COMMONWEALTH of VIRGINIA

Office of the Governor

John E. Littel
Secretary of Health and Human Resources

November 16, 2022

To: The Honorable Glenn A. Youngkin, Governor
The Honorable L. Louise Lucas, Chair, Senate Committee on Education & Health
The Honorable Janet D. Howell, Chair, Senate Finance & Appropriation Committee
The Honorable Robert D. Orrock, Chair, House Committee on Health, Welfare & Institutions
The Honorable Barry D. Knight, Chair, House Appropriations Committee

From: John Littel, Secretary of Health and Human Resources
Robert Mosier, Secretary of Public Safety & Homeland Security

Subject: Chapter 103, Study to Increase the Use of Alternative Custody Arrangements

Chapter 103 of the 2022 Acts of Assembly directs the Secretary of Health and Human Resources and the Secretary of Public Safety and Homeland Security to convene a work group to study options to increase the use of alternative custody arrangements for individuals who are subject to an emergency custody or temporary detention order to reduce the burden on law-enforcement agencies. The language states:

That the Secretary of Health and Human Resources shall, together with the Secretary of Public Safety and Homeland Security, study options to increase the use of alternative custody arrangements for individuals who are subject to an emergency custody or temporary detention order to reduce the time law-enforcement officers are required to maintain custody of such individuals and mitigate the burden the requirement for law enforcement custody places on local law-enforcement officers and local law-enforcement agencies. In conducting such study, the Secretary shall review overall best practices for alternative custody arrangements in other states and develop recommendations for options to (i) allow law-enforcement officers to transfer custody of individuals who are subject to an emergency custody or temporary detention order to another person with the necessary training and certification to maintain custody of such individual in order to reduce the time law-enforcement officers must remain with the person who is the subject of the emergency custody or temporary detention order and (ii) increase the availability of beds for individuals who are subject to an emergency custody or temporary detention order to ensure prompt transfer to an appropriate facility, including expansion of crisis intervention team assessment centers and development of regional crisis receiving centers and other options for increasing the availability of beds at state and private hospitals and other behavioral health facilities for adults and children who are subject to an emergency custody or temporary detention order. In conducting such study, the Secretary shall include opportunity for participation by stakeholders, including the Behavioral Health Commission, Virginia State Police, Virginia Sheriffs' Association, Police Benevolent Association, Virginia Association of Community Services Boards, Virginia Hospital and Healthcare Association, Office of the Executive Secretary of the Supreme Court of Virginia, and other stakeholders. The Secretary shall report his findings and recommendations to the Governor and the Chairmen of the House Committees on Appropriations and Health, Welfare and Institutions and the Senate Committees on Education and Health and Finance and Appropriations by Oct 1, 2022.

In accordance with this item, please find enclosed the *Study to Increase the Use of Alternative Custody Arrangements*. Staff are available should you wish to discuss this request.

cc: Commissioner Nelson Smith, Department of Behavioral Health and Developmental Disabilities

STUDY TO INCREASE THE USE OF ALTERNATIVE CUSTODY ARRANGEMENTS

REPORT TO THE GOVERNOR AND GENERAL ASSEMBLY

2022

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Study Authority

During the 2022 General Assembly Session, Senator Stephen Newman introduced Senate Bill 202. The legislation, as adopted, directed the Secretary of Health and Human Resources, together with the Secretary of Public Safety and Homeland Security, to study

> "options to increase the use of alternative custody arrangements for individuals who are subject to an emergency custody or temporary detention order and mitigate the burden the requirement for law enforcement custody places on local law-enforcement officers and local law-enforcement agencies. In conducting such study, the Secretary shall review overall best practices for alternative custody arrangements implemented in other states and develop recommendations for options to (i) allow law-enforcement officers to transfer custody of individuals who are subject to an emergency custody or temporary detention order to another person with the necessary training and certification to maintain custody of such individual in order to reduce the time law-enforcement officers must remain with the person who is the subject of the emergency custody or temporary detention order and (ii) increase the availability of beds for individuals who are subject to an emergency custody or temporary detention order to ensure prompt transfer to an appropriate facility, including expansion of crisis intervention team assessment centers and development of regional crisis receiving centers and other options for increasing the availability of beds at state and private hospitals and other behavioral health facilities for adults and children who are subject to an emergency custody or temporary detention orders on Appropriations and Health, Welfare and Institutions and the Senate Committees on Education and Health and Finance and Appropriations by October 1, 2022." (Chapter 103).

In May 2022, a diverse group of stakeholders from across the Commonwealth, including representatives from rural and urban law enforcement organizations, health care providers, emergency physicians, hospitals, Community Services Boards (CSBs), and mental health advocacy organizations, were invited to participate in a workgroup to solicit feedback and further study and refine the existing alternative custody program in Virginia. This workgroup (Chapter 103 Workgroup) was co-chaired by Secretary of Health and Human Resources John Littel and Secretary of Public Safety and Homeland Security Robert Mosier. The goal of the Chapter 103 Workgroup was to develop recommendations to alleviate the burden experienced by law enforcement caused by maintaining custody of individuals subject to emergency custody orders (ECOs) and temporary custody orders (TDOs). A listing of the Chapter 103 Workgroup membership is included as Appendix A.

Chapter 103 Workgroup Meetings

Four meetings of the Chapter 103 Workgroup were convened during the summer of 2022. In addition, two smaller working groups were established to allow for further discussion of the objectives outlined in the legislation: a Custody Workgroup and a Bed Capacity Workgroup. These Workgroups met separately to deliberate on the assigned topics and then reported back to the full Workgroup. A listing of all of the Workgroup meetings dates is included as Appendix B. The meetings were posted on the Commonwealth Calendar and the meetings were open to the public. The Chapter 103 Workgroup discussions are summarized below.

- June 16 Workgroup Meeting – The Custody and Bed Capacity Workgroups were established. Ryan M. Zuidema, Chief of Police, Lynchburg Police Department, provided the members presented information and offered the law enforcement perspective/concerns as they pertained to TDOs and ECOs, particularly in more rural communities. Staff from the Department of Behavioral Health and Developmental Services (DBHDS) presented data related to alternative custody. Elizabeth Hobbs with the Sheriff's Association presented on recent changes to Virginia Code §§ 37.2-809, 37.2-809.1, and 37.2-810 made by Senate Bill 268, sponsored by Senator Favola during the 2022 legislative session.
- July 12 Workgroup Meeting – The Workgroup reviewed changes to the Virginia Code by Senate Bill 593 (2022), sponsored by Senator Newman, which allows auxiliary police officers to serve as alternative transportation/custody providers. DBHDS staff also presented on viable transportation/custody strategies from other states, information regarding the alternative transportation/custody contract, and the DBHDS off-duty law enforcement officer program. Stakeholder perspectives were offered from Jonathan Green, Director of Magistrate Services, Supreme Court of Virginia; Jeremy Falls, Sheriff, Fauquier County; and Darrell Hodges, Sheriff, Cumberland County.
- August 9 Workgroup Meeting – DBHDS presented on Virginia's crisis system transformation. Additional stakeholder perspectives were offered from Joran Sequeira, MD, Virginia College of Emergency Physicians; and Ryan R. Dudley, LCSW, MBA, Director, Crisis Services, Hampton-Newport News CSB. Preliminary findings of the Custody Subgroup were reported. Proposed recommendations were presented and circulated for the Workgroup consideration. The proposed recommendations were later emailed to the Workgroup so that additional comment could be received.
- August 25 Workgroup Meeting – Martin Mash of VOCAL Virginia offered a stakeholder perspective from a consumer with lived experience. In addition, DBHDS provided reports from both the Custody and Bed Workgroups, including an update on a presentation from RI International that was made to the Custody Subgroup. This included recommendation regarding changes to licensing regulations to align with best practices in crisis care. The remainder of the meeting focused on discussing and finalizing the draft recommendations.

Summary of Chapter 103 Workgroup Findings

Virginia Code § § 37.2-809 and 809.1, commonly referred to as the "Bed of Last Resort" law, requires state DBHDS hospitals to be the facility of temporary detention for a person under a TDO if no other private bed can be found by the end of the eight-hour emergency custody

period. No other state has a similar law. Since the passage of this law in 2014, the census of the DBHDS hospitals has steadily increased. In May 2013, the statewide average utilization rate of the eight adult state hospitals was 86 percent. In October 2022, the statewide average utilization rate for those eight hospitals was 99 percent, and total utilization at five of the hospitals was at 100 percent or above. Though TDO admissions across Virginia have decreased slightly in recent years, since the passage of the Bed of Last Resort law, the state facilities' proportion of total TDO admissions for Virginia increased year after year through State Fiscal Year 2021. When there is not an available staffed bed at a state hospital, transportation of TDO patients from the emergency department to a state hospital is delayed, sometimes for several hours or days, while DBHDS works with community partners to locate free bed space. Unless an alternative transportation provider has been designated, law enforcement must maintain custody of individuals under TDOs during this delay, taking officers away from their community policing responsibilities and placing a strain on law enforcement agency resources.

Delayed Admission Waitlist –Individuals under TDOs specifying a state hospital as the facility of temporary detention who cannot be admitted immediately to a state hospital are placed on the delayed admission wait list. The wait list is prioritized chronologically. When a bed becomes available at a state hospital, state hospital admissions staff review the individuals on the wait list in order of their placement on the wait list, regardless of geographic location. This ensures that individuals are admitted to a state hospital as quickly as possible, rather than waiting for an available bed at their regional state hospital. During the delayed admission time, state hospital staff are communicating with CSB staff to receive regular updates regarding the patient's status and possible disposition. CSB staff also continue looking for a private bed until a final disposition is reached (i.e., admission to a private or state hospital or the individual is released at the hearing). Since July 1, 2022, DBHDS calculates that the average number of hours law enforcement remains with individuals under TDOs awaiting admission to bed for temporary detention exceeds 43 hours per individual.

Impact of Delayed Admission Waitlist Time – When admissions are delayed, all parties involved in the civil commitment process are negatively impacted, including the individual who is experiencing a mental health crisis. The Workgroup heard about backlogs in emergency departments, and the stress that delayed admissions place on emergency department resources and staff. As noted above, if a magistrate does not designate an alternative transportation provider, law enforcement must maintain custody of an individual under a TDO until custody has been accepted by the temporary detention facility. Admission delays cause significant strain on law enforcement agencies, particularly in rural areas, by taking officers off the streets and away from community policing. Delays in admission also negatively affect individuals under TDOs, who often may be restrained to the emergency department bed and frequently are not receiving psychiatric treatment. Law enforcement expressed concern that individuals waiting for long periods of time in custody without receiving mental health treatment develop a negative perception of law enforcement that continues after those individuals are discharged back to their communities.

The Workgroup quickly agreed that increasing the use of alternative custody and transportation for individuals who are subject to ECOs or TDOs would help alleviate the burden on law enforcement, but that this should not be the sole solution. To maximize opportunities for improvement that would benefit all parties involved in the civil commitment process, the

Workgroup asserted that Virginia should develop a variety of solutions and regionally tailor these solutions to the fullest extent possible.

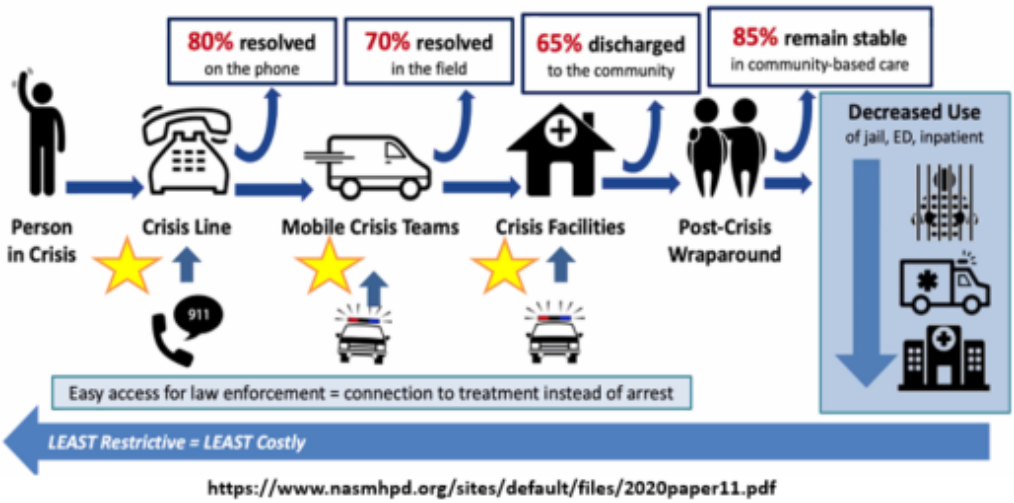
In addition, solutions must be included that offer immediate relief and to allow for the development and implementation of long-term, more impactful solutions. The Workgroup unanimously agreed that the optimal long-term option available to Virginia was to continue the development of behavioral health crisis services system.

For several years, Virginia has been building a comprehensive crisis system to meet the needs of youth and adults in their communities. The new crisis system includes:

- **Call Centers** – Regional or statewide dispatch/call centers, including 988. In July 2022, every state rolled out 988 as the new National Suicide Prevention Lifeline number to call for mental health crises – similar to how people can call 911 for medical emergencies. Ultimately, this will help divert calls away from 911, so people experiencing behavioral health crisis are connected to behavioral health support.
- **Mobile Crisis** – Mobile crisis teams serve individuals whose crisis needs require face-to-face interventions to assess, de-escalate, and connect them to the most appropriate services. Mobile crisis teams include clinicians and peer support. Mobile crisis teams can be accessed through call centers, and it is envisioned that the teams will be able to eventually receive direct calls for assistance from families.
- **Crisis Receiving Centers/Crisis Stabilization** – Within the crisis services continuum is the Crisis Intervention Team Assessment Centers (CITAC), where the exchange of custody occurs between law enforcement and the receiving trained officer or special conservators the peace. A behavioral health clinician is part of the CITAC team and conducts the assessment during the ECO. The assessment can occur in the CITAC or the 23-hour Crisis Receiving Center area where de-escalation and medical evaluation also occur. Should there be need for further treatment, the Crisis Stabilization Unit (CSU) can provide medication and therapy (individual and group) in a less restrictive environment than inpatient hospitalization. DBHDS is in the process of transforming existing standalone CITACs and CSUs into more comprehensive crisis receiving centers (CRCs), which will allow for walk-in or law enforcement drop-off service, either voluntarily or involuntarily, to divert individuals from inpatient hospitalization. These service definitions are detailed below.
    - Crisis Receiving Center (CRC) – A home-like atmosphere in which individuals can receive crisis stabilization services for up to 23 hours. A variety of services may be offered, including peer services and medical services. Individuals may be referred to a 23-hour observation center from a CITAC.
    - Crisis Intervention Team Assessment Center (CITAC) – A site where individuals can receive pre-admission screening to determine the level of care required to manage their behavioral health emergency. This is a site where law enforcement can bring individuals who are under an Emergency Custody Order (ECO) to be evaluated instead of jail and/or a hospital emergency room. These sites may also provide additional services, in which case they might also be referred to as crisis receiving centers (CRCs).
    - Crisis Stabilization Unit (CSU) – A home-like, residential crisis stabilization unit that allows individuals who are experiencing a behavioral health crisis to stay short-term (generally, three to ten days). This can also be a step-down level of care for individuals being discharged from an inpatient psychiatric facility.

When the crisis system is fully built, it is expected that 80 percent of the calls routed to the call center can be resolved over the phone. Of the remaining 20 percent, it is anticipated that fully developed mobile crisis teams can address the crisis in the community 70 percent of the time. A fully developed crisis system has the ability to resolve individuals' crisis needs in the community and should decrease the number of individuals who require inpatient treatment. The Workgroup expressed support for a long-term plan that maintained and expanded existing crisis programs and developed new crisis programs so crisis facilities could take custody of individuals under ECOs and TDOs. Graphic 1 displays the new crisis system outcomes. A map depicting Virginia's existing regional crisis system structure is included as Appendix C.

Graphic 1 – Comprehensive Crisis Center System Model

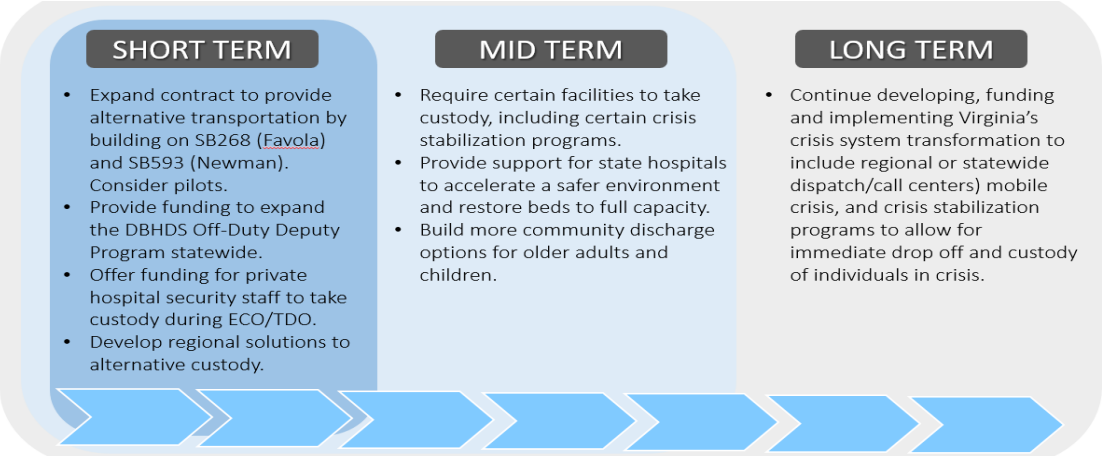


https://www.nasmhpd.org/sites/default/files/2020paper11.pdf

As noted previously, the Workgroup recognized the need for solutions to provide immediate relief while the development of the longer term solution of a statewide comprehensive crisis system was being pursued. Shorter-term solutions supported by the Workgroup included piloting a program for an alternative custody provider, and providing statewide support for off-duty law enforcement officers to take custody of individuals in emergency departments (see Appendix D for more information about the DBHDS Off-Duty Program). The Workgroup also expressed support for regional programs that were working well that could be brought to scale.

In addition, the Department and the state hospitals are currently working diligently to increase staffing levels to enable a return to full bed capacity. The Workgroup expressed support for accelerating these efforts. The reopening of state beds and private beds that were closed during the Covid-19 Pandemic should decrease delays in admission for individuals subject to TDOs. Graphic 2 details several of the proposed solutions discussed by the Chapter 103 Workgroup.

Graphic 2 – Proposed Solutions Discussed by Chapter 103 Work Group



Recommendations Discussed by Chapter 103 Workgroup

The Workgroup expressed consensus for recommendations that 1) maximized options for alternative custody and 2) expanded bed capacity and availability. These recommendations are outlined below.

MAXIMIZING OPTIONS for ALTERNATIVE CUSTODY

Recommendation 1

Ensure Virginia has multiple solutions available

Potential solutions may include:

a. Expand the current alternative transportation contract to include the maintenance of custody of individuals under TDOs while awaiting transport or release a Request for Proposal (RFP) to contract with an entity to provide alternative custody. The Workgroup recommended that expansion begin through a pilot program (See Recommendation 3 for additional details).

b. Explore expanding the DBHDS Off-Duty Officer Program to other parts of the Commonwealth. See Appendix D for more information about the DBHDS Off-Duty Program.

c. Support developing or expanding successful local programs to tailor solutions to best meet the needs of a region instead of relying solely on statewide solutions. Examples of successful local programs include the Co-Responder model in Fauquier County and the Carillion Comprehensive Psychiatric Emergency Program. Workgroup members recommended developing pilots of these regional solutions and also pairing regional solutions with an expansion of CITACs and/or CRCs.

d. Incentivize private hospitals with security staff to take custody of individuals under TDOs. Additional support may need to be provided to private hospitals for additional security staff and for specialized behavioral health training.

e. Review existing laws and regulations to ensure that all receiving facilities/entities in the crisis continuum are able to accept individuals under an ECO or a TDO when clinically indicated. Ensure that crisis facilities have the resources necessary to accept individuals under ECOs and TDOs. Review existing processes/guidelines that may be preventing facilities from establishing MOUs with law enforcement agencies to enable these facilities to assume custody of individuals under ECOs. Additionally, ensure there are statewide standards regarding the operation of all crisis services and require specific crisis stabilization programs to admit individuals under TDOs, with appropriate resource allocation.

Recommendation 2

Streamline funding

a. Merge the alternative transportation and alternative custody funding streams utilized for individuals under a TDO to maximize flexibility for the Commonwealth to implement new alternative custody options.

Recommendation 3

Pilot alternative custody to ensure effectiveness and maximize limited resources from the 2022 General Assembly Session

a. Develop an option for an alternative custody (AC) pilot by:
   i. Expanding or reworking the scope of the existing contract with Allied Universal Security (Allied), or issue an RFP to contract with an entity, to hire and train a workforce comprised of individuals permitted to accept custody of individuals under TDOs, such as auxiliary law enforcement officers and potentially special conservators of the peace (SCOPs). See Appendix D for more information about SCOPs.
   ii. The contractor's staff would complete the three-week DCJS training to qualify as auxiliary law enforcement. In addition, the contractor's staff would complete a week-long training that emphasizes compassionate care and de-escalation techniques.
   iii. The contractor would deploy staff at the request of the law enforcement entity designated in the TDO to take custody of the individual.
   iv. With the $2 million allocation in the current fiscal year, the contractor would hire and train staff for a pilot in a designated geographic area of the Commonwealth. Benefits of this pilot include:
      - Making use of the recently enacted law created by Senate Bill 593 (Newman, 2022) related to the use of auxiliary officers; and
      - Shifting the cost of hiring and training a qualified workforce from law enforcement to the contractor.
      - Combining both safety/restraint training and trauma-informed, recovery-oriented care to enable auxiliary officers to maintain custody of individuals under a TDO with more acute needs.
      - Utilizing one provider for both services limits complexities and smooths transitions from custody to transport.
      - The current contract with Allied does not permit the use of restraint so Allied cannot maintain custody of individuals who are aggressive or at risk of escape. Adding training regarding the use of restraint and de-escalation techniques would enhance the abilities of the alternative transportation workforce and allow them to transport more

highly acute individuals, which should increase utilization of alternative transportation.

Recommendation 4

Improve the experience of the person in mental health crisis

a. Develop programs and options that provide the most person-centered and trauma-informed approach for individuals in crisis during the ECO/TDO process, including:
   i. Review and develop mechanisms to promote treatment in Emergency Departments (EDs), including the ability of ED attending physicians to prescribe psychiatric medications when needed without the full requisite evaluation required of a psychiatrist. Starting new, or restarting existing, medication regimes can facilitate a return to baseline functionality for patients further distressed by the events leading up to the ECO. This also reflects U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) best practices.
   ii. Develop mechanisms to re-evaluate and safely release patients whose acute crisis has passed and who no longer meet the commitment criteria; this may include expanding/clarifying who can release someone from a TDO. Safely releasing an individual who has been stabilized and does not require further inpatient treatment becomes more feasible if mental health treatment is provided to individuals in EDs.
   iii. Create guidance that details the types of restraints and when each type of restraint can be used.
   iv. Develop standards around re-evaluation of patients during the ECO process and particularly during any periods of delayed TDO admission for possible diversion from inpatient state or private hospital care. This is particularly important for the 20 percent of individuals under TDOs who are intoxicated who may no longer need inpatient care after they regain sobriety.
   v. Develop training programs to promote better and more consistent assessment and recommendation for ECO/TDOs statewide, including specialized trainings for de-escalation for clinical staff at the tech level to help with management of patients.
   vi. Work with private hospitals to promote the increased availability of specialized support personnel in the ED to help deescalate, and provide guidance and support/therapy to individuals under TDOs, and to create trauma-informed spaces for patients. This also reflects SAMHSA best practices.
   vii. Develop guidance so that either prescreeners or specialized support personnel can provide progress updates during the temporary detention process to the individual waiting for a TDO bed. While most prescreeners are very good at communicating with individuals during the TDO period, the purpose of this recommendation is to prevent or limit feelings of isolation and neglect that patients who are waiting for a bed may develop.

Recommendation 5

Clear up ambiguous or confusing Code language

a. Review, clarify, and amend sections of Chapter 8 of Title 37.2 that govern the ECO and TDO process. Specific recommendations include:
   i. Provide more definition to the criteria required to issue TDOs. To issue a TDO, a magistrate must find "that the person (i) has a mental illness and that there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future,

(a) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or (b) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs." Clarity could be added regarding what constitutes "serious physical harm to himself or others," "serious harm due to a lack of capacity to protect himself from harm," and "basic human needs."

ii. Consider the creation of separate criteria for alternative custody providers.

iii. Amend § 37.2-813 to permit an attending physician or qualified medical professional where an individual under a TDO is located to be able to release the individual under a TDO when they determine that the individual no longer meets the commitment criteria.

iv. Define what it means to "execute" a TDO to ensure consistency in practice.

v. Review § 37.2-1104 to make obtaining a medical TDO a more usable option during the civil commitment process. This review should be done by a workgroup with broad stakeholder input. The workgroup could also revisit the Medical Screening Guidelines developed in 2018 to promote greater efficiency in the medical screening process that reduces unnecessary medical testing that causes delays in admission to temporary detention facilities.

b. The recommendations identified above have been discussed extensively in the past and require broad stakeholder agreement. The Chapter 103 Workgroup agreed that many of these issues could be reviewed by a stakeholder group comprised of legal, policy, and subject-matter experts. DBHDS is planning on convening this stakeholder group in early 2023 for further exploration.

EXPANDING BED CAPACITY and AVAILABILITY

Recommendation 6

Continue building Virginia's crisis system as a best-practice, enduring solution

a. Continue developing, funding, and implementing Virginia's crisis system transformation to include 988 (regional or statewide dispatch/call centers), mobile crisis teams, and crisis receiving centers that are comprised of services currently provided in CITACS and CSUs and additionally include 23-hour observation.

Recommendation 7

Restore full bed capacity at Virginia's state hospitals

a. Support salary increases, for hospital, facility, security, and contract staff at Virginia's state hospitals, as well as support the hiring of more direct care, facility, and security staff so the Commonwealth's publicly funded hospitals can safely operate when at full capacity. DBHDS experiences recurring challenges recruiting and retaining staff at its state facilities. As a result, DBHDS has had to take operational beds off-line. The General Assembly increased salaries for state hospital direct care staff to 50 percentile of market rate on July 1, 2022. Given the high-risk nature of job duties of these essential positions, and the ability of private hospitals to provide additional compensation and benefits, DBHDS has struggled to compete with recruiting and retaining critical staff. DBHDS is currently assessing the impact of this salary increase in reducing vacancies, turnover rates, and operational capacity across the state hospital system.

Recommendation 8

Target special populations with expanded placement options

a. Build more community discharge options for older adults and children, and focus on placements for individuals on the state hospital extraordinary barriers to discharge list (EBL). Many older adults that are referred to state hospitals to struggle with placement options, due behaviors related to their behavioral health. This is also true for children. The expansion of placement options would assist in diverting these populations from state hospitals while supporting them in their communities.

Acknowledgements

The Secretary of Health and Human Resources and the Secretary of Public Safety and Homeland Security extend their appreciation and gratitude to the members of the Chapter 103 Workgroup members and all who assisted with this study. We also extend a special thank you to those who presented at the Workgroup meetings and at both the Bed Capacity and Custody meetings.

Appendices

Appendix A - Workgroup Membership

Office of the Secretary of Health and Human Resources: Secretary John Littel; Deputy Secretary Leah Mills

Office of the Secretary of Public Safety and Homeland Security: Secretary Robert Mosier; Assistant Secretary Sonny Daniels; Deputy Secretary Maggie Cleary

Office of the Attorney General: Allyson Tysinger; Josh Humphries, Chuck Slemp

Office of the Executive Secretary of the Supreme Court of Virginia: Jonathan Green

Office of Senator Newman: Sarah Owen

Office of Senator Favola

Supreme Court of Virginia: William C. Mims, Senior Justice

Behavioral Health Commission: Nathalie Molliet-Ribet; Claire Mairead

Department of Behavioral Health and Developmental Services: Commissioner Nelson Smith; Meghan McGuire; Suzanne Mayo; Gail Paysour; Mary Begor; Stephen Craver; Lauren Cunningham; Madelyn Lent

Department of Criminal Justice Services: Dallas Leamon

Virginia State Police: Major Ronnie Maxey

Virginia Hospital and Healthcare Association: Jennifer Wicker

Virginia College of Emergency Room Physicians: Aimee Perron-Seibert; Dr. Joran Sequeira; Dr. Bruce Lo

Virginia Association of Community Services Boards: Jennifer Faison

Mental Health America-Virginia: Bruce Cruser

NAMI: Kathy Harkey

VOCAL: Martin Mash

Virginia Sheriffs' Association: Elizabeth Hobbs, Sheriff Jeremy Falls; Sheriff Darrell Hodges

Virginia Sherriff's Association: Richard Vaughan

Virginia Association of Chiefs of Police: Dana Schrad; John Clair

Police Benevolent Association: Detective Mike Wells; Sergeant Joe Woloszyn

Arlington Police/Arlington Department of Human Services: Lt. Steven Proud

Appendix B – Workgroup Meetings Dates

Chapter 103 Workgroup Meeting Dates

Thursday June 16th, 10am-12pm in Richmond

Tuesday July 12th, 10am-12pm in Richmond

Tuesday August 9th, 10am-12pm in Richmond

Thursday August 25th, 1-3pm in Richmond

Custody Subgroup Meeting Dates

Thursday, July 21st, 1-3pm via Zoom

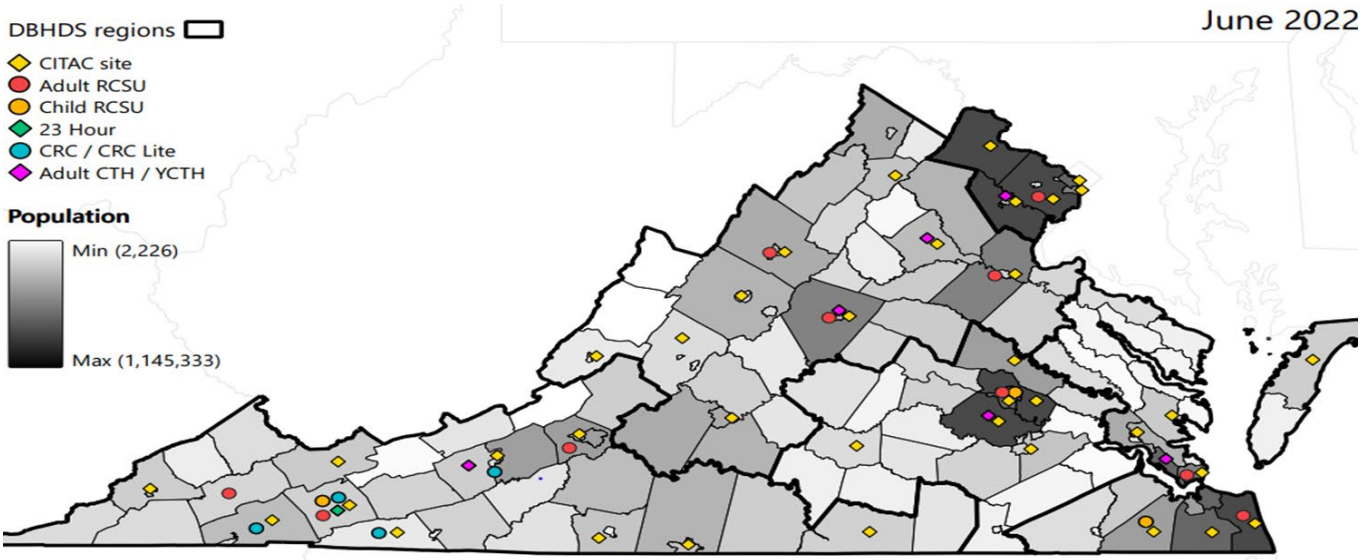
Tuesday, August 9th, 1-3pm in Richmond

Tuesday August 30th, 1-3pm via Zoom

Bed Capacity Meeting Dates

Monday, August 15th, 10am-12pm via Zoom

Appendix C – Virginia's Regional Crisis System



Crisis Sites by Locality

Sites in Development
Southside CRC/CITAC
Danville/Pittsylvania CRC/CITAC
Piedmont CRC/CITAC
Fairfax CRC/CSU
Blue Ridge CRC/CSU
Western Tidewater CRC/CSU
Highlands CRC/CSU
Prince William CRC/CSU
Hampton Newport News CRC/CSU
Horizon CRC/CSU
New River Valley CRC/CSU
Chesapeake CRC/CSU
Arlington CRC/CITAC
Northwestern CRC

Appendix D – Additional Custody Options

DBHDS Off-Duty Law Enforcement Custody Support Program

In 2022, DBHDS implemented a TDO support program utilizing off-duty law enforcement personnel. The program was piloted in the localities in Southwest Virginia.

- The program provides funding to law enforcement agencies in Region 3 to pay off-duty law enforcement personnel to maintain custody of and provide transportation to an individual under a TDO or involuntary commitment who is waiting for admission to a psychiatric inpatient facility (private or state).
- DBHDS pays an agreed upon flat hourly rate to local law enforcement organizations (LLEO) to reimburse for payments to off-duty law enforcement personnel providing this service after a set amount of time, initiated at start of the TDO period. The hourly reimbursement rate includes the funding required to address fringe benefit costs incurred by the LLEO.
- DBHDS and LLEOs will enter into an MOU/MOA providing the terms of the agreement as to roles, responsibilities, and requirements of both parties.
- Localities are to submit a dispatch and invoices with reported service time of off-duty law enforcement personnel to maintain custody of and provide transportation to individuals under TDOs.

The program is currently in place only in Southwest Virginia; however, DBHDS is exploring plans to provide this program on an expanded basis.

The Special Conservator of the Peace (SCOP) Training Program

SCOP officers are authorized to take custody of individuals under an ECO/TDO. By employing SCOP officers at CITACs, CRCs, and CSUs, DBHDS will reduce its reliance on overtime law enforcement, which will generate cost savings, as well as provide relief for local law enforcement departments currently devoting resources to this service. In addition to accepting custody of individuals, SCOPs will provide security for the facilities, allowing individuals in a crisis state to safely receive care outside of a hospital setting.

Several private companies are already licensed to offer SCOP training in Virginia. DBHDS is considering a training program to offer crisis intervention training (CIT) and de-escalation training in addition to entry-level SCOP training. The development of SCOP officers has the potential to significantly reduce our reliance on high acuity care and our reliance on local law enforcement officers.

Appendix E

Two organizations represented on the workgroup submitted written comments on the proposed workgroup recommendations. Written comments were received from the Virginia Sheriff's Association and the Virginia Association of Community Services Boards. These submissions are included as Appendix E.

VIRGINIA SHERIFFS' ASSOCIATION

Comments Regarding Draft Recommendations

Regarding Draft Recommendation 1

Although the increased pay for off duty deputies to fill the needs of extended custody [and CITAC facilities] is appreciated and an important step, it is not likely a sustainable long-term solution for understaffed sheriffs' offices and overstretched personnel.

Amending the current code to lower the hurdles for facilities or locations to assume custody and responsibility for persons under ECO would alleviate the burden on law enforcement and the strain on the available hospital beds. It is essential that any change to lighten the requirements include absolving law enforcement of the liability and responsibility for individuals once they are in the custody of facilities or locations under this subsection.

Regarding Draft Recommendation 3

We support the movement to increase alternative custody by using a non-law enforcement security. However, in the draft recommendation the phrasing "to qualify as auxiliary law enforcement" is not quite on target with current law. The adjustments to the code provided by Senator Newman's SB593 permit police departments to utilize their auxiliary police officers for the execution of ECOs and TDOs after completing a three-week training module at DCJS. This provision provides a means to expand the personnel pool for police departments and reduces the costs by reducing the length of DCJS training for these officers to qualify to perform ECO/TDO functions. Sheriffs' authority to appoint and utilize auxiliary deputies is not limited or expanded by SB593, which applies exclusively to police departments.

The discussion in the workgroup centered around ensuring any private custody provider, such as Allied, would be trained similarly to the DCJS training module for auxiliary police officers. Undergoing that training module would not make Allied employees auxiliary police officers. The pilot program using Allied would not make use of the amendments to the Code of Virginia from SB593, but could make use of the DCJS training module created for the auxiliary police as a result of the code amendments in SB593.

Having Allied available for custody at the request of the law enforcement entity designated by the TDO would be a valuable addition to assist in alleviating the burden on law enforcement. Changing the current use of alternative transportation to the expanded use of private custody and transportation providers equipped and trained to handle the most difficult of ECO/TDO individuals has the potential to significantly benefit law enforcement.

The pilot does not however provide a pipeline for training and hiring future law enforcement officers. Law enforcement officers are hired by individual police departments or sheriffs' offices and must undergo the specific hiring process of each agency and would still need to undergo the complete law

enforcement certification process regulated by DCJS in order to be sworn law enforcement working for a specific agency.

Regarding Draft Recommendation 4

We support developing uniform training and application of the code statewide for magistrates, pre-screeners, and special justices. This would be valuable not only for magistrates, but also for CSBs that are currently decentralized and independent, and also for special justices who perform various functions in the civil commitment process.

Regarding Recommendation 5

We support addressing any need for clarification before the 2023 Session. A small group of stakeholders should make specific recommendations regarding definitions of "custody," "execute," and the criteria to issue TDOs.

Any suggested definition of "execute" including "forthwith" should be limited to circumstances when the individual is in custody. The law enforcement agency should not be required to find a person whose whereabouts are not certain within a particular period of time.

Intoxication and substance use are currently a part of the medical detention order [VA Code 37.2-1104]. However, this code section could be amended with an additional subsection on intoxication and substance use to expand the use of the medical detention order in a hospital setting and facilitate ease of use by allowing access directly to magistrates for this specific purpose.

We also support amending the code to separate those individuals who may need involuntary detention under ECO or TDO because of an inability to care for themselves, but who are not a danger to themselves or others. This third category of people is least likely to need law enforcement involvement in custody or transportation.

Regarding Recommendation 7

Although not explicitly a part of this recommendation, we oppose any expansion or extension of the time limitations on the eight-hour period for ECOs or the 72 hour period for TDOs. Any extended 23 hour stabilization should occur during the 72 hour TDO period which is currently designated by code as a period to begin treatment and further evaluation for involuntary commitment. Some concerns were raised by employees at DBHDS that an individual placed under a TDO would lose certain rights such gun rights, but this is not accurate under the law. [See Va Code 18.2-308.1:3.] Gun rights of individuals are lost at the civil commitment stage, not at the ECO or the TDO stage. As such, there is not the need to avoid loss of rights [as articulated by the DBHDS employee] by extending the ECO period for crisis stabilization rather than using such a facility during the TDO period.

Virginia Association Of Community Services Boards, Inc.
Making a Difference Together

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VACSB Comments on the Alternative Custody Work Group Recommendations

VACSB's members are acutely aware of the burdens that the current practice of delaying TDO admissions to state psychiatric facilities is having on our law enforcement and other stakeholder partners. Indeed, CSBs attempt to help mitigate those circumstances whenever possible by continuing to search for alternative placements to state hospitals throughout the period of the delay. In addition, CSBs are in the unenviable position of coordinating bedside commitment hearings for those individuals who are not able to be admitted to an inpatient setting prior to the code-designated end of the period of temporary detention. If the letter of the bed of last resort legislation were being followed, commitment hearings would occur in the inpatient setting to which the individual was temporarily detained and the role of the CSB would be to present evidence, not to coordinate the hearing itself. The bottom line is that this situation is causing a ripple effect across the system for law enforcement, emergency departments and CSBs, but more importantly, it is severely negatively impacting the individuals who need crisis care and psychiatric treatment.

The Association wants to be clear in its comments that it supports lessening the burden on law enforcement in these situations but does not believe that allowing and providing for alternative custody arrangements is a solution that will address the root cause of the problem, nor will it improve conditions for individuals awaiting an inpatient admission. The current practice of delaying admissions to state hospitals has created a legal and procedural gray area for everyone involved in the process, and while we recognize there has to be some sort-term solutions, the VACSB does not support any efforts to codify the current practice of delaying admissions to state facilities, or any procedural shifts that have come about as a result of the practice.

The VACSB appreciates the opportunity to provide feedback and offers the following comments on the proposed work group recommendations:

Recommendation 1

Option 1 – It is unclear whether expanding the existing contract for Alternative Transportation would mean that custody would be transferred to the existing provider with any regularity. Data provided by DBHDS indicates that the current provider is not meeting its metrics for success with regard to the transportation piece, largely due to staffing challenges, so it seems unlikely that they would be able to consistently provide opportunities to transfer custody. Likewise, there is no guarantee that the Commonwealth would receive viable proposals should it put out an RFP specifically to address the custody piece. We have learned through our experience with Alternative Custody that "statewideness" and dispatch are difficult for a single entity to manage and we would expect the same issues to arise in any plan to strike a contract specific to alternative custody.

Option 2 – The VACSB supports funding to expand the DBHDS Off-duty Deputy Program to interested law enforcement agencies anywhere in the state.

Option 3 – The VACSB agrees that these issues are best solved locally and supports funding to expand programs with proven results and promising pilot projects; however, VACSB believes that restricting this funding to support regional programs or pilots may take opportunities to work with existing programs such as CITACs, which are not strictly regional, and the named drop-in model which is also not a regional program.

Option 4 – The VACSB has no position on this option.

Option 5 – The VACSB opposes this option and contends that there is already a requirement for certain facilities to take custody in that it is very clear in the Code of Virginia that the state psychiatric facilities are responsible for admitting patients when a less restrictive alternative is not an option and a private bed cannot be found. Requiring other entities to take custody simply pushes the core issue down to the local level and these local facilities will have the exact same issues that state hospitals encountered which caused DBHDS to close over 250 beds a year ago. Namely, there is no guarantee that these facilities will be appropriate for a given individual (i.e. pregnant woman who needs a single occupancy room and the facility has only double occupancy available with one bed occupied by a male), the facility may not be fully staffed due to the severe workforce challenges across our system, or they may not be able to accommodate an individual's medical conditions. In addition, requiring certain facilities to take TDOs risks using all of the capacity in a particular facility for that purpose which means they would be unable to take individuals on a voluntary basis, the very individuals who may then escalate and require an involuntary admission.

Recommendation 2

The VACSB believes this would have the net effect of further reducing the number of transports utilizing Alternative Transportation.

Recommendation 3

See comments related to Recommendation 1, Option 1. The VACSB would be interested in hearing more from Allied regarding the feasibility of this recommendation but believes it could be viable on a pilot basis.

Recommendation 4

This recommendation would require significant additional input from stakeholders as the level of detail is insufficient to fully contemplate the possible unintended consequences and risk/liability issues some of the suggestions within this recommendation would raise.

The VACSB supports any movement toward access to psychiatric treatment during the period of the delayed admission. Likewise, the VACSB supports efforts to more fully integrate peer supports at every point in the involuntary process.

Recommendation 5

The VACSB welcomes the opportunity to participate in a group to clarify provisions of the Code of Virginia related to the ECO/TDO process but has some concerns about the viability of completing that work prior to the filing deadline for the 2023 General Assembly session.

Recommendation 6

The VACSB does not support this recommendation. Evaluating an individual a second time in the 8 hour ECO period when that individual has not had any active treatment is highly unlikely to yield a different outcome than

the initial evaluation. Regarding re-evaluation during the TDO period, the Code of Virginia already allows for the treating physician at the state psychiatric facility to which the individual is TDOed to discharge an individual at any time during the period of detention prior to the hearing.

The fact that the individual is not physically present at the facility does not change the ability of the treating physician to re-evaluate and release an individual. The VACSB supports expanding telehealth options that would allow this existing process to occur.

Recommendation 7

The VACSB strongly supports this recommendation. These are the very programs and supports that will divert individuals from inpatient admissions – both voluntary and involuntarily – and will serve to free up needed space in our hospitals – both state and local.

Recommendation 8

The VACSB understands the staffing challenges that state facilities face and submits that the Commonwealth's partners in the safety net that serves individuals with behavioral health and developmental disabilities – the CSBs – have those same challenges. The appropriate recommendation would be to fund support for staffing tools for CSBs at a level comparable to that provided to the state facilities. To ignore the staffing challenges at the CSBs will greatly hamper the ability of Recommendation 7 to be successful.

Recommendation 9

The VACSB strongly supports this recommendation. The number one reason that individuals cannot be discharged from state facilities when they are clinically ready is that they lack appropriate placement options in the community. A focus on placements for individuals on the Extraordinary Barriers to Discharge list has the potential to free up a significant number of beds.