015 and FY 2019, and this remained relatively steady in FY 2020 and FY 2021. Private hospitals began accepting more TDO admissions in FY 2022, which correlates with the decreased availability of state hospital beds. More detail is provided below in Figure 7.

Figure 7: Last Resort Admissions, FY 2017 – FY 2022 (End of May)



State Hospital Staffing Impact – Virginia's state hospital system is operating at an 85 percent or above utilization rate of total bed capacity; however, the hospitals are typically at 100 percent capacity or above staffed bed capacity ongoing. Research and national standards show that operating at 85 percent of capacity is optimal for both patients and staff. Utilization rates significantly above 85 percent can compromise the quality of care and impact patient and staff safety. Staff turnover and vacancy rates have grown along with the increase in average daily census at the state hospitals. The vacancy rates have increased as the state hospitals struggle to retain current staff and successfully recruit new staff. Figure 2 shows the turnover and vacancy rates for key direct care positions in FY 2021. Turnover and vacancy rates for all direct care positions continues to rise, shown below in Figure 8. Some state hospitals continue to experience vacancy rates as high as 60 percent for direct care positions. The major factors impeding recruitment and retention of direct care staff continue to be safety concerns, high patient acuity, mandatory overtime, and poor compensation.

Figure 8: FY 2021 Turnover and Vacancy Rates for Hospital Key Positions



In July 2021, state hospital staffing declined to a level that was unsafe for patients and staff alike, resulting in the previously mentioned temporary closure of five state hospitals. Since July 2021, DBHDS and state facilities have secured staffing agency contracts to supplement direct care staffing to maintain safer staffing levels and to provide treatment and care. The state budget recently passed by the General Assembly provided an increase in compensation for direct care positions to the 50th percentile of market rate.

State Hospital Bed Closures – Since FY 2020, state hospitals have experienced increased census and critical staffing shortages. The staffing shortages reached those critical levels at the beginning of FY 2022, prompting the temporary closure of close five state hospitals to admissions while expediting appropriate discharges to move staff/patient ratios to safer levels. While those hospitals reopened to admissions about six weeks later on a limited capacity, DBHDS has continued to operate only staffed state hospital beds, which has resulted in significant delayed admissions and a decrease in TDO admissions. Currently, 232 state hospital beds still remain offline due to a lack of sufficient direct care staff to operate them. This decrease in available state hospital beds has significantly influenced the number of state hospital admissions in FY 2022, specifically civil temporary detention order (TDO) admissions. State hospitals have continued to admit forensic patients throughout the COVID-19 pandemic.

Extraordinary Barriers to Discharge List – The lack of 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. In FY 2019, the number grew to an average of 13 percent of all individuals in state hospitals, and increased even more to 17 percent in FY 2020. In FY 2021 and FY 2022, the percentage of individuals in state hospitals that were considered clinically ready for discharge, but unable to leave due to a lack of appropriate community resources, remained stable at 16 percent.

Length of Stay for Temporary Detention – One of the elements of the new laws was extending the maximum period of temporary detention for adults from 48 hours to 72 hours. Corresponding data are not available from private psychiatric hospitals. More detail is shown below in Figure 9.

Figure 9: Length of Stay for Civil TDO Admissions, FY2014 – FY2022 (End of December)

Fiscal Year	ALOS for Individuals under a CIVIL TDO and discharged without a civil commitment	Overall ALOS for Individuals under a CIVIL TDO, discharged without commitment AND admitted under a civil commitment after hearing
FY2014	4.43	56.85
FY2015	2.25	52.68
FY2016	2.31	48.07
FY2017	2.51	41.62
FY2018	2.56	38.91
FY2019	2.72	41.09
FY2020	2.50	41.79
FY2021	3.19	35.69
FY2022 (first half)	2.34	33.77

Fiscal Impact of 2014 ECO and TDO Laws on State Hospitals

Treatment Costs for Individuals under Temporary Detention – DBHDS is unable to provide a complete and comprehensive estimate of the full cost of temporary detention because costs are paid from various sources, including private insurance, Medicare, Medicaid, and other funds. There is no available source for all this information. Figure 10, below, shows the costs for temporary detention in state hospitals since FY 2014.. In FY 2021, the cost for civil TDO beds at state hospitals decreased by one percent when compared to the total costs of FY 2020.

Figure 10: Costs for Individuals under TDO Admitted to State Hospitals for FY 2014 – Mid-Year 2022

Total cost for TDO Bed Days by FY at State Hospitals			
	Total Civil TDO Bed Days	Average cost for a Bed Day	**Total Cost for Civil TDO Bed Days[1]**
FY 2014	82,151	$723.83	$59,463,358.33
FY 2015	95,477	$747.14	$71,334,685.78
FY 2016	125,208	$757.86	$94,890,134.88
FY 2017	151,599	$755.50	$114,533,044.50
FY 2018	201,844	$811.00	$163,695,484.00
FY 2019	216,448	$820.00	$177,487,360.00
FY 2020	214,182	$979.63	$209,819,112.66
FY 2021	221,153	$939.16	$207,698,051.48
FY 2022 (7/1/21-12/21)	73, 383	$1,190.17	$87,338,245.11

[1] *Civil bed days times average bed day cost*

A more comprehensive measure of the cost of temporary detention includes the total charges to the Involuntary Commitment Fund (IMCF) administered by Department of Medical Assistance Services (DMAS). An individual's TDO stay may be covered by private insurance, by other public insurance, by Medicaid, by a Medicaid Managed Care Organization, or it may not be covered. When there is no payer available, the psychiatric hospital submits its claims to DMAS for payment through the IMCF, which is funded entirely by general fund dollars. The IMCF pays the hospital and physician costs for uncovered costs associated with individuals hospitalized under a TDO. Figure 11, below, shows statewide expenditures paid by DMAS through the IMCF to private and state psychiatric hospitals in Virginia for temporary detention services. The Medicaid Fund column represents TDO costs covered by Medicaid. The total IMCF and Medicaid expenditures for FY 2015 through FY 2021, and the first two quarters of FY 2022.

Figure 11: Reimbursements for Temporary Detention from the ICMF and Medicaid (Source: DMAS)

TDO Expenditures	ICMF TDO Fund	Medicaid Fund
FY 2015	$14,608,199.46	$1,460,856.37
FY 2016	$16,146,916.20	$1,089,591.37
FY 2017	$17,633,225.52	$1,292,112.50
FY 2018	$16,987,753.57	$1,127,452.49
FY 2019	$17,798,267.70	$1,116,459.45
FY 2020	$11,859,484.19	$1,707,139.33
FY 2021	$13,931,423.35	$1,111,507.47
FY 2022 (Jul-Dec 2021)	$5,658,577.31	$535,839.42

LIPOS Bed Usage – Local Inpatient Purchase of Services (LIPOS) contracts with private hospitals to provide acute, short-term mental health psychiatric inpatient services instead of admitting these individuals to inpatient treatment in state hospitals. While there is no requirement in the 2014 ECO and TDO law changes related to LIPOS, DBHDS continues to monitor the utilization of LIPOS by CSB regions and private hospitals. In order to more effectively manage LIPOS funds and ensure the ability to quickly provide funds to regions as their LIPOS needs change, DBHDS began managing LIPOS based on a reimbursement model with the five CSB regions, and two sub-regions, in FY 2022. This includes providing upfront allocation with quarterly reimbursements. Funds noted in Figure 12 include all funds expended for LIPOS for FY 2022 while the number of beds utilized is for quarters 1-3, due to report timing.

As shown in Figure 12, below, there has been a significant decline in LIPOS usage by private hospitals. The Virginia Hospital and Healthcare Association attributes the decrease in uninsured individuals under a TDO to the increased rates of voluntary admissions. The CSB regions also note that implementation of Medicaid expansion has also contributed to the decreased use of LIPOS. This further accounts for the trend in increased admissions and census pressures on the state hospitals. DBHDS will continue collecting LIPOS data and analyzing trends related to private hospital usage of this program.

Figure 12: Regional LIPOS Beds

LIPOS Bed Days			**LIPOS Funds FY 2022**		
FY 2020	FY 2021	FY 2022 Qtrs. 1-3	Funds expended by region for beds	Total LIPOS fee by region	Total LIPOS spent
696	746	699	$312,033	$111,340	$423,373
3,736	4,079	2,312	$3,747,128	$200,000	$3,947,128
713	661	436	$397,525	$294,5000	$692,125
1,849	1,331	947	$706,144	$270,269	$976,413
2,341	2,303	1,342	$1,292,748	$89,301	$1,382,049
9,335	**9,120**	**5,736**	**$6,455,578**	**$965,510**	**$7,421,088**

In addition, DBHDS contracts with private hospitals to purchase beds with the intention of diverting individuals from state hospital admission when a bed of last resort is requested by a CSB. Typically, private bed purchase by DBHDS occurs during the TDO bed search during the ECO period. If no private bed can be located and a state hospital admission is requested, the state hospital can access the DBHDS LIPOS contract to request admission. Currently there is one contract held by DBHDS for this purpose, with Universal Health Services (UHS). This contract serves children and adolescents, and includes inpatient diversion beds, as well as stepdown beds at residential treatment centers. Figure 13, below, shows the number of children and adolescents diverted from the state-run Commonwealth Center for Child & Adolescents (CCCA) and the total cost of those diversions.

Figure 13: Last Resort Diversion LIPOS Contracts with UHS (July – May)

	Number of children & adolescents diverted	Total funds to purchase children & adolescent beds
FY 2022 (July - May)	30	$568,176

Brief Summary of Efforts to Address the State Hospital Crisis

DBHDS continues to work diligently with the community services boards (CSBs) and private providers to address the growing census pressures related to individuals who are clinically ready to leave state hospitals by investing in residential and support services. Importantly, these efforts require a great deal of effort to implement, but they do not curb the state hospital crisis because the 2014 law changes removed the ability of state hospitals to control their front door. To attempt to alleviate the impact of increasing TDO admissions, DBHDS launched efforts to contract with private providers to divert admissions, worked on ways to target special populations like children and older adults, and developed ways to accelerate discharges. DBHDS is also working on ways to lessen pain points for system partners brought on by the cycle on increasing TDO admissions and delayed bed availability.

Crisis System Transformation

Virginia is currently transforming a stronger, crisis system that meets the needs of youth and adults in their communities, supporting them in the least restrictive environment where they can safely remain. DBHDS is developing a stronger crisis system that includes regional or statewide dispatch/call centers, mobile crisis, and crisis receiving centers that are comprised of services currently provided throughout crisis assessment centers (often referred to as CITACs) and crisis stabilization units, or crisis stabilization units (CSUs), and adding in 23-hour observation. DBHDS is in the process of transforming existing CITACs and CSUs into crisis receiving centers (CRCs), which will allow for walk-in or no-refusal law enforcement drop-off service, either voluntarily or involuntarily to divert individuals from inpatient hospitalization. All new crisis services under Project BRAVO went online for Medicaid reimbursement as planned on December 1, 2021, including mobile crisis, community based stabilization, 23-hour crisis stabilization, and residential crisis stabilization.

Building a comprehensive crisis system is a significant task for a state of Virginia's size that lacks much of this existing crisis services infrastructure. DBHDS will be collaborating with both CSBs and private providers to develop a system that truly meets people's needs as close to home as possible. The crisis system transformation is vital to the crisis continuum, addressing the needs of Virginians experiencing behavioral health crises as well as the critical census challenges Virginia continues to face.

Discharge Projects and Pilots

Beginning in FY 2017, DBHDS began working with three CSBs to create assisted living facilities (ALFs) for individuals who require such a level of care after being discharged from state hospitals. In FY 2018, DBHDS also invested in the development of four additional transitional group homes for individuals who are able to transition into more integrated community settings, in addition to the two group homes that already existed. DBHDS also collaborated with the Department of Aging and Rehabilitation Services (DARS) in 2017 to provide public guardianship slots for individuals in state hospitals who require this prior to discharge, as well as contracting for additional private guardianship slots in FY 2019 and FY 2020. Recent efforts to expand community transitional options include:

- FY 2020 – DBHDS began additional initiatives to expedite the discharges of individuals from state hospitals who are clinically ready to leave. Initiatives included increased partnering with CSB crisis stabilization units (CSUs) for state hospital stepdown and discharges, and partnering with a private assisted living provider and a long-term care organization to facilitate state hospital discharges for individuals who require such levels of care.
- FY 2021 – DBHDS initiated several partnerships to create specialized residential services for individuals discharging from state hospitals. These included the addition of two transitional group homes for adolescents discharging from CCCA; partnerships with eight CSBs for additional transitional supervised housing resources for adults discharging from state hospitals; partnerships with Mount Rogers CSB and Western Tidewater CSB to develop and provide specialized behavioral health services for older adults, including those with dementia; and partnerships with two private hospital systems to provide specialized diversion and stepdown services to individuals who would otherwise be served by a state hospital.
- FY 2022 – DBHDS continued to work with private hospital systems to provide diversion services for individuals referred to state hospitals, specifically CCCA, as well as entered into two partnerships with CSBs and nursing homes to provide specialized nursing home care for individuals discharging from state hospitals. DBHDS also collaborated with Western Tidewater CSB to begin operating a program for individuals with traumatic brain injury that are discharging from state hospitals. DBHDS entered into agreements with Region 2, as well as Mount Rogers CSB, to begin operating new programs that focus on serving individuals with dementia that would otherwise be served by state hospitals. Finally, in FY 2022, DBHDS entered into contracts with four private providers to develop pilot programs to assist with diversion and discharge of individuals from state hospitals. These included a comprehensive psychiatric emergency program and bridge medication clinic with Carilion; an addiction services program with Riverside; a program targeting high utilizers of state hospitals with CBC Solutions; and a program providing enhanced security staff at Mary Washington Hospital, to assist them in serving higher acuity patients.

Alternative Custody

A TDO admission is delayed when the Bed of Last Resort requires a state hospital but there are no beds available in the state hospitals. When this occurs, the state hospital does not deny the admission but delays admission until the bed can be made available. In FY 2022, there were nearly 7,472 delayed admissions to state hospitals. By comparison, in FY 2021, there were 748 delayed admissions to state hospitals. The FY 2022 delayed admission resulted in patients waiting for a bed, and law enforcement who had custody waiting with them, for an average of 43.2 hours for a state or a private bed. Implementation of the following activities began in FY 2022 to help alleviate the challenges of long periods of custody for TDO patients.

- During the 2022 General Assembly Session, DBHDS worked with law enforcement to ease the pain points of custody without causing additional harm to the already fragile

state hospital system. The new legislation allows an alternative custody provider to relieve law enforcement and take custody of a person under a TDO.

- As another good faith effort, DBHDS developed a new opportunity to allow off-duty officers to accept custody of patients waiting for a state hospital TDO bed. This is targeted in Southwestern Virginia where reopening state beds has been difficult because of drop-offs by law enforcement. If this new program is successful, we could consider it as a statewide option.
- The General Assembly required a workgroup to recommends more impactful and longer-term solutions to the custody problem. The work of this group is underway. We are committed to working towards meaningful solutions that relieve pressure from both state hospitals and law enforcement and results in the best possible outcomes for Virginians who depend on these services.

Number of Alternative Hospitals Contacted

The CSBs in each region have regional admissions protocols that establish the processes for contacting the alternative private hospitals prior to requesting admission to the regional state hospital. The regional admissions protocols identify alternative hospitals to be contacted based on regional resources including: (1) Number of crisis stabilization beds, (2) Number of private hospitals, and (3) Capacity of those hospitals to serve individuals with specialized and intensive needs. On average, emergency services staff contact 25 to 30 private hospitals prior to seeking admission to the regional state hospital. Completing these call requirements during Virginia's short ECO timeframe is difficult for CSB emergency services clinicians who are also experiencing staffing significant workforce challenges.

Notifications to State Hospitals

Another element of the new laws added requirements throughout the emergency custody process. First, a law enforcement officer must notify the appropriate CSB of the ECO "as soon as practicable" after the officer takes the individual into emergency custody. After receiving this notification, the CSB evaluator is then required to notify the appropriate state hospital of the pending ECO evaluation, and to communicate that the individual will be referred to the state hospital if no alternative hospital for temporary detention is found. The CSB evaluator is required to make another notification to the state hospital to convey the results of the evaluation. The CSB evaluator may continue to communicate with the state hospital until the case is resolved. DBHDS state hospitals are required to document the initial notifications.

Conclusion

Although the intention of new ECO and TDO laws in 2014 was to ensure all individuals under a TDO receive inpatient treatment, this report shows significant unintended consequences because of this law. Some of the most serious unintended consequences shown in this report include critically high census and dangerously low staffing levels at state hospitals, declining percentage

of total TDO admissions at private hospitals, delayed admission to state hospitals resulting in long waits for patients and law enforcement alike, and drop offs by law enforcement of patients who are not medically cleared or admitted to state hospitals.

As a result, DBHDS and partners are examining possible adjustments to the bed of last resort and to improve Virginia's services for people experiencing a behavioral health crisis. These efforts may include ways to maximize the bed search time, increase the availability of treatment for patients while in emergency departments, and minimize the pain points that partners experience during the delay period through programs such as alternative custody. These types of changes, coupled with major community capacity building initiatives through STEP-VA, crisis system transformation, and DBHDS' North Star plan, will not only make the crisis process a more therapeutic experience, but it will also rebalance the system so individuals can manage their symptoms close to home and avoid crises in the first place.

Appendices

Appendix A: Overview of 2014 ECO/TDO Changes

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

- *Eight hour maximum period of emergency custody*: The legislature extended the maximum period of emergency custody to eight hours from four hours with a possible two hour extension, in §§ 16.1-340 (minors), 19.2-182.9 (NGRI acquittees on conditional release) and 37.2-808 (adults).
- *Law officer notification*: SB 260 specified that a law officer who executes an ECO under §§ 16.1-340 (minors) and 37.2-808 (adults) must notify the appropriate community services board (CSB) of the execution of the emergency custody "as soon as practicable" after execution.
- *Written explanation of ECO and TDO process*: An adult taken into emergency custody or temporary detention must be given a written explanation of the process and the statutory protections associated with these procedures (§§ 37.2-808 and 37.2-809).
- *Eight hour mandatory outpatient treatment (MOT) examination period*: The period of custody to perform an examination required for court review of a MOT plan was changed from four hours to eight hours in §§ 16.1-345.4 (minors) and 37.2-817.2 (adults).
- *State hospitals are "last resort" hospitals for temporary detention*: Under §§ 16.1-340.1 (minors) and 37.2-809 and 37.2-809.1 (adults), state hospitals are required to admit any individual for temporary detention who is not admitted to an alternative treatment facility, such as a community private psychiatric hospital, prior to the expiration of the emergency custody period. This provision ensures that no individual meeting clinical criteria for temporary detention is denied access to care, because the state hospital will serve as the "last resort" in the event the treatment cannot be accessed in a private psychiatric community hospital or other facility. Finally, to ensure that no individual slips through system cracks, an individual who is deemed to need temporary detention may not be released from custody except for the purposes of transportation to the temporary detention facility.
- *State hospitals may seek alternative facilities*: Under §§ 16.1-340 (minors) and 37.2-808 (adults), state hospitals and CSBs may continue to search for an alternative temporary detention hospital for an additional four hours following admission for anyone who is admitted because a suitable alternative facility could not be found by the time the eight hour emergency custody period expired. Any such alternative facility must be willing and able to provide appropriate care. A second enactment clause in SB 260 specified that these provisions expire on June 30, 2018. SB 673 of the 2018 legislative session repealed the expiration of this provision allowing it to be used beyond June 30, 2018.
- *72-hour maximum period of temporary detention*: The maximum period of temporary detention prior to a hearing was extended from 48 hours to 72 hours in §§ 19.2-169.6 (jail inmates), 19.2-182.9 (NGRI acquittees on conditional release) and 37.2-809 and 37.2-814 (adults).
- *Acute Psychiatric Bed Registry*: § 37.2-808.1 was added to SB 260 requiring DBHDS to operate an acute psychiatric bed registry to provide real-time information on bed availability to designated searchers so that CSBs, inpatient psychiatric hospitals, public and private residential crisis stabilization units, and health care providers working in an emergency room of a hospital, clinic or other facility rendering emergency medical care could access information about psychiatric bed availability through the bed registry and this information.