Emergency Mental Health Procedures Stakeholders Meeting – 4/26/21

Finalize Transportation Hold and Intervening Professional Proposal

Intervening Professional Update Proposal

- Add; Physician Assistant, Advanced Practice RN, EMS providers
- Remove reference to Transportation Hold from 27-65-105, create separate stand-alone statute
- Require consistent training for intervening professionals
    - How should training be addressed? Frequency? What body delivers training?
        - More stringent and regular training for all professions with the ability to initiate hold
        - Trauma informed
        - EMS should be reconsidered for .5 hold, due to transportation billing and therefore conflict of interest
        - Peers should be involved in training
        - As we develop training, we should collaborate closely with their specific governing bodies to ensure they endorse the training
        - Training should have a focus on clients rights for voluntary treatment
        - training would need to be annually. All intervening professionals tend to have high staff turnover. Training should also continue options throughout the continuum that includes voluntary options.
        - there are different levels or layers of training related to the skills needed to initiate transport, a 72 hour hold, dropping a hold, transferring to a certification, and shifting to a certification as an outpatient, and finally dropping a certification
        - Facilities in cooperation with OBH can assign training to applicable staff. I would like to see annually and mandatory. Would like to see OBH train.
        - Electronic delivery of training, make readily available for anyone to understand the process - transparency
        - How do these professionals demonstrate competency and how does this affect workforce shortages we're already seeing
            - Designated facilities have regulations for training
        - Thought around incorporating training in schooling such as masters programs
            - State variance makes this difficult, would need to be trained in every states law
            - Can we leverage existing infrastructure?
        - Does the state track unnecessary "bad holds"
            - No current recourse
            - How do we define a bad hold
            - Majority of holds don't become certifications

Transportation Hold Update Proposal

- Current criteria in unclear

    - With clinical backing and proper training, this professional should be able to make a determination if a hold is necessary as opposed to passing off the situation to another professional to make the determination
- Create new 27-65-105.5 for transportation holds
- Align new 27-65-105.5 with 27-65-106 (court ordered evaluations)
- Make exclusive to Law enforcement and EMS
- Establish clear hold criteria and process
- Feedback;
    - .5 offers flexibility for clinicians to evaluate and potentially release rather than initiate an M1
    - Need to train these receiving facilities and clarify screening process
    - Can Law Enforcement initiate both M1 and M.5?
        - Currently yes
        - Potential circumstance where LE is only entity able to respond and might not have ability to make informed decision about M1, would rather empower them to get person to clinician for eval rather than utilize justice system unnecessarily
        - Training needs to be comprehensive
        - Involuntary commitment is last resort
    - 2 hours for screening is not enough time for thorough assessment of criteria, need time for communication and connecting with persons formal and informal network
        - Need time for collaborative information to make determination
    - Should there be a time constraint for screening upon arrival at facility?
        - programs will have to be staffed to be able to provide this evaluation in 2 hrs. Our WIC? EDs are quite busy so 2 hrs may be too short
        - we do need some amount of time as the current situation of the transport hold ending immediately on arrival makes for a challenge
        - Can we provide a maximum time frame or "upon completion of initial screening"
        - Putting a time constraint into rule or statute is setting up a lot of providers, EMS or police for failure.
    - Need for clarification on transporting persons out of their community with no follow up plan for return to their community

What was missed?

- Even in metro ED's with a lot of mental health resources, individuals in crisis will be admitted to the ED but may still have to wait to see a mental health evaluator--just solely because of volume of patients and/or staff. This becomes even more difficult in rural/frontier areas where resources are sparse.

What are anticipated outcomes of these proposed changes?

- Need to be thoughtful in proposed trainings and focus on meaningful outcomes