Virginia Association Of Community Services Boards, Inc.

Making a Difference Together

Senate Finance Health and Human Resources Subcommittee-January 13, 2014

Summary of Comments:

- *Introduced Budget Response*
- *Gaps in Services*
- *Suggested Behavioral Health System Goals for Virginia*
- *Why Invest? ROI for Community Investments*
- *Other Critical Items Related to the Community Services System*
- *Supportive Documentation*

The **Introduced Budget** addresses some of the existing long-term community needs for both crisis response and needed community services that can prevent crises as well as initiates a relatively new and positive direction for youth services:

A. Community services for teens <u>as they transition to young adults roles</u> by addressing:
- Early assessment,
- Intervention and treatment of the child and the family unit
- Peer support and family peer support as part of the overall strategy.
- Provides direction for policy and funding.

B. Expansion in the number of Programs of Assertive Community Treatment (PACT) bringing the number of PACT up to 18 programs, each of which can support 80-100 individuals with the most serious mental illnesses and complex conditions.

C. Expand peer support recovery programs, which are evidence-based and consumer oriented.

D. Expand telepsychiatry so that all CSBs can bring expert assessment and follow-up treatment to many more individuals than with face-to-face strategies.

E. Maintain the unique community effort in the Martinsville area that has wrapped substance use treatment, health services, and employment around individuals with severe addiction, countering the substance use and unemployment problems there. This is a partnership among the Piedmont CSB, economic development, safety net health providers, and employers.

F. Expand number and availability of secure crisis assessment centers, often called CIT assessment centers to another 12 through the biennium. Typically awarded to localities that have:
    - CIT-trained officers and supportive law enforcement commitment,
    - Willing hospitals or other facilities,
    - Strong partnerships already in existence,
    - *Funding is not adequate for "grounds up" centers.*

G. Fund extension of Temporary Detention Order up to 72 hours with a 24 hour minimum: a recommendation of the Commission on Mental Health Law Reform since 2008.
    - Lengthened detention can better stabilize individuals, develop treatment planning for community follow-up, and often avoid inpatient commitment.

The VACSB supports each one of these provisions in the Introduced Budget and requests your support of them and/or additions to them.

Gaps in Services for Behavioral Health

A. Lack of Discharge Assistance Plan (DAP) funding:
    - Assists the transition from state psychiatric hospitals to community living with highly-individualized plans of care and support:
    - Frees up state hospital beds to be used most effectively.

B. Lack of increased services overall for substance use disorder, especially:
    - Lack of detox capability to begin the recovery process
    - Lack of strong and appropriate community recovery supports and wrap-around.

C. Lack of sufficient funding to develop needed crisis and treatment assessment centers in areas of the Commonwealth where provider and hospital resources are limited. This gap exists for both youth and adults.

D. Lack of funds to replicate the successful community effort for recovery and employment to other areas of southwest Virginia where the problem has existed for years, but highlighted about 10 years ago with the abuse of prescription drugs.

E. Lack of attention to evidence-based youth violence prevention programs that allow customizing of local risk factors for youth violence programing.

F. Lack of sufficient funding for peer support and family peer support:
    - Peers specially trained to help use their "lived experience" to assist individuals in recovery-focused supports.
    - Peers can support the workforce and provide a bridge to treatment and improved wellness. In CSBs, peers are well utilized in crisis and long-term community programs. Unfortunately, funding constraints prohibit adequate utilization.

Suggested Goals to Strengthen Virginia's Behavioral Health Policy and Funding Direction

Place highest priority on strong and consistent attention to and funding for a continuum of community services in all areas of Virginia that recognizes issue, intervenes early, *avoids crises*, reduces law enforcement involvement, and improves use of hospitalization when it is needed.

In order to assist Virginians with recovery and independence, establish as policy and funding goals:

- Fund one PACT program for each CSB and assess those localities who need more than one PACT.
- Participation by all law enforcement agencies in CIT training. Assure that a percentage of officers are trained so that every shift is covered by a CIT officer.
- Every locality with CIT-trained officers will have access to a secure CIT Assessment Center, whether hospital-based or not.
- Include peer support/family peer support in all phases of community treatment.
- Promote consistent state wide access to: suicide prevention programs, Mental Health First Aid (or derivatives), and Youth Violence prevention and prevention of youth high-risk behaviors, including substance use.
- Promote and consistently support strategies such as the use of Psychiatric Advanced Directives, which outline health care agents and treatment preferences during crises, but have even greater value in helping individuals understand their crisis triggers and avoid them.
- Promote coordination of behavioral health with primary and specialty care whenever possible.
- Build upon the strong community system that has evolved in Virginia and strengthen it by utilizing all human, fiscal and provider resources to assure capacity for services statewide, regardless of geography.
- Face the reality that services cannot rely upon targeted funding streams for solution but Virginia will have to braid all funding streams to assure capacity state-wide. *Twenty-five percent (25%) of Virginia's population will or do experience mental disorders and these conditions do not pick and choose those of certain incomes, insurance eligibility, race, age or genders.* All reimbursement funding streams should be available for use. Private and public coverage will not reimburse critical housing, employment, outreach, coordination, and wrap-around recovery supports.

Why Invest? Outcomes of Successful Programs proving the return on investment:

PACT, often called a "hospital without walls".

- Sixteen PACT programs serve approximately 1600 individuals with the most intractable symptoms of serious mental illness, many with substance use conditions.
- Most participants in PACT have lived for long periods of their lives in state psychiatric facilities at an expensive annual cost, today at $230,000 per bed per year. The average PACT cost is $15,000 per person per year with medication and housing to be added to that cost.

- With wrap-around services and consistent outreach and attention by the 10 member PACT team, individuals live in their communities, rarely, if ever defaulting to crisis or to arrest.
- Services include intensive case management, comprehensive treatment, individualized supports, outreach, engagement on a daily basis, health, nutrition, safety, wellness and recovery.

Supporting documentation includes PACT information.

DAP funding has proven to be an exceptionally successful strategy and has been used, since the 1990's, as a result of Department of Justice investigations in Virginia's state psychiatric facilities, for individualized treatment and support plans for individuals leaving state hospital beds.

- DAP plans are individualized to the need of the consumer, who does not have to "fit into" a specific program,
- Public psychiatric beds are able to be used most effectively.

CIT Assessment Centers: Outcomes from two of the General Assembly-funded CIT assessment centers are described in the supporting documentation. It is important to note that funding allows these two, Henrico and Richmond/Chesterfield, to operate 12 hours a day involving:

- CIT-trained officers in the community;
- Hospital-based secure transfer of custody to an off-duty CIT trained officer at Center,
- Law enforcement officers involved in ECOs able to be back to their jobs quickly,
- Thorough assessment for behavioral health and medical needs,
- Variety of diversion strategies or eased access to a TDO bed.

NOTE: No state-funded CIT Crisis Assessment Centers have been 'grounds up" operations. Additional funding would be needed for many localities to develop such a Center, especially in rural areas; however, the return on investment warrants the funding.

Other Critical Items for the Community System

- The DOJ Settlement Agreement began a new approach for Virginia's communities, an approach that demands attention to the need for resources in communities. Longer case management for facility transitions, start-up funds for those targeted for transition each biennium, and critical nursing support in each CSB catchment area are necessary ingredients if the community effort to implement the Agreement is to be successful.
- Earliest prevention of disabling conditions begins with Early Intervention Part C services for infants and toddlers with disabilities and delays. The first three years of life set the stage for the infants' futures. Providing services during this time saves millions in education, health, juvenile justice and welfare costs.

Supporting Documentation:

- CIT Assessment Center Outcomes
- Highlights of UVA April, 2013 Survey of all Face-to-Face Evaluations
- PACT Information (DBHDS Source)
- CSB FY 13 People and Services Summary (DBHDS source)

Outcomes of Local Crisis Receiving Centers/CIT Assessment Centers

Crisis Receiving Center in Henrico Area CSB-Received funding of $210,000 from the 2012 General Assembly

Henrico County has had an on-going, active and highly participatory CIT program for all law enforcement officers, first responders, resource officers, and other employees who interact with the public on a regular basis. Having CIT trained officers was a factor that assisted the funding award. The CRC is located in Parham Doctors Hospital.

Numbers of Individuals through Henrico CRC

- The total number of people seen at the CRC since 12/3/2012: 729 individuals.
- The total number seen under an Emergency Custody Order (ECO): 625 individuals.

Law Enforcement Time Involved and Saved

- Prior to the CRC, 2 officers were utilized for an ECO for 4-6 hours (minimum) for a total of 8-12 manpower hours for an approximate average of 10 hours per ECO.
- At the CRC, transfer of custody is typically completed within 1 hour for a total cost of 1 manpower hour (the secondary officer is typically released within 5 minutes of arrival at the CRC).
- The total savings per ECO situation is then 9 hours.
- Multiply 9 hours by 625 = a total savings of 5,625 manpower hours.
- The average cost per hour of police work is $35 per hour.
- Total approximate savings to Henrico Police is $196,875 since 12/3/2012.

Operation:

- For this Fiscal year, the Henrico CRC operates 12 hours a day from 10 am-12 midnight. Once one-time funding from another source has ended, the hours of operation will go to 12 hours per day from 12 noon to 12 midnight.

Dispositions:

- Approximately 64% of those seen at the CRC under an ECO were detained to an inpatient facility (TDO).
- Prior to the CRC the TDO rate was approximately 74%.

• The remaining 36% were: either hospitalized voluntarily (approximately 12%); or diverted from hospitalization (approximately 24%). Of those diverted from hospitalization the possible dispositions include safety plans and hospital medical admission.

Crisis Triage Center in Richmond/Chesterfield-Received funding from the 2013 General Assembly of $281,000.

Numbers Served:

- The Crisis Triage Center at Chippenham Hospital opened on October 1, 2013 with the official "ribbon cutting ceremony" taking place on December 18, 2013
- Since opening on October 1st, 73 individuals have been evaluated at the CTC
- 100% of the cases involved individuals evaluated on an ECO and in the custody of law enforcement

Law Enforcement Time Savings

- Prior to the CTC opening, 2 officers could be involved with an ECO for anywhere between 3-6 hours. This does not include the additional time required for medical clearance after a TDO was obtained from the magistrate.
- The "road officers" now transfer custody to a specially trained CIT officer at the CTC. Typically transfer of custody is accomplished in less than 30 minutes.
- As a result, law enforcement reports that the CTC has saved at least 3 hours per officer for each person brought to the CTC on an ECO

Operation:

- The CTC is open for 10 hours a day, from 2pm to midnight 7 days a week
- Clinical staff have been recruited and hired jointly by RBHA and Chesterfield CSB. The CIT trained officers are hired by Richmond Police Department.
- The CTC is a multi-jurisdictional CIT assessment center. It serves the City of Richmond and Chesterfield County in partnership with HCA Chippenham.
- Efficiencies also result from having a Polycom that enables direct communication with the Magistrate's Offices in Richmond and Chesterfield. Orders are printed out directly at the CTC (saving officers travel time to and from the Magistrate's Office).
- The CTC operates with a monthly CTC Oversight Group consisting of members from police, RBHA, Chesterfield CSB, HCA Chippenham, magistrates, and two advocacy affiliates, NAMI and FACES.

Dispositions:

- Of those evaluated at the CTC, approximately 75% have required a TDO, 15% have been voluntarily admitted and 10% have been diverted from hospitalization
- There have been no injuries to officers or consumers at the CTC
- The CTC allows for integrated care, with medical clearance and mental health evaluations occurring simultaneously in a safe environment with police presence.

Highlights of UVA Summary of April, 2013 Face-To-Face Emergency Evaluations by all CSB Clinicians

- Total of 4,502 face to face emergency evaluations for 4278 unduplicated individuals
- Almost 15% involved minors
- ***40.7% of the evaluations involved individuals who were not receiving treatment
- ***27.3% of individuals were in law enforcement custody
- ***Involuntary action was recommended for 40.2% of the individuals, meaning that CSB clinicians were able to divert to other services/resources in their communities
- Of those recommended for involuntary action, 96.5% were granted a TDO
- In 88.2% of cases, a psychiatric was located within 4 hours
- In 8.4% of cases, a psychiatric bed was located in between 4-6 hours
- In 3.4% of cases, more than 6 hours were needed to locate a psychiatric bed
- 85.2% of individuals were detained in a psychiatric bed within their regions
- 14.8% of individuals were transported to hospitals outside the region
- ***In 25.8% of cases, involuntary hospitalization could have been avoided if services were available within the region
- Immediate psychiatric/medication evaluation, partial hospitalization (23 hours or less in a safe treatment setting), and residential crisis stabilization were the most frequently endorsed services reported as having the best chance of avoiding hospitalization.

Extrapolation of annual data from the month of April would be reasonable since April is considered to be a representative month.

Collaboration with Communities:
PACT & ICT
Programs for Assertive Community Treatment (PACT) and Intensive Community Treatment (ICT)

PACT is a service-delivery model that provides comprehensive, locally based treatment for people with serious and persistent mental illnesses. PACT recipients receive the multidisciplinary, around-the-clock staffing of a psychiatric unit, but within the comfort of their own home and community.

The PACT team provides these necessary services 24 hours a day, seven days a week, 365 days a year. Sometimes, a client's dedication to a new way of life results in a high-level of independence, while others will continue to need the intensive care, as Chris has experienced.

Chris graduated from Hopewell High School where he played varsity football. His mother characterized him as shy, caring and helpful but in his senior year he became withdrawn and guarded, isolating himself from others, but his mother attributed the behavioral changes to "teenage moodiness". His behavior didn't change and at the time Chris was referred to **District 19 CSB**'s PACT program in 2007, he could have been described as a "hermit", locking himself in his room all day only to surface in order to eat. Chris paid no attention to his personal hygiene or appearance, wearing soiled clothing for days, letting his hair and beard grow, totally unaware of his appearance. He was habitually non-compliant in his treatment, not speaking to his case manager or taking his medication and denying any mental illness.

In 2010 Chris experienced an episode of severe psychosis resulting from medication non-compliance and treatment refusal. He became extremely paranoid, assaulting his mother and brother with a screwdriver and was admitted to Central State Hospital.

In 2011, Chris was referred back to District 19 CSB's PACT team. and has been fully compliant with all treatment recommendations. He moved from an assisted living facility to a supervised independent living environment. Chris attends the Sycamore Center daily, participates in weekly socialization outings with the PACT team and is a member of the "I-Work" program where he is currently looking for employment through the assistance of his DARS job coach.

Community Outcomes — FY 2013
Of 1,672 individuals served in 19 sites:
- **94% had no arrests**
- **87% had stable housing**
- **74% lived in private households**
- **9% had some employment experience**

Diagnoses of the 1,672 individuals served:
- **73% had a diagnosis of schizophrenia**
- **13% had a Bipolar Disorder diagnosis**
- **12% had other MI diagnoses or unknown**

Of the 1,672 individuals:
- **35% had a co-occurring substance abuse diagnosis**
- **19% had a co-occurring medical problem**
- **7% had a co-occurring personality disorder and**
- **2% had a co-occurring intellectual disability diagnosis**

State Hospital Outcomes: FY 2013
101 state hospital beds were reduced as a result of PACT and ICT programs

PACT/ICT locations:
Arlington County Community Services Board
Blue Ridge Community Services Board
Horizon Behavioral Health
Chesapeake Community Services Board
Chesterfield Community Services Board
Danville-Pittsylvania Community Services Board
District 19 Community Services Board
Fairfax-Falls Church Community Services Board
Hampton Newport News Community Services Board
Hanover Community Services Board
Henrico Area Mental Health and Developmental Services-(2 locations)
Mount Rogers Community Services Board
New River Valley Community Services
Norfolk Community Services Board
Prince William Community Services Board
Richmond Behavioral Health Authority
Region Ten Community Services Board
Valley Community Services Board

PEOPLE and SERVICES - FY 2013

Services - FY 2013	Mental Health Services Individuals Served	Developmental Services Individuals Served	Substance Use Disorder Services Individuals Served	Services outside a program area Individuals Served
Emergency Services				58,300
Assessment/Evaluation				57,197
Early Intervention				2,429
Motivational Treatment				4,541
Consumer Monitoring				7,685
Inpatient Services	2,002		276	
Outpatient	96,556	645	28,679	
Case Management	57,341	18,466	10,166	
Day Support/Partial Hospitalization/Rehab	10,779	2,624	767	
Sheltered Employment	37	598		
Individual Supported Employment	1,169	934	53	
Group Supported Employment	76	423		
Residential Services	12,216	2,709	6,691	
Total individuals receiving services within program area (may have received more than one service across program area)	180,176	26,399	46,632	
Total unduplicated individuals receiving a service within program area	**112,121**	**20,248**	**34,382**	
Total individuals served outside program areas - not including emergency services (may have received more than one service)				**71,852**
Total unduplicated individuals receiving a service outside program area (not including emergency services)				**67,735**

TOTAL UNDUPLICATED COUNT: Individuals receiving services statewide: 213,902 plus 11,442 infants and toddlers served by CSBs/BHA and another 4,081 served by other Infant and Toddler Program Connection local lead agencies.

ID Waiting List as of 11/4/2013	Urgent	Non-Urgent	Total
	3,755	2,805	6,560

Mental Health (MH) and Substance Use Disorder (SUD) Waiting Lists as of April 2013	Receiving CSB Services	Not Receiving CSB Services	Total
Adult MH	2,646	572	3,218
Children and Adolescents	895	373	1,268
Adult SUD	507	514	1,021
Adolescent SUD	51	32	83

Prevention Services	Consumers Served Duplicated	Consumers Served Unduplicated	Service Hours
Multiple Classroom		38,210	22,959
Recurring		15,825	65,640
Single Events	897,972		46,782
Total	897,972	54,035	135,381