Standard Operating Procedures for Behavioral Health Crises ("Danny's Bills")

The Problem:

- Opioid overdose is a national epidemic, currently killing more Virginians than car accidents.
- 1 in 8 ER visits are due to psychiatric crises in the US.
- The number of patients presenting with psychiatric complaints in the ER has increased by over 50% in the US since 2006.
- Only about 16% of ER physicians report having access to an on-call psychiatrist in the US.
- Between 1970 and 2006, state and county psychiatric inpatient facilities in the country cut capacity from about 400,000 beds to fewer than 50,000.

The Federal Emergency Medical Treatment and Active Labor Act categorizes psychiatric crises as ***equivalent in severity to medical emergencies such as trauma and heart attacks.*** *It is also important to note that according to Virginia Code, Substance Use Disorder is included in the definition of mental illness. Many individuals have to wait for hours in waiting rooms, prompting many who are mentally unstable and/or intoxicated to make erratic and irrational decisions, such as leave the premises and complete suicide, overdose, commit criminal acts, hurt themselves or someone else.*

The Proposed Solution in SB 903 ("Danny's Bill"):

- In response to an overdose or other substance-related emergency:
  - Comprehensive assessment to identify appropriate medical interventions and any secondary psychiatric and/or medical issues.
  - Take-home overdose prevention kit with naloxone
  - Warm handoff to certified peer or case management.
  - Immediate introduction to pharmacotherapy such as a 7-day prescription of buprenorphine

Two Proposed Budget Amendment Requests (bill numbers not yet assigned)

- 1. $300,000 for a planning/feasibility study for pilot program in Winchester area Emergency Department
  - Separate waiting area/immediate diversion (calmer, differently structured environment) from moment of entry once medically cleared.
  - Peer recovery specialist and/or other trained crisis worker to sit with patients and/or be present/accessible in waiting area.
  - Prompt evaluation/assessments – maximum 2 hour wait time.
  - Access to psychiatrist or licensed provider via telemedicine or other means.
  - Case management or other properly trained professionals for referrals, scheduled follow-ups, and transfers (required minimum 3 referrals/resources).
- 2. $300,000 for a planning grant for development of a replicable, sustainable Acute Stabilization Unit/Detox in the Northern Shenandoah Valley

Conclusion:

These standard operating procedures for behavioral health crises would provide cost-effective solutions and improve outcomes, save lives and reduce recidivism. Crisis intervention and stabilization must be made more of a priority in order for the state and our country as a whole to improve our current system by providing a continuum of care. If we are moving away from institutionalized care and transitioning to more focus in the community, then we need the resources and the capacity to support these individuals at the crisis level. These individuals are landing on the streets, in jails, in institutions, and in morgues. We can no longer afford to "treat and street" these individuals.

For questions, contact julie@therecoveryconnectionllc.com or GinnyLovitt@TheCAF.org