Crisis Continuum Implementation and Legislative Updates

VACSB Emergency Services Conference

June 13, 2024

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ten

OCTOBER 1997

Region Ten Community Services Board
Mental Health, Alcohol and Drug, Mental Retardation Services
For Charlottesville and Albemarle, Fluvanna, Greene, Louisa and Nelson Counties

REGION TEN EMERGENCY SERVICES

by Buzz Barnett

When many of Region Ten's staff have finished up a long week late Friday afternoon, checked the voice mail one last time, and head out the door for a nice restful weekend, the Emergency Services Team kicks into high gear. Weekends, particularly Friday and Saturday nights are extremely busy times for the on call staff of clinicians who respond to psychiatric and substance abuse crises in our region. Using a combination of pagers, cellular phones, and our answering service, two staff, one primary and one backup, respond to phone crises from consumers and family members, as well as heading out to local emergency rooms, psychiatric hospitals, the jail, and our Emergency Custody Order evaluation site, to perform face to face evaluations that typically take 2-3 hours each to complete.

The Emergency Services Team as a whole consists of five full time staff who work various shifts throughout the week as well as contracted on call clinicians, who work several shifts a month, usually during the weekend. During fiscal year 1997 the team conducted 1,563 crisis evaluations. Approximately 40% of these evaluations involve individuals brought in on Emergency Custody Orders (ECOs) by the police. ECOs are civil legal orders issued by the magistrate which allow the police to detain for up to four hours an individual who is thought to be an imminent danger to self or others as a result of mental illness or unable to care for self as a result of mental illness so an independent evaluation by a qualified examiner appointed by the local Community Services Board can be conducted.

These evaluations are usually fairly controversial and clinically challenging. The valid, but at times conflicting interests of the consumer, the family, and the community are expressed and debated during this time. First and foremost the intent of the law and the civil rights of the consumer must be observed. Emergency clinicians are put in the challenging position of making risk assessments and predicting dangerousness. Those who are evaluated on the Emergency Custody Order can either be released and returned home, hospitalized on a voluntary basis, or detained for up to 48 hours against their will in a locked local psychiatric facility prior to a formal commitment hearing before a Special Justice.

Should an individual who threatened suicide earlier in the day but is now feeling better be allowed to go home or be hospitalized against his/her will? What about the individual who has gone off psychotropic medication, is beginning to deteriorate in level of functioning and getting increasingly paranoid, but refusing any help? What about an individual with a history of serious suicide attempts who enters a psychiatric hospital voluntarily, but suddenly wants to leave against the doctor's advice? Should a 16 year old who sets a fire in his/her house after a fight with parents about drug abuse be hospitalized psychiatrically against his/her will or served through the juvenile system? Should an adult who has no health insurance benefits, (approximately 20% of the population nationally) who is seeking an appropriate voluntary admission to a local psychiatric facility be sent home or detained as an involuntary patient? There are no easy answers to any of these scenarios, but clinicians take into consideration a number of complex variables before making a decision. Among them are the accuracy of the

See Emergency Services, page 2

EMERGENCY, From page 1

allegations being made, the current mental status of the individual being evaluated, the availability or lack thereof of less restrictive outpatient alternatives, the consumer's perceived ability to contract convincingly for safety in the immediate future, the support system available to the consumer, impulse control patterns, history of suicide attempts or violence, substance abuse history, and current level of intoxication.

Usually in each evaluation of this sort, someone (consumer, family, community) is initially unhappy with the disposition. Consumer groups complain of inappropriate and unnecessary hospitalizations that violate their civil rights. Family groups express concern about the difficulty in getting a family member with mental illness hospitalized. Neighbors, landlords, and friends can't understand why individuals with mental illness who are creating trouble of some sort in the community can't just be "picked up" and made to receive treatment. Emergency Services clinician always walk a fine line -- attempting to honor and protect the rights of the individual while recognizing the need to intervene at times to protect the individual and society from potential danger.

On a recent steamy summer weekend, two of Region Ten's stellar Emergency Services Clinicians were on call. Katie Heidingsfelder, LCSW, and Allison Campbell, M.S., covered both primary and backup duties from 5:00 p.m., one Friday, until 12 midnight on Sunday. First a sampling of some of the crisis phone calls received throughout the weekend: 1) a caller with "family problems," 2) a caller who kicked out her alcoholic boyfriend and is now worried he can't care for himself because of this drinking, 3) a caller seeking detox from crack cocaine, 4) a psychiatric resident at the University of Virginia wanting to contact our psychiatrist about a client being admitted there, 5) a County Department of Social Services Worker calling about a client abusing alcohol, 6) a friend of a depressed person contemplating suicide, 7) the Jail calling about a suicidal inmate there, 8) a mother from another jurisdiction calling about her son who she believes is suicidal, 9) a weekly supportive phone contact with a consumer who is lonely, 10) Western State Hospital calling about a patient who is on pass and needing to be returned because he is hallucinating.

During this same period of time, eleven face to face evaluations were conducted:

* *A client at the Mohr Center, intoxicated/seeing butterflies and bugs/attempting to leave and taken into police custody for the evaluation.*

* *A patient at the UVA ER being assaultive towards family and staff there with possible seizure disorder and a long history of drug abuse.*

* *A patient at the UVA ER who was visiting family in the area and becoming increasingly manic brought to police attention after nearly getting hit while walking out on the road.*

* *A client from a local Adult Home brought to the ER by police after allegedly overdosing on pills. No overdose, but client threatens to kill self if forced to return to the home.*

**Client with domestic problems brought to ER after making suicide attempt with pills.*

**Client seen at ER after calling Region Ten crisis number and reporting hearing voices and having stuck needles in arm.*

**Client threatened to jump off balcony at a local high rise residence. Brought in for evaluation by County Police.*

**Daughter calls Region Ten about suicide note left for her by her parent. ECO taken out and after lengthy evaluation procedure client eventually agreed to a voluntary hospitalization.*

**ECO evaluation of client recently released from hospital/discontinued meds as soon as returned to community/found waling in front of cars on buy street.*

**Adolescent seen on ECO taken out by parent. Client demonstrating sudden change in behavior since stopping medications. Threatening family members with gun/knife and today assaulted a relative.*

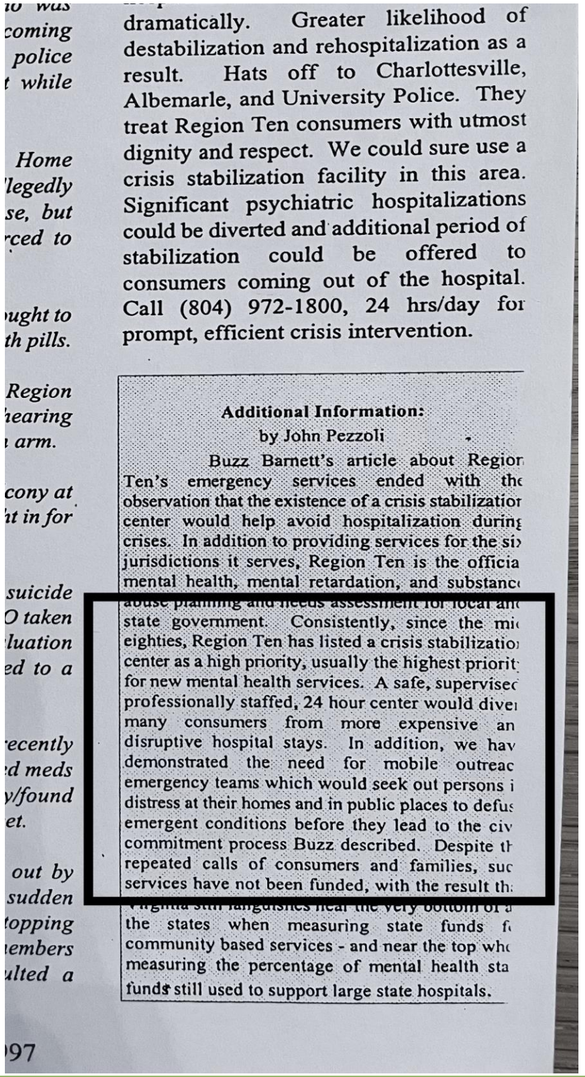
Some General Thoughts About Crisis Work

Generally, the busiest time of the day for crisis evaluations is between 2:00 p.m. and 1:00 a.m. The busiest nights seem to be on Friday and Saturday. Contrary to public opinion, fewer people actually seem to go into acute crisis during major holidays. The week after is another story. Despite an occasional busy spurt, we have yet to reallocate staff for increased crisis during the full moon. Prolonged heat waves seem to activate greater irritability/stress in consumers and staff alike. Because of managed care, length of stay for psychiatric hospitalizations has decreased dramatically. Greater likelihood of destabilization and rehospitalization as a result. Hats off to Charlottesville, Albemarle, and University Police. They treat Region Ten consumers with utmost dignity and respect. We could sure use a crisis stabilization facility in this area. Significant psychiatric hospitalizations could be diverted and additional period of stabilization could be offered to consumers coming out of the hospital. Call (804) 972-1800, 24 hrs/day for prompt, efficient crisis intervention.

Additional Information:

by John Pezzoli

Buzz Barnett's article about Region Ten's emergency services ended with the observation that the existence of a crisis stabilization center would help avoid hospitalization during crises. In addition to providing services for the six jurisdictions it serves, Region Ten is the officia mental health, mental retardation, and substance abuse planning and needs assessment for local an state government. Consistently, since the mi eighties, Region Ten has listed a crisis stabilizatio center as a high priority, usually the highest priorit for new mental health services. A safe, supervise professionally staffed, 24 hour center would dive many consumers from more expensive an disruptive hospital stays. In addition, we hav demonstrated the need for mobile outreac emergency teams which would seek out persons i distress at their homes and in public places to defus emergent conditions before they lead to the civ commitment process Buzz described. Despite th repeated calls of consumers and families, suc services have not been funded, with the result th Virginia still languishes near the very bottom of t the states when measuring state funds f community based services - and near the top wh measuring the percentage of mental health sta funds still used to support large state hospitals.



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Introduction, Page 8

National Guidelines for Behavioral Health Crisis Care

Best Practice Toolkit

SAMHSA
Substance Abuse and Mental Health Services Administration

We must start by defining what crisis services are and what they are not. Crisis services are for **anyone, anywhere and anytime**. Examples of crisis level safety net services seen in communities around the country include (1) 911 accepting all calls and dispatching support based on the assessed need of the caller, (2) law enforcement, fire or ambulance personnel dispatched to wherever the need is in the community *and* (3) hospital emergency departments serving everyone that comes through their doors from all referral sources. These services are for **anyone, anywhere and anytime.**

Similarly, crisis services include (1) crisis lines accepting all calls and dispatching support based on the assessed need of the caller, (2) mobile crisis teams dispatched to wherever the need is in the community (not hospital emergency departments) and (3) crisis receiving and stabilization facilities that serve everyone that comes through their doors from all referral sources. These services are for **anyone, anywhere and anytime.**

Core Services and Best Practices, Page 12

The following represent the *National Guidelines for Crisis Care* essential elements within a **no- wrong-door** integrated crisis system:

1.Regional Crisis Call Center: Regional 24/7 clinically staffed hub/crisis call center that provides crisis intervention capabilities (telephonic, text and chat). Such a service should meet National Suicide Prevention Lifeline (NSPL) standards for risk assessment and engagement of individuals at imminent risk of suicide and offer air traffic control (ATC) - quality coordination of crisis care in real-time;

2.Crisis Mobile Team Response: Mobile crisis teams available to reach any person in the service area in his or her home, workplace, or any other community-based location of the individual in crisis in a timely manner; *and*

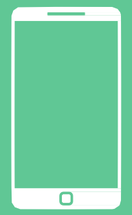
3.Crisis Receiving and Stabilization Facilities: Crisis stabilization facilities providing short-term (under 24 hours) observation and crisis stabilization services to all referrals in a home-like, non-hospital environment.

Although there are many other services that will be incorporated into the continuum of a comprehensive system of care, these three programmatic components represent the three true crisis service elements when delivered to the fidelity of the *Crisis Service Best Practice* guidelines defined in this toolkit. However, crisis systems must not operate in isolation; instead striving to fully incorporate within the broader system of care so seamless transitions evolve to connect people in crisis to care based on the assessed need of the individual.

Governor Youngkin's *Right Help, Right Now* Plan

1. Ensure same-day care for individuals experiencing behavioral health crises
2. Relieve law enforcement's burden and reduce the criminalization of mental health
3. Develop more capacity throughout the system, going beyond hospitals, especially community-based services
4. Provide targeted support for substance use disorder and efforts to prevent overdose
5. Make the behavioral health workforce a priority, particularly in underserved communities
6. Identify service innovations and best practices in pre-crisis prevention services, crisis care, post-crisis recovery and support and develop tangible and achievable means to close capacity gaps

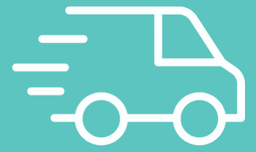
Someone to Call



Crisis Call Centers

When someone calls **988**, a trained crisis worker will provide support such as safety planning, referrals, and a listening ear. If needed, crisis workers can connect to the full continuum of services. Through Virginia's co-responder initiative (Marcus Alert) appropriate calls to 911 can be routed to the 988 call centers.

Someone to Respond



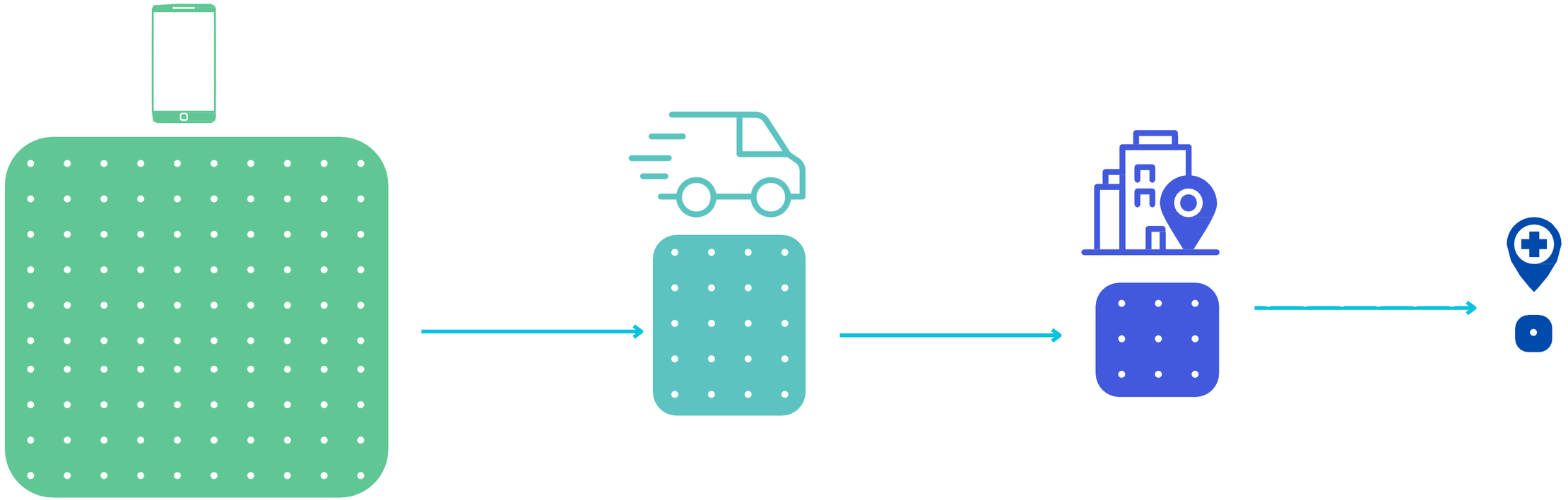
Mobile Crisis

Mobile Crisis Response teams are deployed in real-time, 24 hours a day, to the location of the individual experiencing a behavioral health crisis. These rapid responders provide on-scene evaluation, intervention, and connection to follow-up resources.

Somewhere to Go

Crisis Stabilization Sites

23-hour **Crisis Receiving Centers** and short-term residential **Crisis Stabilization Units** provide a safe, secure community-based environment for assessment, resources, and emergent crisis treatment.



If **100** people call 988, **80** of those calls can be resolved over the phone.

Mobile crisis response can be dispatched for the remaining **20**.

Of those 20, nine may need further treatment at a Crisis Stabilization Site.

Out of those nine, one may require services at a higher level of care, like a hospital, while the other eight return safely to the community.

Individuals in crisis should be matched with the appropriate level of care to meet their needs safely and effectively at that time.

Risk Level

Low — **Moderate** — **High**

Zone of High Variability

Crisis Intervention Continuum

Call Centers

- Peer Warm Lines
- Peer Recovery Centers
- Grief & Other Support Groups
- Community Services Boards Same Day Access
- Transportation Referrals

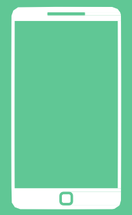
Mobile Crisis

- Behavioral Health & Law Enforcement Co-Response
- Community Based Stabilization
- REACH
- Partial Hospitalization Programs

Crisis Stabilization Sites

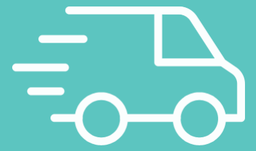
- CPEP
- State Hospitals
- Acute Psychiatric Inpatient
- Medically Managed Detox

Someone to Call



- Nov 6,236
- Dec 7,742
- Jan 8,378
- Feb 8,209
- Mar 9,284
- April 10,266
- May 12,014

Someone to Respond



- 98 Teams across five hubs
- Private providers under MOU also dispatched
- December 15th moved to centralized dispatch via VCC.
- Approaching 6,000 dispatches in that time

Somewhere to Go

- Blue Ridge
- Chesapeake
- Colonial
- Danville-Pittsylvania
- Hampton-Newport News
- Henrico
- Highlands
- Mount Rogers
- Planning District 1
- Prince William/Region 2
- Rappahannock Area
- RBHA
- Valley
- Western-Tidewater

2024 General Assembly Updates

- Legislation
  - HB601/SB543 – Private Health Insurance Coverage
  - HB823/SB497 – Alternative Transportation
  - HB1242/SB546 – Presence of Family during ECO Evaluations
  - HB1269/SB626 – Barrier Crimes
  - HB1336/SB568 – Pharmacy
  - SB34 – Certified Evaluators
  - SB569 – Seclusion & Restraint
  - SB574 – Commission to Study Processes Related to Civil Admissions

- Budget
  - MA funding
  - CIT Funding
  - Mobile Crisis Recruitment and Retention Funding
  - Pharmacy
  - Children's Community Stab Pilot
  - Build out funding

- Public Dashboard & Map at DBHDS.org

Thank You!

J. Curt Gleeson, LPC

Assistant Commissioner, Crisis Services

https://www.instagram.com/joshjohnsoncomedy/reel/C7HO8f9gIGM/