

# **Senate Finance Retreat**

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## **Response to Virginia Tech Tragedy**

*Comments by Marilyn B. Tavenner  
Secretary of Health and Human Resources*

### **Introductory Comments**

- On April 16, Virginia experienced one of its worst tragedies in modern history. The shootings at VA Tech were horrific -- for the victims, for the families and friends of those who were killed or injured, for the university community, and for the Commonwealth as a whole.
- We have all struggled to understand how and why this could happen.
- Because of the magnitude of the tragedy and fact that the individual determined to have been the shooter was himself a Va Tech student with an apparent history of mental health problems and treatment, the incident has received very extensive examination --
  - by multiple law enforcement and mental health oversight organizations, including the Office of Inspector General for the DMHMRSAS;
  - most prominently, by the Virginia Tech Review Panel appointed by Governor Kaine; and
  - ultimately, by the Administration at many levels.
- As a result of these investigations, we have a clearer understanding of some of the “gaps” -- in our campus security and communications systems, in our system for mental health diagnosis and treatment, and in our ability to respond to the aftermath of such events.
- It has been our challenge as an administration to determine how to fill those gaps with the resources available to us.

## Response

- Before I turn to the initiatives implemented and proposed in response to the Virginia Tech tragedy that relate specifically to health and mental health services, allow me to mention briefly just a few other initiatives implemented under other secretariats and their agencies:
  - On August 13, 2007, prior to the commencement of the fall semester, the Administration hosted the first *Governor's Campus Security Conference* at VCU's Siegel Center. It allowed representatives of Virginia's public and private universities and colleges – administration, campus security, emergency management, IT, health, and counseling personnel, along with state and local law enforcement agencies and private vendors -- to share information about campus security strategies and technologies. This will become an annual conference, expanding in the future to take a look at all-hazards preparedness on our university and college campuses.
  - In addition, the *Virginia Higher Education Preparedness Consortium* has been established to promote collaboration among higher education institutions, with a focus on academic, research, and operational elements of preparedness.
  - Further, the Department of Criminal Justice Services' Office of Campus Policing and Security (OCPS) is clarifying the roles of campus police and security personnel and will develop specialized training for both police and security officers on Virginia campuses. They will offer related training to campus administrators, resident advisors and campus housing officials and provide administrative and technical assistance to their campus partners.
- Turning to the initiatives and recommendations pertaining more directly to the HHR agencies -- -- You are well aware of the extensive investigation of the Virginia Tech shootings by the Governor's Review Panel and the recent reviews conducted by the Office of Inspector General (OIG). Both inquiries provided great detail about where the Commonwealth needs to expand services, particularly mental health services. Their findings and recommendations touched several areas, and in some cases, their recommendations have already been implemented.

- **Office of the Chief Medical Examiner**
  - Recognizing that the Chief Medical and her staff responded to the challenges of the Virginia Tech tragedy both expertly and professionally under difficult circumstances, the need for a number of procedural and programmatic changes has become apparent. Many of the needed changes have already been implemented:
    - State agencies, with DSS and VDEM in lead roles, will develop protocols for establishing Family Assistance Centers in response to mass casualty events.
    - VDH will ensure that several public information officers, well-versed in ME operations and victims' services, are available to deploy in needed events -- to both assist victims and ensure that media requests are managed effectively.
    - In mass casualty events, the state's Chief Medical Examiner should be managing the response, not performing postmortem exams.
    - OCME will routinely participate in disaster and national security drills to plan more effectively for ME operations.
    - VDH should continuously recruit board-certified forensic pathologists and other specialty positions to fill vacancies within OCME.
    - Critical incident stress management and counseling services will continue to be provided to EMS and other first responders.
  - Specific resources will be required, however, to ensure an appropriate level of services by the OCME:
    - Salary realignments for the CME and forensic pathology staff
    - Additional staff positions within the OCME
    - Additional medico-legal death investigator staff positions under the OCME

○ **Access to Mental Health Case Management**

- The caseloads of our CSB mental health case managers currently average just under 40 cases per case manager. Nearly all (37 out of 40) of the local CSBs have case manager caseloads that exceed the nationally recommended average of 25. There are case managers carrying caseloads as high as 71.
- Consequently, at many CSBs, direct service time with consumers is too limited and record-keeping consumes a high percentage of work hours.
- Reducing case manager caseloads has two potential benefits:
  - It allows an increase in the intensity of case management, thereby preventing many consumer crises. Fewer crises decrease the demand for more restrictive and expensive services such as inpatient treatment.
  - Second, if changes are to be made in the commitment process, including providing an option for court-ordered involuntary outpatient treatment, it will be critical that the CSB case managers provide the level of support necessary to monitor and coordinate care. Mental health case management is needed to ensure an effective response to both the consumer and the courts.

○ **Access to Mental Health Outpatient Services**

- Both the investigation by the Governor's review panel and a recent statewide survey of CSB outpatient capacity by the OIG confirmed that outpatient treatment options are extremely limited throughout the Commonwealth. This is true for both outpatient counseling and outpatient services provided by a psychiatrist.
- The average wait time for outpatient services in our CSBs:
  - > 30 days for adults and 37 days for children to see a counselor
  - > 28 days for adults and 30 days for children to see a psychiatrist

- About half of CSBs have experienced a decrease in their outpatient capacity over the past decade
  - Outpatient service capacity varies tremendously across the 40 CSBs. Staff vs. population ratios range from:
    - 0 to 9 FTE's per 50,000 population for adults (2 CSBs do not offer OP services to adults); and
    - 0 to fewer than 4 FTE's per 50,000 population for children (1 CSB does not offer OPO services to children).
- Consequently, with such limited outpatient treatment capacity in the local CSBs:
    - it is often impossible to provide therapeutic intervention for those with emerging mental health problems;
    - intervention does not occur early enough to prevent crises;
    - some individuals who request services lose interest during the long wait and therefore do not follow through; and
    - it is not possible to meet the needs and expectations of the court system when individuals are committed to outpatient treatment
- **Access to Crisis Stabilization**
    - The investigation of the VA Tech critical incident revealed that it is common for a CSB to experience difficulty securing a willing detention facility when a temporary detention order has been issued. This is consistent with an earlier statewide review of emergency services that identified inadequate capacity for crisis stabilization programs, inpatient services and other mental health emergency services.
      - Over the past several legislative sessions, the General Assembly has increased the number of crisis stabilizations programs. Still, only 12 residential crisis stabilization programs are operational.

- If crisis stabilization programs that accept temporary detention orders (TDOs) are accessible to every community and CSB in the state, delays in locating a willing TDO facility would be alleviated and some of the current pressure on limited inpatient beds (that are more expensive) will also be relieved.
- **Outpatient Commitment**
    - The OIG’s critical incident review included a detailed examination of outpatient commitment and its use in the New River Valley area because the subject of the investigation had been ordered to outpatient treatment by a local special justice.
    - OIG focused on factors that may have supported or impeded successful compliance with the court order and all orders for outpatient commitment statewide. (Details can be found in the full OIG report.)
    - A number of recommendations have been offered based on the findings. I will mention a few:
      - That the Code be amended to require in the court’s or special justice’s order the name of the provider(s) that will deliver the involuntary outpatient services.
      - That the CSB’s responsibility to recommend a specific course of involuntary outpatient treatment, as required in the Code, be further defined by law, regulation or policy.
      - That CSBs (or BHAs) attend all commitment hearings. This is not currently required.
      - That it be clarified who has the duty to:
        - Locate an outpatient provider to provide court-ordered treatment
        - Ensure that the designated outpatient provider understands his/her responsibilities to the court
        - Arrange the initial outpatient appointment
        - Provide a copy of the court order to the provider

- Notify the CSB/BHA of the outcome of the commitment hearing if they are not present
- That the law also clarify what actions should be taken by the CSB/BHA or provider if the individual ordered into treatment fails to comply – and clarify what role the CSB/BHA has for monitoring treatment by an independent provider.
- That the law clarify the criteria for the court or special justice to hold a second commitment hearing if the persons fails to comply with the initial outpatient treatment order.
- That the criteria for emergency custody and temporary detention be changed to lower the threshold for someone to be held for involuntary evaluation and subsequent treatment from “imminent danger to himself or others” to “substantial likelihood in near future to cause serious harm to himself or others . . . or suffer serious harm due to deterioration.”
- That the law establish a minimum length of time for temporary detention to enable completion of an adequate examination, preparation of report and initiation of stabilization treatment.
- That privacy laws be amended to allow for treatment and evaluation information to be appropriately shared. DMHMRSAS and the OAG have collaborated on recommended amendments to the health privacy law and other relevant sections of the Code.

○ **Changes Already Implemented Administratively by DMHMRSAS**

- Development of core service standards, expectations, and outcomes for inclusion in the FY 2009 CSB Performance Contract, including:
  - Emergency response times
  - Service admission criteria
  - Required staff credentials and training
  - Specific mandatory activities, such as attendance at hearings

○ **Resources Required to Improve Level of Mental Health Services**

- Both the examination of events surrounding the tragedy at Virginia Tech and the realization that changes need to be implemented in connection with our *Comprehensive Services For At-Risk Youth and Families* suggest a need for additional resources to:
  - Expand monitoring and accountability of CSBs
  - Provide school-based mental health services
  - Provide expanded outpatient services to children
  - Increase the availability of outpatient clinicians and therapists
  - Increase CSB emergency services capacity
  - *Increase local government and state-pool funding for at-risk youth and families*